HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

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IN FOCUS: DUAL ELIGIBLE INTEGRATION GRANTS ARE EXPECTED TO BE AWARDED THIS WEEK. WE DESCRIBE THE OPPORTUNITY FOR MEDICARE/MEDICAID MANAGED CARE ORGANIZATIONS AND SUMMARIZE THE CALIFORNIA AND MICHIGAN PROPOSALS.

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ALSO MAKING HEADLINES: FLORIDA AND TEXAS LATEST TO CONTEMPLATE PRISON PRIVATIZATION; LOUISIANA HOLDS STAKEHOLDER MEETING ON PLANNED MANAGED CARE EXPANSION TODAY

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MARCH 30, 2011

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

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IN FOCUS: STATE DEMONSTRATIONS TO INTEGRATE CARE FOR DUAL ELIGIBLES

Summary

This week, the federal Center for Medicare and Medicaid Innovation (CMMI), a division of the Centers for Medicare and Medicaid Services (CMS), will award $1 million grants to up to 15 states to support the design of integrated care models for individuals eligible for both Medicare and Medicaid. Thirty (30) states have submitted design proposals that would integrate state and federal funding sources into a single payment structure. The proposed financing mechanism will vary by state, but we expect that in many states, Medicare Advantage Special Needs Plans (SNPs) and/or Medicaid Long Term Care plans (MLTCs) will play a central role in the care delivery model.

The awards are significant given the large amount of spending, both Medicare and Medicaid, that is attributable to the duals. According to a recent report published by the Kaiser Family Foundation, total Medicare and Medicaid spending on dual eligible beneficiaries in 2005 was $196.3 billion, or approximately 30% of combined spending for all beneficiaries on those programs.[1] Of that total, approximately 60% came from the Medicaid program. Moreover, less than 10% of spending on dual eligibles is currently administered through managed care programs. As such, we view the dual eligible integration grants as a first step toward the creation of an important market opportunity for managed care organizations equipped to deliver both acute and long term care services and supports to this high-cost population.

In the discussion below, we review two the of the dual integration proposals that were made public, California and Michigan.

Introduction

This week's *In Focus* section explores soon-to-be-awarded state grants for integrated care models for dual eligible populations. These grants are provided by the new federal Center for Medicare and Medicaid Innovation (CMMI), a division of the Centers for Medicare and Medicaid Services (CMS) created under the Affordable Care Act (ACA). Up to 15 states will receive a maximum of $1 million each to support the design of integrated care models for individuals eligible for both Medicare and Medicaid. CMMI has identified dual eligible demonstration programs as an opportunity to test innovative service delivery and payment models including risk-based managed care and accountable care organizations (ACOs). Dual eligibles comprise approximately 16 to 18% of enrollees in Medicare and Medicaid, but consume roughly 25 to 45% of spending. The majority of the nearly nine million dual eligible individuals receive care through a divided system. Rates

[1] *"Where Does the Burden Lie? Medicaid and Medicare Spending for Dual Eligible Beneficiaries"* Teresa Coughlin, Timothy Waidmann and Molly O'Malley Watts, Kaiser Commission on Medicaid and the Uninsured, April 2009.

of enrollment in managed care plans are significantly lower in the dual eligible population than in the general Medicaid and Medicare populations, with over 90% of spending on dual eligibles paid on a fee-for-services (FFS) basis.

State responses were due to CMS on February 1, 2011, with awards due in the coming week. Our understanding is that some states were notified unofficially last week and that final decisions will be made public soon. In the RFP, CMS indicates that it is:

> **"Interested in identifying, supporting, and evaluating person-centered models that integrate the full range of acute, behavioral health, and long-term supports and services for dual eligible individuals. Potential models could include those that enhance existing integration vehicles such as the Program for All-Inclusive Care for the Elderly (PACE) and Medicare Advantage Special Needs Plans (SNPs) as well as those that test new/emerging models such as health homes or accountable care organizations (ACOs)."**

The $1 million award is for the design phase of the program. States receiving the award will be the only ones eligible to proceed with the implementation phase of the program. However, implementation is not guaranteed to every state awarded a design phase grant. The newly created Federal Coordinated Health Care Office (FCHCO), authorized by Section 2602 of ACA and headed by Melanie Bella, formerly of the Center for Health Care Strategies (CHCS), will provide technical assistance to states to support both the design and implementation phases.

California Overview

We have selected the California proposal to illustrate the components of a proposal to integrate care for dual eligibles. Additionally, we have provided a comparison with Michigan's proposal later in this issue. As of January 2011, there are 1.1 million dual eligible individuals in California. The state not only has a sizeable dual eligible population, but appears a likely candidate for award of both the design and planning phases on several fronts:

- California's Department of Health Care Services (DHCS) began engaging stakeholders on the subject of dual eligible integration in April 2010. A series of public meetings were held, presenting the initial findings of their stakeholder engagements and allowing for additional public comment. These meetings were summarized in a CHCS paper on which Melanie Bella was lead author.
- State legislators passed a bill in 2010 (Senate Bill 208) directing Medi-Cal, California's Medicaid program, to develop a program to "provide more streamlined and effective care for California's dual eligibles." The bill mandates initial implementation of integrated care pilots in four counties. At least one pilot will be managed by a County Organized Health System (COHS) and another will be implemented within California's Two-Plan County Model. These pilots are set to be implemented during the 2012 calendar year. DHCS plans to enroll up to 150,000 dual eligibles in integrated care in 2011 and 2012 in conjunction with this pilot program.

The following summary of California's proposal for design phase funding walks through a profile of the dual eligible population; a proposed system of delivery, including the types of services and benefits covered; a timeline for implementation; and potential impacts on the managed care marketplace. California's proposal is available on the Department of Health Care Services (DHCS) website at:

http://www.dhcs.ca.gov/Documents/State%20Demonstrates%20to%20Integrate%20Care%20for%20Dual%20Eligibles.pdf

The Dual Eligible Population

The pilot phase of the care integration process will enroll all full benefit dual eligible enrollees on a mandatory basis in two COHS counties and two Two-Plan counties. As of January 2011, there are 1.1 million dual eligible individuals in California.

In 2007, combined state and federal Medicaid spending on dual eligibles in California was nearly $14 billion. Sixty percent of spending, or $8.3 billion, was concentrated in long term care (LTC), while Medicare-covered acute care services consumed 23% ($3.1 billion) and Medicare premiums consumed another 13% ($1.7 billion). Non-Medicare acute services and prescription drugs comprised the remaining 5% ($0.65 billion). California devotes a lower percentage of Medicaid dual eligible spending to LTC than the national average (60% vs. 70% nationally), but higher percentages of spending to Medicare-covered acute care (23% vs. 15% nationally) and to Medicare premiums (13% vs. 9% nationally).

Table 1 – 2007 Medicaid Spending on Dual Eligibles by Service Category

$ (Millions)	Medicare Premiums	Acute Care - Medicare-Covered	Acute Care - Not Medicare-Covered	Prescribed Drugs	Long-Term Care	Total
California	$1,768	$3,155	$435	$217	$8,378	$13,953
% Total	13%	23%	3%	2%	60%	100%
US Total	$10,899	$17,966	$5,624	$1,378	$84,511	$120,378
% Total	9%	15%	5%	1%	70%	100%

Source: Urban Institute estimates based on data from the Medicaid Statistical Information System (MSIS) and Medicaid Financial Management Reports (CMS Form 64) prepared for the Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/7846.cfm

Proposed Integrated Delivery System

California Experience with Integrated Medicaid-Medicare Delivery Systems

- As of March 2011, California had the highest enrollment in the country in dual eligibles and institutional Special Needs Plans (SNPs) with 194,255 currently enrolled. This represents 16% of the 1.2 million Medicare beneficiaries enrolled in these plan types. While dual eligible and institutional SNPs present an attractive opportunity to integrate care between Medicare and Medicaid covered services, SNPs are limited in their ability to coordinate funding across both programs and to cover Home and Community-Based Services (HCBS) and other long term care services.

We note that while there are 21 plans offering dual eligible and/or institutional SNPs in California, enrollment in the five largest plans represents 75% of the total. Five of the 21 SNPs also participate in the Medi-Cal managed care Two-Plan model.

Table 2 – CA Dual Eligible and Institutional SNP Enrollment, March 2011

March, 2011	Dual Eligible Enrollment	% of total	SNP Type	Medi-Cal?	Model*
Kaiser Foundation Health Plan	61,679	31.8%	Dual Eligible	Yes	GMC
SCAN	50,964	26.2%	Dual eligible, Institutional	Yes	Sp. Projects
Health Net	14,232	7.3%	Dual Eligible	Yes	2-plan
Orange County Health Authority	11,552	5.9%	Dual Eligible	No	
San Mateo Health Commission	8,076	4.2%	Dual Eligible	No	
Partnership Health Plan of CA	6,215	3.2%	Dual Eligible	No	
UnitedHealth/Evercare	5,821	3.0%	Dual Eligible	No	
Easy Choice	5,586	2.9%	Dual Eligible	No	
Molina	4,768	2.5%	Dual Eligible	Yes	2-plan
Care1st Health Plan	4,657	2.4%	Dual Eligible	Yes	GMC
IEHP Health Access	4,639	2.4%	Dual Eligible	No	
Chinese Community HP	3,643	1.9%	Dual Eligible	No	
Alameda Alliance	3,472	1.8%	Dual Eligible	Yes	2-plan
Central Health Plan of CA	2,187	1.1%	Dual Eligible	No	
CareMore Health Plan	1,562	0.8%	Dual eligible, Institutional	No	
LA Care	1,542	0.8%	Dual Eligible	Yes	2-plan
MD Care	1,425	0.7%	Dual Eligible	No	
Arcadian	921	0.5%	Dual Eligible	No	
Community Health Group	918	0.5%	Dual Eligible	No	
Arta Medicare Health Plan	232	0.1%	Dual Eligible	No	
Contra Costa Health Plan	164	0.1%	Dual Eligible	Yes	2-plan
Total	**194,255**				

Source: CMS

*GMC=Geographic Managed Care

- California has had success with integrated care programs through the Program of All-Inclusive Care for the Elderly (PACE), which combines Medicare and Medicaid funding to provide preventive, primary, acute, and LTC services for persons eligible for nursing home care. Eligible individuals in pilot counties will be able to enroll in PACE. Only non-profit organizations are eligible to participate in the PACE program.
- California ran the nation's largest Social HMO demonstration including a fully integrated contract with the state for dual eligibles in Los Angeles, Riverside, and San Bernardino counties. The Social HMO provided Medicare and Medicaid services through a care management program for individuals with nursing facility care needs and who are eligible for HCBS. The program was extended after its original demonstration period ended in 2007 and has demonstrated results in reducing nursing home placement and increasing the likelihood of returning home within 90 days following a nursing home admission associated with a hospitalization.
- California obtained a §1115 waiver to reorganize and coordinate the delivery of care for medically vulnerable, high-cost Medi-Cal beneficiaries. However, the state did not include dual eligibles in the waiver at the request of CMS.

Integrated Care Pilots Moving Forward

CA Senate Bill 208 requires DHCS, after March 1, 2011, to begin the planning phase for integrated care pilots, including identifying innovative health care models; developing a timeline and process for selecting, financing, monitoring, and evaluating pilots; and presenting the timeline and process to the appropriate legislative committees. The COHS regions and Two-Plan County regions selected for the integration pilot will share common funding, but it is yet to be determined whether Medicare and Medicaid funding will be combined at the state level or at the health plan level.

Two-Plan County Regions

- California will contract with health plans to provide a combined Medicare and Medicaid benefit package. The benefit will fully integrate medical services, long term care services and supports (LTSS), and behavioral health. Enrollment will begin in December 2012.
- The average Two-Plan county (excluding Los Angeles County) in California has 33,000 dual eligibles.
- If the plan is successful, the state will replicate the original procurement. If not, the state will reprocure with modifications and expand to similar counties in 2015.

County Organized Health System (COHS) Regions

- The state will contract with the COHS to provide a combined Medicare and Medicaid benefit package. The benefit will fully integrate medical services, LTSS, and behavioral health. Enrollment will begin in December 2012.
- San Mateo and Orange County have expressed interest in being a part of the pilot program. These two counties are home to an estimated 83,000 dual eligibles.
- If the plan is successful, the state will expand the model to similar counties in 2014.

Additional Models for Integrated Care

- The state has expressed interest in other models of integration if they can be developed within the necessary timeframe. These models include, but are not limited to, Accountable Care Organizations (ACOs), primary care case management (PCCM) models in a fee-for-service structure, and shared savings programs across Medicare and Medicaid.

Pilot Program Covered Services

Dual eligible integrated care pilots will provide coverage for Medicare and Medicaid services through an integrated delivery system, encompassing all medical services, long-term supports and services (LTSS), and coordinated coverage for behavioral health services. Key points in the proposal for covered services are below:

- Enrollees will receive Medicare services under Parts A, B and D. Additional coverage is provided for coinsurance, copayments and deductibles for Medicare-

covered services. Medicare premiums will not be included in the integrated care pilots; premiums will continue to be paid by the state.

- Enrollees continue to receive all benefits and services covered under Medi-Cal, including those not covered by Medicare.
- Pilot programs will cover LTSS, but some variation will exist depending on the readiness of pilot areas and plans. LTSS considered for integration into the pilot programs include the following:
    - Multipurpose Senior Services Program and Adult Day Health Care will be included if funding is appropriated
    - Institutional long term care
    - 1915(c) Home and Community-Based Services (HCBS) Waiver, Assisted Living Waiver, Nursing Facility/Acute Hospital Waiver
    - Personal care services, home modifications, meals
    - Paramedical/nursing services and physical, speech, and occupational therapies
- Within the design phase, pilots will explore the inclusion of Specialty Mental Health Services Waiver, Developmentally Disabled Waiver, and community behavioral health services. The state will engage CMS and stakeholders on including these waivers/services.

Market Opportunity

Over half of California's Medi-Cal population is enrolled in a Medicaid managed care program. However, less than 15% of California's 1.1 million dual eligibles receive care through a managed delivery system (PACE, Two-Plan Models, COHS), and only PACE currently provides robust management of care and services. Going forward, we expect the managed care organizations that have both SNP licensure and capabilities and Medi-Cal contracts to be best positioned to manage the dual eligible beneficiaries that participate in the initial pilots. In the Two-Plan counties, these include Health Net, Molina, Alameda Alliance for Health, LA Care and Contra Costa Health Plan.

In terms of market size, the state and federal governments combine to spend nearly $21 billion on California's dual eligible population of 1.1 million, of which roughly $14 billion is in Medicaid. The state alone spent $3.2 billion on LTSS for dual eligibles, nearly 75% of total state LTSS expenditures. This works out to a PMPM of nearly $1,600 or a total market opportunity of $2.8 billion. This estimate is based on 150,000 duals enrolled in the pilot program or 13.6% of the state total.

Officials believe there is significant opportunity for state and federal savings through managed coordination of care so long as the financial incentives are aligned to provide quality, integrated care. A key factor in the rollout of dual eligible integrated care models, both in California and in other states, will be how the models are structured to share realized savings. These details were not included in the design proposal.

CA Integrated Care Pilots Timeline

Below is the proposed timeline for implementation of the integrated care program.

February 1, 2011:

- Submit proposal to CMS

March 2011:

- Draft Request for Information (RFI) soliciting interest from counties/potential contractors

April 2011:

- Early: Public stakeholder meeting announcing RFI, review project plan, solicit feedback
- Mid: Release final RFI

May 15, 2011:

- RFI responses due

July – September, 2011:

- Targeted stakeholder outreach
- Finalize integrated care models
- September 1: Submit CMMI Demonstration Plan for CMS Approval

October 2011:

- Identify health care models, provide timeline and processes to legislative committees
- Hold second open stakeholder meeting to announce RFP, gather input
- October 31: Release RFP

December 22, 2011:

- RFP responses due

March 2012:

- Pilot counties announced
- Third open stakeholder meeting

April – November 2012:

- Work closely with counties, CMS, others to finalize pilot development

November – December 2012:

- Begin operating pilots

Michigan Proposal Comparison

Michigan has taken a different approach to integrating care for dual eligibles, focused on the need for a single contractual relationship between Medicaid, Medicare and the entity responsible for quality and delivery of services, in this case, risk-based managed care plans. Additionally, Michigan plans to introduce integrated care on a statewide basis, rather than piloted at the county level. The state is also looking at future integration with SNPs, ACOs and other capitated entities down the road as the dual eligible integrated care process matures. Michigan's RFP response is available at:

http://www.arcmi.org/pdf/MichiganDualsProposal1_31_11final_1.pdf

The plan outlined in the states' solicitation response would require that CMS pay the state a risk-adjusted capitation payment for all Medicare covered services. This payment

would be combined with the Medicaid capitation payment to provide one integrated payment. The delegated entity would bear financial risk for all Medicaid and Medicare expenses associated with acute, pharmaceutical, long term and behavioral care costs.

Table 3 – 2007 Medicaid Spending on Dual Eligibles by Service Category

$ (Millions)	Medicare Premiums	Acute Care - Medicare-Covered	Acute Care - Not Medicare-Covered	Prescribed Drugs	Long-Term Care	Total
Michigan	$335	$697	$68	$28	$2,157	$3,285
% Total	10%	21%	2%	1%	66%	100%
California	$1,768	$3,155	$435	$217	$8,378	$13,953
% Total	13%	23%	3%	2%	60%	100%
US Total	$10,899	$17,966	$5,624	$1,378	$84,511	$120,378
% Total	9%	15%	5%	1%	70%	100%

Source: Urban Institute estimates based on data from the Medicaid Statistical Information System (MSIS) and Medicaid Financial Management Reports (CMS Form 64) prepared for the Kaiser Commission on Medicaid and the Uninsured. Available at: http://www.kff.org/medicaid/7846.cfm

There are currently 204,000 dual eligibles in Michigan. Total spending in 2010 was $7.7 billion of which $3.6 billion was Medicaid and $4.1 billion was Medicare. This works out to a PMPM of over $3,000. Unlike California, there is modest SNP enrollment in Michigan today with only five plans offered across the state. Total enrollment is under 10,000 lives of which 60% is covered by a Molina plan.

Table 4 – MI Dual Eligible and Institutional SNP Enrollment, March 2011

March, 2011	Dual Eligible Enrollment	% of total	SNP Type
Molina Healthcare	5,749	61.2%	Dual Eligible
UnitedHealth/Evercare	2,093	22.3%	Dual Eligible
Fidelis	790	8.4%	Dual Eligible
Midwest Health Plan	383	4.1%	Dual Eligible
CareSource	378	4.0%	Institutional
Total	**9,393**		

Source: CMS

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

It has been two weeks since the Legislature passed a FY 2012 budget, including spending cuts to address roughly half of the projected $23 billion deficit. The Legislature did not then, and still has not acted on Governor Brown's proposal to authorize a voter referendum to extend existing tax increases, a move that will require a two-thirds vote. Deadlines are proving elusive in a push to get the voter referendum on the ballot in the second

week in June. Democrats and Republicans do not appear to be getting any closer to agreement, but there is some indication that Republicans may be willing to settle. Beginning in July, the political dialogue will shift from tax extensions to focusing on a restoration budget for the November ballot.

The state is still on target for a June 1 expansion of the Seniors and Persons with Disabilities (SPD) population into Medicaid managed care plans.

In the news

- ***In major cuts, Gov. Jerry Brown slashes services for poor, sick and elderly***
  Gov. Jerry Brown signed into law billions of dollars in budget cuts Thursday that will mean fewer government services, particularly for the old, the poor and the sick. The Governor signed the new laws to tackle $11.2 billion of the state's estimated $26 billion deficit, even as he scrambled to find Republican support for the other half of his budget plan: a ballot measure asking voters' blessing to renew expiring taxes. Some of the cutbacks, such as the $1.7 billion in reduced Medi-Cal spending, will require federal waivers. Administration officials expressed confidence that such waivers would be forthcoming. If they are, California would pay physicians and others who treat Medi-Cal patients less and force low-income residents to pay more for those services. (LA Times)
- SB 703 was amended on March 24, 2011. The amended bill would still establish a basic health plan administered by the Managed Risk Medical Insurance Board (MRMIB) and pursuant to ACA, but it also spells out more clearly what the Basic Health Program will look like. The bill also gives MRMIB power to determine eligibility criteria and the scope of coverage while also allowing MRMIB to negotiate premium and cost sharing arrangements with health plans. (Link to Amendment)

Florida

HMA Roundup – Gary Crayton

The Florida House and Senate health appropriations subcommittees both passed budget conforming bills last week. A combined house bill could go to the floor in the House sometime this week, with a combined Senate bill sometime next week. Finally, a conference committee will likely take place in early or mid-April to resolve differences between the House and Senate budget bills. There has yet to be a fiscal analysis of agency needs to implement either bill, nor has there been word on any related procurements.

Our expectation is that the final rate reductions will be somewhere between the House and Senate versions of 7% and 10%, respectively. The only reductions to HMOs will occur through a pass-through of the rate cuts (estimated at $90.5 million to $140.9 million). It does not appear as if there is a way to get through the budget process without these rate cuts to inpatient and outpatient services, but hospitals are pushing back on the magnitude of the cuts.

The Senate bill also includes cuts of $600 to $700 million in annual benefits in the medically needy program. This would take effect April 1, 2012 and impact all hospitals in the state.

Gov. Scott also announced plans to evaluate the need for public hospitals in the state, creating a task force to study the issue and evaluate eliminating all public hospital funding.

In the news

- ***Scott announces board to study public hospitals***
  Gov. Rick Scott announced last Wednesday the formation of a commission to review whether government hospitals should continue to exist in Florida – a move that could have major implications for the Jackson Health System and other public health systems. (Miami Herald)
- ***Consultants release study on how to save Jackson***
  The Sibery Group, Chicago healthcare consultants hired by a Jackson union, revealed on Monday a detailed plan that the consultants say can turn around the struggling public hospital system without massive labor cuts. One major obstacle to the turnaround is the absence of capital funding. Steward Health Care System, a Boston company, expressed interest recently in buying Jackson and investing $600 million in capital improvements over time, but that deal has lapsed for the time being. (Miami Herald)
- ***Disabled se FL in federal court***
  Gov. Rick Scott and two state agencies have been hit with a class-action lawsuit alleging Florida has failed to provide needed services to 19,000 disabled people who are stuck on a waiting list. The lawsuit centers on a waiting list for what are known as home- and community-based services, which help disabled people live outside of institutions. The lawsuit contends that the state is violating federal law and that some people have been on the waiting list for more than five years. (Health News Florida)
- ***Legislature wants to privatize prisons, probation officers***
  The Florida Senate added language to its budget proposal on Monday to privatize the public prison and probation system. This move comes as a surprise to many groups that were only expecting privatization of the prison health care system. Privatization could shift nearly $600 million to private companies, and while the budget language doesn't appear to favor any one vendor, a leading contender is GEO Group, whose healthcare arm, GEO Care, has contributed at least $126,000 to state parties and candidates since 2009. (Miami Herald)

Georgia

HMA Roundup – Mark Trail/Megan Wyatt

On Monday, March 28, the Senate Appropriation Committee passed its version of the FY 2012 budget (HB 78). Overall, the Senate Committee cuts Medicaid and PeachCare benefits by $112.1 million in state funds, or over $339 million in total funds. When compared

to the House recommendation, the Senate Committee cuts an additional $26.2 million in state funds or over $78 million in total funds. Like the House recommendation, the Senate Committee takes most of its cuts from Low-Income Medicaid (LIM), but has restored or reduced the providers' cuts and continues to maintain bond funding for the development of the new Medicaid eligibility system.

Some key points in the Senate budget are summarized below and compared with both the House proposal and the Governor's recommendations:

- The Senate budget agrees with the House cut that carries that greatest financial impact to Medicaid. $287 million total funds ($98 million state funds) are cut from LIM "based on projected benefits need." The funds will be used to cover other cash needs that are considered more critical early in FY 2012. Specifically, $18.2 million will go to the Unemployment Trust Fund, and $79.8 million will go to the State Health Benefit Plan (SHBP). The intent is to make up the LIM shortfall in the FY 2012 amended budget. DCH does not think this cut will impact Care Management Organization (CMO) capitation rates, as the intent is to temporarily fund more acute cash needs in other programs.
- The Senate budget introduces a new cut of $21.7 million in state funds by including the 2.25% premium tax within the existing administrative percentage for CMO cap rate range development, and implements a minimum Medical Loss Ratio (MLR) of 87%. (Total Funds: $65.5 million).
- The Senate budget agrees with the House, reducing the 1% Medicaid provider reimbursement cut, which already excluded hospitals and community based services, to a 0.5% cut. The Senate also excludes nursing homes along with FQHCs, RHCs and hospice, although FQHCs, RHCs and hospice were excluded from the Governor's and the House recommendation, as their rate setting methodology is linked to federal criteria.
- The Senate budget agrees with the House, restoring funding for the cut to eliminate optional benefit coverage for adult vision, dental, and podiatry services.

The Senate is expected to vote on the FY 2012 budget proposal on Wednesday March 30, 2011. With the legislature expected to take next week off and likely only two days left in the 40 day session when they return, April 14 is a likely signing day for a resolved and passed FY 2012 budget.

Elsewhere, the Governor is likely to proceed with actions on Health Insurance Exchanges in mid-April, working from an executive privilege perspective after the legislature has gone home.

Illinois

HMA Roundup – Matt Powers

Enrollment packages for the integrated care pilot program were sent out with a start date of May 1. The roll-out begins with 6,000 beneficiaries in Cook County and continues over the following four months. Beneficiaries have 60 days to voluntarily select a plan. If they have not selected a plan after 60 days they will be auto-assigned to the Aetna plan.

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

In the news

- ***State holds Medicaid program steady in face of cuts nationwide***

  Illinois officials are standing behind Medicaid reforms passed in January, set to save $800 million over five years by moving 50% of the state's 2.8 million Medicaid participants to a "medical home" managed care setting, and moving residents from nursing homes and institutional care into community-based settings. Gov. Pat Quinn wants to borrow $2 billion to help pay off a backlog of bills totaling $9 to $10 billion. Half of the borrowing would be used to pay off Medicaid bills and garner an enhanced federal match set to end in June with the expiration of federal stimulus funding. Republicans believe the Medicaid reforms do not do enough to reduce spending and oppose Gov. Quinn's plan to borrow funds. ***(The Southern)***

Indiana

HMA Roundup – Cathy Rudd

On March 21, an RFI was published to solicit vendors for provision of business requirements definitions for the State Health Exchange. Proposals are due on April 4. According to the RFI, "[t]he State will engage one vendor to develop technical requirements and designs and another vendor to develop the detailed business requirements." A link to the RFI is included below:

http://www.in.gov/cgi-bin/idoa/cgi-bin/bidad.pl?spec=RFI-11-60&desc=Health+Care+Reform+Exchange+Initiative+(Business+Req)&method=RFI&code=K

Michigan

HMA Roundup – Esther Reagan

Both the Michigan Senate and House began a recess on Tuesday, due to last through most of next week. Budget bills have yet to be submitted, but could be as soon as early April. Gov. Rick Snyder has said he wants a biennial budget resolved by May, but indications are that it will likely be July or August.

Ohio

HMA Roundup – Alicia Smith

There has been ample time for response to Gov. Kasich's Office of Health Transformation budget proposal, and the attitudes are mixed but generally positive.

The hospital community essentially feels that there was little they could do in the way of pushback against the cuts, and that cuts could have been much worse.

The next House Subcommittee meeting is scheduled for April 4 (3pm-10pm).

Texas

HMA Roundup – Dianne Longley

Several sources, including the Health and Human Services Commission (HHSC), have indicated that the Medicaid managed care RFP will be released in the next week or two. However, some discussion remains ongoing regarding the planned expansion of managed care to South Texas. With this item still under review, it's unclear whether the legislature will sign off on the RFP before or after its release, with the ability to go back and amend.

Budget Update: Tuesday reports a proposal out of the Senate of a 4% provider rate cut. All indications are that the House will stick to its proposed 10% rate cut. This, coupled with several other points of contention, signals the looming possibility of a special budget session. It is likely that the provider rate cut will end somewhere between 4% 10%. The Senate has not indicated where the budget offset comes from for a lower rate reduction, but it does not appear to dip into rainy day funds. Gov. Perry has absolutely ruled out use of rainy day funds in the FY 2012 budget.

In the news

- ***Texas Hospitals: Budget Cuts Are Too Deep***

  Texas Hospital Association officials warned Wednesday morning that the current budget proposal could mean funding cuts of up to 37% for some hospitals. The budget would cut Medicaid reimbursement rates for hospitals, nursing homes and physicians by 10%. It expands Medicaid managed care, which still could hinder hospitals' ability to draw down federal dollars, and includes $225 million in annual cost savings in the Medicaid program, many of which are directed at hospitals. A House vote on the budget is expected later this week. (The Texas Tribune)

- ***House budget bill comes out of committee But measure may be too harsh to pass in Senate***

  A state budget bill (H.B. 1) passed the appropriations committee that would eliminate nearly $23 billion, or 12.3%, from the current two-year budget. The bill would leave an estimated Medicaid shortfall of $6 billion through the next two years, with significant reductions to reimbursement rates. The bill is expected to reach the full House on April 1. H.B 1 is likely to pass the House but does not appear to have the full support of Senate Republicans. (Chron.com)

- ***Zerwas: Texas Health Insurance Exchange May Be Dead***

  State Rep. John Zerwas, who filed legislation to establish a Texas health insurance exchange, said he's been told Gov. Rick Perry's office doesn't support the measure. Rep. Zerwas, a Republican, feared the lack of freedom Texas would have in designing and implementing the exchange if left to federal control. (Texas Tribune)

- ***Perry aides explore privatizing prisoner health care***

  Gov. Rick Perry's office is reportedly exploring the possibility of having private vendors take over the operation of some or all medical clinics at Texas' 112 state

prisons, in addition to hospital care and the pharmacy for the prison clinics. Prison health care now receives budget funding of more than $464 million a year, $51 million short of the actual costs of providing care. (The Statesman)

Washington, D.C.

HMA Roundup - Lillian Spuria

The House Budget Committee is preparing to release its budget resolution in the first week of April. There has been much speculation on whether the budget will include Medicaid block grants to states or not, but the latest indication is that it appears likely.

Although there is discussion in the media of a potential government shutdown in the face of budget disagreements, the general consensus is that both Republicans and Democrats would seek to avoid this.

CMS is nearing completion on Accountable Care Organization (ACO) regulations for release yet this spring.

The National Association of Insurance Commissioners (NAIC) voted Sunday not to endorse Rep. Mike Rogers' (R-MI) bill to exclude broker fees from the MLR calculation under ACA. An NAIC vote would have put considerable weight behind the bill and potentially influenced action from HHS.

In the news

- ***Republicans to Propose Overhaul to Medicaid***
  Rep. Paul Ryan (R., Wis.), the House Budget Committee chairman, is expected to release his budget proposal by the first week in April and will likely propose major changes to Medicaid funding mechanisms. Under the House GOP plan, states would be given block grants to spend the money how they determined best. The money likely would still come with basic "strings attached," such as rules to ensure that it went to health care services for the poor. (Wall Street Journal)

OTHER STATE HEADLINES

Arizona

- ***AZ hospitals warn state on slashing Medicaid rolls***
  Hospitals are speaking out against Gov. Brewer's proposal to freeze Medicaid enrollment and implement a 5% cut to reimbursement rates, as well as the Senate's proposal – yet to pass the House – that would remove 250,000 childless adults from Medicaid enrollment. Major hospital systems have warned that rate cuts will translate into significant layoffs, while the Arizona Hospital and Healthcare Association has stated that enrollment reductions will only drive up emergency room visits. (Arizona Daily Star)

- ***Psychiatric episodes can be treated at clinic that's on the way***
  A round-the-clock behavioral health clinic will become available for the first time in the Southeast Valley. The clinic and 16-bed, short-term residential treatment program provides more care than a crisis intervention hot line, but less help than a psychiatric emergency room. Magellan, which contracts with the state for mental health services, is awarding the outpatient clinic contract to Community Bridges, a non-profit that runs substance abuse education and treatment programs. It also will be running a 24-hour behavioral health clinic in Avondale for the West Valley. More than $68 million in mental health funding cutbacks by the state during the past three fiscal years created a dire need for services offered at the new behavioral health centers. (AZCentral.com)

Connecticut

- ***Battle Emerging Over Proposed Tax On Nonprofit Hospitals***
  Gov. Dannel P. Malloy is pushing for a 5.5 percent tax on non-profit hospitals; a number of hospitals argue they would not recoup the projected $266.6 million they would be required to pay. The tax increases to 5.71 percent after Sept. 30, 2011. Lawrence and Memorial Hospital in New London, CT has said the tax, coupled with the elimination of reimbursements, would create a $2.8 million loss of the hospital. William W. Backus Hospital in Norwich, CT could lose $1.5 million. Hospitals also argue the cuts could force them to reduce staffing or services. (Groton Patch)

Idaho

- ***Medicaid cuts clear Idaho Senate; bill cuts $35M***
  Legislation to cut $35 million from state Medicaid funding has passed the Idaho Senate, clearing its final hurdle in the 2011 session. The measure cuts a total of $108 million, due to lost federal matching funds. The cuts have been debated at length, but lagging revenue, coupled with a reluctance to raise taxes in Idaho's Republican-dominated Legislature, has necessitated further cuts to the health care program for poor and disabled to help balance the state budget. (Idaho Statesman)

- ***Medicaid claims software malfunction could cost Idaho millions***
  Idaho is at risk of losing $2 million in Medicaid duplicate payments to providers. Delayed payments following a May 2010 transition to a new claims processing system resulted in the need for advance payments to keep providers afloat. When original payments were finally processed, the providers were reimbursed twice. The state legislature claims that neither the state, nor Molina Medicaid Solutions, nor providers were prepared for the transition last year. California-based Molina Medicaid Solutions took over the $106 million contract in May 2010. (The Republic)

Louisiana

- ***Louisiana to opt out of health insurance exchanges in federal law***
  Louisiana will opt out of creating a state-level insurance exchange as part of the new federal health care law and return a $1 million federal grant it received to help set up the exchange. The state claims the federal government has been slow in providing guidance on what the exchanges should look like and what coverage the participating insurers would have to provide. (NOLA.com)

- The Department of Health and Hospitals will hold a public hearing Wednesday, March 30, on the Notice of Intent to implement Coordinated Care Networks for Louisiana Medicaid recipients.

Maine

- ***MaineCare cancels contract with Aetna unit***
  The state has broken off a $7 million annual MaineCare contract with a subsidiary of Aetna. State officials plan to drop some of the administrative services provided under the contract and transfer other duties such as managing care of high-cost patients to existing state staff. MaineCare, a division of the Department of Health and Human Services, is reviewing all of its contracts because of "fiscal struggles" in the program. (Morning Sentinel)
- ***Dirigo Health program continues to grow despite uncertain future***
  Despite Republican moves to dismantle funding, about 140 small businesses and roughly 2,000 new individuals have enrolled in the DirigoChoice program since enrollment reopened last fall. DirigoChoice is a public-private partnership with Harvard Pilgrim Health Care, offering subsidized health coverage to eligible individuals as well as insurance plans to small businesses. Gov. Paul LePage's budget proposal phases out the assessments charged to insurance companies on all paid claims, which make up 91% of Dirigo's $47.9 million budget. An estimated 15,600 individuals and 630 businesses are projected to be enrolled in Dirigo by the time the current fiscal year draws to a close on June 30. (Bangor Daily News)

Maryland

- ***One state's hospital cost solution: regulated prices***
  For more than 30 years, Maryland has regulated the rates hospitals can charge. 10 of 46 hospitals in the state have voluntarily agreed to for a program in which the state sets a flat, three-year budget based on current spending levels, and hospitals have the opportunity to use cost-cutting procedures to improve their bottom lines and reap higher profits. Maryland's inner-city hospitals, serving large uninsured and Medicaid populations, are financially strong. The state has the lowest average price in the country for average hospital cases, and the second lowest health insurance costs. (Stateline)

Massachusetts

- ***Patrick administration holding forum on health costs***
  Gov. Patrick's administration plans to hold a forum on April 5 to discuss cost containment efforts and gather feedback from industry representatives and other groups. The administration has engaged stakeholders for the past two years on cost containment strategies, but now Gov. Patrick is trying to push forward legislation granting the authority to scrutinize the fees paid to hospitals and doctors, among other measures. (Boston Globe)

Minnesota

- ***Dayton orders more transparency from health plans***
  Gov. Dayton announced that Minnesota health plans will now be required to compete against each other to manage state-subsidized health care programs for elderly, disabled and poor Minnesotans. Last year the state paid more than $3 billion to health plans doing business with the state. Policy changes include creating a managed care website to display public data on the health plans, preparing an annual report, and submitting data to the Department of Commerce "so that regular financial audits of data will be conducted." The annual report will include: detailed information on administrative expenses, premium revenues, provider payments and reimbursement rates; contributions to reserves; enrollee quality measures; service costs and utilization; enrollee access to services; capitation rate-setting and risk adjustment methods; and managed care procurement and contracting processes. (MN Public Radio)

Nevada

- ***Proposed aid cuts could shutter five nursing homes***
  The Nevada Health Care Association claims that five Nevada nursing homes (10% of state total) holding 700 patients may close because of a $20-per-day reduction in Medicaid payments. Gov. Brian Sandoval's proposed budget reduces nursing home rates to $167 per day. The administration is banking on more people receiving home care through $15.50-per-hour personal care attendants, rather than going into nursing homes. The state has funds to cover such costs. (Las Vegas Review Journal)

New Jersey

- ***N.J. treasurer provides few details on Christie's Medicaid overhaul plan***
  Tuesday's budget hearings did little to make clear what exactly is planned in Gov. Chris Christie's plan to overhaul the state's Medicaid program, saving $300 million. The overhaul will feature a global waiver from CMS, giving the state flexibility to determine eligibility requirements and program funding, but no information was given on timeline for federal approval. More details will follow in the coming weeks, according to Christie's administration. (NJ.com)

Vermont

- ***House gives preliminary approval to health care bill***
  The Vermont House gave preliminary approval last Wednesday to health care reform legislation that's designed to put the state on the path toward a single payer system. A five-member Health Care Board will establish a total state budget for health care, review hospital budgets and private insurance rates, and design a new payment system for health care providers. (Vermont Public Radio)

- ***Vermont charges ahead on health care 'public option'***
  The state House of Representatives on Thursday (March 24) approved legislation that eventually could allow every Vermont resident to obtain state-paid health insurance. Gov. Peter Shumlin has made this proposal a legislative priority, aiming to contain health care costs that have doubled to roughly $5 billion since 2003. (Stateline)

Wisconsin

- ***Walker's health chief taking on shortfall***
  Gov. Scott Walker's budget proposal does not implement significant cuts to BadgerCare Plus and Medicaid programs, allocating $14 billion for the programs in the next two fiscal years and increasing funding by $1.3 billion, but calls for roughly $500 million in health cuts over the next two years. Proposed changes are likely to address LTC and FamilyCare, as well as consider some form of health savings accounts for BadgerCare Plus enrollees. (Journal Sentinel)

PRIVATE COMPANY NEWS

- ***Rural/Metro Corp. to be acquired by private-equity firm for $438 million in cash***
  Warburg Pincus agreed to acquire Arizona-based ambulance and fire protection company Rural/Metro in a cash deal valued at about $438 million. Warburg Pincus will pay $17.25 per share a 37% increase over Rural/Metro's Friday closing price of $12.55. (AZCentral.com)

- ***Sutter Health posts rosy results, warns of financial strains ahead***
  Sacramento-based Sutter Health saw both income and revenues rise in 2010, but Sutter's president cautioned that "unprecedented" financial challenges loom. 2010 total income was $878 million compared with $677 million in 2009. Revenues reached $9.1 billion in 2010, compared with $8.5 billion in 2009. 2010 results were led by its expanding Sutter Medical Network of physicians and the return on its $500 million investment in its pension plan in 2008. However, under new health care rules, Sutter Health expects to lose $2 billion in Medicare reimbursements over the next 10 years, with additional cuts anticipated in Media-Cal because of ongoing state budget problems. Sutter will spend $6.5 billion over the next five years on facilities and a new record system. (Sacramento Bee)

- ***Carilion Clinic Announces Leadership Changes***
  Carilion Clinic President and CEO, Edward Murphy, MD, announced Wednesday that on June 30 he will leave the health system he has led for 10 years. Murphy has taken a job with TowerBrook Capital Partners L.P., where he will help develop and acquire businesses that deal with physician management and alignment, care coordination, and the development of accountable care organizations. Carilion Clinic COO Nancy Howell Agee was named Murphy's replacement by the board of the Roanoke, VA-based not-for-profit health system, effective July 1. (Health Leaders Media)
- ***Saint Mary's Hospital and LHP Hospital Group, Inc. Announce Plans for Joint Venture***
  Waterbury, CT based St. Mary's Hospital will access additional capital financing through a joint venture with LHP Hospital Group, operated by CCMP Capital Advisors. (Hartford Courant)
- ***Cerberus–backed Steward Health System targets two more Massachusetts hospitals***
  Morton Hospital and Medical Center in Taunton, MA and Saints Medical Center in Lowell, MA are both expected to announce partnerships soon. (Boston Globe)
- ***Benchmark, Health Care REIT close deal***
  Benchmark Senior Living of Wellesley, MA, and Health Care REIT of Toledo, OH, closed on a deal to form a partnership that bought the real estate assets of 34 senior housing communities operated by Benchmark. The facilities in the deal are in six New England states. (Modern Healthcare)
- ***Iowa Health, Methodist Health Services explore affiliation***
  Iowa Health and Methodist Health Services Corp. announced intent to explore affiliation between the two not-for-profit organizations. Iowa Health runs 10 of its own hospitals and operates another 13 under contract. Methodist Health Services includes one hospital (298-bed Methodist Medical Center, Peoria, IL) and a network of healthcare provider sites. (Modern Healthcare)
- ***Nautic Partners Buys Reliant Hospital Partners***
  Nautic Partners has acquired Dallas-based Reliant Hospital Partners, an operator of inpatient rehabilitation hospitals. The company operates seven facilities and has two additional hospitals under development. (PEHUB)

HMA Recently Published Research

Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection

The Commonwealth Fund

By Sharon Silow-Carroll, Diana Rodin, Tom Dehner, and Jaimie Bern

A central feature of the federal health reform legislation is its creation of "health insurance exchanges." The exchanges, to be operational in 2014, are envisioned as insurance marketplaces in which individuals and small businesses can compare and purchase health plans, and determine and receive premium subsidies for which they are eligible. States have the option to develop and host their own exchanges, or let the federal government establish and run exchanges for them. States that choose to implement exchanges will be able to tailor the exchanges to their states' particular strengths and circumstances. Yet, they will face a multitude of decisions regarding their governance, design, marketing, administration, technology, and other factors. This States in Action focuses on two critical issues: the role of the exchanges in selecting plans for inclusion and in avoiding adverse selection.

Link to report

Upcoming Appearances

Health Plan Alliance: Spring Leadership Conference

Vernon Smith, Principal
March 31, 2011
Dallas, TX

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

M. Reneé Bostick, Principal – Meaningful Use, April 4, 2011
Tom Dehner, Principal – Regional Collaboratives, April 18, 2011

CVS Caremark Client Forum: *Preparing for Imminent Change and Growth in Medicaid*

Vernon Smith, Principal
April 14-15, 2011
Orlando, FL

Association of State and Territorial Health Officers Spring Conference: *Fiscal Impacts of Health Reform*

Vernon Smith, Principal
April 14-15, 2011
New Orleans, LA

MACPAC Public Meeting: ***Monitoring Access to Care in Medicaid and CHIP***
Jennifer Edwards, Principal
April 15, 2011
Washington, DC

Michigan's 27th Annual Developmental Disabilities Conference: ***Planning for Health Care Reform – A Michigan Update***
Eileen Ellis, Principal
April 20, 2011
East Lansing, MI

Health Care Leadership Forum: ***Health Care Reform Implementation in Michigan***
Eileen Ellis, Principal
April 26, 2011
Battle Creek, MI

The American Society on Aging's 2011 Aging in America Conference:
Understanding and Implementing the CLASS Act: A Breakthrough in Long-Term Services and Support
The Impact of the Economic Downturn on Long-Term Services and Supports
Susan Tucker, Principal
April 28-29, 2011
San Francisco, CA

National Association of State Budget Officers: ***Budget Strategies & State Fiscal Conditions***
Mark Trail, Principal
April 30, 2011
Ft. Lauderdale, FL

National Council of Behavioral Healthcare Annual Conference - Primary and Behavioral Health Care Integration Leadership Summit: ***Key Considerations in Designing the Health Home SPA***
Alicia Smith, Senior Consultant
May 1, 2011
San Diego, CA

Thomson Reuters 2011 Healthcare Advantage Conference: ***What's Next for Medicaid: Unprecedented Challenges of Health Reform, Budget Stress and Political Uncertainty***
Vernon Smith, Principal
May 10, 2011
Salt Lake City, UT

Medicaid Managed Care Congress
Vernon Smith, Principal
May 18-20, 2011
Baltimore, MD

National Commission on Correctional Health Care's "Updates in Correctional Health Care": *Medicaid Payment for Inpatient Hospitalizations: Now and 2014*

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