SAMHSA's Weekly Financing News Pulse: State and Local Edition

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Over the next few weeks, SAMHSA's Financing News Pulse will be suspended while SAMHSA reworks its format and content. Thank you for your continued readership. We look forward to providing you with an improved product in the near future.

SAMHSA's Financing News Pulse is a news consolidation service, designed to provide readers with streamlined access to information published by local, regional, and national media. While the News Pulse attempts to verify our content, the editors of each publication cited in the summaries are ultimately responsible for the accuracy of the information they publish. We encourage readers to inform the News Pulse of any errors so we can note them in future editions; however, we also suggest that they contact the media source directly.

Around the States: State and Local Behavioral Health Financing News

Arizona

- **Court Finds Arizona's Mandatory Medicaid Copayments Illegal**: On August 24, the **9th U.S. Circuit Court of Appeals** ruled that Arizona's mandatory Medicaid copayments are illegal. Though Arizona received a waiver from the **U.S. Department of Health and Human Services** (HHS) authorizing the copayments, the court found that the state designed them only to reduce Medicaid spending. Federal law only permits Medicaid waivers that have a research or demonstration value. Implemented in 2003 and ranging from $4 to $30 for medical services and prescription drugs, the copayments affected approximately 200,000 Medicaid beneficiaries (The Arizona Republic, 8/25; Kaiser Health News, 8/25).

Arkansas

- **Governor Announces Medicaid Care Coordination Initiative**: On August 22, **Governor Mike Beebe** (D) sent a letter to federal health officials outlining the components of a state Medicaid initiative to improve care quality and reduce costs through increased care coordination. Federal officials approved the initiative in May but had not yet received an outline of program specifics, under which Arkansas will transition from fee-for-service financing to an episode-based payment model. State officials will implement the new financing model for nine areas of care, including prevention, long–term care, and developmental disabilities (Houston Chronicle, 8/22).

California

- **California Medical Association Files FOIA Request to Assess State's Analysis of Medicaid Cuts**: The California Medical Association has filed a Freedom of Information Act (FOIA) request with the **Centers for Medicare & Medicaid Services** (CMS) to determine whether state officials considered the effect of proposed Medicaid cuts on health care access. In June, California submitted a request to CMS seeking approval to cut Medicaid spending by $1.5 billion through a combination of reimbursement rate reductions, mandatory copayments, and physician visit limitations. Association officials are requesting that CMS provide documents demonstrating whether the state has considered the impact of the cuts on access (Kaiser Health News, 8/30).

Colorado

- **CMS Finds 50 Percent of Colorado's Medicaid Eligibility Determinations Did Not Meet Federal Requirements**: On August 23, **Centers for Medicare & Medicaid Services** (CMS) officials presented an audit, finding that Colorado's Medicaid eligibility determination process does not meet federal requirements. Conducted from July 1, 2010 to December 7, 2010, the audit found that approximately half of the state's Medicaid eligibility determinations took longer than the maximum allotted time. Federal law requires states to determine eligibility within 90 days for individuals with disabilities and 45 days for all other individuals. CMS officials say they may withhold federal funding if Colorado does not address the deficiency. However, state officials say they have improved the system since the audit and are continuing to make improvements (AP via The Denver Post, 8/23; Kaiser Health News, 8/24).

Georgia

- **DCH to Request $520 Million to Address Medicaid and CHIP Deficit**: The **Georgia Department of Community Health** (DCH) is presenting a request to **Governor Nathan Deal** (R) seeking $520 million to address a Medicaid and Children's Health Insurance Program (CHIP) deficit. State legislators borrowed funds from the programs' budgets in FY2012 to address shortfalls in other programs. However, without additional funds, DCH officials say that the programs face cumulative deficits of $213 million and $359 million for FY2012 and FY2013, respectively. DCH has sent the request to Governor Deal for preliminary review but is still accepting public comment before formally approving a budget request in September (Atlanta Journal-Constitution, 8/25; Kaiser Health News, 8/26).

Kansas

- **SRS to Implement $19.3 Million in Medicaid Cuts**: On August 26, the **Kansas Department of Social and Rehabilitation Services** (SRS) outlined $19.3 million in Medicaid cuts through as-yet-undetermined reforms. Announced the cuts as part of $43 million in reductions, the cuts are slated for the current fiscal year (Kansas Health Institute, 8/26).

- **Kansas' Medicaid Program Implements Electronic Prior Authorization Program to Save $1.5 Million**: On August 23, the Kansas Medicaid program implemented an electronic prescription drug prior authorization program. Designed to save time and reduce costs, the system cost $750,000 and is slated to save $1.5 million in its first year of operation (Kansas Health Institute, 8/22; Kaiser Health News, 8/23).

Louisiana

- **Update: Aetna Continues Challenging DHH's Selection Process for Coordinated Care Network Participants**: **Aetna Inc.** is continuing a challenge of the **Louisiana Department of Health and Hospitals'** (DHH) selection process for Medicaid coordinated care network (CCN) program participants. After DHH rejected Aetna's original complaint, Aetna officials have asked **Louisiana Commissioner of Administration Paul Rainwater** to reject all of DHH's CCN selections. Aetna alleges that DHH officials did not follow department rules for selecting participating organizations, particularly claiming that the state compared companies' proposals rather than analyzing them individually. Authorized under the FY2012 budget, the $2.2 billion program will provide health coverage through private insurers and offer financial incentives for preventive and primary care. Slated to begin in January, state officials estimate the program will serve over 800,000 beneficiaries and save $135 million in its first year of operation (The Times-Picayune, 8/23; Kaiser Health News, 8/24).

New York

- **New York Recovers $2.3 Million in Medicaid Overpayments**: **New York State Comptroller Thomas DiNapoli** has announced that state auditors recouped $2.3 million in Medicaid overpayments. State auditors identified 21 providers charged with abusing Medicaid, Medicare, or other health programs that continued to receive Medicaid funding. State officials removed eight of those providers from Medicaid and are reviewing the remainder (AP via The Wall Street Journal, 8/23).

Ohio

- **Dayton Psychiatric Hospital to Open by October**: By October, the former Twin Valley state mental health hospital, which closed in 2008, will reopen under private ownership as the Access Hospital Dayton psychiatric hospital. The $1.7 million physician-owned facility will offer 28 inpatient beds when it opens, and hospital officials plan to expand to 110 beds within one year (Dayton Daily News, 8/28).

Oklahoma

- **TPS Working to Authorize $1.3 Million in Privately Provided School Mental Health Services**: Tulsa Public Schools officials are working to authorize temporarily suspended student mental health services. In June, the district eliminated the $1.3 million that it previously paid six agencies to provide mental health services at district schools. The agencies independently raised funds to provide the services but were told that they cannot provide on-campus services during regular school hours because they do not have a formal contract with the district. TPS officials say they are working with the agencies to establish formal contracts to allow them to provide services (Tulsa World, 8/27).

Oregon

- **Update: State Implementing Medicaid Reform Legislation**: Oregon officials have begun working with mental, physical, and dental health professionals to begin implementation of the state's Medicaid reform law. Four working groups are currently developing materials for a February report to the legislature that will assist in the implementation. Under the law, the state will consolidate the 40 managed care organizations that administer coverage into regional Coordinated Care Organizations (CCO) that will coordinate physical, mental, and dental care for Medicaid beneficiaries and dual eligibles. State officials estimate the law will save $700 million in the second year of the current biennium (The Lund Report, 8/24).

Wisconsin

- **Report Estimates National Health Reform will Reduce Uninsurance, Increase Premiums**: **Gorman Actuarial, LLC** has released a report projecting that the national health care reform law will reduce the number of uninsured Wisconsin residents but will result in higher premiums for health coverage. The authors estimate that the number of uninsured residents will decrease 65 percent by 2016, from 520,000 to 180,000. In contrast, without the law's individual insurance mandate, the authors project the number of uninsured residents would decline by only 62,000. However, the report estimates that the law will increase health coverage premiums, causing 23,000 individuals to lose coverage because their employers eliminate their health plans (AP via Business Week, 8/25).