HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN THIS ISSUE:

IN FOCUS: WE REVIEW OHIO'S RECENTLY ANNOUNCED MEDICAID TRANSFORMATION PLANS WITH A FOCUS ON IMPLICATIONS FOR HOSPITALS, NURSING HOMES AND MANAGED CARE ORGANIZATIONS

HMA ROUNDUP: FLORIDA BUDGET PROPOSALS CONTEMPLATE LARGER THAN EXPECTED INPATIENT RATE REDUCTION; TEXAS MEDICAID MANAGED CARE RFP IMMINENT? MASSACHUSETTS RELEASES DUAL ELIGIBLE INTEGRATION RFI; CALIFORNIA BUDGET MEASURES PASS BUT MANY HURDLES LEFT; ILLINOIS ABD MANAGED CARE EXPANSION UNDERWAY

ALSO MAKING HEADLINES: NEW HAMPSHIRE CONTEMPLATES MEDICAID MANAGED CARE; OHIO PROPOSAL TO PRIVATIZE PRISONS; PLANNED PROVIDER RATE CUTS MEET RESISTANCE IN TEXAS, NEBRASKA, INDIANA, WASHINGTON AND ELSEWHERE; EXCHANGE PLANNING UPDATES

RECENTLY PUBLISHED HMA RESEARCH: HEALTH INSURANCE EXCHANGES: STATE ROLES IN SELECTING HEALTH PLANS AND AVOIDING ADVERSE SELECTION

MARCH 23, 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: OHIO MEDICAID TRANSFORMATION

This week, our *In Focus* section focuses on the Ohio Executive Medicaid Budget Proposal put forth by Governor John Kasich's newly-established Governor's Office of Health Transformation. The office was created on January 13, 2011 to immediately address Medicaid spending and the long-term efficiency of the Ohio Medicaid program, and to improve overall health system performance. The office is led by former HMA colleague Greg Moody. Governor Kasich's swift action is in response to an Ohio Medicaid program that spent $15.8 billion in SFY 2010, an amount equal to 30 percent of all state government spending and 4 percent of the Ohio economy. Due to growth in Medicaid caseloads and the expiration of enhanced federal matching funds, the state share of baseline Medicaid expenditures is forecasted to increase 42.8 percent from $3.7 billion to $5.3 billion in FY 2012 and another 6.5 percent in FY 2013. Accordingly, Gov. Kasich believes the current program growth is unsustainable and threatens to crowd out other state budget and policy priorities.

Overview

The Executive Budget Proposal includes a package of Medicaid reforms designed to:

- improve care coordination, with an initial focus on dual-eligible enrollees;
- integrate behavioral and physical health care;
- rebalance long-term care, and
- modernize reimbursement (i.e., reform payments to hospitals, nursing facilities and managed care organizations).

The Executive Budget Proposal estimates Medicaid savings of $4.3 billion over the FY 2012 and FY 2013 period of which $2.3 billion is the state share. (Table 1) The proposal has significant implications for three groups: hospitals, long-term care service providers (including nursing homes), and managed care organizations (MCOs).

The full Medicaid Transformation Budget Proposal is available here:

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

A March 17, 2011 House Finance Committee Testimony is available here:

http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=YSBfFwKL1SU%3d&tabid=86

TABLE 1: SUMMARY OF SFY 2012-2013 OHIO MEDICAID EXECUTIVE BUDGET PROPOSAL

GRF State	SFY 2011	SFY 2012	%	SFY 2013	%	SFY 2012-2013
Initial Trend	**$ 3,737,265,147**	**$ 5,335,729,055**	**42.8%**	**$ 5,680,339,444**	**6.5%**	**$ 11,016,068,499**
Revised Baseline	$ 18,240,342	$ (82,727,222)		$ (103,091,587)		$ (185,818,809)
Additional Costs		*$ 343,728,971*		*$ 649,428,780*		*$ 993,157,751*
Franchise Fee Revenue		*$ 161,602,571*		*$ 157,258,801*		*$ 318,861,372*
Savings and Cost Avoidance		*$ (944,873,117)*		*$ (1,376,702,881)*		*$ (2,321,575,998)*
Subtotal		*$ (522,268,797)*		*$ (673,106,887)*		*$ (1,195,375,684)*
Budget	**$ 3,755,505,489**	**$ 4,813,460,258**	**28.2%**	**$ 5,007,232,557**	**4.0%**	**$ 9,820,692,815**
State Share	*$ 3,143,279,568*	*$ 4,301,495,336*	*36.8%*	*$ 4,705,852,933*	*9.4%*	*$ 9,007,348,269*

All Funds	SFY 2011	SFY 2012	%	SFY 2013	%	SFY 2012-2013
Initial Trend	**$ 18,020,279,696**	**$ 19,342,184,313**	**7.3%**	**$ 20,796,914,822**	**7.5%**	**$ 40,139,099,135**
Revised Baseline	$ (157,440,336)	$ (379,813,556)		$ (454,545,028)		$ (834,358,584)
Additional Costs		*$ 959,811,555*		*$ 1,849,269,574*		*$ 2,809,081,129*
Franchise Fee Revenue		*$ 449,395,358*		*$ 438,657,744*		*$ 888,053,102*
Savings and Cost Avoidance		*$ (1,526,660,553)*		*$ (2,775,230,114)*		*$ (4,301,890,667)*
Subtotal		*$ (497,267,196)*		*$ (941,847,824)*		*$ (1,439,115,020)*
Budget	**$ 17,862,839,360**	**$ 18,844,917,117**	**5.5%**	**$ 19,855,066,998**	**5.4%**	**$ 38,699,984,115**
All Funds	*$ 10,480,554,867*	*$ 11,814,893,182*	*12.7%*	*$ 13,171,301,004*	*11.5%*	*$ 24,986,194,186*

SOURCE: Governor's Office Health Transformation, March 17, 2011 House Finance Committee Testimony

Changes Affecting Hospitals

Under the current prospective payment system, the Executive Budget Proposal argues that hospitals are rewarded for volume, rather than quality and improved outcomes. The proposal aims to modernize Medicaid payment methodologies to both improve patient outcomes and reduce state expenditures through payment changes. Additionally, the proposal eliminates temporary funding for children's hospitals, extends a five percent hospital rate increase (associated with funding from the continuation of the existing franchise fee) and reauthorizes the allocation program for federal disproportionate share hospital (DSH) payments.

Payment changes and reductions:

- Select outpatient services will no longer be reimbursed at a percentage of billed charges as of January 1, 2012; instead, reimbursement will be based on each hospital's specific outpatient cost-to-charge ratio thereby limiting reimbursement to cost for these services. ***FY2012/2013 state savings: $66.2 million***
- The current methodology for determining which inpatient calims qualify for higher "outlier" reimbursement has allowed the number of qualifying claims to increase by 35 percent since 2007. This proposal brings inflationary factors in line with the cost outlier qualification measure, effective October 1, 2011. ***FY2012/2013 savings: $157.4 million***
- Ohio Medicaid will no longer pay above the Medicaid maximum reimbursement amount for Medicare Part B crossover claims, effective January 1, 2012. The state is currently overpaying providers when a person is enrolled in both Medicaid

and Medicare and Medicaid has a lower reimbursement rate. ***FY2012/2013 state savings: $94.5 million***

- The state will set specific Medicaid managed care capital rates beginning January 1, 2012 and will annually update those rates. Medicaid MCOs currently reimburse hospitals at the same capital rate as is calculated for fee-for-service (FFS) inpatient capital costs despite the fact that the Medicaid MCO population consumes, on average, nearly 45 percent less capital resources than the FFS population. ***FY2012/2013 state savings: $126 million***
- The Ohio Hospital Association (OHA) has proposed to continue the existing franchise fee, set to expire June 30, 2011. The proceeds and associated federal matching funds will be used to extend a temporary 5 percent hospital rate increase (associated with funding from the existing franchise fee), also set to expire June 30, 2011. This proposal implements an OHA fee methodology, which will net ***$554 million in gains for hospitals*** and $434 million in general revenue funds (GRF) for the state for FY2012/2013, at a state expense of $371 million.
- The Executive Budget Proposal also reauthorizes through October 2013 the Hospital Care Assurance Program (HCAP) responsible for implementing the federal DSH payment program. Ohio hospitals fund the state share of HCAP through a provider assessment, which must be reauthorized by the state every two years. ***Hospitals receive $560 million in DSH payments annually***.

In aggregate, these changes are estimated to increase total inpatient spending by 0.6 percent, though spending on a per member per month (PMPM) basis will decline 1.8 percent. Total outpatient spending is forecasted to decline 4.5 percent, or 6.7 percent on a PMPM basis. (Table 2)

TABLE 2: BUDGET IMPACT ON HOSPITALS – INPATIENT AND OUTPATIENT

	SFY2011	SFY2012	% Change
Inpatient Hospital Payments	**$1.05 Billion**	**$1.06 Billion**	**+ 0.6%**
Per Member Per Month	**$159.37**	**$156.53**	**- 1.8%**

	SFY2011	SFY2012	% Change
Outpatient Hospital Payments	**$0.44 Billion**	**$0.42 Billion**	**- 4.5%**
Per Member Per Month	**$66.31**	**$61.87**	**- 6.7%**

SOURCE: Governor's Office Health Transformation, March 17, 2011 House Finance Committee Testimony

Changes Affecting Nursing Facilities and Long-Term Care Service Providers

State Policy Changes

A significant portion of the Executive Budget Proposal is dedicated to the rebalancing of Ohio's fragmented long-term care delivery system. Medicaid-eligible individuals in need of long-term care services currently choose from multiple waiver programs and delivery models:

- ***PASSPORT*** – a home and community based services (HCBS) waiver for individuals age 65 and over or age 60 and over with a disability;
- ***Ohio Home Care*** – HCBS waiver for individuals with physical disabilities who are age 59 or younger;
- ***Ohio Home Care/Transitions Aging Carve-out*** – HCBS waiver for individuals 60 or older who were enrolled in Ohio Home Care and who have service needs that cannot be met with the PASSPORT service package;
- ***CHOICES*** – HCBS waiver for individuals age 65 and over or age 60 and over with a disability with a self-direction component available in selected regions of the state;
- ***Assisted Living*** – HCBS waiver for the aged and individuals with disabilities age 21 and over who live in assisted living facilities;
- ***Program of All-Inclusive Care for Elders (PACE)*** – a capitated program with an all-inclusive service package that serves individuals age 55 and over in Cleveland and Cincinnati;
- ***Nursing Facility*** – an institutional delivery model for long term services;
- ***Hospice*** – a program that is focused on care at the end of life that can be used alone or in combination with other options for long term services; and
- ***State Plan Home Health and Private Duty Nursing*** – services that can be used alone or in combination with other options for long term services.

The proposal takes a three-step approach to a unified long-term care (LTC) system:

1. ***Unified Budget*** – As of July 1, 2011, Medicaid funding for LTC services will be combined into a single line item in the state budget. As a result, LTC spending will be driven by the LTC settings and services individuals choose, rather than line item appropriations. A focus is placed on achieving greater transparency in pricing of LTC services.
2. ***"Front Door"*** for Accessing Services – A clear access point for individuals entering the LTC system will help individuals make choices on LTC settings and services.
3. ***A Single Waiver*** –Five current HCBS waivers will be replaced with a single LTC services waiver that incorporates provider and enrollment requirements, defined service packages, and consistent care management across populations. The waiver design will consider the role of home health services and private duty nursing. Additionally, the state will seek authority to design the waiver enrollment priorities to reduce hospital and nursing facility utilization. Enrollment is set to begin by July 1, 2012.

Payment Changes and Reductions

The Executive Budget Proposal aims to reform nursing facility payment policies to drive down per capita spending on nursing homes and reward person-centered care and quali-

ty outcomes. Ohio spends more per capita on nursing homes than all but five states and nursing facility rates are approximately $4.75 higher than the national average.

The proposal makes the following changes to the nursing facility rate methodology:

- The price for most services will be set at 25th percentile of historical peer group cost experience (includes direct care, ancillary and support services, and capital)
- The consolidated services per diem, previously bundled with the nursing facility rate, will be included in the direct care price. As a result, facilities serving higher acuity individuals will receive more funding.
- The current process-oriented quality incentive program will be replaced with a patient-oriented quality program. The current quality incentive payment is 1.7 percent of the nursing facility rate, and results in winners and losers under the rate structure. Under the proposal, 8.75 percent of the total nursing facility rate will be tied to quality of care and quality of life. The quality measures will be designed so that every nursing home in the state has the opportunity to earn the full price Medicaid reimbursement for nursing home care.

Combined FY2012/2013 state savings: $399.9 million

The proposal also reduces Medicare cross-over payments for Medicaid and Medicare dual-eligible patients (***FY2012/2013 state savings: $8.5 million***) and reduces payments for "leave days" when a patient is not in the nursing facility. Currently, Medicaid pays 50 percent of the facility's rate for up to 30 leave days per calendar year. Under the proposal, Medicaid will pay 25 percent of the facility's rate for up to 15 leave days per calendar year (***FY2012/2013 state savings: $16.2 million***).

Finally, the budget proposal decreases the nursing facility franchise fee assessed on licensed nursing home beds, summarized in Table 3 below:

TABLE 3: NURSING FACILITY FRANCHISE FEE EXECUTIVE BUDGET PROPOSAL

	SFY2011	SFY2012	SFY2013
Per Bed Per Day Rate	**$11.95**	**$11.38**	**$11.60**
Total Fees Collected		**$392.1 Million**	**$392.9 Million**

SOURCE: Governor's Office Health Transformation, March 17, 2011 House Finance Committee Testimony

In aggregate, nursing facility rates are budgeted to decline 7.3 in FY 2012.

TABLE 4: ESTIMATED NURSING FACILITIES STATE EXPENDITURES AND RATES UNDER EXECUTIVE BUDGET PROPOSAL

	SFY2011	SFY2012	% Change
Nursing Facilities (incl. Fee)	**$2.68 Billion**	**$2.47 Billion**	**- 7.8%**
Statewide Avg. Rate	**$117.53**	**$164.50**	**- 7.3%**

SOURCE: Governor's Office Health Transformation, March 17, 2011 House Finance Committee Testimony

Changes Affecting Medicaid Managed Care Organizations (MCOs)

Capitated Medicaid managed care plans cover over 1.6 million of the nearly 2 million Medicaid enrollees in Ohio. The state budgets FY2011 capitation payments of approximately $5.1 billion and FY2012 payments of approximately $6.3 billion. Several provisions of the Executive Budget Proposal significantly impact Medicaid MCOs, including changes to capitation rates, a carve-in of the pharmacy benefit, changing requirements for non-contracted hospital payments, and enrolling children with disabilities in managed care plans.

- ***Capitation Rates:*** An actuarial review of MCO capitation rates resulted in several recommendations included in the proposal:
    - Medical cost inflation calculations will use the lower boundary of the inflation trend.
    - Administrative components of the capitation rate are reduced to reflect reductions in administrative requirements put in place by the Ohio Medicaid program.
    - Administration components of the capitation rate are also reduced to reflect actual managed care plan experience and national trends.
    - Increased managed care enrollment allows administrative costs to be spread more efficiently across more lives. ***Combined FY2012/2013 state savings: $144 million***.
- ***Pharmacy Benefit:*** A provision of the federal Affordable Care Act (ACA) allows MCOs to have the same access to manufacturer drug rebates as currently in place under Medicaid FFS programs. As a result, states that previously "carved-out" the pharmacy benefit from capitated managed care plans are reconsidering their Medicaid pharmacy policies. The Executive Budget Proposal carves the pharmacy benefit back into the managed care program effective October 1, 2011. The state will also engage plans, providers and advocacy groups to develop standardized prior authorization criteria. ***FY2012/2013 state expenditure: $114 million***.
- ***Hospital Non-Contracting:*** On average, Medicaid MCOs pay hospitals more than 104 percent of Medicaid FFS rates. The budget proposal sets reimbursement rates at 100 percent of FFS rates for hospitals that will not contract with Medicaid MCOs. ***FY2012/2013 state savings: $119.6 million***.
- ***Pediatric Accountable Care Organization (ACO) Development:*** Ohio Medicaid currently serves 37,544 disabled children through their FFS program at an annual cost of $313 million. The budget proposal will improve care coordination for disabled children and encourage the development of pediatric accountable care organizations (ACOs) to meet their complex medical and behavioral health needs. Medicaid MCOs play a key role in the state's multi-phase development plan. (Table 5)

TABLE 5: PEDICATRIC ACO DEVELOPMENT PLAN

Responsibility	Current	Phase I	Phase II	Phase III
Medicaid Contract	**FFS**	**MCO**	**MCO**	**ACO**
Care Coordination	**None**	**MCO**	**ACO**	**ACO**
Financial Risk	**Medicaid**	**MCO**	**MCO**	**ACO**
Savings	**None**	**Medicaid**	**MCO/ACO**	**ACO/Medicaid**

SOURCE: Governor's Office Health Transformation, March 17, 2011 House Finance Committee Testimony

Phase I begins July 1, 2012 with the enrollment of all non-institutional, non-HCBS waiver disabled children into Medicaid MCO plans. MCOs are encouraged to form new relationships with developing ACOs in Phase II to achieve savings through ACO care coordination. Phase III is optional depending on the willingness of potential ACO sites to take on the full risk and responsibilities of a free-standing ACO.

Pediatric ACO development is expected to cost the state $87 million in FY2012/2013, a result of $288 million in savings through utilization control, and $375 million in costs associated with moving from a retrospective to prospective payment system.

- ***MCO Premium Sales Tax***: The proposal generates additional revenue with a sales and use tax on managed care plan premiums. Increased managed care enrollment, as prescribed by the Executive Budget Proposal, will generate sales tax revenue gains for the state of $135.4 million in FY2012/2013.

The Medicaid managed care rates are budgeted for a 1 percent reduction in trend.

TABLE 6: BUDGET IMPACT ON MEDICAID MANAGED CARE ORGANIZATIONS

	SFY2011	SFY2012	% Change
MCO State Expenditures	**$5.12 Billion**	**$6.31 Billion**	**+ 23.4%**
Admin./Trend Changes			**- 1.0%**

SOURCE: Governor's Office Health Transformation, March 17, 2011 House Finance Committee Testimony

Below we list the Medicaid MCOs doing business in Ohio by market share.

TABLE 7: CURRENT MEDICAID MCO MARKET SHARE

Health Plan	Membership (Mar-11)	Market Share
CareSource	847,419	52.3%
Molina	245,228	15.1%
Centene	159,724	9.9%
UnitedHealth	119,264	7.4%
WellCare	101,139	6.2%
Paramount	92,154	5.7%
Amerigroup	55,285	3.4%
Total	**1,620,213**	

SOURCE: ODJFS

Changes Affecting the Behavioral Health Care System

The current structure for Ohio Medicaid reimbursements for community mental health benefits differs from other community-based services in that there are few limits on the amount, frequency, and duration of services consumed. Ohio adults with severe mental illness (SMI) represent only 10 percent of the Medicaid population, but account for 26 percent of total Medicaid expenditures. The budget proposal seeks to implement utilization management controls and cost containment measures to ease spending pressure in this area.

Integrating Behavioral and Physical Health Benefits

Until now, Ohio has administered behavioral health benefits separate from Medicaid physical health benefits under the Department of Mental Health and the Department of Alcohol and Drug Addiction Services. This separation of administration has resulted in patients receiving care without the benefit of shared provider information or referrals between the physical and behavioral health systems. Not only are costs rising as a result, but health outcomes are not improving. The budget proposal makes significant changes to promote integration of behavioral health benefits.

During state fiscal years 2012 and 2013, the Office of Health Transformation will integrate the Medicaid alcohol and other drug treatment and mental health carve-out benefits into the general Medicaid program. Additionally, Governor Kasich's administration has applied for a federal planning grant from the Center for Medicare and Medicaid Innovation to design and implement care coordination strategies for 113,000 residents of nursing facilities, HCBS recipients with nursing home-level care, and those with severe mental illness. This planning will explore opportunities for care coordination through managed care, ACOs, and other health home models.

Managing Behavioral Health Service Utilization

The budget proposal implements the following utilization management controls and cost containment measures:

- ***Tiered Rates*** – The budget proposal allows the initial unit of certain services to be reimbursed at a higher rate than subsequent units provided on the same date of service. Initially this will only apply to community psychiatric supportive treatment (CPST). CPST will be paid a full rate for the first hour and 50 percent of the full rate for subsequent hours. ***FY2012/2013 state savings: $60.3 million***.
- ***Defined Benefit Package*** – The budget proposal establishes basic benefit limits that specify the amount, frequency and duration of services as required by federal Medicaid regulations. In Table 8 below, the proposed limits are presented next to recommendations made by a 2009 workgroup comprised of constituents representing all aspects of the behavioral health system. Additionally, Table 8 indicates the percent of clients unaffected by the proposed limits, based on 2005-2010 claims data. ***FY2012/2013 state savings: $135.2 million***.

TABLE 8: PROPOSED MEDICAID BEHAVIORAL HEALTH SERVICE LIMITS

Service	Workgroup	Proposed	% Unaffected
CPST	130 hours	104 hours	96%
Pharmacy Management	24 hours	24 hours	98%
Counseling	100 hours	52 hours	97%
Diagnostic Assessment by MD	4 hours	2 hours	95%
Diagnostic Assessment	10 hours	4 hours	90%
Partial Hospitalization	90 days	30 days	50%

- *Nursing Facility Reimbursement* – The proposal will eliminate duplicate payments for mental health services provided to nursing home residents. Only admission and discharge-related services and those associated with continuity of care will be reimbursed separately. Community mental health providers will be able to contract with nursing homes for the provision of additional mental health services. ***FY2012/2013 state savings: $39.1 million***.

Changes Affecting Other Providers

TABLE 9: BUDGET IMPACT ON PHYSICIANS (STATE SHARE)

	SFY2011	SFY2012	% Change
Physician Payments	$341.6 Million	$371.7 Million	+ 8.8%

TABLE 10: BUDGET IMPACT ON HOME CARE NURSING SERVICES (STATE SHARE)

	SFY2011	SFY2012	% Change
Ohio HomeCare Waivers	$ 50.9 Million	$ 51.4 Million	+ 1.1%
Private Duty Nursing	$154.5 Million	$161.9 Million	+ 4.8%
State Plan Home Health	$105.5 Million	$107.2 Million	+ 1.5%
Rate Per 4 hours	$123.23	$117.21	- 4.9%

TABLE 11: BUDGET IMPACT ON HOME CARE AIDE SERVICES (STATE SHARE)

	SFY2011	SFY2012	% Change
Ohio HomeCare Waivers	$281.0 Million	$294.4 Million	+ 4.7%
State Plan Home Health	$117.9 Million	$122.9 Million	+ 4.2%
Rate Per 4 hours	$59.98	$58.50	- 2.5%

SOURCE: Governor's Office Health Transformation, March 17, 2011 House Finance Committee Testimony

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

The California legislature passed a FY 2012 budget last week on a majority vote. The budget includes spending cuts addressing about half of the projected $23 billion deficit. The Legislature did not act on the Governor's proposal to authorize a voter referendum

to extend existing tax increases. (Authorizing a voter referendum to approve tax extensions would require a two-thirds vote of the Legislature.) The latter two changes would have further closed the budget deficit. The Governor's initial deadline for action on these items was not met and it is not clear if the Governor and the Legislature will continue negotiating on these items in the Legislature, seek to go to the ballot on the tax extensions by a majority vote, move to make more budget cuts, or seek an initiative that would place the tax extensions on the ballot in November.

In terms of rate changes for Medicaid providers, the planned 10 percent reduction was included in the budget, effective June 1 and applied to all provider groups other than inpatient hospitals. The cut is still subject to a federal appeals court ruling that requires that the state demonstrate that the rate reductions do not affect quality and access. California's appeal of this case to the U.S. Supreme Court will not be heard until the fall and a decision may not be forthcoming until spring 2012.

The budget, subject to federal approval, also creates new copayments for a number of services that further reduce provider rates. The budget adopts a number of other changes to health care programs.

The Medi-Cal changes apply to the fee for service program and will be passed on to Medi-Cal managed care plans through actuarial rate reductions.

In the news

- Lawmakers OK billions in program cuts in California budget (LA Times)
- California hospital systems try to be accountable (California Healthline)
- California legislature oks deep budget cuts (SF Chronicle)
- Programs that were cut in state budget (SF Chronicle)
- Hospitals are wary of California budget plan to shift emergency funds (LA Times)

Florida

HMA Roundup – Gary Crayton

The Florida House and Senate Health appropriations subcommittees both passed budget conforming bills this week. The House bill was voted out of the Health Care Appropriations Subcommittee Tuesday and the Senate Budget Subcommittee on Health and Human Services Appropriations subcommittee is expected to vote its bill out tomorrow. Next week, the bills will be combined with those voted out of the other subcommittees and voted on by the broader Appropriations committees before going to the floor most likely the following week. Finally, a conference committee will likely take place in early or mid-April to resolve differences between the House and Senate budget bills. Below we outline the key healthcare provisions of each bill:

House:

- 7 percent rate reductions for hospital inpatient, outpatient, CHD
- $90.5 million HMO rate reduction (pass through)

- $10.4 million reduction for Healthy Kids rate freeze
- $2.5 million reduction for Medikids rate freeze
- Provides budget authority for buy backs of hospital reductions

Senate:

- 10 percent rate reductions for hospital inpatient, outpatient, CHD
- $140.9 million HMO rate reduction (pass through)
- $10.4 million reduction for Healthy Kids rate freeze
- $2.5 million reduction for Medikids rate freeze
- Provides budget authority for buy backs of hospital reductions

Our expectation is that the final rate reductions will be somewhere between the House and Senate versions. Rarely are final rate changes outside the parameters established by the respective subcommittees.

In the news

- Medicaid overhaul on a roll in House (HealthNews Florida)
- Cuts to come – How big? (HealthNews Florida)
- $1B in cuts in Senate HHS Budget (HealthNews Florida)

Georgia

HMA Roundup – Mark Trail

As we mentioned last week, Georgia Governor Nathan Deal had introduced a bill to create a healthcare exchange authority with a governing board for the exchange and with a dedicated trust fund. The trust fund would allow the exchange to be self-sustaining and would have prevented dedicated funds to be redirected by the legislature or another department. The Governor pulled the bill after it encountered resistance from Tea Party representatives which surprised many in the Legislature. The current thinking is the Governor will likely create an executive office to oversee the creation of the exchange through an administrative order. This would preclude the need for legislative approval but would also preclude the governor's ability to create a dedicated trust fund.

In the news

- Georgia House signs off on health care compact (Bloomberg BusinessWeek)

Illinois

HMA Roundup – Matt Powers

The Integrated Care Program is poised to begin this month as the first managed care enrollment packets for the aged and disabled populations in suburban counties have been sent out to enrollees. Consumers will have 30 to 60 days to pick a plan with the expectation that the program should be fully ramped within the next quarter with enrollment of around 2,500 per week (total ~38,000 lives).

In the news

- IL Republicans want $5 billion in cuts to education, health care, pensions (Chicago Sun-Times)

Massachusetts

HMA Roundup – Tom Dehner

On March 18th, Massachusetts issued a Request for Information (RFI) to solicit information from a broad spectrum of parties regarding the initiative to integrate Medicare and Medicaid benefits for individuals who are eligible for both programs (Dual Eligibles). Massachusetts is looking to contract with an Integrated Care Entity to ensure access to appropriate services, integrate comprehensive care at the person level, improve care coordination, and create payment systems that hold provider systems responsible for the care they deliver. MassHealth proposes to assume complete operational responsibility for the care of this population. The model envisions creating a global payment system for all Medicare and Medicaid services, a broader continuum of behavioral health services, and Community Support Services. Under the proposed model, MassHealth believes this level of integration is necessary to achieve better health outcomes for this population and to provide higher quality, more cost effective, person-centered care.

Budget Update: The Governor's bill is still in committee and the House and Senate will address it through the ordinary course of the legislative process. The House Speaker believes that lawmakers need to take their time and address it carefully, while the Senate President is more eager to get things moving along. We believe that the next major catalyst for the budget talks will be sometime in early April.

In the news

- Blue Cross' status as nonprofit scrutinized amid outcry over pay (Boston Globe)

Michigan

HMA Roundup – Esther Reagan

On March 16th, the Medical Services Commission delivered a presentation to Senate Appropriations Subcommittee on Community Health. The presentation estimates that FY 2011 Medicaid expenditures will reach $12 billion, but the program offers significant value for taxpayers, given that enrollment has increased 41 percent from FY 2002 to FY 2010 while Medicaid General Fund spending decreased 21 percent over the same period.

The presentation also makes several executive budget recommendations for the FY 2012. The recommendation includes a 1 percent claims tax that would contribute almost $400 million to the budget, but includes no cuts to eligibility and no cuts to rates. Further, the proposal includes expanding Medicaid managed care and initiating a program to better manage the dual eligible population. Also of interest, the report makes a strong argument against rate cuts, by highlighting what it calls the Medicaid Rate Cut "Death Spiral".

(Presentation available upon request)

In the news

- As Capitol protestors lock arms, Republicans hold hearings on upping public sector health premiums (MLive.com)
- Snyder's health insurance cost-cutting plan isn't so much carrot as stick (MLive.com)

Texas

HMA Roundup – Linda Wertz

We are hearing conflicting messages regarding the timing of the release of the state's Medicaid managed care RFP with recent speculation suggesting it will be published in the next day or two. Other sources maintain it may not be available until the end of the session in May.

Budget Update: The Governor has agreed to use $3.1 billion of rainy day funds for this year's (FY 2011) budget. However, the Governor maintained that the rainy day fund not be used for the upcoming biennium's budget. While this year's budget hole is fixed by using the rainy day fund, the FY 2012/2013 budget maintains the 10 percent rate cut to providers.

In the news

- Lawmakers push for changes to hospital hiring law (Texas Tribune)
- In search of cuts, health officials question NICU overuse (NY Times)

Washington, D.C.

HMA Roundup - Lillian Spuria

The Congressional Budget Office's (CBO) preliminary analysis of President's Obama's FY 2012 Budget proposal was released last Friday and estimated higher deficits than the President's Budget. The analysis also included a ten year score for the physician fee fix ($298 billion) while the President's budget only forecasted a two-year fix. The next important milestone at the federal level will be the House Republicans' budget resolution which Representative Paul Ryan is expected to introduce in April.

In the news

- Health Exchange head start reaps dollars (Stateline.org)
- States rush to settle Medicaid bills (USA Today)
- GOP leaders target 2012 Budget – Ryan gauges pulse of Medicaid Reform (Congress.org)

OTHER STATE HEADLINES

Alabama

- Alabama's Gov. Bentley planning overhaul of state health plan (Birmingham News)

Arizona

- Gov. Brewer's new Medicaid plan to cut few people from program (AZ Central)

Colorado

- Colorado House leader wants Colorado out of federal health reform but into exchanges (Denver Post)

Connecticut

- State could lose another four nursing homes (CT Mirror)

Indiana

- Indiana Medicaid mental health list worries advocates (NECN.com)
- Indiana wants to use health savings accounts for Medicaid expansion, but feds noncommittal (CB online)

Kansas

- Senate approves provider tax for community DD programs (Kansas Health Institute)

Minnesota

- Bill aims to cut spending on health care for poor (Star Tribune)

Missouri

- Conservatives in MO legislature back health insurance exchanges (News Tribune)

Montana

- New bills for health insurance exchange coming forward (Billings Gazette)

Nebraska

- Medicaid providers warn rate cuts would have dismal consequences (Lincoln Journal Star)

New Hampshire

- Managing Medicaid: Contract it out (Union Leader)

Ohio

- Kasich's Medicaid plan isn't only cuts (Columbus Dispatch)
- Sale of prisons, fewer inmates part of budget plan (Columbus Dispatch)

Washington

- Washington state nursing homes face 'crippling' cuts (The Olympian)
- A panel decides Washington state's health care costs (NY Times)

HMA Recently Published Research

Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection

The Commonwealth Fund

By Sharon Silow-Carroll, Diana Rodin, Tom Dehner, and Jaimie Bern

A central feature of the federal health reform legislation is its creation of "health insurance exchanges." The exchanges, to be operational in 2014, are envisioned as insurance marketplaces in which individuals and small businesses can compare and purchase health plans, and determine and receive premium subsidies for which they are eligible. States have the option to develop and host their own exchanges, or let the federal government establish and run exchanges for them. States that choose to implement exchanges will be able to tailor the exchanges to their states' particular strengths and circumstances. Yet, they will face a multitude of decisions regarding their governance, design, marketing, administration, technology, and other factors. This States in Action focuses on two critical issues: the role of the exchanges in selecting plans for inclusion and in avoiding adverse selection.

Link to report

Upcoming Appearances

Health Plan Alliance: Spring Leadership Conference

Vernon Smith, Principal

March 31, 2011

Dallas, TX

CVS Caremark Client Forum: ***"Preparing for Imminent Change and Growth in Medicaid"***

Vernon Smith, Principal

April 14-15, 2011

Orlando, FL

Association of State and Territorial Health Officers Spring Conference: ***"Fiscal Impacts of Health Reform"***

Vernon Smith, Principal

April 14-15, 2011

New Orleans, LA

The American Society on Aging's 2011 Aging in America Conference:

"Understanding and Implementing the CLASS Act: A Breakthrough in Long-Term Services and Support "

"The Impact of the Economic Downturn on Long-Term Services and Supports"

Susan Tucker, Principal

April 28-29, 2011

San Francisco, CA

National Association of State Budget Officers: ***"Budget Strategies & State Fiscal Conditions"***

Mark Trail, Principal

April 30, 2011

Ft. Lauderdale, FL

Thomson Reuters 2011 Healthcare Advantage Conference: ***"What's Next for Medicaid: Unprecedented Challenges of Health Reform, Budget Stress and Political Uncertainty"***

Vernon Smith, Principal

May 10, 2011

Salt Lake City, UT

Medicaid Managed Care Congress

Vernon Smith, Principal

May 18-20, 2011

Baltimore, MD

National Commission on Correctional Health Care's "Updates in Correctional Health Care" *Topic: Medicaid Payment for Inpatient Hospitalizations: Now and 2014*

Donna Strugar-Fritsch, Principal

May 23, 2011

Phoenix, AZ

Communities of Practice (CoP): HMA Principals are leading CoP sessions with CMS for state Medicaid agency staff in the following areas:

- M. Reneé Bostick, Principal - State Medicaid HIT Plans and HIT Implementation, March 21, 2011
- Susan Tucker, Principal – Auditing, March 28, 2011
- M. Reneé Bostick, Principal – Meaningful Use, April 4, 2011
- Tom Dehner, Principal – Regional Collaboratives, April 18, 2011