

MEDICAID REFORM PROPOSAL TRACKER

4/2011

Review of State Medicaid Reform

Third Edition

National Associat



Medicaid Reform Proposal Tracker

REVIEW OF STATE MEDICAID REFORM – THIRD EDITION

Introduction

In states across the nation, Governors and State Legislatures are considering strategies to slow Medicaid growth and improve services and supports for Medicaid beneficiaries, including older adults and persons with disabilities. The National Association of States United for Aging and Disabilities (NASUAD) is following these developments with an emphasis on Medicaid-financed programmatic changes that will impact state long-term services and supports systems and the people they support.

The Medicaid Reform Tracker is composed of the following sections:

- Summary table of state-by-state activities; Overview of new state Medicaid reform efforts;
- Update of ongoing Medicaid reform efforts; and
- Overview of policy and court activity possibly impacting future Medicaid reform activities.

The Medicaid Reform Tracker is updated monthly. For more information, please contact Sara Tribe at stribes@nasuad.org.

Summary Table of State-by-State Activities

Medicaid Reform Proposal Tracker (April 2011)©



	Coordination of Care						Payment Structure			Reductions			Efficiencies			Partnerships		HCBS Expansion		Request to Federal Govt			
	Primary Care Case Management	Medical Homes	Managed Care/Care Coordination	Chronic Care Case Management	Dual Eligibles	Integration of Medicare Medicaid	Payment for Performance	Authority for Care Coordination Payments	Managed Care/Capitated Service Delivery	Reimbursement Rates	Eligibility	Service Elimination	Service Reduction	Medicaid Program Integrity	Health Information Technology	Combining State Administrative Offices	Hospital Readmissions	Guiding Body for Reform Initiatives	Target Partnerships*	Money Follows the Person	Nursing Home Diversion	Request for Waiver of Maintenance of Effort	Federal Medicaid Block Grant
Alabama																							
Alaska																							
Arizona			X		X	X	X	X	X	X	X	X	X			X						X	
Arkansas		X	X				X	X						X									
California		X	X	X	X		X	X	X	X	X	X											
Colorado																							
Connecticut		X	X		X	X		X	X										X	X			
Delaware																							
Florida	X		X					X													X		
Georgia																							
Hawaii																							
Idaho																							
Illinois			X				X	X		X			X	X							X		
Indiana																							
Iowa																							
Kansas																						X	X
Kentucky		X	X	X	X	X	X	X	X				X	X		X		X					
Louisiana																							
Maine																							
Maryland																	X	X					
Massachusetts		X	X		X	X	X	X	X				X	X		X							
Michigan																							
Minnesota																							
Mississippi																							
Missouri																							
Montana																							



Medicaid Reform Proposal Tracker (April 2011)©

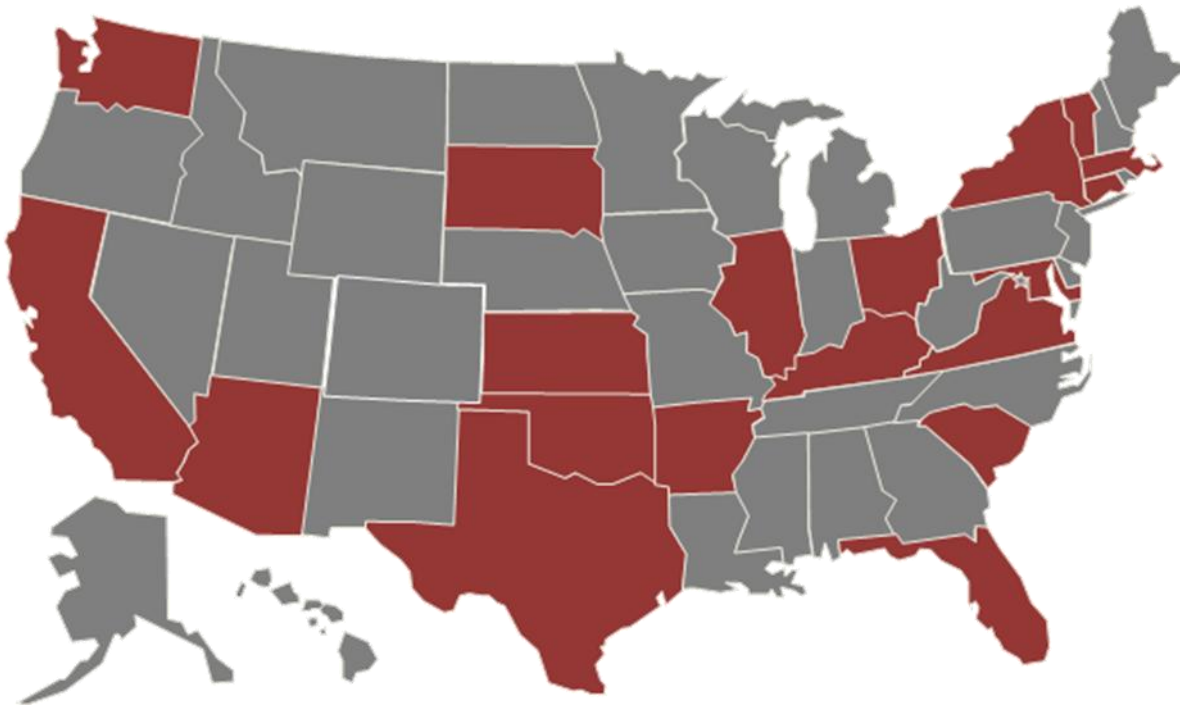
	Coordination of Care						Payment Structure			Reductions			Efficiencies				Partnerships		HCBS Expansion		Request to Federal Govt			
	Primary Care Case Management	Medical Homes	Managed Care/Care Coordination	Chronic Care Case Management	Dual Eligibles	Integration of Medicare Medicaid	Payment for Performance	Authority for Care Coordination Payments	Managed Care/Capitated Service Delivery	Reimbursement Rates	Eligibility	Service Elimination	Service Reduction	Medicaid Program Integrity	Health Information Technology	Combining State Administrative Offices	Hospital Readmissions	Guiding Body for Reform Initiatives	Target Partnerships*	Money Follows the Person	Nursing Home Diversion	Request for Waiver of Maintenance of Effort	Federal Medicaid Block Grant	
Nebraska																								
Nevada																								
New Hampshire																								
New Jersey																								
New Mexico																								
New York		X	X		X			X	X	X		X					X							
North Carolina																								
North Dakota																								
Ohio		X	X		X	X	X	X	X			X				X	X				X			
Oklahoma																								
Oregon																								
Pennsylvania																								
Rhode Island																								
South Carolina		X	X					X	X	X	X	X					X				X			
South Dakota										X		X			X									
Tennessee																								
Texas			X					X	X			X												
Utah																								
Vermont						X												X						
Virginia	X		X		X	X		X									X							
Washington			X	X			X	X							X	X		X						
West Virginia																								
Wisconsin																								
Wyoming																								
District of Columbia																								
Totals	2	8	14	3	8	7	8	10	11	8	3	3	7	4	4	2	5	6	3	1	5	2	1	

* *Targeted Partnership* - a partnership in which a particular group is targeted for participation
Medicaid Reform Tracker is a monthly copywrited publication of the National Association of States United for Aging and Disabilities.
Please go email Sara Tribe at Stribe@nasuad.org if you would like to receive monthly updates

State Updates

The report updates state Medicaid reform information provided in the first two editions of Medicaid Reform Tracker, and includes reform effort overviews in five new states: Florida, Maryland, South Carolina, South Dakota and Virginia. See Figure 1, below, for a snapshot of national Medicaid reform activity.

Figure 1: National Overview of States that Have Proposed Broad Medicaid Reform (in red)



Source: NASUAD Medicaid Reform Tracker

New Editions to the Medicaid Reform Proposal Tracker

States added to Medicaid Reform Tracker include: Florida, Maryland, South Carolina, South Dakota, Virginia and Oklahoma.

Florida

On March 31, 2011, the Florida House of Representatives passed House Bills 7101 and 7109, both intended to help transition Medicaid beneficiaries into managed care plans. In a press release, House Speaker Cannon commented that the adoption of these “meaningful and comprehensive” Medicaid reform bills is the “first step toward fixing a broken program that both lacks the ability to provide quality care to patients, and drains our state’s financial resources at the expense of other vital services and programs.”

Currently, approximately 76 percent of Florida’s Medicaid beneficiaries are already required to choose some form of managed care for primary and acute care services within 30 days of becoming Medicaid

eligible. Managed care models currently used by the states include primary care case management, provider service networks, health maintenance organizations and nursing home diversion waiver programs¹. Florida's new managed care expansion plan would gradually require different groups of beneficiaries to enroll in managed care plans (seniors, women and children, and people with developmental disabilities, respectively) with the intent of "improving care for Medicaid beneficiaries, reduce widespread fraud, and control costs Florida's Medicaid program." The effective date for both house bills is July 1, 2011.

[Florida House Bill 7107](#)

[Florida House Bill 7109](#)

[Speaker of the Florida House of Representatives Press Release on House Bills 7107 and 7109](#)

[Florida Committee on Health Regulation, Overview of Florida Managed Care, November, 2011](#)

Maryland

As part of a broader health care reform effort, on April 12, 2011, Maryland Governor Martin O'Malley signed legislation, the Maryland Health Benefit Exchange Act, creating the framework of a health benefit exchange. His actions make Maryland one of the first states to sign into law exchange. The legislation is intended to provide a "choice of plans, information on rates, benefits and quality." Governor O'Malley further stated, "When up and running, Maryland's health benefit exchange will provide seamless, one-stop shopping for individuals and small businesses to find high quality health coverage at an affordable price." Governor O'Malley expects that the exchange and other provisions of the Affordable Care Act (ACA) will save Maryland approximately \$800 million over ten years. In an effort for the exchange to remain transparent and broaden the scope of input throughout the implementation process, the new law is intended to create an inclusive process for stakeholder groups including insurance companies, providers, public health advocates, and insurance brokers.

In July 2010, Governor O'Malley signed an Executive Order, establishing the Maryland Health Care Reform Coordinating Council (MHCRC). Testimony by the House Health and Government Operations Committee described that the MHCRC was tasked with creating a blueprint for a "well planned and inclusive implementation of health care reform that is both visionary and realistic." On February 15, 2011, three bills were submitted by the House Health and Government Operations Committee, which included three recommendations of the MHCRC. The original recommendations were: a) Establish the framework for Maryland Health Benefit Exchange; b) conform Maryland's insurance laws with the new benefits of the ACA; and c) make the Maryland Health Quality and Cost Council a permanent fixture so that it can continue to implement initiatives that help bend the cost curve.

On February 16, 2011, Maryland received one of seven Early Innovator Grants from the Department of Health and Human Services. This \$6 million grant is a cooperative agreement to help states develop and implement the technological infrastructure to operate a Health Insurance Exchange. Each state grantee must: a) ensure their exchange technology is reusable and transferable to other states; b) handle eligibility and enrollment, premium tax credits and cost-sharing reductions of eligible consumers; and c) be able to provide data to HHS or other Federal agencies as needed.

¹ Florida's nursing home diversion waiver is a Medicaid managed LTC arrangement

[Press Release Governor O'Malley Signs Maryland Health Benefit Exchange Act](#)
[Executive Order, Health Care Reform Coordinating Council](#)
[Maryland Health Care Reform Coordinating Council Website](#)
[February 2011, House Health and Government Operations Committee Testimony on Three House Bills:](#)
[Maryland Blue Print for Health Care Reform](#)
[Federal Early Innovator Grant for Health Care Exchange](#)

South Carolina

Beginning in April 2011, South Carolina eligible Medicaid beneficiaries will be required to choose a coordinated health care plan, which will include the establishment of a relationship with a primary care physician for each enrollee. A majority of Medicaid beneficiaries are currently enrolled in one of South Carolina's four Managed Care Organizations (MCOs) or the existing Medical Homes Network (MHN). An initiative recently approved by the federal Centers for Medicare and Medicaid Services (CMS) expands the state's care coordination plan through an existing MCO, and pending Healthy Connections Choices program under section 1115 waiver authority, which aims to "deliver higher quality care to patients and significant cost savings to the state." South Carolina's Department of Health and Human Services is also recommending the approval of two new Medical Homes Networks. Starting in April 2011, new Medicaid enrollees and those beneficiaries enrolled in traditional Medicaid, will be asked to choose either an MCO or a MHN. If they do not choose a plan, a South Carolina Department of Health and Human Services (SCDHHS) case manager will select a plan for the beneficiary. The following groups of Medicaid beneficiaries will not be required to join a coordinated care plan: a) those also receiving Medicare benefits; b) Medicaid waiver enrollees; and c) children with disabilities and foster children.

In an effort to cut the projected FY11 \$7.5 million Medicaid budget shortfall, beginning April 4, 2011, SCDHHS announced a three percent decrease in reimbursement payments to providers through June 30, 2011, and MCOs will receive reductions to both capitation rates and administrative fees. Also in an effort to decrease its budget shortfall, SCDHHS has announced service reductions to podiatry, vision and dental services, nursing service at adult day health care, and certain diabetes home care visits and equipment. After a review ordered by Governor Nikki Haley, SCDHHS is reversing previously planned reductions to the following services: hospice, respite care through the Community Long Term Care Community Choices 1915(c) waiver, home delivered meals and nutritional supplements. SCDHHS has created a Medicaid Sustainability Project in an effort to leverage the expertise of Medicaid provider partners to design budget recommendations that both reduce expenditures and increase access to quality health care.

[South Carolina DHHS Managed Care Press Release](#)
[SCDHHS Medicaid Rate Adjustment Press Release](#)
[Medicaid Services to be Eliminated or Reduced](#)
[SCDHHS Reversal of Planned Medicaid Cuts](#)
[Medicaid Sustainability Project](#)

South Dakota

South Dakota Governor Dennis Daugaard's FY12 budget proposal, released in February 2011, outlines plans to eliminate the state's \$127 million structural deficit. While the Governor's budget includes a ten percent cut to Medicaid, a budget amendment was passed in March 2011, which decreases the Medicaid cuts from ten to six percent. The amendment also changes how Medicaid funding is distributed to providers. Medicaid reimbursement rates will now be applied on a tiered system to hospitals, nursing facilities and other Medicaid providers depending on how dependent facilities are on Medicaid funding. For example, providers such as nursing homes, which receive the majority of their reimbursements from Medicaid, will receive less of a Medicaid cut than those that rely less on Medicaid. Conversely, a hospital that primarily receives reimbursement through Medicare and private resources, would potentially receive a larger reduction in Medicaid reimbursement.

Governor Daugaard also said in his State of the State Address that in an effort to increase administrative efficiency, he would be moving the three Medicaid-funded behavioral health divisions from the Department of Human Services to the Department of Social Services (DSS). The Governor anticipates this will increase administrative efficiency because DSS currently works with the majority of Medicaid-funded programs.

[Governor Daugaard's Budget Proposal Press Release](#)
[Governor Daugaard's FY12 Budget Recommendations](#)
[South Dakota Pass FY12 Budget](#)
[Governor Daugaard's State of State Address](#)

Virginia

The bipartisan Virginia Health Reform Initiative (VHRI) Advisory Council was convened in August 2010, by Virginia Governor Robert McDonnell, who appointed 24 political, health system, civic and business leaders to serve as members. The aim of the initiative is to help Virginians access affordable health care. The Governor said the "recommendations of the Council will help create an improved health system that is an economic driver for Virginia while allowing for more effective and efficient delivery of high quality health care at lower cost." The council has since informed health policy discussions in Virginia, including conducting research and offering insight into what the Governor reports is, "the most effective way that Virginia can prepare for future Medicaid growth... expand managed care and care coordination models to everyone and every service in the program."

A December 2010 VHRI Advisory Council report indicated 69 percent of Medicaid beneficiaries were enrolled in one of Virginia's two managed care models (MCOs or primary care case management programs) and 31 percent were enrolled in a fee-for-service Medicaid plan. Older adults and people with disabilities are the main populations currently enrolled in Virginia's fee-for-service plans, are often eligible for both Medicare and Medicaid (dual eligibles), and/or require long term care services such as behavioral health, home care, or long term nursing facility services. These two groups are also the primary focus of Virginia's effort to transition beneficiaries to coordinated care. Governor McDonnell's budget proposal includes expanding Medicaid managed care to save \$3.5 million in FY12.

[Governor McDonnell's Remarks, Expanding Managed Care
Virginia Health Reform Initiative Advisory Council
Report of the Virginia Health Reform Initiative 12/2010](#)

Oklahoma

In February 2011, the Oklahoma House of Representatives approved House Bill 2130 which established a state health insurance exchange². On April 14, 2011, Governor, Mary Fallin announced that Oklahoma, one of the recipients of the seven Early Innovator Grants from HHS to establish Health Insurance Exchanges, would not accept the \$54 million in grant funds for development and implementation of Oklahoma's health insurance exchange. Governor Fallin reported that Oklahoma will establish a Health Insurance Private Enterprise Network which will increase access to "affordable, private, portable health insurance plans through a free market-based network that offers choice and competition to consumers." The development and implementation of the exchange will be overseen by a board made up of members from the private sector, chaired by the Insurance Commissioner, and funded by state or private resources.

[Health Care Exchanges](#)

[Early Innovator Grants](#)

[Governor Fallin on Return of Federal Grant Dollars](#)

[House of Representatives on HB 2130 and Return of Federal Grant Dollars](#)

² [Health Care Exchanges](#) are online marketplaces for health care insurance plans where consumers can compare plans from different public and private companies. On February 16, 2011, six states and a multi Northeast state consortium received one of seven [Early Innovator Grants](#) from the U.S. Department of Health and Human Services (HHS). These grants, totaling \$241 million, are intended to fund state development and implementation of the technological infrastructure needed to operate a state Health Insurance Exchange. Each state grantee must ensure their exchange technology is reusable and transferable to other states. For more information on: [States Considering Health Care Exchanges](#)

Updated Coverage of Ongoing State Initiatives

The following states were reviewed in prior editions of the Medicaid Reform Proposal Tracker. The information below has been updated to reflect recent state Medicaid reform activity.

Arizona

On January 25, 2011, Arizona Governor Janice Brewer requested that the U.S. Secretary of the Department of Health and Human Services, Kathleen Sebelius, use her section 1115 demonstration authority to waive the maintenance of effort (MOE) requirement in the Affordable Care Act (ACA), which would allow Arizona to reduce the number of eligible Medicaid beneficiaries. The MOE requirement refers to an ACA rule that does not permit states to reduce Medicaid enrollment. Secretary Sebelius responded to Governor Brewer on February 15, 2011, advising that the MOE provision of ACA does not require Arizona to renew its waiver demonstration, which expires on September 30, 2011. At that time, Arizona may allow the waiver to expire or pursue a different demonstration with new eligibility requirements. Either approach would require Arizona to follow the phase down provisions included in its Section 1115 Terms and Conditions.

Though the federal government will allow Arizona to reduce Medicaid enrollment via a new waiver, in a 2000 ballot initiative entitled Proposition 204, Arizona residents voted to expand Medicaid coverage to all residents at or below 100 percent of the federal poverty limit. Because the Legislature is not permitted to change or repeal voter-approved laws, any plan to significantly change enrollment is likely to go before the state Supreme Court. Arizona's Governor recommends a rollback of Proposition 204 that would focus on eliminating some coverage for 250,000 childless adults and individuals who have to spend-down to be eligible for Medicaid.

The Governor also seeks to cap TANF parents at approximately 30,000 beneficiaries, a level that can be sustained by Tobacco Settlement and Tobacco Tax Revenues. These cuts would lead to an estimated savings of FY 2012 General Fund of \$541.5 million. The reductions also likely would result in Arizona losing approximately \$1.1 billion in federal Medicaid match. The Governor has assured stakeholders no TANF child or childless adult with serious mental illness will be included in the group of people who lose their Medicaid coverage. Governor Brewer also proposed a five percent provider rate cut that would be implemented October 1, 2011, for state FY12 savings of \$95.0 million.

In Arizona's proposed Medicaid Reform Plan, several longer term reforms are noted including integrating Medicaid and Medicare coverage for dual eligibles, paying hospitals for reduced readmissions and other quality measures, continuing to develop strategies to reduce systematic Medicaid fraud and abuse, and a focus on wellness efforts including "exploration of financial penalties for unhealthy behaviors such as smoking and obesity."

[Letter from Governor Brewer to US Secretary of HHS, Kathleen Sebelius](#)

[Letter from Secretary Sebelius to Governor Brewer](#)

[Proposition 204 Rollback](#)

[Governor's Budget Summary](#)

[Proposed Medicaid Reform Plan](#)

Arkansas

In a February 11, 2011 letter to the U.S. Secretary of the Department of Health and Human Services, Kathleen Sebelius, Governor Mike Beebe of Arkansas described a proposal to fundamentally transform Arkansas' health care fee-for-service system based upon a payment-reform initiative developed through a partnership with CMS, including representatives from both Medicare and Medicaid and private health insurers. In order to avoid rate cuts, elimination of vital services, or a federal waiver to cut back on Medicaid eligibility, Governor Beebe proposed alternatives in his letter: "In conjunction with Medicare, Arkansas BlueCross and BlueShield, and private insurance plans, Arkansas Medicaid will design and then implement the nation's first statewide payment-reform initiative. The initiative will pay partnerships of local providers to act as health homes. To promote efficiency and long-term effectiveness, reimbursement will be for episodes of high-quality care."

Proposed cost-containment and quality-improvement strategies include: a) the application of standards of effectiveness and efficiency to the health care delivery system; b) a focus on three subsystems: illness, wellness, and long term care; c) consideration of the rules of the health care delivery system: price, units and payers; d) and increased use of care coordination, medical management and electronic health records.

In the letter, Governor Beebe goes on to say that, based on current data and existing health system delivery capabilities, the proposed public-private partnership would contain costs by minimizing differences between systems of reimbursement, maximizing efficiency and the amount of supportive services available to beneficiaries, and assisting providers, especially smaller entities such as rural primary care practices.

[Letter from Governor Beebe to US Secretary of HHS Sebelius
Arkansas Medicaid Enterprise, Department of Health and Human Services](#)

California

California Governor Jerry Brown has proposed a wide array of Medicaid savings initiatives totaling \$1.7 billion in State and Federal cuts to California's Medicaid program, which would impact older adults and persons with disabilities. Key provisions include proposals to eliminate a Medicaid State Plan Adult Day Health Care benefit; new caps on benefits; mandatory copayments for physician, emergency room and hospital visits; and provider rate reductions such as home health care and nursing home providers.

Medi-Cal, California's Medicaid program, serves 7.7 million Californians, which represents 19.7 percent of the total state population. California Governor Jerry Brown's proposed budget focuses on reducing the level of benefits, increasing beneficiary cost-sharing, and reducing payment to providers. The proposal establishes maximum annual benefit dollar caps on some adaptive equipment and medical supplies, limits non-life saving drugs (six per month), and limits the number of annual doctor visits to ten. The above limits are projected to result in a combined state savings of \$206.6 million in 2011-2012, while an anticipated 90 percent of current beneficiaries would experience no change in their Medi-Cal benefits. The proposed caps would apply to all Medicaid beneficiaries including those who are eligible under Aged, Blind, or Disabled eligibility groups.

California's In-Home Supportive Services (IHSS) program pays workers to visit and provide basic services for 450,000 low-income older adults and people with disabilities. Governor Brown's 2011-2012 budget plan includes a 43 percent cut to the IHSS program that would reduce the hours of care for all IHSS participants by eight percent; eliminate all domestic service hours (homemaking, cooking and laundry) for participants living with someone else; and require participants to submit a physician's certification stating that without home care services, they would have to move into an institutional setting.

The Governor's budget proposal reduces provider payments by 10 percent, though recent State and Federal court rulings have prevented states from implementing provider rate freezes and reductions. California has appealed to the U.S. Supreme Court to overturn adverse appellate court rulings that have blocked the above provider payment reductions. The proposed state savings of \$719 million in 2010-2012 on the above rate reductions assumes that California prevails in the pending rate legislation. Governor Brown's revised budget will be available in May, 2011.

In an effort to pave the way for key elements of the ACA by 2014, California has proposed changes to its 1115 Comprehensive Demonstration Project Waiver. These changes include: a) accelerating enrollment of newly eligible adults under ACA (individuals under age 65 with incomes of 133 percent of the federal poverty level) through California's current county-based Health Care Coverage Initiative (HCCI); b) promoting primary care and care coordination through several initiatives including enrollment in health homes for Medicaid beneficiaries with chronic conditions; c) preserving and strengthening California's safety net systems, allowing safety net providers to participate in managed and coordinated systems of health care delivery; d) standardizing the eligibility and enrollment process into coordinated care programs for those Medicaid beneficiaries currently enrolled in HCCI; and e) implementing payment reforms for safety net systems. Payment reforms within the section 1115 Waiver aim to move safety net systems away from a fee-for-service payment model using new models such as global capitated payment (each public hospital safety net system receives a set payment for each Medi-Cal beneficiary that is served by the system) and value based purchasing (development of incentives for providers to improve health care delivery methods and health outcomes).

Under the proposed 1115 Waiver, medical homes services would be extended to all seniors and people with disabilities enrolled in organized delivery systems of care, dual eligible and all newly eligible beneficiaries enrolled in HCCIs. The Medicaid home provider will be required to offer care management, disease and medical management and community-based care coordination. The Section 1115 Waiver would also establish a Delivery System Investment Pool (DSIP) which would support the public safety net hospital systems, especially in their provision of services to patients with multiple chronic conditions who need the most care and highest level of coordination. The DSIP funds would target strengthening coordinated systems of care, enhancing access to care and improving quality of patient care for the most needy Medi-Cal enrollees.

[Governor's Budget Summary for the California Department of Health and Human Services](#)
[Department of Health and Human Services Budget Detail](#)
[Governor's Budget Highlights](#)
[California Section 1115 Comprehensive Demonstration Waiver - Bridge to Reform](#)
[Governor's Cuts to In-Home Supportive Services Program](#)

Connecticut

With the goals of reducing Medicaid costs, preparing for national health care reform, and improving service delivery, Connecticut is working toward reforming its systems of Medicaid managed and coordinated care. Connecticut Governor Daniel Malloy announced plans for restructuring the state's relationships with Medicaid managed care plans by January, 2012. Connecticut also will release a request for proposals to secure an administrative services organization (ASO) intended to enhance efficiency in the fee-for-service Medicaid program particularly for older adults living in their own homes. Through Connecticut's proposed health care reform initiative approximately 600,000 Medicaid beneficiaries would receive services through medical home arrangements. The administration also approved a major expansion of the Money Follows the Person (MFP) program aimed at transitioning older adults and persons with disabilities from nursing home to community settings as an additional cost saving measure.

Connecticut, in collaboration with multi-state Northeast consortium (Maine, Massachusetts, Rhode Island and Vermont) received one of seven Early Innovator Grants from the U.S. Department of Health and Human Services, which are cooperative agreements to help states develop and implement the technological infrastructure to operate a Health Insurance Exchange. Governor Malloy reported that this \$36 million grant will "help make ACA mandated health insurance exchanges accessible and convenient for New England businesses and residents."

Connecticut received another federal grant on April 7, 2011. The State Demonstrations to Integrate Care for Dual Eligible Individuals Federal Grant program awarded Connecticut \$1 million to help pioneer a coordinated system of care for older adults and people with disabilities who are dually eligible for Medicare and Medicaid (dual eligibles). Making up 19 percent of Connecticut's population, dual eligibles account for 58 percent of Medicaid, and 25 percent of Medicare expenditures. Connecticut will use the federal funds to contract with Integrated Care Organizations (ICOs), which coordinate medical care at the local level. Connecticut expects to achieve needed Medicare and Medicaid savings through the coordination of medical providers for dual eligibles including primary care, specialists, hospitals and nursing facilities.

[Connecticut Medicaid Reform Press Release](#)

[Grant for New England Health Insurance Exchanges](#)

[Federal Early Innovator Grant for Health Care Exchange](#)

[Federal Grant Recipient: State Demonstrations to Integrate Care for Dual Eligible Individuals](#)

Illinois

In January, the Illinois General Assembly approved and submitted House Bill 5420, a Medicaid reform measure designed both to reduce spending and to improve health care to Medicaid recipients. The Illinois Medicaid program currently supports 2.8 million Illinois residents; the proposed changes are expected to save the state \$770 million over five years and \$65.3 million in FY12. The main areas of focus in the reform measure are cost saving improvements to long term care, coordinated care, technology, fraud reduction, eligibility determination, and state payments to providers.

Key proposal changes impacting older Americans and persons with disabilities include a new budgeting strategy that will help move more people out of nursing homes and into the community by allowing the

governor to reallocate money from institutional to community care (which costs roughly three times less) without approval from the General Assembly. Another key proposal change is creating a global budget to track how all long-term care funding is spent across programs, agencies and age groups.

The Medicaid reform measures included in House Bill 5420 require that at least 50 percent of all Medicaid consumers enroll in coordinated care by 2015 (i.e., one primary physician tracking and making all health care decisions with the patient). Coordinated care reform would include state payment for performance-related outcomes, and the use of best practices and electronic medical records. Improved technology is expected by legislators to lead to better data collection and sharing among state agencies which will increase the state's ability to track Medicaid eligibility, enrollment, re-enrollment, and to identify fraud. Reform measures also allow the state to pursue a greater number of fraud cases and assess higher fines.

Medicaid reform measures include eligibility cost savings, which would require proof of Illinois residency, one month of income verification, elimination of automatic enrollment or re-enrollment (presumptive eligibility) of any group of people except for pregnant women. Medicaid reform also tightens eligibility requirements for children under the ALL KIDS program, by creating an Illinois residency requirement and an income limit (income at or below 300% of the federal poverty level).

[House Bill 5420 Overview](#)

[Governor Quinn, Landmark Medicaid Reform, Press Release](#)

Kansas

In a March 9, 2011 letter, Kansas Governor Sam Brownback, requested that the U.S. Secretary of Health and Human Services, Kathleen Sebelius, grant a complete waiver of federal Medicaid maintenance-of-effort (MOE) requirements, and provide funding for the Medicaid program in the form of a federal block grant. Governor Brownback explained that together the MOE waiver and a Medicaid block grant would give Kansas the flexibility needed to provide the best Medicaid services to its neediest citizens.

Governor Brownback proposed in his FY12 budget to increase Medicaid spending by \$265 million to a total of \$1.14 billion in state funds in order to sustain Medicaid at its current level for one more year. He explained that this would give Kansas the necessary time to reconfigure its Medicaid program to both serve vulnerable Kansans and maintain fiscal responsibility.

On February 16, 2011, Kansas received one of seven Early Innovator Grants from the U.S. Department of Health and Human Services (HHS). This \$32 million grant will assist Kansas in the development of the infrastructure of its exchange. Kansas is currently in preliminary discussions with the State of Missouri to partner on an exchange.

[Letter from Governor Brownback to US Secretary Kathleen Sebelius](#)

[Federal Early Innovator Grant for Health Care Exchange](#)

Kentucky

In November, 2010, Kentucky Governor Steve Beshear, announced a plan for closing the state's Medicaid budget gap of \$142.4 million in state funds over the biennium, while improving health outcomes for Kentuckians. In an effort to avoid measures such as cutting or freezing provider payments, raising taxes and fees for health care providers, or reducing benefits, Governor Beshear proposed reaching the budget goal by providing incentives for health care providers to control costs and utilizing public-private partnerships to implement innovative cost saving measures. Governor Beshear explained that, "the private sector can bring efficiency and innovation to the Medicaid program, both of which will be critically important as we continue to provide the care needed by more than 800,000 Kentuckians who depend on the program."

On January 5, 2011, the Kentucky Cabinet for Health and Family Services (CHFS) announced the release of six Requests for Information (RFIs) on strategies used by other states to manage health care costs, and the intent of creating action plans for new state programs based on the returned information. Kentucky's RFIs to obtain ideas for performance-based program innovations and cost containment include:

- Managed Care: Managed care models and other strategies for the delivery of quality, coordinated, comprehensive care under a capitated payment system within the context of a medical home
- Capitated Pharmacy Management: Innovative patient-centered pharmacy management programs that operate under a capitated payment system
- Dental Managed Care Organization: Creative dental service delivery models or purchasing options to assist the Department of Medicaid Services (DMS) with an emphasis on regular visits and preventive care
- Program of All Inclusive Care for the Elderly (PACE) and other capitated strategies: Innovative PACE models and other capitated strategies for the delivery of quality, coordinated, comprehensive care under a capitated payment system within the context of a medical home
- Pay for Performance: Program models that successfully improve the quality and efficiency of health care

In January, 2011, Governor Beshear signed an executive order creating the Medicaid Managed Care Oversight Branch to oversee the Department for Medicaid Services' implementation of managed care program innovations. Also part of the plan to rebalance the Medicaid budget is collaboration with U.S. Department of Justice and other federal authorities to resolve instances of fraud and abuse.

On April 7, 2011, CHFS released a request for proposals (RFP) to establish a master agreement for qualified managed care organizations (MCOs) to manage a risk-based, capitated Medicaid managed care arrangement. The contracts will include "a holistic approach to coordinated care including comprehensive services for physical, mental, dental and preventive health, and management of the following areas: a) provider network; b) utilization; c) disease; d) quality; e) customer service; f) IT systems; and g) claims. The RFP Kentucky indicates that aging, blind and disabled categorical populations will be included in the statewide managed care program, however people who reside in LTC facilities and HCBS waiver participants will not be included. CHFS intends to have the contracts in place by July 1, 2011.

[Kentucky Cabinet for Health and Family Services Requests Information for Medicare and Medicaid](#)

[Medicaid Cost Containment Announcement – Governor Beshear](#)
[Medicaid Managed Care Request for Proposal](#)

Massachusetts

In an effort to balance Massachusetts's FY12 budget, Governor Deval Patrick has proposed several strategies for Medicaid (MassHealth) cost-containment that move away from a fee-for-service method of payment and toward various strategies for coordinated health care. Massachusetts has developed a model for Medical Homes in which primary care practices work with patients to coordinate all aspects of their health care. Massachusetts proposes to enhance the Medical Homes model by gradually phasing in the use of bundled payments for certain conditions, including fixed payments to groups of physicians within an integrated practice for costs related to treatment for a particular condition. Massachusetts' existing Medical Homes model is expected by both Governor Patrick, and Secretary of the Department of Health and Human Services, Judy Ann Bigby, to act as a foundation for the implementation of accountable care organizations (ACOs). ACOs are patient-centered coordinated care models that the Patrick Administration and Secretary Bigby expect to help bring Massachusetts' plans for coordinated health care to scale.

Also focusing on improving the coordination of care for Medicaid beneficiaries, MassHealth is launching a project to manage health care for the population of young people (ages 21-64) who are eligible for both Medicare and Medicaid (dual eligibles). The new system will closely mirror the one currently in place for dually eligible seniors in which care entities will be accountable for the delivery, coordination and management of health and community support services that promote improved health outcomes, quality of life and independence.

Massachusetts, in collaboration with multi-state Northeast consortium (Connecticut, Maine, Rhode Island and Vermont) received one of seven Early Innovator Grants from the U.S. Department of Health and Human Services. Led by the University of Massachusetts Medical School, this grant provides \$36 million toward helping partner states develop and implement the technological infrastructure to operate a Health Insurance Exchange. It is expected that the technology developed by the Northeast consortium will be shared with other New England states.

Some of the other MassHealth cost-saving measures recommended in Governor Patrick's FY12 budget proposal include containing provider rates and capitation payments, limiting payments for preventable hospital re-admissions, implementing co-pays for some services, adopting additional program integrity measures and limiting coverage for certain optional benefits.

[Governor Patrick Budget FY2012 – Report on Health Care Cost Containment](#)
[Changing the Payment Structure for Health Care in Massachusetts](#)
[Massachusetts' New Approach to Health Care Costs: Washington Post](#)
[Federal Early Innovator Grant for Health Care Exchange](#)

New York

Governor Cuomo signed an Executive Order on January 5, 2011, creating the Medicaid Redesign Team, tasked with identifying strategies to reduce costs while improving the quality of health care in New York. Governor Cuomo gave the Medicaid Redesign Team a budget reduction target of \$2.85 billion. . The team sought ideas from the public at large as well as stakeholders on topics such as health care delivery workforce, insurance, economics, business, and consumer rights among others. Jason Helgeson, the former Wisconsin Medicaid Director who led that state's Medicaid Rate Reform Project, was appointed New York's first Medicaid Director, and is responsible for leading New York's Medicaid Redesign Team.

The Medicaid Redesign Team voted on 79 cost-cutting measures that totaled \$2.3 billion in savings. The proposed cuts are a combination of ideas from the health care industry, public hearings, and a series of meetings held in every region of the state. The Team proposals meet the Governor's budget target by introducing a global annual cap on State Medicaid expenditures of \$15.1 billion including many broad-based proposed mechanisms: a) reforming the Medicaid payment and program structure (\$1.1 billion in savings); b) implementing a two percent across-the-board rate reduction (\$345 million in savings); c) prepaying certain for certain Medicaid services to leverage additional enhanced Federal matching funds under ARRA (\$66 million benefit); and d) implementing industry-led cost containment initiatives (\$640 million in savings).

Many of the specific recommendations of the Team focus on increasing managed care for Medicaid beneficiaries including: a) moving more high-cost, high-need Medicaid beneficiaries into managed care though facilitating access to patient-centered medical homes with a focused on care coordination; b) creating an office for the development of patient-centered primary care initiatives; c) increasing use of care management (entire Medicaid population to be enrolled in care management within three years); d) mandating enrollment in Managed Long Term Care plans for adults in need of community-based long term care; and e) developing initiatives to integrate managed care for dual eligibles.

Some other specific recommendations of the Team are as follows: a) designing comprehensive fee-for-service pharmacy reform; b) developing an automated exchange/Medicaid eligibility system; c) expanding the usage of both palliative care and hospice; d) developing a uniform assessment tool for statewide long term care services; e) restructuring reimbursement for proprietary nursing homes; f) reforming medical malpractice rules; g) centralizing responsibility for Medicaid estate recovery process; and h) applying the 60 month look back period to non-institutional long term care beneficiaries. The Medicaid Redesign Team will continue to generate ideas and will submit quarterly reports for further health care reforms until the end of Fiscal Year 2011-12, when it will disband.

New York was the recipient of one of seven Early Innovator Grants from the U.S. Department of Health and Human Services (HHS). This \$27 million grant will help New York develop and implement the technological infrastructure to operate a Health Insurance Exchange.

[Executive Order: Medicaid Redesign Team](#)

[Additional Details on Medicaid Redesign Team](#)

[Governor's Budget Summary](#)

[Updates on Medicaid Redesign Team Recommendations - text](#)

[Updates on Medicaid Redesign Team Recommendations – chart](#)

[Federal Early Innovator Grant for Health Care Exchange](#)

Ohio

Governor John Kasich signed an Executive Order on January 13, 2011, establishing the Governor's Office of Health Transformation (OHT) and named Greg Moody, advisor to former Ohio Governor Bob Taft, to be its executive director. The Executive Order points to the opportunity to “reset the basic rules of health care competition so the incentive is to keep people as healthy as possible.” This includes the transformation of primary care to a prevention-based system that helps reduce both chronic disease and chronic care costs. The immediate needs addressed by the OHT will be Medicaid spending issues, the long-term efficient administration of the Ohio Medicaid program, and improvement of overall health system performance in Ohio.

Together with the state health and human services agencies (Aging, Health, Mental Health, Developmental Disabilities, Job and Family Services/Medicaid, Alcohol and Drug Addiction Services), as well as the Office of Budget and Management and the Department of Administrative Services, the new OHT will lead the effort to modernize and plan for the long-term efficient administration of the state's Medicaid program, incentivize preventative health practices, initiate and guide health insurance market exchange planning, and improve cost-containment strategies. OHT also will draw upon public and private sector best practices to recommend a permanent HHS organizational structure, and oversee transition to that permanent structure in an effort to improve Medicaid's overall performance.

In February, 2011, the OHT released a report entitled “Ohio’s Demonstration Model to Integrate Care for Dual Eligibles,” which details Ohio health policy plans for a new approach to health care that includes a person-centered, total-care management. The model, Integrated Care Delivery System (ICDS), would provide a Medicaid service package that meets the needs of dually eligible individuals. ICDS would include the following initiatives: a) Coordination of rate development between Medicare and Medicaid; b) alternative implementation models such as managed care plans, accountable care organizations and health homes; c) rate-setting methods that base payment on outcome and coordination of care; and d) Medicaid funds to provide room and board for individuals receiving community based services. Ohio was one of 15 states awarded federal funds through a new ACA initiative, intended to develop new more efficient and less confusing ways to meet the needs of dual eligibles. The Federal Coordinated Health Care Office, also created by provisions within the ACA is expected to work with the 15 grantees to implement strategies to coordinate all medical care, reduce duplication of services, and increase access to care for this high-need, high cost population.

[Executive Order establishing the Office of Health Transformation \(OHT\)](#)

[Columbus Dispatch on the OHT](#)

[2011 Plan to Integrate Care for Dual Eligibles](#)

[OHT publication: “Better Health, Better Care and Cost Savings through Improvement”](#)

[OHT publication: “Medicaid Hot Spots” \(most costly areas of Medicaid\)](#)

[Federal Coordinated Health Care Office \(Office of Dual Eligibles\)](#)

[State demonstration Project Initiative for Dual Eligibles](#)

Texas

In keeping with his commitment ensured continued balanced budgeting, Governor Perry expressed his intention of working within the available state revenue, requiring each state agency to evaluate all programs for potential cost saving measures, and not to raise taxes on Texas families and businesses. On January 15, 2010, the Governor, Lieutenant Governor and House Speaker directed state agencies to identify a five percent state budget savings (\$205 million reduction) for the 2010-2011 biennium, an additional 2.5 percent for the 2011 fiscal year, and 10 percent for the 2012-2013 biennium. Lt. Governor Dewhurst added, “Contrary to taking an across-the-board approach, the House and Senate will continue to work through program by program to identify savings and determine our funding priorities with the revenue we have available.”

The Department of Aging and Disability Services (DADS) proposed reductions in Home and Community Based Services rates based on a methodology change, long-term care provider rates, and non-Medicaid programs, In-Home Family Support, MR³ In-Home Family Support, MR Community Services, and the state’s Promoting Independence program. Additionally, with the goals of maintaining essential Medicaid services and accountability while cutting costs, each of five agencies comprising Texas’s Health and Human Services System individually submitted their requests for legislative appropriations for FY2010-11. Some of the major resulting cost-saving budget items are as follows: a) a reduction in the number of hours of Medicaid State Plan Personal Care Services; b) provider rate reductions (\$64.3 million savings); c) revenue management of federal funds (\$39.5 million); d) administrative reductions, program delays and salary savings (\$64.7 million); e) client service reductions including no services for 285 children on the wait list for Children with Special Health Care Needs program, and f) trauma funds for hospitals (\$36.6 million). Additional cost-saving measures for FY2012-13, include capitating services in both Medicaid and CHIP and an expansion of managed care including STAR-Plus programs in which the state pays a fixed amount per Medicaid enrollee.

[Governor Perry’s Consolidated Proposed Budget FY12-13](#)
[Governor Perry on Fiscal Responsibility and Budget](#)
[Governor Perry’s Remarks at Medicaid Reform Bill Signing](#)
[STAR+PLUS - Texas Medicaid Managed Care Program](#)

Vermont

In his January 6, 2011, Inaugural Address, Governor Shumlin noted his intention of replacing Vermont’s current health care system with a single-payer model intended to provide “universal, affordable, quality health care that follows the individual and is not tied to employment.” On February 8, 2011, Governor Shumlin signed a healthcare reform bill setting out a three-stage process for moving the state to a single-payer health system over four years. To help inform single-payer system decisions, Governor Shumlin assembled a healthcare team that invited providers, consumers, businesses, municipalities, insurers, and Vermont’s congressional delegation to the table.

³ Texas uses the term “mental retardation” for the title of this program. Current nomenclature used for this population is persons with intellectual and developmental disabilities (ID/DD).

Anya Rader Wallack, Special Assistant to the Governor for Health Care, explained that a single-payer system would help to streamline the current fragmented healthcare system by eliminating duplication as well as “getting insurers out of managed medicine, and allowing providers to use technology and appropriate quality oversight to get waste out of the system.”

The first of three proposed healthcare reform stages beginning July 1, 2011, includes: a) creating a health benefit exchange as permitted under the federal Affordable Care Act (ACA); and b) convening a six-member Vermont Health Reform Board to develop payment reform and cost containment methodologies, focusing on outcomes rather than fee-for-service payments, which is intended to result in sustainable rates of growth in health care spending. According to Wallack, “this redesigned primary care network will eventually be the backbone of a reformed delivery system for the state.”

Along with the multi-state North East consortium (Connecticut, Maine, Massachusetts and Rhode Island), Vermont received one of seven Early Innovator Grants from the U.S. Department of Health and Human Services. The \$36 million grant is intended to aid northeastern states develop and implement the technological infrastructure to operate a single interstate Health Insurance Exchange. The second stage of a single-payer health system is proposed to begin on January 1, 2014, when the Vermont Health Benefit Exchange is expected by the Administration to become operational.

In the third and final stage of the proposed healthcare reform, Vermont will ask the federal government for permission to move to a publically-financed Vermont Health Benefit Exchange. Prior to 2014 Vermont will request a continuation of its Vermont health access plan 1115 Waiver, and a Medicare waiver to permit integration of those programs with exchange payment reforms and administrative simplifications. The effort’s goal is to reduce breaks in coverage as people move between public and private programs. If granted, the State proposes that premium payments by individuals and employers in Vermont would be eliminated unless employers chose to continue individually providing health coverage. In a March 2011 meeting with the Obama Administration, Shumlin received a positive response indicating that the Administration would grant a federal waiver to allow Vermont’s single-payer system to substitute for the health insurance exchange mandated under ACA.

House Bill 202, regarding Vermont’s single-payer health system, passed in the State House of Representatives on March 23, 2011, and is currently awaiting a vote by the Senate.

[Governor Shumlin’s Inaugural Address](#)

[Testimony of Anya Rader Wallack on Governor Shumlin’s Health Reform Proposal](#)

[Dr. William Hsiao’s report, “The Vermont Option, Achieving Affordable Universal Health Care”](#)

[Burlington Free Press: Obama supports Vermont’s single-payer system](#)

[Federal Early Innovator Grant for Health Care Exchange](#)

[Passed House Bill 202, Single-Payer Health Care](#)

[House Bill 202 Activity](#)

Washington

In an executive order designed to reduce budget expenditures for 2011, Governor Gregoire mandated the Medicaid Purchasing Administration (MPA), as well other state agencies reduce their current budget expenditures by 6.3 percent. To achieve this budget reduction, MPA is eliminating state payment of Medicare prescription drug copayments for full benefit dual-eligible (Medicare and Medicaid) recipients, effective January 1, 2011.

In a budget plan designed to reduce health care costs over the next ten years, Governor Gregoire of Washington State has proposed major changes to the Medicaid program that are intended to both improve health care quality and save money. Washington State already has implemented several initiatives that have reduced health care costs while improving health care delivery: a) implementing intensive chronic care management programs for high-need older adults and persons with disabilities ; b) creating pilot projects to divert patients from more expensive emergency room care to community clinics; c) nonpayment to hospitals for unnecessary readmissions; d) coordinating and monitoring care for consumers with a history of overusing high-cost services; and e) reducing the number of avoidable Caesarian deliveries.

Building on Medicaid cost saving and quality improvement efforts, Governor Gregoire has proposed further changes including consolidating a majority of the state's health care purchasing into a single agency and taking advantage of various provisions of the federal health reform law. Washington State will be working with the federal Center for Innovation on a pilot project that will assist with transitioning the focus of Washington's health care system to payment on the basis of quality of outcomes instead of number of medical procedures performed, coordinated care, and encouraging personal responsibility for health and cost-effective treatment decisions. To support the effort, the Governor and state agencies will bring together public and private purchasers and payers to identify best practices and develop plans to reproduce successes over time.

[Budget Reduction Rule - Medicare Prescription Drug Copayments](#)
[Governor Gregoire's Budget Proposal](#)

Policy and Court Activity Impacting Medicaid Legislation

In this section, NASUAD provides an overview of policy and court activity developments with potential implications for state Medicaid reform efforts:

Increased State Role in Determination of Medical Necessity

On April 7, 2011, reversing an earlier decision, the U.S. Court of Appeals for the Eleventh Circuit found that the Georgia Department of Community Health (DCH) was not required to defer to the determination of medical necessity by a treating physician concerning the number of hours of required weekly in-home personal care. A prior federal trial court decision on the same issue found that a treating physician's judgment, absent evidence of Medicaid fraud or abuse, was entitled to deference as long as it was "within the reasonable standards of medical care." The April 7 appeals court determination reversed the federal trial court's prior decision, however, rejected the state's contention that it should be "the final arbiter of medical necessity." Rather the U.S. Court of Appeals held that both the state and the treating physician have roles to play, and the "threat of escalating Medicaid costs was an insufficient basis for finding the state should get the final 'say' with respect to medical necessity determinations."

[Eleventh Circuit Court of Appeals' Decision Regarding Medical Necessity](#)

Medicaid Rate Reductions

On March 10, the U.S. District Court for the District of Idaho issued its ruling in *Unity Service Coordination Inc. v. Armstrong*, finding the state to be out of compliance with federal Medicaid law. At issue in this case are the payment rates for providers who coordinate services for Medicaid recipients with intellectual and developmental disabilities, which were approved by CMS and adopted by Idaho in 2009. Six Idaho service coordination agencies initiated the legal challenge, citing the cost studies conducted by the state to justify these rates as evidence of Idaho's noncompliance with Section 30(A) of the Medicaid Act. The court agreed, finding the state's methodology to be inadequate, noting that CMS' approval of the state plan amendment does not prevent the court from engaging in its own analysis of the rates compliance with federal law.

In its analysis, the court relies in part on a Ninth Circuit precedent, which includes the recent California case *Independent Living Center of Southern California, Inc., v. Maxwell-Jolly*. Here, the court found that in order for states to comply with the procedural and substantive requirements of the Medicaid Act, states must rely on responsible cost studies in setting rates, and the adopted rates must be reasonably related to provider costs. Currently, the Ninth Circuit's ruling in *Independent Living* is before the U.S. Supreme Court, and arguments are expected to begin when the Court's next term begins in October 2011.

Finding that Idaho's "only apparent shortcoming in the cost study was the failure to develop an accurate rate for indirect costs," the court suggests that the remedy in this case will address this specific issue, instead of conducting an entirely new study. These details will be addressed on March 25, when the District Court will hold a hearing to determine an appropriate remedy.

On April 4, 2011, the National Association of Medicaid Directors (NAMDM) transmitted a letter on Medicaid payment rate requirement to the Center for Medicaid, CHIP and Survey & Certification (CMCS) within the

National Association of States United for Aging and Disabilities

Centers for Medicare and Medicaid Services. In the letter, NAMD sought assistance and clarification on the rules regarding adjustments in provider reimbursement rates found in Section 1902(a)(30)(A) of the Social Security Act (SSA). In a recent ruling, the Ninth Circuit Court of Appeals took the position that states must conduct costs studies before altering the payment rates for any category of provider, and that their rates must be shown to be reasonably related to provider costs. NAMD explained that this ruling is inconsistent with other circuit courts, and that states in the Ninth Circuit should not be held to stricter conditions than states in the rest of the country. NAMD requested that CMS issue a guidance document, including reiteration of the positions that the statute requires neither cost studies nor a demonstration by states that rates are related to provider costs.

[NAMD Letter to CMS](#)

Recovery of Reimbursements from Medicare

On March 11, the U.S. Court of Appeals for the First Circuit held that state Medicaid agencies may not recover reimbursement directly from Medicare, citing both statutory authority and consistency with CMS' regulations.

The appeal was filed by the Commonwealth of Massachusetts, on behalf of state Medicaid program, MassHealth, upon the district court's dismissal of its lawsuit claiming that CMS violated the Medicaid Act by refusing to allow MassHealth to recover reimbursements directly from the agency in four instances of retroactive dual eligibility. In each of these four cases, an individual who received Medicaid funds was later deemed retroactively eligible for Medicare during this same time period. To recover the Medicaid payments issued to these individuals, Massachusetts sought to secure reimbursement directly from the federal government, circumventing the established reimbursement process that recognizes service providers as the appropriate claimants.

In affirming the district court's judgment dismissing the Commonwealth's lawsuit, the First Circuit agreed with the lower court's interpretation of the Medicare statute to "unambiguously forbid" states from recovering reimbursements directly from CMS, and emphasized that the state has alternative mechanisms to receive reimbursements, including requiring providers to file a demand bill with CMS on the state's behalf.

ABOUT NASUAD

The National Association of States United for Aging and Disabilities, founded in 1964, represents the nation's 56 officially designated state and territories agencies on aging and disabilities. The association's mission is to design, improve, and sustain state systems delivering home and community based services and supports for people who are older or have a disability, and their caregivers.

NASUAD works to:

Innovate

Collect, analyze and facilitate use of information among states on innovation and effective policies and programs

Advocate

Represent states' interests in design and development of comprehensive long term services and supports

Assist

Provide state specific technical assistance on systems design, information, planning, and transformation

Collaborate

Foster the development of strategic partnerships

Convene

Facilitate communications among federal, state and local decision makers through various media including national meetings

NASUAD Contact Information:

National Association of States United for Aging and Disabilities
1201 15th Street, NW
Suite 350
Washington, DC 20005
202-898-2578
www.nasuad.org