

## National Update

### In This Issue

["Why Not the Best?"  
A Tool for Hospital  
Improvement](#)

[Accountable Care  
Organizations: 3-D  
Health Care Coming  
to a Locale Near You](#)

[The Community  
Living Assistance  
Services and Support  
Program and Long-  
Term Care](#)

[Opportunities Under  
the 340B Drug  
Pricing Program](#)

[HMA Launches  
Investment Services](#)

[State Legislative  
Notes](#)

[CMS Terminated  
Providers  
Memorandum](#)

### Fast Facts

HHS [issued](#) "Meaningful Use" guidelines for EHRs.

18 of 29 states running their own high-risk pools have developed agreements with HHS as

### "Why Not the Best?" A Tool for Hospital Improvement



Improving hospital performance is becoming increasingly critical to hospitals' survival as 1) more health care purchasers - consumers, businesses, Medicaid programs, etc. - demand, examine and use public reports on hospital quality and cost in their health care decisions; and 2) reimbursement moves in the direction of performance-based payments.

The Commonwealth Fund's ["Why Not the Best?"](#) (WNTB) website promotes a high performance health system by disseminating quality-related data and examples of top hospitals' best practices and tools. Health Management Associates (HMA) is pleased to have been a partner in that work since the website's development in 2007 and its launch in 2008.

The website allows users to see how well individual hospitals are performing on recommended process measures, patient experience, readmission and mortality rates, patient safety measures (central line associated bloodstream infections) and costs. Additional patient safety, outpatient and other measures will be added in coming months. WNTB uses publicly available data collected by the Centers for Medicare and Medicaid Services (CMS) and other reliable sources. Hospital leaders can compare their hospital performance with peer organizations and national benchmarks, and identify areas in need of improvement.

of mid-July.

HHS launched [Healthcare.gov](#) for information on insurance coverage and health reform.

3 out of 5 dual eligibles have multiple chronic conditions, according to a [study](#).

HHS [shifted \\$25 million](#) in funding to state AIDS Drug Assistance Programs.

Connecticut and Washington, DC have applied to [expand](#) Medicaid early under health reform.

The House and Senate [approved](#) a six-month Medicare "doc fix" to temporarily prevent a cut in physician payments.

NGA issued a [report](#) on State roles in delivery system reform as national health reform is implemented.

## Quick Links

[About Us](#)

[Expertise](#)

[Services](#)

## Events

### "Health Reform and its Impact on the States"

[Vern Smith](#)

*Keynote Speaker*

Council of State Governments, Midwest Legislative Conference  
August 10, 2010  
Toronto, Ontario

### "The Future of Medicare and Medicaid and the Impact of Health Care Reform on Michigan Consumers and Providers"

[Vern Smith](#)

*Keynote Speaker*

Aging Services of Michigan Leadership Institute  
August 11, 2010

The website then provides a wealth of information to help hospitals *improve* their quality, efficiency, etc. HMA has prepared for the website more than 35 case studies of high-performing hospitals and summary tables of key tools and strategies.

This information provides best practices and guidance to audiences ranging from hospital and hospital system CEOs and other administrative leaders, to directors of performance improvement departments, to clinical leaders working directly with front-line staff.

The case studies, many based on multi-day site visits, provide in-depth information about management and clinical strategies that appear to raise the hospital's performance. The reports also discuss the hospital's measurement and data collection methods, results and trends in select measures, challenges encountered and addressed, and lessons for other hospitals. For example, one hospital that excels in patient satisfaction scores utilizes the following (for more information see [case study](#)):

- an organizational model in which staff nurses are given a strong voice in determining clinical practice, standards, and quality of care;
- minimization of patient transfers; patients generally stay in the same room from admission through discharge, reducing transfers that could result in medical errors, falls, missed treatments, and lost belongings, improving staff and patient satisfaction as well as clinical outcomes and efficiency; and
- financial incentives to unit managers whereby about 20 percent of their annual bonus is tied to meeting patient satisfaction goals.

HMA also prepares summary reports and tables that assess and synthesize the key factors and strategies that contribute to superior performance across multiple hospitals studied. We highlight organizational, environmental, and cultural factors, as well as specific administrative and clinical tools and processes. For example, hospitals that lead the pack in practicing recommended "core measures" in heart attack, heart failure, pneumonia, and surgical care typically:

- develop "care maps" or standard protocols that establish evidence-based procedures as the default for specific clinical conditions;
- engage hospital physicians and other relevant staff in the design of care maps, helping to ensure "buy-in" and actual use; and
- build tools to facilitate adoption of care maps, such as electronic checklists to guide care decisions, including reminders of acceptable "exceptions" to the

Plymouth, Michigan

**MMIS 2010  
Making Medicaid  
Information  
Sustainable**

[M. Renée Bostick](#)

August 15-19, 2010

Portland, Oregon

**"Prisoner Health Care  
Payment Issues:  
Medicaid, Rate Cap  
Legislation and More"**

[Donna Strugar-Fritsch](#)

Midwest Association of  
Correctional

Administrators

Aug. 31 - Sept. 2, 2010

Grand Hotel

Mackinac Island, Michigan

**"Health Reform and  
Medicaid"**

[Vern Smith](#)

AHIP

September 15, 2010

Washington, DC

**"Federal Health Care  
Reform and its Impact  
on Medicaid Services"**

[Vern Smith](#)

South Carolina Medicaid

Managed Care Conference

October 21, 2010

Columbia, South Carolina

**"Health Reform,  
Medicaid and Medicaid  
Managed Care"**

[Vern Smith](#)

*Keynote Speaker*

Annual Meeting, Medicaid

Health Plans of America

November 5, 2010

Washington, DC

**Contact Us**

Phone:  
1-800-678-2299

[Email](#)

[Locations:](#)

Atlanta, Georgia  
Austin, Texas  
Boston, Massachusetts  
Chicago, Illinois  
Columbus, Ohio  
Indianapolis, Indiana  
Lansing, Michigan  
New York, New York  
Sacramento, California  
Tallahassee, Florida  
Washington, DC

recommended protocol and the need to document them.

Feedback has indicated that these case studies have been helpful and are widely used.

The Commonwealth Fund plans in coming months to add new types of data to 'Why Not the Best?' and new case studies prepared by HMA highlighting hospitals with low readmission rates, "Highest Value" hospitals (as designated by the Leapfrog Group), and hospitals that achieve the lowest infection rates.

While some strategies presented are common building blocks necessary for basic quality improvement across many types of performance measures, we are also discovering new and innovative practices that appear to be making a difference in specific areas. In a post-national health reform world that is moving toward greater transparency and paying for quality and efficiency rather than quantity, these kinds of performance improvement strategies may be critical for hospitals' survival.

For more information, contact [Sharon Silow-Carroll](#), Principal, at (212) 575-5929.

## Accountable Care Organizations: 3-D Health Care Coming to a Locale Near You

### *Building a Bridge to Value through Accountability*

Increasing the value of health care-providing better quality care at a lower cost-is crucial to the success of the new federal health care reform legislation known as the Patient Protection and Affordable Care Act (PPACA). The legislation includes numerous opportunities for providers to engage Medicare and state Medicaid programs in strategies that seek to better align payment with high quality in a health care system that largely pays for the quantity and intensity of care, regardless of outcomes. A recent payment reform concept included in the legislation is the Accountable Care Organization, or ACO. An ACO is a provider-led organization that manages the full continuum of patient care, quality, and overall costs for a defined population. In exchange for limiting risk-adjusted spending growth against a benchmark, the ACO is rewarded a share of those savings from the payer to be distributed among participating providers.

The ACO model incorporates payment reform strategies such as pay-for-performance (P4P) and the Patient-Centered Medical Home (PCMH). P4P is a method to reward providers, typically primary care physicians or hospitals, with bonus payments or other incentives when they meet or exceed

Join Our Mailing List!

performance thresholds on particular quality measures, but its influence is limited to those selected measures. The PCMH model takes a whole-patient approach by paying primary care providers (PCPs) additional per member fees or enhanced rates to support a variety of activities, such as post-discharge care planning, extended office hours or adoption of information technologies, with the idea that better primary care will reduce hospital readmissions, ER visits and unnecessary tests, for example. But rewards to PCPs based on these outcomes may be at the expense of lost income to hospitals and specialists rather than being aligned with them to collaborate on efficiency and coordination across the full spectrum of the delivery system.

### ***Who Wants to Be an ACO?***

The idea behind the Medicare Shared Savings program included in the Patient Protection and Affordable Care Act is to promote local accountability for a Medicare patient population under parts A and B. The definition of an ACO and many features of the shared savings demonstration derive from the Medicare Physician Group Practice (PGP) Demonstration, which included a mix of integrated delivery systems and multi-specialty practices, including Geisinger Health System, one of the best known models of an accountable care organization.

Providers eligible to become an ACO under the Medicare demonstration include:

- Physicians in group practice;
- Networks of individual practitioners (e.g, Independent Practice Associations, or IPAs);
- Partnerships or joint ventures between hospitals and physicians;
- Hospitals employing physicians; and
- Other groups as determined by the Secretary.

A number of these existing types of groups are gearing up for the demonstration or moving ahead with their own ACO plans. Recently, the national hospital alliance Premier Health announced an ACO collaboration that will include 19 health systems with 70 hospitals. However, these early adopters are the exception to a largely fragmented, decentralized delivery system. Indeed, the goal of the demonstration is to encourage more integration and organization in the health care delivery system. A number of health plans, as well, are launching their own pilots with hospitals and IPAs to burnish their ACO credentials. Pediatric hospitals and providers will also have an opportunity to participate in a Pediatric ACO demonstration over the same time period as the Medicare demonstration, 2012 through 2016; grants will be awarded through collaboration with state Medicaid programs.

### ***What Medicare Wants***

According to CMS, ACOs will facilitate coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs, and in exchange will share in the savings that result from more efficient and effective care. An eligible ACO must meet seven structural requirements defined in the statute, most of which require more specificity and clarification from the Health and Human Services (HHS) Secretary. An ACO must:

1. Have a formal legal structure to receive and distribute shared savings.
2. Have a sufficient number of primary care professionals for the number of assigned beneficiaries, with a minimum of 5,000 members.
3. Have sufficient information regarding participating ACO health care professionals to support beneficiary assignment, and for determining payments of shared savings.
4. Have a leadership and management structure that includes clinical and administrative systems.
5. Have systems to a) promote evidenced-based medicine, b) report necessary data to evaluate quality and cost measures and c) coordinate care.
6. Demonstrate it meets patient-centeredness criteria.
7. Agree to participate in the program for at least three years.

### ***We've Only Just Begun-to Ask Questions***

Despite intense interest and enthusiasm, a review of ACO requirements reveals plenty of questions and concerns, of which a few are considered here.

#### *Clinical integration v. market competition*

State and federal anti-trust and anti-kickback laws are part of the current landscape to prevent price-fixing among competitors. The legislation's intent is that antitrust is not an impediment to the clinical integration required of ACOs to participate in the demonstration. Some physician groups and hospitals are awaiting guidance from the Justice Department and the Federal Trade Commission to ensure that regulators will not interpret collaboration as collusion. Others have expressed concern about providers acquiring excessive market power and dominance that may justify regulation of ACO payment rates in some regions.

#### *Assigned beneficiaries, but no "lock-in"*

In the Medicare shared savings demo, beneficiaries are to be assigned to an ACO based on previous care patterns, but there is no beneficiary lock-in of patients to specific providers. The assignment is necessary to establish per capita benchmark spending against which the ACO's shared savings will be determined. The ACO will have to organize its services to incentivize beneficiaries to (voluntarily) seek care within the ACO. This lack of patient lock-in is a distinguishing feature between the ACO model operating in a fee-for-service environment, and a managed care capitation model. Notably, Medicare Advantage (MA) plans cannot participate in the demonstration. Some advocates are questioning whether beneficiaries will understand the difference

between an ACO and MA. Theoretically, capitation is the ultimate provider accountability model. Risk-sharing could be an ACO feature, through partial capitation or bundled payments for particular episodes of care, but providers do not have to bear risk. Will the demonstration spell the end of Medicare Advantage plans or the rise of MA 2.0?

*Show me the savings*

A participating ACO would qualify for shared savings only if actual, risk-adjusted per beneficiary spending levels are below a yet-to-be-determined "benchmark" level. (There is no downside risk; an ACO will not incur a payment penalty if savings targets are not achieved.) Since ACOs would still generally operate in a FFS environment, can they effectively improve quality and bend the cost curve when the model does not restrict patient provider choice or impose any financial risk to providers?

*Can everybody just get along?*

The ACO model presupposes that doctors and hospitals can work together in their local markets-that they can change the culture-when in reality, relationships are often defined by market power and mired in mistrust. Will primary care providers be willing to work only for their ACO? Will specialists join or balk at ACOs? How can safety net institutions leverage their community strengths as a valued partner in a local or regional ACO? Perhaps Medicare's purchasing power - and the unsustainable path of Medicare spending - will be enough to make physicians, hospitals and specialists sustainable partners in patient-centered care. Beyond getting along, how savings get divided-that is, shared-among the ACO's participating providers may be the true test of collaboration.

***Incrementalism We Can Believe In***

Whatever the hopes and cautions expressed about ACOs, there is consensus that U.S. health care must evolve, and ACOs represent an incremental step in payment and delivery system reform for which both Republicans and Democrats show support. 3-D health care, as defined by the three dimensions of ACOs - local accountability, aligned payment incentives and performance measurement - will be tested around the country in many different configurations. HMA has an outstanding track record working with clients in all three areas and will continue to serve as an honest broker of policy analysis and technical assistance on payment reform to meet each client's unique needs.

For more information, contact [Lisa Duchon](#), Senior Consultant, at (512) 473-2626.

**The Community Living Assistance Services and Support Program and Long-Term Care**

A key issue in long-term care financing in the United States has been



the significant proportion of people in need of long-term assistance who do not qualify for Medicaid but who cannot afford private payment. Some of these individuals ultimately spend down their assets in a nursing home and achieve Medicaid eligibility. Others may go without needed assistance with the risk of dire consequences for themselves or their family members. Private long-term care insurance to help defray these costs has been a modest factor in the long-term care financing picture with limited enrollment of several million individuals.

In addition to its highly publicized expansions of health insurance coverage, the new federal health reform legislation, the Patient Protection and Affordable Care Act (PPACA), establishes a national, voluntary long-term care insurance program. The insurance will provide participants with cash to help pay for long-term care if they become functionally limited. The cash benefit can be used to pay for home and community-based care and other long-term care expenses. The costs of benefits provided under this new initiative, known as the Community Living Assistance Services and Support (CLASS) program, will be fully paid for by individual workers through payroll deductions. Participation is voluntary, although workers whose employers participate will be enrolled automatically unless they opt out.

Many key details of the program will be worked out over the next two years by the Department of Health and Human Services. These elements include benefit levels, premium amounts and the system for determining benefit eligibility.

**Enrollment:** The program will begin enrollment in late 2012 or (more likely) 2013, with initial participants becoming eligible for benefits after five years. The CLASS program is currently structured to have its greatest impact on workers receiving the program through employers. Workers are eligible for the CLASS Act if they pay into the system for five years, for three of which they must be employed at least part-time. Although final employer requirements are still to be determined, most analysts anticipate that employers who offer CLASS coverage will be required to automatically enroll all employees with an "opt-out" for the individual employee. Others may enroll individually.

**Premiums:** Although premiums will be determined through the pending HHS program specification and will depend on benefit design and actuarial analysis, some elements of premium structure are laid out in the PPACA statute. Because age rating of premiums is allowed, premiums might be unaffordable for many older people unless the extent of age rating is quite limited. Full-time students and individuals with incomes under 100% of poverty pay very low premiums by statute.

**Eligibility:** Similar to private long-term care policies and many Medicaid long-term care programs, benefits are triggered by limitations in "Activities of Daily Living," known as ADL Limitations. Individuals with ADL Limitations expected to last at least 90 days will be eligible for benefits, with benefit amounts to vary depending on impairment. It is possible that HHS will rely to a significant extent on existing state and county disability determination and long-term eligibility determination systems for determining benefit eligibility.

**Benefits:** While most details of benefit design will be specified over the next two years, by statute the lowest benefit level must average at least \$50 per day (inflation-adjusted) and allow for higher cash benefits depending on the degree of impairment. The Congressional Budget Office projected average benefits to be \$75 a day.

**The Future of Long-Term Care Financing:** The CBO has projected that the CLASS program will enroll 10 million individuals by 2019. Although this might seem a modest amount relative to the United States population, it would represent a dramatic increase in the number of people with long-term care insurance, almost tripling that total. A higher proportion of long-term care expenses will now be covered by private insurance payments rather than individual "out-of-pocket" payments. Moreover, the CLASS Act has some important structural similarities with the Social Security program that suggest that it may be expanded more in future years. Social Security initially enrolled only half of all workers, and it was expanded multiple times over decades to become a nearly universal program, being extended to include virtually all workers and spouses and dependents. A similar dynamic is potentially at work with CLASS. The CLASS program is financed, like Social Security, on a pay as you go basis, despite the presence in both programs of individual premiums paid in over years. As with Social Security, with each new population added there will be a budgetary infusion of new premiums, which will temporarily expand net revenues until the new group begins to draw down benefits. Both this budgetary dynamic as well as the political and policy appeal of expansion may drive future expansions.

For more information, contact [Eliot Fishman](#), Principal, at (212) 575-5929.

## Opportunities Under the 340B Drug Pricing Program



The 340B Drug Pricing Program provides low cost drugs to safety net providers across the country. It is not a government purchasing program, but a discount program administered by the federal Health Resources and Services Administration (HRSA) Office of Pharmacy Affairs. The 340B Drug

Pricing Program was established in response to the passage of Section 340B of U.S. Public Law 102-585, the Veterans Health Care Act of 1992. The program provides access to reduced price prescription drugs to over 14,000 health care facilities certified by HRSA as "covered entities." These covered entities serve more than 10 million people in all 50 states, plus commonwealths and territories. However, many eligible facilities are not enrolled, and those that already participate may have opportunities to increase their savings. Health reform also makes changes that will have complex effects on the many entities involved in the 340B program.

Covered entities that can purchase 340B drugs are delineated in federal statutes. These entities include: federally-qualified health centers (FQHCs), family planning projects, Ryan White Care Act clinics, state-operated AIDS Drug Assistance Programs (ADAP), black lung clinics, comprehensive hemophilia diagnostic treatment centers, native Hawaiian Health Centers, urban Indian organizations, sexually transmitted diseases clinics, tuberculosis clinics, disproportionate share hospitals, and family planning (Title X) entities. The Patient Protection and Affordable Care Act (PPACA) expands 340B eligibility to outpatient settings of free-standing children's hospitals, free-standing cancer hospitals, hospitals designated as critical access hospitals, rural referral centers, and sole community providers. However, these new categories of covered entities may not purchase "Orphan drugs" at 340B pricing, which significantly reduces savings available for providers who administer outpatient cancer drugs.

The discount pricing available to 340B entities is derived from the federal Medicaid rebate program. The "ceiling" price (i.e. the highest allowed price for a specific drug) is equal to the difference between a manufacturer's reported Average Manufacturer Price (AMP) and the federal Medicaid rebate. For example, if the AMP for Drug A is \$10 and the rebate is \$6, the most a covered entity would pay is \$4. The 340B program also has a Prime Vendor, which negotiates deeper discounts for drugs and supplies directly with manufacturers. These discounts are available to covered entities that enroll (at no cost) with the Prime Vendor.

Hospitals and clinics can use 340B to reduce their expense for drugs provided free or at low cost to uninsured patients. They can also increase their retained margin on drugs purchased under 340B and billed to private insurance, Medicaid managed care, and Medicare Part D plans. Drugs purchased using 340B pricing cannot be provided to Medicaid fee-for-service patients, because Medicaid agencies are already receiving rebates on these drugs and the 340B discount constitutes a prohibited "double discount."

### ***Eligibility and Enrollment***

Though the 340B program has been in existence for more than a decade, many eligible clinics and hospitals have not enrolled. There may be several reasons for the lack of enrollment: not knowing the program exists, not understanding the eligibility requirements and enrollment process, uncertainty of the work involved to enroll or the workload to operate the program, or a decision that program savings do not justify operational requirements.

FQHCs and other designated clinics are automatically eligible as 340B covered entities. They can operate their own pharmacies to dispense drugs, contract with one or more local pharmacies, or both. Enrollment requires submitting a simple form and, if using a contract pharmacy, submitting a guarantee that an appropriate contract is in place with the pharmacy. Only public hospitals and non-profit community hospitals that are DSH-eligible and have a Medicare DSH adjustment of 11.5% or greater can be covered entities. Rural Referral Centers and Sole Community Hospitals must have a DSH adjustment of 8% or more, and Critical Access Hospitals do not have a DSH requirement and are automatically eligible so long as other requirements are met. All non-profit hospitals must have a contract with a unit of government attesting to provision of free care to the uninsured in order to enroll as a covered entity.

For hospitals, only drugs dispensed in outpatient settings are eligible for purchase under 340B. This includes emergency rooms, clinics, and retail pharmacies operated by the hospital. Hospitals can also contract with local retail pharmacies.

*HRSA recently issued a new rule allowing a covered entity to have unlimited contract pharmacy arrangements in place. This has created a new opportunity for all covered entities to expand their use of 340B. In particular, hospitals that are covered entities and that own an FQHC should closely evaluate expanded savings available under this arrangement.*

### ***Federal Rebate Changes in Health Reform***

The PPACA affects the 340B program in many ways, with the federal Medicaid rebate changes possibly being among the

most significant. The PPACA increases the minimum rebate for generic drugs from 11% to 13% of Average Manufacturer Price (AMP), and most brand drugs from 15.1% to 23.1% of AMP (blood factor products and pediatric-only drugs increase to 17.1%). The rebate for brand drugs also takes into account Best Price, setting the rebate as the greater of the minimum rebate (e.g. 23.1% of AMP) or the difference between AMP and Best Price. Best Price can be generally described as the lowest price offered to any commercial purchaser.

Prior to the PPACA, AMP was defined as the average price paid to the manufacturer by wholesalers for drugs distributed to the retail pharmacy class of trade. The definition of "pharmacy class of trade" included many entities not traditionally considered as "retail" entities, e.g. mail order pharmacies, physicians, and clinics. The PPACA changes the definition, and effective October 1, 2010 the AMP will be defined based on the price of drugs distributed to "retail community pharmacies." Because large non-community pharmacy purchasers will now be excluded, the value of AMP will likely increase for many drugs.

With the increase in the minimum rebates and the change in the definition of AMP, many are under the impression that 340B prices will decrease for all drugs. Though this may be the case for some drugs, it will not be the case for every drug.

The effect on a generic drug is easy to predict. If AMP does not change for a generic drug, the ceiling price will decrease from the pre-PPACA level. However, if the relative AMP for a generic drug increases by more than 2.3% due to the new definition, the 340B ceiling price will be higher than the pre-PPACA price. The AMP change will also affect brand drugs with rebates based on the minimum rebate percentage; an increase in AMP of more than 10.4% will increase the ceiling price. Brand name drugs whose rebate is based on a best price may not see any change in the ceiling price.

Because state Medicaid rebate programs can invoice more than 20,000 individual product codes on a quarterly basis, prices change quarterly, and the definition of AMP will not change until the fourth quarter of 2010, it will be difficult for the entities involved to predict the full effect of the PPACA on their drug prices in advance. The additional discounts negotiated by the 340B Prime Vendor may also keep prices unchanged.

HMA can help newly eligible entities assess potential savings and enroll in 340B, and assist those that already participate in exploring opportunities to expand 340B savings.

For more information, contact [Donna Strugar-Fritsch](#),

Principal at (517) 482-9236 or [Kevin Gorospe](#), Principal, at (916) 446-4601.

## HMA Launches Investment Services

In response to an increase in engagement requests from the investment community, HMA recently launched a new initiative to coordinate its efforts with this important client base. HMA Investment Services was created in April, 2010 and is operated out of our New York City office under the leadership of Greg Nersessian. Greg joined HMA after spending over a decade in the financial services industry, most recently as a senior equity analyst covering managed care stocks for Credit Suisse.

The goal of HMA Investment Services is to leverage the firm's expertise in the administration of publicly funded healthcare programs in order to provide guidance for investors on capital deployment decisions in the healthcare marketplace. For example, HMA Investment Services supports private equity firms on due diligence projects and in resolving issues that arise with companies that are already part of their investment portfolio. HMA Investment Services also works with traditional investment firms, such as mutual funds and hedge funds, to help them better understand issues that might impact the profitability of companies with publicly-traded securities.

While HMA Investment Services is in its early stages of development, the initial response from the investment community has been positive. We have organized investor lunches in New York, Boston and San Francisco, to discuss various issues impacting state Medicaid programs including state budget deficits and the implementation of the Patient Protection and Affordable Care Act (PPACA). We also hosted a conference call for investors earlier this month to discuss the implications for Medicaid funding if the temporary increase in the FMAP is not extended. Going forward, HMA IS will continue to host events of this nature while also coordinating private meetings and phone calls between investment clients and our senior staff.

Looking ahead, HMA Investment Services is excited to expand the services that it provides to its client partners. Investment clients will enjoy access to our experienced staff of consultants as well as our latest research on issues impacting publicly-funded healthcare programs including the implementation of all aspects of the PPACA. We will also be launching a website for investment clients that will host value-added content including up-to-date analysis of developing issues impacting state healthcare programs, webinars and tutorials on topics of broad interest and a

calendar of important upcoming events.

Given the breadth of changes outlined in the PPACA, this is an exciting time for public and private enterprises tasked with shaping the future of the healthcare delivery system. In particular, state governments will play a pivotal role in designing programs that deliver healthcare services to a broader pool of individuals in a high quality and cost efficient manner. States have historically relied on private sector enterprises to support the administration of their healthcare programs, a dynamic we expect will continue going forward. In that light, given HMA's unmatched expertise in the administration of state healthcare programs, we believe our firm is well positioned to add value to investors who are ready to deploy capital to enterprises that can support these goals.

For more information, contact [Greg Nersessian](#), Principal, at (212) 575-5929.

## State Legislative Notes



Following are brief highlights of legislative developments from states in which HMA has offices. Many states are concerned about whether extra federal funding for Medicaid will be approved for the first half of 2011. One of the components of the American Recovery and Reinvestment Act (ARRA), the federal economic stimulus law passed in 2009, was an enhanced Federal Medical Assistance Percentage, or FMAP, for states from October 2008 through December 2010. This enhanced funding was estimated to provide about \$87 billion to states over the 27-month period. More recently there has been significant pressure on Congress from states, providers and advocates to extend the enhanced FMAP funding for an additional six months, through June 2011. Some states assumed in their budgets that extra funding would be available. As we go to press, Congress has yet to act on any measure to extend the funding. Should the extension not be approved, states will be forced to implement drastic program reductions to compensate for the lost funds.

### California

- Among the extensive legislation being considered, the California legislature is working to adopt language to create a state health insurance exchange and take

other actions to implement federal health care reform, as well as to implement the state's renewal of its 1115 Medicaid waiver.

### Florida

- Florida continues to support expansion of Medicaid managed care programs. The 2010 Legislature directed the Medicaid agency to request a three-year extension of the current Medicaid Reform 1115 Waiver, to convene an advisory panel regarding the continued use of intergovernmental transfers in a managed care environment, and to require managed care plans to adopt anti-fraud plans. The Florida House and Senate also passed separate measures that would substantially expand risk-based managed care in Medicaid, and although their differing proposals could not be reconciled before the end of the 2010 session, managed care expansion is likely to be a major policy focus of the 2011 session.

### Georgia

- The Legislature passed a hospital provider tax of 1.45%, and a hospital rate increase in Medicaid rates equivalent to 11.5%. The state has had an insurance premium tax for several years but had exempted the Medicaid MCOs because they had a separate quality assessment fee. With the recent disallowance by CMS of the assessment fee, the Legislature removed the exemption from the premium tax. As a result, the MCOs will pay the 2.25% premium tax starting July 1, 2010. All other providers will receive the same payment rates for the new fiscal year.
- Other budget activity included a requirement to push the final MCO payment for SFY 2011 into FY2012 to avoid further cuts.

### Illinois

- Medicaid Rates and eligibility were spared in the latest legislative session.
- A package of Medicaid fraud measures passed.
- A health reform task force was formed as part of the [Health Care Justice Implementation Act of 2010](#).
- The State postponed significant budget issues until after the November Gubernatorial election - and may have some interim cuts in July 2010.
- Beginning July 1, 2010, Indiana [allowed](#) criminal history checks for employees of home health agencies and personal service agencies to be performed by private agencies. The legislation also removes the June 30, 2010, expiration date for limited criminal

history checks that were accepted for individuals living in the state longer than 2 years. After that date, all employees of these agencies are required to obtain national criminal history background checks.

### **Massachusetts**

- Negotiations to agree to a bill implementing the recommendations of the state's Special Commission on the Health Care Payment System broke down before any legislation was filed. The legislatively-created Special Commission recommended in June 2009 that the state transition to an all-payer system of global payments with adjustments to reward the provision of accessible and high-quality care. It is anticipated that legislation to implement the recommendations of the Special Commission will be filed and debated in the 2011-12 legislative session.

### **Michigan**

- Michigan does not yet have a budget for the state fiscal year that begins on October 1, 2010. While the Democrat-controlled House and Republican-controlled Senate have each passed a budget, revised revenue projections are not sufficient to support either bill. A key factor is the potential reduction or elimination of the enhanced Medicaid federal matching rate on January 1, 2011. In addition, state general fund revenues for the current fiscal year are below required levels. Some of the "one time" money that was slated for use in FY 2011 may now be required to balance FY 2010. It is possible that the state will enter FY 2011 with a "continuation budget" and that a final budget will not be enacted until after the November election. A "lame duck" session could be especially interesting as 30 of 38 state senators will not be eligible to return in January due to term limits and some of the remaining 8 face strong challenges in the November elections.

### **New York**

- In June 2010, New York legislated that health insurance premiums must be reviewed and approved by the state before they take effect; medical loss ratios must meet or exceed 90% for small businesses and individuals; COBRA benefits are extended from 18 to 36 months for unemployed individuals; and unmarried adults under age 29 may stay on their parent's group insurance policy.
- Concurrently, the state faces an \$8.2 billion deficit for 2010-2011.

## Ohio

- The Ohio legislature is in summer recess, and additional legislation is not expected until after the November election. Ohio is currently in the second year of a two-year biennial budget (2010-11). The current budget made few changes to Medicaid policy, except to support increased levels of spending using enhanced FMAP and increases in hospital and nursing facility franchise fees. State officials estimate that Ohio currently faces an \$8 billion deficit going into fiscal year 2012.

## Texas

- The state is facing an \$18 Billion budget deficit, or about 20% of the next two-year budget.
- Rate cuts have been made to Medicaid providers and health plans under the current budget. The Legislative Budget Board approved mid-cycle budget reductions for all agencies, including the health and human service agencies. In total, the five health and human services agencies were reduced 3.7% (\$205,010,920) of the appropriated general revenue funds for FY 2010-2011. This included a one-percent provider rate reduction for all programs except Medicaid Community Care, Foster Care, and Adoption Subsidies, effective September 1, 2010. Possible additional cuts are under discussion.

## CMS Terminated Providers Memorandum

CMS recently issued an informational memorandum announcing the planned development of a process to provide state Medicaid agencies with information on providers that have been terminated from the Medicare program or from Medicaid programs in other states. The process is required pursuant to Sections 6401(b)(2) and 6501 of the Patient Protection and Affordable Care Act of 2010 (PPACA), also known as the health reform act, and will be implemented in January 2011. State Medicaid agencies need this information, as they must terminate these providers from participating in their Medicaid programs as well. CMS will similarly provide information about providers terminated from CHIP participation.

*[Health Management Associates](#) is an independent national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides*

*leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, investors, multi-state health system organizations and single site health care providers, as well as employers and other purchasers in the public and private sectors.*

[Forward to a Friend](#)

✉ **SafeUnsubscribe®**

This email was sent to [dchesher@healthmanagement.com](mailto:dchesher@healthmanagement.com) by

[info@healthmanagement.com](mailto:info@healthmanagement.com).

[Update Profile/Email Address](#) | Instant removal with [SafeUnsubscribe™](#) | [Privacy Policy](#).

Email Marketing by



Health Management Associates | 120 N Washington Sq, Ste 705 | Lansing | MI | 48933