HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

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APRIL 6, 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

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IN FOCUS: THE RHODE ISLAND GLOBAL MEDICAID WAIVER AND FEDERAL MEDICAID BLOCK GRANTS

With Medicaid block grants in the spotlight this week, our *In Focus* section examines the Rhode Island Global Consumer Choice Compact, Section 1115 Medicaid waiver program approved in early 2009. On Tuesday, the U.S. House Budget Committee released its FY 2012 Budget Resolution which proposes converting federal responsibility for Medicaid expenditures to a block grant as a way to rein in costs in Federal Medicaid spending. In order to illustrate some the potential trade-offs associated with a block grant and its implications for spending and care coordination, we examine the Rhode Island waiver and summarize some of the key arguments for and against it as a model for Medicaid savings. We also compare the Rhode Island waiver to the block grant proposal included in the House Budget Resolution, identifying key differences.

We note that the House's block grant proposal is not likely to become law in the foreseeable future. The Senate has already indicated its resistance to the idea as has President Obama. In fact, converting Medicaid to a block grant program has been proposed at least three times in the past, by President Ronald Reagan in 1981, by House Speaker Newt Gingrich in 1995 and by President George W. Bush in 2003, never garnering enough support to pass. In each case, the proposal failed to overcome concerns by Congress that it will lose administrative control of the programs if states were given additional flexibility over program design, and concerns by the states that the federal contribution will fail to keep pace with medical inflation, shifting more financial responsibility onto state budgets. Nevertheless, we expect that the merits of the proposal will be debated and provide some background for consideration.

About Section 1115 Waivers

Rhode Isand's Global Consumer Choice Compact, the legislation that converted the federal contribution to Rhode Island's Medicaid program to a block grant, was administered under a Section 1115 waiver. Section 1115 of the Social Security Act allows states, with federal approval, to conduct Medicaid demonstration projects, waiving certain provisions of the Medicaid statute. Waivers must further the objectives of Medicaid and be budget neutral for the Federal government. States often use Section 1115 waiver authority to cover populations currently outside the Medicaid population, such as non-disabled childless adults. States must offset the additional cost through savings elsewhere in the Medicaid program so that total expenditures do not exceed what they would have been absent of the waiver. A common way to offset additional expenditures is through expansion of capitated managed care to new populations.

A Center for Medicare and Medicaid Services (CMS) summary of the waiver is available here:
RHODE ISLAND GLOBAL CONSUMER CHOICE COMPACT

The Rhode Island Waiver

Rhode Island's Section 1115 waiver, approved on January 16, 2009, allows the state to operate its entire Medicaid program under the waiver for a period of five years at which point the waiver would have to be renewed. The goal of the waiver is described in the terms and conditions as follows:

> *Rhode Island's Global Consumer Choice Compact Demonstration establishes a new State-federal compact that provides the State with substantially greater flexibility than is available under existing program guidelines. Rhode Island will use the additional flexibility afforded by the waiver to redesign the State's Medicaid program to provide cost-effective services that will ensure beneficiaries receive the appropriate services in the least restrictive and most appropriate setting. In exchange for the increased flexibility and the opportunity to invest in Medicaid reform, the State will operate the Medicaid program during the Demonstration under a mutually agreed upon five year aggregate cap of federal funds, thereby assuming a degree of financial risk with respect to caseload and per member per month cost trends.*

With that, two key elements of flexibility were afforded the state by the waiver. First, the waiver encompassed two provisions already approved under previous waivers such as:

- Allowing the state to help Medicaid-eligible persons enroll in employer-based coverage and
- Expand home and community-based services for long-term care populations.

Second, the global waiver added two new initiatives:

- Allowing the state to establish a waiting list for long-term care services and
- Enabling the state to contract on a competitive basis with a limited number of medical equipment suppliers.

The changes described above would have likely been possible without Rhode Island agreeing to a budget ceiling for federal financial responsibility. What makes the Rhode Island waiver unique, however, is the alleviation of certain federal *approval requirements* for implementing future administrative alterations to its program. Specifically, the waiver identifies three categories of changes to the state's Medicaid program where the federal approval process would be relaxed.

- Category I includes administrative changes for which the State has current authority under the State plan and which does not affect beneficiary eligibility, benefits, overall healthcare delivery systems, payment methodologies or cost sharing. Examples of Category I changes are changes to provider enrollment procedures and prior authorization requirements. Rhode Island must notify CMS of any Category I changes before implementing the change but implementation does not require approval by CMS.
- Cateogry II includes program modifications that would otherwise be made as a State Plan Amendment (SPA). These changes may affect benefit packages, overall healthcare delivery systems, cost sharing levels, and post-eligibility contributions to the cost of care. Such changes do not, however, include changes that affect beneficiary

eligibility (including changes to the level of spenddown eligibility). Category II changes largely revolve around the definition of Home and Community Based Services (HCBS) as well as their authorized amount, duration and scope. Changes to payment methodologies for Medicaid covered services including DRG payments to hospitals or acuity based payments to nursing homes are also Cateogry II changes. Rhode Island must notify CMS in writing of Category II changes 45 days prior to implementation and provide an assessment of cost of the change.

- Category III changes require modification to the current waiver or expenditure authorities. All adjustments to eligibility thresholds would fall under Category III as would cost sharing amounts and changes to the budget neutrality cap. Rhode Island must notify CMS in writing of Category III changes, and submit an amendment to the demonstration

With that, the flexibility afforded by the waiver, particularly around Cateogry II changes, constituted the key benefit to the state, particularly with respect to expanding HCBS services. Prior to approval of the global waiver, Rhode Island's HCBS waivers had ceilings limiting the number of beneficiaries who could receive services under the waiver. The global waiver allowed these ceilings, or caps, to be removed, which has, according to the State, increased access to home and community-based services for Medicaid long term care (LTC) beneficiaries. As of the 4th quarter of FY 2010, there were no waiting lists for Medicaid LTC services.[1] Additionally we note that as of September 2010, Rhode Island:

- Safely transitioned 923 individuals to a community setting in the Nursing Home Transition program; and
- Transitioned 22 individuals to a community setting.

In exchange for this flexibility, Rhode Island agreed to a five-year cap on combined federal and state Medicaid spending. The federal government reimburses at a set percentage of Rhode Island's Medicaid expenditures up to the cap, set at $12.075 billion for 2009 through 2013. If expenditures exceed this amount, they would be fully funded by the state. Savings must remain within the Medicaid program and be used to support endeavours that promote the following principles:

- **Consumer Empowerment and Choice:** To provide consumers more information and control over their health care and community support options.
- **Personal Responsibility:** To allow consumers to become better health care purchasers for themselves and their families.
- **Community-based care solutions:** To offer community-based health care solutions and alternatives to institutional care for individuals who can appropriately remain in their community.
- **Prevention and Wellness:** To strive to better enable consumers to receive individualized health care that is outcomes-oriented and focused on prevention wellness, recovery and maintaining independence.

[1] http://www.eohhs.ri.gov/documents/documents11/Designated_Medicaid_Report_Apr_June_2010.pdf

- **Competition and Value:** To allow for greater competition between health care providers and ensure cost-effective purchasing strategies that promote value to taxpayers.
- **Pay for Performance:** To employ Medicaid purchasing and payment methods that encourage and reward service quality and cost-effectiveness by linking reimbursement to common, evidence-based quality performance measures, including patient satisfaction.

Under the global waiver, enrollees receiving primary and acute care services are enrolled in a capitated managed care plan. RIte Care is Rhode Island's Medicaid managed care program for children and families, providing coverage to over 120,000 people (of 166,500 total as of June 2010[2]), with eligibility up to 175% of the federal poverty level (FPL) for parents and up to 250% of FPL for pregnant women and children. The waiver requires a minimum of two plans be available for beneficiaries to choose from. Plans are currently offered by Neighborhood Health Plan of Rhode Island and United Healthcare of New England. RIte Care had a FY 2011 budget of $602 million. The state paid an average PMPM of $265.20 in FY 2011. Monthly premiums are paid for RIte Care coverage above 150% FPL.[3]

Support of the Global Waiver

On March 28, a *Wall Street Journal* op-ed endorsed the Rhode Island waiver, praising a reduction of $1.1 billion ($2.7 billion versus $3.8 billion projected) in Medicaid spending over an 18-month period. The article cited savings from audits of hospitals and nursing homes, as well as fraud prevention, in addition to LTC reforms. Despite the questions articulated below, and a pending state study of reported savings, many groups support the global waiver, including Rhode Island AARP.[4]

Opposition to the Global Waiver

A week earlier, on March 22, the *Center on Budget and Policy Priorities* released a brief cautioning, "Rhode Island's global waiver not a model for how states would fare under a Medicaid block grant."[5] The CBPP brief pointed out:

- The state did not need to agree to a global cap on spending to receive approval for the flexibility to implement these changes. Rhode Island could have implemented waivers separate from the block grants to allow for the shifting of Medicaid LTC populations from nursing facilities to home and community-based care. The same goes for savings achieved through competitive contracting on medical supplies.

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[2] http://statehealthfacts.org/comparemaptable.jsp?ind=774&cat=4

[3] http://www.rilin.state.ri.us/senatefinance/issue_briefs/ib6%20-%20rite%20care%20and%20rite%20share.pdf

[4] http://online.wsj.com/article/SB10001424052748704893604576198710204114624.html

[5] http://www.cbpp.org/files/3-16-11health2.pdf

- The global spending cap placed on combined state – federal expenditures is actually higher than what the state was projected to spend on Medicaid without the waiver in place. As a result, federal expenditures increased over the 18 month period the waiver has been active.
- State claims of savings under the global waiver are inflated by two factors. First, the infusion of Recovery Act funding for Medicaid through enhanced federal matching rates on spending increases the apparent savings achieved. Second, the waiver allowed the state to receive federal match on services previously funded entirely by the state. These do not result in an actual decrease in total expenditures, despite appearing as savings to the state.

House Budget Resolution

The House Committee on the Budget released the FY 2012 Budget Resolution Tuesday, April 5th proposing $5.8 trillion in spending cuts relative to the Congressional Budget Office's (CBO) current-policy baseline. Included in the budget, as was expected, is the transformation of federal Medicaid spending into block grant funding to states. The Budget Resolution is light on details, but block grants would be tailored to meet each state's needs and be indexed for inflation and population growth.[6]

According to a CBO analysis of the budget resolution, Medicaid would convert to a federal block grant program in 2013. Block grants would be increased annually with population growth and with growth in the consumer price index for all urban consumers (CPI-U). Although the repeal of certain provisions of the ACA would relieve some future Medicaid spending pressure to states, there would still be a need to reduce state Medicaid spending significantly, the report cautions. Additionally, the current growth in Medicaid spending outpaces that of the included growth factors for block grants amounts. Further, aside from the factors of inflation in the CPI-U, annual block grant amounts will not be responsive to economic downturns. To maintain current service, eligibility and payment levels in a downturn, states would need to either raise additional revenue or significantly alter the costs of administering their Medicaid program.[7]

House Budget Resolution - Federal Medicaid Expenditures vs. CBO Projection												
$ Billions	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2011-2021
Medicaid $ - CBO	275	260	275	293	306	325	345	367	392	422	455	**3,715**
ACA Medicaid Expansion - CBO	-	-	-	30	55	77	84	87	93	97	105	**628**
House Bill Savings vs. CBO	-	(1)	(13)	(45)	(63)	(73)	(82)	(102)	(112)	(131)	(150)	**(772)**
Savings excluding ACA repeal	-	(1)	(13)	(15)	(8)	4	2	(15)	(19)	(34)	(45)	**(144)**
Medicaid $ - House Budget	275	259	262	248	243	252	263	265	280	291	305	**2,943**
% Change Fed. Funding	0%	0%	-5%	-15%	-21%	-22%	-24%	-28%	-29%	-31%	-33%	**-21%**
% Change Fed. Funding (excluding ACA repeal)	0%	0%	-5%	-6%	-3%	2%	1%	-5%	-6%	-10%	-13%	**-5%**

Sources: FY 2012 Budget Resolution, April 5, 2011. http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf; "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," March 30, 2011. http://cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf

Sources: FY 2012 Budget Resolution, April 5, 2011. http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf; "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," March 30, 2011. http://cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf

[6] http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf

[7] http://cbo.gov/ftpdocs/121xx/doc12128/04-05-Ryan_Letter.pdf

The House Budget Resolution proposes significant cuts to Medicaid spending. However, more than three quarters of the savings in Federal Medicaid outlays would be achieved through repeal of the Medicaid coverage expansion to all individuals under 138% FPL in 2014. There would still remain a 5% reduction in Federal Medicaid funds flowing to states over the next decade, with individual year reductions of as much as 6% in the near term, and as much as 13% in the longer term. While significant flexibility would be granted to states in administering their Medicaid program, there would still be mounting pressure to reduce state spending.

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

The legislature continues to discuss SB 703. The bill would take advantage of provisions in the ACA to establish a Basic Health Program for individuals between 133% and 200% FPL. The state is currently evaluating how the implementation of a Basic Health Plan would impact future planning for the exchange, and how it would affect state costs relative to the alternative model of allowing those beneficiaries to purchase insurance in the exchange using federal subsidies.

In the news

- **California's Department of Managed Health Care Announces ACOs Should Expect Licensure Requirement**
  The California Department of Managed Health Care (DMHC) is currently considering the regulatory landscape for Accountable Care Organizations (ACOs) in California. At a public meeting on January 19, 2011, the DMHC announced it will most likely require ACOs to be licensed. Licensure requirements will most likely address financial solvency and stability, as well as measures to ensure quality of health care. (National Law Review)

Florida

HMA Roundup – Gary Crayton

The House and Senate budget bills continue to work their way through the chambers in the fifth week of a nine week session. The House is likely to pass its budget bill by Thursday with a Senate vote likely early next week. It is unknown whether the House and Senate bills will be reconciled through conference or through back-and-forth revisions.

There has been no change in the proposed provider rate cuts in either bill. Our expectation is that the final rate reductions will be somewhere between the House and Senate versions of 7% and 10%, respectively. Gov. Rick Scott has indicated that he will sign whichever bill is put on his desk. The only reductions to HMOs will occur through a pass-through of the rate cuts (estimated at $90.5 million to $140.9 million).

From our discussions with local officials, hospital resistance to the rate cut has been less forceful than we would have expected, perhaps reflecting their acknowledgment that reimbursement reductions are unavoidable given the political and budget conditions in the state. On the other hand, hospitals are continuing to fight back against the $600 to $700 million in cuts associated with the elimination of the Medically Needy program.

Effective April 1, 2011, reimbursements to all developmentally disabled (DD) providers are to be adjusted based on the Emergency Rule issued March 31, by Gov. Scott. DD providers are facing as much as 40% rate cuts from now through the end of June. Providers are protesting that they could handle gradual cuts through next fiscal year, but the current cuts will force facility closures.

In the news

- **Gov. Rick Scott orders immediate cuts to programs for disabled**
  Florida Gov. Rick Scott ordered deep cuts Thursday to programs that serve tens of thousands of residents with Down syndrome, cerebral palsy, autism and other developmental disabilities. Though a range of state services face cuts from this year's Legislature, the governor invoked his emergency powers to order the state Agency for Persons with Disabilities to immediately roll back payments to group homes and social workers by 15 percent — an amount providers say could put them out of business and threaten their clients' safety. (Orlando Sentinel)
- **Medicaid bill drops 90% rule**
  A Senate committee today eliminated a proposal that would have required HMOs to spend 90 percent of the money they receive on patient care. Instead, the Senate Health and Human Services Appropriations Subcommittee approved a profit-sharing plan backed by the managed-care industry. Under that plan, the state would receive a cut if HMOs make Medicaid profits of more than 5 percent. The move mirrored a profit-sharing plan that the House approved last week in its version of the Medicaid overhaul bill. (HealthNews Florida)

Georgia

HMA Roundup – Mark Trail/Megan Wyatt

The legislature is off this week and returns next week to resolve the FY 2012 budget. The Governor previously indicated he was seeking to have the budget resolved by April 14.

As mentioned last week, the Governor is likely to proceed with action on a Health Insurance Exchange in mid-April, invoking executive privilege after the legislative session has ended.

Illinois

HMA Roundup – Matt Powers

The Illinois Department of Healthcare and Family Services (HFS) held a meeting early last week to discuss a reexamination of the Medicaid hospital rate structure. Specifically, the state is interested in moving to more claims-based reimbursement rather than fixed

payments to hospitals. Under the current structure, only 58% of hospital reimbursements are based on DRG and per-diem claims. The remainder is paid under fixed quarterly payments designed to compensate Medicaid and uncompensated care providers. This structure has allowed the state to hold Medicaid reimbursement rates flat, making up the difference in negotiated supplemental payments, and trading an adaptive payment structure for predictable state Medicaid expenditures. This rate structure is a significant impediment to risk-based managed care penetration, and the state has indicated serious interest in completely rebuilding the hospital reimbursement rate structure. The next public meeting will be held on April 29 at 1:00 PM.

On the rate front, the 6% provider cut discussed in earlier issues remains on the table.

We are happy to announce that the State of Illinois awarded Health Management Associates the contract for Health Benefits Exchange planning. HMA, with subcontractors CSG, Wakely and others, will assist the state in developing strategic options for the HBE and options for an HBE eligibility, verification and enrollment system.

Michigan

HMA Roundup – Esther Reagan

The Senate is looking to vote this month on a proposal to levy a 1% tax on all insurance claims paid. The measure would raise an estimated $1.2 billion to support the state Medicaid program. The claims tax would replace the existing 6% tax levied on the 14 Medicaid HMOs and the $1.2 billion that tax raises, including federal matching funds. The claims tax proposal is in response to the expectation that Michigan's existing HMO tax will be ruled non-compliant by the federal government. The proposal, expected to be introduced in the next week, is reported to exclude Medicare claims from the tax.

New Jersey

HMA Roundup – Eliot Fishman

New Jersey's executive budget proposal identified two changes to the managed long term care (MLTC) program:

1. Carve in of state personal care assistant (PCA) plans and adult day care into the regular Medicaid managed care benefit. This is significant, as managed care enrollment is mandatory for the non-dual aged, blind and disabled (ABD) populations. This would begin with a state plan amendment on July 1.
2. A waiver for implementation of MLTC for other LTC benefits would be initiated.

The Governor and legislature are both supportive of MLTC , and a waiver is now in an early drafting phase. The budget won't be finalized until May or June, however, and the waiver timeline is still to be determined.

New York

HMA Roundup – Deborah Zahn

Among the executive budget proposals included in the final New York budget were the following:

- Two percent reduction in all provider payments (with some exemptions), resulting in "no less than" $345 million in savings.
- Permanent elimination of annual inflation factors.
- Required mandatory enrollment in Medicaid MLTC for persons twenty-one years or older residing in the community in need of home and community-based long term care services.
- Carved-in pharmacy benefits in to the Medicaid managed care benefit package.
- Establishment of Behavioral Health Organizations.

Texas

HMA Roundup – Dianne Longley

On March 31, the Senate Finance Subcommittee on Medicaid submitted its recommendations to the full Senate finance committee. Below is a link to the summary of that report. Recommendations on provider rates are as follows:

> *"Priority one recommendations included smaller cuts to provider reimbursement rates. The original Senate budget called for 30 to 40 percent cuts in the amount of money paid back to doctors and hospitals that treat Medicaid patients. The subcommittee recommended that there be no reduction in reimbursements to doctors and a very small reduction, 3 percent, to hospital and nursing home reimbursements. Committee Chair Senator Steve Ogden proposed a motion that would move the recommendations regarding hospital and nursing home reimbursements, accounting for about $600 million in general revenue, into a list of pending items. Ogden said that the committee should wait until another subcommittee, the Subcommittee on Fiscal Matters, charged with finding additional sources of non-tax revenue, submits its report. Until then, Ogden said he doesn't know how the state can pay for the recommended reimbursement rates given the current revenue picture. By pending the items, however, the Finance Committee is obligated to revisit the issue before it votes on a final budget."*
>
> Link to the full story: **http://www.senate.state.tx.us/75r/senate/new.htm**

The House is debating the budget today and, most likely, through the weekend. They plan to pass it out of the House this weekend, or Monday at the latest. The Senate has already stated they will not support the drastic cuts included in the House budget, but they are still struggling to come up with the revenue sources they need to reduce the cuts. The general feeling is that this will go to a special session, which is reported to begin on July 11 if it is necessary.

In the news

- **Hospitals, Advocates at Odds Over Preemie Bills**
  Hospitals are backing legislation that would eliminate Medicaid reimbursement for providers who induce labor before the 39th week of pregnancy. But hospitals are opposing a bill that would limit early inductions or C-sections that aren't medically necessary. The hospitals maintain that collecting and analyzing the data would put a strain on hospital resources and state budgets. (Texas Tribune)

OTHER STATE HEADLINES

Alabama

- **Hospital authority to declare bankruptcy**
  The Roanoke Health Care Authority voted to declare Chapter 11 bankruptcy and will close the Randolph Medical Center. The authority also voted to accept proposals next Wednesday on the sale of Southern Family Health Care. (Randolph Leader)

- **Alabama Legislature approves bill to shelter Medicaid from budget cuts**
  Alabama lawmakers approved a bill last Thursday, providing an extra $156 million to the Alabama Medicaid Agency and a few other agencies. The extra money was sought so that those critical agencies would see little reduction in spending when Gov. Bentley declares proration, or across-the-board spending cuts, in the General Fund. Bentley said two months ago that he would declare 15 percent proration in the General Fund. (AL.com)

Arizona

- **Arizona lawmakers approve $1.1 billion in budget cuts**
  The Legislature gave final approval Friday to a budget including $1.1 billion in cuts. Gov. Jan Brewer is expected to sign it next week. Half of the budget cuts, or $510 million, come from the Arizona Health Care Cost Containment System, primarily by freezing enrollment of childless adults in the Medicaid program. Hospitals have been bracing for the cuts while fiercely lobbying for an alternative plan that would tax their revenues and draw down more federal funding. (AZ Republic)

Connecticut

- The Department of Social Services is procuring an Administrative Services Organization (ASO) to administer the medical portion of its entire scope of health care programs. The Department's primary objective in contracting with an ASO is to improve quality of care and the care experience for our members, while reducing cost.

- **Malloy Retreats From SustiNet**
  Gov. Malloy issued a strong statement against SustiNet, claiming he does not want to add to the difficulty of balancing the state budget by assuming new

health care costs for the state, nor does he want to turn over $7 billion in health care spending to a private-public entity with no accountability to taxpayers. (Hartford Courant)

Louisiana

- **Private hospitals in Louisiana to collect extra Medicaid payments**
  Private hospitals across the state will collect $83 million in extra Medicaid payments under the Low-Income and Needy Care Collaboration Agreement program. Private hospitals agree to cover the costs of providing care to low-income and needy populations that are now served by public entities such as local public hospital districts or the Department of Health and Hospitals. Louisiana is the second state, after Texas, to get a waiver from CMS to operate such collaborations. (Times-Picayune)

- **Jindal: Prisons must be sold**
  The Jindal administration told legislators Wednesday that three state prisons need to be sold to stave off cuts in health-care programs for the poor. Part of the governor's proposed $24.9 billion state operating budget hinges on using $86 million from the prison sales to fund the state's Medicaid program. The money generated from prison sales would be one-time funds. The Medicaid expenditures are re-occurring. (The Advocate)

Minnesota

- **Health plans will return extra profits to the state**
  The state announced Tuesday that four major health plans - BlueCross BlueShield, HealthPartners, Medica, and UCare – agreed to a 1 percent cap on their profits on state business and will return any profit above 1 percent to the state next April. The governor's office did not have an exact estimate, but had the agreement been in place last year it would have meant a give back of about $85 million. (Star Tribune)

Montana

- **Schweitzer vetoes, amends 2 bills on health care reform**
  Gov. Brian Schweitzer on Friday vetoed two Republican bills requiring Montana to join a multistate lawsuit against federal reform and rejecting enforcement of an individual mandate. Gov. Schweitzer, in an amendment, cautioned that the multistate lawsuit would cost the state money. Additionally, he said he would sign the bill prohibiting state enforcement of the federal law's individual health insurance mandate if it includes a "legislative finding" that says the mandate would impose unneeded costs because it has "no low-cost public health insurance option." (Missoulian)

Nebraska

- **Committee proposes less of a cut to Medicaid providers**
  The Legislature's Appropriations Committee put forward a proposal in the 2011-13 state budget for 3 percent cuts to Medicaid and children's health insurance

providers, rather than the 5 percent reductions proposed in Gov. Dave Heineman's budget. It also voted to hold rates flat for providers serving behavioral health and aging programs. It is unclear if these reduced cuts will be enough to balance the budget, but the provider community strongly opposed anything higher. (Journal Star)

Ohio

- **Medicaid expansion to cost $2.3B**
  The Medicaid expansion under federal health care reform will cost Ohio taxpayers $2.3 billion from 2014 to 2019, according to new state projections. The revised projections highlight an estimated 50% increase in Medicaid enrollment. (Columbus Dispatch)

Oklahoma

- **Oklahoma Senate leader rejects insurance exchange plan**
  The Oklahoma Senate will not consider a bill to help establish a state health insurance exchange, an announcement that surprised Gov. Mary Fallin, who just this week urged lawmakers to pass the bill. The state was awarded a $54 million federal grant to set up the IT infrastructure for a health insurance exchange. (Bloomberg Business Week)

Rhode Island

- **RI readies for federal health care reform law**
  The state Senate voted 31-6 to pass legislation Tuesday creating a state health insurance exchange. The Senate bill also creates a board to oversee the exchange's operations. The board must deliver a progress report to lawmakers by Jan. 1, 2012. The bill now moves to the House. Meanwhile, a legislative panel plans to meet Wednesday to discuss details of how the exchange will work. (Boston Globe)

South Carolina

- **House OKs Medicaid cuts**
  The bill would enact a 3 percent across-the-board cut for doctors in addition to House authority already given to the state's health agency to make unspecified cuts in state payments to hospitals and doctors beginning July 1, part of an effort to save another $125 million. (The State)

Washington

- **House Dems outline plan to close $5 billion state budget shortfall**
  House democrats proposed a budget to close a $5 billion deficit on Monday and expect to pass it by Friday. The budget plan preserves the Basic Health Plan, which provides subsidized health insurance for the working poor, at a reduced level for the next two years. Gov. Gregoire's budget proposal had sought to eliminate the Plan. (Seattle Times)

West Virginia

- **West Virginia Moves Ahead on Exchanges**
  Gov. Earl Ray Tomblin signed legislation Monday - really, really quietly - to authorize the creation of an exchange. That puts the state right behind California, which became the first to authorize its exchange in September. The West Virginia legislation sets up the exchange within the insurance commissioner's office, and will cover the small-business market and the individual market in the exchange. (S.B. 408)

United States

- **A Public Opinion Surprise**
  A Kaiser Family Foundation survey revealed this week that Medicaid is a surprisingly popular program. Only 13% of respondents supported major cuts to the program, compared with 8% in supporting major cuts in Medicare and Social Security. (KFF.org)

- **Senate repeals health law's 1099 provision, sends bill to president**
  The Senate voted Tuesday, 87 to 12, to repeal the 1099 tax-reporting requirement in Democrats' healthcare reform bill. The measure now goes to the president, who is expected to sign it. (The Hill)

- **Cuts Leave Patients With Medicaid Cards, but No Specialist to See**
  Inflated state Medicaid enrollments and state budget cuts to Medicaid spending have resulted in many specialists refusing to accept Medicaid beneficiaries. The new health law calls for a temporary two-year increase in Medicaid payments for some primary care services, but this does not affect specialists. Under the law, states generally cannot roll back Medicaid eligibility, but they can cut Medicaid by reducing provider payment rates or by eliminating optional benefits. (New York Times)

- **UnitedHealth, Humana to See 0.4% Medicare Rate Rise in 2012**
  Medicare Advantage payments to U.S. health insurers will increase 0.4 percent in 2012, less than projected because of lower-than-expected spending on doctor visits, regulators said. CMS announced in February the private health plans may expect an average 1.6 percent gain in payments. (Bloomberg)

PRIVATE COMPANY NEWS

- **Acadia Healthcare Co.** acquired **Youth & Family Centered Services Inc**. Terms were not disclosed. Acadia is a portfolio company of **Waud Capital Partners**. Youth & Family, Austin, Texas, operates 13 behavioral healthcare facilities for youths and adolescents in eight states. The combined company will operate more than 1,700 patient beds and generate more than $260 million in annual revenue.

- **Steward bringing Lowell hospital into fold**
  Steward Health Care System yesterday unveiled its second deal in four days to buy a Massachusetts community hospital, saying it had signed a letter of intent to purchase 157-bed Saints Medical Center in Lowell, MA and convert it to a for-profit institution. The president of a group of 40 primary care doctors and 160 specialists affiliated with Saints said he opposed the alliance with Steward. The chief executive of rival Lowell General Hospital, which lost out in the bidding for Saints, said he would challenge the deal as state regulators review the proposed sale. (Boston Globe)

- **Kindred subsidiaries acquire four home health agencies**
  Kindred Healthcare said its subsidiaries have acquired four California home healthcare agencies from CareSouth Homecare Professionals, a privately held company based in Augusta, GA. CareSouth's four locations are in Southern California and San Jose, Calif. The assets had revenues of $11 million in fiscal 2010, according to a news release. (Modern Healthcare)

- **HealthPartners acquires Minn. System**
  HealthPartners said it acquired Lakeview Health System, Stillwater, MN. The deal, first announced last December, adds the 66-bed Lakeview Hospital to three-hospital HealthPartners based in Bloomington, MN. For the year ended Sept. 30, 2009, Lakeview Health reported a loss of nearly $292,000 on revenue of $99.7 million. (Modern Healthcare)

HMA Recently Published Research

Concurrent Care for Children Requirement: Implementation Toolkit

National Hospice and Palliative Care Organization

With Contribution from Brenda Klutz and Nicky Moulton

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law enacting a new provision, Section 2302, termed the "Concurrent Care for Children" Requirement (CCCR).

The District of Columbia Pediatric Palliative Care Collaborative (DCPPCC) and the National Hospice and Palliative Care Organization (NHPCO) are pleased to provide the Concurrent Care for Children Implementation Toolkit, which details information on the options available to states implementing Section 2302 or are considering expansion of pediatric palliative care services to children living with life-limiting or life-threatening conditions.

HMA is acknowledged in the publication.

Link to Report

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

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

MACPAC Public Meeting: *Monitoring Access to Care in Medicaid and CHIP*

Jennifer Edwards, Principal
April 15, 2011
Washington, DC

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

Tom Dehner, Principal – Regional Collaboratives, April 18, 2011

Michigan's 27th Annual Developmental Disabilities Conference: *Planning for Health Care Reform – A Michigan Update*

Eileen Ellis, Principal
April 20, 2011
East Lansing, MI

Health Care Leadership Forum: ***Health Care Reform Implementation in Michigan***

Eileen Ellis, Principal
April 26, 2011
Battle Creek, MI

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

National Council of Behavioral Healthcare Annual Conference - Primary and Behavioral Health Care Integration Leadership Summit: ***Key Considerations in Designing the Health Home SPA***

Alicia Smith, Senior Consultant
May 1, 2011
San Diego, CA

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": ***Medicaid Payment for Inpatient Hospitalizations: Now and 2014***

Donna Strugar-Fritsch, Principal
May 23, 2011
Phoenix, AZ