HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: A REVIEW OF REPUBLICAN GOVERNORS' MEDICAID REFORM PROPOSALS

HMA ROUNDUP: ILLINOIS EXCHANGE DEVELOPMENT MOVING FORWARD; DUAL ELIGIBLES IN MICHIGAN TO BE NOTIFIED OF HEALTH PLAN OPTIONS;

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IN FOCUS: REPUBLICAN GOVERNORS' MEDICAID REFORM PROPOSALS

This week, our In Focus section reviews a letter published by the Republican Governors Public Policy Committee on Tuesday, August 30. The letter outlines more than 30 policy proposals generally intended to grant states greater flexibility in managing their Medicaid program. While the governors assert their belief that the Affordable Care Act (ACA) should be repealed, the letter indicates that the proposals, put forward by the governors and other state officials, should be considered regardless of the status of ACA implementation. The letter includes input from all 31 Republican governors (including Puerto Rico and Guam), but is not intended to imply that every governor supports each individual proposal. Further, none of the proposals put forth would require mandatory participation by any state administration, but rather allow states greater flexibility to manage their Medicaid program, with looser eligibility rules, elimination of waiver approval for programmatic changes, and additional freedoms. These proposals are the foundation for a Health Care Summit hosted by the Republican Governors Public Policy Committee, October 24-25, 2011 in Washington, D.C.

We have pulled out some of the proposed policy solutions that we find interesting and provide our take on the impact, likelihood, and feasibility of each proposal. We note that our take on these proposals reflects the opinions of the authors, not necessarily that of the firm.

Solution #1: *Provide states the option to define and negotiate a broad outcome-based Program Operating Agreement (POA) with CMS. The only notification required would be when a state elects to update or change an agreed upon POA. States would publicly report the outcome measures established within the POA on a routine basis. CMS oversight should only be triggered when there is a significant deviation in the reported versus projected measure. The number of measures should be finite. Eliminate the onerous federal review process for operating the Medicaid program within each state, such as requiring waivers for designing systems, benefits, services, and payment and reimbursement rates. The relationship between the federal and state government should be based on the principles of value-based purchasing rather than rigorous, complex and lengthy processes.*

Our Take: This proposal is designed to greatly increase states' flexibility to design and administer their Medicaid programs by restricting federal oversight to reviewing compliance with outcomes-based performance metrics. Given that the federal government funds 57% of Medicaid costs, we are skeptical that HHS/CMS will be open to abdicating oversight responsibility to such an extent.

Solution #2: *States can create a specific "dashboard" to measure accountability utilizing recognized measures of quality, cost, access and customer satisfaction that reflects the states' priorities and permits an assessment of program performance over time. Where possible, states will utilize the expertise of state, local and national organizations that have developed appropriate measures. In many cases, states already have developed extensive measures of quality and accountability, including customer satisfaction. These dashboards should utilize those processes instead of recreating onerous administrative burdens for states.*

Our Take: We believe improving program accountability across states through standardized, evidence-based performance measures is something that both the federal government and the states will be interested in pursuing. We could envision a task force being established to pursue these objectives.

Solution #3: *Repeal Maintenance of Effort (MOE) requirements established by the PPACA. This would return flexibility to states and allow them to make changes in eligibility that are essential to the efficient and effective operation of their programs.*

Our Take: This will be a contentious issue as many Democrats view MOE repeal as a step backward on the road to ACA implementation. That said, advocates for MOE repeal will argue that the federal government should have funded the mandate as opposed to shifting the costs to states without providing adequate financial support. (We note that some states have already requested MOE waivers due to budgetary duress.) Interestingly, many of the states that have the most expansive Medicaid eligibility rules, and therefore stand to benefit most from MOE repeal, are states with Democratic governors such as the two largest Medicaid states, New York and California. It will be interesting to see where those governors come out on this issue.

Solution #4*: Program integrity should be the responsibility of the state. Currently, common practice is to utilize federal contractors for program integrity initiatives, most of whom are not familiar with individual state programs and simply engage in "pay and chase," where claims are paid and then states seek payments afterward. Instead, states and their staffs should be able to utilize existing federal funding sources to proactively fight fraud and abuse activities.*

Our take: It makes sense to us that states have greater responsibility for, and benefit financially from, attacking fraud and abuse in the system.

Solution #7: *Federal and state financial participation in the Medicaid program should be rational, predictable and reasonable. As aforementioned, the dramatic expansion of Medicaid scheduled for 2014 could have dire consequences on the management of the program. Because of PPACA, there are essentially two different programs within Medicaid and states are expected to maintain duplicate systems for program eligibility and program financing.*

Our take: Under the Affordable Care Act, the federal matching rate for "newly eligible" beneficiaries will be substantially higher than for "previously eligible" beneficiaries,, beginning at 100% FMAP in 2014 (in many states) and scaling down to 90% by 2020. This is the first time that the amount of federal financial participation in the program will vary based upon a beneficiary's eligibility group and it results in a number of issues that will be challenging for states to address including how to define "previously eligible" and whether to continue using systems and processes linked to the previous eligibility definitions. Given the added complexity this provision creates, the Republican governors are advocating for a more straightforward formula for federal financial participation. Whether this means a "blended matching rate" for all Medicaid and CHIP beneficiaries, as the Obama Administration supports, or a "block grant" type arrangement is left unclear.

Solution #11: *Provide states with the flexibility, without requesting waivers or initiating the state plan amendment process, to pay providers based on providers meeting quality care and value-based criteria rather than the current fee-for-service approach. Allow innovative payment methodologies to encourage care coordination for all Medicaid eligibles, without exception. Other options could be capitated payments, shared savings, and incentive arrangements when such payments encourage coordination, reduce cost shifting and improve care delivery.*

Solution #12: *Provide states with the ability to implement bundling projects (a provider is paid an amount for a discrete event, such as hip replacement, and that provider pays other providers for all necessary care for the event, with providers sharing in savings).*

Our take: Solutions #11 and #12 both turn to payment reform, shifting away from fee-for-service, encounter-based payments, to a payment structure that rewards quality, value, and coordination of health care services. In a 2009 report on Massachusetts payment reform efforts, the Rand Corporation concluded that bundled payments offered the greatest potential reduction in Medicaid spending. A single bundled payment for a discrete event or treatment of a chronic condition could reduce Medicaid expenditures by nearly 6%, according to Rand's modeling.[1] While very few states indicate interest in similar time-limited Medicaid "global payment" or "integrated care hospitalization" program demonstrations available under ACA, more states would likely be interested in an open-ended opportunity to design their own initiative.

The potential for savings may be very real, however the proposal seems to imply that the greatest obstacle to Medicaid payment reform is the federal CMS waiver approval process. Even without the need for waiver approval to implement payment reforms, states would still need to work closely with the provider community, much of which is opposed to significant payment reforms. That said, we note that more than 20 states have passed legislation related to the exploration of and formation of Accountable Care Organizations (ACOs). To the extent that the provider community is engaged in and supports the development of ACOs in the future, bundled payments and other quality and value-based delivery models may be seriously pursued.

Solution #13: *Give states the ability to use only one managed care organization if client volume in an area is insufficient to support two. CMS now requires at least two managed care organizations in each area.*

Our take: This is a provision that is likely supported by rural states where the ability to establish sufficient scale is an obstacle in building a sustainable managed care program.[2] We would expect managed care organizations to favor this proposal, while patient advocates (who strongly support beneficiaries' ability to choose among plans) and hospitals (who would lose negotiating leverage) are likely to oppose the measure.

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1 http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR733.sum.pdf

2 We would note that states already have the ability to request rural exceptions in their managed care waivers under which all Medicaid enrollees in rural counties are assigned to the single MCO. Choice of providers within the MCO must be available. In addition, federal policy allows states to request permission to establish a "preferred option" in counties with only one managed care plan. For those counties the Medicaid members are assigned to the MCO and have the option to disenroll from the MCO to the fee-for-service program at any time.

Solution #14: *Establish reasonable, rational and consistent asset tests for eligibility. Amend PPACA's definitions of income to count child support payments (current law in Medicaid), and reverse the use of Modified Adjusted Gross Income (MAGI) in order to avoid new eligibility for higher-income Americans.*

Our take: The Affordable Care Act explicitly eliminates asset tests as component of eligibility determination. As such, theoretically someone that has one million dollars in assets but income less than 138% FPL would be eligible for Medicaid beginning in 2014. This is obviously an outcome that states would reasonably like to avoid. That said, while there may be ideological merits to this provision, the practical impact is likely to be small. Asset tests are a permitted criteria for Medicaid eligibility determination today, but according to Kaiser State Health Facts, only four states actually impose them for children (Texas, South Carolina, Missouri and Utah) as of January 2011[3]

Solution #15: *Give states the flexibility to streamline and improve the eligibility determination system by contracting with private firms.*

Our take: Currently, private organizations can support the enrollment process for eligible beneficiaries but are not permitted to make eligibility determinations. This provision would enable states to outsource the entire eligibility and enrollment function in order to improve efficiency and lower costs. With the eligibility simplification measures outlined by the Affordable Care Act, and the role that exchanges and exchange navigators will play in determining eligibility, our sense is that the eligibility determination process will be far more transparent than it is today. As such, we believe that allowing for private sector administration of this function (with appropriate safeguards in place) may be less of a contentious issue going forward.

Solution #18: *Eliminate the obsolete mandatory and optional benefit requirements. Provide states the flexibility to design appropriate benefit structures to meet the needs of their recipients in a cost-effective and efficient manner as part of the state's negotiated plan.*

Our take: In our opinion, the current system of mandatory and optional benefit categories engenders perverse incentives which detract from the goals of improving quality and efficiency in the program. As such, this is an issue that warrants further discussion in our opinion, though we would expect resistance from patient advocates, providers and HHS/CMS for whom this provision could lead to significant changes in benefit composition based on budget conditions and the political party in power at the time.

Solution #19: *Eliminate benefit mandates that exceed the private insurance market benchmark or benchmark equivalent. Design benefit packages that meet the needs of specific populations, including allowing a plan that puts non-disabled populations into Section 1937 benchmark plans. Amend Section 1937 to include cost-sharing provisions and allow states the authority to enforce cost sharing.*

Our take: This provision aligns with the Republican position that Medicaid beneficiaries bear some level of financial responsibility for benefits received. Pushback to this provision is likely to be loudest from provider groups, including safety net hospitals, which

[3] (http://www.statehealthfacts.org/comparetable.jsp?ind=228&sort=290&st=3)

are likely to view benefit restrictions and higher cost sharing as a source of uncompensated care and a cost shift from the state to them.

Solution #20: *Purchase catastrophic coverage combined with an HSA-like account for the direct purchase of health care and payment of cost sharing for appropriate populations determined by each state.*

Our take: This proposal would represent a drastic shift in the design and function of the Medicaid program. We would expect significant resistance from CMS on this point. However, it is possible that it could be pursued under a limited pilot program in low-risk populations. The Healthy Indiana Plan (HIP) is based on a Medicaid program model that includes an HSA. Programs following in the design of HIP could receive greater federal support.

Solution #21: *Provide states the option of rewarding individuals who participate in health promotion or disease prevention activities.*

Our take: This proposal could gain broad support as it fits under the widely-held belief that increased spending on prevention and healthy lifestyles equates to significant future savings in reduced incidences of chronic disease and hospitalizations. However, with the significant federal funding participation in Medicaid, and the increase in federal funding participation under the ACA Medicaid expansion, we believe CMS may not wish to relinquish approval of such measures.

Solution #24: *Lower the threshold for premium payments to 100% FPL to encourage a sense of shared beneficiary ownership in health care decisions.*

Our take: The concept of individual financial responsibility on the part of Medicaid beneficiaries is a key ideological concept across many Republican proposals to modify or reform the Medicaid program. Democrats would likely oppose such a measure as it places an even greater financial burden on low-income individuals. Additionally, the provider community could oppose anything related to increased individual financial responsibility if they believe it could reduce their likelihood of getting paid.

Solution #26: *At a state's discretion, permit states to redesign Medicaid into multiple parts. Medicaid Part A would focus on preventive, acute, chronic and palliative care services; and Part B would focus on long-term supports and services (LTSS). This would enable a state to better manage the different needs between populations who only need LTSS. Eligibility for Part B would be based on income and functional screening of an individual's long-term services and LTSS needs.*

Our take: While this proposal would significantly restructure a state's Medicaid enrollment, it would primarily serve to redesign and realign the enrollment buckets in which beneficiaries reside, particularly with the expansion of Medicaid benefits to all individuals below 138% of the federal poverty level. Further, it allows states a different way of customizing their benefit package around the needs of the Part A or Part B population. While we acknowledge that the design presents the state with the opportunity to prevent individuals from receiving LTSS, there is nothing in the proposal to suggest that intention.

Solution #27: *Engage in shared savings arrangements for dual eligible members when the state can demonstrate the Medicare program reduced costs as a result of an action by a state Medicaid program.*

Our take: We believe states would take advantage of this proposal, as currently there is no benefits to states from reducing Medicare expenditures for dual eligibles. Shared savings arrangements could take hold as part of the CMS efforts to integrate care for dual eligibles.

Solution #30: *Give states the flexibility to enroll more members, especially families, in premium assistance programs including Medicare benefits, when it is cost efficient. Medicaid should be the payer and insurer of last resort.*

Our take: We see a potential for pushback from CMS and patient advocate groups on the appropriateness of instituting premium assistance programs for dual eligible individuals, many of whom have limited physical and cognitive ability. However, it could be implemented in a limited pilot program approach, especially within lower-risk populations.

Solution #31: *Extend Medicare coverage of skilled nursing facilities by 60 days.*

Our take: We would expect significant opposition from the federal government, as a 60 day extension of SNF coverage would only serve to aggravate the current federal budget deficit. Given the current budget debate climate, we would be surprised to see this proposal gain any significant traction.

HMA Medicaid Roundup

Illinois

HMA Roundup – Matt Powers / Jane Longo

Senate Bill 1555 requires the state to create the Illinois Health Benefits Exchange by October 1, 2013. The bill also created the Illinois Health Benefits Exchange Legislative Study Committee to conduct a study regarding implementation of the Exchange. The Committee must complete their study and report their findings by September 30, 2011. The legislative study committee met for the first time recently to hear testimony from various parties, including consultants engaged by the state in the exchange design process. The fall veto legislative session will be a critical milestone in the exchange development process. The legislature must approve exchange design plans to allow time for submittal to the federal government by June 2012. The study committee met again in Springfield on Tuesday, August 30, to take testimony from the public and stakeholders.

In other news

- **Judge gives preliminary nod to disabilities deal**

  A federal judge on Tuesday gave her preliminary approval to a settlement that could eventually help thousands of disabled, low-income Illinois residents live more independently while saving the state money in the process. If the judge gives the deal her

final approval, it could affect not only 20,000 low-income people with physical disabilities and mental illnesses living in Cook County nursing homes, but also thousands more nursing home residents throughout Illinois. Illinois could save $2,320 per person annually by housing Medicaid-eligible people with disabilities in houses and apartments with community services instead of in nursing homes, advocates and state officials agreed. (NECN.com)

- **Illinois Medicaid's managed care effort stumbles**

  Many doctors and hospitals are refusing to join the new Medicaid program of HMO-style care for people with serious disabilities, which the state hopes will better coordinate care and lower costs for some of its neediest recipients. The providers' rationale: They dislike the bureaucratic hassles and cost-cutting measures associated with managed care. The ranks of those who have said no, for the moment, include prominent medical centers and physician practices with a long track record of serving the disabled, among them Northwestern Memorial Hospital, Rush University Medical Center, the University of Chicago Medical Center, Children's Memorial Hospital and Loyola University Health System. Because of the situation, hundreds if not thousands of vulnerable, chronically ill individuals are being forced to find new doctors, some of whom appear ill-equipped to handle their needs, according to consumer advocates and families. (Chicago Tribune)

Michigan

HMA Roundup – Esther Reagan

The Health Claims Assessment bill, which passed last Wednesday, is awaiting Gov. Snyder's signature. There has been indication that he is likely to sign the bill into law before the Labor Day weekend. The bill serves to replace both the Medicaid HMO plan tax, as well as the mental health prepaid use tax, through an assessment on all paid health insurance claims. We previously reported that a late addition to the bill was an annual limit on funds raised through the assessment. It is clear now there will be no retroactive adjustment of the assessment amount. However, if the assessment value exceeds the limit set forth in the bill, future year assessment amounts with be prospectively reduced.

Elsewhere, enrollment letters are being sent to dual eligible individuals to notify them that they can voluntarily enroll in a Medicaid health plan that also offers a Special Needs Plan (SNP) beginning October 1.

Texas

HMA Roundup – Dianne Longley

Medicaid rate schedules are being released this week. So far, rates appear to be in line with the Medicaid rate reductions set by the legislature earlier this year. As we have previously noted, the rate reductions represent a 3% cut in rates for physician services and a 5% cut in hospital rates.

In other news

- **Parkland's CEO to Move to New Role**

  Parkland Memorial Hospital will soon have new leadership. The Dallas hospital's Board of Managers decided on Tuesday to move Dr. Ron Anderson to a new position at the end of his term as CEO. Anderson's current contract ends Dec. 31. In a statement, Dallas County Judge Clay Jenkins, the county's top elected official, said he appreciated Anderson's decades of experience to Parkland and the medical. (NBC - Dallas Fort Worth)

- **Rural Texas hospitals prepare for cuts**

  In the coming months, rural Texas hospitals are facing cuts to programs and services that jeopardize already strained resources. Hospital administrators are bracing themselves and trying to come up with solutions before Thursday, when "cost-saving" measures to Medicaid determined during the 82nd Legislature go into effect. About 12 percent of Texas' population lives in rural areas, which have a higher percentage of people on federally funded health care. Most rural hospitals are already strapped for resources. (My San Antonio)

- **Feds audit Medicaid in Texas amid report that orthodontic spending same as 49 states combined**

  Federal auditors are examining Medicaid charges for dental braces for Texas children after a television station found the state spent as much on orthodontic services last year as all 49 other U.S. states combined. Texas spent $184 million on orthodontic treatment for children under Medicaid last year — nine times more than California spent during the same time period, according to state records obtained by WFAA-TV during a six-month investigation. The state says the federal-state program for the elderly, poor and disabled is not supposed to pay for children to get braces for cosmetic reasons, though some dentists and orthodontists told WFAA that does happen. The state attributes at least some of the difference between what Texas and other states are spending to a 2007 court ruling that found Texas children needed improved access to health care under Medicaid. (Washington Post)

- **Texas Curbs Spending by $1B by Deploying EHRs, Telehealth in Prisons**

  The Texas prison system's adoption of electronic health records and telemedicine helped reduce state spending by about $1 billion over the past decade, FierceEMR reports. The Texas Department of Criminal Justice implemented an EHR system developed by Business Computer Applications. Health care providers use the EHR system to track medical, dental, mental health and pharmacy services at 120 state prisons, 3 federal prisons and 15 youth prisons, as well as county jails. Michael Bourdeau, director of correctional managed care information systems for UTMB, said the adoption of the EHR system helped bring Texas' daily medical costs per inmate to $9.67. In comparison, California spends about $41.25 in daily medical costs per inmate. In addition to an EHR system, Texas' prisons use a telemedicine system that provides access to health care providers at the UTMB and Texas Tech University. (iHealthBeat)

OTHER HEADLINES

Arizona

- **Ruling: AHCCCS copays break law**

  A federal appeals court ruled Wednesday that mandatory copayments charged to Arizona's poorest residents violate federal law. The three-judge panel of the 9th U.S. Circuit Court of Appeals said federal health officials failed to show how the copays, imposed in November after a seven-year court battle, served any purpose besides cutting the state's Medicaid budget. Raising copayments for more than 200,000 of Arizona's poorest residents and making them mandatory, the judges said, helped balance the state budget but didn't meet that federal standard. The copays, which range from $4 to $30, were first approved by lawmakers in 2003 and were in place for about four months before a class-action suit was filed and a federal judge put them on hold. That stay was lifted in November by a separate appeals-court panel. (AZ Central)

California

- **Insurers question plan to cover adult day care patients**

  When Gov. Jerry Brown eliminated the Adult Day Health Care program, his administration quickly designated the state's Medi-Cal managed care plans as the entity to ensure that many of the program's 35,000 seniors are cared for. But the trade group that represents 39 California managed care plans has fired off six pages of questions about the plan, asking state officials to "temper beneficiaries' expectations" of what insurers may or may not do to replace the program. The letter from the California Association of Health Plans also reminds Department of Health Care Services officials that managed care plans "are not responsible for" services that the day care centers provided, such as day-to-day supervision; socialization; or routine physical, occupational or speech therapy. (California Watch)

- **Will Ending Adult Day Health Care Services Save State Money?**

  The California Department of Health Care Services recently sent a letter to most Medi-Cal beneficiaries participating in the adult day health care program, informing them that their coverage for ADHC will end Dec. 1. In Sacramento, legislators are holding hearings on how to help 36,000 elderly and disabled residents continue to receive ADHC-type services in other programs. A lawsuit pending in federal court challenges whether the state can adequately supply replacement services for this population. ADHC providers have accused the department of bad planning for rushing elimination of the services. It is still unclear how much all of those programs will cost the state and exactly how many beneficiaries they will cover. It is also not definite how much money will be spent during this transition, and how much will be spent in the future. The state has allocated $85 million to end ADHC as a Medi-Cal benefit. About $42 million funded a three-month extension of the ADHC program. That leaves the state with $43 million for the transition, including outreach, the administrative cost of tracking and enrolling ADHC beneficiaries in a managed care plan, expanding the two waiver plans, the $60 per person monthly enhancement, the rural contractor, additional money for PACE and extending IHSS hours. (California Health Line)

Colorado

- **Colorado scaling back Medicaid after drastically underestimating numbers, cost**

  Two years after lawmakers expanded Medicaid to cover poor adults without children, the state is vastly scaling back the program because the number of people eligible for coverage is nearly three times as high as first projected and the cost of insuring them is almost nine times original estimates. The new coverage followed the 2009 passage of major health care legislation that allowed the state to impose a fee on hospitals while drawing down matching federal money to expand Medicaid coverage. House Bill 1293 was estimated to generate about $1.2 billion for Medicaid programs when fully phased in, and the measure called for expanding eligibility levels. A new eligibility class was created for adults without dependent children and whose income was up to 100 percent of the federal poverty level, or $10,890 per year for an individual. (Denver Post)

Georgia

- **State Medicaid program to request more money from governor**

  The state agency that runs the Medicaid and PeachCare for Kids programs will ask Gov. Nathan Deal to find more than $570 million in state coffers to cover shortfalls in the 2012 and 2013 budgets for the health care programs. The request, presented Thursday to the Department of Community Health board, should not surprise the governor's office. Lawmakers this spring borrowed money from Medicaid to cover funding gaps in other state programs -- including a major shortfall in the state employee and retiree health care plan. Lawmakers also delayed payments owed by Medicaid to give the budget some relief. Whether the state can find the money to close the Medicaid and PeachCare gaps is unclear. The shortfall for the 2012 fiscal year -- which is the current budget year -- is more than $213 million. The shortfall for 2013 is about $359 million. Medicaid officials said Thursday that operating without the additional money would be difficult. (Atlanta Journal Constitution)

Kansas

- **Kansas inks $135 million contract for Medicaid screening**

  Kansas this week signed a $135 million contract for a new state computer system designed to centralize applications for Medicaid and other joint state-federal assistance and insurance plans for those in need, state officials announced Tuesday. The contract revealed Tuesday broadly calls for Accenture Inc., the U.S. arm of a Dublin-based international global management, consulting and technological outsourcing firm, to develop by 2013 an $8- million centralized online network to screen and process requests for food stamps and various health services for children, pregnant women, people with disabilities and those who are elderly. The new system, formally known as the Kansas Eligibility Enforcement System, or KEES, also is designed to be the state's alternative to plans for a new state-run, health-insurance exchange required by the new federal health care law in 2014. (Kansas Reporter)

Massachusetts

- **Boston hospital system to snap up Medicaid health plan**

  Partners HealthCare, one of the largest systems in Boston, announced Aug. 11 that it plans to acquire Neighborhood Health Plan, which manages care for 240,000 members, most of whom are enrolled in Medicaid or Commonwealth Care, a state-sponsored insurance plan for adults. The two companies said no money would change hands and that NHP would remain its own corporate entity. However, NHP would become an affiliate of Partners, like Brigham and Women's Hospital and Massachusetts General Hospital are part of Partners. Partners promised to make grants to NHP to "improve the infrastructure and expand programs for community health centers." Partners spokesman Rich Copp said no specific amount is being announced at this point, but he said it would be "significant." (American Medical Association)

Montana

- **Lindeen plans to plow ahead on creating health insurance exchange for Montana**

  State Auditor Monica Lindeen said Thursday her office will continue to work on setting up a federally required Internet marketplace for health insurance in Montana — even though the 2011 Legislature refused to give the state authority to create its own version. Lindeen said she'll be sending two staffers, including her chief legal counsel, to a conference next month in Arlington, Va., where federal health officials will explain how states could work in partnership with the feds to create a state-based "health insurance exchange." States are required to have an exchange by 2014, but the 2011 Montana Legislature refused to authorize one, as majority Republicans said they wanted nothing to do with implementing the 2010 federal health reform law. The law says that the federal government will create exchanges in states that don't do it on their own. (Billings Gazette)

New Mexico

- **Medicaid error could cost state $100 million**

  Just when it looked as if New Mexico might catch a break with higher tax revenues, an accounting error is dampening the mood. And state human-services officials are looking to lawmakers as well as its congressional delegation for help. Accounting errors made in the Medicaid program during former Gov. Bill Richardson's administration have the Human Services Department scrambling to figure out the full extent of the financial hit. Estimates hover around $100 million, but the figure isn't definitive. (Santa Fe New Mexican)

North Carolina

- **N.C. Employers Embrace Medicaid Medical Home Network**

  Drug maker GlaxoSmithKline, pharmacy chain Kerr Drug, analytics firm SAS, the state and Blue Cross and Blue Shield of North Carolina announced that their employees will be able to voluntarily enroll in the nonprofit Community Care of North Carolina network. The network, made up of physicians, hospitals, social service agencies and county health departments, is credited with saving the state millions of dollars since its founding in 1998. In recent years, the program has expanded to serve some Medicare

patients under a special waiver. The Community Care network – and its participating physicians – each receive a small fee of about $2.50 per enrollee per month in order to boost coordination of care, such as hiring nurse care mangers or improving data systems to support the doctors' practices. Employers offering the network to workers will also pay the network a fee for those who participate. (Kaiser Health News)

- **N.C. Medicaid cuts take hold in October**

  New cuts to health services for the poor take hold in October, with the elimination of eye exams and glasses for adults on Medicaid. Medicaid recipients are receiving notices about reductions, eliminations or other changes to an array of health services in the next few months. The $354 million Medicaid cut in the state budget includes limits and other changes to services totaling $16.5 million. In addition to getting rid of routine adult eye care and glasses, the state plans to limit payments for deep cleaning dental treatments for people who have gum disease to once every two years from once a year. Outpatient physical therapy, occupational therapy and speech therapy for adults will be limited to three visits a year. The Medicaid service reductions were included in Gov. Bev Perdue's proposed budget and adopted by the legislature. More health care limits may come as the state Medicaid office looks for more savings in the program. Lanier Cansler, head of the state Department of Health and Human Services, said the department looked for the least-damaging cuts. (Charlotte Observer)

South Carolina

- **State's rural hospitals in critical condition**

  Many of the state's 30 rural hospitals, once the heart of their communities, are struggling to find a niche in a health care system that values the complicated procedures offered at large hospitals much more than the basic and emergency services provided by rural hospitals. Less than half the beds in those 30 hospitals were filled on an average day from 2007-09, according to a Medicaid/Medicare study. Their occupancy rate dropped by 8 percent during that period. Ten of the smallest 13 hospitals operated at a financial loss in those years; the seven smallest lost $34.5 million. (The State)

United States

- **Insurers See Growing Risks As Well As Revenues In Medicaid Managed Care**

  The Medicaid expansion in 2014 provides a potential bonanza for insurers if the law survives court challenges and opposition by Republican contenders for the White House. The expansion will add 16 million enrollees, mostly in private plans, bringing the total nationwide to about 65 million and raising the stakes for controlling costs. With the expansion of Medicaid managed care underway in at least 20 states and the surge of enrollment in 2014, insurers expect $60 billion in new annual revenues. But Medicaid managed care is a risky business. Many new enrollees are older and sicker than the people health plans typically cover. The political environment is fierce, and insurers face resistance from doctors, hospitals and perhaps patients. Investors see the warning signs. As it became clear Medicaid managed care would grow, stock prices surged - Amerigroup's price doubled between early 2010 and last month. But a poor earnings report in July sunk its share price from a high of $75 that month to $47 Friday. Competitors such as Molina and Centene also fell. (Kaiser Health News)

- **Medicaid fetches higher drug rebates than Medicare**

  Medicaid patients have received higher rebates for their prescription drugs than patients enrolled in the Medicare Part D program, according to an August report by the Dept. of Health and Human Services Office of Inspector General. Medicaid, which uses a statutory inflation-based formula to set discounts, collected $2.9 billion in rebates from drug manufacturers for every $6.4 billion in expenditures in 2009, the report found. Part D, which relies on rebates negotiated with drug companies, collected only $4.5 billion in rebates for every $24 billion worth of spending. House and Senate Democrats have introduced legislation that would create incentives for drug manufacturers to provide larger rebates for seniors in Part D plans. Drug companies that give larger rebates to low-income seniors would receive a proportional reduction in the rebates they are required to pay the government. (American Medical Association)

- **Study: States enrolling more children in CHIP**

  Even as states struggled to meet their Medicaid obligations during the recession, most increased the percentage of kids covered under the Children's Health Insurance Program (CHIP). Thirty states boosted the proportion of eligible kids covered under the federal-state program and the national average moved from 80 percent to nearly 85 percent, according to a new report by the Robert Wood Johnson Foundation and the Urban Institute. Preliminary U.S. Census data suggests that expansion is continuing, the study says. That's good news for state policy makers charged with expanding overall Medicaid enrollment by 39 percent under the Affordable Care Act. According to the study's authors, the same techniques states used to sign up a rising number of uninsured kids during the recession could be applied to adults in 2014 when Medicaid income eligibility is ordered to expand from 100 percent of the federal poverty level to those earning 133 percent or less. (StateLine)

PRIVATE COMPANY NEWS

- **Humana Announces Agreement to Acquire Arcadian Management Services**

  Humana Inc. announced today that it has signed an agreement to acquire Arcadian Management Services, an Oakland, Calif.-based Medicare Advantage HMO with approximately 64,000 members in 15 U.S. states. Terms were not disclosed. Arcadian Management Services was founded in 1996 and is dedicated to improving the health of its members by providing access to high-quality, cost-effective health care. Most Arcadian members reside in small or medium-sized communities across the U.S. Arcadian's 2010 revenue was $622 million. The transaction is subject to both federal and state regulatory approvals and is expected to close in late 2011. Humana's acquisition of Arcadian is not expected to materially impact its financial earnings guidance for the year ending December 31, 2011. (Humana)

- **Riverside Expands Hospice Platform**

  The Riverside Company's American Hospice platform company entered the Texas market with the acquisition of two hospices from Hospice Care of the Southwest. With

the additions, American Hospice now has locations in six states, including Arizona, Georgia, New Jersey, Oklahoma, Virginia and Texas. Hospice Care of the Southwest is retaining its primary operation in Amarillo, Texas. (Riverside Company)

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.

Date	State	Event	Beneficiaries
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
September 15, 2011	Washington	RFP Released	880,000
September 15, 2011	Nebraska	RFP Released	60,000
September 15, 2011	Kentucky RBM	Contract awards	N/A
October 1, 2011	Kentucky	Implementation	460,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 1, 2011	Kentucky RBM	Implementation	N/A
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 7, 2011	Hawaii	Proposals due	225,000
October 15, 2011	New Hampshire	RFI Released	N/A
November 14, 2011	Hawaii	Contract awards	225,000
December 1, 2011	Hawaii	Implementation	225,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 15, 2012	New Hampshire	Contract awards	N/A
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
Early 2012	Nebraska	Contract awards	60,000
April 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
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 WELCOMES…

Izanne Leonard-Haak, Principal – Harrisburg, PA

Most recently, Izanne has served as the Acting Deputy Secretary in the Office of Medical Assistance Programs (Acting Medicaid Director), a position she has held for about a year now. Prior to this post, Izanne served as the Chief Operating Officer of the Medicaid Program, as well as the Chief of Staff, the Director of Managed Care Development, and the Director of Planning and Budget Development. These positions spanned a 26 year career in the Medicaid office, but this was during Izanne's second time in the Medicaid Program. Earlier in her professional life, Izanne served as the Director of Medical Assistance Operations, overseeing Medicaid claims processing and the information system, and prior to that as a Policy Analyst. In between these two stints in Medicaid, Izanne worked in the Office of Income Maintenance as a Special Assistant, as Director of the Bureau of Policy Development, and as Director of Income Maintenance Operations (manag-

ing the 67 County Assistance Offices). Izanne started her career in Washington, DC at the U.S. Department of Health and Human Services, where she worked in The Medicaid Bureau as the Supervisor of Utilization Control, and as an Analyst in the Office of Youth Development and Delinquency Prevention. Izanne earned her Bachelor of Arts degree at the Immaculata College, and her Masters of Science degree in Public Administration at the University of Southern Illinois.

HMA Recently Published Research

Children's Health Care: Making Great Strides

Jennifer Edwards, DrPH, HMA Managing Principal

It is an often-repeated criticism that we have not seen monumental change in health care quality in the past decade despite the "call-to-arms" of the Institute of Medicine's seminal report, *Crossing the Quality Chasm*. Just quantifying the problem - 98,000 lives a year lost to medical errors and a finding that less than 50 percent of care meets standards of clinical evidence - has not mobilized enough changes in health care delivery to register much improvement in health outcomes. There is some new work quietly percolating, though, that has the potential to make major improvements in health outcomes for children. (Link to report)

California 1115 Medicaid Waiver

Stan Rosenstein, HMA Principal Advisor

The historic renewal of the California 1115 Medicaid waiver will bring billions of new federal dollars to the state's hospital safety net system, enabling California to begin full-scale implementation of national health care reform and jump start reform of its public hospital delivery systems. The 1115 waiver provides California flexibility to use Medicaid funding in new ways to improve its program. (Link to report)

Florida Reviews Taxpayer Funded Hospitals

Elaine Peters, HMA Principal

The new Florida Commission on Review of Taxpayer Funded Hospital Districts is considering "whether it is in the public's best interest to have government entities operating hospitals, and what is the most effective model for enhancing health care access for the poor." Governor Rick Scott, a former for-profit hospital executive, has said he is "confident this new Commission will protect Florida taxpayers, and at the same time, the Commission's guidance will help provide Floridians a high-quality health care system." The Commission will evaluate how effectively privately owned and nonprofit hospitals can care for the uninsured and low-income populations, a role generally filled by public hospitals. Expected outcomes include a more rational approach to compensating hospitals. (Link to report)

Achieving Efficiency: Lessons from Four Top-Performing Hospitals

Sharon Silow-Carroll, HMA Managing Principal

Jennifer Edwards, DrPH, HMA Managing Principal

Aimee Lashbrook, HMA Senior Consultant

Despite widespread acknowledgment of waste and inefficiency in the U.S. health care system, there have not been dramatic breakthroughs that point to more cost-effective alternatives. But changes under way at leading health care organizations suggest significant improvements in quality and value can be achieved. A new report synthesizing findings from four hospital case studies showcases opportunities for all hospitals to achieve greater efficiency. The case studies focus on four of the 13 Leapfrog Group–designated "Highest Value Hospitals." (Link to report)

UPCOMING HMA APPEARANCES

Stifel Nicolaus Healthcare Conference, 2011

Tom Dehner, Dianne Longley, Greg Nersessian

September 7-8, 2011

Boston, Massachusetts

Osteopathic Physicians and Surgeons of California, 22nd Annual Fall Conference

Dennis Litos, featured speaker

September 9, 2011

Monterey, California

Keys to Success: Unlocking Critical Issues Involved in Creating an Arizona Health Insurance Exchange – Sponsored by St. Luke's Health Initiatives

Donna Strugar-Fritsch, featured speaker

September 16, 2011

Phoenix, Arizona

America's Health Insurance Plans – Medicaid Conference

Vernon Smith, faculty

September 14, 2011

Washington, DC

Western Association of Medicaid Pharmacy Administrators

Vernon K. Smith, keynote speaker

September 19, 2011

Anchorage, Alaska