



6th Annual

Family Impact Seminar

February 2011



Briefing Report

Medicaid:

What are States Doing to Control Costs? Are Children at Risk?

The New Mexico Family Impact Seminar
is a service project for the New Mexico Legislature
provided by:

The Department of Extension Family and
Consumer Sciences and the Department of Family
and Consumer Sciences in the College of
Agricultural, Consumer and Environmental Sciences
at New Mexico State University

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Purpose and Presenters

New Mexico Medicaid: *What are States Doing to Control Costs? Are Children at Risk?* is New Mexico State University's sixth annual Family Impact Seminar. Family Impact Seminars- which do not lobby for particular policies – provide up-to-date, objective and nonpartisan solution-oriented research information on current issues that affect families. The Family Impact Seminars are intended for state legislators and their aides, Governor and Lieutenant Governor's Office staff, legislative service agency personnel, and state agency representatives. Briefing Reports supplement the seminars.

One of the ultimate goals of the Departments of Family and Consumer Sciences and Extension Family and Consumer Sciences in the College of Agricultural, Consumer, and Environmental Sciences is to enhance the quality of life for families in New Mexico. To this end, we bring the Family Impact Seminar to New Mexico.

New Mexico Medicaid: *Where Does It Go? What Does It Do? Are Children At Risk?*

Carolyn Ingram is senior vice president at the Center for Health Care Strategies (CHCS). In this role, she leads the organization's efforts to help state agencies maximize opportunities to improve care and coverage presented under health reform. In particular, her work focuses on assisting states in meeting the needs of the expansion population and developing the interface between Medicaid and the health insurance exchanges. She also oversees CHCS' efforts to enhance the leadership capacity of Medicaid directors and other key Medicaid stakeholders to effectively manage and pursue innovations in publicly financed care delivery.

Prior to joining CHCS, Ms. Ingram served as the director of New Mexico's Medicaid program from 2003 through 2010. During her tenure, Ms. Ingram made multiple program improvements that resulted in increased utilization of services and greater quality of care, while at the same time containing program costs and ensuring fiscal accountability for the people of New Mexico.

Ms. Ingram has a bachelor's degree from the University of Puget Sound and is currently pursuing a master's degree.

Medicaid and the New Health Care Reform: *Changes and Connections. Are Children at Risk?*

Laura Tobler is a nationally recognized expert on state health care policy issues. Currently, Ms. Tobler serves as a Program Director for the Health program at the National Conference of State Legislatures (NCSL), a membership organization of the states. She has been with NCSL since 1995 and serves as a lead staff person on policy issues related to Medicaid, health reform, and access to health care. Ms. Tobler has authored many papers, articles, books, and issue briefs on a variety of health topics. She received her Bachelor of Science from Pennsylvania State University and her Master's of Public Policy from Rutgers University.

States' Strategies for Controlling Costs: *Are Children at Risk?*

Vernon Smith is a Principal with Health Management Associates (HMA), where he focuses on Medicaid, Medicare, SCHIP, state budgets and trends in the health care market place. He has authored several reports on enrollment, spending and policy trends in Medicaid and SCHIP, on the Medicare prescription drug benefit, and on state directions to address the uninsured.

Dr. Smith has spoken on these issues before many national and state audiences, including the National Governors Association, the National Conference of State Legislatures, the Council of State Governments, the National Association of State Budget Officers, the National Association of State Medicaid Directors, medical and hospital associations, the National Health Policy Forum, committees of the U.S. Congress, and Medicaid reform groups in several states. He has been a guest on National Public Radio and quoted on these issues in the *New York Times*, *The Washington Post*, *The Wall Street Journal*, *Newsweek* and *USA Today*.

Before joining HMA, Dr. Smith served as Michigan Medicaid director and as budget director for the human services agency during 30 years of public service. He holds a Ph.D. degree in economics from Michigan State University.

For further information on the New Mexico Family Impact Seminar Contact:

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Visit our website at: <http://aces.nmsu.edu/ces/familyimpactseminar>. For further information on bringing a family perspective to policy making, see the Policy Institute for Family Impact Seminars website at: www.uwex.edu/ces/familyimpact/wisconsin.htm.

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Ann Vail, former Department Head of Extension Home Economics and Family and Consumer Sciences/New Mexico State University, for identifying the need for the Family Impact Seminar and providing staff and initial financial resources for its implementation.

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Carolyn Ingram, Laura Tobler, and Vernon Smith for sharing their expertise via their seminar presentations and briefing report articles, so that we can might improve the quality of life for persons living in New Mexico

Sonja Serna, Specialist Information Technology, Extension Computer Support Services, and other department members for their assistance.

The Family Impact Seminar Advisory Committee for providing guidance regarding the Family Impact Seminar:

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MEDICAID:

How are States Controlling Costs? Are Children at Risk?

How did Medicaid get in such a state of emergency? How and when did Medicaid become such a huge percentage of the state's budget? Do other states have the same funding concerns regarding Medicaid? When did Medicaid become the health provider of all? Where did the Medicaid tsunami come from? There are the critical issues facing New Mexico today.

New Mexico experiences many challenges related to poverty. Approximately 25% of the state's children live in poverty. There is only one state with a higher teen pregnancy rate. The state high school dropout rate is one of the highest in the nation. New Mexicans miss more than 1 million meals a year according to a new study.¹ Childhood obesity and diabetes are at critical levels. And with poverty comes many health issues. Medicaid was originally created to provide healthcare for low income individuals, so Medicaid has been a substantial part of the state budget for a long time. Over time, the menu of coverage areas has expanded. All states, including New Mexico, have exercised the option of providing for these additional areas of coverage. However, these were decisions made in healthier economic times.

Since 1992, with the exception of 1995-2000, Medicaid costs have increased by approximately 10% per year.² Nationally, low-income children and families represent about 75% of Medicaid beneficiaries. However, disabled individuals and the elderly represent just one-quarter of the beneficiaries, but account for 70% of the expenditures. This reflects their intensive use of acute and long-term care services. Many of these recipients are dually eligible for Medicare and Medicaid. The percentages in New Mexico are very similar. With the new health care reform, there will be newly eligible categories. Some of these categories will be mandatory, resulting in another expansion of Medicaid.

In New Mexico, we are especially concerned about the coverage of children. Are they at risk with the budget changes ahead? It should be noted that mandatory coverage of EPSDT (early periodic screening, diagnosis, treatment) includes any "medically necessary" services allowed for federal reimbursement. This means that states must cover all optional services available under the federal menu of services for children who need them, even if the state does not choose to cover those optional services for their other Medicaid-enrolled people.

Medicaid accounts for nearly 20% of the average state's budget and nearly 70% of all state health expenditures. In New Mexico, Medicaid uses approximately 27% of the state's budget. As state income figures have declined in recent years, Medicaid expenditures


¹ Study commissioned by a group of New Mexico agencies using a USDA formula to calculate the number of missing meals based in population under 185% of poverty. Study reported by Juan Carlos Rodriguez in the Albuquerque Journal.

² From a survey of all 50 state Medicaid directors


have increased as more individuals became eligible due to job loss and additional categories of coverage. Over 200,000 more were enrolled in New Mexico Medicaid in 2010 than in 1997. As it does nationally, Medicaid in New Mexico funds long-term care for almost one third of those over age 85.

The Legislature must decide how much money the state has available to provide Medicaid coverage. Just like creating a family budget, they have to determine how much of the state's income is available for this portion of the budget. Over the years, many states, not just New Mexico, have added areas of coverage in part because the federal government has provided approximately 40% of the cost. (Medicaid is the greatest source of federal income.) Many states, not just New Mexico, now find themselves in financial crises. The math tells us that the state must provide 60% of the cost of Medicaid. As enrollment numbers and category areas increase, so does the total dollar amount required.

With the new health care reform interfacing with Medicaid, there will be mandatory increases in both enrollees and categories of coverage. The federal government will supply greater than 60% coverage in some areas for a period of time. However, the remainder adds to the total that will be required from the state. The math gives us the picture. It shows us where and how the Medicaid tsunami developed. The Legislature must now determine the safety measures needed to protect New Mexico—and its vulnerable populations—against financial devastation.



***New Mexico Medicaid:
Where Does It Go,
What Does It Do?
Are Children at Risk?***



Family Impact Seminar, Santa Fe
February 3-4, 2011

Carolyn Ingram
Senior Vice President, CHCS

CHCS Mission

To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.

►Our Priorities

- Enhancing Access to Coverage and Services
- Improving Quality and Reducing Racial and Ethnic Disparities
- Integrating Care for People with Complex and Special Needs
- Building Medicaid Leadership and Capacity



Overview

- National Medicaid perspective
- Overview of New Mexico Medicaid program
- Opportunities to better manage Medicaid services in New Mexico
- State budget issues
- Future of the program
 - Medicaid expansion
 - Health reform implications
 - New reform-related funding opportunities

Much is Asked of Medicaid

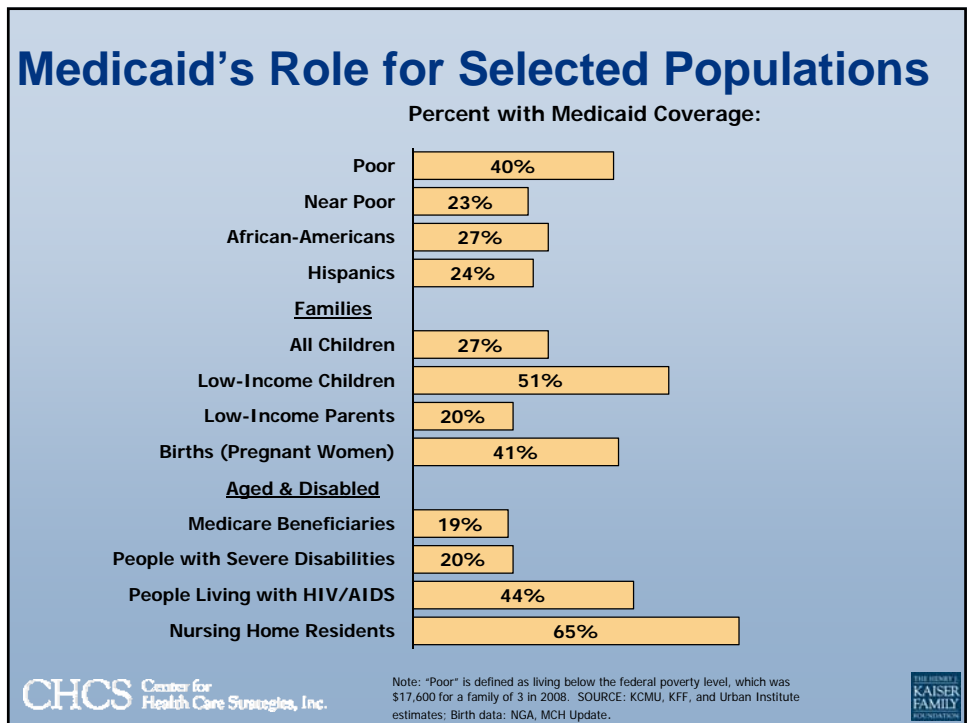
- To assure maternal and child health
- To provide chronic and long-term care
- To finance the safety net
- To fill the gaps in Medicare and cover “dual eligibles”



***America's Largest Health
Coverage Program***

Medicaid Fast Facts

60 million	People in the United States with Medicaid coverage.
\$427 billion	Projected Medicaid spending for FY 2010.
1 million	Medicaid beneficiaries resulting from a 1% increase in unemployment; enrollment increased by 5.4% in FY2009 and is projected to increase by 6.6% in FY2010.
16 - 20 million	Additional Medicaid beneficiaries expected between 2014-2019 through health reform.
41%	Births in the U.S. covered by Medicaid.
27%	Children in the U.S. covered by Medicaid.
50%	Medicaid beneficiaries under 65 who are from diverse racial/ethnic groups.
5%	Medicaid beneficiaries account for nearly 60% of total program spending.
41%	Total long-term care costs in U.S. financed by Medicaid; 34% of all Medicaid dollars used for long-term care.
\$250 billion	Total Medicare and Medicaid dollars spent on the nearly 9 million people who are dually eligible, equaling roughly 46% of all Medicaid spending.



Medicaid is Complex and Challenging

- Medicaid provides multiple services following state and federal laws
 - ▶ No two state Medicaid programs are identical
 - ▶ New Mexico has 49 categories of eligibility and provides approximately 50 different types of services
 - ▶ Some services require co-payments for individuals at higher income levels
 - ▶ States may provide services not normally allowed by Medicaid statutes by seeking waivers

Medicaid Covers Mandatory and Optional Services for Different Populations

Mandatory

- ▶ Inpatient Hospitalization
- ▶ Outpatient Hospital Services
- ▶ Physicians' Services
- ▶ Lab & X-Ray Services
- ▶ Home Health
- ▶ Nursing Facility services for certain individuals
- ▶ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services for Children

No lifetime limits on benefits; but services can have scope and duration limits

Optional

- ▶ Prescription Drugs
- ▶ Eyeglasses & Hearing Aids
- ▶ Organ Transplants
- ▶ Psychologists' Services & other Behavioral Health Services
- ▶ Podiatrists' Services
- ▶ Dental Services
- ▶ Physical, Occupational and Speech Therapies
- ▶ Rehabilitative Services
- ▶ ICF/MR
- ▶ Case Management
- ▶ Emergency Hospital Services
- ▶ Hospice
- ▶ Transportation Services
- ▶ Prosthetic Devices
- ▶ Personal Care

Both Mandatory and Optional Populations are Covered in New Mexico

Mandatory

- SSI (aged, blind, disabled)
- Foster Care (non-IV E), Adoption Subsidy, State Custody
- CMS
- Transitional Medicaid
- Medical Asst. for Preg. Women & Newborns
- Qualified Medicare Beneficiaries & Disabled (QMB)
- Specified Low-Income Medicare (SLIMBs & QI1s)
- Medical Assistance for Refugees
- Emergency Medical services for Undocumented Aliens

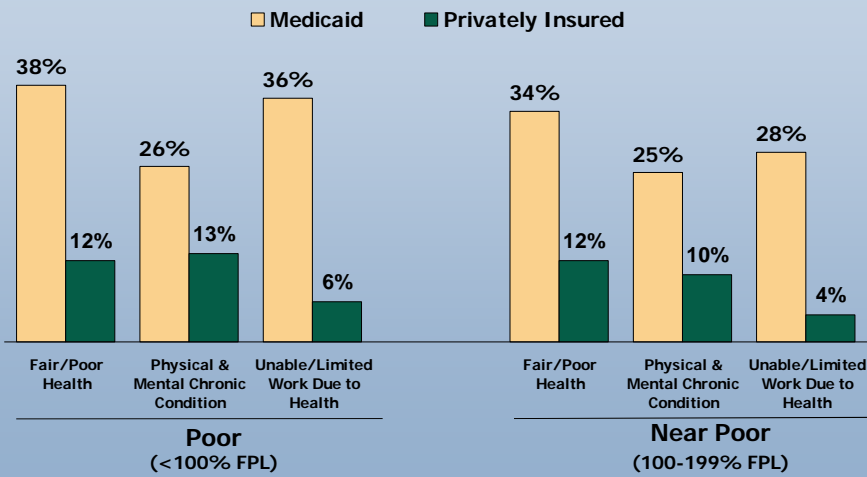
Optional

- JUL Medicaid
- Children 133-185%FPL
- Preg. related 133-185% FPL
- Family planning
- WDI
- Breast/Cervical cancer
- Institutional care aged, blind, disabled
- HIV/AIDS
- Disabled & Elderly (aged, blind, disabled)
- Medically Fragile
- Developmentally Disabled

Who Manages the Program?

- Human Services Department
 - ▶ Physical & behavioral health services, acute & nursing home care
 - ▶ Department of Health
 - Most Home & Community Based Waivers
 - Developmental Disabilities, HIV/AIDS, Medically Fragile, Mi Via
 - FIT Program, Breast & Cervical Cancer, Early Intervention
 - ▶ Children, Youth and Families
 - Children Behavioral Health Programs
 - ▶ Aging and Long Term Services Department
 - Disabled & Elderly Wavier, PCO, PACE,
 - ▶ Public Education
 - School Based Health Programs

Medicaid Enrollees are Sicker and Have More Disabling Conditions than the Privately-insured

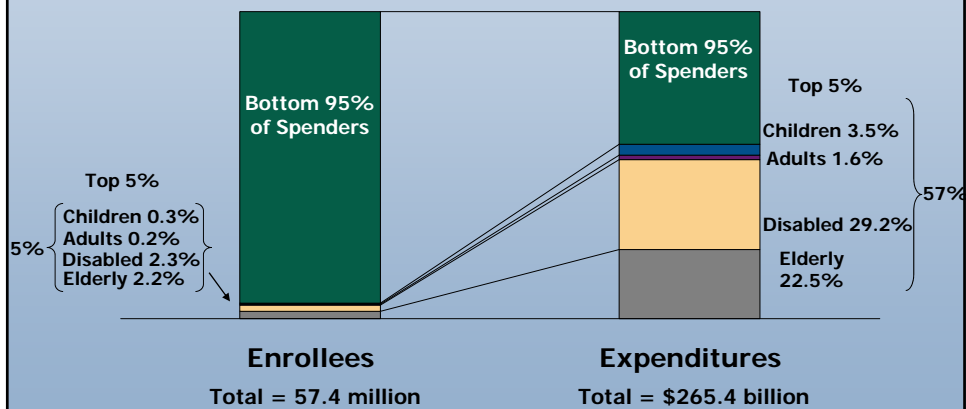


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Note: Adults 19-64.
SOURCE: KCMU analysis of MEPS 3-year pooled data, 2004-2006.



Top 5% of Enrollees Accounted for More than Half of Medicaid Spending in 2004

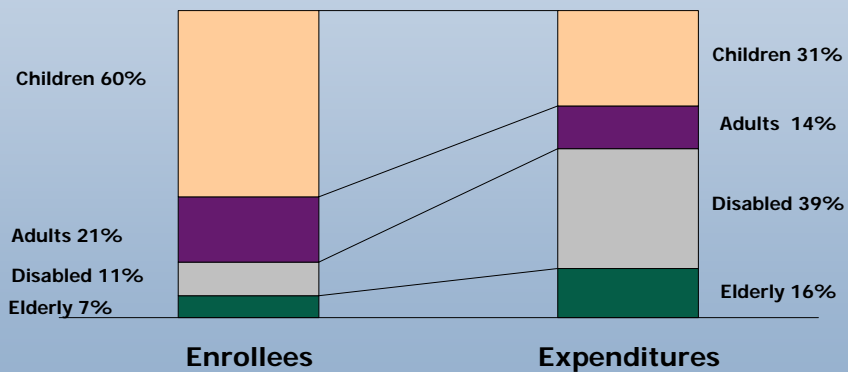


CHCS Center for Health Care Strategies, Inc.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on MSIS 2004.



Comparison Between Enrollment Groups & Costs for New Mexico's Population



CHCS Center for Health Care Strategies, Inc.

SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute FY 2007 estimates based on MSIS.

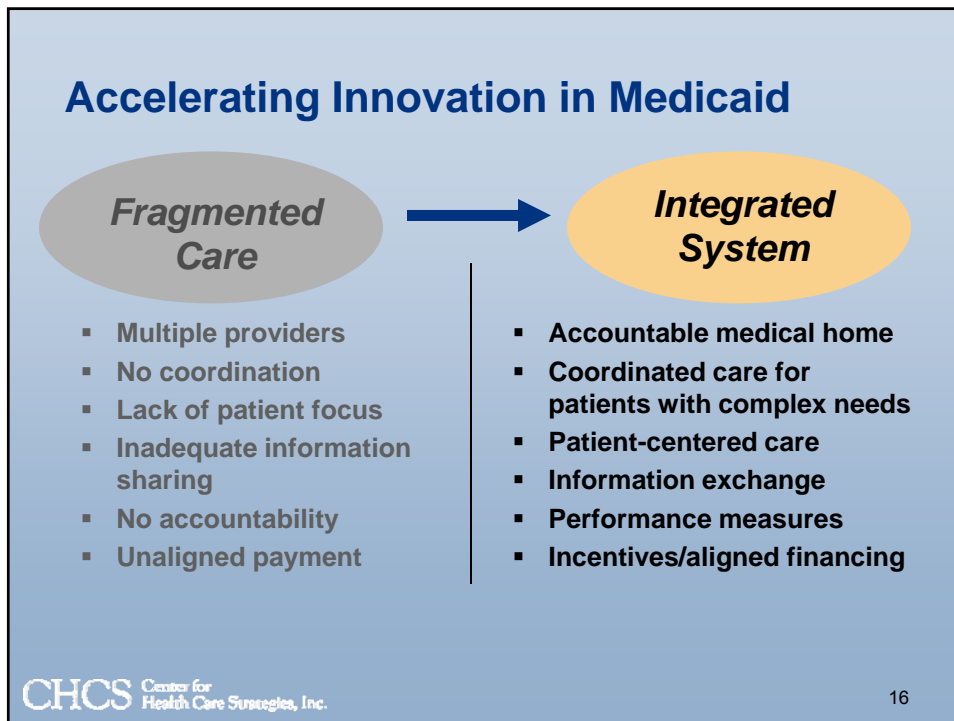
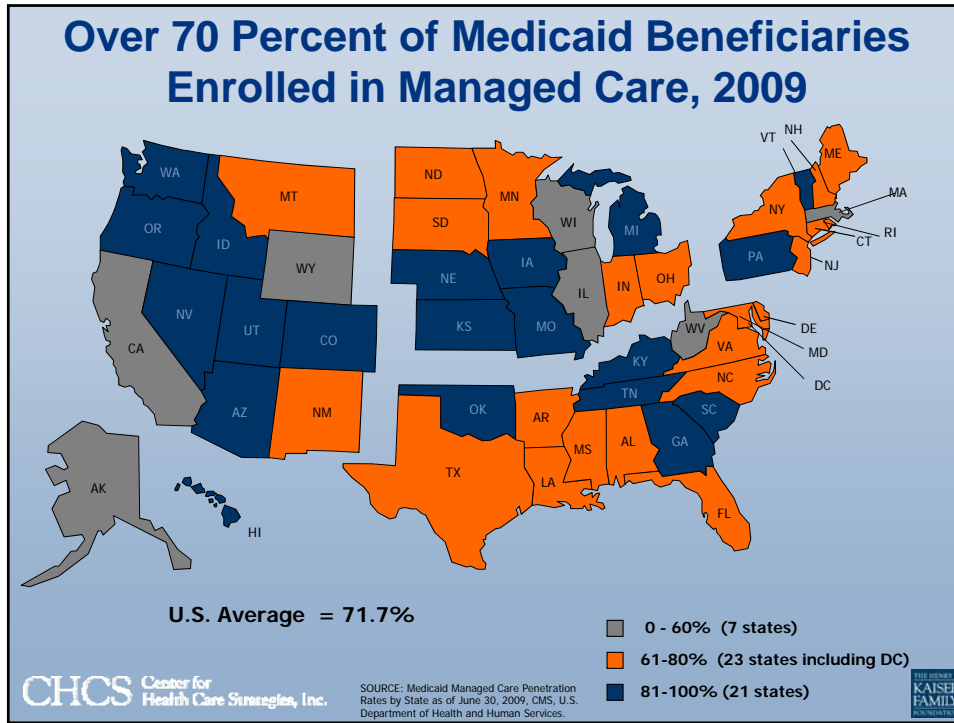


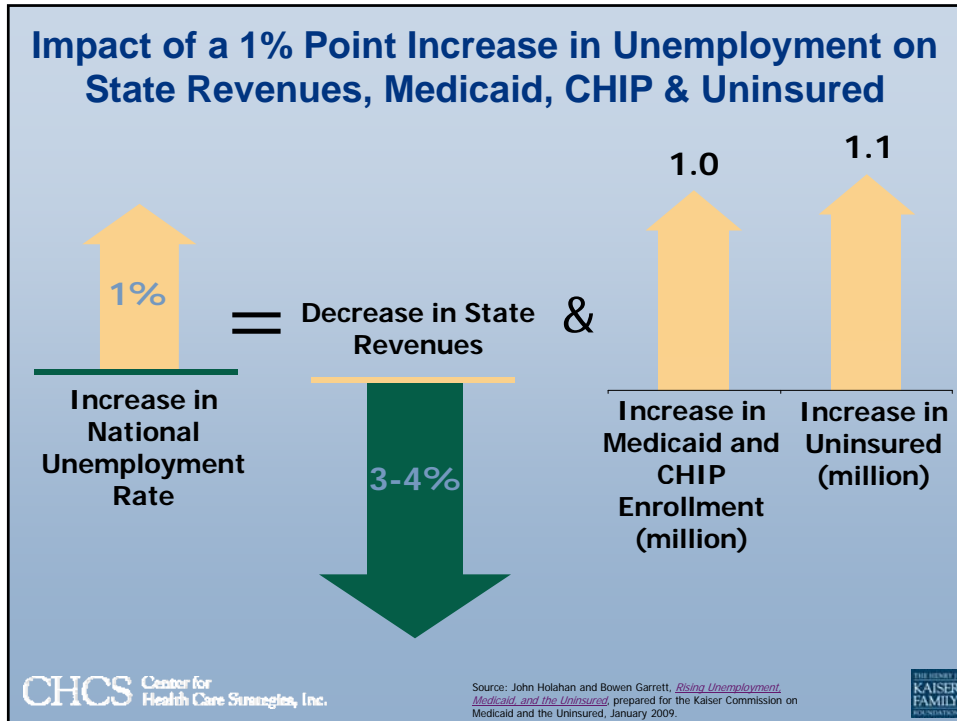
Cost of Chronic Disease in New Mexico

Eligibility Category	Average Monthly Cost Per Member
Family Planning	\$17
Kids up to 235% FPL	\$203 - \$223
Foster Care	\$1,046
Aged, Blind, Disabled	\$1,114 - \$1,853
HCBW Medically Fragile	\$2,092
Breast/Cervical Cancer	\$2,172
Institutional Aged	\$2,628
HCBW (Aged, AIDS, Blind, Disabled, Brain Injury)	\$2,719 - \$3,162
EMSA	\$3,164
Institutional Disabled	\$4,821
HCBW Developmentally Disabled	\$6,857

Children in Medicaid are relatively healthy compared to adult population

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What percentage of the state's budget goes to Medicaid?

- 27% of the state's operating budget
 - Includes state general fund and federal matching funds
- Only 11% of the state general fund
- FMAP cliff
 - Enhanced ARRA FMAP goes away June 30, 2011
 - MOE under ACA restricts changes in eligibility

FACT: About \$280 million of New Mexico's Medicaid budget covers behavioral health services

Current Budget Projections for New Mexico Medicaid

- Projected General Fund Need FY12: *\$1,167,766*
- LFC General Fund Recommendation: *\$1,107,390*
 - Additional GF need: *\$60,376,000*
- DFA General Fund Recommendation: *\$1,118,338*
 - Additional GF need: *\$49,427,000*

National Health Reform Impacts and Opportunities

- Major Medicaid expansion
 - Transition Medicaid from welfare program to insurance program
 - Complicated Medicaid interface with health insurance exchanges
- Exciting grant and demonstration opportunities
- Substantial health insurance reforms
- Implementation challenges may require enhanced state capacity

Medicaid Expansion Funding

- For newly eligible and enrolled Medicaid expansion populations states receive:
 - ▶ 100% FMAP in 2014-2016
 - ▶ 95% FMAP in 2017
 - ▶ 94% FMAP in 2018
 - ▶ 93% FMAP in 2019
 - ▶ 90% FMAP in 2020 and beyond
- States that have already expanded to adult populations receive phased-in FMAP increase reaching 90% in 2020
- In 2015 CHIP match increases by 23% for all states (up to a 100% cap)

Impact on State Budgets

- Maintenance of eligibility (MOE)
 - ▶ Requirement that prohibits states from changing current Medicaid eligibility levels, procedures and methodologies unless declared emergency
 - 2014 for adults; October 2019 for children
 - ▶ Violation of the MOE requirement would eliminate all federal funding for the state's Medicaid program
 - ▶ MOE requirements do not prohibit states from:
 - Eliminating or reducing optional benefits
 - Establishing an enrollment cap for CHIP if federal allotment is exhausted
 - Enhanced waste, fraud and abuse monitoring
 - Reducing provider rates and other cost containment

Funding the Exchange

- Building the Exchange
 - ▶ 100 percent federal funding for planning and building non-Medicaid infrastructure
 - ▶ 90 percent federal funding for Medicaid portion of electronic enrollment system
- Operating the Exchange
 - ▶ Until 2015, federal government will fully fund Exchange costs
 - ▶ Federal government will fund 75 percent of Medicaid electronic enrollment system and 50 percent of other administrative costs

Medicaid Link to the Exchange is Critical

- Seamless and integrated eligibility process for all State health subsidy programs
 - ▶ Intensive partnership is expected between Exchange and Medicaid
 - ▶ No wrong door, consumer-centric, uniform application
 - ▶ Electronic enrollment, renewal, data matching to establish, verify and update eligibility
- New Mexico's existing State Coverage Insurance program:
 - ▶ Creates a valuable platform to support the future Exchange infrastructure
 - ▶ Provides lessons for covering expansion population

Health Reform Financing Opportunities

- Demonstrations to test financing and delivery system reforms focusing on:
 - Medical/Health Homes
 - Multiple chronic disease at 90% FMAP for 2 years
 - Bundled payments around episodes of care
 - Accountable care organizations (ACOs)
 - Eliminate cost-sharing for preventive services (states receive 1% FMAP increase)
- New entities will focus on financing issues
 - Center for Medicare and Medicaid Innovation
 - Federal Coordinated Health Care Office (duals)
 - Allows for 5 year dual-eligible demonstration waivers
 - Medicaid and CHIP Payment and Access Commission (MACPAC)
 - Medicare Independent Payment Advisory Board

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Other Medicaid Health Reform Opportunities

- Increase primary care payments to 100% of Medicare
 - Fully funded at 100% FMAP in 2013 and 2014
- Increase drug rebate for brands to 23.1% and generics to 13% of AMP under managed care
- Prohibit federal match for health-care acquired conditions
- Extend MFP demonstration through 2016
- State plan option for HCBS for individuals up to 300% SSI
 - Option to extend full Medicaid benefits
- Community First Choice Option
 - Attendant supports for individuals with disabilities - 6% FMAP increase for these services (sunset 2016)
- State Balancing Incentive Program
 - Enhanced FMAP for states increasing percentage of HCBS

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What does all this Mean for the Future of the Program?

- Cost Containment
 - Integrating long-term care
 - Payment reform
 - Bundled payments
 - Benefit Structure Redesign
- Opportunities under Health Reform
 - Health Homes
 - Integrated long-term care
 - Payment changes
 - Primary Care Provider Payment Bump

Health Reform Resources

- CMS
 - <https://www.cms.gov/Center/healthreform.asp>
- Health Reform GPS
 - <http://www.healthreformgps.org/>
- Kaiser Family Foundation
 - <http://healthreform.kff.org/>
- National Academy for State Health Policy
 - <http://nashp.org/health-reform>
 - <http://www.statereform.org>
- National Governors Association
 - [Health Reform Implementation Resource Center](#)
- AcademyHealth – State Coverage Initiatives
 - <http://www.statecoverage.org/health-reform-resources>

Visit CHCS.org to ...

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services.
- **Subscribe** to CHCS e-mail updates to learn about new programs and resources.
- **Learn** about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

www.chcs.org

Medicaid Provisions in the Affordable Care Act



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The Forum for America's Ideas



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Medicaid Has Always Been a Cornerstone for Reform

- States have continually relied on Medicaid to meet new demands and initiate reforms
 - Improving infant mortality rates
 - Significantly reducing uninsured rate among children
 - Providing coverage for children with special health needs
 - Providing coverage for those living with HIV/AIDS
 - Covering people with disabilities in the labor market and providing community based long-term care (LTC)
 - Developing new care coordination models
 - Initiating Electronic Health Records (EHRs)
 - And much more.



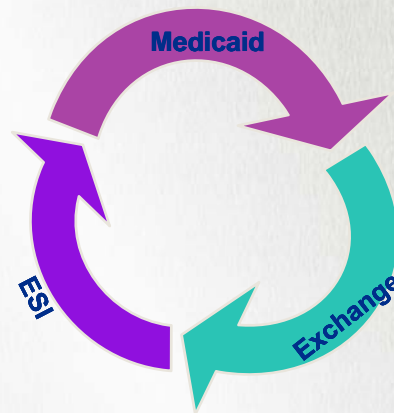
Access Key Provisions

- Expands Medicaid significantly (to 133% FPL)
- Maintains an employer-based system, with employer requirements
- Maintains private insurance market
- Requires most people to have insurance ("individual mandate")
- Creates temporary high-risk pools
- Requires creation of health insurance exchanges, with subsidies for many (up to 400% FPL)
- Requires plans to allow coverage for young adults on their parent's policy.
- Enacts health insurance reforms (e.g., no preexisting condition exclusions)
- Establishes a long-term care program (CLASS) -- community living assistance



A system of coverage per CMS

- Creating a *system* of coverage across Medicaid/Exchange/ESI
- Make "No Wrong Door" a reality





Comparative Data: 2008-2009

State	% uninsured	% < poverty uninsured (nonelderly)	% adults < poverty uninsured	% children < poverty uninsured	% firms that offer insurance
US	17	40	47	17	55
AZ	20	43	47	22	52.1
ID	15	36	50	17	45
NE	12	34	41	20	45.4
NV	20	38	57	30	55
NM	23	42	51	25	51
UT	14	32	40	25	46.4

Poverty Level In 2010: \$10,830 for individual; \$22,050 family of 4

Sources: Kaiser Family Foundation, State Health Facts, from the Census Bureau Current Population Survey



Medicaid Expansion

Establishes a national minimum eligibility level at 133% of federal poverty level (FPL). Effective level is 138% of the FPL with the 5% income disregard.

- In 2010: \$14,941 for individual; \$30,428 family of 3

Questions to ask:

- How many newly eligible individuals?
- How many are currently eligible but not enrolled?
- "How Would States Be Affected by Health Reform?" Jan. 2010, John Holohan and Linda Blumberg say:
 - 182,051 new eligibles or 11.1% pop (7.2%)
 - 99,407 eligible but not enrolled or 6.1% pop (8.9%)



Medicaid Expansion

- Eligibility based on Modified Adjusted Gross Income (MAGI) with no asset tests (exempt: SSI,* child welfare, SSDI,** medically needy, Medicare Savings Programs)
- Adds new mandatory categories of Medicaid-eligibles:
 - (1) Single, childless adults who are not disabled;
 - (2) Parents;
 - (3) Former Foster Care Children (aged-out of foster care, up to age 26) effective 2014.

*SSI: federal Supplemental Security Income

**SSDI: federal Supplemental Disability Income



Coverage for new adults

- According to the law, "newly eligible" individuals will be those adults:
 - with incomes below 133 percent FPL (138% with the 5% income disregard)
 - not eligible for full benefits under the state plan or waiver programs;
 - not eligible for benchmark coverage or benchmark-equivalent coverage;
 - eligible but not enrolled (or were on a waiting list) for such benefits or coverage through a waiver under the plan that had capped or limited enrollment that was full.
 - Waiting on further guidance.
- Provides all "newly eligible" adults with a benchmark benefit package or benchmark-equivalent that meets the minimum essential health benefits available in the Exchange.



Coverage for foster children

- The ACA amends [42USC1396a](#) and establishes a new mandatory eligibility category under Medicaid for former foster children up to age 26 who were in the foster care system when they became 18 years of age (or a higher age set by the state for ending foster care benefits) and were enrolled in Medicaid when they aged-out of the system. Children who qualify for Medicaid through this eligibility pathway will receive all benefits under Medicaid, including Early and Period Screening, Diagnostic and Treatment (EPSDT) benefits. This provision is effective January 1, 2014.

While many states end eligibility for foster children at age 19, New Mexico has already expanded eligibility for foster care children up to the age of 21.

- How does the state identify former foster children for enrollment in Medicaid that have already aged out of the foster care system?



Enhanced FMAP for New Eligibles

Enhanced FMAP for Newly Eligible Enrollees 2014-2020

Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and thereafter	90%

There are special provisions for "expansion states"



Medicaid Expansion Features

Temporary Maintenance of Effort/Eligibility

- Prohibits eligibility changes that are more restrictive than those in place on date of enactment (March 23, 2010)
- Expires in 2014 when the health care exchanges become effective

State Financial Hardship Exemption from Maintenance of Effort

- Governor must certify that state is in deficit or will be in deficit to qualify for the hardship exemption (12/31/2010). No state has applied to date



Early Expansion

- Option for states to begin expansion for certain non-elderly individuals with incomes up to 133% of FPL effective April 1, 2010. Coverage would be reimbursed at the state's *regular* Medicaid FMAP (estimated to be 80.49% for 2010.)
 - Connecticut and Washington, D.C (WA just approved)



Changes for children receiving hospice care.

- The law amends [42USC1396d\(o\)\(1\)](#) to allow children, as defined by the state, who are eligible for Medicaid or the Children's Health Insurance Program (CHIP), to receive hospice care without forgoing any other service to which the child is entitled under Medicaid or CHIP.



Family Planning Services & Tobacco Cessation

- ACA creates a state option to provide Medicaid coverage for family planning services through a state plan amendment to certain low-income people up to the highest level of eligibility for pregnant women upon enactment of the law.
- Effective Oct. 2010, requires Medicaid to cover counseling and pharmacotherapy for cessation of tobacco use by pregnant women. Prohibits cost-sharing.



Pediatric Accountable Care Demo Project

- The DHHS secretary must establish the Pediatric Accountable Care Organization Demonstration Project
- Allows state to recognize pediatric medical providers that meet specified requirements as accountable care organizations for purposes of receiving incentive payments.
- Participating states, in consultation with the DHHS secretary, will establish an annual minimal level of savings in expenditures for items and services covered under Medicaid and CHIP, which must be reached by an accountable care organization to receive an incentive payment.
- The demonstration project is to begin on January 1, 2012, and end on December 31, 2016. The section does not provide specific appropriations, rather authorizes the appropriation of such sums as may be necessary to carry out this section.



Other Medicaid Mandates/Changes

- Phase-in Medicare rates for primary care providers (100% federal match for increment above current rate) for 2013 and 2014 only
- Coverage of preventive services, no cost-sharing
- Reimbursement of Medicaid services provided by school-based health clinics
- Non-Payment for certain Health Care Acquired Conditions (mirrors Medicare provision)
- Background checks for direct patient access employees of long term care facilities and providers



Other Medicaid Mandates/Changes (cont.)

- Incentives for Coverage of Preventive Services
 - Add 1 percentage point to regular FMAP
- Incentive Grants for the Prevention of Chronic Diseases (1/1/2011) to promote healthy lifestyles
- Medical Home – State Option



Reduction in DSH Payments

Directs the HHS Secretary to reduce DSH payments to states by \$14.1 billion between FY 2014-FY 2020

Fiscal Year	Reduction
2014	\$500 million
2015	\$600 million
2016	\$600 million
2017	\$1.8 billion
2018	\$5 billion
2019	\$5.6 billion
2020	\$4 billion

Reductions will be made quarterly in equal installments



Reduction in DSH Payments

- Requires the Secretary to carry out the reductions using the "DSH Health Reform Methodology" that will impose the largest reductions on states that:
 - Have the lowest percentage of uninsured individuals (determined on the basis of: (1) data from the Bureau of the Census; (2) audited hospital reports; and (3) other information likely to yield accurate data) during the most recent year for which the data is available; or
 - Do not target their DSH payments to: (a) hospitals with high volumes of Medicaid inpatients; and (b) hospitals that have high levels of uncompensated care (excluding bad debt).
- Could affect access to health care for children and their parents who remain uncovered.



What Happens to CHIP?

- Extends the current CHIP authorization through 9/30/15.
- From FY 2016 to FY 2019, states will receive a 23 percentage point increase in the CHIP match rate, capped at 100 percent.
- CHIP-eligible children, who cannot enroll in CHIP due to federal allotment caps, will be deemed ineligible and will then be eligible for tax credits in the exchange.
- Requires states to maintain current income eligibility levels for CHIP through September 30, 2019.
 - Prohibits states from implementing eligibility standards, methodologies, or procedures that were more restrictive than those in place on the date of enactment (March 23, 2010), with the exception of waiting lists for enrolling children in CHIP.
 - Conditions future Medicaid payments on compliance with the maintenance of effort provision.



CHIP & the Exchange

CHIP and the Health Insurance Exchange

- Provides that after FY 2015 states may enroll targeted low-income children in qualified health plans that have been certified by the Secretary.
- Requires the Secretary to review in each state the benefits offered for children and the cost-sharing imposed by qualified health plans offered through a Health Insurance Exchange (no later than April 1, 2015).
- Requires the Secretary to certify plans that offer benefits for children and impose cost-sharing that the Secretary determines are at least comparable to the benefits and cost-sharing protections provided under the state CHIP (certification of comparability of pediatric coverage).

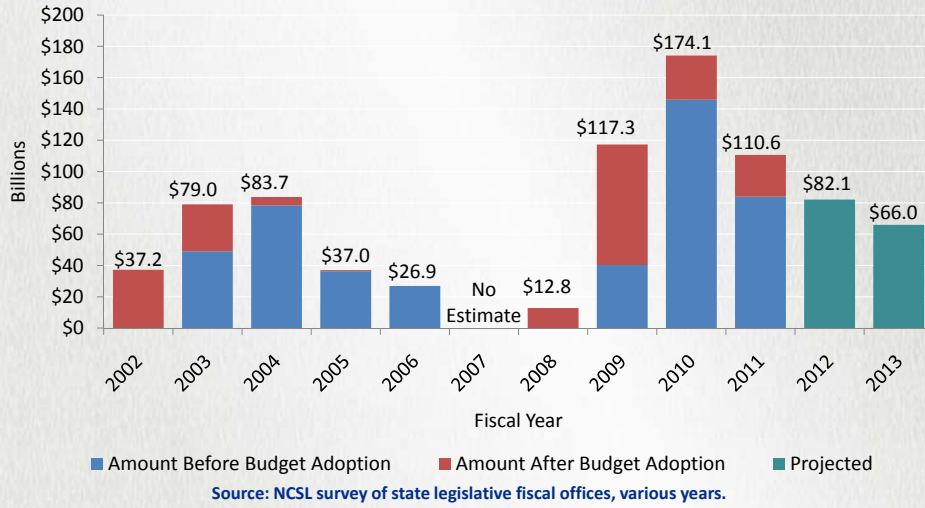


Some State Concerns

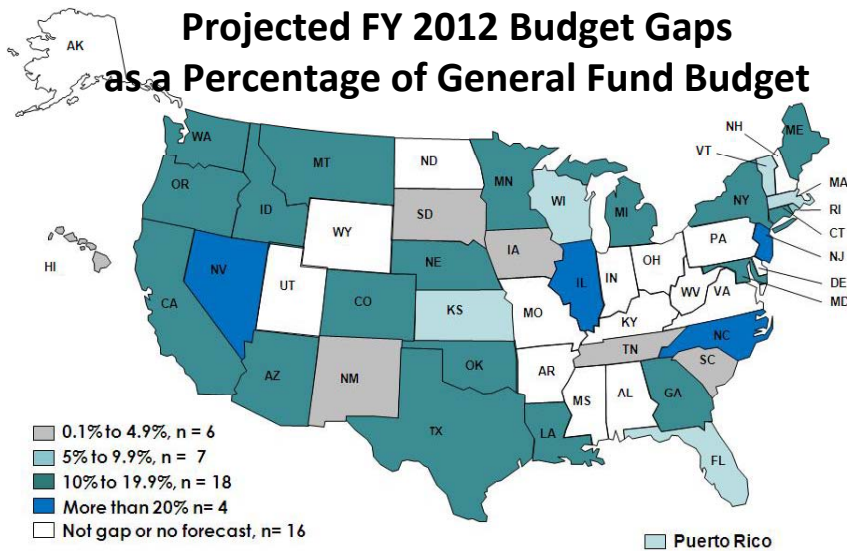
- Transformation left largely to the states
- Budget Issues
 - Underfunding of the underlying program
 - No coverage for undocumented immigrants
 - No statutory countercyclical trigger
 - Implications of reduction in federal assistance in the future
 - Long-term care
- Budget Impacts
 - Newly eligible and others who will "come out of the woodwork"
 - Systems upgrades for eligibility & interoperability with the Exchanges
 - Staffing: State and local government
 - Workforce/Infrastructure
 - Provider reimbursement; Training & recruitment
- Election turnover and steep learning curve
- Planning for effective public outreach to partners and the public
- System upgrades for Medicaid/Exchange interoperability
- Health care workforce shortages
- State flexibility

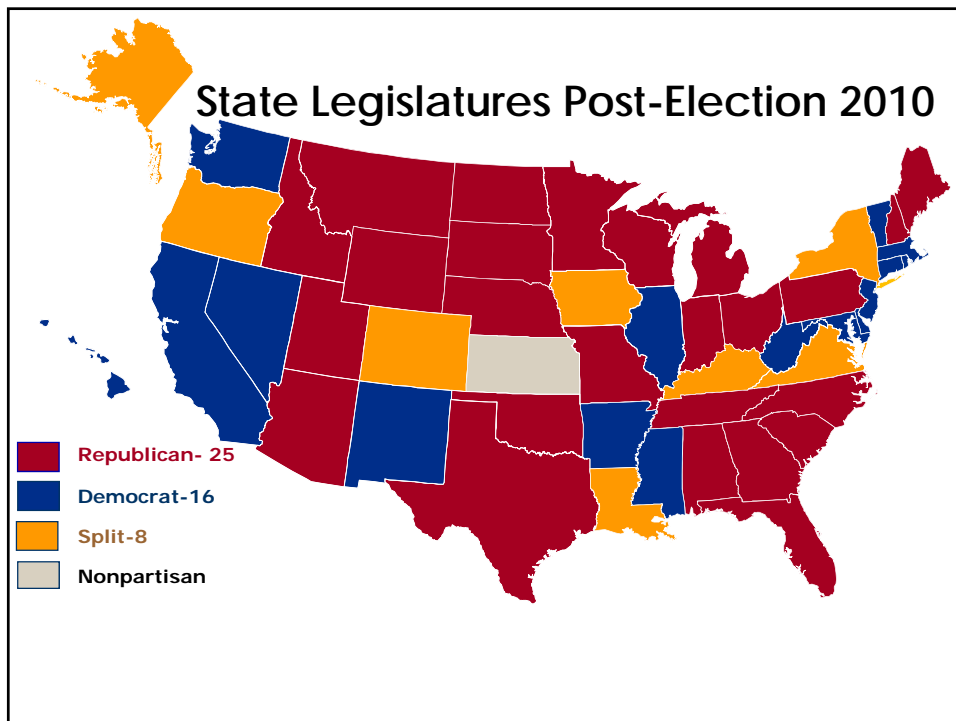
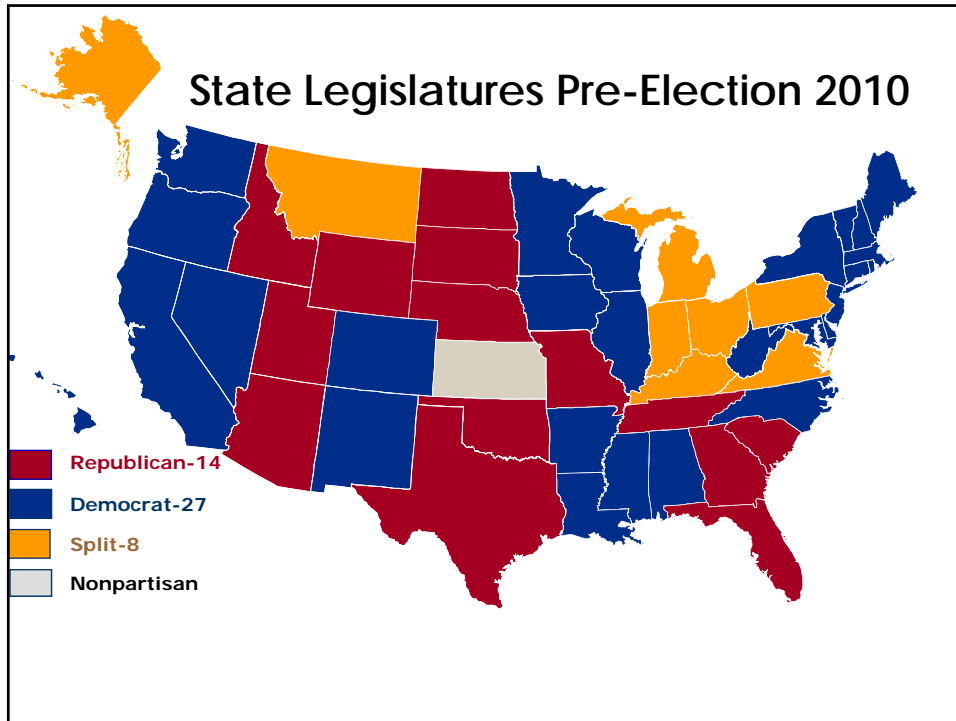


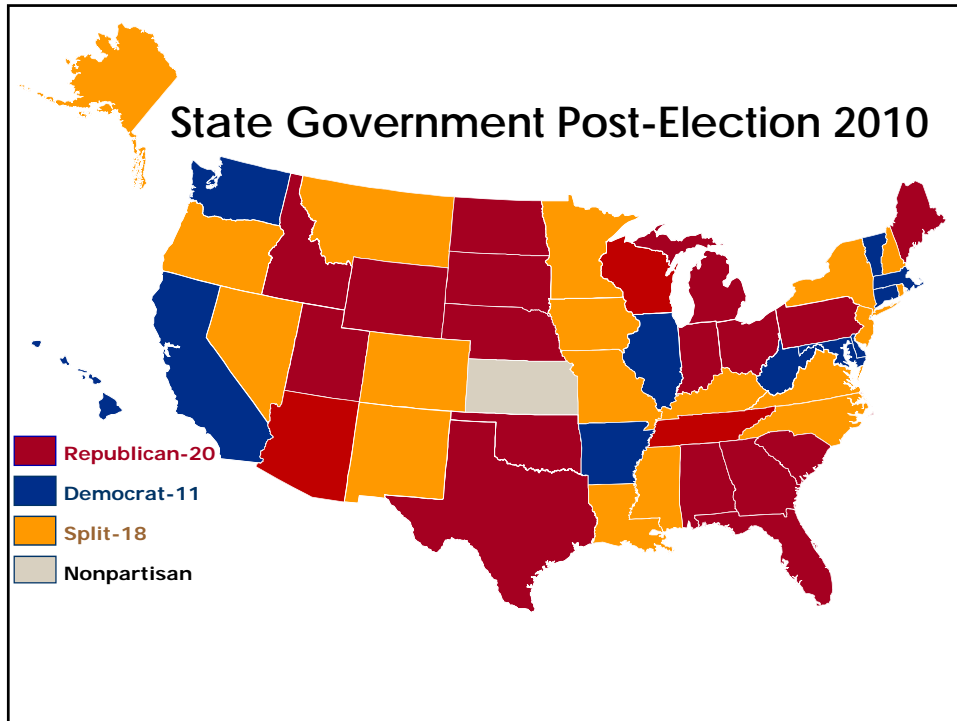
State Budget Gaps FY 2002-FY 2013 (projected)




Projected FY 2012 Budget Gaps as a Percentage of General Fund Budget








NATIONAL CONFERENCE OF STATE LEGISLATURES
The Forum for America's Ideas

Home Visiting Programs

Maternal, Infant, and Early Childhood Home Visiting Programs

- Provides funding to States, tribes, and territories to develop and implement one or more evidence-based Maternal, Infant, and Early Childhood Visitation model(s).
- Model options would be targeted at reducing infant and maternal mortality and its related causes by producing improvements in prenatal, maternal, and newborn health, child health and development, parenting skills, school readiness, juvenile delinquency, and family economic self-sufficiency.
- Establishes competitive grants appropriated at \$100 million in 2010, \$250 million in 2011, \$350 million in 2012, \$400 million in 2013 & 2014
- A maintenance of effort (MOE) applies and prohibits grants from supplanting existing funding for these services.
- First grants were awarded on July 21, 2010 to 49 states, the District of Columbia, and five territories.



School Based Health Centers

The Act includes two provisions for school-based health centers:

- An emergency \$200 million appropriation for SBHCs' construction and equipment needs. In FY 2011, DHHS will award \$100 million in federal funding for construction, renovation, and/or equipment for SBHCs to build their infrastructure capacity to offer primary health care services. Section 4101(a) of the Affordable Care Act allows for SBHCs to access \$200 million in competitive federal funds over the next four years. These funds cannot be used for personnel or health service provision.
- New Mexico awarded \$26.4 million
- SBHCs became an authorized federal program in Section 4101(b) of the ACA with a federal \$50 million authorization for operations. These funds have not yet been appropriated.



Preventing Childhood Obesity

- Authorizes \$25 million in funding for the Childhood Obesity Demonstration project, which was established through the CHIP legislation. HHS will award grants to develop a comprehensive and systematic model for reducing childhood obesity.



Pregnancy Assistance Fund

- \$250 million over 10 years to support pregnant and parenting teens and women in completing their education and combat violence against pregnant women.
 - Support for pregnant/parenting student services at institutions of higher education; including maternity coverage in student health plans, housing, child care, flexible/alternative academic scheduling, parenting education, material needs (requires match)
 - Support for pregnant/parenting teens at high schools and community service centers (no match)
 - Improving services for pregnant women who are victims of domestic violence, sexual violence, sexual assault, and stalking; including passing funds through to Attorneys General for technical assistance or for other state offices providing svcs. to victims
 - Increasing public awareness and education about the services available
- New Mexico awarded \$1.3 million



Other Non-Medicaid Provisions that will affect children

- Prohibits health insurers from denying coverage to children with pre-existing conditions as of September 23, 2010. Beginning in 2014, the law applies this requirement to all covered people
- Extends health care coverage for young adult children under their parent's health plan up to the age of 26. 37 states had similar laws pre-reform including NM.
- Employers are required to provide a reasonable amount of time in an appropriate place for breastfeeding mothers to express milk. Some exemptions for small employers.



Non-Medicaid Provisions, cont.

- Requires coverage of not only basic pediatric services under all new health plans, but also oral and vision needs, starting in 2014.
- Requires new plans to cover prevention and wellness benefits and exempts these benefits from deductibles and other cost-sharing requirements.
- Requires the creation of a health insurance exchange to serve as a health insurance marketplace and to facilitate enrollment in public programs.
- Prohibits lifetime limits.



NCSL Resources on Health Reform

- **Federal Health Reform Main Page**
<http://www.ncsl.org/healthreform>
- **State Actions to Implement Reform**
<http://www.ncsl.org/?tabid=20231>
- **State Reports and Research**
<http://www.ncsl.org/?TabId=21448>
- **State Actions to Implement Health Benefit Exchanges**
<http://www.ncsl.org/?TabId=21388>
- **States Challenging Health Reform**
<http://www.ncsl.org/?TabId=18906>

State Strategies for Controlling Costs: Are Children at Risk?

Family Impact Seminar

Vernon K. Smith, PhD
Health Management Associates

Santa Fe
February 3-4, 2011
© 2011

Outline for today

- Quick background: State budgets, Medicaid spending and enrollment trends
- Changes states have made to Medicaid due to fiscal pressure
- Potential impacts on children and families
- A glimpse into the future.

HEALTH MANAGEMENT ASSOCIATES

Medicaid Today: America's Largest Health Program

2011 Enrollment :

- 57 Million Average Monthly Enrollment
- 70 million ever enrolled (counting turnover and new enrollees)

2011 Projected Spending:

- \$447 billion
- Historically, 57% federal, 43% state funds
- 1/6 of National Health Expenditures

State Administered:

- States administer program so spending qualifies for federal matching funds
- Medicaid is the largest source of federal funds (40%) received by states

Sources: HMA projections for Federal FY 2011, based on: CBO, *Medicaid Baseline*, August 2010; CMS, Office of the Actuary, National Health Statistics Group, 2010; and National Association of State Budget Officers, *State Expenditure Report*, Dec. 2010
HEALTH MANAGEMENT ASSOCIATES

Medicaid Is the “Workhorse” of the U.S. Health Care System

Health Insurance

- For low-income families, persons with disabilities and the elderly

Assistance to low-income Medicare beneficiaries

- 15% of beneficiaries/40% of Medicaid spending

Long-Term Care

- Institutions and home and community-based services; 35% of Medicaid spending

Support for Safety Net Providers

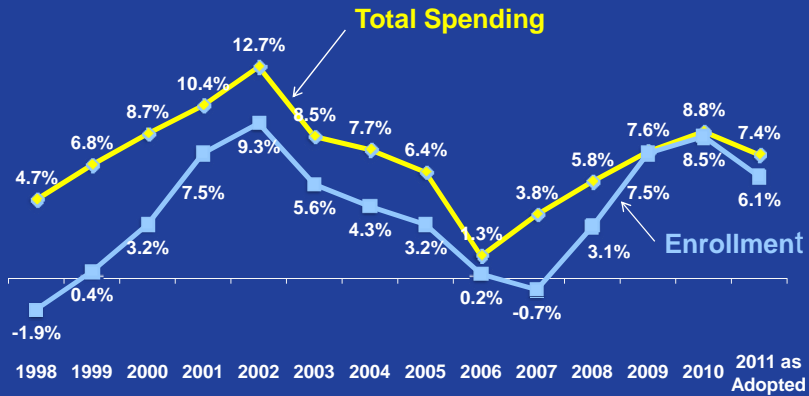
- E.g., hospitals and community health centers serving the uninsured

Financial Support for other Programs

- E.g., mental health, school and public health programs

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U.S. Medicaid Spending and Enrollment Percent Changes, FY 1998 – FY 2011

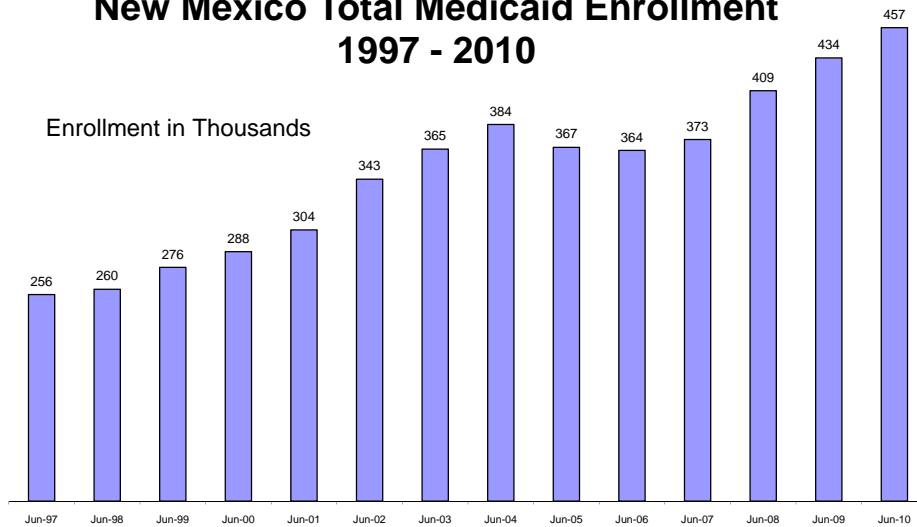


SOURCE: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured, September 2010.
NOTE: Enrollment percentage changes from June to June of each year. Spending growth percentages in state fiscal year.

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New Mexico Total Medicaid Enrollment 1997 - 2010

Enrollment in Thousands



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New Mexico and U.S. Medicaid Enrollment: Percentage Changes FY 1998- FY 2011



SOURCES: Calculated by Vernon Smith from data in: Eileen R. Ellis, Dennis Roberts, David M. Rousseau, *Medicaid Enrollment in 50 States, June 2009 Update*, Kaiser Commission on Medicaid and the Uninsured, February 2010. Data for 2010 and 2011 provided by state officials to Health Management Associates for Kaiser Commission on Medicaid and the Uninsured, 2010. Data for are June-June /state fiscal years.

HEALTH MANAGEMENT ASSOCIATES

The Recession Has Officially Ended, But States Continue to Deal With Ongoing Fiscal Crises

- FY 2010:**
 - 48 states addressed budget shortfalls totaling \$191B (29% of their budgets) – largest gap on record
- FY 2011:**
 - 46 states addressed budget gaps totaling \$130B (20% of their budgets); 11 states reporting new mid-year budget shortfalls
- FY 2012:**
 - 40 states have projected budget gaps totaling \$113B

E. McNichol, P. Oliff and N. Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities, December 16, 2010.

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Slowing Medicaid Cost Growth is a Challenge, Because Costs Are Already Low

Medicaid enrollees are sicker, compared to low-income adults with private health insurance

- Over twice as likely to be in fair or poor physical or mental health; more chronic health conditions

Medicaid per capita costs are lower (adjusted for health status)

- 1/4 less for adults; 1/3 less for children

Medicaid per capita cost growth has been lower

- 23% less than for persons with private health insurance

Sources: Health status, per capita costs and above quotes: Ku and Broaddus, "Public and Private Health Insurance: Stacking Up the Costs," *Health Affairs*, online 24 June 2008; and, Hadley and Holahan, *Inquiry*, 2004; Per capita cost growth: Holahan and Cohen, *Understanding the Recent Changes in Medicaid Spending and Enrollment Growth Between 2000-2004*, Kaiser Commission on Medicaid and the Uninsured, May 2006.

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And it is hard now to find new places to cut because . . .

Provider payments are already low

Benefit restrictions often net little savings

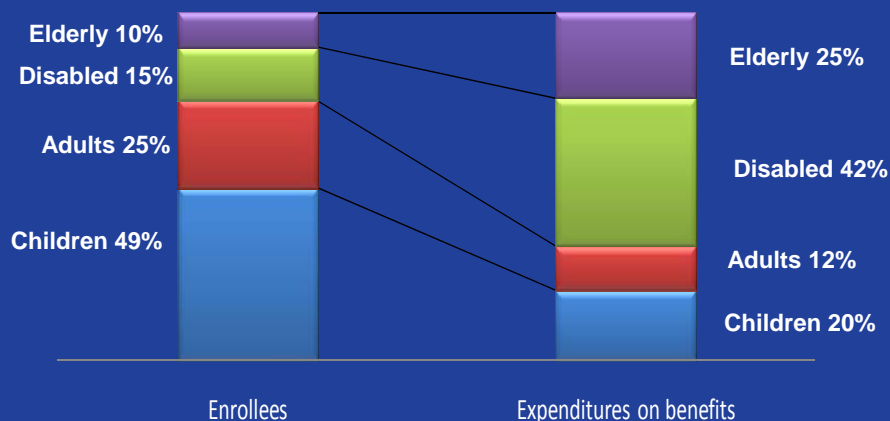
All the easy cuts were made earlier

Some options are limited by federal law

Cuts to the program have real impacts on beneficiaries, providers and the economy

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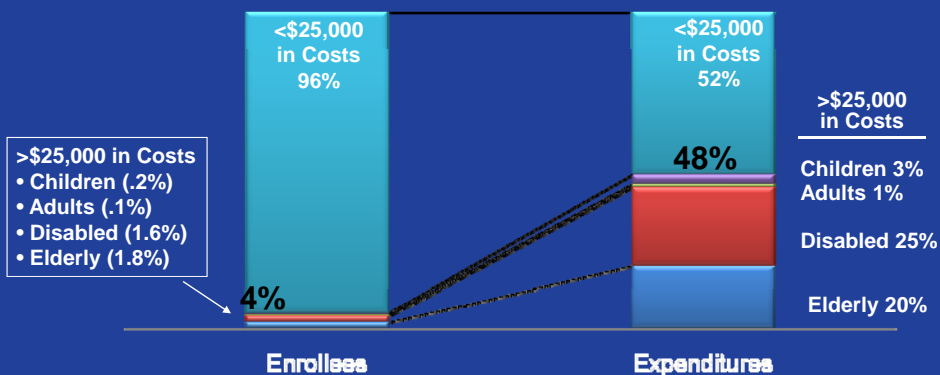
Medicaid Enrollees and Expenditures: 2/3 of Dollars are for Elderly and Disabled



SOURCE: KCMU and Urban Institute estimates based on 2007 MSIS and CMS64 data.

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4% of Medicaid Enrollees Account for Almost Half of Expenditures

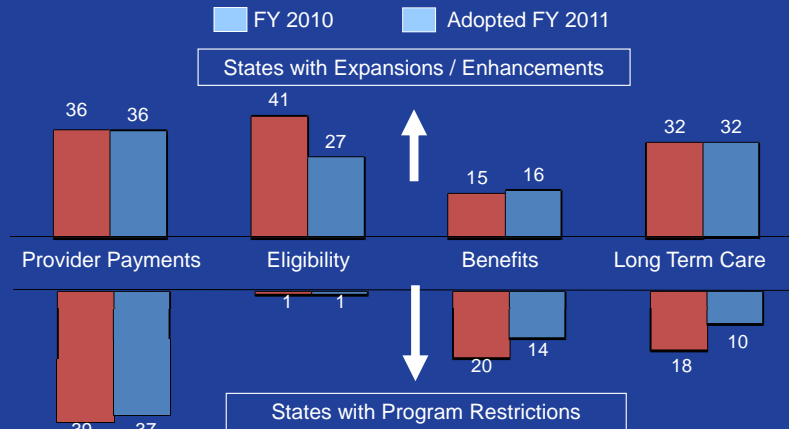


Note: For the total U.S. population, the top 1% accounts for 23% of health spending; the top 5% accounts for 50%; the top half account for 96.5%. SOURCE: Urban Institute estimates for Kaiser Commission on Medicaid and the Uninsured based on MSIS data, 2005.

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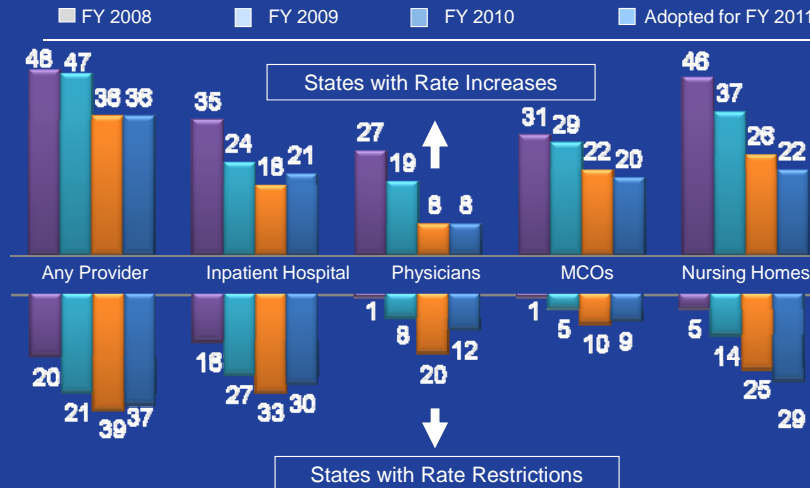
To Control Costs, States Took the Following Medicaid Policy Actions for FY 2010 and FY 2011



NOTE: Past survey results indicate not all adopted actions are implemented. Provider payment restrictions include rate cuts for any provider or freezes for nursing facilities or hospitals.
 SOURCE: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured, September 2010.
<http://www.kff.org/medicaid/8105.cfm>

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States with Provider Rate Changes FY 2008 – FY 2011



NOTE: Past survey results indicate adopted actions are not always implemented. Any provider also includes dentists and outpatient hospital providers. Rate restrictions include rate cuts for any provider and also frozen rates for inpatient hospitals and nursing homes.
 SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, September 2008, September 2009, and September 2010.

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To Control Costs and Improve Quality, Medicaid Increasingly Uses Managed Care

States continue to broaden use of managed care

- Including aged and disabled, going to rural areas

States using initiatives to improve quality using performance measures, pay-for-performance, medical homes, chronic care management and other strategies

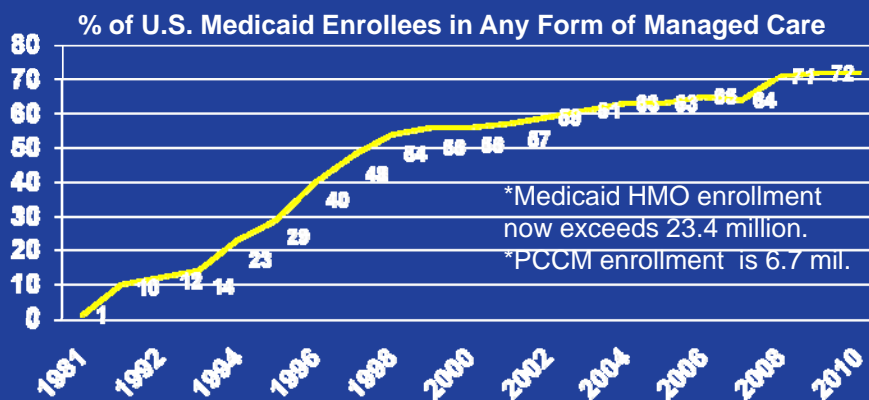
States continue to expand the use of Health Information Technology

- Encouraging adoption and meaningful use of electronic health records (EHRs) and health information exchanges (HIEs)

SOURCE: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured, September 2010. <http://www.kff.org/medicaid/8105.cfm>

HEALTH MANAGEMENT ASSOCIATES

U.S. Medicaid Managed Care Enrollment Continues to Grow



Note: "Managed Care" includes HMOs, PIHPs, HIOs and state-administered Primary Care Case Management Plans (PCCMs).
Source: CMS, Medicaid Managed Care Reports, 1994-2009.

HEALTH MANAGEMENT ASSOCIATES

Across the States, Medicaid Is Driving Innovation and Quality Improvement

- Better information on best practices and performance
 - Consumer guides and performance report cards for MCOs
 - Identifying, highlighting and encouraging best practices that improve care
- Quality Initiatives
 - Care management programs for high risk / high cost patients
 - Performance improvement projects; E.g., reducing avoidable emergency visits
 - Focused work groups to improve service delivery
 - Strong contract requirements and enforcement
- Reimbursement Strategies
 - Bonus payments for high performance on selected HEDIS® or CAHPS® quality performance measures that change annually
 - Penalties for poor performance
 - Prohibit payment for "Never events"
 - Higher fees for providers meeting medical home or chronic care management standards

SOURCE: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, "Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends," The Kaiser Commission on Medicaid and the Uninsured, September 2010. <http://www.kff.org/medicaid/8105.cfm>

HEALTH MANAGEMENT ASSOCIATES

Current Policy Directions: Comprehensive, Integrated Coordinated Care to Contain Costs, Improve Care and Provide Better Value

Patient-centered medical homes

- ACA Health Home Option: enhanced funding for care coordination for individuals with chronic care needs

Coordinated care for nearly 9 million dual eligibles

- Duals account for 40% of all Medicaid expenditures; 25% of all Medicare spending
- New CMS Center for Medicare and Medicaid Innovation: \$10 billion for demonstrations and pilots to address quality, access, costs, efficiencies, beneficiary and provider satisfaction
- Accountable Care Organizations (ACOs) begin in 2012 as integrated, coordinated systems, with shared savings models for Medicare, with opportunities for Medicaid

Source: "State Roles in Delivery System Reform," National Governor's Association, 2010

HEALTH MANAGEMENT ASSOCIATES

Impacts on Children and Families

- Medicaid covers only “medically necessary” services, so any benefit cuts specifically affect persons who need them.
 - Children are protected under Medicaid law, even if services are cut for adults
- Cuts to provider payments can affect access and availability of services for families and children.
 - Managed care plans must assure access for all enrollees to needed services, regardless of rates.

HEALTH MANAGEMENT ASSOCIATES

The Two Primary Issues for Medicaid Now: Budget Pressures and Implementing Reform

- Fiscal pressures due to the economy continue to dominate state decisions about Medicaid.
- *“Medicaid growth is simply unsustainable and threatens to consume the core functions of state government.”*
 - Governor Jan Brewer, (R – Arizona), January 24, 2011, when signing request to HHS for a waiver of “Maintenance of Effort” law, and to allow Arizona to cut 300,000 from Medicaid eligibility.
- Even in “these insanely difficult times,” states continue to work to improve quality and access through Medicaid – but the challenge is daunting.

SOURCE: Vernon Smith, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Laura Snyder, “Hoping for Economic Recovery, Preparing for Health Reform: Medicaid Spending, Coverage and Policy Trends,” The Kaiser Commission on Medicaid and the Uninsured, September 2010. <http://www.kff.org/medicaid/8105.cfm>

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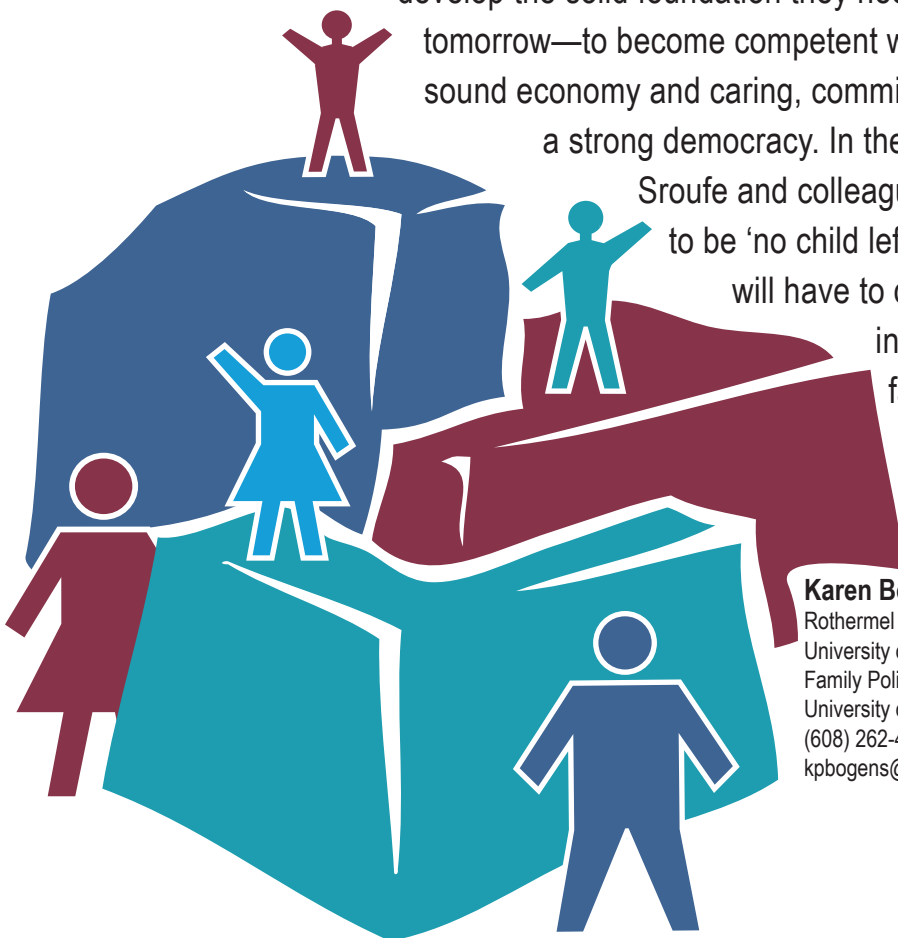
Families are the Cornerstone

Investments in family policies can create the conditions for families to do their best in rearing the next generation, in economically supporting their members, and in caring for those who cannot always care for themselves—the elderly, frail, ill, and disabled. Yet families can be damaged by stressful conditions—the inability to earn a living, or afford health insurance, or find quality child care, or send their kids to good schools. Policies that support families are politically popular and typically are much more effective than policies aimed only at individuals. When the family foundation is strong today, children are more likely to

develop the solid foundation they need for

tomorrow—to become competent workers in a sound economy and caring, committed citizens in a strong democracy. In the words of

Sroufe and colleagues, “For there to be ‘no child left behind,’ we will have to do a better job in leaving no family behind” (2005).



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The checklist on the following page is a useful guide for viewing public policy or potential public policy through a family lens. With it, policymakers and those who implement policies can assess the impact of policy on families.

Assessing the Impact of Policies & Programs on Families

Family Impact Checklist

The first step in developing family-friendly policies is to ask the right questions:

- ▶ What can government and community institutions do to enhance the family's capacity to help itself and others?
- ▶ What effect does (or will) this policy (or program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer. These questions are the core of a family impact analysis that assesses the intended and unintended consequences of policies, programs, and organizations on family stability, family relationships, and family responsibilities. Family impact analysis delves broadly and deeply into the ways in which families contribute to problems, how they are affected by problems, and whether families should be involved in solutions. Guidelines for conducting a family impact analysis can be found at www.familyimpactseminars.org/fi_howtocondfia.pdf.

Family impact questions can be used to review legislation and laws for their impact on families; to prepare family-centered questions or testimony for hearings, board meetings, or public forums; and to evaluate programs and operating procedures of agencies and organizations for their sensitivity to families. Six basic principles serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank-ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. This tool, however, reflects a broad bi-partisan consensus, and it can be useful to people across the political spectrum.

Principle 1. Family support & responsibilities. Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

Principle 2. Family membership & stability. Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?



The Policy Institute for
Family Impact Seminars

The Institute aims to strengthen family policy by connecting state policymakers with research knowledge and researchers with policy knowledge. The Institute provides nonpartisan, solution-oriented research and a family impact perspective on issues being debated in state legislatures. We provide technical assistance to and facilitate dialogue among professionals conducting Family Impact Seminars in 28 sites across the country.

The Policy Institute for Family Impact Seminars adapted the family impact checklist from one originally developed by the Consortium of Family Organizations. The suggested citation is Policy Institute for Family Impact Seminars. (2000). *A checklist for assessing the impact of policies on families* (Family Impact Analysis Series No. 1). Madison, WI: Author. The checklist was first published in Ooms, T., & Preister, S. (Eds.). (1988). *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington DC: Family Impact Seminar.

For more information on family impact analysis, contact Director Karen Bogenschneider of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 3rd Fl Middleton Bldg, 1305 Linden Drive, Madison, WI 53706.

Phone (608) 263-2353
FAX (608) 265-6048
<http://www.familyimpactseminars.org>

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Principle 3. Family involvement & interdependence. Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

Principle 4. Family partnership & empowerment. Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy and program development, implementation, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services required? Does it integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?

Principle 5. Family diversity. Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- account for its benefits to some family types but not others? Is one family form preferred over another? Does it provide sufficient justification for advantaging some family types and for discriminating against or penalizing others?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?
- acknowledge intergenerational relationships and responsibilities among family members?

Principle 6. Support of vulnerable families. Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?