HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup: Trends in State Health Policy

IN THIS ISSUE:

IN FOCUS: A SUMMARY OF THE FLORIDA STATE SENATE'S MEDICAID REFORM BILL

HMA ROUNDUP: UPDATES FROM CALIFORNIA, FLORIDA, GEORGIA, ILLINOIS, NEW YORK, NEW JERSEY, MASSACHUSETTS, MICHIGAN, TEXAS, AND WASHINGTON DC,

ALSO MAKING HEADLINES: MASSACHUSETTS GOV. PATRRICK PROPOSES HEALTH FEE OVERHAUL; NEW JERSEY GOV. CHRISTIE SEEKS TO EXPAND MEDICAID MANAGED CARE; SEVEN STATES TO DEVELOP ONLINE SHOPPING SYSTEMS FOR HEALTH INSURANCE; LOUISIANA REVISED HEALTH-CARE DELIVERY PLAN RELEASED

UPCOMING APPEARANCES:

BARCLAYS CAPITAL 2011 GLOBAL HEALTHCARE CONFERENCE (MARCH 15, 2011)

FEBRUARY 23, 2011

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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INTRODUCTION

We hope you enjoy our first issue of the Health Management Associates *Weekly Roundup*. Our goal is to provide you with in-depth research and analysis on the latest issues in state health policy, leveraging the experience and insights of Health Management Associates' 62 Principals and Senior Consultants, most of whom joined the firm after long and successful careers leading state-sponsored healthcare programs. For those that are not familiar with our firm, we hope this publication showcases the breadth and depth of our organization's insights on state health policy issues and serves as a reliable source of up-to-date information and valuable insight from people who know these programs intimately. With implementation of the Affordable Care Act (ACA) well underway, and with states still grappling with budget constraints, we believe you will benefit from our perspective at this critical juncture.

In each issue we will take an in-depth look into one topic affecting the healthcare services sector. Our *In Focus* topic this week is a review of the Florida State Senate's Medicaid Reform bill, which outlines an ambitious plan to redesign the state's Medicaid delivery system. After the *In Focus* section, we provide updates about the latest developments in state Medicaid programs through a roundup of news from each of HMA's 11 offices. We will also look at recent news related to state-sponsored healthcare issues in the past week. We hope you find the content informative and useful. In order for you to get a sense for the type of material the *Weekly Roundup* will cover, we are publishing this issue and next week's free of charge. Beginning with the March 9th issue, access to the *Weekly Roundup* will be on a subscription basis.

Thank you for your interest,

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IN FOCUS: FLORIDA SENATE MEDICAID REFORM BILL

This week, our *In Focus* section looks at the Florida Senate's Medicaid Reform bill, which was released last Thursday. In the discussion below, HMA Principals and former Florida Medicaid Directors Gary Crayton and Dyke Snipes describe the key provisions of the bill and explore how the changes may impact the Medicaid delivery system in the state, including the Medicaid managed care program. The Senate bill proposes a number of ambitious changes to the current delivery system, including expanding managed care to the vast majority of Floridians that remain in the fee-for-service Medicaid system, eliminating the Medi-Pass (Primary Care Case Management or PCCM) program, creating a managed long term care program and implementing tort reform.

Background

The Florida Senate released its draft Medicaid Reform language Thursday morning, February 17, 2011. The draft bill was developed in conjunction with several committees and was presented through the Senate Subcommittee on Health and Human Services Appropriations. The bill is over two hundred pages long with almost ninety sections; it can be accessed via the following link:

http://www.flsenate.gov/usercontent/committees/2010-2012/medicaid/billdraft23427.pdf

The bill can be broken into four major components:

1) New Managed Care Program; Super Waiver Authority vs. State-only Program;
2) Significant modifications to the interim program;
3) KidCare eligibility provisions and other changes;
4) Tort reform/sovereign immunity for Medicaid providers (including health plans);

In this report, we identify each of the key provisions of the bill and then provide some background on the current Medicaid managed care program in the state.

Key Provisions

New Managed Care Program; "Super Waiver Authority vs. State-only Program" (key changes to current policy in bold)

These sections of the bill:

- Create the "Medicaid Managed Care" program. The Medicaid managed care program is "established as a statewide, integrated managed care program for all covered medical assistance services and long-term care services."

- Use an invitation to negotiate (ITN) process (bid) to select plans to provide services to almost all Medicaid recipients. Separate ITNs will be issued for the managed medical assistance program and the managed long-term care program.
- **Divide the state into 19 regions** in which qualified plans will be considered to provide services under a capitated arrangement.
- Establish standards for managed care contracts, including **5-year durations,** non-renewal of contracts, a primary care physician for each member, prompt pay, required rate of pay for non-contracted providers of emergency services, plan network adequacy, encounter data reporting, quality and performance standards, fraud prevention, grievance resolution, penalties, performance bonds, solvency standards, guaranteed savings, and penalties.
- Require that the agency **may not select more than one plan per 20,000 Medicaid recipients within each region, with a maximum of 10 plans per region.**
- Provide that plans will be paid per-member, per-month payments based on an assessment of each member's acuity level, and that payment for LTC plans will be combined with rates for medical assistance plans.
- Establish specified benefits each plan must cover, but allow for additional services as specified in the General Appropriations Act (GAA). Allow plans to customize benefit packages for non-pregnant adults, vary cost-sharing provisions, and provide coverage for additional services, subject to standards of sufficiency and actuarial equivalence.
- Specify that most recipients are required to enroll in managed care, with certain exceptions (specifically excludes persons with developmental disabilities from mandatory managed care).
- Require the Agency for Health Care Administration (AHCA) to **begin implementing the new managed care medical assistance component as of December 31, 2011,** and finish implementing the component in all regions no later than December 31, 2012.
- Establish a comparable managed long-term care (LTC) program with similar features as the acute care component (i.e., ITN process, plan qualifications, etc.). However, **the LTC component is required to begin by March 31, 2012**, with full implementation in all regions by March 31, 2013.

Managed Care Provisions

- The bill requires AHCA to "initiate any necessary procurements required to implement the managed care program as soon as practicable, **but no later than July 1, 2011**;" requires the agency to submit a plan amendment or necessary waivers by August 1, 2011; and expects approval of any waivers by the federal Centers for Medicare and Medicaid Services (CMS) by December 1, 2011. **If CMS does not approve the waiver and withholds federal funds, the state will operate the program using only state monies**, and Florida will officially withdraw from the Medicaid program effective December 31, 2011.

- The bill requires qualified plans to compensate primary care physicians with payments equivalent to, or greater than, the Medicare rate for primary care services no later than January 1, 2013.
- It automatically creates the Children's Medical Service Network as a qualified plan under the new program.
- If a plan that wins a bid requests a rate increase during the contract period which was not solicited by the agency, it will in effect be deemed to have given notice to leave the program, and statutory sanctions will be applied.
- Recipients will have 30 days to select a plan. After 30 days, recipients will be auto assigned using a quality/performance-based assignment process. A plan that does not meet the minimum quality standards is banned from auto assignment.
- Plans receive additional value for accreditation in the ITN process, but once contracts are awarded under the new program, all plans will be required to be accredited within a year, and if the plan is not accredited within 18 months, the plan will be suspended from auto assignment.
- Each plan will have to institute specific fraud and abuse prevention and detection programs.
- Plans are required to submit encounter data in specific ways. Plans will be assessed a $5,000 fine per day for failing to submit the appropriate encounter data. If the plan fails to comply within 30 days, the fine is increased to $10,000 per day. Once a plan is assessed total fines of $300,000 or more, the plan will be disqualified from the Medicaid program for three years.
- Plans must pay for emergency services, and if the provider is a non-participating provider, the rate shall be the fee-for-service rate the agency would pay.
- Plans must post and maintain a surety bond in the amount of $1.5 million or a letter of credit in that amount. If the plan leaves a region before end of the contract period, the state may assess against the surety bond.
- During the first contract period, the plan **must guarantee a minimum savings of 7%** compared to what fee-for-service expenditures would have been for the same services and populations.
- If a plan leaves a region early, certain penalties apply. If the agency terminates a plan for noncompliance in two or more regions, the plan will be banned from all other regions and all other state programs (i.e., Healthy Kids, state group, etc.).
- **Plans are required to maintain a 90% minimum loss ratio (MLR)** calculated after two years of operation and annually thereafter. A plan spending less than 90% on direct patient care shall repay the state at various percentages depending on the difference. We note that in the most recent round of rate negotiations, the state targeted an 89% MLR across the 11 non-reform counties.
- Plans may limit the types of providers in their networks. Certain entities must be included in the first year of the contract (i.e., FQHCs, nursing homes, etc.), but a

plan may remove these providers from the network after a year as long as they can demonstrate network adequacy without said provider.

- The bill requires plans and providers to negotiate in good faith. If a plan in a region without a qualified plan is unable to contract with a provider after three good-faith attempts (defined by the agency), the plan may request a review by the agency. If the agency agrees the plan has negotiated in good faith, the agency shall consider the provider part of the network, and the payments to that provider shall be the average of the payments of similar providers in similar regions.
- The agency may calculate the hospital Medicaid rate, but this rate may not be the basis for contract negotiations between a managed care plan and a hospital.
- The agency shall develop a methodology and request a waiver that ensures the availability of intergovernmental transfers in the Medicaid managed care program to support providers that have historically served Medicaid recipients. Such providers include, but are not limited to, safety net providers, trauma hospitals, children's hospitals, statutory teaching hospitals, and medical and osteopathic physicians employed by or under contract with a medical school in this state. The agency may develop a supplemental capitation rate, risk pool, or incentive payment for plans that contract with these providers. A plan is eligible for a supplemental payment only if there are sufficient intergovernmental transfers available from allowable sources.
- The bill defines capitation and requires that **rates must be actuarially sound** but does not define who makes that determination.
- Accountable care organizations (ACOs) are included within the definition of managed care plan; however, ACOs are not defined other than as defined in federal law.
- Medicaid recipients will be required to pay a premium of $10 per month for an individual or $10 to cover all recipients in a family. The section implies if they do not pay, they are disenrolled. The agency will determine how this process will work.
- Medicaid recipients must participate, in good faith, in medically approved smoking cessation programs, weight lose programs and alcohol or substance abuse programs.
- The bill "grandfathers" persons currently in nursing homes from being required to enroll in a managed care plan.

Interim Program Changes

With the respect to the fee-for-service program that remains after the changes described above, the bill:

- **For adults other than pregnant women , effectively eliminates all benefits under the "Medically Needy Program," except for physician services.** Pregnant women and children still receive full benefits.

- Explicitly prohibits the expenditure of Medicaid-related funds beyond the amounts appropriated in the GAA. If the agency expects to exceed its budget authority, it must notify the Legislature and request a budget amendment. If the amendment is not allowed, the agency must make necessary reductions in Medicaid services to remain within budget.
- Requires Medicaid recipients to pay a $10 monthly premium and participate in certain wellness programs.
- Requires Medicaid recipients pay copayments for physician services and a $100 copayment for nonemergency utilization of a hospital's emergency department.
- Allows a Medicaid recipient with "access" to employer-sponsored coverage to use Medicaid funds to pay the premium for the private insurance.
- **Increases the current MLR requirements for behavioral health services provided through managed care plans to 90% from 80%.**
- Modifies the transfer of assets limitations for eligibility for LTC services.
- Increases Medicaid fee-for-service payments to primary care physicians to 100% of Medicare rates effective January 1, 2013 (as required by federal law).
- Effectively eliminates the provision and use of Medicaid funds for transportation services provided via the Commission for the Transportation Disadvantaged. Medicaid transportation services will be provided through managed care plans or a bid contract.

KidCare Program Changes

The bill includes several provisions meant to increase enrollment in the Florida KidCare Program. Specifically, the bill:

- Increases the MLR in Healthy Kids to 90% from 85%.
- Coordinates the application process with the school breakfast and lunch programs in public schools. Allows the school districts to share certain data with the Florida Healthy Kids Corporation.
- Requires public schools to provide applications for KidCare at the beginning of each school year and allows the districts to share certain information on income and other demographic information with the Healthy Kids Corporation.

Tort Reform/Sovereign Immunity

- The bill includes several provisions meant to limit the awards for certain causes of action and extends sovereign immunity designation to specific Medicaid providers.

Managed Care Market Opportunity

In order to assess the market opportunity for Medicaid managed care plans in Florida, we begin by describing the current enrollment distribution by delivery system type. As the table below indicates, there are currently 2.9 million Floridians enrolled in the

Medicaid program. Of that total, 39% are in a Medicaid HMO, 21% are in the MediPass (PCCM) program and 33% are in fee for service. In conjunction with the Senate plan described above, everyone currently in the MediPass and fee for service programs would transition into either a Medicaid HMO or Provider Service Network (PSN, similar to Accountable Care Organization) beginning calendar year 2012 except for certain excluded populations such as the developmentally disabled.

One open question is whether or not the dual eligibles will be included. The bill requires that the state submit a waiver request to the federal government to enroll dual eligibles in managed care on a mandatory basis, something that is not permitted today. If the federal government approves this request, the market opportunity would increase by approximately 300,000 lives. With their inclusion, we estimate that the size of the market available to Medicaid HMOs and PSNs would increase by between 900,000 to 1.2 million enrollees or from between 68% to 91% depending on the outcome of the waiver request.

Florida Medicaid Enrollment by Delivery System

Feb-11	Enrollees	% of total
Medicaid HMO	1,120,566	38.8%
Provider Service Networks/ACOs	196,190	6.8%
MediPass (PCCM)	613,987	21.3%
Nursing Home Diversion	19,145	0.7%
Fee for Service	936,805	32.5%
Total	**2,886,693**	

Source: Florida Agency for Healthcare Administration

From a spending standpoint, we note that the state spent $17.3 billion on Medicaid in FY 2010 (federal and state share), of which $2.9 billion, or 17%, went through Medicaid managed care plans. The managed care appropriation for the FY 2012 budget is $3.5 billion. HMA estimates that if all of the provisions described were implemented, the total size of the market opportunity for managed care plans would increase to between $10 billion and $12 billion if not more. We note that the bill requires that the whole program be rebid, including the current contracts.

Incumbent Plans

Below we identify the incumbent plans operating in Florida and their existing market share. At this time, we would expect all of the existing plans to participate in the RFP. In terms of new entrants, most of the large Medicaid managed care plans are already in Florida except for Aetna and WellPoint. Given the size of the proposed expansion, we believe there is ample market opportunity for additional participants in the market and note that the bill allows for a maximum of 10 plans per region.

Medicaid Managed Care Enrollment as of February 2011

Feb-11	Members	% of total
WellCare	346,560	29.4%
Sunshine (Centene)	187,081	15.9%
Amerigroup	177,240	15.1%
Total Health Choice	105,066	8.9%
UnitedHealth	88,612	7.5%
Molina Healthcare	63,289	5.4%
Humana	51,471	4.4%
Vista(Coventry)	42,643	3.6%
Universal	36,662	3.1%
Freedom	21,226	1.8%
JMH Health Plan	15,183	1.3%
Preferred Medical Plan	14,692	1.2%
Healthy Palm Beaches	11,405	1.0%
Simply Healthcare Plan	10,791	0.9%
Medica	5,328	0.5%
Positive	74	0.0%
Total Florida	**1,177,323**	

Source: Florida Agency for Healthcare Administration monthly enrollment report

Impact on Providers

The change in the Medically Needy (MN) program would have a significant impact on Medicaid payments to hospitals. The total cost of the MN program for state fiscal year 2011-2012 is projected to be $1.448 billion of which $1.001 billion ($760 million inpatient and $241 million outpatient) is for hospital payments. This represents almost 70% of total MN funding. It has been stated by industry representatives that limiting the MN program to only physician services for non-pregnant adults will result in an $800 million cut to all hospitals, including a $300 million cut to safety net hospitals. Hospitals are concerned that with the MN program cut, they will still be getting these patients, but without any funding. This will result in cost shifting to other payers.

Additionally, under the fee-for-service delivery system, local governments provide IGTs to be used as the state share of Medicaid expenditures which draw down federal funds and increase hospital payments. The IGT funded increase in hospital payments for the current year is as much as $700 million. The bill requires the Agency to develop a methodology and request a waiver that ensures the availability of IGTs in the Medicaid managed care program. It is yet to be determined if local governments will continue to provide IGTs under a fully managed care delivery system.

Finally, in terms of the impact on long term care facilities, the intent is to eventually move all individuals that receive long term care services (nursing home and community waiver services) into managed care plans. However, individuals currently residing in nursing homes are exempt from participation in managed care. The "good faith" rate negotiation provisions described earlier apply to all providers including nursing homes.

Next Steps

The Florida House of Representatives is expected to release its Medicaid Reform bill sometime in the next week, and HMA anticipates that the House bill will also propose expanding the Medicaid managed care program state-wide. While there are likely to be differences in the design and approach of the two bills, we expect those differences to be reconcilable. With Governor's Scott's stated support, we expect that the state will ultimately move forward with a large expansion of the current Medicaid managed care program, which covers 1.1 million Floridians today. Based on the Senate bill, the planned expansion could begin as early as the beginning of calendar year 2012.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

Budget update: On January 10, 2011, Governor Brown proposed a budget that requested $12.5 billion in budget reductions and called for a special election in June to determine if 1) another $12 billion in existing tax increases set to end on June 30, 2011 would be extended another 5 years and 2) whether another $1 billion in existing tobacco tax money should be shifted to Medi-Cal. The $12.5 in reductions includes $1.7 billion in reductions to benefits and rates provided by Medi-Cal. The Governor asked the legislature to adopt the budget and called for the special election within 60 days. The Democratic majority in the legislature can pass the budget, including all cuts. A two-thirds vote is required to schedule the special election in June, requiring some support from the Republicans in the legislature. The legislature is seeking to meet these deadlines, but it is unclear if the Democrats will vote for $12.5 billion in cuts or if the Republicans will put up the votes necessary to schedule the special election on extending the tax increases.

Nursing homes, physicians, prescriptions and outpatient hospital services will all be facing a 10% rate cut. Managed care plans will receive rates that actuarially reflect the impact of the rate reductions. Since 2008, the federal courts have stopped California from reducing provider rates. The 9th Circuit Court decision to stop the rate reductions will be heard by the US Supreme Court this fall, and it is possible that the Supreme Court will overturn the decision and allow the state to reduce rates. The two legislative houses in California are currently wrapping up their budgets and sending them to the conference committee, which may start as early as this week.

In the news

- Senate Panel OKs Medi-Cal Cost Increases, Reimbursement Cuts (California Healthline)

Florida

HMA Roundup – Gary Crayton

The hot topic in Florida this week was the Senate's Medicaid Reform bill discussed above. The House bill is expected within the next week.

In the news

- Hot-button Medicaid bill (Health News FL)
- Florida Medicaid Plan: Fewer Choices, HMO-like Plans (northescambia.com)
- Florida's Medicaid proposal could put $24 billion from feds at risk (Palm Beach Post)
- Sebelius reacts to Gov. Rick Scott's Medicaid, drug monitoring cuts (St. Petersburg Times)
- Governor Scott Cancels $18 million RBM contract with MedSolutions (St. Petersburg Times)

Georgia

HMA Roundup – Mark Trail

As expected, the Georgia managed care contracts were extended by one year (to June 30, 2013) with an option to extend the contracts through June 30, 2014. The Governor's office and the Department of Community Health extended the current contracts in order to further evaluate any potential changes to the program, including whether the ABD contract will be folded into a larger RFP or not. Other issues on the table include the number of managed care organizations that will be selected to participate, whether or not they will be required to operate statewide and any new contract requirements or performance expectations.

On the rate front, providers are facing only a 1% rate reduction in the FY 2012 budget, which has been met with some relief.

In the FY 2011 amended budget, the House increased the amount of state funds to the Disproportionate Share Hospital program to $21 million from $7 million. This change is expected to benefit private hospitals in the state. The Senate is taking up the measure this week.

In the news

Firm to pay $13 million for Medicaid fraud in Georgia (Atlanta Journal Consitution)

Illinois

HMA Roundup – Matt Powers

Governor Quinn's budget was released on February 16th and included a 6% cut to provider rates including hospitals. Reaction from the provider community has been negative, with the Illinois Hospital Association (IHA) stating "we are deeply concerned that the proposed cuts to the Medicaid program will have a devastating impact on the

well-being of hundreds of thousands of Illinoisans and the financial stability of many hospitals across the state."

(IL Governor's budget)

Local reports suggest that the contracting between hospitals and the managed care organizations selected to participate in the ABD program in the counties surrounding Chicago is moving more slowly than anticipated.

Massachusetts

HMA Roundup - Tom Dehner

The focus this week in Massachusetts is on Gov. Patrick's payment reform bill. On Thursday, February 17, Governor Deval Patrick announced comprehensive health care payment and delivery reform legislation, the goal of which is to control rising health care costs and improve patient care through more active regulation. The bill, named "An Act Improving the Quality of Health Care and Controlling Costs by Reforming Health Systems and Payments":

- Encourages the formation of integrated care organizations (commonly referred to as Accountable Care Organizations or "ACOs") by providing standard criteria for ACOs;
- Requires that an ACO be certified by the Division of Health Care Finance and Policy (DHCFP), with financial oversight by the Division of Insurance (DOI), and directs DHCFP to standardize alternative payment methodologies;
- Requires that if contracts between payers and ACOs include shared savings, that savings must also be shared with consumers;
- Provides that the Attorney General will use existing authority to monitor ACOs to ensure no anti-trust violations occur;
- Aims to expand the use of alternative payment methods and significantly reduce fee-for-service payments by the end of 2015;
- Ensures transparency of payer and provider costs, provider payments, clinical outcomes, quality measures, and other information necessary to discern the value of health services, which helps guarantee that consumers and businesses have accurate and available information about their health care;
- Clarifies the Commissioner's authority to reject premium increases where the underlying provider rates are excessive. Specifically, the Commissioner may disapprove rates that contain provider increases inconsistent with the following criteria:
    - The rate of increase in the state's Gross Domestic Product;
    - The rate of increase in total medical expenses in the region as reported by the Division of Health Care Finance and Policy;
    - A provider's rate of reimbursement with a carrier, especially in relation to the carrier's statewide average relative price;

- Whether the carrier and a contracting provider are transitioning from a fee-for-service contract to an alternative payment contract;
- As provider rates decline, carriers are required to factor such savings into the premiums charged to consumers.

(MA Governor's Payment Reform Bill)

In the news

- Patrick proposes health fee overhaul (Boston Globe)

Michigan

HMA Roundup - Eileen Ellis

Budget Update: The FY 2011-12 Executive budget proposes a number of program reductions and policy changes to reduce State spending in Medicaid. Included in the proposal are: 1) A proposal to transfer all Medicaid enrollees dually eligible for Medicare to managed care in the middle of FY 2012. 2) Proposed legislation to end current policy exempting behavioral health drugs from Michigan's Preferred Drug List (PDL). 3) A policy change that would mandate enrollment into managed care for all Medicaid-eligible Children's Special Health Care Services enrollees. 4) A 40% reduction in payments to hospitals for Graduate Medical Education (GME). With the exception of the GME cut, provider payment rates and HMO capitation rates are unchanged. Further, the Executive also proposed modifying Michigan's Use Tax to eliminate taxes imposed upon Medicaid Health Maintenance Organizations and Medicaid Pre-Paid Inpatient Health Plans (PIHPs). This assessment was used to generate non-federal match funds to support Medicaid rates paid for managed physical and mental health care. The Governor proposes creating 1.0% tax on all paid health insurance claims to offset the loss in revenue associated with the use tax changes.

In the news

- Replacement Tax on Insurers Key To D.C.H. (Gongwer News)
- Medicaid spared; teaching hospitals face cuts: Providers surprised by insurance claims tax (Crain's Detroit)
- Additional D.C.H. Cuts Include Mental Health (Gongwer News)

New York

HMA Roundup - Eliot Fishman

The Medicaid redesign team continues to debate proposals to reform the state's $50 billion program. On February 9, 2011, the redesign team released a proposed list of changes and related savings to the program. Included in the list were the following options and related savings for the FY 11/12 budget year:

- Reduce and control utilization of personal care services — $150 million
- Imposes a uniform surcharge for both Medicaid and private payers; eliminates hospital-based physician surcharge — $125 million

- Eliminate the 1.7% 2011 trend (inflation) factor for Hospital Inpatient & Outpatient, Nursing Home, Home Care, & Personal Care Services as of 4/1/2011 — $102 million
- Reduce the underwriting gain used in calculating premium rates from 3% to 1.0% for the Medicaid and Family Health Plus managed care programs — $94 million
- Reduce the projected increase to Managed Care rates by 1.7% as of 4/1/2011 — $84 million
- Eliminate Medicaid coverage for Targeted Case Management Services for recipients that are in Medicaid Managed Care Plans — $58 million
- Eliminate funding included in Medicaid and FHPlus premiums for direct marketing of Medicaid recipients and facilitated enrollment activities for Managed Care in all counties — $57 million
- Move the NYS Medicaid Pharmacy program under the management of Medicaid Managed Care to leverage additional clinical and fiscal benefits — $50 million
- Change the way the preferred drug list is developed, in order to increase savings — $38 million
- Carve in for behavioral health services into managed care — $9 million

Link to NY Medicaid Redesign Proposed List and Savings

In the news

Advocates argue to carve out behavioral health from managed care contracts (Crain's New York)

New Jersey

HMA Roundup - Eliot Fishman

Governor Christie officially announced a move to mandatory managed long term care in his budget speech on February 22. The state has not identified its timeframe for filing a medicaid waiver to implement mandatory managed long term care. The New Jersey legislature has twice passed budget language requiring the state to release plans for a move to mandatory managed long term care, suggesting that there is significant legislative support for the move. Christie also announced the upcoming filing of a broader waiver to restructure and reduce medicaid costs, with projected savings of $300 million. Details on both announcements have not been released as of yet.

In the news

- Christie budget to cut $540M from Medicaid funds, transfer participants into managed care (nj.com)
- Gov. Christie's prepared 2011 budget remarks (nj.com)

Texas

HMA Roundup – Linda Wertz

The possible use of rainy day funds has entered into budget negotiations. Republican Representative John Zerwas has proposed spending up to $8 billion of the state's rainy day fund in order to cover the revenue shortfalls in this biennium and the next. The Governor has opposed the move.

The Medicaid managed care RFP is scheduled for release by the end of February but may be delayed. The expected start date for the new contracts is currently September 1, 2012.

In the news

- Conservative group urges Medicaid shift to market-based plans (Dallas Morning News)
- Republicans seek alternatives for Medicaid costs (Houston Chronicle)
- Poll Showing 90% of Texans oppose nursing home cuts (PRNewswire)
- State keeps pressing for waiver to change Medicaid, but success is unlikely (NY Times)
- Cutting Medicaid harder than issuing sound bites, senators learn (Dallas Morning News)

Washington, D.C.

HMA Roundup - Lillian Spuria

Discussions inside the beltway focused on the President's budget this week. Medicaid and Medicare savings proposals of more than $60 billion over ten years would help pay for a two-year extension of the Medicare physician payment "fix." These cuts represent a 0.6% reduction relative to projected Medicare and Medicaid baseline expenditures of $10.5 trillion over the same period. The next step will be the Congressional Budget Office's (CBO) scoring of the bill which will likely be released in the next 1-2 weeks and will be available at this link. Following the CBO's analysis, the House and Senate Budget Committees will each draft a budget resolution outlining proposed spending plans for FY 2012.

(A copy of HMA's analysis of the President's budget is available upon request)

In the news

- States Seeking To Cut Medicaid Rolls Get Some Help – From The Feds (KHN)
- Reined-In Demand for Health Care is Here to Stay: Moody's (WSJ Health Blog)
- Paul Ryan vows to target Medicare and Medicaid (**Politico**)
- 7 states get grants to develop online shopping systems for health insurance (LA Times)
- CBS News poll: Most Americans don't want to strip healthcare law of its funding (LA Times)

- Medicaid fight shapes up as states deal with budget crunching (TheHill.com)

OTHER STATE HEADLINES

Alaska

- Alaska Cites Court Ruling in Refusing Federal Health-Care Money (Bloomberg.com)

Arizona

- Arizona Medicaid cuts get green light, for now (Stateline)
- Obama administration unlikely to block Arizona plan to cut 250,000 from Medicaid rolls (Washington Post)

Connecticut

- Many hospital officials are still calculating the fallout of Gov. Daniel P. Malloy's proposed budget, but those that have done the math say it deals them a big hit. (CT Mirror)

Louisiana

- Revised health-care delivery plan released (2theadvocate.com)

Minnesota

- Gov. Mark Dayton's plan to expand the state's Medicaid rolls by 95,000 people has been approved by federal authorities. (Minneapolis Star Tribune)

Ohio

- Report: Health Care Spending Cap to Protect Against Financial Ruin; Advocates Call For Lawsuit Withdrawal (Gongwer News)
- Gov. John Kasich tries to tame the Medicaid beast (Cleveland Plain Dealer)
- Hospitals make Ohio Gov. Kasich a deal on Medicaid: keep paying fee in return for no rate cuts (Cleveland Plain Dealer)
- Ohio Medicaid rolls shrink for 1st time in 3 years (wfmj.com)
- Advocates see $500 million in Medicaid savings with home care (Columbus Dispatch)
- Hospitals make Ohio Gov. Kasich a deal on Medicaid: keep paying fee in return for no rate cuts (Cleveland Plain Dealer)
- Ohio lost money in Medicaid fraud settlement because of lack of state law (Columbus Dispatch)

Pennsylvania

Pennsylvania to end the AdultBasic Health Program (kaiserhealthnews)

Tennessee

- States Pushing Managed Long-Term Care For Elderly And Disabled Medicaid Patients (KaiserHealthNews)

West Virginia

Senate panel kills insurance exchange bill (Charleston Daily Mail)

HMA Recently Published Research

Analysis of Health Care Proposals in the FY 2012 President's Budget

This paper provides a high-level analysis of key Medicaid, Medicare, and other health care proposals included in the FY 2012 President's Budget. The FY 2012 budget communicates the Administration's agenda and legislative priorities for the upcoming fiscal year; it is the first step in the annual budget process. In the next step of the process, the House and Senate Budget Committees will each draft a budget resolution outlining proposed spending plans for FY 2012.

Report available upon request

New Opportunities for Addressing Behavioral Health Needs and Other Options in the ACA

The Patient Protection and Affordable Care Act (ACA) offers an important opportunity for states to improve health care for people with chronic conditions and behavioral health needs, and potentially contain long-term costs. In the December 2010/January 2011 issue of the Commonwealth Fund's *States in Action* newsletter, HMA's Sharon Silow-Carroll, Principal, and Diana Rodin, Consultant, define health homes, discuss the ACA provision and the latest federal guidance to states, and present opportunities and options for states to pursue.

Link to report

Weathering the Storm: The Impact of the Great Recession on Long-Term Services and Supports

This report is a comprehensive analysis of the impact of the recession for both Medicaid and non-Medicaid funded long-term services and supports (LTSS) in each state. Based on a survey of 50 states, territories, and the District of Columbia, this report explores how the recession affects state services and supports for the aged and disabled populations as states adjust policies to deal with difficult budget constraints. It also illustrates state-by-state how LTSS are financed and provides a very early snapshot of the likelihood of states pursuing some of the LTSS provisions within the Affordable Care Act (ACA).

Link to report

Making the Investments Work: Important Benefits and Key Challenges in Implementing Health Reform in Florida

This report presents key features of the new national health reform law and explores the important potential benefits to Florida along with the main challenges. The report highlights the Medicaid expansion, health insurance exchange, and insurance market reform features of the Affordable Care Act. It also explains how the new benefits are funded and how that will affect Florida taxpayers. A few other important features of the law are briefly explained, such as the requirements placed on individuals to obtain insurance and larger employers to offer it or pay an assessment, and new grant opportunities related to improving health care delivery and financing.

Link to report

HMA WELCOMES…

Dianne Longley - Principal

Austin, TX

Ms. Longley joined HMA as a principal in January 2011. Prior to joining HMA, Ms. Longley was Director of Health Insurance Initiatives for the Life, Health and Licensing Division at the Texas Department of Insurance. Her primary responsibilities included directing research, data collection and analysis related to health insurance, health technology and health care issues, and providing technical assistance to various legislative committees. She also had responsibility for directing implementation of federal health insurance reform and oversaw Department activities related to implementation of several legislative initiatives designed to improve health care transparency as it relates to reimbursement and health insurer payment issues. From 2001 through 2006, she served as Director of the Texas State Planning Grant Program, a comprehensive five-year study of the uninsured, and continues to coordinate the Department's efforts to expand health insurance coverage in Texas, including implementation of the recently enacted Healthy Texas Program for small employers. Her professional appointments include the National Workgroup for Electronic Data Interchange (WEDI) Board of Directors, Governor's Health Care Policy Council, East Texas Rural Healthcare Access Program, National Uniform Claim Committee, Texas Health Care Information Council, and the Texas Hospital Data Advisory Committee. She holds a Bachelor of Science Degree from Texas A&M University.

Katharine Lyon, Ph.D. - Principal

Tallahassee, FL

Dr. Lyon comes to HMA from the Florida Department of Children and Families, where she has served as the Director of Mental Health. In this position she provided direct and indirect oversight of Florida's statewide system of mental health care, including all mental health related contracts. Prior to this, Dr. Lyon was Vice President of the Florida Council for Community Mental Health, a trade association of seventy behavioral healthcare organizations.

Before relocating to Florida, she served as the Associate Director of the Division of Behavioral Healthcare in the Rhode Island Department of Mental Health, Retardation, and Hospitals where she oversaw all adult mental health, substance abuse treatment, and prevention services for the state of Rhode Island. She has also spent several years of her career working in clinical settings as a Staff Psychologist.

Dr. Lyon earned her Bachelor of Science degree at the University of Florida, a Master of Arts degree at Florida Atlantic University, and her PhD in Clinical Psychology at the State University of New York at Binghampton.

UPCOMING APPEARANCES

Barclays Capital 2011 Global Healthcare Conference

On March 15, 2011, HMA Principal Dianne Longley will be presenting at the Barclays Capital 2011 Global Healthcare Conference in Miami, Florida. Topics to be addressed include an update on the Texas Medicaid managed care RFP and the potential impact on managed care organizations and providers operating in the state, the outlook for provider rate changes in the FY 12/13 biennial budget, and a status report on the implementation of key programmatic changes required by the ACA, including the creation of a Health Benefits Exchange. In addition to a presentation and break-out, Ms. Longley will be available for one-on-one meetings on Tuesday, March 15th. Please contact your Barclay's salesperson for more details.