HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MEDICAID SAVINGS PROPOSALS IN FEDERAL BUDGET DISCUSSIONS

HMA ROUNDUP: DETAILS ON BUDGET AGREEMENTS IN CALIFORNIA, TEXAS AND OHIO; FEDERAL EXCHANGES REGULATIONS EXPECTED JULY 7

OTHER HEADLINES: ATTEMPTS TO BLOCK MEDICAID CUTS PLANNED IN ARIZONA, NEW JERSEY; EXCHANGE PLANNING IN NEW YORK, MISSISSIPPI AND MISSOURI

PRIVATE CO. NEWS: PROVIDER CONSOLIDATION CONTINUES

MEDICAID MANAGED CARE RFP CALENDAR UPDATED:
KENTUCKY CONTRACT AWARDS EXPECTED SOON

JUNE 29, 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: MEDICAID SAVINGS PROPOSALS IN FEDERAL BUDGET DISCUSSIONS

This week, our *In Focus* section looks some of the proposed changes to the Medicaid program being discussed as part of the federal FY2012 budget and debt limit negotiations. Medicaid and Medicare are targets by both Democrats and Republicans as potential sources of savings for the Federal budget and as such, it appears increasingly likely that Medicaid will be targeted for federal cost savings in the new fiscal year. In CY 2012, the federal government is projected to spend approximately $270 billion on Medicaid, while states' expenditures will exceed $209 billion. This week, we describe two Democratic cost savings measures originally proposed in the President's FY2012 budget, and a third proposed in the President's April 13 speech, "Framework for Shared Prosperity and Shared Fiscal Responsibility." A future issue will discuss Republican-led policy options.

1. Changes to Medicaid prescription drug and durable medical equipment (DME) policies;
2. Elimination or reduction in Medicaid provider tax amounts; and
3. Transition to a blended Federal Medical Assistance Percentage (FMAP) rate.

According to HHS, proposed Medicaid prescription drug and DME policy changes would save nearly $820 million in 2012 alone. When combined with the reduction in Medicaid provider tax amounts, these two proposals generate federal savings of $10.3 billion over five years. Potential ten year savings could be closer to $40 billion. These two policy changes were part of a package of Medicaid and Medicare cost savings measures in the President's FY2012 budget intended to offset the cost of the Medicare physician payment fix, estimated at roughly $54 billion over the next five years.

At this point it is difficult to project the outcome of these discussions. On the one hand, entitlement reform has become a focus point of the debt limit discussions and given the sensitivity to any Medicare-related proposals following Representative Ryan's budget plan, a focus on Medicaid seems likely. On the other hand, given the fragile condition of state finances, it is difficult to envision a scenario where the federal government attempts to balance its budget by shifting costs to the states, as the provider tax and FMAP proposals are designed to do. So while we describe the Democratic proposals currently on the table below, our sense is that other ideas are likely to be floated before we approach a resolution to the debate.

Medicaid Rx and DME Policy Changes

The President's budget included three changes intended to promote more competitive pharmaceutical pricing. Combined, the following proposed changes are estimated to generate 2012 federal savings of $600 million, 5-year savings of $4.4 billion, and 10-year savings of $12.9 billion. These changes would also generate state savings, though they could be offset by a concurrent decrease in drug manufacturer rebates.

- The first proposal would reduce the market exclusivity period from twelve to seven years. Originally implemented in the Affordable Care Act (ACA), the market exclusivity period policy was set at 12 years and applies only to brand biologic drugs. Additionally, this proposal would prohibit the practice of "ever-greening" whereby pharmaceutical manufacturers gain extended exclusivity through small changes to the product.
- The second proposal grants the Federal Trade Commission the authority to prohibit "pay and delay" agreements, which are used to keep generic drugs off the market. Pay-for-delay settlements have been permitted under a series of 2005 court decisions. In 2009, 19 pay-for-delay settlements were reached between manufacturers.
- The final prescription drug proposal would streamline pharmacy benefit contraction in the Federal Employee Health Benefits Program through a pooling of all drug purchases, intended to leverage better discounts from manufacturers.

The President's budget included a new proposed Medicaid savings measure, in the form of a federal upper payment limit (UPL) for Medicaid reimbursement of durable medical equipment (DME). Like UPLs for hospital and nursing home services, the payment limit will be tied to Medicare rates. State payments for DME would be prohibited from exceeding what Medicare would have paid for similar equipment. UPLs are designed to encourage competitive payments rates by state Medicaid programs. . This proposal is estimated to generate $210 million in 2012 savings, over $2.3 billion in 5-year savings, and $6.4 billion in 10-year savings. States would share in these savings as a result of decreased payment rates to DME suppliers.

Medicaid Provider Tax Limitations

Currently, 47 states utilize a Medicaid provider tax to supplement Medicaid payments to providers. These taxes are applied to the revenue of hospital providers, as well as intermediate care facilities, nursing facilities, managed care organizations (MCOs), and other providers. This tax revenue is generally applied to increased Medicaid provider rates, receiving federal match. In many states, due to federal matching rates, provider taxes represent a net gain to providers and the state, at a cost to the federal government.

As of October 1, 2011, states will be allowed to collect a tax on up to 6% of a provider's revenue. The President's budget proposal would phase down the tax threshold from 6% to 3.5% of provider revenue by 2017. This is estimated to generate 5-year federal savings of $3.5 billion, and 10-year savings in excess of $18 billion. These savings would not be shared by states, who will need to reduce provider rates or generate additional revenue to replace lost provider tax revenues.

It should be noted that the tax base of hospital providers is sufficient to support the current level of hospital taxes. Nursing homes and intermediate care facilities are more likely to see a negative impact from this proposal. However, a final budget agreement could differ significantly from the President's proposal and hospital provider taxes should not be considered to be off the table in budget discussions. Below, we profile current state provider taxes.

States with provider taxes in place, by provider type, FY 2011

	Hospital Tax	ICF Tax	Nursing Facility Tax	MCO Tax
Alabama	Y		Y	
Alaska				
Arizona				Y
Arkansas	Y	Y	Y	
California	Y	Y	Y	
Colorado	Y	Y	Y	
Connecticut			Y	
Delaware				
DC	Y	Y	Y	Y
Florida	Y	Y	Y	
Georgia	Y		Y	
Hawaii				
Idaho	Y		Y	
Illinois	Y	Y	Y	
Indiana		Y	Y	
Iowa	Y	Y	Y	
Kansas	Y		Y	
Kentucky	Y	Y	Y	
Louisiana		Y	Y	
Maine	Y	Y	Y	
Maryland	Y	Y	Y	Y
Massachusetts	Y		Y	
Michigan	Y		Y	
Minnesota	Y	Y	Y	Y
Mississippi	Y	Y	Y	
Missouri	Y	Y	Y	
Montana	Y	Y	Y	
Nebraska		Y		
Nevada			Y	
New Hampshire	Y		Y	
New Jersey	Y	Y	Y	Y
New Mexico				Y
New York	Y	Y	Y	
North Carolina		Y	Y	
North Dakota		Y		
Ohio	Y	Y	Y	
Oklahoma			Y	
Oregon	Y		Y	
Pennsylvania	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y
South Carolina	Y	Y		
South Dakota		Y		
Tennessee	Y	Y	Y	Y
Texas		Y		Y
Utah	Y	Y	Y	
Vermont	Y	Y	Y	
Virginia		Y		
Washington	Y	Y		Y
West Virginia	Y	Y	Y	
Wisconsin	Y	Y	Y	
Wyoming				

Source: "MEDICAID FINANCING ISSUES: PROVIDER TAXES." May 2011.
http://www.kff.org/medicaid/upload/8193.pdf

Medicaid Blended Matching Rate

A Democratic proposal to replace the various federal matching rates for Medicaid with a single blended FMAP rate has garnered significant attention in the last week.. States currently receive different federal matching rates for Medicaid and CHIP services, averaging around 57% and 70%, respectively. With the Medicaid expansion in ACA, the federal matching rate for newly eligible enrollees will begin at 100% and scale down to 90% by 2020.

Under the new proposal, the federal government would set a single blended matching rate in each state for all Medicaid and CHIP expenditures, not including administrative costs. The proposal would eliminate the administrative burden of determining if an individual is newly eligible or previously eligible under the ACA Medicaid expansion. However, in an Issue Brief released last week, the Center for Budget and Policy Priorities (CBPP) raises several concerns. The full CBPP report is available here.

Key concerns raised in the brief are highlighted below:

- To determine a blended FMAP rate, federal officials would need to estimate enrollment in each eligibility category, as well as federal and state expenditures under current eligibility and FMAP rates. Rates would likely be tied to a base year and adjusted based on projected Medicaid expansion enrollment. With uncertainty as to how individuals will behave, this task could prove extremely difficult. The CBPP suggests that this challenge could be alleviated by waiting to institute a blended FMAP rate until Medicaid expansion has stabilized.
- Additionally, under Medicaid expansion FMAP rates, states that have already provided coverage to parents and childless adults will receive different FMAP rates, adjusted year by year to equalize with other states by 2020. This, cautions CBPP, would increase the degree to which enrollment projections are crucial to the process of rate setting.
- The key point provided by the CBPP is that the blended FMAP rate will represent a significant shift in Medicaid costs to states. The administrative savings provided from eligibility simplification are overstated, as the CBPP believes HHS will provide regulatory guidance to reduce the administrative burden to states prior to the Medicaid expansion. Moreover, the CBPP believes that blended FMAP rates will be set below what states currently receive in federal matching funds for Medicaid services and that the blended FMAP rates will be used as a budget balancing mechanism in the future, achieving federal savings through a shift in Medicaid costs to the states, at the same time Medicaid enrollment is increasing by an estimated 16 million new beneficiaries.

With projected federal savings of $5 billion annually, we estimate the impact of state reimbursement would be roughly a 2.5% reduction in federal matching funds each year. It should be noted that according to a White House fact sheet, released after the President's April 13 speech (available here), the blended FMAP rate is intended to adjust automatically to provide additional federal funding to states in times of economic recession, eliminating the need for legislative assistance to states in fiscal crises.

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein / Jennifer Kent

After months of negotiations with Republicans, Governor Brown finally admitted defeat and negotiated a budget with the Democratic leadership that suspends plans for a November 2011 ballot initiative to continue the sales tax and other revenues for five years. While the Governor expressed frustration with the Republicans "almost religious reluctance" to new revenues, it has become clear that Democratic leaders and stakeholders will launch several ballot initiatives for the 2012 ballot to change the state's Prop 13 tax structure and how revenues are raised by state and local government.

Since the Governor's veto of the Legislature's budget last week, the biggest change is a $4 billion assumption of higher revenues in 2011-12, backed by $2.5 billion in "trigger" cuts in case some or none of that money materializes. Several questionable provisions in the Legislature's previous budget were also removed, including funding from selling state assets ($1.2 billion), money from the state's First 5 Commissions ($1 billion), and repayment from the federal government for old Medi-Cal debt ($700 million).

Key to the approval of this budget is the requirement that the Governor's Department of Finance will certify on December 15 whether the $4 billion projection is accurate. The department will be required to choose between its own forecast and the Legislative Analyst's, whichever is higher.

The "trigger" cuts are essentially in three tiers and are not specified other than in the program area (also known as "unallocated reductions"), based on how much of the extra $4 billion comes in.

- If the state receives $3 billion to $4 billion of the assumed revenue, the state will not impose additional cuts and roll over any balance of the deficiency into the 2012-13 budget.
- If the state receives $2 billion to $3 billion of the assumed revenue, the state will impose about $600 million of cuts and roll the remainder into the 2012-13 budget. The $600 million in cuts include:
    - $100 million cut to In-Home Supportive Services hours
    - $100 million cut to Department of Developmental Services
    - $15 million cut related to Medi-Cal Managed Care
    - $10 million cut to Department of Social Services in anti-fraud grants
- If the state receives $0 to $2 billion of the assumed revenue, the state will also impose as much as $1.9 billion in additional cuts, proportionate to revenues, focused primarily in K-12 spending.

All cuts would take effect Jan. 1, 2012, except for the school year reduction, which districts could impose starting Feb. 1, 2012.

In the news

- **Decision Due on Fate of Adult Day Health Care**
  The state of California wants to eliminate its current adult day health care network by Sept. 1, and given the 60-day period required for implementation of that, federal approval for axing the program is expected to come this week -- specifically, by midnight on Thursday. If the Sept. 1 elimination date is approved, that would give the state less than two months to evaluate the current program's patients, outline a plan to care for them, apply for a federal waiver, have CMS approve it and then launch the program. (California Health Line)

Florida

HMA Roundup – Gary Crayton

In the past week, CMS granted AHCA a 30-day extension of the current waiver, with the potential of several additional 30-day extensions to bridge between the current waiver, and the new state health reform implementation.

AHCA announced the award of the health reform redesign contract to Mercer Health & Benefits. The $2 million contract runs through June 30, 2012. Mercer will aid the state in transitioning Medicaid enrollees into a full managed care program. Mercer beat out Milliman Inc. for the contract.

Illinois

HMA Roundup – Jane Longo / Matt Powers

Governor Quinn has yet to sign the budget passed by the legislature several weeks ago. His administration is reportedly reviewing several non-health care related provisions, including changes to concealed-carry laws as well as the expansion of gambling licenses.

In the news

- **Illinois racing to erase $1.8B in Medicaid bills in June**
  Illinois is on track to pay nearly $2 billion in Medicaid bills by the end of June. Lawmakers on Wednesday approved a plan to delay a $365 million payment into Illinois' rainy day fund, and instead use that money to pay some of the billions of dollars Illinois owes to Medicaid providers. Comptroller Judy Baar Topinka said the state is racing to maximize a federal Medicaid match that expires at the end of the month. Illinois is getting 57 cents on the dollar for qualifying Medicaid bills that it pays this month. Starting in July, that rate falls back to the normal 50 cents on the dollar. Maximizing the $365 million, Topinka said, should allow her to pay $1.85 billion in Medicaid bills by June 30. She estimates Illinois could receive an extra $90 million to $100 million from the federal government. (Statehouse News Online)

Michigan

HMA Roundup – Esther Reagan

The Claims Tax bill (SB 248) proposes a 1% tax on all health related claims to replace an expiring 6% use tax on Medicaid MCOs. Since there was an assumption of its passage when the Senate and House approved the budget for the Department of Community Health (DCH), failure to pass it would create a significant hole of more than $100 million in the DCH budget. There have been suggestions that the legislature would move on the bill this week, however, rumors of insufficient votes may have created a delay. The Michigan Manufacturers Association has been lobbying heavily against the bill's passage. Additionally, the bill's sponsor reported opposition from the Attorney General's office to certain parts of the bill, a claim denied by the AG's spokesman. Governor Snyder has publicly said he expects the bill to pass before the adjourns for the summer.

Ohio

HMA Roundup – Alicia Smith

The conference committee on HB 153, Gov. John Kasich's $55.7 billion budget, approved the conference report out to the Senate and House on Monday evening. The Senate passed the budget on Tuesday, and the House passed the bill late Wednesday afternoon. The bill will go to the Governor who is expected to sign it.

The budget includes a $130 million Medicaid reserve fund carved out of Office of Budget and Management funding projections for caseloads, which were higher than estimated by the legislature's budget analysts. If OBM turns out to be right, the funding will be tapped. Some senators opposed the provision on the grounds that it gave the budget agency too much discretion with a large amount of money.

Additionally, the budget includes an additional $86.8 million in Medicaid funding for nursing homes, with the state share of those funds totaling $31.2 million. The funding was added through an amendment that also included 16 items on regulatory relief. A brief analysis of the nursing home amendment is available here: (Gongwer News). Below we summarize some of the key points:

- Reduces the statewide average rate reduction from 7.3% to 6.0%;
- Increases direct care from 100% to 102% of the 25th percentile in 2012 and 2013;
- Provides stop-loss provisions for facilities facing rate reductions of 10% or more in fiscal year 2012;
- Increases the direct services quality component of the price in 2013;
- Sets the rate for low acuity residents at $130 per day in 2013;
- Exempts nursing facility residents from Part B crossover payment restrictions;
- Recalibrates leave day policy; and
- Nursing facilities receive 100% of franchise fee gains from these changes.

Additionally, the amendment clarifies three points related to integration of care for dual eligible individuals. As a reminder, Ohio was not awarded a dual integration planning grant from CMS, but the administration declared it would pursue dual integration regardless. The amendment:

- Creates a joint legislative committee for unified long term care services and supports;
- Requires Medicaid to report to the committee at least quarterly on the dual eligible integrated care demonstration, unified Medicaid waiver, and other topics; and
- The legislature at any time can decide to enact legislation related to dual eligibles.

In the news

- **Ohio to rebid Medicaid contracts amid managed-care expansion**
  To better coordinate case management for 37,000 blind and disabled children on Medicaid, Ohio is reworking its entire $5 billion worth of contracts with private health plans covering 1.6 million low-income Ohioans – and hopes to attract more insurers to its managed-care program in the process. (Biz Journals)

Texas

HMA Roundup – Dianne Longley

The legislature passed the health care reform bill (SB 7) and it is now awaiting the Governor's signature. Of the two remaining "must pass" bills (SB1 and SB 2) related to the state's budget, SB 2 passed on Monday, while SB 1 passed the Senate Tuesday morning and is now headed to the House, where it is expected to pass. These two bills are primarily related to school finance issues.

Senate Bill 7 achieves at least $467 million in savings assumed in the state budget. The bill:

- Carves in prescription drug benefits into Medicaid MCOs with existing patient protections;
- Repeals the prohibition against managed care in South Texas;
- Includes co-payments for non-emergency visits to hospital emergency rooms;
- Implements Medicaid and CHIP reimbursement focused on patient outcomes;
- Creates the health care collaborative certificate, which provides safe harbor from antitrust lawsuits for providers who join together to provide care, promoting quality and coordination of services;
- Requires public reporting of hospital rates of preventable re-admissions and complications; and
- Authorizes Texas to enter into a health care compact.

In the news

- **In-Home Nursing Companies Facing Cuts Again**
  Companies that provide intensive in-home care to patients who might otherwise be in nursing homes could face big cuts under a cost-saving budget proposal the Health and Human Services Commission (HHSC) will consider today. A provision in the recently adopted 2012-13 budget directs the Department of Aging and Disability Services (DADS) to trim $15 million from the Community-based Alternatives, or CBA, program, but without cutting wages for direct care workers. Instead, the provision directs the program to dramatically lower administrative costs, which takes a direct hit at the businesses that care for the program's clients. Specifically, the budget provision says the CBA administrative costs should be lowered to the level of a different — and opponents say less-intensive — home care program, the Primary Home Care and Community Attendant Services. (Texas Tribune)

United States

HMA Roundup – Lillian Spuria

State health insurance exchange regulations are due to be released on July 7. These regulations are expected to have significant impact on states in the process of exchange planning, as well as the stakeholder community.

In the news

- **Overlapping Health Plans Are Double Trouble for Taxpayers**
  Dual eligibles account for 16% of Medicare's enrollees, but 27% of its spending. And they make up 15% of Medicaid's enrollment, but 39% of Medicaid spending, according to the Centers for Medicare and Medicaid Services. Chronic diseases and heavy use of nursing homes in this older population account for much of its outsize cost. But these aren't the whole story. How the bills are split between the two payers causes the federal government and the states, who share in the cost of Medicaid, to mismanage care and waste money on inefficient treatment, federal officials and health-care professionals say. While it is impossible to quantify how much of the cost of dual eligibles' care reflects this imperfect coordination between Medicare and Medicaid, the effect is significant, according to the consensus of many who have studied the issue. (Wall Street Journal)
- **White House Nixes "Mystery Shopper" survey of doctors**
  A controversial plan that would have "mystery shoppers" pose as patients to investigate how hard it is for patients to obtain primary care was been nixed by the Obama Administration, Tuesday. The program, announced two months ago would have assembled more than four thousand mystery shoppers to contact 465 physicians officers in nine states to "accurately gauge availability of Primary Care Physicians," according to the Federal Register. (International Business Times)

- **Concierge care for dual eligibles pushed as cost-cutting measure**
  Paying upfront fees for enhanced coordinated care for patients eligible for both Medicare and Medicaid might produce improved outcomes and lower program costs over the long run, according to a strategy that Rep. Michael Burgess, MD (R, Texas), has suggested to federal officials. Current CMS rules don't make concierge care arrangements impossible, but they are very difficult. Medicare allows participating physicians to charge fees for services not covered by Medicare. But the HHS Office of Inspector General has cautioned participating physicians against charging too much in the process for services reimbursable by Medicare. (American Medical News)
- **Medicaid health providers brace for new round of fee reductions**
  Cutting the number of people served by Medicaid is generally prohibited by the new national health law. So is denying coverage to patients for visits to hospitals and doctors, although "optional" benefits such as prescription drugs and mental health treatment can be dropped. But the one Medicaid cost that states have usually been able to cut without worrying too much about the federal government is reimbursement to the providers themselves. And that is what most of them are doing this year. At least 33 states have reduced provider fees for the fiscal year that starts July 1, according to a report by the National Association of Budget Officers. "Provider pay cuts are the lesser of three evils," says Matt Salo, head of the National Association of Medicaid Directors. (Stateline)

OTHER HEADLINES

Arizona

- **Court won't halt Medicaid cuts**
  The Arizona Supreme Court on Friday declined to stop proposed Medicaid cuts from taking effect next week or rule on whether the enrollment freeze is constitutional. Gov. Jan Brewer and state legislators approved wide-ranging reductions in AHCCCS to save the state an estimated $500 million and help balance the fiscal 2012 budget. But nearly half of the savings comes from capping programs that serve childless adults and parents earning above 75% of the federal poverty level, groups covered under a voter-approved expansion. If federal health officials approve the state's plan, which appears likely, enrollment for the childless-adult program would be frozen Friday. AHCCCS has estimated that about 135,000 people would lose coverage in the first year, either because they miss re-enrollment deadlines or their income goes up. (Arizona Republic)
- **Arizona revises Medicaid-freeze plan**
  Arizona officials would allow some young people to retain publicly funded health-care coverage under new changes to a plan for a partial enrollment freeze in the state's Medicaid program. Those young people from low-income families previously would have been dropped under the planned July 1 freeze for coverage of childless adults with incomes above a federal standard but below the current one used by the state. (Arizona Republic)

Georgia

- **Feds to keep fighting Albany hospital deal**
  The Federal Trade Commission says it will appeal a federal judge's ruling Monday that rejected a request for an injunction to block the sale of an Albany hospital. The FTC, in a statement Tuesday, reiterated its position that Phoebe Putney Health System's proposed purchase of Palmyra Medical Center would cause higher costs for area residents. (Georgia Health News)

Hawaii

- **Governor signals veto of health, other bills**
  Gov. Neil Abercrombie informed state House and Senate leaders Monday that he might veto nearly two dozen bills, including a bill intended to protect the state's landmark Prepaid Health Care Act. Lawmakers agreed to delete a provision that terminates the Prepaid Health Care Act on the effective date of federal legislation that is as good or better than the 1974 state law. The state law requires businesses to provide health insurance to employees who work 20 hours a week or more, which has put Hawaii among the national leaders in health insurance coverage. Abercrombie, according to a statement, placed the bill on the potential veto list because he believes it could have unintended consequences for the federal waiver that Hawaii received in order to implement the state law. (Honolulu Star Advertiser)

Kansas

- **Kansas Lieutenant Governor Jeff Colyer leads forum on Medicaid reform**
  Lt. Gov. Jeff Colyer said Wednesday Kansas must reform its Medicaid program in the face of rising costs and potentially staggering budget deficits. More than 200,000 Kansans receive Medicaid, including the elderly, the developmentally disabled, and low-income families and children. Kansas is budgeted to spend $1.2 billion on Medicaid services in the fiscal year beginning July 1. Total spending, including the federal match, is $2.8 billion. Colyer is leading a task force on Medicaid reform. Wednesday's forum was the first of several he will hold around the state. (LJ World)

Maine

- **Maine law phases out subsidized health care program**
  Maine Gov. Paul LePage has signed into law legislation that will phase out funding of a state program that provides subsidized health care coverage to just more than 8,000 state residents. The subsidized coverage in the DirigoChoice program—available to individuals and employees working at small companies—is funded through a 2.14% surcharge on health care claims. The new law, though, will reduce the surcharge to 1.87% next month, to 1.64% in July 2012 and 1.14% in July 2013. The surcharge will end Dec. 31, 2014, as will the DirigoChoice program under the legislation, L.D. 1043, that the governor signed earlier this week. (Business Insurance)

Massachusetts

- **Health plans that cut costs by limiting choices may be on the rise**
  More state employees chose this spring to enroll in plans that limit which providers they can see. Among the 78,000 people who had to renew their coverage in April and May, the percent who chose limited network plans increased this year from 19 to 31. Those plans, first offered by the Group Insurance Commission in April 2010, exclude some of the most popular but most expensive hospitals, such as those in the Partners HealthCare network. Enrollees were rewarded with lower annual costs and a three-month holiday on premium payments. Those who switched saved between $600 and $1400. (Boston Globe)
- **Legislators vow bill to curb health care costs**
  State legislative leaders made their strongest statements yet in support of placing significant cost controls on health care, predicting yesterday that they will agree on a bill as early as the fall. Senate and House leaders who spoke on the first day of a public hearing sponsored by Governor Deval Patrick's administration provided new details about the proposal they are writing, and what they consider the key elements needed to improve the quality of care for patients, while at the same time reining in payments to hospitals and doctors. (Boston Globe)
- **Mass. finds new system not cutting health costs**
  Early results show that putting doctors and hospitals on a budget — a payment method promoted as a way to curb health costs — has not saved money in Massachusetts, Attorney General Martha Coakley concluded in a report released yesterday. One reason, an investigation by her staff found, is that providers with market clout still appear able to negotiate high payments, just as they do under the traditional system that pays them a separate fee for each procedure or visit. (Boston Globe)

Minnesota

- **Budget talks focus on health and human services spending**
  With just two days to negotiate an agreement with Republican lawmakers before a potential government shutdown, Gov. Mark Dayton and Republican leaders are trying to find additional cuts in health and human services spending, the fastest-growing part of state government. Dayton and GOP legislative leaders plan to resume budget negotiations Wednesday morning, following two closed-door meetings Tuesday. But neither side was willing to say whether a shutdown can still be avoided or if a budget deal is even within their reach. Lawmakers must approve, and Dayton must sign, a new two-year budget deal by midnight Thursday, the last day of the current fiscal year. If they don't agree on a plan to close the projected $5 billion deficit, many state functions will be closed as of July 1. (Minnesota Public Radio)

Mississippi

- **Mississippi examines creation of health insurance exchanges**
  The state of Mississippi has until Jan. 1, 2014, to set up health insurance exchanges for individuals, small businesses and others as part of last year's federal health care over-

haul. Officials are trying to figure out how to most effectively set up and operate the program. About 60 people attended a meeting Thursday in Jackson on how the exchanges work and how they can best be set up and administered in Mississippi. (Clarion Ledger)

Missouri

- **Lawmakers to study creation of Missouri health care exchange**

  Senate President Pro Tem Rob Mayer, R-Dexter, has appointed an interim committee to study whether Missouri should follow federal guidelines and enact a health insurance exchange. A bill creating the "Show-Me Health Insurance Exchange" cleared the Missouri House this year with unanimous support. The measure died in the state Senate, however, after several Senators expressed concerns. (STL Today)

New Jersey

- **N.J. Senate committee approves resolution to stop Medicaid cuts**

  A resolution aimed at stopping Gov. Chris Christie sweeping changes to New Jersey's Medicaid program has survived its first legislative test. The Senate Budget Committee approved the resolution introduced by two Democratic senators on a party line vote, with all four Republicans voting against it. Christie plans to ask the federal government later this month to approve $300 million in cuts to the health care program for low-income people. Some of the savings would come from limiting eligibility and requiring patients to participate in managed-care programs. (NJ.com)

New York

- **Consensus reached on NY health exchange bill**

  A slimmed down, less restrictive version of Sen. Kemp Hannon's insurance exchange bill, S.5849, was agreed upon by the Cuomo administration and the state Legislature. The New York Health Benefit Exchange Act calls for setting up the exchange as a public benefit corporation with nine unpaid directors, seven of them gubernatorial appointees and two legislative. It leaves unsettled several key policy questions, but sets an April 1, 2012, deadline for resolving them. Among the unresolved issues: how to finance certain benefits' costs, and rules for extending certain benefits required under state law but not federal law to people who buy insurance in the exchange. (Crain's New York Health Pulse)

Oregon

- **Oregon House passes health care transformation bill to reduce costs**

  A bill presenting the centerpiece of Gov. John Kitzhaber's plan to save costs and improve health care passed swiftly through the Oregon House today. House Bill 3650 would attempt to transform health care in Oregon by creating coordinated teams of doctors, nurses, dentists and other providers focused on prevention and primary care. It passed 59-1 in the House with little debate and heads next to the Senate. (Oregon Live)

Puerto Rico

- **Puerto Rican Gov't Bolsters Beleaguered Medicaid Program**
  Puerto Rico's Health Insurance Administration will disburse $43 million to bolster the Medicaid system, which is threatened by a series of non-payments. The announcement made on Tuesday puts an end - at least for the moment - to the threat of a partial collapse of Mi Salud ("My Health," in Spanish), as Medicaid is known in Puerto Rico. The government agency will pay the $43 million to insurer Medical Card Systems, one of the three providers of Mi Salud, which on Monday warned that due to delays in payments it was in danger of being unable to continue to provide assistance to the public. (Fox News Latino)

PRIVATE COMPANY NEWS

- **Highmark to Acquire WPAHS**
  Highmark Inc. announced Tuesday morning that it is in the process of acquiring the financially troubled West Penn Allegheny Health System. The move was unanimously approved by the boards of both companies. The acquisition could challenge the dominance of the University of Pittsburgh Medical Center in the Pittsburgh-area market. UPMC has been in a protracted contracting dispute with Highmark. Unless it is renewed, the current contract between Highmark and UPMC will end on June 30, 2012, but members will still be able to access UPMC hospital services through mid-year 2013. (Health Leaders Media)
- **Metropolitan Health Networks, Inc. to Acquire Continucare Corporation**
  Metropolitan Health Networks, Inc., ("Metropolitan") and Continucare Corporation, ("Continucare") announced jointly today that they have entered into a definitive merger agreement whereby Metropolitan will acquire Continucare in a cash and stock transaction valued at approximately $416 million at the time of announcement. The transaction will create a company that provides care to over 68,000 Medicare Advantage and Medicaid customers. The combined company will own 31 primary care medical practices, utilize a network of more than 250 contracted, independent, primary care practices, and will operate in 18 Florida counties, including the Daytona, Miami, Ft. Lauderdale, West Palm Beach, and Tampa metropolitan areas. (MarketWatch)
- **Water Street Healthcare Partners Buys MarketLab**
  Chicago-based Water Street Healthcare Partners has acquired MarketLab Inc., a distributor of products to the clinical laboratory, hospital nursing and magnetic resonance imaging markets. The company is headquartered in Caledonia, Michigan. Water Street said that it is committing up to $70 million of equity financing to both acquire, and grow, MarketLab. (PE Hub)

RFP Calendar

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order. Contract awards in the Kentucky HMO RFP may be announced in the next week.

Date	State	Event	Beneficiaries
June 30, 2011	Kentucky RBM	Proposals due	N/A
July 1, 2011	Kentucky	Implementation	460,000
July 1, 2011	New Jersey LTC	Implementation	200,000
July 15, 2011	Washington	RFP Released	880,000
July 19, 2011	Massachusetts Behavioral	Proposals due	386,000
July 25, 2011	Louisiana	Contract awards	892,000
July 30, 2011	Kentucky RBM	Contract awards	N/A
August 3, 2011	Washington	Bidder's conference	880,000
August 15, 2011	Kentucky RBM	Implementation	N/A
August 31, 2011	Texas	Contract awards	3,200,000
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 17, 2011	Washington	Proposals due	880,000
December 19, 2011	Washington	Proposals due	880,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 1, 2012	New York LTC	Implementation	120,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA Recently Published Research

States in Action: States' Role in Promoting Meaningful Use of Electronic Health Records

The Commonwealth Fund

Principal Renee Bostick provided the following update to The Commonwealth Fund's April/May 2011 newsletter, *States in Action:*

> This issue of States in Action discusses the responsibilities, opportunities, and challenges for state Medicaid agencies in implementing programs to encourage providers to adopt electronic health records (EHRs). It focuses on the Medicaid Electronic Health Record Incentive Program, established by the Health Information Technology for Economic and Clinical Health (HITECH) Act in the American Recovery and Reinvestment Act of 2009 and jointly administered by the Centers for Medicare and Medicaid Services (CMS) and state Medicaid agencies. The issue includes lessons from states' early experiences in implementing the Medicaid EHR Incentive Program.

The EHR Incentive Program is just one of many health information technology (HIT) initiatives supported and encouraged by the federal government. With state Medicaid agencies facing competing demands as well as limited resources, states can benefit from aligning their efforts to promote health information technology and collaborating with other agencies, states, and stakeholders to share or reduce costs, limit duplication, and avoid confusion for providers. (Link to Brief)

UPCOMING HMA APPEARANCES

Michigan Association of Health Plans' 2011 Summer Conference: "The Case for Integration: Mental Health and Substance Abuse Services and Primary Care"

Alicia Smith, featured speaker

July 16, 2011

Boyne Falls, Michigan

National Commission on Correctional Health Care: "Health Administrator Boot Camp"

Donna Strugar-Fritsch, featured speaker

July 8, 2011

Las Vegas, Nevada

The Health Industry Forum: "The Evolution of State Health Insurance Exchanges"

Jennifer Kent, featured speaker

July 13, 2011

Washington, D.C.