HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MEDICAID MANAGED LONG TERM CARE PROGRAMS

HMA ROUNDUP: FLORIDA SENATE ADDS MINIMUM 90% MLR BACK INTO BILL; STANDING ROOM ONLY AT TEXAS MEDICAID MANAGED CARE RFP VENDOR'S CONFERENCE; MASSACHUSETTS SELECTS EIGHT PLANS FOR THE COMMCHOICE PROGRAM; ILLINOIS SET TO DISCUSS HOSPITAL PAYMENT REFORM

ALSO MAKING HEADLINES: FLORIDA GOV. BACKS OFF CUTS TO DISABLED; TEXAS SENATE MOVES PAYMENT REFORM FORWARD, PUSHES CUTS TO HOSPITALS; MEDICAID CUTS LOOM IN HAWAII; FEDS PICK UP 50 PERCENT OF NEW JERSEY'S CHILDLESS ADULT MEDICAID COSTS; VERMONT HEALTH REFORM MOVES FORWARD; AND MORE…

INTRODUCING: MEDICAID MANAGED CARE RFP CALENDAR

APRIL 20, 2011

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

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IN FOCUS: MEDICAID MANAGED LONG TERM CARE PROGRAMS

This week, our *In Focus* section explores state programs to coordinate care for Medicaid beneficiaries of long term care services and supports (LTSS) through managed long term care (MLTC) programs. These programs, operated through federal waivers, are designed to coordinate the delivery of care to aged and disabled beneficiaries that are eligible for institutionalized care or home and community based services. There are currently eleven states that contract with managed care organizations to deliver services to beneficiaries of LTSS. Total enrollment in these programs exceeds 530,000. This enrollment number compares to 15 million aged and disabled beneficiaries nationwide. In that context, managed long term care remains a relatively nascent concept on a national scale, though some states have had programs in place for many years. As we discuss below, each program has its own distinct design features depending on how the state has chosen to pursue its objectives. The eligibility groups covered, the geographical reach of the programs, the integration of Medicaid and/or Medicare acute care benefits, the level of financial risk associated with institutional levels of care and the types of managed care organizations (MCOs) that participate in the programs are some of defining characteristics that distinguish each of the programs. In the discussion below, we also look at MLTC programs in Arizona, Hawaii, Florida, New Mexico, New York, Tennessee, Texas and Washington. Finally, we provide an overview of states currently in the process of evaluating MLTC expansions.

In aggregate, we estimate that there are over 530,000 beneficiaries currently enrolled across 11 MLTC programs[1]. Of that 530,000 total, approximately three-quarters of the enrollment is served by multi-state, for-profit managed care organizations. UnitedHealth/Evercare and Amerigroup have the largest MLTC operations, each with roughly 22% of the market share. Each operates MLTC programs in six states. Single-state, mostly not-for-profit MCOs represent 27% of the market and are the only options available in two states, Minnesota and Wisconsin. We note that our enrollment figures overstate total MLTC enrollment because we are counting Hawaii's QExA and Texas' STAR+PLUS as exclusively MLTC programs even though only a subset of those beneficiaries are eligible for LTSS.

[1] Note - Massachusetts' Senior Care Options is not included in the table below because enrollment figures were not available

MLTC Program Enrollment by State, Plan, 2011

State	Program name	Aetna	Amerigroup	Coventry	Humana	UnitedHealth	WellCare	Centene	Molina	State-specific plans	Total
Arizona	ALTCS	8,606	0	0	0	2,959	0	3,079	0	12,976	27,620
Hawaii	QExA		0	0	0	19,999	22,863	0	0	0	42,862
Florida	Nursing Home Diversion	0	2,655	1,236	1,337	2,150	0	1,807	0	9,156	18,341
Minnesota	Senior Health Options	0	0	0	0	0	0	0	0	36,850	36,850
New Mexico	CoLTS**	0	19,200	0	0	19,200	0	0	0		38,400
New York	MLTC	0	973	0	0	0	1,294	0	0	27,164	29,431
New York	Medicaid Advantage +	0	13	0	0	0	62	0	0	9,643	9,718
Tennessee	CHOICES**	0	4,920	0	0	13,710	0	0	0	11,370	30,000
Texas	STAR+PLUS	0	88,121	0	0	57,870	0	58,191	51,677	0	255,859
Washington	Medicaid Integration Project	0	0	0	0	0	0	0	4,281	0	4,281
Wisconsin	Family Care	0	0	0	0	0	0	0	0	37,267	37,267
Total		**8,606**	**115,882**	**1,236**	**1,337**	**115,888**	**24,219**	**63,077**	**55,958**	**144,426**	**530,629**
% of Total		*1.6%*	*21.8%*	*0.2%*	*0.3%*	*21.8%*	*4.6%*	*11.9%*	*10.5%*	*27.2%*	

*** HMA Estimate*

Sources available upon request

In addition to the MLTC enrollment discussed above, there are approximately 15,000 Medicaid beneficiaries across the country enrolled in the Program of All-inclusive Care for the Elderly (PACE). PACE is a program that integrates payment and care delivery for dual eligible across all programs including Medicare and Medicaid acute and long term care. PACE plans are all not-for-profit organizations in which a designated PACE center serves as the medical home for the beneficiary. The PACE model has struggled to gain sufficient scale, with only 15,000 covered lives across 75 organizations Accordingly, as we discussed in our March 30th 2011 Weekly Roundup, many states are considering new models for integrated care for dual eligible, creating potential opportunities for managed long term care plans in the future. To that end, we note that last week, the Centers for Medicare & Medicaid Services announced the award of 15 $1 million dollar grants for the planning of coordinated care programs for individuals eligible for both Medicare and Medicaid benefits, or dual-eligibles. The states selected were California, Colorado, Connecticut, Massachusetts, Michigan, Minnesota, New York, North Carolina, Oklahoma, Oregon, South Carolina, Tennessee, Vermont, Washington and Wisconsin.

State MLTC Program Descriptions

Arizona

Overview and Enrollment

Arizona was the first state to undertake a major MLTC expansion; doing so in 1988. The Arizona Long Term Care System (ALTCS) is a statewide mandatory enrollment program, currently serving 27,620 aged, blind and disabled (ABD) Medicaid beneficiaries and dual-eligibles needing nursing home-level care in March of 2011. The ALTCS program was implemented under a Section 1115 demonstration waiver granted by CMS. ALTCS contracts with both national plans and local or county-based health plans, with a little over half of enrollees in plans offered by Aetna, Centene and UnitedHealth. Another approximately 22,000 developmentally disabled individuals are covered through an Arizona-only plan under the ALTCS umbrella.

ALTCS Enrollment by Plan

Plan	Membership (Mar-11)	Market Share
Mercy Care LTC (Aetna)	8,606	31.2%
Pima County LTC	4,337	15.7%
Bridgeway Health Solutions (Centene)	3,079	11.1%
EverCare Select (UnitedHealth)	2,959	10.7%
SCAN-LTC	2,944	10.7%
Pinal County LTC	1,497	5.4%
Yavapai County LTC	1,000	3.6%
Cochise HealthSystems	871	3.2%
Other	2,327	8.4%
Total	**27,620**	

Source: Arizona Health Care Cost Containment System (AHCCCS)

Key Features

- Mandatory enrollment
- Nursing or institutional care facility level of care requirement
- No dual-eligibility requirement

Covered Services and Medicare Integration

- Nursing facility services
- HCBS services
- Behavioral health services

Currently, contracted plans are not required to achieve Special Needs Plan (SNP) status, but many plans are operating as SNPs.

Payment Rate Structure

For the April 1, 2011 through September 30, 2011 period, the statewide average PMPM for combined Medicaid and Medicare services is $3,296. The average acute care only PMPM for the same period is $559. These PMPM rates reflect an April 1st 2011 5% payment reduction for inpatient and outpatient hospital services, physician services, transportation and behavioral health services. The state also implemented a 2.5% cut on home health and adult day health services. These reductions were part of a larger package of budget cuts and took effect on April 1, 2011.

RFP Status

Arizona issued an RFP on January 31, 2011 for the reprocurement of the existing ALTCS contracts. The RFP does not include service area expansion or eligibility category expansion. The state will select one plan in each of 7 regions other than Maricopa where it will select three. We note that there are currently four plans operating in Maricopa. Award announcements are tentatively due to be announced on May 9, 2011 with an operational start date of October 1, 2011. In our March 2 weekly roundup, we valued the total contracts at roughly $1 to $1.3 billion.

Florida

Overview and Enrollment

For the last 12 years, The Florida Nursing Home Diversion (NHD) Program, also known as the Long-Term Care Community Diversion Pilot Project, has provided coordinated care and services to elderly Medicaid enrollees with both Medicare A and B eligibility. The NHD program is completely voluntary, and offered to eligible persons alongside several other program options, including the Program of All-Inclusive Care for the Elderly (PACE), the Aged and Disabled Adult Waiver program, and the Assisted Living for the Elderly Waiver program. There are currently 18,341 enrollees in the NHD program, with roughly half in programs offered by Amerigroup, Coventry, Humana, UnitedHealth, and Centene, and the other half in Florida-only plans.

Florida NHD Enrollment by Plan

Plan	Membership (Apr-11)	Market Share
American Eldercare	4,017	21.9%
Amerigroup	2,655	14.5%
UnitedHealth/Evercare	2,150	11.7%
Sunshine Tango (Centene)	1,807	9.9%
Humana	1,337	7.3%
Vista Independence Plan (Coventry)	1,236	6.7%
United Home Care Services	1,103	6.0%
Universal Health Care	1,056	5.8%
Little Havana	1,030	5.6%
Neighborly Care Network	738	4.0%
Project Indpendence at Home	611	3.3%
Hope Choices	207	1.1%
Urban Jacksonville Sr. Connections	159	0.9%
Yourcare Brevard	148	0.8%
Sunrise	76	0.4%
Worldnet	11	0.1%
Total	**18,341**	

Source: Florida Department of Elder Affairs

Key Features

- Voluntary enrollment
- Nursing facility level of care requirement, plus additional criteria
- Dual-eligibility requirement

Covered Services and Medicare Integration

- Nursing facility services
- HCBS services (waiver-based only)

When a beneficiary is enrolled in a plan that also provides a Medicare Advantage plan, care and services are integrated between Medicaid and Medicare.

Payment Rate Structure

Approved plans were paid a state average PMPM for the 2010 to 2011 period of $1,510 for Medicaid services. The state reports to be avoiding $675 million in Medicaid expenses that would be paid for NHD enrollees served through a traditional per diem nursing home payment structure.[2]

RFP Status

Florida does not contract with plans through a procurement, but rather, potential plans submit an application to the Florida Department of Elder Affairs to be approved as a Medicaid provider. Plans must demonstrate the capacity and experience to coordinate and provide for services in a non-restrictive, appropriate care setting.

Hawaii

Overview and Enrollment

Hawaii's QUEST Expanded Access (QExA) program was implemented in 2008 and currently enrolls Medicaid aged and disabled individuals of all ages, including those that "spend down" to Medicaid coverage. QExA has mandatorily enrolled 42,862 beneficiaries, with nearly 20,000 lives in a UnitedHealth plan and nearly 23,000 in a WellCare plan. As of December 2010, there were 2,400 QExA spend down enrollees.

QExA Enrollment by Plan

Plan	Membership (Dec-10)	Market Share
UnitedHealth/Evercare	19,999	46.7%
Ohana/WellCare	22,863	53.3%
Total	**42,862**	

Source: Hawaii Med-QUEST Division

Key Features

- Mandatory enrollment
- Aged, blind and disabled population
- Nursing facility level of care requirement
- No dual-eligibility requirement

Covered Services and Medicare Integration

- Nursing facility services
- HCBS services
- Behavioral health services

Currently, contracted plans are not required to achieve Special Needs Plan (SNP) status.

RFP Status

Hawaii issued an RFI in January 2011 on the QUEST program, but excluded the QExA ABD population from the RFI.

[2] http://elderaffairs.state.fl.us/english/diversion/Long-Term%20Care%20Community%20Diversion%20Pilot%20Project%20Legislative%20Report.pdf

New Mexico

Overview and Enrollment

New Mexico began enrollment in August 2008 in the Coordination of Long Term Services (CoLTS) program, with expansion to all counties statewide as of April 1, 2009. CoLTS enrolls both Medicaid and Medicare beneficiaries and dual-eligibles, needing full nursing and long-term care services, as well as healthy full dual-eligible individuals. There are approximately 38,400 enrollees statewide, split between plans offered by Amerigroup and UnitedHealth.

Key Features

- Mandatory enrollment
- Aged, blind and disabled population
- Nursing facility level of care requirement (for waiver population only)

Covered Services and Medicare Integration

- Nursing facility services
- HCBS services

CoLTS enrollees receive a full range of Medicaid benefits offered under the state's 1915(b) waiver program. In addition, certain individuals qualify for personal care services based on a level of care designation. Finally, there is a waiting list for enrollment into a HCBS waiver program. Plans are required to coordinate Medicaid and Medicare benefits and both Amerigroup and UnitedHealth offer SNPs in certain counties in the state. Less than 2,000 lives were enrolled in SNPs as of February, 2011.

Payment Rate Structure

CoLTS paid an average PMPM for FY 2011 of $1,844 for Medicaid services.[3]

RFP Status

New Mexico issued a RFP on March 14, 2011, seeking a vendor to assist the State to "develop a unique and visionary plan for New Mexico's Medicaid program that will substantially change the program's structure to improve cost management, health outcomes, give Medicaid enrollees greater choice and ensure the long term sustainability of the program." It is unclear what impact this could have on the current managed care program.

New York

Managed Long Term Care

Overview and Enrollment

In 1997, New York consolidated its PACE program under the umbrella of the Managed Long Term Care (MLTC) program. PACE and MLTC programs are offered side by side to eligible enrollees in Medicaid and Medicare. Plans vary depending on age and health status, with some requiring Medicare enrollment in addition to Medicaid. Currently,

[3] http://www.nmlegis.gov/lcs/lfc/lfcdocs/perfaudit/CoLTS%20Final.pdf

there are approximately 30,000 lives covered in New York under MLTC plans, with nearly all enrolled in New York-only plans. Amerigroup enrolls less than 1,000, while WellCare enrolls almost 1,300.

NY MLTC Enrollment by Plan

Plan	Membership (Apr-11)	Market Share
VNS Choice	8,748	29.7%
Guildnet	6,212	21.1%
Elderplan	3,619	12.3%
Senior Health Partners	2,605	8.9%
Comprehensive Care Management	1,950	6.6%
Independence Care Systems	1,642	5.6%
WellCare	1,294	4.4%
Amerigroup	973	3.3%
HHH Choices	960	3.3%
Fidelis Care	391	1.3%
Senior Network Plan	380	1.3%
Elderserve	362	1.2%
Elant	154	0.5%
Total Aging in Place Program	141	0.5%
Total	**29,431**	

Source: New York State Department of Health

Key Features

- Voluntary enrollment
- Must be 18 or older
- Nursing facility level of care requirement
- No dual-eligibility requirement

Covered Services and Medicare Integration

- Nursing facility services (no limit)
- Non-waiver HCBS services only

Payment Rate Structure

Different capitation rates are paid for an enrollee depending on age category (generally 21-64 and 65+ for the partial capitation plans and 55+ for the PACE plans).

Medicaid Advantage Plus

Overview and Enrollment

Starting in 2003, New York began enrolling Medicaid and Medicare eligibles individuals into a new program called Medicaid Advantage. Medicaid Advantage plans cover only acute care services for aged, blind and disabled beneficiaries while a separate program, called Medicaid Advantage Plus (MAP) is geared toward beneficiaries requiring a nursing home level of care. Currently, there are over 9,700 lives enrolled in MAP plans in

select counties across the state. Nearly all are enrolled in state-specific plans, with 13 enrollees in an Amerigroup plan, and 62 enrollees in a WellCare plan.

NY MAP Enrollment by Plan

Plan	Membership (Apr-11)	Market Share
Elderplan	431	33.4%
Guildnet	326	25.3%
Senior Whole Health	249	19.3%
HIP/GHI	106	8.2%
WellCare	62	4.8%
VNS Choice Plus	58	4.5%
NYS Catholic Health Plan	44	3.4%
AmeriGroup	13	1.0%
Touchstone/Prestige	0	0.0%
Fidelis	0	0.0%
Liberty Health Advantage	0	0.0%
Affinity	0	0.0%
Metro Plus	0	0.0%
HealthFirst/Managed Health	0	0.0%
UnitedHealth	0	0.0%
Total	**1,289**	

Source: New York State Department of Health

Key Features

- Voluntary enrollment
- Must be 18 or older
- Nursing facility level of care requirement
- Dual-eligibility requirement

Covered Services and Medicare Integration

- Nursing facility services (100 day limit)
- HCBS services
- Behavioral health services

In addition to approval by the state to operate as a MAP plan, plans must also be SNPs and MLTC plans.

Payment Rate Structure

PMPM rates are paid based on region and age group, with the 18-64 age group PMPMs in 2010 ranging from $3,145 to $3,798, and the 65 and older age group PMPMs ranging from $2,537 to $3,807.

RFP Status

New York does not contract with MAP plans through procurement, instead granting approval to plans meeting the guidelines to operate as a MAP plan.

Texas

Overview and Enrollment

Texas began enrollment in the STAR+PLUS program for Medicaid beneficiaries, including dual-eligibles, receiving Social Security Income or qualifying for certain waiver services. The STAR+PLUS program is currently limited to a few geographic areas in the state. STAR+PLUS enrollees are enrolled entirely in large, national managed care plans, with enrollment, as of April 2011, exceeding 255,000. Approximately one-third (88,000) are enrolled in an Amerigroup plan, with Centene enrolling more than 58,000, UnitedHealth enrolling nearly 58,000, and Molina enrolling more than 51,000.

Plan	Membership (Apr-11)	Market Share
Amerigroup	88,121	34.4%
Superior (Centene)	58,191	22.7%
UnitedHealth/Evercare	57,870	22.6%
Molina	51,677	20.2%
Bravo Health*	0	0.0%
Total	**255,859**	

**Undergoing readiness review*

Key Features

- Mandatory enrollment (for ages 21 and older)
- No level of care requirement
- No dual-eligibility requirement

Covered Services and Medicare Integration

- HCBS services (waiver-based only)
- Behavioral health services

Hospital services are carved-out of STAR+PLUS. Nursing home stays are excluded from the managed care capitation rate except for the first ninety days following admission. Contracted plans in the Dallas/Ft. Worth area are required to be SNPs, and while it is not required in other areas of the state, many plans have elected to become SNPs to better integrated care for dual-eligibles.

Payment Rate Structure

Texas pays a STAR+PLUS PMPM of roughly $580.

RFP Status

Texas HHSC issued an RFP, covered in our April 13th roundup, to reprocure some managed care contracts and procure expansion in several regions. Included in the RFP is an expansion of STAR+PLUS into the El Paso, Lubbock and Hidalgo service areas. We have estimated this will bring an additional 53,000 lives into the STAR+PLUS program, and we have estimated the annual? contract value at $496 million.

Tennessee

Overview and Enrollment

Tennessee began enrolling individuals in Tennessee CHOICES in August, 2010. The program is targeted to Medicaid enrollees receiving nursing facility care and Medicaid adults and elderly with physical disabilities needing a nursing home level of care or at risk for institutionalization. CHOICES has mandatorily enrolled nearly 30,000 enrollees. We have estimated a little over 11,000 are enrolled in Blue Cross Blue Shield of Tennessee, with close to 13,000 enrolled in a UnitedHealth plan, and nearly 5,000 enrolled in an Amerigroup plan.

Key Features

- Mandatory enrollment
- Nursing facility level of care requirement, or risk of institutionalization
- No dual-eligibility requirement

Covered Services and Medicare Integration

- Nursing facility services (only medically necessary)
- HCBS services (waiver-based only)

Currently, contracted plans are not required to achieve Special Needs Plan (SNP) status.

Payment Rate Structure

The CHOICES program pays a blended PMPM capitation rate at two levels, depending on whether the enrollee is a dual-eligible or a non-dual.

Washington

Overview and Enrollment

The Washington Medicaid Integration Partnership (WMIP) is a pilot project begun in 2005 to coordinate care for aged, blind and disabled (ABD) Medicaid enrollees in Snohomish County who are 21 or older. WMIP has enrolled 4,281 individuals, served entirely by Molina Healthcare of Washington.

Key Features

- Ages 21 and older only
- No level of care requirement
- No dual-eligibility requirement

Covered Services and Medicare Integration

- Nursing facility services
- HCBS services
- Behavioral health services

RFP Status

Molina Healthcare of Washington is currently the only plan in the WMIP program. There is no current indication as to whether Washington intends to expand the WMIP program to other counties or service areas or whether there is an intention to reprocure the current WMIP contract.

Other states considering MLTC programs

- **California:** The "Bridge to Reform" program is planned to move 380,000 Seniors and Persons with Disabilities (SPD) into managed care plans beginning June 1, 2011.
- **Louisiana:** The Home and Community Based Long-Term Care Act was passed in 2010 (HB 1185), a resolution directing the Medicaid agency to implement a managed long-term care pilot program for older adults and persons with disabilities.
- **New Jersey:** The Governor and legislature are both supportive of MLTC. NJ's executive budget called for two elements of MLTC:
    - Carve-in of State Plan PCA? and Adult Day into the regular Medicaid managed care benefit (managed care is mandatory for non-dual ABD.)
    - A waiver for implementation of MLTC for other LTC benefits is expected to be initiated and take effect during the state fiscal year starting in July 2011.
- **Ohio:** Ohio's newly created Governor's Office of Health Transformation is considering a variety of initiatives that could include managed long term care (see our Weekly Roundup report dated March 23, 2011)
- **Rhode Island:** Issued RFI for Long Term Care Rebalancing on December 21, 2010. Status: Submissions have been opened.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Gary Crayton

The Senate is on vacation all of this week. However, the House is set to be in session on Thursday and Friday of this week. Initially, it was thought that the Senate would take up the House budget bill, offer some amendments, and pass it back to the House. However, the Senate is now indicating that they want more of their bill to be featured in the final version. The issue of cuts to the medically needy program will continue to be a major focal point of discussion.

Additionally, there is still a significant divide on the MCO bills offered by the House and Senate. The Senate added back in the 90% MLR provision, and there continues to be debate on regions, with South Florida being a particular issue of strong divide.

In the news

- **New Jackson CEO: 'We can't wait' to fix problems**

  Newly-appointed Jackson Health System CEO, Carlos Migoya, has plans to hold talks with Jackson management and the Miami-Dade County Commission, search for a No. 2 administrator with deep hospital experience and fly to Tallahassee, where the Legislature is contemplating cuts that could cost Jackson perhaps $200 million next year. (Miami Herald)

- **Gov. Rick Scott to rescind order to cut payments for disability services**

  Gov. Rick Scott said last Thursday he would rescind his order to cut state payments for disability services after House and Senate leaders agreed to fill a $174 million deficit. The announcement comes two weeks after Scott informed lawmakers he would invoke emergency powers and cut up to 40 percent the rates charged by group homes and case workers who help the developmentally disabled. (Miami Herald)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The proposed 6%, across-the-board rate cut in Medicaid is still on the table, with the hospital community expected to begin its campaign to mitigate the cuts this week. The Executive branch does not appear to be negotiating changes to the proposal at this point. Rules related to payment changes for hospital outliers and clinic rates for hospital systems were delayed for consideration until May 2011. The legislative session is set to end on May 31.

There is a HFS meeting set for next Friday, April 29, 2011 at 1:00 PM CDT, to discuss the department's initiative to restructure and modernize the hospital reimbursement system. Meeting will be held in Chicago and Springfield.

In the news

- **Blagojevich's All Kids insurance program costly to taxpayers**

  The expansion of the All Kids health insurance program cost Illinois more than $74 million last year, the state auditor general reported Thursday. In addition, All Kids paid the medical bills of children and young adults who no longer qualified for the program, while misclassifying other children whose coverage would have been eligible for federal reimbursement. (Chicago Sun Times)

Massachusetts

HMA Roundup – Tom Dehner

The Connector Board granted approval last week to eight CommChoice plans for the July 1, 2011 to December 31, 2012 period. The approved plans are Blue Cross Blue Shield of Massachusetts, BMC HealthNet Plan, CeltiCare Health Plan, Fallon Community Health Plan, Harvard Pilgrim Health Plan, Health New England, Neighborhood Health Plan, and Tufts Health Plan. Changes in the procurement and contracting agreements are claimed to produce significant savings for the CommChoice program in the future.

Elsewhere, the House has filed their budget and the Senate is set to file theirs shortly. As suspected, nothing significant is likely to occur regarding payment reform through the budget process and will likely be addressed in separate legislation.

Texas

HMA Roundup – Dianne Longley

Texas HHSC held the vendor conference meeting on Monday for their Managed Care RFP (discussed in last week's Roundup). The conference was reportedly "standing room only" and a list of attendees will be released by HHSC in the coming days.

The full Senate Finance Committee began budget hearings Tuesday morning. They are expected to last through Thursday, at which time they anticipate sending the budget bill to the full Senate for debate. They would like to pass the bill out of the Senate no later than May 1st. The bill as it exists now includes $9 to $10 billion in additional "non-tax" revenue, all of which will have to be approved by both the Senate and the House, which the Senate Finance Chairman acknowledges will be a tough sell. The Senate version also includes about $11 billion in additional spending, including the higher rate reimbursement for health and human services. The Lt. Governor has also become more vocal within the past few days, issuing specific support for health and human services increases.

In the news

- **El Paso Hospitals May Be Allowed to Hire Docs**

  Hospitals in El Paso may soon get to independently hire physicians, dentists and other health care providers — a regional approach to lifting part of Texas' corporate practice of medicine ban. The El Paso hospital district currently serves more than 800,000 residents, many of whom are uninsured. (Texas Tribune)

- **Senate Approves Health Payment Reform**

  Medicaid and the Children's Health Insurance Program could transition to a performance-based, rather than procedure-based, payment model, under bills the state Senate unanimously passed this week. SB 7 establishes a pay-for-performance mechanism, while SB 8 sets up the Texas Institute of Health Care Quality and Efficiency — a 15-member board. (Texas Tribune)

- **Ogden Revives Key Piece of Federal Health Reform**

  A bill authored by the influential chair of the Senate Finance Committee, Sen. Steve Ogden, R-Bryan, would create a state health insurance exchange, a marketplace for the public to seek out insurance options. Gov. Perry has opposed such a move. (Texas Tribune)

- **Senate Budget Takes Aim at Texas Hospitals**

  Several budget riders the Senate Finance Committee quietly approved late last week curb how much hospitals are paid for uninsured and underinsured patients, limit how they can use state and federal reimbursements, and open the door to even bigger cuts — all on top of a 10 percent reduction in what the state will pay most health care providers for Medicaid-covered patients. (Texas Tribune)

- **At Nursing Homes, Fears of a Budget 'Armageddon'**

  Should the Senate fail to amend House Bill 1, the general appropriations bill for the next biennium, Medicaid reimbursement rates for all providers in Texas would be reduced by 10 percent. Nursing homes would be hit even harder. The industry has crunched the numbers, and state officials confirm they could be short the amount they would need to fully cover provider rates by a total of 33 percent, or $1.2 billion. (New York Times)

United States

HMA Roundup – Lillian Spuria

In the past week, the House passed the Ryan budget proposal and President Obama unveiled his administration's framework for budget reduction and entitlement spending reform. The Senate is likely to respond soon with their budget proposal. It remains to be seen how much it will mirror the President's proposal. One key to watch is how much the debt ceiling compromise will impact the Democrats' ability to negotiate on the budget. Additionally, there is speculation on whether there will be a deficit reduction and budget proposal statement out of the "Gang of Six."

OTHER STATE HEADLINES

Hawaii

- **Medicaid cuts of $180M warned**
  The next two years of federal Medicaid cuts will eliminate $150 million, affecting 1 out of 5 every Hawaii residents, and state legislators are looking for an additional $30 million in savings, the head of the state Department of Human Services told groups attending simultaneous town hall meetings on Tuesday. (Star Advertiser)

Kansas

- **Provider tax signed into law**
  The governor quietly signed into law a bill that will create a new provider tax for providers of services to the state's developmentally disabled. Local programs for the developmentally disabled would pay a 5.5 percent tax on their gross revenues. Revenue generated by both the tax and the matching funds — roughly $47 million — would be used to increase the Medicaid rates paid to providers of services for the developmentally disabled. (Kansas Health Institute)

Mississippi

- **Analysis: Chaney had an exchange backup all along**
  The state insurance commissioner has selected the Comprehensive Health Insurance Risk Pool Association, a nonprofit that provides coverage to those who are not eligible for private insurance because of health conditions, as the entity to operate the federally mandated health exchange. (NEMS360)

Nevada

- **Health care transparency bills clear state Senate committee**
  A Senate Committee passed several significant health care transparency bills. SB209: Requires the state to create a website that would allow consumers to compare medical facilities based on these events. SB264: Requires "adverse health events" to be publicly reported. It defines the events as actions to a patient that resulted in or has the potential to harm a patient. That includes an infection acquired at the facility, death and serious injury. SB338: Expands the state reporting system to include nursing homes with 25 or more beds. SB339: Requires patients or their representative to be notified if they get a facility-acquired infection. SB340: Requires hospitals and surgical centers to report the names of physicians doing procedures. (Las Vegas Sun)

New Jersey

- **U.S. to pick up half N.J.'s tab for adult Medicaid, saving state more than $300M**
  The federal government has agreed to pay for half of the state's Medicaid program for low-income, childless adults through 2013, saving New Jersey more than $300 million. The U.S. Department of Health and Human Services made the announcement last week. It said the 50 percent matching grant is effective immediately and runs through the end of 2013. (NJ.com)

New York

- **Report: Market should rule NY exchange**
  New York should create a market-based health insurance exchange, according to a study by the Manhattan Institute's Center for Medical Progress. The report isn't likely to get a favorable reception from insurance regulators. More at: www.manhattaninstitute.org

- **New behavioral health initiative presents challenges**
  Behavioral health services providers have an April 1, 2013, deadline for getting patients into managed care and setting up behavioral health organizations. New York City will be eligible to create a limited number of specialized managed care plans and integrated physical and behavioral health provider systems within two years. Providers would be paid on a capitated rate basis or similar payment methodology to manage, coordinate and pay for behavioral and medical services, said the coalition. (Crains New York)

Oklahoma

- **Oklahoma governor returns $54M health care grant**
  Under mounting pressure from local Republican legislators, Oklahoma Gov. Mary Fallin is turning her back on a $54 million health reform "early innovator" grant. It is by far the largest health reform grant that any state has rejected. Other states have returned or turned down $1 million exchange planning grants. (Politico)

Vermont

- **Vermont Senate panel unanimous on health reform**
  Members of the Senate Health and Welfare Committee, unanimously voted out a bill, which would put Vermont on the road toward creation of a government-financed

health insurance plan called Green Mountain Care by 2017. The legislation, a priority for Gov. Peter Shumlin, already passed the House. (Burlington Free Press)

Virginia

- **High court backs Va. agency probing abuse of the mentally ill**
  The U.S. Supreme Court has opened the door for an independent Virginia agency to sue the state to uncover abuse and neglect of people in state institutions for the mentally ill or developmentally disabled. (Times Dispatch)

PRIVATE COMPANY NEWS

- Susquehanna Growth Equity has acquired MediMedia Information Technologies, a Yardley, Penn.–based provider of managed care information for the healthcare industry. No financial terms were disclosed. www.mminfotech.com

RFP CALENDAR

We are introducing our Medicaid managed care RFP calendar this week. The events are color coded by state opportunity and listed in date order. We will be updating this list as new information becomes available, though we note that RFP timelines often slip without any formal announcement.

Date	State	Event	Beneficiaries
May 1, 2011	Ilinois ABD	Implementation	40,000
May 9, 2011	Arizona LTC	Contract awards	25,000
May 11, 2011	Kentucky	Vendor conference	460,000
May 23, 2011	Texas	Proposals due	3,300,000
May 25, 2011	Kentucky	Proposals due	460,000
June 1, 2011	California ABD	Implementation	380,000
June 24, 2011	Louisiana	Proposals due	875,000
July 1, 2011	Kentucky	Implementation	460,000
July 25, 2011	Louisiana	Contract awards	875,000
August 31, 2011	Texas	Contract awards	3,300,000
October 1, 2011	Arizona LTC	Implementation	25,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	875,000
March 1, 2012	Texas	Implementation	3,300,000

HMA RECENTLY PUBLISHED RESEARCH

CLASS Technical Assistance Briefs – Spring 2011

The SCAN Foundation

HMA Principals Susan Tucker and Marshall Kelly contributed a series of briefs to the SCAN Foundations CLASS Technical Assistance Briefs series, released earlier this month.

1. **Elements of a Functional Assessment for Medicaid Personal Care Services**

   By: Marshall E. Kelly and Susan M. Tucker

   This brief discusses the results of the identification and analysis of the assessment instruments and data elements states use for determining medical conditions, activities of daily living and cognitive functional ability within Medicaid-funded personal care services programs. It identifies the elements states use for an assessment of a person's physical and cognitive limitations and need and compares these elements to the requirements of the CLASS Plan. (Link to Report)

2. **Determining Need for Medicaid Personal Care Services**

   By: Susan M. Tucker and Marshall E. Kelly

   This brief focuses on the ranking and scoring criteria and mechanisms that state Medicaid programs use to determine functional need and the level of services provided for Medicaid-funded personal care services programs. Because CLASS requires a determination of need and must identify a benefit level for which regulations must be promulgated, this information can be very useful for the development of the CLASS Plan. (Link to Report)

3. **Functional Assessment Processes for Medicaid Personal Care Services**

   By: Susan M. Tucker and Marshall E. Kelly

   This brief focuses on components of states' Medicaid functional assessment processes with an eye toward how these processes could potentially inform the development of regulations for CLASS. We explore how states handle the assessment process and determine who performs the assessment and where it is performed. Each of these components is important to the design of CLASS so that those determined eligible can receive appropriate benefits. (Link to Report)

"Issues in Missouri Health Care in 2011"

Prepared for the Missouri Foundation for Health

HMA staff worked with the Missouri Foundation for Health (MFH) and Health Care Foundation of Greater Kansas City (HCF) to provide updated resources to help policymakers, health care professionals, and community-based organizations better understand important aspects of the state's health system. Among the topics covered in a series of issue briefs include the following:

- The State of Health in Missouri: Coverage, Access, and Health Status (PDF)
- Uninsured Prescription: Policy Options for Covering Missouri's Uninsured (PDF)
- Coverage Issues for Missourians with Chronic Health Care Conditions (PDF)
- Electronic Health Records and Health Information Exchange (PDF)
- Addressing Medicaid Fraud and Abuse: Facts and Policy Options (PDF)
- Meeting the Needs of Missourians Who Are Elderly or Have Disabilities: Long-Term Care (PDF)
- Treating the Whole Missourian: Mental Health and Substance Use Disorders (PDF)
- Basic Pharmacy Reimbursement Principles in MO HealthNet (PDF)

- Buying Value: Improving the Quality of Missourians' Health Care (PDF)
- Real Opportunities for Ending the Addiction: Tobacco Use Prevention and Cessation (PDF)
- Transforming Missouri Medicaid: Federal Waiver Options and Processes (PDF)
- Assuring an Adequate Health Care Workforce in Missouri's Medically Underserved Areas (PDF)

Concurrent Care for Children Requirement: Implementation Toolkit

National Hospice and Palliative Care Organization

With Contribution from Brenda Klutz and Nicky Moulton

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act (PPACA) into law enacting a new provision, Section 2302, termed the "Concurrent Care for Children" Requirement (CCCR). The District of Columbia Pediatric Palliative Care Collaborative (DCPPCC) and the National Hospice and Palliative Care Organization (NHPCO) are pleased to provide the Concurrent Care for Children Implementation Toolkit, which details information on the options available to states that are implementing Section 2302 or are considering expansion of pediatric palliative care services to children living with life-limiting or life-threatening conditions.

HMA is acknowledged in the publication.

Link to Report

HMA Speaking Engagements

Association of State and Territorial Health Officers (ASTHO), CFO Conference: *Medicaid and Health Reform: Fiscal Implications for the States.*

Vernon Smith, Principal
April 21, 2011
New Orleans, LA

Health Care Leadership Forum: *Health Care Reform Implementation in Michigan*

Eileen Ellis, Principal
April 26, 2011
Battle Creek, Michigan

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, California

National Association of State Budget Officers: ***Budget Strategies & State Fiscal Conditions***

Mark Trail, Principal
April 30, 2011
Ft. Lauderdale, Florida

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, California

CBHA: Reading Some of the Tea Leaves for Healthcare Reform's Directions

Matt Powers, Principal
May 9, 2011
Oak Brook, IL

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, Utah

Medicaid Pharmacy Administrators Conference, South East Region: *"Medicaid and Health Reform in an Era of Economic and Political Uncertainty."*

Vernon Smith, Principal
Charlottesville, VA
May 17, 2011

Medicaid Managed Care Congress

Vernon Smith, Principal
May 18-20, 2011
Baltimore, Maryland

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, Arizona