

MEDICAID OPT-OUT IMPACT ANALYSIS



September 1, 2010

Wyoming Department of Health



Commit to your health.

The Wyoming Department of Health has analyzed the potential consequences to the State of Wyoming should it choose to “opt-out” of participating in the Medicaid program. This report focuses on examining the probable impacts on the Department of Health, clients, providers, and other State agencies. Also included is information relating to changes that will likely be recognized as a result of the Patient Protection and Affordable Care Act.

Medicaid Opt-Out Impact Analysis

WYOMING DEPARTMENT OF HEALTH

INTRODUCTION

The Wyoming Department of Health (WDH) has been asked to provide information concerning the potential impacts to our department, and other departments, should the State of Wyoming (“State”) determine that it wishes to “opt-out” of participating in the Medicaid program. This inquiry comes on the heels of the passage of the Patient Protection and Affordable Care Act (PPACA; [1]P. L. No. 111-148) a Federal statute that was signed into law in the United States by President Barack Obama on March 23, 2010. Along with the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (signed into law on March 30, 2010), the Act is a product of the health care reform agenda of the 111th Congress.

While there is considerable interest in the effects on Wyoming health care due to the passage of both the PPACA and Health Care and Education Reconciliation Act, this report does not provide such analysis. Instead, it focuses solely on the potential consequences should Wyoming opt out of Medicaid participation.

This report is intended to support and further analyze the *Medicaid Opt-Out Impact Executive Summary*, submitted by the WDH to the Governor on April 19, 2010. This analysis does not offer thorough consideration of many areas that will also be affected by the State dropping out of the Medicaid program, including:

- Complete fiscal impacts to hospitals and local governments that will still be mandated under Federal law to provide emergency care to individuals even though Medicaid is no longer available as a payment source.
- The full effect of taking hundreds of millions of dollars each year out of the state’s economy by turning back the Federal share of funding Medicaid.

OVERVIEW OF WYOMING MEDICAID

Funding - Medicaid is a Federal and State funded program available for individuals and families. The Federal agency that has oversight of State Medicaid programs is The Center for Medicare and Medicaid (CMS). Although it is a nationwide program, each state has its own eligibility requirements, subject to the legislative/regulatory requirements determined by the Federal government for coverage, and each state determines to a certain extent how their program will be administered. The Federal government matches Wyoming’s spending for covered services on an open-ended basis. The Federal match rate, known as the Federal medical assistance percentage (FMAP), ranges from 50 percent to 83 percent from state to state and is inversely related to state per capita income. The current FMAP in Wyoming, which includes an enhanced match from the American Recovery and Reinvestment Act (ARRA), is 61.59 percent. Prior to ARRA, Wyoming’s FMAP was 50 percent.

Eligibility - Medicaid is the largest source of funding for medical and health-related services for people with limited income in Wyoming. Medicaid services fill a wide range of needs, including those of people living with disabilities, students needing therapies in special education programs, consumers in mental health and substance abuse services, children in foster care and child protective services, individuals living with

developmental disabilities in the community, pregnant women and young children, seniors at risk for nursing home admission, and many others.

EqualityCare, the name of Wyoming's Medicaid program, provides assistance for health care services to low income residents who meet age and health requirements and qualify for one of four major eligibility categories. This program is means tested; however poverty alone does not necessarily qualify an individual for Medicaid. Medicaid eligibility is based on categorical eligibility, residency, citizenship and identity, social security eligibility as verified by social security number, family income and, to a lesser extent, resources or health care needs. Appendix A details EqualityCare eligibility.

Among the groups of people served by Medicaid are certain eligible United States citizens and resident aliens, including low-income adults and their children, and people with certain disabilities. Families, children, pregnant women, elderly and disabled adults who meet the income requirements typically qualify. However, low-income adults without children typically do not qualify.

Federal Poverty Level (FPL) requirements are: pregnant women and children ages zero to five years of age are covered at 133 percent of the Federal Poverty Level (FPL); children ages six to 18 years of age are covered at 100 percent FPL; family care adults are covered at approximately 36 percent FPL; and individuals eligible for the Breast and Cervical Cancer Treatment Program are covered at 250 percent FPL. Appendix B details EqualityCare eligibility by category in 2008 and 2009. Since 1996, Medicaid eligibility has been separate from welfare cash assistance eligibility. Twenty years ago, most persons receiving Medicaid services received welfare. The reverse is true today. The vast majority of all persons enrolled in Medicaid are not receiving any welfare cash assistance.

Without Medicaid and a program to replace it, these individuals would lose access to prenatal care, inpatient and outpatient hospital services, professional medical care, pharmaceuticals, infant and child preventive care, behavioral health care, dialysis, and hospice care. These individuals would also lose funding for vision and dental care, home health care and medical equipment and supplies.

Medicaid coverage of emergency services¹ for non-citizens is mandated by the Federal government. A non-citizen must qualify under a Medicaid coverage group. This means they must be a child, pregnant woman or a parent with a dependent child and meet the income requirements for that group. A legal immigrant, who has not resided in the United States for five years and who does not have 40 quarters of work, would also be eligible for emergency services if they meet the requirements of one of these groups.

In State Fiscal Year (SFY) 2009, emergency services coverage was provided for 570 non-citizens at a cost of \$2,201,987. Approximately 94 percent of all expenditures for emergency services are related to labor and delivery services.

A baby born to a non-citizen in the United States is automatically eligible for Medicaid for one year if the mother was eligible for Medicaid, including emergency services, at the time of the birth. In 2008, approximately nine percent of births financed by Medicaid were births to non-citizens. It is likely that all of these costs would be assumed by a Wyoming hospital without a Medicaid program in the state.

Wyoming Medicaid also provides assistance to low-income individuals who qualify for both Medicaid and Medicare ("dual eligibles"); including helping them pay for their portion of Medicare costs, as well as nursing facility costs if they reside in an institution. Some services for this population are funded only by

¹ Emergency services are defined as services required after the sudden onset of a medical condition, including labor and delivery, manifesting itself by acute symptoms of a sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

Wyoming Medicaid. For other services, Medicare is the primary payer and Wyoming Medicaid provides additional payments. Claims for these services are referred to as crossover claims.

Covered Services - The following mandatory health care services are covered by Wyoming Medicaid, as required by CMS:

- Physician
- Rural Health Clinic (RHC) services
- Laboratory and x-ray
- Nurse-midwife
- Inpatient and outpatient hospital
- Certified pediatric nurse practitioner or family nurse practitioner
- Nursing facility
- Early and periodic screening, diagnostic and treatment (EPSDT)
- Home health care
- Family planning and supplies
- Transportation²
- Federally Qualified Health Center (FQHC)

Wyoming Medicaid also provides a number of optional services to some Medicaid beneficiaries, including:

- Dental
- Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS)
- End stage renal disease (ESRD)
- Intermediate Care Facilities for the Mentally Retarded (ICF/MR)
- Mental health and substance abuse
- Prescription drugs
- Targeted case management
- Vision
- Waiver habilitation

Waivers - A state may also submit a Medicaid waiver application to CMS requesting to waive certain Federal Medicaid requirements. These waivers allow states more flexibility in their Medicaid programs. Wyoming currently has seven Medicaid waivers:

- Children’s Mental Health Home- and Community-Based Services (HCBS) Waiver for Children with Severe Emotional Disturbance
- Home- and Community-Based Services (HCBS) Waiver Program for Children with Developmental Disabilities
- Home- and Community-Based Services (HCBS) Waiver Program for Adults with Developmental Disabilities
- Acquired Brain Injury Home- and Community-Based Services (HCBS) Waiver Program
- Long-Term Care Home- and Community-Based Services (HCBS) Waiver for aged and physically disabled individuals
- Assisted Living Facility Home- and Community-Based Services (HCBS) Waiver for aged and physically disabled individuals
- Family Planning Waiver

² Transportation services are not a mandatory service, but states are required to ensure necessary transportation to providers.

WYOMING WITHOUT MEDICAID

As the largest source of Federal support to the states, Medicaid is also a major engine in state economies, supporting millions of jobs across the country. Its guarantee of open-ended Federal financing that matches State spending enables states to respond to losses of private health insurance attributable to unemployment and rising health insurance premiums, increases in health care costs, emergencies and disasters, and an aging society.

This analysis merely scratches the surface of opting out of the Medicaid program. However, it is understood that dealing with the burden of funding health coverage to new Medicaid eligibles under health care reform may be an impact to the General Fund and therefore merits consideration of options for covering the uninsured. While some that lose Medicaid coverage under an opt-out scenario may find coverage as a result of health care reform, it is clear that coverage may not be affordable nor provide the services needed by many. There would also likely remain a significant number of individuals who would not be able to obtain coverage under the current health reform bills.

If we legitimately assume that not all Medicaid eligible recipients would be able to get other health coverage, payments to providers will be affected. There is the potential for doctors, dentists, therapists, hospitals, nursing homes, and other providers to see a reduction of up to \$250 million per year. It will eliminate Medicaid reimbursement of almost \$4 million to federally qualified health centers and \$6.8 million to Indian health services. There will be a loss of funding for providers of social-based services, such as personal care services and non-emergency medical transportation, as these services will likely not be covered under the proposed Exchange plans.

The notion that any State would abandon participation in Medicaid is uncharted territory and predicting the impact of such a drastic measure would not likely capture the full breadth and depth of the impact. Medicaid is so integral to the U.S. social fabric that removing it would surely unravel the protections, supports and safety net in place for the young, the poor and the disadvantaged. While recent rhetoric laments unfunded federal mandates and the impossibility of finding resources to pay for them, the notion that opting out of Medicaid is a feasible alternative is suspect. Even a surface exploration of the ramifications reveals that Medicaid's impact is far-reaching and fundamental to how the nation values social parity. Medicaid's entitlement to healthcare is a Statement that rejects the idea that sound health and treatment for sickness, disease and disabilities is reserved for those with the resources to pay for it. - AARP

The Medicaid maintenance-of-effort (MOE) requirements in PPACA are designed to prevent states from eliminating or reducing coverage for certain groups of eligible individuals prior to the implementation of the new law's expansion provisions. Effective March 23, 2010, all states are required to maintain eligibility standards for adults in Medicaid until January 1, 2014, when the new health exchanges are operational; and for children in Medicaid and CHIP until October 1, 2019. Violating the MOE requirement will result in a state losing *all* Medicaid funding, including funding for children, parents, pregnant women, seniors, people with disabilities, and administrative costs.

A thorough review of the PPACA has been conducted and there is no direct mandate to participate in the Medicaid program. However, two recent lawsuits for violations of ARRA may be relevant if there are reduced or even eliminated Medicaid services. These lawsuits have yet to be successful, although one court did indicate that reductions in Medicaid may be a violation of the American's with Disabilities Act (ADA).

The Gray Panthers of San Francisco, et al. v. Arnold Schwarzenegger, et al.
U.S. District Court, Northern District of California, San Francisco Division

Plaintiffs, consisting of advocate organizations, service providers, and Medi-Cal beneficiaries, alleged that the State had violated Sections 5000(a) and 5001(f)(3) of ARRA because it had 1) reduced levels of Medi-Cal benefits or services below levels that existed on July 1, 2008, and 2) deposited or credited ARRA funds into the State's rainy day or reserve fund that should have been used to fund Medi-Cal expenditures.

Plaintiffs sought injunctive relief restoring retroactively the nine optional Medi-Cal services eliminated by State law. In the alternative, plaintiffs sought an order compelling the State to forego additional FMAP enhanced payments available under ARRA, and returning all FMAP enhanced payments received under ARRA at a ratio of \$2 Federal money for every \$1 of State money expended for the provision of Medi-Cal services.

Plaintiffs' motion for preliminary injunction was denied, and the court issued its formal ruling in favor of the State. On appeal, the Ninth Circuit ruled in favor of DHCS and denied plaintiffs' motion for an emergency injunction. Following the ruling, plaintiffs dismissed all claims against all defendants.

Oster, David (formerly V.L.), et al. v. John A. Wagner, Director of DSS, et al.
U.S. District Court, Northern District of California

Plaintiffs assert that the State would violate Federal and State law by revising the medical necessity criteria for determining when the delivery of In-Home Supportive Services (IHSS) is required. The case was filed on behalf of beneficiaries and providers that would be affected by the benefit reduction.

In H.R. 3962, eligibility for enrollment in an Exchange health plan is found in Section 302. All individuals are eligible unless they are enrolled in "another health benefits plan or other acceptable coverage." Medicaid is included in the definition of "acceptable coverage." If a state did opt out of Medicaid, families currently eligible for Medicaid above the income thresholds proposed for premium and cost-sharing would likely face increased cost sharing and a reduction in covered benefits. Those below the thresholds may not have coverage, may not be eligible for subsidized coverage, or would have whatever coverage Wyoming determined to provide with State-only funds.

Medicaid is an example of a federally established program with optional State participation. States may participate – and obtain the substantial Federal funds flowing through the program – if they meet certain requirements and conditions. There is no obligation for a state to participate in Medicaid and no obligation, nor authority, for the Federal government to provide Medicaid services to a state in the event that a state chooses not to participate. The stated purpose of the Medicaid program is to enable...

...each state, as far as practicable under the conditions in such state, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care...The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary, State plans for medical assistance.³

Therefore, the Secretary would be unable to direct Federal Medicaid funds toward services for individuals in a state that did not have a Medicaid plan and program. Because Federal Medicaid funding is a reimbursement to states, a state has to make expenditures under the program.

In our review of the impacts of opting out of Medicaid, it became clear that doing so would likely have the most significant impact on the uninsured in Wyoming. It is likely most clients currently on Medicaid would end up uninsured due to a financial inability to purchase medical insurance through a health care exchange, although that analysis will largely depend on the health care exchange that is developed, either by the State, private interests, or the Federal government. Furthermore, there is no indication that residents of Wyoming would be exempt from paying the taxes that will be required to support this mandate and others in the PPACA. Based on the limited information available about what the exchanges may look like, there are some areas where the exchange could take the place of Medicaid while in others areas this is clearly not possible.

Eliminating Medicaid would also impact State and local government agency funding by eliminating Federal Medicaid dollars as a source of revenue. Besides Federal revenue losses to State sister agencies, such as mental health and developmental services, local government agencies would also see a significant reduction in Federal revenues, which would challenge their missions to serve the general public. According to the Henry J. Kaiser Family Foundation website, each Medicaid dollar circulates throughout a community on an average of seven times.

Opting-out of Medicaid may also increase costs to counties as more uninsured individuals will be seeking indigent care for emergency medical services and long-term care.

Long-term care expenditures include spending on nursing facilities; Intermediate Care Facilities for the Mentally Retarded (ICFs/MR); mental health facilities, including inpatient psychiatric services for individuals age 21 and under, and other mental health facilities for people age 65 and older; home health and personal care, including standard home health services, personal care, targeted case management, hospice, home and community-based care for the functionally disabled elderly, and services provided under home and community-based services waivers which serve the aged, individuals with mental illness, traumatic brain injury and developmental disabilities

It would be difficult to remove Medicaid from the provision of long-term care services. Medicaid funding is a primary source of revenue for nursing facilities in Wyoming (see Appendix E), representing almost 63 percent of total nursing home expenditures in 2009. Many individuals with developmental disabilities rely on Medicaid for long-term care, and a small percent of assisted living residents rely on Medicaid. Other than limited rehabilitative care, Medicare does not provide long-term care services. Without Medicaid or a replacement program, Wyoming would have to cover the Federal share of long-term care services, otherwise, nursing homes and home care providers would be left with the option to provide uncompensated care or discharge individuals unable to pay for their own care.

³ 42 U.S.C. 1396 (emphasis added)

In addition to the substantial Federal funding support, one of the primary benefits of Medicaid funding for long-term care is a state's ability to leverage significant funds to promote fundamental change in the delivery system. No other single source of financing for long-term care is large enough to accomplish this. Flexibility under Medicaid waiver provisions has been instrumental in the on-going shift of care delivery from institutional settings to the community, as well as in building and enhancing the infrastructure necessary for this to happen. New opportunities to further expand community-based services exist in the new health reform legislation that could be considered to continue and increase long-term care cost savings.

In opting-out of Medicaid, Wyoming would have to repeal the statutory framework and unwind the program's interface with numerous related programs and initiatives through legislation and regulation. Medicaid is tied to several programs in statute, regulation, and operations: TANF, early intervention programs, Foster Care, mental health, public health departments and programs (immunizations, tuberculosis (TB), cancer screenings, etc.), state-operated facilities, WIC, FQHCs and Rural Health Centers (RHCs), academic medical centers – the list is very long. Unwinding Medicaid may create opposition from many stakeholders in various sectors, including clients and their families, advocacy groups, and providers.

IMPACT TO WDH PROGRAMS

The following analysis identifies the WDH facilities and programs that will feel the most impact of losing Medicaid funding currently used to operate their programs and provide services to clients.

EqualityCare Program (Medicaid)

The Wyoming Medicaid Program (Medicaid) is projected to receive almost \$550 million in Federal Medicaid funds for the 2011-2012 biennium, of which 94 percent will go directly to medical professionals to pay for patient services. If the State of Wyoming were to opt out of this program, WDH would have to replace these funds with General Fund monies, other funding sources, or severely reduce or eliminate some benefits currently provided to Wyoming residents. While it is understood that the simple math of losing 50 – 61 percent of funding to a program is significant, the actual outcomes of those programs should be understood. Over 80,000 Wyoming residents stand to lose critical health care and almost 9,000 medical professionals could have their income affected.

Kid Care CHIP

Kid Care CHIP is Wyoming's Children's Health Insurance Program which makes health care affordable for children of eligible families. There are currently 5,414 children enrolled in the Kid Care CHIP Program. Kid Care CHIP receives 65 percent of its funding from the Federal government for the Federal Fiscal Year (FFY) 2009, which translates into \$9,194,597. The total budget amount of the Kid Care CHIP Program for administrative and expenditures is \$14,290,662.

While not addressed in PPACA, it is believed that without a Medicaid program, the Kid Care CHIP Program would need to be terminated. There are many areas where Medicaid is referred to as it applies to the Kid Care CHIP Program, and when determining eligibility for the Kid Care CHIP Program, states are required to screen children for Medicaid coverage. Because these two programs are so intertwined, more research would need to be done to determine whether Kid Care CHIP could operate without a Medicaid system to support it. Wyoming has sent this question to CMS for a definitive answer.

It appears that many of the 5,414 children currently receiving Kid Care CHIP will likely qualify for exchange coverage as the household income requirements for current eligibility is between 134 percent and 200 percent of the Federal Poverty Level (FPL). The new legislation provides funding for Kid Care CHIP through 2015, which is an additional two years compared to current law, continues the authority for the

program through 2019, and requires states to maintain eligibility standards for children in Medicaid and Kid Care CHIP through 2019. Kid Care CHIP eligible children who cannot enroll in the program due to Federal allotment caps must be screened to determine if they are eligible for Medicaid, and, if not, they would be eligible for tax credits in a plan that is certified by the Secretary of Health and Human Services by April 2015 to be comparable to Kid Care CHIP in the exchange.

Wyoming State Hospital (WSH)

The most notable impact to the Wyoming State Hospital (WSH) if the State were to opt-out of Medicaid would be in regard to nine voluntary patients in the Extended Psychiatric Services Program. Two patients are Medicaid covered, one may be discharged soon, and the other expected to be a long-term patient with Medicaid pharmacy expenses of \$350 per month. Seven other patients are currently eligible for Medicare and Medicaid. Medicaid pays the co-pay, as well as paying 20 percent for diabetic supplies. Medicaid pays an estimated \$1,500 to \$2,000 per month for these seven patients.

Absent Medicaid, it is absolutely critical that community providers for seriously and persistently mentally ill (SPMI) persons have other available funding streams for critically important psychotropic treatment regimes. Without effective medication funding streams, the mental health of SPMI persons is at risk, which could result in accelerated rates of involuntary hospitalizations throughout the state, impacting community acute care behavioral health units and the WSH.

It should also be noted that the Chris S. Settlement Agreement, entered into between the State of Wyoming and Protection and Advocacy, Inc. (U.S.D.C. Docket No. 94-CV-311-J) contains at least one provision that refers to Medicaid, requiring the State to expand the choice of service providers under the Medicaid Program, pursuant to medical necessity and Medicaid rules. It also requires the State to include the use of psychologists as providers of Medicaid services.

Wyoming Life Resource Center (WLRC)

The Wyoming Life Resource Center (WLRC - formerly the Wyoming State Training School or WSTS) is a state-owned facility, operated under the Department of Health (WDH). It has operated since 1912 evolving continuously as best practices have changed. Today, WLRC is a beautiful 90-acre campus housing not only WDH programs, but a Headstart program, a public high school, and an office complex. The WDH programs provide state-of-the-art care, learning and job opportunities for Wyoming residents with significant intellectual and developmental disabilities, brain injuries, and long-term medical and therapeutic needs. Should Wyoming not have Medicaid available for WLRC residents needing medical care, it would impact the General Fund in two ways:

- Increased expenditures for Medicare eligible residents in order to cover physician services for residents who cannot afford the entire cost of the bill, and
- Reduced revenue to the General Fund from patient contributions because any amount a resident can afford to pay for medical services including Part A&B and D premiums will be deducted from the patient contributions.

Most WLRC residents are eligible for Medicaid and many of them are also eligible for Medicare. Medicare residents would have to pay 20 percent of the acceptable charges a physician may bill, and physicians may bill as they see fit for Medicare patients, unlike the restrictions for Medicaid. This would increase expenditures for previously eligible Medicaid and dual-eligible residents in order to cover physician services for residents who cannot afford the entire cost of the services. If Medicare residents applied for and received a supplemental policy to assist in paying overages, the residents would have to pay for Medicare

Parts A&B and D premiums, which are currently covered by Medicaid. This would reduce the revenue WLRC reimburses the General Fund each month in the form of patient contributions.

Second, a few WLRC residents are not eligible for Medicaid and there are also some residents that do not qualify for Medicare. Any physician services, including hospital stays and other medical treatments, would be the responsibility of the resident. It is very likely that WLRC residents would apply for indigent care at a hospital emergency room, compounding the problem, as most hospitals would provide only minimal care and try to send the patient home as quickly as possible. Prescription drug costs would need to be paid for individuals not eligible for Medicare Part D.

Intermediate Care Facilities for persons with Mental Retardation (ICF/MR) Certification is a Federal requirement in order for the WLRC to receive Federal funding. This is necessary in order to receive Medicaid reimbursement to the General Fund for the ICF clients, which are the majority population at WLRC. In the WLRC statute, it is now referred to as ICF/ID (Intellectually Disabled). If we do not have the ICF/ID licensure, we are not able to receive Federal reimbursement. The ICF/ID standards address client services, criteria for clients that may be served, staff to client ratios, informal and formal active treatment training for clients, health care standards, behavior intervention and restraint procedures, incident and abuse and neglect reporting, staff training and credentialing, professional services, and environmental health and safety standards.

Without ICF/MR licensing, WLRC would not be able to accept Medicaid clients from out of state. Further, the General Fund would not receive Medicaid dollars for per diem expenses of approximately \$12,000,000 annually. Also, with the administration of the program partially funded by Federal Medicaid indirectly, it would result in the laying off of about 220 employees at the WLRC. If the State did not participate in Medicaid, the WLRC would no longer comply with the ICF/MR certification standards. Most of the clients who are eligible for Medicaid may not be able to find or afford supplemental health insurance due to the severity of their health conditions.

Wyoming Retirement Center (WRC)

The WRC is the safety net nursing home operated by the State of Wyoming. During this biennium, the WRC averaged 48 Medicaid residents each month, and during that time those Medicaid patients paid \$854,400 from their personal resources and Medicaid paid \$3,734,100. If Medicaid did not provide funding for these patients, the costs of care would need to be covered by General Fund monies or the clients would need to be re-located. In essence, the entire WRC budget of \$11.5 million would need to be State funded or all patients would have to find alternative means of care.

Many of the residents would have to transfer back to the State Hospital. There is no percentage of reduction in patients that would enable the WRC to operate without Medicaid revenue or other funding. This would be catastrophic to many residents since, as the “safety net,” a large number of WRC residents have been transferred to the WRC by other facilities, unwilling or unable to care for them. There are no other options for our Medicaid residents, as private community nursing homes will not take them without assistance to help cover the costs of care.

Medicaid Home and Community Based Waivers

Wyoming Medicaid has six separate Home and Community Based (HCBS) Medicaid waivers, i.e., programs having permission from the Federal government to selectively waive one or more Medicaid requirements and allow for keeping clients in their home or community in order to avoid institutionalization.

- HCBS Waiver Program for Children with Developmental Disabilities (DD)
- HCBS Waiver Program for Adults with DD
- HCBS Waiver Program for Adults with Acquired Brain Injury
- Long-Term Care HCBS Waiver
- Assisted Living Facility HCBS Waiver
- Children's Mental Health HCBS Waiver

These waivers provide non-medical services and supports, including habilitation services, respite, personal care, equipment, etc. These services are not covered under medical insurance or any other programs. Therefore, unless these services are funded through state funds or unless the participant has unpaid caregivers, the participants would go without these services. The loss of services could increase the participants' risk of institutionalization (nursing home, Wyoming Life Resource Center, State Hospital), homelessness, placement in foster care for children, or placement in the criminal justice system.

If a participant has family, the family would have to pay privately for services or provide the services themselves. However, many adult participants do not have families that are actively involved in their lives. The ultimate cost could revert to the state as some of the participants become homeless, go into foster care, or enter the criminal justice system. While this certainly would not happen to everyone, the risk is there for many of the participants.

Currently, waiver participants receive their medical care through the Medicaid State Plan. However, many children on the Child DD Waiver may be able to be covered on their parents' health insurance. The adults on the DD and ABI waivers are under 300 percent of the poverty level, and therefore most do not have the disposable funds needed to purchase health insurance. Furthermore, health insurance is unlikely to provide the non-medical services that are needed for this population. Finally it is important to note that most of the waiver costs for providing services to this population are for supervision to assure the health and safety of the participants.

In SFY 2009, the total number of people receiving waiver services was 4,470. Expenditures for waiver clients totaled \$141.4 million and expenditures for waiver services were 24 percent of total Wyoming Medicaid expenditures. Loss of over 50 percent of program funding would require the State to reduce services by 50 percent, or reduce the number of participants served by at least 50 percent depending on the criteria used to determine who the State would continue to serve, or a combination of reducing services and reducing the number of participants or eliminate the programs altogether.

CMS is providing resources to assist States' efforts to balance their long-term care system through structural system changes that facilitate and promote community living. The Olmstead decision, issued in July 1999, requires states to administer services, programs, and activities "in the most integrated setting appropriate to the needs of qualified individuals with disabilities." This decision interpreted Title II of the Americans with Disabilities Act (ADA), which gives civil rights and protections to individuals with disabilities and guarantees equal opportunity for individuals with disabilities in public accommodations, employment, transportation, State and local government services, and telecommunications. Wyoming's goal for establishing a balanced long-term care services and supports system is evolving in order to meet client needs while controlling growth in costs. A balanced long-term care system is a sustainable, person-driven, long-term support system in which people with disabilities and chronic conditions have choice, control and access to a full array of quality services that assure optimal outcomes, such as independence, health and quality of life.

If Wyoming had only 50 percent of the current funding to cover waiver services, more restrictive eligibility criteria could be imposed than is now in place since the services would be state funded and

therefore would not be required to meet Federal regulations. Wyoming could also choose to reduce the services provided on the waivers.

Mental Health and Substance Abuse Services

Mental health and substance abuse services are in short supply in rural Wyoming. Our frontier areas create barriers to improving the availability and accessibility mental health and substance abuse services. Roughly 12 percent of Medicaid clients struggle with mental illness and/or substance abuse. These clients have significant health care needs but commonly experience obstacles to obtaining adequate psychiatric services. The Mental Health and Substance Abuse Services Division (MHSASD) is responsible for managing Federal and state funded mental health and substance abuse providers and programs, including but not limited to, Federal substance abuse and mental health block grants, Medicaid funded community-based mental health and substance abuse services, contracts with Community Mental Health and Substance Abuse Centers (CMHSAC), court supervised treatment programs (f/n/a drug courts), veterans programs and prevention programs. While a majority of the mental health and substance abuse services in Wyoming are funded with state General Funds, a significant portion is paid for through Medicaid. In 2008, the Wyoming State Legislature directed the maximization of Medicaid as a way for the Division to better utilize funding sources and leverage Federal funds to save state General Funds.

In FY 2009, the Wyoming State Legislature expended approximately \$18,000,000 on the Medicaid state plan rehabilitative services for mental health and substance abuse treatment services provided to 10,607 unique Medicaid clients, which included necessary mental health and substance abuse evaluations, agency and community based individual and family therapy, group therapy, targeted case management and individual rehabilitative services. If the State opted out of Medicaid, many of the mental health and substance abuse programs leveraging Medicaid dollars would be detrimentally affected. Specifically, services and programs provided by CMHSACs, psychologists, psychiatrists and treating providers working under the supervision of these providers, and the Children's Mental Health Waiver (CMH Waiver) providers would suffer as these providers would no longer be able to access Medicaid as a funding source

In FY 2009, CMHSACs billed approximately \$10,284,797 in Medicaid mental health and substance abuse services. If the State opted out of Medicaid, the State would not enjoy the approximate \$5 million in Federal match and the opt-out may create access issues. If substance abuse and mental health treatment services were not available through Medicaid, a significant number of providers may no longer participate in delivering services. This could greatly reduce the number of low-income, uninsured Medicaid eligible individuals in the state who would receive necessary services.

Additionally, the CMH Waiver would cease to exist or be detrimentally impacted as Medicaid Federal match supports half of the CMH Waiver budget of approximately \$4,600,000. The CMH Waiver serves as a cost-effective alternative to hospitalization of children with serious emotional disturbance and allows them to remain in the community setting at a significantly reduced expense. If the CMH Waiver was no longer an option for children, the State would bear increased expense and costs for serving children in a hospital or in-patient setting.

Many mental health and substance abuse health care professionals in Wyoming are Medicaid providers; an opt-out would reduce funding available to these providers. A reduction in funding could compromise our already fragile MHSAs provider structure and result in a loss of providers, creating access issues for all Wyoming residents and families seeking mental health and substance abuse services.

Office of Health care Licensing and Surveys

The Wyoming Office of Health care Licensing and Surveys (OHLS) assures that patients and residents receive quality care from health care facilities required to be licensed by the State of Wyoming. The activity and results of the work accomplished by the OHLS is leveraged throughout the state to all facilities, and is the high-profile watchdog that is necessary to protect the health and safety of all Wyoming residents, not just those receiving Medicaid or Medicare. The OHLS also promotes health and safety through on-site inspections and complaint investigations. The OHLS licenses and/or certifies the following types of facilities:

- Adult Day Care Facility
- Adult Foster Care Home
- Ambulatory Surgical Center
- Assisted Living Facility
- Birthing Center
- Boarding Home Facility
- Community Mental Health Center
- Comprehensive Outpatient Rehabilitation Facility
- Critical Access Hospital
- End Stage Renal Dialysis Center
- Federally Qualified Health Center
- Freestanding Diagnostic Testing Center
- Home Health Agency
- Home Health Agency - Branch Location
- Hospice Program
- Hospital
- Wyoming Life Resource Center
 - Intermediate Care Facility for the Mentally Retarded
 - Outpatient Physical Therapy/Speech Pathology Facility
- Psychiatric Hospital
- Rehabilitation Facility
- Rural Health Clinic
- Nursing Facilities

Approximately 50 percent or \$1,000,000 annually of the budget for the OHLS would be affected by opting-out of Medicaid. Most nursing homes are dually certified and the majority of their residents are Medicaid recipients. While the Federal requirements and funding for this program are intended to oversee those facilities which receive Federal support, the extended outcome is that the OHLS is the only oversight for facilities, and therefore fills a critical role in monitoring the quality of care received by Wyoming residents.

Aging

The Aging Division serves the entire state of Wyoming by coordinating services, policies, procedures, and the direction of the future of aging with members of the State Aging Network. The Aging Division follows the Older Americans Act, which was reauthorized in 2006.

The Division receives Federal funding for Title III and VII programs, including: Title III – B, Supportive Services; Title III-C1, Congregate Meals (on-site); Title III – C2, Home Delivered Meals; Title III – D, Preventative Health; Title – E, National Family Caregiver Support; Title VII, Elder Rights; Title VII, Long-Term Ombudsman; and Nutrition Services Incentive Program (NSIP). In addition, the Division oversees the General Funds for other programs, including: Community-Based In-Home Services; the Senior Companion Program; the Foster Grandparents Program; the Retired Senior Volunteer Program; and the State Ombudsman Program.

In 2009, the total number of unduplicated clients, aged 60 years and over, served by these programs in Wyoming was approximately 45,000. During the 2009-2010 biennium, the total Federal funds received by the Aging Division on behalf of services and programs for senior citizens were \$13,590,392. During this same biennium, the total General Funds received was \$18,680,868. The average cost per client was \$718. Wyoming is considered a “minimum allotted state” for Federal funds from the Administration on Aging. Therefore, no additional Federal funds would be allocated to Wyoming from the Administration on Aging if other Federal funding were to be withdrawn (opting-out of Medicaid).

Should the State of Wyoming determine to opt-out of Medicaid, the cost per client would increase in the number of services needed to be provided by the Title III and Title VII programs listed above, primarily in the Home Delivered Meals, Ombudsman, National Family Caregiver Support, and the Community Based In-Home Services programs. Additional General Funds would be required to supplement the withdrawal of Federal funds in order to serve our aging population.

Because all of the Aging Division’s current programs are not “means tested,” no information on the number of Medicaid eligible clients being served is recorded by the Division. The Division can verify, however, that in FY 2009, 17.9 percent of the 45,000 people being served by the above programs, all aged 60 years and over, lived at or below the Federal Poverty Level (FPL).

Wyoming ranks among the five fastest aging populations in the United States. As such, the opting-out of Medicaid would have substantial negative consequences. Clients currently receiving services through the Medicaid Home and Community Based Services program could be shifted to the generally funded Community Based in Home Services Program (CBIHS). This additional client load would potentially: 1) burden the provider system with additional clients while escalating the General Funds needed to provide services to stay at home, or 2) require a reduction of in-home services, forcing seniors into exponentially more costly early institutionalization.

The statewide and national goals of providing a high quality of life, independence, dignity, and freedom of choice would be adversely affected for all of Wyoming’s senior citizens, today and in the future, as we prepare for the wave of baby boomers to enter the aging network. The Wyoming Department of Health’s Aging Division exists to provide a flexible and responsive continuum of services that enables Wyoming’s older adults to age-in-place with maximum dignity and independence.

The CBIHS is a 100 percent State-funded program. The CBIHS program would recognize a huge increase in clients needing and requesting services. The impact means a larger waiting list and Wyoming would have to evaluate becoming a “means tested” program.

The ramifications to the Senior Nutrition programs if the State of Wyoming opts out of Medicaid would likely mean that clients who currently participate in the Medicaid waiver programs and receive meals could shift to C1 and C2. Elderly Nutrition Projects would see a client increase and the projects would experience a decrease in funding on a per meal basis. For the Nutrition Program, funding is partially based on the number of meals. To continue serving the current client load, the program would need additional General Funds of approximately \$6 million per year for an additional 2,500 clients.

Breast and Cervical Cancer Early Detection Program

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) was established by Congress in 1993 (Public Law 101-35). The Wyoming Breast and Cervical Cancer Early Detection Program (WBCCEDP, a.k.a. Women’s Health Source) allows participating health care providers to receive reimbursement for enrolled women’s breast and cervical screening and diagnostic services.

While this national program, implemented through the Centers for Disease Control and Prevention (CDC), operated primarily as a screening program in the early years, a major change occurred in 2000 with the passage of the National Breast and Cervical Cancer Treatment Act (Public Law 106-354). In January 2001, CMS provided guidance to all 50 state health officials directing states to provide full Medicaid benefits to uninsured women under the age of 65 years, who are identified through the NBCCEDP, and are in need of treatment for breast or cervical cancer, including pre-cancerous conditions. In addition, programs were required to find alternative sources for treatment for women who are diagnosed with breast or cervical cancer, if they did not qualify to receive treatment through Medicaid.

In October 2001, Wyoming's State Plan was approved by CMS and the program began transitioning women to Medicaid for coverage of their breast or cervical cancer or high-grade cervical pre-cancer treatment. From October 2001 through March 2010, the program transitioned 567 women to Medicaid; 174 women for breast cancer, 20 women for cervical cancer, and 373 for high-grade cervical pre-cancer. In 2009 alone, 90 women were transitioned to Medicaid.

Should the State of Wyoming decide to opt-out of Medicaid, there would no longer be a way to provide cancer treatment for low-income, uninsured women diagnosed through this program. Therefore, Wyoming would be out of compliance with the CDC's regulation that at least 90 percent of all women diagnosed through the program begin cancer treatment within 60 days of their cancer diagnosis. This requirement is one of 11 core performance indicators the CDC requires of all programs. It is unknown what the penalty would be for not meeting this indicator. However, in the past, the CDC has restricted all funding when programs fall out of compliance with any of the 11 performance indicators. It is possible that all funds for this program may be lost if the State opts out of Medicaid, even though the funds are not funds received directly from Medicaid.

In addition, if the treatment option was no longer available through Medicaid, a significant number of health care providers would no longer participate in the program. This would greatly reduce the number of low-income, uninsured women in the state who would receive life saving early detection services. This would result in more Wyoming women dying of breast and cervical cancer.

A May 2009 report by the U.S. Government Accountability Office (GAO) stated that there were few alternatives to Medicaid coverage for breast or cervical cancer treatment available to low-income, uninsured women. This report also estimated that Wyoming Medicaid spent \$1,601,317 on breast and cervical cancer treatment in 2006, which includes State and Federal dollars.

HIV Treatment Program

The Wyoming Department of Health's HIV Medication Program provides persons living with HIV/AIDS access to comprehensive health care and other supportive services. These programs serve as the payer of last resort for persons who are uninsured, under-insured, or are otherwise unable to access medical treatment. The HIV Medication Program is administered through Medicaid. A new system would be required to handle this program, the 340B pricing (a law stating the government may purchase medications at a reduced price), and rebates which save the program a significant amount of money. The HIV Treatment Program currently pays at the Medicaid rate, saving the program over \$80,000 each year. The program currently has thirty clients who are eligible for Medicaid or are enrolled in the Prescription Drug Assistances Program (PDAP). The program would not be able to serve clients with medications or medical care without Medicaid funding and support.

Community and Public Health Programs (CPHD)

The CPHD programs will not incur any penalties if the State opts out of Medicaid. Many of the programs in CPHD are focused on improving health outcomes for women, infants and children. Without Medicaid, these health outcomes will be negatively affected. Women who are presumptively eligible for the Pregnant Women Program (PWP) are able to get prenatal vitamins as soon as they apply for Medicaid. Folic acid is very important to the development and health of the fetus and has been shown to decrease the neural tube defects of infants. Without the PWP, pregnant women would not be able to receive free prenatal vitamins with folic acid.

Since approximately half of all deliveries in Wyoming are paid for by Medicaid, losing Medicaid would mean that mothers currently eligible for the PWP would not have another source of payment for prenatal care or delivery services. Maternal mortality could increase as pregnant women without prenatal care would not receive treatment for their chronic illnesses or pregnancy complications. The lack of prenatal care could also lead to an increase in poor birth outcomes, including low birth weight and preterm birth.

Losing Medicaid would also result in losing the Pregnant by Choice 1115b waiver, which provides family planning services to women who had a delivery paid by Medicaid. Without access to pregnancy planning services, more women could have unintended pregnancies. Unintended pregnancy is a risk factor for low birth weight and preterm delivery.

Public Health Nursing (PHN)

Without Medicaid available, PHN would anticipate a higher demand for their services with no additional nursing resources. Because some of the PHN offices bill Medicaid for services, they would see a decrease in revenue. The estimate of these funding reductions is unavailable at this time. Direct services provided through a partnership between Medicaid and PHN, such as LT 101s and screening, brief intervention and referral to treatment (SBIRT), would also be affected.

Epidemiology

Medicaid data is vital in providing information for health outcomes of Wyoming people of low socioeconomic status. Medicaid data is one of the only existing sources of these data. Data for several of the performance measures required in the annual Title V Block Grant come from Medicaid. Because reporting these data is required, \$1.2 million in annual grant funds would be in jeopardy without the data.

Immunization

If Wyoming was no longer a Medicaid participant, it is possible that some or all of Wyoming's Federal immunization funds would no longer be available. During the past calendar year, Wyoming received \$ 1,154,590 in Financial Assistance funding for immunization program operations from the following sources:

- Section 317 Federal discretionary funds - \$ 842,074
- Vaccines for Children (VFC) - \$ 312,516

Approximately 85 percent of the operational funds for the Immunization Section come directly from Federal funds. In addition to these operational funds, Wyoming received approximately \$4.5 million in Federally-funded vaccines for the children of Wyoming residents from the following sources:

- Section 317 Federal discretionary funds - \$ 450,000
- Vaccines for Children (VFC) - \$ 4,050,000

Approximately 62 percent of vaccine funding for Wyoming's children comes directly from Federal funds. It is currently unknown what portion of these Federal funds could be in jeopardy if Wyoming were to no longer participate in the Medicaid program, the total amount of Federal funds that could potentially be lost is approximately \$5.65 million per year

Maternal and Family Health (MFH)

Many MFH programs, such as Children's Special Health (CSH), Maternal High Risk (MHR), and Newborn Intensive Care (NBIC), provide supplemental funding and are the payer of last resort after payment from Medicaid or private insurance. MFH does not have the budget to cover expenses currently covered by Medicaid.

There are no tertiary care hospitals within the state of Wyoming. MHR and NBIC programs provide transportation coverage for mothers and infants to be transported out of the state for necessary high risk perinatal care. Medicaid would be the primary payer for these programs with the exception of travel not covered. There is a financial cap of \$5,000 for MHR and \$40,000 for NBIC. Without Medicaid, one high risk delivery or one infant in neonatal intensive care could deplete the MHR and NBIC budgets. This would leave no funding available to assist other families, which could result in families not able to access tertiary care for the mother or infant. SSI coverage would not be an option for premature babies where families are not eligible for Medicaid based on their income.

Without Medicaid support of breast pump rental, it is likely that fewer women would initiate or continue breastfeeding. WIC and a few PHN offices would be the only source for assistance with breast pump rental. Breastfeeding improves both maternal and infant health.

MFH provides care coordination for approximately 1,500 children and youth with special health care needs (CYSHCN) who are enrolled in Children's Special Health. Approximately 75 percent of the children on CSH are also enrolled in Medicaid. Without Medicaid, CSH would be responsible for paying the medical bills for these children. There is an annual \$40,000 cap for medical services for each child. In the current CSH annual budget of \$125,000, there are not sufficient funds to cover the cap for our current caseload. Additionally, the cap amount would be insufficient to cover medical services for many of the CYSHCN with complex medical conditions. For example, one heart operation for a child with sub aortic stenosis results in hospital charges of \$41,000, and that costs excludes charges for physicians, the anesthesiologist and other fees. As a result, CSH funds would be quickly depleted each year, or the CSH budget would need to be increased to an estimated \$300 million to cover the cap amount on only half of the CSH clients. Without this coverage, CYSHCN would not receive the medical care they need, resulting in poor health outcomes and increased financial difficulties for families.

MFH coordinates genetics clinics throughout the state. Without Medicaid, many families would not be able to receive genetic counseling or testing. Medicaid covers visits to genetics clinics, as well as medically necessary testing for their clients. Many parents who do not have insurance or who have private insurance with a deductible opt out of the visit and testing because of the cost.

Women, Infants and Children (WIC)

Over 70 percent of WIC participants are also Medicaid participants. Eliminating the Medicaid Program in Wyoming would have huge consequences for the high-risk pregnant, breastfeeding, and post-partum women, infants, and children that WIC serves. This population has greater medical needs than the average population. For every low birth weight baby prevented through good nutrition and adequate prenatal care, more than \$400,000 are saved. Part of the WIC Program's responsibility is to refer

participants for medical care. Without Medicaid, WIC will be unable to refer the majority of participants who can't afford to pay for medical care.

Program regulations allow WIC to consider those on Medicaid as “adjunctively income eligible.” This eliminates the need for extensive income screening. Without this ability, the program’s administrative burden will be greatly increased. Additionally, Medicaid has paid for medical food/formula that WIC is unable to cover for a WIC/Medicaid participant. Medicaid also supports the electric breast pump program for Medicaid/WIC clients. Without Medicaid support, this program would be eliminated, and it is likely that fewer women would initiate or continue breastfeeding.

Oral Health

For Oral Health, losing Medicaid means a need for a large increase in General Funds. The Marginal Dental Program assists Wyoming children with dental treatment. The current caseload for this program is approximately 100 children. Without Medicaid coverage, this number is expected to increase a minimum of threefold. Because General Funds are used for this program, the budget would need to be increased to meet the increased caseload.

Without Medicaid, the Orthodontic Program would be obligated to continue care for all clients currently in treatment. This would result in an estimated increase from the current budget of \$1.2 million to nearly \$4 million.

Many Wyoming adults receive dental treatment services on adult Medicaid. Without Medicaid, these clients would need to enroll in the Marginal/Senior Dental Program. Serving more than 900 adults in the past year at a cost of \$475,000, this program would need approximately \$1 million in additional General Funds annually to meet the increased demand for services.

End Stage Renal Disease Program

There are two End Stage Renal Disease Program (ESRD) designations within the State of Wyoming -- State funded ESRD and Medicaid funded ESRD.

The State funded End Stage Renal Disease Program (ESRD) receives approximately \$850,000 per year from legislative approved funding. The State funded program is charged by the Wyoming State Legislature to be a payer of last resort after private insurance, Medicare, and Medicaid payments have been made. ESRD costs under the State funded program would be increased for 58 of the 143 ESRD clients who currently receive Medicaid assistance.

Most recipients of Medicaid funded ESRD services are dually eligible for both Medicaid and Medicare services. During the 90-day Medicare eligibility determination period, Medicaid will reimburse Medicaid funded ESRD services for eligible individuals and will reimburse for services if Medicare denies eligibility.

Of the 73 total Medicaid funded ESRD recipients in SFY 2009, expenditures for 15 recipients were Medicaid only funded. Expenditures for these recipients totaled \$1,100,000 in SFY 2009, an increase of 11 percent from SFY 2008, representing an increase of four recipients. ESRD services expenditures for non-dually eligible individuals were less than one percent of total Medicaid expenditures in SFY 2009. Medicaid funded ESRD expenditures per recipient were \$73,354 in SFY 2009.

Opting-out of Medicaid in Wyoming would potentially produce these results for the State funded ESRD program:

- Either a greater cost for the same number of clients or insufficient resources to serve as many clients
- In order to maintain the same number of clients with the additional per-client cost, additional funding would be needed for the ESRD Program
- Because there is no information in ESRD client files as to the actual amount paid from other sources (private insurance, Medicare, or Medicaid), we can only estimate a dollar cost to be somewhere between 10 percent and 40 percent increase for the currently covered 58 clients.
- There are no specified penalties, but the reduced funding will require the program to pay out more per client or cover fewer clients.
- It is unknown by ESRD how many current Medicaid clients who are eligible for ESRD assistance are not enrolled in the ESRD program, but would apply for assistance if Medicaid were no longer available.
- If the number of ESRD clients increased significantly because of the loss of Medicaid, and if other ESRD funding is available, the program may require additional staff to handle the increased workload.

Primary Care Office (PCO) Grant

The Office of Rural Health could lose the Primary Care Office (PCO) grant, which is \$98,000 per year in Federal grant funding for salary and travel to support the following program requirements. If the State opted out of Medicaid, the Office of Rural Health could lose this grant.

- *J-1, Conrad 30 Visa Waiver* - Physicians are required by terms of the grant, to treat Medicare, Medicaid, and Kid Care patients to fulfill contract requirements. If there are no Medicaid eligible patients to treat, they may be declared not in compliance with program requirements. There are currently 18 J-1, Conrad 30 physicians practicing in Wyoming.
- *National Health Service Corps Loan Repayment Program* requires participants to treat Medicare, Medicaid, Kid Care and uninsured patients. If participants in these programs discontinued treating Medicaid eligible patients, they may be declared not in compliance with program requirements and will be forced to practice in another state. There are over 30 health care professionals (primarily mental health) practicing in Wyoming and participating in this program, which pays them \$50,000 toward loan repayment for a two-year service obligation (which totals \$1.5 million per biennium in Wyoming). The Office of Rural Health received additional Primary Care Office funds of \$30,000 per year for three years through an ARRA grant. This grant focuses on increasing the number of NHSC eligible sites, thereby increasing the number of locations in which participants can practice. The Office of Rural Health could lose this grant if the State opted out of Medicaid.
- *Community Health Centers/Federally Qualified Health Centers* – Medicaid accounts for a considerable portion of reimbursements and the centers are required to treat Medicaid patients. Wyoming's three Community Health Centers, two homeless clinics, and one migrant health clinic (all are FQHCs) may be declared not in compliance with program requirements and may be forced to close, as they would no longer qualify for Federal funding. FQHCs serve approximately 20,000 Wyoming residents, many of whom are uninsured or only have Medicare or Medicaid insurance. In 2009, Wyoming's FQHCs received Federal funds of \$7 million in addition to reimbursement from Medicare, Medicaid, and Kid Care for services rendered.
- *Rural Health Clinics (RHC)* services include primary care services delivered by physicians, nurse practitioners, nurse midwives, and physician assistants, as well as services and supplies incident to the

providers' services. Medicare designates a health clinic as an RHC if it is located in an area designated as a shortage area (shortage areas are defined geographic areas designated by the Department of Health and Human Services as having either a shortage of personal health services or a shortage of primary medical care manpower). RHCs differ from FQHCs based on several criteria related to location, shortage area, corporate structure, requirements for a board of directors and clinical staffing requirements. Sixteen RHCs in Wyoming receive increased Medicare and Medicaid reimbursements to keep them financially stable and to encourage existing clinics to treat Medicare and Medicaid patients. A Wyoming study from 2008 indicated, on average, an RHC receives about \$25,000 in increased Medicaid reimbursement annually. Losing this increase, and losing the complete State portion of Medicaid reimbursement would likely cause several RHCs to close. Eight of these clinics are affiliated with Critical Access Hospitals, although not necessarily located in the same community as the hospital. Eight are independent clinics owned by private practice physicians. It is very likely RHC patients may forgo care until it becomes emergent or life threatening, as this is quite common in rural America. If these rural clinics close, patients may have to travel to the next closest clinic (all clinics in Crook County are RHCs so these residents may travel to SD for care; the only clinic in Baggs is a RHC--these patients might go to Craig, Colorado, or drive over 50 miles to Rawlins; Medicine Bow patients may go to Hanna (19 miles), Rawlins (60 miles), or Laramie (57 miles). Clinics in Worland are RHCs, as are several in southern Big Horn County. Many clinics may not accept additional uninsured patients (formerly insured by Medicaid) forcing the patients to travel even further or seek care in the closest emergency room, driving the cost of care higher. Current locations with RHCs or eligible to become RHCs have a total population of over 360,000 residents (see Appendix C for list of RHCs).

Wyoming Health care Professional Loan Repayment Program

This program requires participants to treat Medicare, Medicaid, and Kid Care patients. If participants in this program discontinued treating Medicaid patients, they could be considered in default of their contracts. Program rules would need to be modified.

Physician Recruitment Grant Program

This program requires the facility/provider to treat Medicare, Medicaid, and Kid Care patients. If participants in this program discontinued treating Medicaid patients, they could be considered in default of their contracts. Program rules would need to be modified.

Critical Access Hospitals

Critical Access Hospitals (CAH) are small rural hospitals (25 beds or less) with limited revenue and tight budgets. If the number of uninsured grows due to loss of Medicaid, the hospitals' uncompensated care will increase and revenues decrease. If the State of Wyoming opted out of Medicaid, funds for Qualified Rate Adjustments (QRA) and Intergovernmental Transfers (IGT) would no longer be available to those hospitals that were eligible to supplement Medicaid payments (see hospital section).

IMPACTS TO OTHER STATE AGENCIES

The Department of Health collaborates with a number of other Wyoming State agencies that also provide services to Medicaid recipients. The following brief analysis identifies, from our perspective, the potential implications of opting out of Medicaid to some of the agencies with which Wyoming Medicaid frequently works.

Attorney General's Office

Medicaid Fraud Control Unit

The mission of each Medicaid Fraud Control Unit (MFCU or Unit), as established by Federal law, is to investigate and prosecute fraud by Medicaid providers, as well as patient abuse and neglect. The Units are required to be "single, identifiable" entities whose professional staff works full time on MFCU duties. The Units are administered by the States themselves, but are funded on a matching basis by the Federal Government. All MFCUs currently receive 75 percent of their funding from the Federal government and 25 percent from their State government. The MFCUs' authority to investigate patient abuse and neglect extends to Medicaid-funded facilities, as well as to "board and care" facilities that do not receive Medicaid funding. MFCUs may, in certain circumstances, also investigate program fraud involving Medicare or other Federal programs, upon the approval of the Department of Health & Human Services Office of Inspector General (HHS/OIG) or another relevant agency Inspector General.

States are required as part of their Medicaid State plans to maintain a MFCU, unless the Secretary of HHS determines that certain safeguards are met regarding fraud and abuse. Forty-nine states and the District of Columbia currently maintain Units. The MFCUs operate on an interdisciplinary model and are required by statute to employ investigators, auditors, and attorneys. The MFCUs are required to have statewide authority to prosecute cases or to have formal procedures to refer suspected criminal violations to an office with such authority.

Should Wyoming opt-out of Medicaid, the Medicaid Fraud Control Unit (MFCU) would lose funding and the office would no longer be needed. The biennial budget for MFCU is just over \$1 million. The Federal match is \$778,000 and this unit employs four people. Simply by the presence of MFCU, health care providers have a deterrent to defrauding payers of health care services. If the State shifts the care of the current Medicaid recipients to another payer source, Wyoming would bear the entire cost of detecting fraud within whatever entity takes over.

Department of Corrections

Individuals who are actively incarcerated in Department of Corrections' institutions are not Medicaid eligible, and there is no Medicaid rate applied for inmates who receive services through the community. That is not necessarily true for those who are on probation and parole, or who are re-entering communities following a period of incarceration. Re-entry becomes even more difficult if they do not have the ability to get insurance. Therefore, it is probable that without a Medicaid fall-back, re-entry issues would become more difficult for releasing inmates.

Department of Family Services

The Department of Family Services' (DFS) Medical Eligibility Determination Unit has 53 full-time positions. DFS currently conducts the determinations of eligibility for Wyoming Medicaid. DFS also provides consulting, supervision, fiscal, and human resources support to these clients, as well as others. These services would no longer be needed without a Medicaid program. The average monthly Medicaid recipient caseload for 2009 was 64,391.

Summarized in the following table is a schedule that provides actual revenue from the Federal government for 2007-2008 and estimated revenue for 2009-2010 and 2011-2012 for the DFS. This Federal revenue would not be available should Wyoming opt-out of Medicaid. Should Wyoming continue to participate in the Medicaid Program, enrollment and eligibility determinations may be accomplished through a state Exchange. The Exchange could allow individuals to apply for insurance, Medicaid, Kid Care CHIP, and other social service programs, if the State chose to coordinate procedures.

	2007/2008	2009/2010	2011/2012
General Fund	\$4,194,692	\$4,778,611	\$4,972,576
Federal Fund	\$3,804,704	\$4,311,780	\$4,449,198
Total	\$7,999,396	\$9,090,391	\$9,471,774

IMPACTS TO MAJOR PROVIDER AND CLIENT GROUPS

The following analysis describes the anticipated impacts of opting out of Medicaid on major provider groups. In looking at the impacts of opting out of Medicaid, careful consideration should be given to three groups that are currently covered and which are high cost and may not be covered under private insurance, or, if they were, could be cost prohibitive. The three groups listed below account for approximately 40 percent of the Medicaid budget and amounts are broadly rounded.

Biennium Costs (standard match rate 50 percent):

Providers of Waivers Services:

Total cost: \$200,000,000
 General Fund: \$100,000,000

Nursing Facilities:

Total Cost \$146,000,000
 General Fund: \$73,000,000

Foster Care:

Total cost: \$50,000,000
 General Fund: \$25,000,000

Further details are provided below and in the report appendices on the impacts to provider groups including physicians, long-term care nursing facilities, hospitals, pharmacies, and other providers.

Physicians

Wyoming Medicaid uses a physician fee schedule to pay for medical services provided by several categories of practitioners, including physicians, psychiatrists, physician assistants, physical and occupational therapists, ophthalmologists, and nurse practitioners (see Appendix D). Wyoming Medicaid limits visits to hospital outpatient departments, physician offices and optometrist offices to a maximum of 12 per calendar year for recipients over the age of 21.

Family planning visits, Health Check (Early Periodic Screening, Diagnosis and Treatment) services and emergency services for all recipients are exempt from the 12-visit limit. Expenditures for physicians were over \$53 million in SFY 2009. The average Medicaid patient load for a physician is about eight percent; however, some clinics and physicians have over 25 percent of their patients with Medicaid coverage.

Long-term Care Nursing Facilities

Medicaid is the largest payer for nursing facility care, far exceeding Medicare, private insurance and individual out-of-pocket payments. In Wyoming, about 62 to 63 percent of nursing home residents are covered by Medicaid, and all but three of the nursing facilities have over 50 percent Medicaid patients. The reduction in Federal match for nursing facility claims would not only negatively impact a facilities income; it is possible that many of them would go out of business.

Because of the aging “baby boomer” population, the fastest growing aspect of Medicaid is nursing home coverage. Diminishing income would threaten the already fragile infrastructure of the network in the state, put many of these facilities out of business, and restrict access to a vulnerable population group. A significant gap would be created for the aged and disabled population currently eligible for Medicaid and who would ostensibly not be helped by health care reform. Medicaid calculates facility per diem rates each fiscal year using facility-specific cost data based on each provider’s fiscal year end. A facility’s per diem rate to other clients may not exceed the maximum rate established by Medicaid. The current median per diem rate is \$161.75.

Medicaid reimburses separately, outside of the facility’s per diem, for physician visits, hospitalizations, laboratory services, x-rays, and prescription drugs for residents of a nursing facility. Medicaid provides additional reimbursement outside of the per diem rate on a monthly basis for services provided to a recipient with extraordinary medical needs. Appendix E identifies the long-term care nursing facilities in Wyoming, including details on where they are located and the percentage of their income that is Medicaid based.

Hospitals

Wyoming Medicaid covers inpatient hospital services, with the following exceptions: alcohol and chemical rehabilitation services, cosmetic surgery, and experimental services. In addition, Wyoming Medicaid covers only those surgical procedures that are medically necessary. Wyoming Medicaid may not cover a surgery if there is a non-surgical alternative or if a provider performs the surgery only for the convenience of the patient. Inpatient hospital expenditures totaled \$83.8 million in SFY 2009, and these expenditures were 17 percent of total expenditures in SFY 2009.

Wyoming Medicaid also covers outpatient hospital services. Outpatient hospital departments provide outpatient hospital services, including emergency room, surgery, laboratory, radiology, and other testing services. Wyoming Medicaid limits visits to hospital outpatient departments, physician offices and optometrist offices to a maximum of 12 per calendar year for recipients over the age of 21. Limits do not apply to recipients under age 21 or Medicare crossovers. Family planning visits, Health Check and emergency services for all recipients are exempt from the 12-visit limit. Outpatient hospital expenditures for SFY 2009 totaled \$25.2 million, and these expenditures were five percent of total expenditures.

Opting out of Medicaid would not only increase the number of uninsured that hospitals are required to serve, it will eliminate their income for supplemental payments to disproportionate share hospitals (DSH). Wyoming Medicaid makes additional payments to hospitals that serve a disproportionate number of low-income patients. These DSH payments are required and funded by Federal law and are capped according to state specific allotments.

In addition to DSH payments, Wyoming directs additional funding support to safety-net hospitals through Medicaid reimbursements structured around upper payment limits (UPL) allowable under Medicare. These payments are Qualified Rate Adjustments (QRA). In the absence of a Medicaid program, the DSH program, along with other supplemental reimbursement, such as UPL payments, would cease to exist in Wyoming (see Appendix F). Depending on the State’s ability to provide for services to low-income

individuals who would not be eligible for Federal insurance subsidies, hospitals could experience a significant increase in demand for services from individuals and families unable to pay for the services at the same time they are losing a funding source to cover the cost of uncompensated care.

Pharmacies

The reduction in the number of prescriptions filled by pharmacies would negatively impact a provider’s income, especially independent pharmacy owners in remote locations (see Appendix G). Diminishing income would threaten the infrastructure of the pharmacy network in the state, put many of these pharmacies out of business, and restrict access to a vulnerable population group.

Prescription drug coverage is just one of the services provided under the Medicaid umbrella, and is a mandatory service for child populations, but an optional service for adult categories of service. Prescription drug coverage is the single largest optional service at 8.25 percent of the total expenditures for optional services. Wyoming covers most prescription drugs and specific over-the-counter drugs. A prescription and co-payment are required for all drugs for most recipients. Exceptions may apply for specific products or conditions, such as pregnancy.

It would be difficult, if not impossible, to provide the same level of prescription benefit to the above-mentioned clients with only 50 percent of the funding currently available. The disabled, as well as those clients with mental health conditions, would be particularly at risk.

Foster Care Children Prescriptions (with federal match) SFY 2009	
Clients served (based on a monthly running average)	953
Total number of claims	34,637
Total expenditure	\$3,212,326
Average Per Member Per Month (PMPM) cost	\$280.90
Avg PMPM Cost with no federal matching funds (based on 50% match rate)	\$140.45
<i>*This population utilizes many expensive mental health medications. We would have to eliminate coverage of certain medications and this is an enormously sensitive topic of debate in the mental health treatment arena.</i>	

Medicaid Prescriptions for Children SFY 2009	
Running average of clients served per month	8,823
Total number of pharmacy claims per month	219,888
Total expenditure per month	\$18,374,664
Average Per Member Per Month (PMPM) cost*	\$173.55
Average PMPM Cost with no Federal matching funds, based on 50% match rate	\$86.77
<i>*This would be a particular problem with the developmental disabled children. Their average monthly pharmacy services expenditure is \$460.78 PMPM</i>	

Prescriptions for Medicaid Adults SFY 2009	
Clients served, based on a monthly running average	6,074
Total number of claims	267,238
Total expenditure	\$18,266,053
Average Per Member Per Month (PMPM) cost*	\$250.61
Average PMPM Cost with no Federal matching funds, based on 50% match rate	\$125.31
<i>*DD and LTC Waiver clients have a much higher average PMPM cost and would be more adversely impacted by decreasing the pharmacy budget. The expensive mental health classes, as well as prescription drug therapies for clients with concurrent chronic health conditions drive a large portion of this group’s expenditures as well.</i>	

Other Providers

For information on other provider groups and total expenditures for in-state and out-of-state, please see the most current Annual Report for Wyoming Medicaid available on the WDH EqualityCare website. Should Wyoming discontinue Medicaid and replace it with a state only program, the State of Wyoming would have to cope with the loss of the millions of dollars in FMAP. We certainly would have to tighten eligibility requirements, reduce benefits, or reduce reimbursement for services as compared with the current system. It is imperative that providers make enough on an encounter that they can remain in business. Wyoming is already facing provider access and availability issues not only for Medicaid, but for the entire population. If a provider loses income for every case they treat, they will inevitably go out of business. Should the State of Wyoming cast away the safety net entirely? Many of Wyoming’s primary care physicians, who derive significant percentages of their income from Medicaid, would be forced to leave the state, as few Medicaid clients can pay for private insurance or pay cash for medical care.

Client Costs

While there is a common perception that Medicaid clients, and in particular children, have annual health care expenditures of significantly more than other children, there are several reasons for the difference. It is important to remember that the program is a “safety-net” and, therefore, absorbs many clients and costs that are not covered by private insurance programs. In addition, Medicaid costs cover full dental, mental, preventive, and vision care, along with transportation to medical care for children. In comparison, private health insurance benefits vary widely and are typically less comprehensive. Many private plans do not offer dental or vision care, services that are important for children and some low cost private plans do not even offer basic services like prescription drugs or preventive care.

Economists Jack Hadley and John Holahan of the Urban Institute have shown that, after accounting for the fact that children and adults covered by Medicaid have a higher incidence of health problems and thus tend to require more care, it is less expensive to provide health care with Medicaid than private insurance. They found public insurance was about ten percent less expensive for children and about 30 percent less expensive for adults. In addition to having higher medical costs, private health insurance has administrative costs that, on average, are about twice those of public insurance. Finally, private health insurance premiums have risen faster than per capita Medicaid costs in the last few years.

The table below indicates costs for different Medicaid groups

	Eligibles	Total Cost	Eligibles	Recipients	Cost per Eligible's	Cost per Recipient
Children	50,088	\$110,987,650.00	50,088	43,123	\$2,215.85	\$2,573.75
Foster Care	3,803	31,724,100.00	3,803	3,541	8,341.86	8,959.08
DD Waiver Child	831	21,663,414.04	831	823	26,069.09	26,322.50
Adult (Family Care)	7,644	26,959,034.00	7,644	6,591	3,526.82	4,090.28
Adult DD Waiver	1,343	89,297,853.79	1,343	1,357	66,491.33	65,805.35
Adult ABI -Waiver	173	7,238,867.57	173	177	41,843.17	40,897.56
Pregnant Women	6,144	32,876,214.00	6,144	6,781	5,350.95	4,848.28
Disabled SSI - Child *		11,485,713.11		1,009		11,383.26
Disabled SSI - Adult *		35,673,216.32		4,788		7,450.55

*Not able to calculate the unduplicated eligible count for SSI when the split is by age.

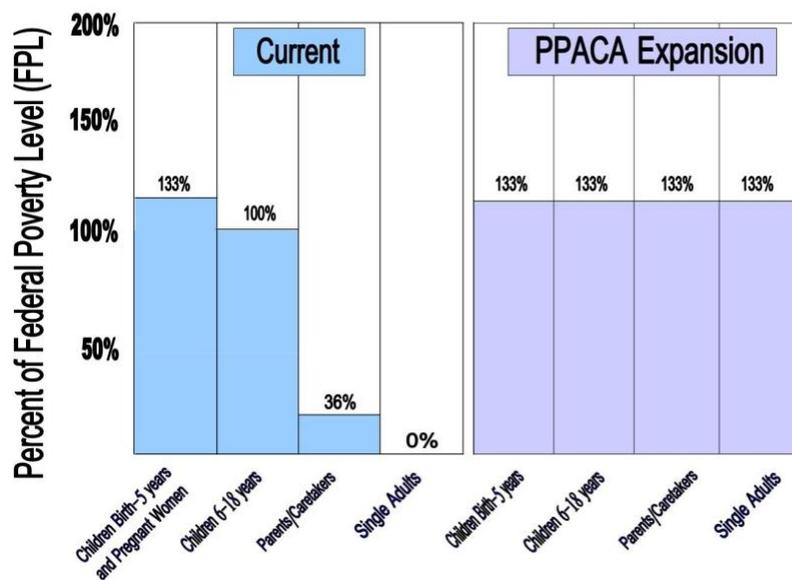
Administrative Costs

To put an administrative structure in place to operate a State program or to contract it out and administer will be with 100 percent State funds. For the 2009-2010 biennium, costs for administering the Wyoming Medicaid program are projected to be approximately \$93,685,742. Approximately two-thirds of the amount is reimbursed with Federal funds.

ADMINISTRATIVE COSTS		BFY 09-10 Projected	Projected General Fund
Unit	Program Description	Expenditures	Expenditures
0401	Office of Health care Financing (OHCF) Administration	57,719,395	20,078,433
0403	HCF Administration (DD)	7,988,294	3,690,687
0420	Children's Health Insurance Program (SCHIP)	2,067,903	723,766
	Total:	67,775,592	24,492,886

MEDICAID AND THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The Affordable Care Act will bring major changes to the Medicaid program. Beginning in 2014, Medicaid will be mandated to cover all non-elderly low income individuals with income at or below 133% of the federal poverty level (FPL) who are legally residing in the United States and who are not eligible for Medicare. Wyoming Medicaid currently covers children from birth through age five and pregnant women at this income level. The Medicaid expansion in 2014 will include two new groups of non-elderly adults who are not currently covered in most states: parents/caretakers, except those at very low income levels and childless adults. In Wyoming, parents/caretakers are currently covered at approximately 36% of the FPL and Wyoming does not cover childless adults regardless of their income. Wyoming will also be required to transition children ages six through eighteen who are currently covered by Kid Care CHIP since coverage of this group will also be mandated.



New standards and processes for determining eligibility for all current Medicaid groups for children and families and the newly mandated groups must also be implemented in 2014. The current complex categorical system of eligibility groups for children and families will be replaced by a single group for all individuals in households with income below 133% of the federal poverty level which is \$ 1,200.00 per month for an individual or \$ 2,400.00 per month for a family of four in 2010. Enrollment is estimated to increase by 25,000 to 30,000 individuals. Income for current eligibility groups and the new group will be based on modified adjusted gross income (MAGI) based on taxable income as defined by the Internal Revenue Service with a standard 5% deduction. This is a significant change from the way income is currently calculated.

Medicaid will need to coordinate efforts with the new insurance exchange(s) and with Kid Care CHIP to implement these new enrollment processes. Because Medicaid eligibility policy is administered through the Department of Health and most Medicaid eligibility determinations are made by the Department of Family Services, it will also be necessary to conduct a complete review to determine the most efficient way to deliver Medicaid eligibility services in the future based on new requirements and system models. The type of system changes required are extensive and the current shared eligibility system will most likely be unable to handle the changes. An assessment of the current system has been contracted by the Department of Family Services and results of that analysis will be available in September of 2010. Future enrollment systems must include streamlined enrollment in a modern interoperable system that promotes interagency coordination and is seamless to individuals and families. Generally, states can only claim 50% federal matching funds on Medicaid administrative expenditures; however, there may be some grant funding available to improve these processes in the states. Further, any technical system changes are matched at 90% federal funding.

The federal government will provide most of the spending for services for those newly eligible - 100% federal funding from 2014 through 2016 decreasing to 90% federal match in 2020. There could be a modest increase in those who would qualify under current law (woodwork effect) and increased federal funding will not be available for these expenditures.

The tables below indicate projected expansion expenditures and corresponding General Fund and Federal Match				
Parent or caretaker relative: Medicaid currently covers about 4,700 of these individuals on a monthly basis at approximately 36% FPL . At 133% FPL, approximately 7,200 additional individuals would be newly eligible for Wyoming Medicaid. Estimated cost to Wyoming is:				
FY 2014	100% FMAP	\$ 26,000,000	-0-	General Fund
FY 2015	100% FMAP	\$ 26,000,000	-0-	General Fund
FY 2016	100% FMAP	\$ 26,000,000	-0-	General Fund
FY 2017	95% FMAP	\$ 24,700,000	\$ 1,300,000	General Fund
FY 2018	94% FMAP	\$ 24,440,000	\$ 1,560,000	General Fund
FY 2019	93% FMAP	\$ 24,180,000	\$ 1,820,000	General Fund
FY2020 forward	90% FMAP	\$ 23,400,000	\$ 2,600,000	General Fund

Childless Adult: Wyoming Medicaid currently does not cover single childless adults who are not disabled. PPACA requires this coverage up to 133% FPL. It is projected that this would add 17,400 new recipients to the Wyoming Medicaid program.				
FY 2014	100% FMAP	\$ 63,000,000	-0-	General Fund
FY 2015	100% FMAP	\$ 63,000,000	-0-	General Fund
FY 2016	100% FMAP	\$ 63,000,000	-0-	General Fund
FY 2017	95% FMAP	\$ 59,850,000	\$ 3,150,000	General Fund
FY 2018	94% FMAP	\$ 59,220,000	\$ 3,780,000	General Fund
FY 2019	93% FMAP	\$ 58,590,000	\$ 4,410,000	General Fund
FY2020 forward	90% FMAP	\$ 56,700,000	\$ 6,300,000	General Fund

The cost of covering the newly eligible should be minimized, if not overcome by the savings that will result to the state from the elimination of certain programs that are currently 100% state funded that will no longer need to be funded once this coverage is available. One example would be the Community Mental Health Centers. Further a significant reduction or elimination in uncompensated care should be realized by hospitals and clinics.

While coverage of the newly eligible groups of individuals should have a significant impact on reducing the number of uninsured in Wyoming, it will also bring some significant challenges in assuring access to health care. The Department will need to work closely with stakeholder groups to assess the impact of this new mandate and to assist with planning and implementation efforts that will be necessary to deal with access issues.

Preliminary estimates by the Department indicated that an additional 25,000 individual would become eligible for Medicaid in Wyoming once the new expansion groups are fully implemented and a Kaiser Family Foundation study placed the estimate at 29,000. The Department has contracted for a study that will be used to further define more uniquely who the expanded group will be and the potential cost to Medicaid of providing services to these new individuals. The study will also analyze the offsets recognized to the State general fund and will be available in late August 2010.

Options exist in the PPACA that deserve full analysis, as they involve future demonstration projects and long-term care. Prior to opting-out of Medicaid, Wyoming should note and consider the following options that are available in the new legislation. These new programs are intended to reduce expenditures in Medicaid and are worthy of consideration should the State continue participating in Medicaid. Options under PPACA and the Health Care and Education Reconciliation Act include:

- Extend the Medicaid Money Follows the Person Rebalancing Demonstration Program through September 2016 (effective 30 days following enactment) and allocate \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives (funds appropriated for fiscal years 2010 through 2014).
- Provide states with new options for offering home- and community-based services through a Medicaid State Plan rather than through a waiver for individuals with incomes up to 300 percent of the maximum SSI payment and who have a higher level of need; and permit states to extend full Medicaid benefits to individual receiving home- and community-based services under a state plan (effective October 1, 2010).
- Medicaid Preventive Services provides FMAP incentive payment to states that eliminate cost-sharing requirements for Medicaid clinical preventive services that have been recommended by the U.S. Preventive Services Task Force (USPSTF) and for vaccines for adults. One percentage point increase in FMAP for states that eliminate cost sharing for preventive services and vaccines for adults.
- Medicaid Health Home for Enrollees with Chronic Conditions Planning Grant. Beginning January 1, 2011, there is a Medicaid state option to provide coordinated care to enrollees with chronic conditions. The U. S. Department of Health and Human Services will establish minimum standards for health homes and award planning grants to states to develop a State Plan Amendment. Twenty-five million dollar maximum planning grant award per state. States will receive a 90 percent FMAP for such health home services during the first eight fiscal year quarters that the State Plan Amendment is in effect.
- Establish the Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care. Provide states with an enhanced Federal matching rate of an additional six percentage points for reimbursable expenses in the program. Sunset the option after five years (effective October 1, 2011).
- Create the State Balancing Incentive Program to provide enhanced Federal matching payments to eligible states to increase the proportion of non-institutionally-based, long-term care services.

Selected states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally-based, long-term services and supports (effective October 1, 2011, through September 30, 2015).

- Enrollment health information technology (HIT) for health and human services programs. The U. S. Department of Health and Human Services grants to eligible entities, including states, to develop new and adapt existing technology systems to implement enrollment standards and protocols. These systems will be used to enroll individuals in Federal and state health and human services programs.
- Improve workforce training and development:
 - Increase the number of Graduate Medical Education (GME) training positions by redistributing currently unused slots, with priorities given to primary care and general surgery, and to states with the lowest resident physician-to-population ratios (effective July 1, 2011); increase flexibility in laws and regulations that govern GME funding to promote training in outpatient settings (effective July 1, 2010); and ensure the availability of residency programs in rural and underserved areas. Establish Teaching Health Centers, defined as community-based, ambulatory patient care centers, including Federally-qualified health centers and other Federally-funded health centers that are eligible for Medicare payments for the expenses associated with operating primary care residency programs (initial appropriation in FY2010).
 - Increase workforce supply and support training of health professionals through scholarships and loans; support primary care training and capacity building; provide state grants to providers in medically underserved areas; train and recruit providers to serve in rural areas; establish a public health workforce loan repayment program; provide medical residents with training in preventive medicine and public health; promote training of a diverse workforce; and promote cultural competence training of health care professionals (effective dates vary). Support the development of interdisciplinary mental and behavioral health training programs (effective FY2010) and establish a training program for oral health professionals (funds appropriated for six years beginning in FY2010).
 - Address the projected shortage of nurses and retention of nurses by increasing the capacity for education, supporting training programs, providing loan repayment and retention grants, and creating a career ladder to nursing (initial appropriation in FY2010). Provide grants for up to three years to employ and provide training to family nurse practitioners who provide primary care in federally qualified health centers and nurse-managed health clinics (funds appropriated for five years beginning in FY2011).
 - Support the development of training programs that focus on primary care models, such as medical homes, team management of chronic disease, and those that integrate physical and mental health services (funds appropriated for five years beginning in FY2010).
- Improve access to care by increasing funding by \$11 billion for community health centers and the National Health Service Corps over five years (effective FY2011); establishing new programs to support school-based health centers (effective FY2010) and nurse-managed health clinics (effective FY2010).
- Appendix H provides a PPACA implementation timeline relative to the Medicaid provisions.

OTHER CONSIDERATIONS

ARRA

The American Recovery and Reinvestment Act of 2009 (ARRA), health information technology provisions, afford states and their Medicaid providers with a unique opportunity to leverage efforts to achieve the vision of interoperable information technology for health care. The Wyoming Medicaid Program will play a critical role in fulfilling such a vision. Specifically, the Wyoming Medicaid Program is responsible for planning, and implementing the Medicaid provider incentive program, a program to provide incentive

payments for the “meaningful use” of certified electronic health records (EHR) technology. The planning process will address how the program will operate in concert with the larger health system and statewide efforts.

In partnership with the CMS, the Wyoming Medicaid Program is responsible for defining and verifying eligibility for incentive payments, processing payments, and preventing duplicative incentive payments for those providers eligible under both Medicare and Medicaid programs. In addition to the specifics of the provider incentive program, the Wyoming Medicaid Program will be working in conjunction with the Regional Extension Center for provider outreach and training in meeting and validating meaningful use. Should Wyoming opt-out of Medicaid, our providers would likely forgo the opportunity to receive up to \$63,000 each for incentive payments. It is estimated that in the first year a potential of over \$11,000,000 could be paid to Wyoming providers for program participation.

CONCLUSION AND RECOMMENDATION

Because Medicaid has been in place as a significant payer source within the health care industry for so long, much of the industry touches the program in one way or another. A complete analysis of the benefits and impacts of Wyoming Medicaid is essential to fully understanding how the program affects the state as a whole. The complexity, expense, and far-reaching impact of Medicaid means that, even without Federal health reform, attention to Medicaid remained essential. Regardless of any health care reform measures, Wyoming needs to be proactive in shaping our program to best fit the needs of the residents in our state with the resources available. It is a challenge to meet the health care needs in a state that is sparsely populated and geographically diverse. Human services are thinly spread and often not available in individual communities. The current challenge of maintaining ample providers to serve the residents of Wyoming will be significantly increased without the support that is inherent in the current safety-net programs.

The expansion of Medicaid eligibility with a time-limited increase in the FMAP may lead to an increased strain on the taxpayers and budgets of the state when the 100 percent FMAP begins to be reduced. However, the strain that will ensue should Wyoming determine to opt-out of participating in Medicaid without a solid plan to replace it is truly immeasurable. Further, Wyoming residents will be paying Federal taxes for services that residents of this state will never benefit from.

It is the recommendation of the writers of this report that Wyoming consider convening a committee or other task force to evaluate and analyze the current Medicaid program and any potential changes that could maintain cost effective, quality care for this otherwise uninsured population. This should include a comprehensive fiscal impact analysis accomplished by professionals experienced in this type of evaluation. It should further explore opportunities for options to continue participation in the Medicaid program in order to leverage Federal funding while minimizing the impact to Wyoming’s General Fund. At this time an evaluation is underway by The Lewin Group, specific to Wyoming Medicaid that can and should guide future decisions and planning.

Future planning could include the possibility of separate coverage programs for certain populations as provided for under the Deficit Reduction Act (DRA) and/or waivers that may allow for coverage of the entire Medicaid program. The DRA provides States with flexibility to make significant reforms to their Medicaid Programs. States may use these new opportunities in combination with other options under the Medicaid Program, State Children’s Health Insurance Program (SCHIP), and other programs as a strategy to align the Medicaid Program with today’s health care environment. States can expand access to affordable mainstream coverage, promote personal responsibility for health and accessing health care, and improve quality and coordination of care. The DRA provides flexibilities that states may use to pursue innovative ideas in health care, such as consumer-directed health care and rebalancing long-term care. There has been

some success in other states and Wyoming should evaluate these outcomes and the application they may have to our health care infrastructure and the population for which coverage needs to be provided.

This report has not been shared or distributed outside of the Department of Health other than a preliminary report to the Governor's Office. Therefore, we have not received any stakeholder questions, comments or concerns.

REFERENCES

The Henry J. Kaiser Family Foundation: <http://www.kff.org/>
Agency for Health care Research and Quality: <http://www.ahrq.gov/>
The Urban Institute: <http://www.urban.org/>
National Governor's Association: <http://www.nga.org/>
Chuck Milligan for the NGA
National Association of State Medicaid Directors: <http://www.nasmd.org/>
EqualityCare Annual Report: http://www.health.wyo.gov/health_carefin/equalitycare/index.html

APPENDIX A

MEDICAID ELIGIBILITY

EqualityCare eligibility is based on residency, citizenship and identity, social security eligibility as verified by social security number, family income, and, to a lesser extent, resources or health care needs. There are four major categories of Wyoming Medicaid eligibility in Wyoming:

- Children
- Pregnant Women
- Family Care Adults
- Aged, Blind or Disabled

The detailed descriptions of these eligibility categories are provided below, and a summary of this information is in Exhibit 3 of Appendix C of the EqualityCare Annual Report. Since 1996, Wyoming Medicaid eligibility has been separate from eligibility for welfare cash assistance. Twenty years ago, most persons receiving Wyoming Medicaid services received welfare. The reverse is true today. The vast majority of all persons enrolled in Wyoming Medicaid are not receiving any welfare cash assistance.

Federal statutes define more than 50 groups of individuals who may qualify for Medicaid coverage. Eligibility for some categories is determined using Federal Poverty Level (FPL) guidelines. Eligibility for other categories is determined by Supplemental Security Income (SSI) standards or the Family Care income standard. In many instances, differences like these are due to differences in the Federal law that created each eligibility category. Some of these standards are based on an index that changes every year (i.e., FPL or SSI standard), whereas others are not (i.e., Family Care income standard). Childless adults who do not fit into one of the eligibility categories described below are not covered regardless of income or resources.

Children

- A newborn is automatically eligible if their mother was eligible for Wyoming Medicaid at the time of the birth.
- Low-income children are eligible if family income is less than or equal to 100 percent of the FPL or 133 percent of the FPL, depending on age of the child.
- Family Care children are eligible when a caretaker is determined eligible (i.e., family income is less than or equal to the 1996 Family Care Standard).
- Foster care children in Department of Family Services (DFS) custody are eligible, including some children who enter subsidized adoption or who age out of foster care when they become 18 years old.

Pregnant Women

- Pregnant women are eligible if family income is less than or equal to 133 percent FPL. Women with income below the 1996 Family Care Standard must cooperate in establishing paternity for the baby, so Wyoming Medicaid can pursue medical support
- Presumptive eligibility allows for coverage of outpatient services for 60 days pending Wyoming Medicaid eligibility determination

Family Care Adults

- Family Care adults (caretaker relatives with a dependent child) are eligible if the family income is less than or equal to the 1996 Family Care Standard.

Aged, Blind or Disabled (ABD) - The following groups of ABD individuals are eligible for Wyoming Medicaid:

- SSI and SSI-related
 - SSI – A person receiving SSI automatically qualifies for Wyoming Medicaid
 - SSI-related – A person no longer receiving SSI payment may be eligible using SSI criteria
- Institution – Residents who are living in the following types of institutions are eligible if their personal income is less than or equal to 300 percent of the SSI standard. Resources are also taken into consideration. Individuals do not have to be eligible for SSI.
 - Nursing Home
 - Hospice
 - ICF-MR (State Training School/Wyoming Life Resource Center)
 - WY State Hospital – Age 65 and older
- Home and Community Based Waiver - Individuals with income less than or equal to 300 percent of the SSI standard who are in need of specific waiver services may be eligible to enroll in one of the State’s six waiver programs. Resources are also taken into consideration. Individuals do not have to be eligible for SSI.

Additionally, there are several other categories of eligibility as listed below.

Medicare Savings Programs - The following groups of individuals eligible for Medicare qualify to receive premium and cost sharing assistance from Wyoming Medicaid:

- Qualified Medicare Beneficiaries (QMB) are eligible when their income is less than or equal to 100 percent of the FPL. Resources are also taken into consideration. Wyoming Medicaid pays for Medicare premiums, deductibles and cost sharing.
- Specified Low Income Medicare Beneficiaries are eligible when their income is less than or equal to 135 percent of the FPL; Wyoming Medicaid pays for Medicare premiums only.

Special Groups - The following special groups are eligible for Wyoming Medicaid:

- Breast and Cervical Cancer Treatment Program – Uninsured women diagnosed with breast or cervical cancer are eligible for Wyoming Medicaid if their income is less than or equal to 250 percent of the FPL.
- Tuberculosis (TB) Program – Individuals diagnosed with tuberculosis are income eligible based on special income standards specific to the TB program.

Employed Individuals with Disabilities

- Employed individuals with disabilities are eligible for Wyoming Medicaid if their unearned income is less than or equal to 300 percent of the SSI standard. Employed individuals with disabilities must pay a premium.
- Individuals do not have to be eligible for SSI.

Non-Citizens with Medical Emergencies

- A non-citizen who meets all eligibility factors of a Wyoming Medicaid group except for citizenship and social security number is eligible for emergency services.

APPENDIX B
ELIGIBILITY TABLE

Eligibility Category	SFY 2008 Eligible Individuals	SFY 2009 Eligible Individuals	Percentage Change from SFY 2008
Children	49,964	52,365	5
ABD Total	13,718	13,606	-1
<i>ABD SSI</i>	<i>6,361</i>	<i>6,558</i>	3
<i>ABD HCBS</i>	<i>4,104</i>	<i>4,257</i>	4
<i>ABD Institution</i>	<i>3,253</i>	<i>2,791</i>	-14
Family Care	7,409	7,632	3
Pregnant Women	6,372	6,131	-4
Other Total	4,729	5,367	13
<i>Medicare Savings Program</i>	<i>3,312</i>	<i>3,560</i>	7
<i>Non-Citizens with Medical Emergencies</i>	<i>1,055</i>	<i>1,163</i>	10
<i>Special Groups</i>	<i>241</i>	<i>448</i>	86
<i>Employed Individuals with Disabilities</i>	<i>121</i>	<i>196</i>	62
Total Eligible Individuals⁴	78,757	81,984	4

⁴ The total number of eligible individuals is the unduplicated count of individuals in each eligibility category for the SFY. The sum by category listed in Table 1 will differ from the number of total unduplicated individuals in SFY 2009 because individuals may be counted in more than one eligibility category.

APPENDIX C
RURAL HEALTH CLINICS – SEPTEMBER 2009

Town	Clinic name	RHC Type
Baggs	Noyes Health Care Center	Independent
Basin	Big Horn Clinic	Provider Based (CAH) Hot Springs Memorial Hospital
	Midway Clinic	Provider Based (CAH) South Big Horn Hospital Dist.
Glenrock	Oregon Trails	Provider Based (CAH) Memorial Hospital of Converse County
Green River	Castle Rock Medical Center	Independent
Guernsey	Register Cliff Rural Health Clinic	Provider Based (CAH) Memorial Hospital of Converse County
Hulett	Hulett Clinic	Provider Based (CAH) Crook County Hospital District
Lovell	North Bighorn Hospital Clinic	Provider Based (CAH) North Big Horn Hospital
Lusk	Rawhide Rural Health Clinic	Provider Based (CAH) Niobrara Health and Life Center
Medicine Bow	Medicine Bow Health Clinic	Independent
Moorcroft	Moorcroft Clinic	Provider Based (CAH) Crook County Hospital District
Newcastle	Cedar Hills Family Clinic	Independent
Saratoga	Platte Valley Medical Clinic	Independent
Sundance	Sundance Clinic	Provider Based (CAH) Crook County Hospital District
Thermopolis	Red Rock Family Practice	Independent
Upton	Cedar Hills Family Clinic	Independent

 Indicates Provider Based

APPENDIX D
PHYSICIAN SERVICES BY TYPE

Pay to Provider Type	Number of Unique Providers Paid	Number of Unique Medicaid Recipients Receiving Services	Total Amount Paid
Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine	1	249	\$59,183.69
Allergy and Immunology, Allergy	1	593	\$338,096.07
Anesthesiology	38	5,591	\$2,477,888.61
Dermatology	7	1,621	\$231,358.52
Emergency Medicine	11	16,512	\$3,427,829.73
Family Practice	83	19,352	\$6,667,058.79
Internal Medicine	40	6,678	\$2,487,930.49
Internal Medicine, Cardiovascular Disease	4	794	\$304,825.01
Internal Medicine, Endocrinology Diabetes and Metabolic	1	85	\$13,314.88
Internal Medicine, Gastroenterology	1	475	\$151,544.04
Internal Medicine, Nephrology	1	41	\$15,202.44
Internal Medicine, Pulmonary Disease	1	181	\$124,875.24
Internal Medicine, Rheumatology	2	227	\$29,709.03
Internal Medicine, Medical Oncology	8	323	\$972,007.95
Neurological Surgery	4	823	\$763,338.02
Obstetrics And Gynecology	26	6,313	\$9,631,376.31
Obstetrics And Gynecology, Gynecology	2	130	\$102,837.49
Ophthalmology	14	2,392	\$436,191.37
Orthopedic Surgery	34	4,191	\$1,664,584.54
Otolaryngology	14	2,937	\$908,386.77
Pathology	7	2,620	\$185,493.73
Pediatrics	25	15,662	\$7,123,998.40
Pediatrics, Neonatal-Perinatal Medicine	3	2,142	\$779,063.17
Physical Medicine And Rehabilitation	2	109	\$86,440.22
Plastic Surgery	6	253	\$107,282.79
Psychiatry And Neurology: Neurology	9	1,263	\$667,957.13
Psychiatry And Neurology, Psychiatry	26	2,307	\$3,552,971.92
Diagnostic Radiology	19	17,147	\$1,935,721.73
Surgery: General Surgery	25	1,891	\$786,604.25
Surgery, Vascular	3	31	\$15,643.95
Urology	12	2,354	\$681,388.49
Physician, General Practice	58	21,640	\$6,432,735.12
Total	488	136,927	\$53,162,839.89

APPENDIX E
LONG-TERM CARE NURSING FACILITIES

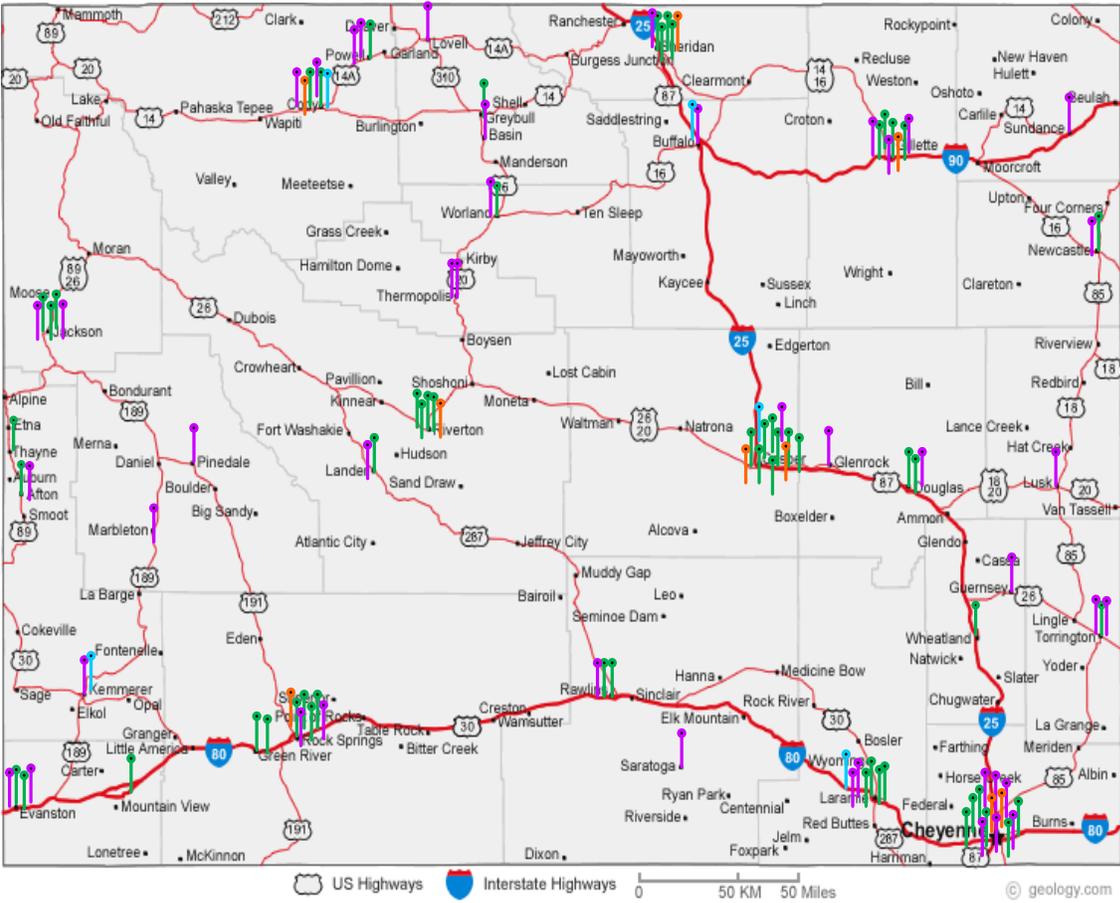
Provider Name	Location in Wyoming	Certified Beds	Medicaid %	Estimated Medicaid Beds	Medicaid Reimbursement in SFY 2009
Amie Holt Care Center	Buffalo	50	.5737	29	\$1,299,647.22
Bonnie Bluejacket N/H	Basin	37	.7321	27	\$965,362.50
Castle Rock Convalescent	Green River	59	.6417	38	\$1,922,335.51
Cheyenne Health care	Cheyenne	105	.5748	60	\$2,164,692.51
Crook County Nursing Home	Sundance	32	.6908	22	\$852,283.08
Douglas Care Center	Douglas	60	.6846	41	\$2,143,960.15
Goshen Care Center	Torrington	75	.6721	50	\$2,323,221.69
Iverson Memorial Hospital Long Term Care	Laramie	9	.0463	0	
Laramie Care Center	Laramie	105	.6764	71	\$1,879,370.90
Life Care Center of Casper	Casper	120	.5078	61	\$2,772,708.77
Life Care Center of Cheyenne	Cheyenne	160	.4081	65	\$2,847,569.04
MHCC Care Pavilion	Rawlins	10	.9372	9	\$305,525.83
Morning Star Care Center	Fort Washakie	45	.6468	29	\$1,168,332.22
Mountain Towers Health care	Cheyenne	170	.6943	118	\$2,583,127.05
New Horizons Care Center	Lovell	85	.7116	60	\$2,728,725.20
Pioneer Manor	Gillette	150	.6296	94	\$4,063,308.56
Platte County Memorial N/H	Wheatland	43	.7212	31	\$998,304.36
Poplar Living Center	Casper	120	.5965	72	\$3,211,898.20
Powell Nursing Home	Powell	100	.6076	61	\$1,689,815.61
Rocky Mountain Care	Evanston	60	.6871	41	\$1,648,557.29
Sage View Care Center	Rock Springs	101	.6086	61	\$1,659,996.44
Shepherd of the Valley	Casper	180	.6512	117	\$3,796,500.86
Sheridan Manor	Sheridan	128	.5861	75	\$2,204,263.52
South Central Wyoming Health care	Rawlins	90	.6847	62	\$1,337,177.77
South Lincoln Nursing Center	Kemmerer	24	.5362	13	\$763,307.51
St. John's Hospital	Jackson	60	.5854	35	\$1,414,189.08
Star Valley Hospital and N/H	Afton	24	.7670	18	\$1,019,262.90
Sublette Center	Pinedale	50	.5189	26	\$622,264.97
Thermopolis Rehab & CC	Thermopolis	60	.6177	37	\$1,219,035.49
Valley View Rehab & CC	Saratoga	46	.7277	33	\$1,199,980.80
West Park Hospital Care Center	Cody	128	.5812	74	\$2,001,630.73
Weston County Manor	Newcastle	54	.6951	38	\$1,851,808.38
Westview Health Care Center	Sheridan	102	.4892	50	\$1,930,926.53
Westward Heights N/H	Lander	60	.5384	32	\$1,166,389.56
Wind River Health care	Riverton	90	.6592	59	\$2,093,194.03
Worland Health Care/Rehab	Worland	87	.6090	53	\$1,367,001.13
Wyoming Retirement Center	Basin	90	.8597	77	\$1,538,646.77
Totals		<u>2,969</u>	<u>.6258</u>	<u>1,843</u>	<u>\$64,754,322.16</u>

APPENDIX F
HOSPITALS

Non-State Operated Hospital	Location in Wyoming	Total Paid in SFY 2009 (IP and OP)	Total SFY 2008 QRA Payments (IP and OP)	FFY 2006 DSH Payments	Total SFY 2009 Payments Including QRA & DSH Payments (IP and OP)
Converse County Memorial Hospital	Douglas	\$1,655,551	\$445,993		\$2,101,544
Crook County Medical Services District	Sundance	\$53,626	\$0		\$53,626
Hot Springs County Memorial Hospital	Thermopolis	\$773,086	\$361,264		\$1,134,350
Johnson County Memorial Hospital	Buffalo	\$316,272	\$174,435		\$490,707
Niobrara Health and Life Center	Lusk	\$167,769	\$122,967		\$290,736
North Big Horn Hospital	Lovell	\$340,826	\$8,230		\$349,056
Platte County Memorial Hospital	Wheatland	\$646,847	\$409,606		\$1,056,453
Powell Hospital	Powell	\$1,800,497	\$944,978	\$11,934	\$2,757,409
South Big Horn Critical Access Hospital	Basin	\$66,274	\$31,894		\$98,168
Star Valley Hospital	Afton	\$1,166,351	\$345,306		\$1,511,657
Washakie Memorial Hospital	Worland	\$1,210,901	\$380,959		\$1,591,860
West Park Hospital	Cody	\$2,172,326	\$226,110		\$2,398,436
Weston County Health Services	Newcastle	\$211,425	\$50,725		\$262,150
Campbell County Memorial Hospital	Gillette	\$3,936,488	\$1,498,226		\$5,434,714
Cheyenne Regional Medical Center	Cheyenne	\$11,660,843	\$3,891,346		\$15,552,189
Iverson Memorial Hospital	Laramie	\$2,659,538	\$1,251,797		\$3,911,335
Memorial Hospital of Carbon County	Rawlins	\$1,128,958	\$341,402		\$1,470,360
Memorial Hospital of Sheridan	Sheridan	\$2,175,601	\$1,052,533		\$3,228,134
Memorial Hospital of Sweetwater County	Rock Springs	\$2,444,087	\$875,948		\$3,320,035
South Lincoln Hospital District	Kemmerer	\$231,841	\$124,963		\$356,804
St. John's Hospital	Jackson	\$1,634,018	\$731,118		\$2,365,136
Totals For Non-State Operated Hospitals		\$36,453,125	\$13,269,800	\$11,934	\$49,734,859

Private Hospitals	Location in Wyoming	Total Paid in SFY 2009 (IP and OP)	Total SFY 2008 QRA Payments (IP and OP)	FFY 2006 DSH Payments	Total SFY 2009 Payments Including QRA & DSH Payments (IP and OP)
Community Hospital	Torrington	\$1,399,976	\$0		\$1,399,976
Evanston Regional Hospital	Evanston	\$2,163,817	\$0	\$25,447	\$2,189,264
Lander Valley Medical Center	Lander	\$3,747,765	\$0	\$114,142	\$3,861,907
Riverton Memorial Hospital	Riverton	\$3,795,072	\$0	\$140,623	\$3,935,695
Wyoming Behavioral Institute	Casper	\$3,907,056	\$0		\$3,907,056
Wyoming Medical Center	Casper	\$10,906,619	\$0		\$10,906,619
Elkhorn Valley Rehabilitation Hospital	Casper	\$1,081,189	\$0		\$1,081,189
Mountain View Regional Hospital	Casper	\$493,144	\$0		\$493,144
Totals For Private Hospitals		\$27,494,638	\$0	\$280,212	\$27,774,850
Totals for All Hospitals		\$63,947,763	\$13,269,800	\$292,146	\$77,509,709

APPENDIX G LOCATION OF PHARMACIES IN WYOMING



-  Walgreen's
-  Corporations
-  Independents
-  Hospitals & Clinics

APPENDIX H

IMPLEMENTATION TIMELINE FOR MEDICAID RELATIVE TO THE NEWLY ENACTED PPACA

In understanding the impact of opting out of Medicaid, it is also important to recognize and consider the implications the newly enacted PPACA will have on state Medicaid programs. The provisions of PPACA and timeline as it impacts Medicaid are as follows:

2010

- Effective March 23, 2010, requires states to maintain eligibility standards for adults in Medicaid until January 1, 2014, when the new health exchanges are operational, and for children in Medicaid and Children's Health Insurance Program (CHIP) until October 1, 2019. If a state violates the Medicaid or CHIP Program maintenance of effort (MOE), it would forgo all of its Federal Medicaid funding, including funding for children, pregnant women, parents, seniors, people with disabilities, and administrative costs. This requirement differs from the ARRA requirement because it also applies to CHIP; it is a significantly longer period of time; and eliminates all Federal Medicaid funding for violations, not just the extra Medicaid fiscal relief included in ARRA.
- Creates a state option to cover low-income adults without regard to disability, parental status, or most other categorical limitations through a Medicaid State Plan Amendment.
- Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals through a Medicaid State Plan Amendment up to the highest level of eligibility for pregnant women.
- Creates a new option for states to provide CHIP coverage to children of state employees who are eligible for health benefits if certain conditions are met.
- Increases the Medicaid drug rebate percentage for brand name drugs to 23.1 percent, except for the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1 percent; increases the Medicaid rebate for non-innovator, multiple source drugs to 13 percent of average manufacturer price; and extends the drug rebate to Medicaid managed care plans.
- Provides funding for and expands the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services, including those dually eligible for Medicare and Medicaid.
- Requires the Secretary of U.S. Department of Health & Human Services to issue regulations to establish a process for public notice and comment for section 1115 waivers in Medicaid and CHIP.

2011

- Prohibits Federal payments to states for Medicaid services related to health care acquired conditions (HAC).
- Creates a new Medicaid State Plan option to permit Medicaid enrollees with at least two chronic conditions, one condition and risk of developing another, or at least one serious and persistent mental health condition to designate a provider as a health home.
- Provides states taking up the option with 90 percent Federal match.
- FMAP for two years for home health related services, including care management, care coordination and health promotion.
- Creates the State Balancing Incentive Program in Medicaid to provide enhanced Federal matching payments to increase non-institutionally-based long-term care services.
- Establishes the Community First Choice Option in Medicaid to provide community-based attendant support services to certain people with disabilities.

2012

- Creates new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations effective January 1, 2012, through December 31, 2016; to make global capitated payments to safety net hospital systems effective fiscal years 2010 through 2012; to allow pediatric medical providers organized as accountable care organizations to share in cost-savings effective January 1, 2012, through December 31, 2016; and to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition effective October 1, 2011, through December 31, 2015.

2013

- Increase Medicaid payments for primary care services provided by primary care doctors for 2013 and 2014 with 100 percent Federal funding.

2014

- Expand Medicaid to all non-Medicare eligible individuals under age 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133 percent FPL based on modified adjusted gross income (MAGI) and provides enhanced Federal matching for the newly eligible.
- Expands the mandatory Medicaid income eligibility level for children age 6 through 18 from 100 percent FPL to 133 percent FPL.
- Makes the state option to cover former foster children mandatory and limits coverage to children who have aged out as of the date of enactment. Reduce states' Medicaid Disproportionate Share Hospital (DSH) allotments.
- Increase spending caps for the territories.