

August, 2011

Medicaid Reform Proposal Tracker

Review of State Medicaid Reform

Fifth Edition

Medicaid Reform Proposal Tracker

Review of State Medicaid Reform- Fifth Edition, August 2011

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
- Overview of policy and court activity possibly impacting future Medicaid reform activities
- Overview of State Cost Containment Efforts

The Medicaid Reform Tracker is updated monthly. For more information or to suggest Medicaid reforms for inclusion in the next edition, please contact Sara Tribe at strobe@nasuad.org.

Medicaid Reform Proposal Tracker (August 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	Accountable Care Organizations (ACOs) ¹	Payment for Performance	Authority for Care Coordination Payments	Managed Care/ Capitated Service Delivery	Reimbursement Rates	Eligibility	Service Elimination	Service Reduction	Beneficiary Responsibility	Medicaid Program Integrity	Health Information Technology	Combining State Administrative Offices	Reducing Hospital Readmissions	Guiding Body for Reform Initiatives	Target Partnerships ²	Money Follows the Person	Nursing Home Diversion	Medicaid Expansion Pre-2014	Request for Waiver of Maintenance of Effort	Governor support of Federal Medicaid Block Grant ³	
Alabama																											
Alaska																											
Arizona			X		X		X		X	X	X	X	X	X	X			X							X	X	
Arkansas		X	X				X	X	X							X											
California		X	X	X	X		X	X	X	X	X	X				X							X	X			
Colorado																											
Connecticut		X	X		X	X		X	X	X	X					X					X	X	X				
Delaware			X		X			X	X	X							X		X		X	X	X				X
Florida	X	X	X					X	X			X			X							X					
Georgia																											
Hawaii		X	X					X		X	X	X															
Idaho																											
Illinois		X	X				X	X	X		X				X	X						X					
Indiana																											
Iowa																											
Kansas		X						X	X			X					X								X	X	
Kentucky		X	X	X	X	X	X	X	X						X	X		X		X							
Louisiana																											
Maine							X																				X
Maryland			X				X												X	X							
Massachusetts		X	X		X	X	X	X	X	X					X	X		X									
Michigan					X																						
Minnesota					X					X					X									X			
Mississippi																											
Missouri																											
Montana																											
Nebraska																											
Nevada																											
New Hampshire	X	X	X				X	X		X						X			X								
New Jersey			X		X				X		X														X		
New Mexico			X						X		X			X													
New York		X	X		X			X	X	X		X							X								

	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	Accountable Care Organizations (ACOs) ¹	Payment for Performance	Authority for Care Coordination Payments	Managed Care/Capitated Service Delivery	Reimbursement Rates	Eligibility	Service Elimination	Service Reduction	Beneficiary Responsibility	Medicaid Program Integrity	Health Information Technology	Combining State Administrative Offices	Reducing Hospital Readmissions	Guiding Body for Reform Initiatives	Target Partnerships ²	Money Follows the Person	Nursing Home Diversion	Medicaid Expansion Pre-2014	Request for Waiver of Maintenance of Effort	Governor support of Federal Medicaid Block Grant ³
North Carolina																										
North Dakota																										
Ohio		X	X		X	X	X	X	X	X			X						X	X			X			X
Oklahoma																										
Oregon			X		X			X	X	X								X								
Pennsylvania																										
Rhode Island																										
South Carolina		X	X		X			X	X	X		X	X	X					X				X			X
South Dakota											X		X				X									
Tennessee					X																					
Texas			X				X		X	X		X		X								X				X
Utah																										
Vermont					X	X					X									X						
Virginia	X		X		X	X			X	X										X						X
Washington		X	X	X	X	X		X	X	X			X	X		X	X	X		X						X
West Virginia																										
Wisconsin			X		X				X		X		X	X		X							X		X	X
Wyoming																										
District of Columbia																										
Total	3	15	23	3	19	8	4	13	16	21	18	8	3	13	5	7	9	4	7	9	3	3	9	3	4	11

¹Accountable Care Organizations (ACOs) are a network of doctors and hospitals that shares responsibility for providing care to Medicare patients. In this chart states are listed as utilizing ACOs, if they are using ACOs as part of their Medicaid reform plan (i.e. developing plans for combined Medicare and Medicaid savings).

²Targeted Partnership is a partnership in which a particular group is targeted for participation in aiding Medicaid

³Though several governors have expressed support for federal Medicaid block grants, only Washington state and Texas have passed bills to establish Medicaid block grants.

Medicaid Reform Tracker is a monthly copy written publication of the National Association of States United for Aging and Disabilities.

Please email Sara Tribe at Stribe@nasuad.org if you would like to receive monthly updates

New Editions to the Medicaid Reform Proposal Tracker

States added to the Medicaid Reform Proposal Tracker in this edition include: New Hampshire, New Jersey, Oregon, and Wisconsin.

New Hampshire

On June 2, 2011, Governor John Lynch signed into law Senate Bill 147, which requires the New Hampshire Department of Health & Human Services (DHHS) to establish a more robust Medicaid managed care program that ensures the enrollment of all eligible Medicaid members in a managed care program under contract with DHHS. The bill requires this transition to occur no later than 12 months after the contract is awarded to the vendor or vendors of the managed care model.

The current New Hampshire Medicaid Managed Care model consists of a Prepaid Ambulatory Health Plan (PAHP) delivering disease management under the Section 1915(b) enrollment authority. Enrollment in the plan is voluntary and services are available to categorically eligible blind and disabled populations but not aged. A PAHP is a form of managed care that provides less than comprehensive services on an at-risk or other than state plan reimbursement basis, and does not provide, arrange for, or otherwise have responsibility for the provision of any inpatient hospital or institutional services. There are several types of PAHPs that States use to deliver a range of services. For example, a Dental PAHP is a managed care entity that provides only dental services.

Under Senate Bill 147, Models for managed care may include but not be limited to a capitated managed care organization contract, an administrative services organization, an accountable care organization, a primary care case management model, or a combination the above models. Services managed within the model will include all mandatory Medicaid covered services and may include, but not be limited to home and community based care services and supports for all long-term care populations, care coordination, utilization management, disease management, pharmacy benefit management, provider network management, quality management, and customer services. Covered populations will include aid for the permanently and totally disabled (APTD), those utilizing Medicaid long-term care services (both community and institutional), and children with severe disabilities (HC-CSD).

The DHHS commissioner is required to issue a request for proposals for five year contracts no later than October 15, 2011, to enter into contracts for all Medicaid populations with vendors of a managed care model that demonstrate the “greatest ability to satisfy the state’s need for value, quality, efficiency, innovation and savings.” Once the bidding process is complete, the commissioner is responsible establishing a capitated rate based on the chosen model(s) that is full risk to the vendors. The target date for implementation of the managed care contract is July 1, 2012.

Additionally, the New Hampshire Citizens Health Initiative, created by Governor John Lynch, is a multi-stakeholder group that brings people together from across the state to meet the goals of ensuring more New Hampshire citizens will have access to quality health care, and the growth in health care costs is sustainable. In addition to expanding electronic prescribing, members of the initiative are also working with insurance companies to develop criteria for "pay-for-performance" standards, increasing preventative health care, and improving New Hampshire’s model for Medical Homes.

[Medical Home Project in New Hampshire](#)

[Health Payment Reform – Move to Accountable Care Organizations \(ACOs\)](#)

[New Hampshire Citizen Health Initiative](#)

[SB0147 \(2011\) – Act Relative to Medicaid Managed Care](#)

New Jersey

Contained in New Jersey Governor Chris Christie’s FY12 budget is a plan to cut \$540 million from the state’s Medicaid program by moving more beneficiaries into managed care and limiting adult coverage. To address coverage, New Jersey will have to seek a waiver from the federal government, because the federal Affordable Care Act (ACA) generally prohibits states from limiting Medicaid enrollment.

The eligibility changes are part of a larger state effort to expand Medicaid managed care enrollment, increase Medicaid physician pay, increase scrutiny of managed care contracts and institute cost-sharing for Medicaid enrollees. New Jersey will expand Medicaid managed care by requiring 130,000 existing aged, blind and disabled enrollees to enroll in a Medicaid managed care plan. As of April 2011, about 75 percent of New Jersey Medicaid and Children’s Health

Insurance Program enrollees were enrolled in a managed care plan. With the changes proposed in the FY'12 budget, nearly 92% of enrollees will be served through managed care.

New Jersey's FY12 proposed budget includes the initiative to move Medicaid fee-for-service beneficiaries into managed care plans offered by four participating HMOs. As of October 1, 2011, Medicaid beneficiaries will receive the following services through their HMO: home health services, pharmacy services, personal care assistant services, outpatient rehabilitation therapies (Physical Therapy, Occupational Therapy, Speech Therapy); and adult and pediatric medical day care services.

Mandatory enrollment of Medicaid beneficiaries into HMOs is expected to take place in two stages. Covered services will include virtually all long-term care services except nursing facilities. The first phase started on July 1, 2011 and includes the non-dual population of aging, blind and disabled Medicaid beneficiaries, populations served by the Department of Developmental Disabilities (DDD) including Community Care Waiver clients, clients already covered by a commercial or Medicare HMO, and breast or cervical cancer clients. The second stage will start on October 1, 2011 and include all dual eligibles (QMB, SLMB and other full duals), an increased range of waiver clients, clients with traumatic brain injury, and those clients participating in the AIDS Community Care Alternatives Program (ACCAP) and Community Resources for People with Disabilities (CRPD).

Services which will remain covered by Medicaid fee-for-for service include mental health and substance abuse services except for DDD clients, nursing facility care beyond 30 days, transportation through LogistiCare except for emergency ground transportation, and institutional services.

Governor Chris Christie joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[New Jersey DHHS on Changes to Medicaid Managed Care](#)

[New Jersey DHHS Power Point Explaining Changes to Medicaid Managed Care](#)

[AmedNews Review of Medicaid Reductions](#)

Republican Governors Association Letter to U.S. Legislators - Repeal of ACA

Oregon

On July 1, 2011, Oregon Governor John Kitzhaber, signed House Bill 3650 to establish Coordinated Care Organizations (CCOs) for recipients of the Oregon Health Plan which includes Medicaid and other state-based public insurance programs. A CCO is a local entity that receives a global (set) budget for management of prevention, physical health services, mental health, and dental care. The goal of the legislation is to hold down costs while improving the coordination and quality of services provided. If savings are achieved and quality metrics are met, providers in the CCO can share in the savings.

Oregon's legislation lays out a broad strategy for CCOs and establishes four workgroups that will make detailed recommendations to the legislature in 2012. The legislature will then be required make the final policy decisions for July 2012 CCO implementation. The workgroups will assess the following aspects of CCOs: 1) eligibility criteria; 2) global budget methodology; 3) outcomes, quality, and efficiency metrics; and 4) Medicare-Medicaid integration of care and services.

[Oregon House Bill 3650 – Summary of CCO Legislation](#)

[Governor Kitzhaber on “Remaking Health Care”](#)

[Oregon 2012 Budget – Wrap Up of Legislative Session](#)

Wisconsin

On June 16, 2011, the Wisconsin Assembly passed the 2011-2013 budget highlighting Wisconsin's focus on expanding programs that support self-directed services and developing systems to encourage and reward individual responsibility by assisting recipients in making healthy lifestyle choices, managing their benefits effectively and avoiding unnecessary care. The budget measure also cuts nearly \$800 million in state and federal funds from Medicaid and BadgerCare (Medicaid funded program for youth, families and farmers), including \$265 million from Family Care (managed long-term care) and \$467 million in unspecified Department of Health Services (DHS) program cuts.. Additionally, through both the 2011-2012 budget and the budget repair bill (2011 Wisconsin Act 10, Assembly Bill 11),

responsibility for health care decision-making is shifted from the Wisconsin Legislature to DHS.

Additionally, Wisconsin's budget bill directs DHS to seek a waiver for the maintenance of effort (MOE) restrictions from the federal government; if the waiver is granted, DHS would be allowed to make policy changes to reduce eligibility for BadgerCare and other Medicaid programs. The budget repair bill seeks a waiver to remove people from Medical Assistance programs who have incomes between 133 and 200 percent of the federal poverty level. Passage of the budget repair bill also gives DHS the "emergency" authority to make changes in Medicaid programs without legislative approval, but included a public hearing requirement. Subsequently, the budget bill dropped the public hearing requirement, essentially giving DHS leadership more direct responsibility to make changes to Medicaid programs without legislative or public approval.

Governor Scott Walker joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Wisconsin 2011-2013 Budget](#)

[Wisconsin Budget Repair Bill \(Act 10\), March 2011](#)

[Impact of Budget Repair Bill](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

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 as of July 31, 2011.

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, 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.

After a several-month effort led by Governor Brewer, On July 5, 2011, Arizona's Health Department was granted federal approval to reduce Medicaid eligibility. The change will not end coverage for children or adults currently receiving Medicaid, rather, it bars new beneficiaries from enrolling, and it is expected to save \$282.4 million in state funds.

Prior to the eligibility reduction, in June, 2011, several public interest law firms brought a petition to prevent the Arizona Health Care Cost Containment System (AHCCCS) from changing eligibility standards to the Arizona Supreme Court. However, the Supreme Court ruled in favor of the state, allowing the new eligibility standards to go into effect in July. It is likely that public interest law firms and others will continue to bring the State to court in an effort to reverse the eligibility changes.

Originally presented in Governor Brewer's March 2011 Medicaid Reform Plan, the following benefit changes impacting adults 21 years and older (with some exceptions) in Arizona Long Term Care System programs, will be effective October 1, 2011: a) 25-day annual inpatient hospital limit; b) decreased respite hours; c) coverage exclusion for certain non-emergency services provided by hospital

emergency departments; and d) elimination of non-emergency medical transportation within certain counties and populations.

Several longer term reforms noted in Governor Brewer's Medicaid Reform Plan include 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." Governor Brewer also proposed a five percent provider rate cut that would be implemented October 1, 2011, for state FY12 general fund savings of \$95.0 million.

Governor Brewer joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

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

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

[Proposition 204 Rollback](#)

[Proposed Medicaid Reform Plan](#)

[Childless Adult Transition Plan - AHCCCS](#)

[Federal Approval for Decreased Medicaid Eligibility](#)

[Court Case Regarding the Override of Proposition 204](#)

[Medicaid Eligibility Reduction - Supreme Court Involvement](#)

[AHCCCS Benefits Change Fact Sheet](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

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 including partnerships of local providers to act as health homes and reimbursement 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 his letter, Governor Beebe suggests that, 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.

In May, 2011, The U.S. Department of Health and Human Services gave Arkansas conditional approval, allowing the Governor to submit a formal proposal for a waiver needed to enact his Medicaid payment reform initiative.

[Letter from Governor Beebe to US Secretary of HHS Sebelius
Medicaid Payment Reform Approved by Federal Government](#)

California

On June 30, 2011, California Governor Jerry Brown signed into law the 2011-2012 California budget, including a wide array of Medicaid savings initiatives totaling \$1.7 billion in State and Federal cuts to California's Medicaid program, and greatly impacting older adults and persons with disabilities. The budget-reducing provisions include: a) elimination of the Medicaid State Plan Adult Day Health Care benefit; b) new caps on benefits; c) mandatory increases to copayments for physician, clinic, dental, emergency room and hospital visits; d) 10 percent provider rate reductions to physicians, home health agencies, physicians, certain hospitals, pharmacies and nursing facilities; and f) increased premiums for families with incomes at or above 150 percent of the federal poverty level.

Medi-Cal, California's Medicaid program, serves 7.7 million Californians, which represents 19.7 percent of the total state population. California's enacted 2011-2012

budget decreases funding to both mental health services (decrease of \$861.2 million in general funds) and developmental services (net decrease of \$582.2 million in general funds over two years).

California's In-Home Supportive Services (IHSS) program pays workers to visit at home and provide basic personal services for 450,000 low-income older adults and people with disabilities. Governor Brown's 2011-2012 budget eliminates services for recipients who do not obtain medical certification from a licensed health care professional for the program. The budget predicts this eligibility requirement will produce \$67.4 million in savings for the state. California also will exercise the federal option for home and community-based attendant services, yielding a six percent increase in federal matching funds and a savings of \$128 million in state funds.

In an effort to pave the way for key elements of the ACA by 2014, California has proposed changes to its 1115 Comprehensive Demonstration Waiver. The 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 by 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; and e) implementing payment reforms for safety net systems. Payment reforms within the section 1115 Waiver aim to replace the fee-for-service payment model with 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 medical home provider will be required to offer care management, disease and medical management and community-based care coordination. California HHS estimates that approximately two million Medi-Cal beneficiaries will be enrolled in medical

homes throughout the course of the Waiver. 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.

[Governor's Enacted 2011-2012 Budget Summary](#)

[Governor's Budget Highlights](#)

[California Section 1115 Comprehensive Demonstration Waiver - Bridge to Reform](#)

[Governor's Cuts to In-Home Supportive Services Program](#)

[Issue Brief on California's Health Benefit Exchange](#)

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 assisting older adults and persons with disabilities in their transition from nursing home to community settings as an additional cost saving measure. Connecticut was the first state in the U.S. to receive approval from CMS to expand Medicaid coverage under the Affordable Care Act, to low income adults allowing an estimated 45,000 adults to become eligible for Medicaid as of June 2010.

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 in April, 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.

On July 15, 2011, Governor Malloy unveiled Connecticut’s 2012-2013 budget which includes many cost-saving measures. Connecticut has plans to reduce Medicaid reimbursement rates to hospitals, physicians and durable medical equipment suppliers (projected savings of \$7.7 million state funds in FY12, and \$10 million in FY13); limit eligibility in Medicaid for childless, low income adults; and implement a more restrictive asset test for Medicaid eligibility.

[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](#)
[CMS Approval for the Expansion of Medicaid](#)
[Connecticut FY2012-13 Budget Balancing Plan](#)

Delaware

The Delaware Division of Medicaid and Medical Assistance (DMMA) within the Department of Health and Social Services is amending Delaware’s current 1115 Waiver, by developing a plan for mandatory managed/integrated Medicaid long term care (LTC) expansion called the Diamond State Health Plan – Plus (DSHP – Plus). Specifically, the 1115 waiver amendment proposes to integrate Nursing

Facility services and home and community based services into the existing managed care delivery system. In partnership with the Delaware Division of Services for Aging and Adults with Physical Disabilities (DSAAPD) and other stakeholders, the goals of the consumer-centered initiative are to utilize a managed, capitated, integrated approach to improve access to community based long-term care services, decrease health care system and administrative inefficiencies, and reduce Medicaid LTC costs.

In a May 2011 presentation, DMMA explained that the current managed care delivery system operated under the 1115 Waiver, serves LTC individuals with the exception of dual eligibles, has a primarily fee-for-service payment methodology, and is heavily reliant on nursing facility service. With a focus on older adults and people with disabilities, DSHP – Plus would integrate both nursing facility and home and community based services (HCBS) into the existing Delaware managed care system. The Medicaid LTC expansion would bring a majority of dual eligibles into managed care with the exception of the following populations: individuals receiving services through the MR/DD HCBS waiver, those residing in a ICF/MR center, state only non-Medicaid beneficiaries, and people enrolled in PACE.

In order to reduce cost and increase the administrative efficiency of the Medicaid program, Delaware plans to streamline Medicaid by tasking DMMA with intake, and the determination of medical and financial eligibility (tasks previously shared with DSAAPD). With a focus on HCBS, DSHP – Plus would also reinforce the use of Money Follows the Person, Care Transitions, and nursing home diversion programs. The anticipated implementation date for DSHP – Plus is in April 2012. On July 15, 2011, a summary of the waiver proposal was submitted to CMS for initial review.

[Delaware Division of Medicaid and Medical Assistance News Page](#)

[Diamond State Health Plan Plus Planning](#)

[DSHP Waiver Proposal 1115 Demonstration Waiver Amendment Summary](#)

Florida

On June 2, 2011, Florida Governor Rick Scott approved House Bills 7107 and 7109, both intended to transition a majority of Florida Medicaid beneficiaries into for-profit managed care plans. Rather than utilizing the traditional Medicaid fee-for-service payment structure, Florida managed care plans would be paid a set amount

per beneficiary including all of a patient's health care needs. The new payment structure offers health plans (both capitated HMOs or provider service networks of physicians and hospitals), capitated rates that are 5% less than projected fee-for-service spending. If they meet quality standards, the health plans are allowed to keep the first five percent of savings as profit but are required to share additional profits with the state. The plan also includes \$10 monthly premiums for Medicaid enrollees and \$100 for nonemergency services provided in emergency rooms. Proposals for Medicaid cost-sharing must be approved by the U.S. Department of Health and Human Services before implementation, therefore the cost-sharing portion of Florida's new health care payment structure remains pending.

Prior to the passage of the health reform bills, approximately 67 percent of Florida's Medicaid beneficiaries already were 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 Florida 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 establish the Medicaid program as a statewide, integrated managed care program for all covered services including long-term care, and gradually require different groups of beneficiaries to enroll in managed care plans (seniors, women and children, and people with developmental disabilities). The plan would also require beneficiaries to pay premiums for home and community-based services and impose some funding limitations on services. H.B. 7107 authorizes Florida's Agency for Health Care Administration (AHCA) to: a) establish provider requirements for eligible and varying models of managed health care plans (HMOs, plans for special populations and medical home plans); b) regionalize the plan to ensure comprehensive coverage in rural areas; c) create strong plan accountability measures; d) ensure meaningful recipient choice; and e) select a limited number of qualified plans to participate in the Medicaid managed care program. The effective date for both house bills is July 1, 2011.

Governor David Heineman joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to

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

gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Florida House Bill 7107](#)

[Florida House Bill 7109](#)

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

[Florida House Staff Analysis of Medicaid Managed Care, H.B. 7107 and 7109](#)

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

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

Hawaii

Several upcoming Medicaid reforms were highlighted during a May 10, 2011, Med-QUEST review of the Hawaii State Department of Human Services (DHS) Medicaid budget proposal. The Med-QUEST division (MQD) of DHS coordinates Medicaid programs which provide coverage to older adults and people with disabilities in Hawaii. Proposed Medicaid reforms include: 1) eligibility reduction; 2) service reduction; 3) reimbursement decreases to health plans and health care providers; 4) Electronic Health Record (EHR) integration; 5) Medical Homes development; and 6) health insurance exchange support.

Hawaii's Med-QUEST division has proposed to decrease the financial eligibility level of Medicaid recipients from 200 percent of the Federal Poverty Level (FPL) to 133 percent FPL. This change would eliminate Medicaid coverage of about 4,500 Hawaii residents. Proposed service reductions include both weekly chore hours and non-medical transportation.

On May 6, 2011, Governor Ambercrombie announced Hawaii's establishment of medical homes for people with chronic conditions as a strategy to improve the quality of coordinated care through technology, health provider communication, and patient access to primary care. To encourage an effective transition of health care providers into using certified electronic health record technology, Hawaii is participating in the Medicaid EHR Incentive program with the Centers for Medicare and Medicaid (CMS). Under this program, incentive payments are made to eligible

Medicaid health care professionals and hospitals that demonstrate effective use of EHR.

[Hawaii Med-QUEST Division Proposal for Budget and Future of Health Care Coverage](#)

[Med-QUEST Program Eligibility](#)

[Governor Ambercrombie May 6, 2011 Health Homes Press Release](#)

[Hawaii Medicaid Electronic Health Record Incentive Program](#)

[Hawaii Biennium Budget 2012-2013](#)

Illinois

In January, Illinois Governor Pat Quinn signed landmark Medicaid Reform contained in House Bill 5420 into law, a 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 \$624 million to \$774 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 reduction of state payments to providers.

A key proposals impacting older Americans and persons with disabilities includes a new budgeting strategy that requires the Illinois Department of Health Services, Department of Health Care and Family Services, and the Department on Aging, to create a “unified budget” for long term care that will increase efficiency, and facilitate the transition of clients from institutional to community settings.

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. primary care services through one physician, most often through a medical home).

Coordinated care reform would include state payment for performance-related outcomes, the use of best practices and electronic medical records, and increased utilization of medical homes. 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. In July, 2011, the Obama administration's Centers for Medicare and Medicaid Services asserted that the above anti-fraud provisions of the new Illinois law do not comply with the federal health care reform law, due to the federal law against limiting Medicaid eligibility. Bipartisan state legislators in support of the anti-fraud Medicaid reforms, hold that the Illinois reforms do not change or curb eligibility, rather they advance greater oversight of the program to ensure Medicaid recipients are eligible.

[Medicaid Reform \(House Bill 5420\) Summary](#)

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

[U.S. HHS Challenge to Anti-Fraud Medicaid Law](#)

[Illinois 2012 Budget Summary](#)

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. In June, 2011, Governor Brownback joined other Republican governors in co-signing a National Governors Association letter to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

In February of 2011, an executive reorganization order was signed by Governor Brownback, to transfer all operations of the Kansas Health Policy Authority, including Medicaid, to the Kansas Department of Health and Environment (KDHE). As of February 2011, administration of the Medicaid program was shifted to the new Division of Health Care Finance within KDHE which is overseen by Brownback's

administration. Governor Brownback indicated that combining agencies would save the state \$3 million in administration funds for FY12.

[Letter from Governor Brownback to US Secretary Kathleen Sebelius
Federal Early Innovator Grant for Health Care Exchange
Transitioning Medicaid Program to Kansas Department of Health and Environment](#)

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."

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 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; capitated pharmacy management, dental managed care, Program of All Inclusive Care for the Elderly (PACE); and pay for performance.

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) information technology systems; and g) claims. Within 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.

On July 7, 2011, Kentucky awarded contracts to the following four MCOs to provide comprehensive, coordinated health care services to over 560,000 Medicaid recipients across Kentucky: Passport Health Plan, CoventryCare of Kentucky, Kentucky Spirit Health Plan, and WellCare of Kentucky. The Beshear Administration has submitted a Medicaid managed care plan proposal to the Centers for Medicare and Medicaid Services (CMS), and awaits federal approval in order to begin enrollment in the MCOs by October 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](#)
[Medicaid Rebalancing Plan](#)
[New Firms Chosen for Kentucky Medicaid Managed Care](#)
[Medicaid Managed Care Contract – Kentucky Spirit Health Plan](#)

Maine

On May 17, 2011, Governor Paul LePage signed a health care reform bill entitled, "An Act to Modify Rating Practices for Individual and Small Group Health Plans and To Encourage Value-based Purchasing of Health Care Services." The health care bill (LD 1333) is intended to bring down health insurance costs by increasing market competition, allowing individuals and businesses to buy insurance from other New England states. Governor LePage reported that LD 1333 will help to create jobs by lowering health insurance costs for small businesses, allowing them to hire more staff. The measure also helps small businesses mitigate risk by allowing companies with fewer than 50 employees to jointly purchase health insurance. House Speaker Robert Nutting, indicated high health care costs in Maine left 130,000 residents without health insurance. Provisions within LD 1333 are intended to lower costs

enough to help achieve coverage for a significantly larger proportion of Maine's population. The bill maintained the requirement that health care plans must provide reasonable access to services for all members and incentivize quality and efficiency over fee-for-service billing.

Maine, in collaboration with a multi-state Northeast consortium (Connecticut, 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. Maine is currently engaged in this partnership to ensure the development of an exchange that offers affordable high-quality health insurance options which will cover employees of small businesses, and under-insured or uninsured individuals.

Governor LePage, joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Governor LePage Press Release on Health Reform \(LD 1333\)](#)

[Maine State Legislature, Health Care Reform Bill \(LD 1333\)](#)

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

[Maine's Health Care Exchange Efforts](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

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 a health insurance exchange into law. 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), 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 recommendations of the MHCRC. Examples of the original 16 MHCRC recommendations include: a) Establish the framework for Maryland Health Benefit Exchange; b) improve care coordination and access to quality care, especially for special populations; c) promote workforce development; d) achieve cost savings through payment reform; e) promote improved access to primary care; f) reduce health disparities through performance-based incentives; and g) establish a Governor's Office of Health Reform.

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.

[Press Release Governor O'Malley Signs Maryland Health Benefit Exchange Act Executive Order, Health Care Reform Coordinating Council](#)

[Press Release: Maryland Health Care Reform Coordinating Council Recommendations](#)

[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](#)

Massachusetts

On July 11, 2011, Governor Deval Patrick signed the FY2012 Massachusetts budget, which includes several strategies for Medicaid (MassHealth) cost-containment effecting its nearly 1.3 million beneficiaries, including approximately \$770 million in state fund cuts and savings to the MassHealth program. The budget contains a reduction in nursing facility rates and the introduction of a nursing facility pay-for-performance initiative; \$1 million was appropriated for new MassHealth auditing initiatives intended to reduce Medicaid fraud; and the creation of a Health Insurance Technology Trust to allow the state to leverage federal reimbursement from the federal government for the development of electronic health records for MassHealth.

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 is working toward enhancing 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 Massachusetts 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 in Massachusetts for dually eligible seniors in which health 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.

In April 2011, Massachusetts became one of 15 states to receive a design contract of up to \$1 million from the U.S. Department of Health and Human Services entitled State Demonstrations to Integrate Care for Dual Eligible Individuals. With the goals of eliminating duplication of services, expanding access to needed care, improving quality of life, and lowering costs, the demonstration funding will assist Massachusetts in the process of fully coordinating primary, acute, behavioral and long-term supports and services for dual eligibles.

[Governor Patrick Budget FY2012 – Report on Health Care Cost Containment](#)

[Massachusetts 2012 Enacted Budget - Brief](#)

[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](#)

[State Demonstrations to Integrate Care for Dual Eligible Individuals](#)

Minnesota

Governor Mark Dayton's first two official acts as governor in January, 2011, were signing two executive orders intended to expand Medicaid benefits to Minnesotans in an effort to increase coverage for quality health care to an estimated 95,000 more low-income residents, protect 20,000 health care jobs, increase reimbursement rates for health care providers, and draw up to \$1.2 billion in additional federal Medicaid funds. Governor Dayton explained that the Medicaid expansion would come at no net cost to the state because of the additional federal contribution.

On February 17, 2011, Minnesota received federal approval from CMS to expand its Medical Assistance (MA) program, providing improved and expanded Medicaid coverage to 95,000 Minnesotans. Of the early health care expansion, U.S. Secretary of Health and Human Services, Kathleen Sebelius said, "we applaud Governor Dayton for using the flexibility the Affordable Care Act provides states to expand coverage for its lowest-income Minnesota residents... Today's action will bring substantial new federal support to the state and help improve the health of its citizens." Beginning on March 1, 2011, Minnesotans had the option to take

advantage of the expanded coverage through the state's MA program. In a press release, Governor Dayton noted that the health care expansion would enroll 12,000 childless adults with incomes below 75 percent of the Federal Poverty Level and not previously insured.

The Dayton Administration announced plans in April, 2011, to launch the use of data analytics to detect and prevent Medicaid fraud. The Administration issued a Request for Proposals for quantitative tools to be used by all state agencies with the goal of fraud and waste detection and reduction.

In April 2011, Minnesota became one of 15 states to receive a design contract of up to \$1 million from the U.S. Department of Health and Human Services entitled State Demonstrations to Integrate Care for Dual Eligible Individuals. With the goals of eliminating duplication of services, expanding access to needed care, improving quality of life, and lowering costs, the demonstration funding will assist Minnesota in the process of fully coordinating primary, acute, behavioral and long-term supports and services for dual eligibles.

[Governor Dayton Executive Order on Medicaid Expansion Press Release](#)

[Governor Dayton Expedites Medicaid Opt-in Start Date](#)

[Minnesota Receives Federal Approval for Medicaid Expansion](#)

[RFP - Medicaid Fraud Reduction](#)

[State Demonstrations to Integrate Care for Dual Eligible Individuals](#)

New Mexico

In March, 2011, the New Mexico Human Services Department (HSD) issued an RFP for redesigning the state's Medicaid program, and on May 9, 2011, HSD announced the RFP winner. With the goal of achieving sustained cost efficiencies and long term sustainability of the Medicaid program, details within the RFP indicate that Governor Susana Martinez and HSD intend to transform New Mexico's Medicaid program in several key ways: a) change the way health care services are made available and paid for by Medicaid; b) increase responsibility of Medicaid providers to improve health care quality and outcomes; c) increase responsibility of Medicaid enrollees (i.e. through cost-sharing and practicing healthy behaviors); d) change Medicaid's benefit packages and their availability to Medicaid beneficiaries; e) change the overall structure of the Medicaid program.

New Mexico's Medicaid program currently operates under several different federal waivers and utilizes seven different managed care organizations (MCOs). Through the new contract, HSD intends to streamline Medicaid's structure to "improve cost management, health outcomes, give Medicaid enrollees greater choice, and ensure the long term sustainability of the program." Within the RFP, HSD indicates one of the priorities for Medicaid redesign planning is including input from the business community, particularly small businesses.

Governor Susana Martinez joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[New Mexico Medicaid Redesign Request for Proposal](#)

[Press Release - Medicaid Redesign Project Finalist Chosen](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

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. 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; 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 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 a 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.

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. And in April 2011, New York became one of 15 states to receive a design contract of up to \$1 million from the U.S. Department of Health and Human Services entitled "State Demonstrations to Integrate Care for Dual Eligible Individuals." With the goals of eliminating duplication of services, expanding access to needed care, improving quality of life, and lowering costs, the demonstration funding will assist New York in the process of fully coordinating primary, acute, behavioral and long-term supports and services for dual eligibles.

[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](#)

[State Demonstrations to Integrate Care for Dual Eligible Individuals](#)

Ohio

Governor John Kasich signed an Executive Order on January 13, 2011, establishing the Governor's Office of Health Transformation (OHT) and highlighting the opportunity to “reset the basic rules of health care competition...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 are Medicaid spending issues, the long-term efficient administration of the Ohio Medicaid program, and improvement of overall health system performance in Ohio. Changes suggested by the OHT will build upon the rapid expansion of Medicaid managed care in Ohio, which began in 2006 and continues through the present. Ohio managed care is administered by seven health plans and includes medical transportation, coordinated care, and a 24/7 nurse consulting service. Working together with the six state health and human services agencies, the Office of Budget and Management, and the Department of Administrative Services, the OHT will lead the effort to incentivize preventative health practices, initiate and guide health insurance market exchange planning, and improve cost-containment strategies.

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 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 (ACOs) and health homes; c) rate-setting methods that base reimbursement on outcomes and coordination of care; and d) Medicaid funds to provide room and board for individuals receiving community based services.

On June 1, 2011, the Ohio Department of Job & Family Services introduced the Medicaid Provider Incentive Program (MPIP) which offers incentive payments to eligible professionals and hospitals that adopt, implement, and demonstrate meaningful use of certified electronic health records (EHR) technology. Under MPIP, eligible professionals can receive up to \$63,750 over a maximum of 6 years of participation in the program and eligible hospital payments are based on a number of factors and will be distributed over four years. MPIP will continue until 2021.

Governor John Kasich, joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

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

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

[OHT publication: "Medicaid Hot Spots" \(most costly areas of Medicaid\) 2011 Plan to Integrate Care for Dual Eligibles](#)

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

[Medicaid Managed Care Expansion](#)

[Medicaid Provider Incentive Program for Electronic Health Records](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

South Carolina

Effective March 1, 2011, South Carolina's Department of Health and Human Services received approval from the Centers for Medicare and Medicaid Services (CMS) to expand its Healthy Connections Choices care coordination program to include most Medicaid beneficiaries. Under Healthy Connections Choices, nearly all of South Carolina's 830,000 Medicaid recipients will be required to enroll in one of two types of CMS-approved managed care health care delivery models: Managed Care Organizations (MCO), or Medical Homes Networks (MHN).

Healthy Connections Choices works with managed care organizations, medical homes networks, and special enrollment counselors to guide recipients through the choice process. Patients are expected to take responsibility to work with their health partners, and are eligible for special rewards for healthy behaviors and enhanced benefits such as eyeglasses and dental care for adults, smoking cessation classes and programs tailored to specific chronic diseases. The expansion is expected to be phased in over 12 months.

In April 2011, new Medicaid enrollees and those beneficiaries enrolled in traditional Medicaid are 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 April 2011, South Carolina became one of 15 states to receive a design contract of up to \$1 million from the U.S. Department of Health and Human Services entitled State Demonstrations to Integrate Care for Dual Eligible Individuals. With the goals of eliminating duplication of services, expanding access to needed care, improving quality of life, and lowering costs, the demonstration funding will assist South Carolina in the process of fully coordinating primary, acute, behavioral and long-term supports and services for dual eligibles.

Governor Nikki Haley joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Health Connections Choices – Mandatory Managed Care](#)

[South Carolina DHHS Managed Care Press Release](#)

[Medical Homes/Coordinated Care in South Carolina - Background](#)

[State Demonstrations to Integrate Care for Dual Eligible Individuals](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

[Medicaid Sustainability Project](#)

South Dakota

The South Dakota FY2012 budget was passed in March, 2011, keeping intact most of Governor Dennis Daugaard's proposed cuts, giving most government agencies a 10 percent or more funding reduction. South Dakota lawmakers reduced the Governor's proposed cuts to Medicaid from 10 to six percent. The difference in overall general fund spending from the previous budget year is over \$40 million. The March Medicaid budget 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 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 since DSS currently works with the majority of Medicaid-funded programs.

Governor Daugaard joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Governor Daugaard's Budget Proposal Press Release](#)

[South Dakota Pass FY12 Budget](#)

[Reductions to Medicaid Provider Reimbursement Rates - Claims Detail from South Dakota MMIS](#)

[Governor Daugaard's State of the State Address](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

Texas

In keeping with his commitment to ensure a balanced budget, Texas Governor Rick Perry, expressed his intention to work 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, MR² In-Home Family Support, MR Community Services, and the state’s Promoting Independence program. Texas also has plans to reduce Medicaid reimbursement rates to hospitals.

Addressing the need for cost savings in the Medicaid program in his 2012-2013 budget, Governor Perry noted the federal limitations influencing the ability of Texas lawmakers. Regarding provisions with the Affordable Care Act Perry wrote:

“The changes to Medicaid, including the increased costs to states and federally mandated caseloads in the Medicaid program, a decrease in the federal government’s cost share for the program, and restrictions on changing the structure of the program – threaten the financial health of our state and will force the state to consider cuts to key priorities important to Texans. I am committed to resisting federal encroachment and will continue to urge Washington to allow our state to exercise creativity and flexibility in designing our Medicaid program and managing Medicaid dollars.”

In an effort to tailor the Medicaid program specifically to the needs of Texas patients, families and tax payers, Governor Perry has expressed support for replacing the current national system with flexible Medicaid block grants to states. Governor Perry explains, “Not only would this allow states to tailor their programs to meet the specific challenges of their populations, it would

² 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).

also prime the pump of innovation... it makes it possible for creative thinkers everywhere in the country to come up with new solutions to pressing problems.” In June, 2011, Governor Perry joined other Republican governors in co-signing a National Governors Association letter, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

On July 19, 2011, Governor Perry signed Senate Bill 7 into law, including provisions aimed at reducing Medicaid fraud; entering into a health care compact with other states; creating payment incentives to managed care organizations for preventing non-emergency visits to hospital emergency rooms; implementing co-payments for non-emergency visits to emergency rooms; streamlining the administration of and delivery of services through Section 1915(c) Waiver programs; rewarding physicians for the provision of high-quality, cost-effective health care; and requiring the state to formally request a Medicaid block grant from HHS.

[Governor Perry’s FY2012-2013 Budget](#)

[Health and Human Services Consolidated FY2012-2013 Budget](#)

[Governor Perry on Fiscal Responsibility and Budget](#)

[Governor Perry’s Remarks at Medicaid Reform Bill Signing](#)

[Medicaid Provider Reimbursement Rate Reductions](#)

[STAR+PLUS - Texas Medicaid Managed Care Program](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

[S.B. 7 Amendment to Health Care – Quality and Efficiency](#)

Vermont

On May 26, 2011, Governor Shumlin signed Green Mountain Care, Vermont’s plan for universal health care into law. In his January 2011, Inaugural Address, Governor Shumlin noted his intention to replace 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.” Included in the bill was the creation of the Green Mountain Care Board, charged with undertaking immediate efforts to control health care costs, create a health insurance exchange and support work for detailed planning of the new single-payer system. The independent board will have the authority to control the rate of growth in both health insurance premiums and health care provider payments and will set rates for

providers and medical manufacturers, establish minimum benefits, develop global payment methodologies, and run payment reform pilot projects. In addition, the Board will recommend the benefits package to be provided under a single payer if the legislature votes to implement such a system and a federal waiver is approved. Because a single-payer financing plan is not outlined in Vermont law, the Green Mountain Care Board must present a viable plan to the legislature by January 2013.

In February 2011, Governor Shumlin laid out a three-stage process for moving the state to a single-payer health system over four years. The first stage, which began July 1, 2011, includes creating a health benefit exchange as permitted under the federal Affordable Care Act (ACA); and convening a six-member Vermont Health Reform Board to develop payment reform and cost containment methodologies.

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 Shumlin Administration to become operational. In partnership 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 in developing and implementing the technological infrastructure to operate a single interstate Health Insurance Exchange.

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 will ask CMS to allow the state to become the Medicare administrative entity. The goal of the effort 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.

In April 2011, Vermont became one of 15 states to receive a design contract of up to \$1 million from the U.S. Department of Health and Human Services entitled State

Demonstrations to Integrate Care for Dual Eligible Individuals. With the goals of eliminating duplication of services, expanding access to needed care, improving quality of life, and lowering costs, the demonstration funding will assist Vermont in the process of fully coordinating primary, acute, behavioral and long-term supports and services for dual eligibles.

[Governor Shumlin's Speech after Signing Health Reform into Law](#)

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

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

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

[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"](#)

[State Demonstrations to Integrate Care for Dual Eligible Individuals](#)

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 amendments to Virginia's 2010-2012 budget include Medicaid savings of \$10.4 million, which is achieved through increasing cost savings of managed and coordinate care, controlling Medicaid utilization, and recovering inappropriate Medicaid payments. Virginia's new Medicaid Provider Incentive Program is expected to provide \$442,350 in general funds and \$4 million in federal matching funds to implement a new program to enable care providers to receive federal grant funding to implement electronic health records technology. The budget amendments include language mandating electronic submission of Medicaid claims by July 1, 2012, in order to increase the quality of care and decrease fraud and abuse. Also included in Governor McDonnell's budget amendments is funding and proposed savings for increased audits and data mining activities, aimed at reducing fraud, waste and abuse in the Medicaid system.

Governor McDonnell joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Governor McDonnell's Remarks, Expanding Managed Care](#)
[Budget Summary Governor McDonnell's Amendments to 2010-2012 HHS Budget](#)
[Virginia Health Reform Initiative Advisory Council](#)
[Report of the Virginia Health Reform Initiative 12/2010](#)
[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

Washington

In a budget plan designed to reduce health care costs while improving quality of care over the next ten years, and to reduce the overall trend in health care spending to no more than four percent annual growth by 2014, Washington Governor Gregoire, has proposed major changes to the Medicaid program. Washington State has implemented several initiatives that have reduced health care costs while improving health care delivery including: 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) promoting prevention, healthy lifestyles and healthy choices.

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. In a April, 2011, letter to Kathleen Sebelius, Secretary of the U.S. Department of Health and Human Services (DHHS), Governor Gregoire enumerated new Medicaid reforms outlined in Washington State's Global Medicaid Modernization Initiative, for which the Governor is seeking DHHS/CMS support "in the form of flexibility, waivers, fiscal resources and/or technical assistance." The proposed Medicaid reforms include: a) value based benefit and payment reforms (transforming health care system to incorporate a primary care base and promoting delivery of value-based, patient-centered care); b) delivery system reform (integrating care across care settings especially for dual eligibles, expanding the use of health homes, and emphasizing efficient use of resources and communication among providers; c) consumer engagement (placing more responsibility with patients); d) prevention and wellness (improving preventive services); and e) administrative simplification. To support the effort, Governor Gregoire and state agencies will expand the current engagement of stakeholders in the Medicaid modernization effort, by seeking further input of Medicaid beneficiaries and their representatives, Tribes, public and private purchasers, payers, local governments and other stakeholders.

In April, 2011, Washington was one of 15 states to receive a \$1 million planning grant administered by CMS, to improve care for its 137,000 older adults and people with disabilities covered by both Medicare and Medicaid (dual eligibles). The Washington State Department of Social and Health Services will use the funds to develop new patient-centered systems of integrated medical, behavioral and long-term care for these populations.

On May 11, 2011, Governor Gregoire signed six bills aimed at "continuing to transform health care in Washington State." One of the bills establishes Washington's health care insurance exchange (SSB 5445). Pending federal approval, the bills collectively support the Governor's plans to: a) Use evidence-based guidelines to purchase the most effective supplies and medications; b) adopt national payment reform strategies (i.e. ending payments for botched surgeries); c)

pay for positive patient outcomes rather than fee-for-service payment; and d) increased insurance coverage and access.

On May 31, 2011, Governor Gregoire signed Senate Bill 5596, a bipartisan bill passed with unanimous support, requiring the state to apply the U.S. Department of Health and Human Services (HHS) for a waiver that would replace its Medicaid program with an indexed, eligibility-driven block grant. SB 5596's authors explain that the block grant would "allow the state to operate as a laboratory of innovation for bending the cost curve, preserving the safety net, and improving the management of care for low-income populations." Washington state is currently awaiting the decision of HHS Secretary Kathleen Sebelius regarding whether they will be allowed to implement a Medicaid block grant.

[Governor Gregoire's Budget Proposal](#)

[Medicaid Cuts/Restorations](#)

[Governor Gregoire's Letter on Global Medicaid Modernization to Secretary Sebelius](#)

[Washington State Global Medicaid Modernization Initiative Proposal](#)

[Six Bills to Enact Health Care Reform in Washington State](#)

[Grant to Integrate Medicare-Medicaid Patient Care](#)

[Senate Bill 5596 – Medicaid Block Grant](#)

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 (NAMD) transmitted a letter on Medicaid payment rate requirement to the Center for Medicaid, CHIP and Survey & Certification (CMCS) within the 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.

On May 28, 2011, in response California Medicaid recipients' and providers' challenge to Medicaid provider cuts in the set of cases consolidated under the name *Douglas v. Independent Living Center of California*, No. 09-958, the Department of Justice filed a brief in support of California, stating, in part, that there is no federal law that allows private individuals to sue states to challenge rate cuts to Medicaid, and that such legal recourse does not comport with the congressional intent behind the existing enforcement mechanisms, which rely on the HHS Secretary to make compliance determinations. In this determination, the Obama Administration expressed its views that the California laws reducing Medicaid would be upheld despite Medicaid recipient and provider court challenges that the California plan violated the

federal Medicaid statute. Most recently, key Senate and House Democrats submitted an amicus brief in support of the plaintiffs. In public comments on the Lawmakers' actions, spokes persons questioned the U.S. Department of Justice's steps to support the defendants.

[NAMD Letter to CMS](#)

[Administration Challenges Medicaid Cuts, New York Times](#)

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.

CMS Guidance on Maintenance of Effort Requirements

CMS released a Dear State Medicaid Director letter that provides guidance on the maintenance of effort (MOE) provisions in the Affordable Care Act (ACA). The letter contains a series of Q&As that build upon the guidance CMS previously issued on the MOE provisions of the American Reinvestment and Recovery Act (ARRA), as well as a new Q&A on the ways in which states who have identified a program integrity concern can strengthen program integrity procedures consistent with the MOE provisions.

[State Medicaid Directors' Letter \(SMDL #11-009\)](#)

Medicaid Cost Containment Efforts

Some states also are engaged in broad Medicaid cost containment efforts which do not necessarily involve broad systems and/or policy reforms intended to significantly restructure the operation and/or delivery of Medicaid-financed services. Examples of Medicaid cost containment efforts include provider payments changes, pharmacy controls, de-institutionalization efforts, benefit reductions, eligibility changes, copays, and changes to the Medicaid application and renewal processes. Below, NASUAD provides a brief overview of recent proposals or soon to be implemented cost containment proposals.

Colorado

In an effort to curb rising Medicaid costs and balance Colorado's budget for FY2012, Governor John Hickenlooper, and the Colorado Legislature approved several measures which will reduce Medicaid reimbursement rates and limit benefits. Most of the changes took effect on July 1, 2011.

Medicaid provider rate reductions include a .75 percent cut to acute care, pharmacy and health provider rates including home health. Community based long term care provider rates were reduced by .5 percent including private duty nursing and home and community based (HCBS) service programs. Further reductions include payments to the mental health capitation program, specified medical equipment, inpatient renal dialysis, nursing facility rates and managed care capitation rates. The Comprehensive Primary and Preventive Care (CPPC) Grant Program, established to increase access to primary and preventive care for medically indigent patients, has been repealed. Additionally, the state no longer will provide a separate Medicaid payment to hospitals for readmissions within 48 hours to the same hospital for related conditions.

Colorado's Accountable Care Collaborative is scheduled to enroll 63,000 additional clients nearly doubling its current size by November 2011, and Money Follows the Person grant funds are expected to provide additional transitional services to move clients from nursing facilities to community based long term care facilities.

In April 2011, Colorado became one of 15 states to receive a design contract of up to \$1 million from the U.S. Department of Health and Human Services entitled State Demonstrations to Integrate Care for Dual Eligible Individuals. With the goals of

eliminating duplication of services, expanding access to needed care, improving quality of life, and lowering costs, the demonstration funding will assist Colorado in the process of fully coordinating primary, acute, behavioral and long-term supports and services for dual eligibles.

[Approved Budget Reductions for Medicaid in Fiscal Year 2011-2012](#)

[Medicaid Provider Reimbursement Rate Reductions](#)

[Repeal of Comprehensive Primary and Preventive Care Grants Program - Article](#)
[Repeal of Comprehensive Primary and Preventive Care Grants Program - Letter](#)
[State Demonstrations to Integrate Care for Dual Eligible Individuals](#)

Nebraska

As of July 1, 2011, Nebraska Department of Health and Human Services (DHHS) is reducing Medicaid Reimbursement rates, reflective of the 2.5 percent Medicaid practitioner rate reduction included in the state's FY2012 budget. The rate reduction applies to the following fee schedules: Physician services; chiropractic, physical therapy, occupational therapy, speech therapy and audiology, ambulatory surgical care, visual care, ambulance, dental, podiatry, clinical laboratory and anesthesia. Primary care services will not experience a rate reduction at this time.

Governor David Heineman joined other Republican governors in co-signing a National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate, requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Nebraska Department of Health and Human Services \(DHHS\) Rate Reductions](#)

[Nebraska DHHS Practitioner Fee Schedules](#)

[Medicaid Provider Reimbursement Rate Reductions](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

Pennsylvania

On June 30, 2011, Pennsylvania governor Tom Corbett, signed the 2011-2012 budget, with a reduction of \$3.3 billion from FY2010-11 levels. The budget includes reductions in services for persons with physical and intellectual disabilities and older adults due to funding cuts to various waivers and programs which support

these populations (OBRA, Independence, CommCare, Attendant Care and Aging Waivers and both the LIFE and Act 150 programs). Service cuts and increased co-pays for Medicaid transportation to medical appointments were also included in the FY11-12 budget. The budget highlights cost-containment initiatives including deinstitutionalization, combining and consolidating Medicaid waivers, and a focus on prevention of fraud, waste and abuse. Pennsylvania's Department of Public Welfare has also indicated plans to reduce Medicaid reimbursement rates to hospitals.

Health Choices is a program developed by Pennsylvania's Department of Public Welfare that makes it mandatory for all Medicaid recipients to receive their health care through one of three HMO's. Under Health Choices, Medicaid beneficiaries choose an HMO and a family doctor who provides basic health care and refers to specialists when necessary. A May 2011 report entitled "An Evaluation of Medicaid Savings from Pennsylvania's HealthChoices Program," indicated that the state's Health Choices Physical-Health Medicaid Managed Care Program has saved Pennsylvania as much as \$5.9 billion in state and federal funds over the last decade, and projected further savings of \$3.6 billion over the next five years. Increased savings were also predicted if the program is expanded to cover the entire state; currently it covers 42 out of 67 counties.

In January, 2011, Governor Corbett joined 32 other governors asking President Obama and members of Congress for greater flexibility to manage and reduce growing state Medicaid costs. The governor co-signed another National Governors Association letter on June 13, 2011, to members of both the U.S. House and Senate requesting a repeal of the Affordable Care Act (ACA) in order to gain increased flexibility with management of Medicaid spending, including the possibility of a Medicaid block grant.

[Pennsylvania 2011-2012 Budget](#)

[Budget Facts 2011-2012 – Commonwealth Foundation](#)

[Medical Transportation Reductions - House Bill 1301](#)

[Health Choices Program](#)

[Medicaid Managed Care Report](#)

[Payment reductions to Hospitals](#)

[Republican Governors Association Letter to U.S. Legislators - Repeal of ACA](#)

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

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