

MEDICAID REFORM PROPOSAL TRACKER

3/2011

Review of State Medicaid Reform

Second Edition



Medicaid Reform Proposal Tracker

REVIEW OF STATE MEDICAID REFORM – SECOND EDITION

Introduction

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

The Medicaid Reform Tracker is composed of three sections:

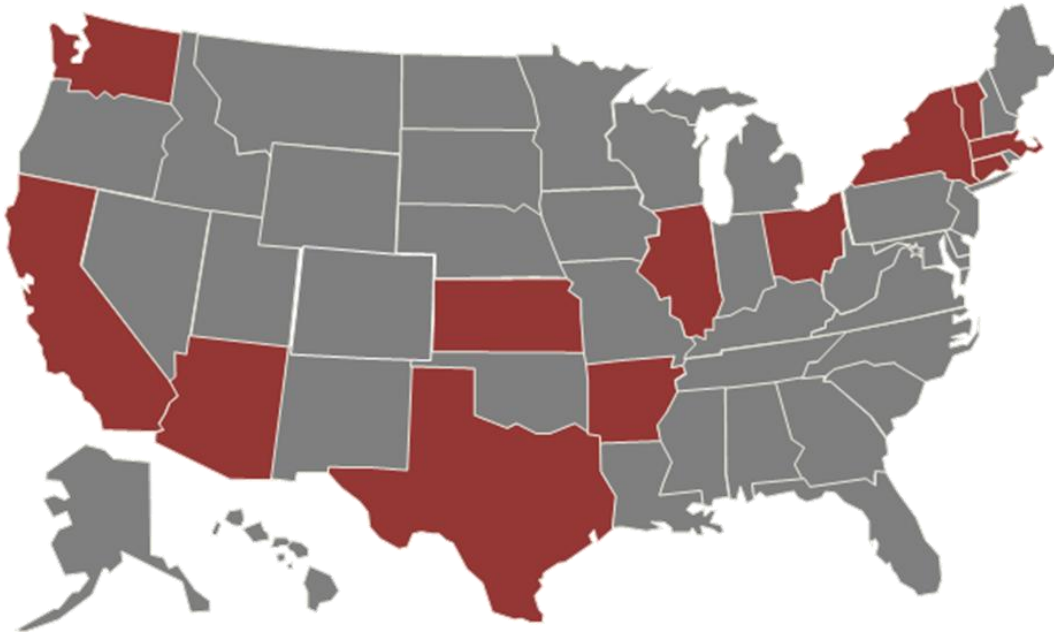
- Section one provides an overview of new state Medicaid reform efforts;
- Section two provides an update of ongoing reform efforts; and
- Section three provides an overview of specific state Medicaid cost control strategies that may or may not be part of a broader initiative.

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

State Updates

Since the initial edition, which covered a review of state activity in December and early January, the number of states with Medicaid Reform proposals on which NASUAD reported has increased from six to 13. States that have begun initiatives since the initial edition of Medicaid Reform Tracker are Arkansas, Arizona, Connecticut, Kansas, Kentucky, Massachusetts, and Vermont. Figure 1, below provides a quick national overview.

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



Source: NASUAD Medicaid Reform Tracker

Section 1. New State Initiatives

In Section 1, NASUAD offers an overview of states that announced and/or initiated a Medicaid Reform initiative since early February 2011.

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 by a partnership among Medicaid, Medicare and private health insurers. In order to avoid rate cuts, elimination of vital services, or a federal waiver to cut back on Medicaid eligibility, Governor Beebe proposed alternatives in his letter: "In conjunction with Medicare, Arkansas BlueCross and BlueShield, and private insurance plans, Arkansas Medicaid will design and then implement the nation's first statewide payment-reform initiative. The initiative will pay partnerships of local providers to act as health homes. To promote efficiency and long-term effectiveness, reimbursement will be for episodes of high-quality care."

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

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

For More Information

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

Arizona

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

Though the federal government will allow Arizona to reduce Medicaid enrollment, in a 2000 ballot initiative entitled Proposition 204, Arizona residents voted to expand Medicaid coverage to all residents at or below 100 percent of the federal poverty limit. Because the Legislature is not permitted to change or repeal voter-approved laws, any plan to significantly change enrollment is likely to go before the state Supreme Court.

Arizona's Governor recommends a rollback of Proposition 204 that would focus on eliminating some coverage for 250,000 childless adults and individuals who have to spend-down to be eligible for Medicaid. The Governor also seeks to cap TANF parents at approximately 30,000 beneficiaries, a level that can be sustained by Tobacco Settlement and Tobacco Tax Revenues. These cuts would lead to an estimated savings of FY 2012 General Fund of \$541.5 million. This would also result in Arizona losing approximately \$1.1 billion in federal Medicaid match. The Governor ensures that no TANF child or childless adult with serious mental illness will be included in the group of people who lose their Medicaid coverage. Also included in this State's general fund savings, Governor Brewer proposed a five percent provider rate cut that would be implemented October 1, 2011, for state FY12 savings of \$95.0 million.

For More Information

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

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

[Proposition 204 Rollback](#)

[Governor's Budget Summary](#)

[Proposed Medicaid Reform Plan](#)

Connecticut

With the goals of reducing Medicaid costs, improving service delivery, and preparing for national health care reform, on February 8, 2011, the Administration of 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) that will enhance efficiency in the fee-for-service Medicaid program particularly for older adults living in their own homes through information and assistance services.

In Connecticut's proposed health care reform initiative approximately 600,000 Medicaid beneficiaries will receive services through a medical home arrangement. The administration also approved a major expansion of the Money Follows the Person (MFP) program for older adults and persons with disabilities transitioning from nursing home to community settings as an additional cost saving measure.

On February 18, 2011, Governor Malloy announced that Connecticut residents and businesses will benefit from a \$35.6 million federal grant issued to help New England states develop a state-of-the-art, online gateway to health insurance options. Supported by the non-profit New England State Consortium Systems Organization, this grant will help make ACA mandated health insurance exchanges accessible and convenient for New England businesses and residents.

For More Information

[Connecticut Medicaid Reform Press Release](#)

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

Kansas

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

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

For More Information

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

Kentucky

In November, 2010, Kentucky Governor Steve Beshear, announced a Medicaid rebalancing 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 this 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."

Part of this Medicaid rebalancing effort includes issuing Requests for Information (RFI) on strategies used by other states to manage health care costs, then creating action plans for programs based on the returned information. Kentucky's RFIs to obtain ideas for performance-based program innovations and cost containment include:

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

In January, 2011, Governor Beshear signed an executive order creating the Medicaid Managed Care Oversight Branch to oversee the Department for Medicaid Services' implementation of managed care

program innovations. Also part of the plan to rebalance the Medicaid budget is collaboration with U.S. Department of Justice and other federal authorities to resolve instances of fraud and abuse.

For More Information

[Kentucky Cabinet for Health and Family Services Requests Information for Medicare and Medicaid Medicaid Cost Containment Announcement – Governor Beshear](#)

Massachusetts

In an effort to balance Massachusetts's FY12 budget, Governor Deval Patrick has proposed several strategies for Medicaid (MassHealth) cost-containment. With the goal of ensuring access and quality care for its members using high efficiency strategies, MassHealth will be 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 eligible). This will include transforming the current fee-for-service delivery system to a new model that focuses on care coordination and integrates both Medicare and Medicaid. Collaborating with consumer advisory groups, MassHealth is working to ensure that the new integrated system of service delivery meets the needs of, and is attractive to the target population so that they will choose to enroll. The new system will closely mirror the one currently in place for dually eligible seniors in which care entities will be accountable for the delivery, coordination and management of health and community support services that promote improved health outcomes, quality of life and independence.

In another proposed cost-containment strategy, MassHealth will conduct a competitive procurement in which managed care organizations and providers who demonstrate the ability to provide best price, high-quality care will have the opportunity to expand membership. Though this procurement process does not include seniors or dual eligibles, it will promote innovative approaches to care management and delivery as well as payments for services for the population of low-income adults.

Some of the other MassHealth cost-saving measures proposed by Governor Patrick include containing provider rates and capitation payments, limiting payments for preventable admissions, implementing co-pays for some services, adopting additional program integrity measures and limiting coverage for certain optional benefits.

For More Information

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

Vermont

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

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

The first of three proposed healthcare reform stages beginning July 1, 2011, includes: 1) creating a health benefit exchange as permitted under the federal Affordable Care Act (ACA); and 2) convening a six-member Vermont Health Reform Board to develop payment reform and cost containment methodologies, focusing on outcomes rather than fee-for-service payments, which is intended to result in sustainable rates of growth in health care spending. According to Wallack, "this redesigned primary care network will eventually be the backbone of a reformed delivery system for the state." The second stage is proposed to begin on January 1, 2014, when the Vermont Health Benefit Exchange is expected by the Administration to become operational. The Shumlin administration proposes including in Vermont's exchange employer groups with fewer than 100 employees, state and municipal employees, Medicaid, Medicare, private insurers and workers' compensation. The third and final stage of the proposed healthcare reform will be asking for permission from the federal government to move to the publically financed Vermont Health Benefit Exchange. Prior to 2014 Vermont will request a continuation of its Medicaid waiver and a Medicare waiver to permit integration of those programs with exchange payment reforms and administrative simplifications with the goal of reducing dislocation 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 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. The White House reported comments by President Obama about Vermont's single-payer plan, "I think it is a reasonable proposal. I support it. If your state can create a plan that covers as many people as affordably and comprehensively as the ACA does, without increasing the deficit, you can implement that plan. And we'll work with you to do it."

For More Information

[Governor Shumlin's Inaugural Address](#)

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

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

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

Section 2. Updated Coverage of Ongoing State Initiatives

The following states were reviewed in the February 2011 Medicaid Reform Tracker. The information below has been updated to reflect recent state activity.

California

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

Medi-Cal, California's Medicaid program, serves 7.7 million Californians which represents 19.7 percent of the total state population. Like all Medicaid programs, Medi-Cal costs generally fluctuate based on the number of enrolled beneficiaries, the rates paid to providers, and the level of benefits provided. California Governor Jerry Brown's proposed budget focuses on reducing the level of benefits, increasing beneficiary cost-sharing, and reducing payment to providers. The proposal establishes a maximum annual benefit dollar cap on hearing aids (\$1,510), durable medical equipment (\$1,604), incontinence supplies (\$1,659), urological supplies (\$6,435) and wound care (\$391), limits non-life saving drugs (six per month), and limits the number of annual doctor visits to ten. The above limits are projected to result in a combined state savings of \$206.6 million in 2011-2012, while an anticipated 90 percent of current beneficiaries would experience no change in their Medi-Cal benefits. The proposed caps would apply to all Medicaid beneficiaries including those who are categorically eligible under Aged, Blind, or Disabled eligibility groups.

The Governor's budget proposal would eliminate state plan Adult Day Health Care (ADHC), affecting 27,000 beneficiaries and 330 ADHC centers throughout the state. This cut would result in a proposed combined savings of \$178 million in 2010-2012. Also, included in the proposal is an increase from a voluntary \$1 copayment to a mandatory \$5 copayment for physician, clinic, dental, and pharmacy services (\$3 on lower-cost preferred drugs) which would result in a proposed cost offset of \$294.4 million in 2011-2012. Under the Deficit Reduction Act, Federal law allows providers to deny services if the beneficiary does not provide the required copayments, as long as they give a referral to a county indigent health program. Additionally, the proposed copayment on emergency room services is \$50, while hospital stays would require a copayment of \$100/day (\$200 maximum). The proposal would eliminate cough and cold medications and nutritional supplements from Medi-Cal coverage.

The budget proposal reduces provider payments by 10 percent for home health, nursing homes, physicians, pharmacy, clinics, medical transportation, and certain hospitals. Though recent State and Federal court rulings have prevented states from implementing rate freezes and reductions, California has appealed to the U.S. Supreme Court to overturn adverse appellate court rulings that have blocked provider payment reductions of up to 10 percent. The proposed state savings of \$719 million in 2010-2012 on the above rate reductions assumes that California prevails in the pending rate legislation.

Governor Brown's revised budget will be available Mid-May 2011.

For More Information

[Governor's Budget Summary for the California Department of Health and Human Services](#)
[Department of Health and Human Services Budget Detail](#)
Governor's Budget Highlights: <http://www.dhcs.ca.gov/Documents/2011-12%20Gov%20Budget%20Highlights%20Final.pdf>

Illinois

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

Key proposal changes impacting older Americans and persons with disabilities include a new budgeting strategy that will help move more people out of nursing homes and into the community by allowing the governor to reallocate money from institutional to community care (which costs roughly three times less) without approval from the General Assembly. Another key proposal change is creating a global budget to track how all long-term care funding is spent across programs, agencies and age groups. The Medicaid reform measures require that at least 50 percent of all Medicaid consumers enroll in coordinated care by 2015 (i.e., one primary physician tracking and making all health care decisions with the patient). Coordinated care reform would include state payment for performance-related outcomes, and the use of best practices and electronic medical records. Improved technology is expected by legislators to lead to better data collection and sharing among state agencies which will increase the state's ability to track Medicaid eligibility, enrollment, re-enrollment, and to identify fraud. Reform measures also allow the state to pursue more fraud cases and assess higher fines.

Medicaid reform measures include eligibility cost savings, which would require proof of Illinois residency, one month of income verification, elimination of automatic enrollment or re-enrollment (presumptive eligibility) of any group of people except for pregnant women. Medicaid reform also tightens eligibility

requirements for children under the ALL KIDS program, by creating an Illinois residency requirement and an income limit (income at or below 300% of the federal poverty level).

For More Information

[Overview of Medicaid Reform Measures](#)

[House Bill 5420 Overview](#)

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

New York

Governor Cuomo signed an Executive Order on January 5, 2011, creating the Medicaid Redesign Team, which was tasked with figuring out ways to reduce costs while improving the quality of health care in New York. Modeled after the Wisconsin Medicaid Rate Reform Project, Governor Cuomo gave the Medicaid Redesign Team a budget reduction target of \$2.85 billion for New York's 4.7 million Medicaid beneficiaries. The team sought ideas from the public at large as well as stakeholders in the following areas: health care delivery workforce, insurance, economics, business, and consumer rights among others. Jason Helgerson, 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 as well.

The Medicaid Redesign Team completed their work prior their deadline of March 1, 2011, voting on 79 cost-cutting measures that totaled \$2.3 billion in savings. The proposed cuts are a combination of ideas from the health care industry, public hearings, and a series of meetings held in every region of the state. The proposals of the Team 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: Reforming the Medicaid payment and program structure (\$1.1 billion in savings), implementing a two percent across-the-board rate reduction (\$345 million in savings), prepaying certain Medicaid payments to leverage additional enhanced Federal matching funds under ARRA (\$66 million benefit), and 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: 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; creating an office for the development of patient-centered primary care initiatives; increasing use of care management (entire Medicaid population to be enrolled in care management within three years); mandating enrollment in Managed Long Term Care plans for adults in need of community-based long term care; and developing initiatives to integrate managed care for dual eligible.

Some other specific recommendations of the Team are as follows: increasing spending controls on home health care and personal care; designing comprehensive fee-for-service pharmacy reform; developing an automated exchange/Medicaid eligibility system; expanding the usage of both palliative care and hospice;

establishing utilization limits for physical, occupational and speech therapy; developing a uniform assessment tool for statewide long term care services; restructuring reimbursement for proprietary nursing homes; reforming medical malpractice rules; and centralizing responsibility for Medicaid estate recovery process and applying the 60 month look back period to non-institutional long term care beneficiaries; The Medicaid Redesign Team will continue to generate ideas and will submit quarterly reports for further health care reforms until the end of Fiscal Year 2011-12, when it will disband.

For More Information

[Executive Order: Medicaid Redesign Team](#)
[Additional Details on Medicaid Redesign Team](#)
[Governor's Budget Summary](#)

Updates

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

Ohio

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

Noted in the Executive Order, Ohioans spend more per person on health care than residents in all but 13 states, however, higher spending has not led to better health outcomes for 2.4 million Medicaid recipients. Together with the state health and human services agencies (Aging, Health, Mental Health, Developmental Disabilities, Job and Family Services/Medicaid, Alcohol and Drug Addiction Services), as well as the Office of Budget and Management and the Department of Administrative Services, the new OHT will lead the effort to modernize and plan for the long-term efficient administration of the state's fragmented Medicaid program, incentivize preventative health practices, initiate and guide health insurance market exchange planning, and improve cost-containment strategies. OHT will also draw upon public and private sector best practices to recommend a permanent HHS organizational structure and oversee transition to that permanent structure in an effort to improve Medicaid's overall performance.

OHT released two reports in March, which further illustrate the Office's purpose and goals. One of the documents entitled, “Better Health, Better Care and Cost Savings through Improvement,” offers details on Ohio's plan for modernization in line with Governor Kasich's policy priorities: rebalancing long-term care;

integrating physical and behavioral health care; improving care coordination; and evaluating payment and provider rates. The other document entitled, "Medicaid Hot Spots," reviews the highest cost populations and types of Medicaid spending, which may hold the greatest potential for savings including: nursing home care; non-institutionalized Medicaid enrollees who receive primary care from hospitals; adults with severe mental illness; and overutilization of unnecessary emergency room visits.

For More Information

[Executive Order establishing the Office of Health Transformation](#)
[Columbus Dispatch on the OHT](#)

Updates

[OHT publication: "Better Health, Better Care and Cost Savings through Improvement"](#)
[OHT publication: "Medicaid Hot Spots" \(most costly areas of Medicaid\)](#)

Texas

To assist with his commitment to balancing the state budget, Governor Perry expressed his intention of not raising taxes on Texas families and businesses, working within the available state revenue, and requiring each state agency to evaluate all programs for potential cost saving measures. 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, MR¹ In-Home Family Support, MR Community Services, and the state's Promoting Independence program. Additionally, with the goals of maintaining essential Medicaid services and accountability while cutting costs, each of five agencies comprising Texas's Health and Human Services System individually submitted their requests for legislative appropriations for FY2010-11. Some of the major resulting cost-saving budget items are as follows: a reduction in the number of hours of Medicaid State Plan Personal Care Services, provider rate reductions (\$64.3 million savings); revenue management of federal funds (\$39.5 million); administrative reductions, program

¹ 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).

delays and salary savings (\$64.7 million); client service reductions including no services for 285 children on the wait list for Children with Special Health Care Needs program, and trauma funds for hospitals (\$36.6 million). Additional cost-saving measures for FY2012-13, include capitating services in both Medicaid and CHIP and an expansion of managed care including STAR-Plus programs in which the state pays a fixed amount per Medicaid enrollee.

For More Information

[Governor Perry's Consolidated Proposed Budget FY12-13](#)

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

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

Washington

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

In a budget plan designed to save \$26 billion in health care costs over the next ten years, Governor Gregoire of Washington State has proposed major changes to the Medicaid program that are intended to both improve health care quality and save money. On the forefront of health care delivery reform, Washington State has already implemented several initiatives that have reduced health care costs while improving health care delivery: a) implementing intensive chronic care management programs for high-need older adults and persons with disabilities ; b) creating pilot projects to divert patients from more expensive emergency room care to community clinics; c) nonpayment to hospitals for readmissions that are directly related to a recent admission; d) coordinating and monitoring care for consumers with a history of overusing high-cost services; and e) reducing the number of avoidable Caesarian deliveries.

To continue the practices of Medicaid cost saving and quality improvement, 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 federal health reform provision (the Affordable Care Act). Washington State will be working with the federal Center for Innovation on a pilot project that will assist with transitioning the focus of Washington's health care system to payment on the basis of quality of outcomes instead of number of medical procedures performed, coordinated care, and encouraging personal responsibility for health and cost-effective treatment decisions. To facilitate this health care transition, the Governor and state agencies will bring public and private purchasers and payers to the table to identify best practices and develop plans to reproduce successes over time.

For More Information

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

Section 3. Overview of Specific State Medicaid Cost Containment Methods

In this section, NASUAD provides an overview of specific Medicaid cost containment strategies that may or may not be part of a broader reform initiative:

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 pay rates for providers who coordinate services for developmentally disabled Medicaid recipients, 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 incorporating the rates 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 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.

Recovery of Reimbursements from Medicare

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

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

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

ABOUT NASUAD

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

NASUAD works to:

Innovate

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

Advocate

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

Assist

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

Collaborate

Foster the development of strategic partnerships

Convene

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

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