HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN THIS ISSUE:

IN FOCUS: THE IMPACT OF DRUG REBATE EQUALIZATION ON STATE PHARMACY EXPENDITURES AND AN UPDATE ON STATE PLANS TO "CARVE-IN" PHARMACY BENEFITS.

HMA ROUNDUP: UPDATES FROM CALIFORNIA, FLORIDA, GEORGIA, INDIANA, OHIO, TEXAS, AND WASHINGTON DC

ALSO MAKING HEADLINES: CALIFORNIA REPUBLICANS SAY BUDGET TALKS HAVE BROKEN DOWN; KANSAS GOVERNOR BROWNBACK JOINS OTHER GOP GOVERNORS IN CALL FOR MEDICAID BLOCK GRANTS; OHIO GOVERNOR RELEASES MEDICAID REDESIGN PLANS

MARCH 16, 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

AUSTIN, TEXAS • CHICAGO, ILLINOIS • COLUMBUS, OHIO • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN
SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, D.C.

Contents

Health Management Associates (HMA) is an independent health care research and consulting firm. HMA operates a client service team, HMA Investment Services, that is principally focused on providing generalized information, analysis, and business consultation services to investment professionals. Neither HMA nor HMA Investment Services is a registered broker-dealer or investment adviser firm. HMA and HMA Investment Services do not provide advice as to the value of securities or the advisability of investing in, purchasing or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of, and not influenced by, the interests of other clients, including clients of HMA Investment Services.

IN FOCUS: DRUG REBATE EQUALIZATION

This week, our *In Focus* section looks at the Medicaid prescription drug rebate provisions of the Affordable Care Act (ACA), with a focus on the impacts of and opportunities presented by expanding Federal Medicaid drug rebates to capitated Medicaid managed care programs. Created by the Omnibus Budget Reconciliation Act of 1990, the Medicaid Drug Rebate Program requires a pharmaceutical manufacturer to enter into a national rebate agreement with the Department of Health and Human Services (HHS) in order to have its drugs covered under Medicaid. These rebates are shared between the federal government and states. According to the Centers for Medicare and Medicaid Services (CMS), approximately 550 pharmaceutical companies currently participate in the Drug Rebate Program.[1]

Background

Prior to the passage of the ACA, Medicaid drug rebates only applied to outpatient drugs reimbursed through traditional fee-for-service (FFS) payment structures. As capitated Medicaid managed care enrollment grew, many states had an economic incentive to "carve-out" prescription drugs from capitated managed care arrangements and reimburse them instead through FFS payment systems. Drug rebates for 2010 totaled $10.4 billion, with a state share of $4.4 billion (ARRA adjusted). Total state prescription drug spending for 2010 was $11.4 billion.[2]

TABLE 1: 2010 MEDICAID PRESCRIPTION DRUG EXPENDITURES AND REBATES

$ (Billions)	Federal Share	State Share	Total
Rx Expenditures	$15.79	$11.35	$27.14
Rx Rebates	$5.99	$4.36	$10.35
Rx Rebates as % of Expenditures	37.9%	38.4%	38.1%

ACA Section 2501(c) enacted the Drug Rebate Equalization Act (DRE) which changes Medicaid drug rebate policy to extend rebates to Medicaid managed care organizations. This change will impact states differently depending on their current carve-out status:

- For states with **no carve-out** ("carve-in" states), drug rebate equalization provides a new revenue source as drugs covered under Medicaid managed care will now be included in the drug rebate program. ACA rules require states to maintain responsibility for billing pharmaceutical manufacturers for rebates on managed care pharmacy claims.

---

[1] "Medicaid Drug Rebate Program – Overview." Centers for Medicare and Medicaid Services. Accessed 3/11/2011 at https://www.cms.gov/MedicaidDrugRebateProgram/

[2] FY 2010 CMS-64 Quarterly Expense Report, Centers for Medicare and Medicaid Services. Not currently available online. ***Note: The American Recovery and Reinvestment Act (ARRA) provided additional Federal aid to state Medicaid programs in the form of an enhanced federal Medicaid matching rate . In this analysis,we have backed out the impacts of the enhanced rate, as it expires in the near term. These adjustments are noted by the term, "ARRA adjusted."***

- For states with a **partial carve-out** (many states have only carved-out certain drug classes or drugs for certain populations), drug rebate equalization still provides a significant new revenue source, but not at the level of full carve-in states.
- States with a **full carve-out** will gain no new revenue from drug rebate equalization. However, carve-out states may now consider transitioning to a carve-in approach without concern over sacrificing rebates.

Financial Impact on States with No Carve-Out

States who have not elected to carve-out drugs will see immediate additional revenue as a result of drug rebate equalization. In the Tables 2 and 3 below, we have estimated the financial impact to states of extending drug rebates to prescriptions filled by Medicaid managed care enrollees. First, we estimate the percentage of drug spending that is returned to states in the form of rebates on their FFS expenditures. As Table 2 indicates, many states that have fairly broad managed care programs continue to book significant prescription drug expenditures paid on a FFS basis. For example, using a normalized federal matching rate, Florida would have spent over $500 million in 2010 on prescription drugs outside of its managed care program.[3]

TABLE 2: 2010 DRUG EXPENDITURES AND REBATES FOR CARVE-IN STATES

No Carve-out ($000)	2010 FFS State Rx Expenditures (ARRA Adj.)	2010 State Rx rebates (ARRA Adj.)	Rebates % of Expenditures
Arizona	$2,659	$0	0.0%
Colorado	$119,613	$51,046	42.7%
Florida	$516,833	$224,803	43.5%
Georgia	$166,344	$88,642	53.3%
Hawaii	$1,904	$261	13.7%
Kentucky	$163,066	$67,787	41.6%
Massachusetts	$252,758	$82,538	32.7%
Minnesota	$119,047	$52,508	44.1%
Nevada	$50,654	$19,206	37.9%
New Mexico	$1,920	$606	31.6%
Pennsylvania	$196,689	$91,747	46.6%
Rhode Island	$12,099	$6,715	55.5%
South Carolina	$76,774	$37,568	48.9%
Virginia	$113,775	$44,692	39.3%
Total	**$1,791,473**	**$768,118**	**38.0%**

[3] FY2010 CMS-64 Quarterly Expense Report (ARRA Adjusted). Centers for Medicare and Medicaid Services. Not currently available online.

Across all of the "no carve-out" states, FFS prescription drug rebates averaged 38 percent of prescription drug spending in 2010 and netted non-carve-out states roughly $768 million in revenue (similarly adjusted for a normalized federal matching rate).

Next, we estimate the amount of new rebate revenue that will be available to states from the DRE. In Table 3, we estimate prescription drug spending to be 15 percent of total Medicaid managed care expenditures, and then apply the rebate percentage of expenditures calculated in Table 2 for FFS rebates. For states with very small FFS prescription drug expenditures (such as Arizona and Hawaii) we use the average rebate level.

TABLE 3: ESTIMATED DRE REBATE REVENUES FOR CARVE-IN STATES

No Carve-out ($000)	State MCO expenditures (ARRA Adj.)	% of MCO expenditures on Rx	Est. Rx expenditures through MCOs	DRE Rebates
Arizona	$2,319,598	15.0%	$347,940	$142,215
Colorado	$55,235	15.0%	$8,285	$3,536
Florida	$1,318,840	15.0%	$197,826	$86,047
Georgia	$759,788	15.0%	$113,968	$60,732
Hawaii	$500,289	15.0%	$75,043	$10,297
Kentucky	$217,182	15.0%	$32,577	$13,542
Massachusetts	$1,273,532	15.0%	$191,030	$62,381
Minnesota	$1,222,484	15.0%	$183,373	$80,880
Nevada	$142,814	15.0%	$21,422	$8,123
New Mexico	$556,482	15.0%	$83,472	$26,348
Pennsylvania	$2,543,236	15.0%	$381,485	$177,947
Rhode Island	$261,653	15.0%	$39,248	$21,782
South Carolina	$378,489	15.0%	$56,773	$27,781
Virginia	$814,667	15.0%	$122,200	$48,002
Total	**$12,364,290**	**15.0%**	**$1,854,644**	**$769,611**

Under these assumptions, we estimate non-carve-out states will net more than $769 million in new rebate dollars, or approximately 6 percent of their total managed care spending for the year. States with large Medicaid managed care programs will see their rebate amounts more than double.

Financial Impact on States with a Partial Carve-Out

Eight states elect to carve-out only a segment of prescription drug spending, typically for one or more select classes of drugs - HIV/AIDS drugs, mental health and antipsychotics, antihemophilic factors - or for a selected segment of the Medicaid population such as the aged, blind and disabled (ABD). Total FFS pharmacy expenditures for these states (state only and ARRA adjusted) were $2.4 billion in 2010.(Table 4)

TABLE 4: 2010 DRUG EXPENDITURES AND REBATES FOR PARTIAL CARVE-OUT STATES

Partial Carve-out ($000)	2010 FFS State Rx Expenditures (ARRA Adj.)	2010 State Rx rebates (ARRA Adj.)	Rebates % of Expenditures	Partial Carve-Out Drugs/Classes
California	$1,484,897	$612,045	41.2%	AIDS Drugs, Dependency Treatment, Psychiatric Drugs
Kansas	$59,297	$28,082	47.4%	Antihemophilic Factors
Maryland	$147,070	$61,064	41.5%	Mental Health Drugs, HIV/AIDS Drugs
Michigan	$173,048	$78,220	45.2%	Psychotropics, HIV/AIDS Drugs, Selected Others
New Jersey	$284,622	$99,333	34.9%	HIV/AIDS Drugs, Antipsychotics, Antihemophilic Factors, ABD Population
Oregon	$50,703	$19,448	38.4%	Mental Health Drugs
Vermont	$1,269	$501	39.5%	* VT under waiver allowing state to be treated as MCO
Washington	$159,473	$78,876	49.5%	Protease Inhibitors, OTC Contraceptives, Rxs written by a DDS
Total	**$2,360,379**	**$977,570**	**42.2%**	

Using a normalized federal matching rate, partial carve-out state FFS prescription drug rebates averaged 42 percent of prescription drug spending in 2010, or $978 million. In Table 5 below, we make the simplifying assumption that prescription drug spending represents 12.5 percent of total Medicaid managed care expenditures, accounting for the subset of carve-out drugs paid FFS. Again, we are applying the FFS rebate percentage of expenditures calculated in Table 4.

TABLE 5: ESTIMATED DRE REBATE REVENUES FOR PARTIAL CARVE-OUT STATES

Partial Carve-out ($000)	State MCO expenditures (ARRA Adj.)	% of MCO expenditures on Rx	Est. Rx expenditures through MCOs	DRE Rebates
California	$3,140,119	12.5%	$392,515	$164,220
Kansas	$145,088	12.5%	$18,136	$8,589
Maryland	$1,209,234	12.5%	$151,154	$62,760
Michigan	$1,454,054	12.5%	$181,757	$82,156
New Jersey	$944,055	12.5%	$118,007	$41,184
Oregon	$483,801	12.5%	$60,475	$23,197
Vermont	$424,196	12.5%	$53,025	$20,958
Washington	$716,918	12.5%	$89,615	$44,324
Total	**$8,517,466**	**12.5%**	**$1,064,683**	**$447,388**

Under these assumptions, partial carve-out states will net more than $477 million, a nearly 50 percent increase in prescription drug rebate revenue. Summing the impact on both carve-in and partial carve-out states, we estimate that over $1.2 billion of new rebate dollars will be available to these states. With all of these states grappling with difficult budget conditions, this influx of new revenue will serve as a welcome source of relief going forward.

Full Carve-Out States

States that have previously fully carved-out prescription drugs will not benefit from the change in rebate treatment since they are already accessing these rebate dollars. Nevertheless, going forward these states may reconsider whether or not to continue carving out this benefit. Choosing to carve the pharmacy benefit back into the managed care rate will not increase their rebate revenue but could reduce overall expenditures if the managed care plans can 1) achieve a higher generic penetration rate or 2) reduce overall medical costs by better integrating the pharmacy benefit into medical management programs.

In the 14 states that have carved pharmacy benefits out of their managed care programs, total rebate dollars in 2010 would have been approximately $2.1 billion using a normalized federal matching rate (Table 6). Of this total, New York represents $845 million or 40 percent.

TABLE 6: 2010 DRUG EXPENDITURES AND REBATES FOR FULL CARVE-OUT STATES

Full Carve-out	2010 FFS State Rx Expenditures (ARRA Adj.)	2010 State Rx rebates (ARRA Adj.)	Rebates % of Expenditures
Connecticut	$249,642	$84,265	33.8%
Delaware	$65,320	$30,118	46.1%
District of Columbia	$25,848	$7,155	27.7%
Illinois	$716,029	$199,447	27.9%
Indiana	$180,141	$60,079	33.4%
Missouri	$310,118	$95,206	30.7%
Nebraska	$58,539	$22,505	38.4%
New York	$2,179,567	$844,644	38.8%
Ohio	$392,133	$86,637	22.1%
Tennessee	$246,740	$99,748	40.4%
Texas	$931,997	$406,187	43.6%
Utah	$43,718	$16,155	37.0%
West Virginia	$84,543	$38,506	45.5%
Wisconsin	$256,925	$124,045	48.3%
Total	**$5,741,261**	**$2,114,697**	**36.7%**

Traditionally, states have weighed a number of factors to make carve-out decisions and recent studies have stressed the importance of considering individual state circumstances in policymaking. While the appeal of drug rebate revenue is clear, there is also demonstrated evidence that Medicaid managed care organizations are typically more efficient in managing prescription drug benefits (CHCS 2003),[4] and that rebate revenue should be considered against both utilization and quality factors. (PMPC)[5]

A January 2011 study published by The Lewin Group projected that 13 carve-out states would average savings of 16.7 percent in 2012 and 20.6 percent across a ten-year period (2012-2021) by transitioning to a full carve-in. The lowest projected savings of any of the 13 states analyzed was 9 percent. The study cites the advantages of MCOs in delivering lower-cost care through lower dispensing fees on drugs, steering enrollees toward medically-equivalent generics, lower usage rates and long term reductions in cost escalation trends. The study does, however, caution that individual state dynamics and operational challenges may lessen the impact on state spending.[6]

[4] "Comparison of Medicaid Pharmacy Costs and Usage between the Fee-for-Service and Capitated Setting." Center for Health Care Strategies, Inc. November 2003.

[5] "Carving Out Prescription Drugs from Medicaid Managed Care: A Review of the Evidence." Pennsylvania Medicaid Policy Center. 2009. Accessed on 03/14/2011 at http://www.pamedicaid.pitt.edu/documents/Carve%20Out_rp_09.pdf

[6] "Projected Impacts of Adopting a Pharmacy Carve-In Approach Within Medicaid Capitation Programs." The Lewin Group. January 2011.

With that, we note that a number of states are considering changes to their carve-out policies in light of the DRE.

- Ohio Governor John Kasich has proposed reverting back to a carve-in effective October 1, 2011.

  http://healthtransformation.ohio.gov/LinkClick.aspx?fileticket=xbVypJaBZrg%3d&tabid=86

- In Michigan, the Michigan Association of Health Plans and the Michigan Association of Community Mental Health Boards (MACMHB) are jointly reviewing how the state handles the pharmacy benefit. Presumably of interest is the "partial" carve-out for psychotropics.

  http://www.hcwreview.com/michigan%e2%80%99s-health-plans-and-mental-health-agencies-reach-agreement-on-advocacy

- New Jersey is considering changing its partial carve-out; however, no details are available. This carve-out pays plans directly above the capitation rate for HIV/AIDS drugs, antipsychotics, antihemophilic factors, and other high cost drugs and for prescriptions for the ABD population.

- New York is considering reverting back to a carve-in from its full carve-out.

  http://www.health.ny.gov/health_care/medicaid/redesign/docs/2011-02-24_presentation.pdf

- Texas is proposing to eliminate its full carve-out in May 2012.

Impact of Drug Rebate Equalization

Looking forward, drug rebate equalization is likely to have several effects:

- As discussed above, states who have previously carved-out drug spending may consider a carve-in model, enticed by savings associated with the potentially more efficient pharmacy benefit management offered by Medicaid MCOs. To the extent this scenario unfolds, Medicaid managed care organizations will experience an increase in per member per month (PMPM) revenue in full carve-out states. The plans would not keep any of the rebate amounts due to the state, but could negotiate their own rebates with manufacturers or through their pharmacy benefit management (PBM) companies. Moreover, the integration of pharmacy spending could enable more effective medical management resulting in greater savings. In this regard, state decisions to carve-in the pharmacy benefit should be viewed as a benefit to the Medicaid managed care organizations and their PBMs, but a negative for the companies that contract with states directly to coordinate these services under a FFS structure (pharmacy benefit administrators or PBAs).

- States may consider transitioning additional populations to a capitated Medicaid managed care setting. Medicaid MCOs may offer relief from budgetary pressures while still providing revenue under an extended drug rebate program.

- In carve-in states, Medicaid managed care organizations and their PBMs may experience a reduction in the commercial rebates they previously obtained on Medicaid MCO utilization as manufacturers seek to offset the cost of higher government rebates. The extent to which these rebate amounts decline will depend on the negotiating leverage of the managed care organization and the PBM. Some manufacturers may decline to negotiate additional rebates with MCOs. We estimate that prescription drug rebates negotiated by Medicaid MCOs and their PBMs are typically in the mid-single digit range, suggesting that a complete loss of these manufacturer rebates would have to be offset by an approximate 1 percent reduction in total medical expenses through better medical management.
- Pharmaceutical manufacturers will be negatively impacted by the state and federal government's ability to access Medicaid rebates through health plans. As discussed above, we estimate that the DRE will result in approximately $1.2 billion in additional rebate dollars paid to states. Incorporating the federal portion of the rebate, we estimate the total to be approximately $2.8 billion per year. As mentioned above, manufacturers will likely attempt to offset higher government rebates by negotiating lower commercial rebates with PBMs and MCOs. Below we list the categories of drugs that are most heavily prescribed within the Medicaid programs.

TABLE 7: 2007 MEDICAID DRUG CLAIMS BY CLASS[7]

Drug Groupings	% of Medicaid Claims
Central Nervous System Drugs	16.2%
Respiratory Agents	12.8%
Analgesics and Anesthetics	11.1%
Cardiovascular Agents	10.0%
Anti-Infective Agents	9.3%
Endocrine and Metobolic Drugs	7.5%
Unknown	6.9%
Topical Prodcuts	5.8%
Neuromuscular Drugs	5.8%
Gastrointestinal Agents	5.8%
Nutritional Products	3.7%
Hematological Agents	2.3%
Misc. Products	1.5%
Genitourinary Products	1.1%
Antineoplastic Agents	0.2%
Biologicals	0.1%

[7] FY 2007 Quarterly Drug Utilization Cube. "Medicaid Statistical Information System (MSIS) Drug Utilization Datamart." Accessed on March 16, 2011 at http://msis.cms.hhs.gov/drugmart.htm. Note: This chart does not present data for each National Drug Code (NDC) but summarizes drug payments and claim counts using the MEDISPAN drug groupings developed by Wolters Kluwer Health, Inc.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

We expect ABD beneficiaries in the two-plan and geographic managed care (GMC) model counties to receive notification of their health plan options in the next week. As a reminder, the state is transitioning 380,000 ABD beneficiaries to managed care plans on a mandatory basis starting July 1, 2011.

In the news

- Republicans say budget talks have broken down (Sacramento Bee)
- Officials say proposed cuts to Medi-Cal have ripple effects (California Healthcare)

Florida

HMA Roundup – Gary Crayton

Preliminary discussions of the House and Senate Medicaid reform bills began this week though no amendements have been filed yet. Also, the Chairman of the Senate Appropriations Committee is expected to release his proposed state budget On March 21st. This document will provide insight into the direction the state Senate will take with respect to Medicaid payment rates, benefits and other budgetary issues.

In the news

- Florida may take ax to many mental health programs (The Ledger)
- Medicaid bill eyes HMO profits (Health News Florida)
- How buyout firm eyeing Jacksonville operates (Miami Herald)

Georgia

HMA Roundup – Mark Trail

The 2012 budget has now passed the House of Representatives and is headed to the Senate. The 1 percent across the board provider rate cuts (except hospitals) has been reduced by the House to -0.5 percent. While the Governor had also proposed to eliminate adult emergency dental, vision, and podiatry coverage, the House has reintroduced coverage for these services. The House also added 33 slots for an independent care waiver for the severely physically disabled, increased the expectation for managed care rebate collections to $14.5 million from $11 million, and moved to 12 month eligibility reviews for CHIP instead of 6 month recertification to be eligible for CHIPRA-related bonus funds.

The state also has issued an RFI for a new eligibility system with the expectation of an RFP by late summer. The eligibility system is funded by a $10 million bond package which will give the state $100 million in total to build a new eligibility system (due to a

90 percent federal matching rate). The state intends to rebuild the TANF, SNAP, and other program eligibility systems, as well as helping to build the backbone for the exchange.

Lastly, we note that the governor pulled the bill he had previously submitted that would have created a health insurance exchange after receiving pressure from the Tea Party.

In the news

- Smart cards pushed to reduce Medicaid fraud (Georgia Health News)
- Senate passes Medicaid fraud bill (Atlanta Journal-Constitution)

Indiana

HMA Roundup – Cathy Rudd

The Indiana Family and Social Services Administration announced that it is seeking stakeholder input through an online questionnaire for design of its Exchange (the Indiana Insurance Market, Inc.). The questionnaire is divided into different sections for response by insurers and brokers, businesses, consumers and healthcare providers. The agency indicates that responses are confidential and will be used to develop design options for the Exchange. The agency will accept input from March 9 through March 30, 2011. (Full Press Release)

In the news

- Ind. Medicaid mental health list worries advocates (Bloomberg Businessweek)

Ohio

HMA Roundup – Alicia Smith

Tuesday, Governor John Kasich released his budget proposal for the FY 12/13 biennium. Below we summarize some of the key elements of the proposal.

- **Integrated Care:** The Executive Budget develops an individual-centered Integrated Care Delivery System (ICDS) for 113,000 dual eligible beneficiaries residing in nursing homes. The ICDS will evaluate alternative models for care coordination including managed care and ACOs. The proposal recommends that the ICDS be implemented by September 2012. The Executive Budget will allow Medicaid to enroll dual eligibles in managed care.
- **Health Homes:** The Executive Budget includes a Health Home initiative to expand on the traditional medical home model by enhancing coordination of medical and behavioral health care consistent with the needs of individuals with severe and/or multiple chronic illnesses.
- **Pediatric ACOs:** The Executive Budget encourages the development of pediatric ACOs by enrolling disabled children (38,000) who do not reside in an institution or receive home and community based waiver services in Medicaid managed care beginning July 1, 2012. Managed care plans will be encouraged to form new contract relationships with developing ACOs where the ACO assumes responsibility for care coordination and a portion of the risk for children enrolled in the

ACO. ACO sites may eventually decide whether or not to take on the full risk and responsibilities of a free-standing ACO.

- **Behavioral Health:** The Executive Budget will integrate Medicaid behavioral health care and physical health care benefits. This will be done in a phased-in approach beginning in SFY 2012.
- **Hospital payments:** The Executive Budget proposes a number of changes to modernize Medicaid hospital reimbursement. In aggregate, these changes reduce total hospital spending by $477 million over the biennium.
- **Nursing facility payments:** The Executive Budget proposes a number of changes to nursing facility reimbursement. In aggregate, these changes reduce total nursing facility spending by $427 million over the biennium.
- **Managed Care:** The Executive Budget proposes a number of changes to managed care payment. In aggregate, these changes reduce total managed care spending by $158 million over the biennium. Among the changes include carving-in pharmacy benefits, using the lower bound of the actuarial capitation rate range, setting the payment rate for services provided at out of network hospitals at the FFS rate and implementing a managed care sales and use tax.

Texas

HMA Roundup – Dianne Longley

The state is holding stakeholder meetings over the next two weeks to discuss the planned expansion of Medicaid managed care. While a manged care RFP was expected to be released by the end of March, but it is becoming increasingly possible that it may get delayed as the legislature debates budget balancing measures including the use of the state's $9.4 billion rainy day fund. The House Appropriations Committee is expected to vote on a budget bill in the next week or so at which point it will move to the House floor for a vote possibly by the end of the month. The legilative session is scheduled to wrap-up by the end of May though a special session may be possible if the legislature cannot reconcile its differences by that time.

In the news

- Texas struggles to fill a Texas-sized budget hole (Stateline)

Washington, D.C.

HMA Roundup - Lillian Spuria

On Tuesday, March 15, the Medicaid and CHIP Payment and Access Commission released its initial report to Congress. The purpose of the report is mainly to help Congress better understand the Medicaid and CHIP programs with little in the way of policy recommendations. The highlight of the report is the MACStats section, which includes state-specific information about program enrollment, spending, eligibility levels, optional Medicaid benefits covered, and the federal medical assistance percentage (FMAP), as well as an overview of cost-sharing permitted under Medicaid and the dollar amount of common federal poverty levels (FPLs) used to enroll people in these programs. The remaind-

er of the report acts mainly as a primer. However, discussion of the methodology that the Commission will use for further analysis may provide some insight into future policy directions.

(Link to Full Report)

In the news

- Dems hail reform's impact on drug costs (Modern Healthcare)
- This week: Reform anniversary approaches (The Hill)

OTHER STATE HEADLINES

Alabama

- A health care Q&A with Alabama Governor Robert Bentley (Stateline)

Arkansas

- Arkansas officials say planned changes can curb, but not eliminate, growing Medicaid costs (KSPR.com)

Arizona

- Arizona health care groups, Gov. Brewer to meet (Arizona Republic)
- Arizona lawmaker wants return of Medicaid hospice care (Arizona Republic)

Connecticut

- Beyond the budget: Health exchange another major task for Malloy (CT Mirror)

Idaho

- Idaho House committee moves bill cutting $34 million in Medicaid programs in 2012 (CB Online)

Illinois

- States make deep cuts in mental health funding (Chicago Sun-Times)
- Illinois families of disabled face cuts in home care (Chicago Sun-Times)

Kansas

- Brownback joins other GOP governors in call for Medicaid block grant (Kansas Health Institute)
- Insurance Department hearing will focus on health reform provision (Kansas Insurance Department)

Maine

- Maine discovers millions in Medicaid overpayments (Bangor Daily News)

Mississippi

- Haley Barbour draws fire for Medicaid changes in Mississippi (Kaiser Health News)

New York

- At state-run homes, abuse and impunity (NY Times)

Ohio

- Ohio invites Medicaid stakeholders to propose cost savings initiatives (Cleveland Plain Dealer)
- Medicaid is 30% of state budget and growing (Springfield News-Sun)

Oklahoma

- Oklahoma House passes bill to create program to receive federal Medicaid funds (The Oklahoman)
- Okla. House OKs hospital fee to shore up Medicaid (Bloomberg Businessweek)

Pennsylvania

- Health care advocates see future pain in Corbett budget (Philadelphia Inquirer)

Virginia

- Carilion, Aetna join forces to offer insurance products (Roanoke Times)

West Virginia

Lawmakers pass hospital Medicaid tax (Charleston Gazzette)