HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: ILLINOIS HEALTH INSURANCE EXCHANGE: NEEDS ASSESSMENT REPORT

HMA ROUNDUP: FLORIDA MCO RATE UPDATES; CALIFORNIA, PENNSYLVANIA SUBMIT DUAL ELIGIBLE LOIS; GEORGIA HEALTH INSURANCE EXCHANGE COMMITTEE MEETS; NEW YORK HEALTH HOMES PROGRAM DELAYED

OTHER HEADLINES: LOUISIANA MEDICAID MCO IMPLEMENTATION DELAYED; CMS PUSHES FOR MINIMUM MLR IN FLORIDA; WASHINGTON LIMITS NON-EMERGENCY ER VISITS; NAMD URGES SUPER COMMITTEE TO CONSIDER GRANTING STATES GREATER FLEXIBILITY TO COORDINATE CARE FOR DUAL ELIGIBLES

RFP CALENDAR: WASHINGTON BIDDERS' CONFERENCE SEPTEMBER 29; ALTCS CONTRACTS GO LIVE OCTOBER 1

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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: WE REVIEW KEY TAKEAWAYS FROM ILLINOIS HEALTH INSURANCE EXCHANGE NEEDS ASSESSMENT REPORT

This week, our *In Focus* sections reviews the key considerations in the exchange design and development process in Illinois, as presented in a report released earlier in September, *Illinois Exchange Strategic and Operational Needs Assessment*. This report, which has now been made available to the public, was one component of a project led by Health Management Associates, with support from Wakely Consulting Group. An additional report on enrollment and eligibility processes was led by HMA, along with CSG Government Solutions. The intent of the report is to inform the insurance Exchange planning process. The report addresses the following topics:

- provides background information on the Affordable Care Act (ACA),
- provides an Exchange needs assessment for the state,
- addresses mandatory Exchange services and functions,
- projects Exchange start-up and operating costs, and
- provides insights on policy decisions the state will need to make in designing its Exchange, coordinating it with the Illinois insurance market, and integrating it with existing Illinois public programs.

Initial projections are that the Illinois Exchange will enroll 486,000 individuals in 2014, the first year of operation. Of that total, 149,000 will enroll in the Small Business Health Options Program, or SHOP Exchange, and 337,000 as individual purchasers. Of the individual purchasers, an estimated 73% will receive some form of premium or cost-sharing tax credit. As the Exchange becomes well-established, enrollment is projected to grow, particularly over the first few years of operation. By 2016, the Illinois Exchange is projected to serve over 1 million customers. Exchange enrollees will include: individuals without insurance and certain individuals in state programs today (many of whom will have access to subsidized coverage through the Exchange), people who purchase non-group insurance today and will use the new Exchange market to purchase insurance, and people (some insured and others currently uninsured) who work for small employers that choose to use the SHOP Exchange.

The report and additional documents, meeting agendas, and written testimony are available on the Illinois Health Benefits Exchange Legislative Study Committee website.

Link to website: Illinois Health Benefits Exchange Legislative Study Committee

Link to report: Illinois Exchange Strategic and Operational Needs Assessment

Link to Sept. 21 presentation: Final Report and Findings

Challenges of the ACA Exchange Timeline

To begin providing coverage options for eligible individuals on January 1, 2014, Illinois' Exchange must be operational for an open enrollment period beginning in October, 2013. State Exchange plans must be submitted to HHS in the Fall of 2012 for federal approval by January 1, 2013. This timeline demands that the state make a number of key policy and planning decisions well over a year before an Exchange begins providing coverage. The report stresses that timing is an issue not only for state planning efforts but also for health plans that intend to be certified to offer products through the Exchange in 2014. Key next steps that need to be addressed are state legislative authorization of the Exchange and the establishment of an Exchange organization

In a September 21 presentation, the following timeline was presented. We note that this timeline is merely a recommendation and does not represent set deadlines for Exchange milestones.

Exchange Milestones	Timeline
Enabling Legislation IT RFP	December 2011
Appoint Board Hire staff Establish administrative systems	March 2012
Begin website development Begin billing / enrollment systems	April 2012
Begin market outreach Work w/ Insurers on QHP* design	July 2012
Begin certification of QHPs Design appeal and grievance processes	October 2012
Submit Exchange Plan to HHS Implement full plan	December 2012
Testing of IES** and other operations	Throughout 2013
Open Enrollment begins	October 2013

* *Qualified Health Plan; ** Integrated Eligibility System*

Key Mandatory Exchange Development Areas

There will be several significant decisions required in the Exchange development process as it pertains to the Exchange organization, the scope of Exchange functions, and the impact on the regulatory and business landscapes of the current insurance market in Illinois.

Given the large number of new functions Exchanges must perform and the operational complexity of these functions, Illinois should consider design and organizational approaches to the Exchange that enable prompt decision-making and provide flexibility to adapt quickly to shifting market conditions. Because of the importance of ensuring the public's trust in Exchange board decisions and of insulating members from political pressures, in defining its board membership Illinois should give priority to competence and experience rather than the status of an individual as a representative of an identified interest group.

Operational expectations of Exchanges are substantial. This report reviews mandatory Exchange requirements and addresses whether existing state infrastructure is available or could be leveraged to serve the function for Illinois. The functions of the Exchange can be grouped into the following fourteen domains:

1. Eligibility determination
2. Online shopping
3. Enrollment, billing, and collections
4. Customer service
5. Producer management
6. Navigator management
7. Communications and outreach
8. Plan specification and qualified health plan management
9. Financial management
10. Risk adjustment (if done by the Exchange)
11. Oversight, governance, and program evaluation
12. Mandate certification and eligibility appeals
13. Consumer protections
14. Reporting for federal and state oversight

Serious Information Technology Needs Exist

A number of mandatory Exchange functions will require substantial investments in information technology infrastructure. Illinois' existing technological infrastructure currently offers little framework that could be adapted or expanded to provide the functionality required for the Exchange. This is a problem likely faced by nearly all states. The significant element of IT development relating to eligibility and enrollment systems is dealt with in the separate report prepared by HMA and CSG.

Exchange Must be Self-Sufficient when Federal Start-Up Funds Expire

The report provides an estimated breakdown of start-up costs for the Illinois Exchange. These funding streams are provided through federal grant funding:

- $75.0 million for Systems Development and Support:
    - $45.4 for the eligibility determination and enrollment system;
    - $15.8 million for a website;
    - $9.6 million to develop a customer service call center; and
    - $4.1 million for a premium-billing system.
- $17.3 million for Program Operations, predominantly in the following:
    - (1) Facility and Related of $809,959;
    - (2) Salary and Benefits of $8.4 million; and
    - (3) Consulting and Professional Support of $7.0 million.

Under the ACA, by 2015 Exchanges are required to be self-sustaining. Illinois needs to identify appropriate revenue to support its Exchange after the funding currently being provided by the federal government for start-up and establishment is spent. The report provides the following key points on Exchange funding:

- In 2015, expenses are estimated to be between $57 million and $89 million, or between $9 and $13.50 PMPM, exclusive of any broker (producer) fees.
- Operating costs per enrollee will decline as enrollment increases.

- These measures compare favorably with existing benchmarks.
- If revenue is collected only from Exchange-participating plans, it would add between 2.2% and 3.3% in 2015 to premiums, depending on enrollment scenarios.
- If the assessment is spread over the entire health insurance market, the surcharge percentage required to break even is closer to 0.3% in 2015.

Insurance Broker Community Key in Stakeholder Process

The ACA and Exchanges will substantially change how health insurance is purchased by individuals and small businesses by streamlining and simplifying the process of shopping for and purchasing health insurance. The report cautions that if insurance brokers (known as "producers" in Illinois) are hostile to the Exchange and have incentives to avoid sending business to it, their actions could threaten the success of the Exchange. Today, brokers play an important role in Illinois for individuals and small business purchasing insurance. The report recommends including the broker community in the stakeholder engagement process to develop a policy and financial model that avoids the potential tension between brokers and the Exchange.

The Basic Health Plan Option

Illinois has the option of establishing a Basic Health Program (BHP) in lieu of Exchange coverage for people ineligible for Medicaid who have income at or below 200% of FPL. Because the BHP would allow the state flexibility in benefit design and cost sharing, it may be an opportunity to design a plan that is intended to address the needs of the low-income population and to improve continuity of care across transitions in coverage and within families who would otherwise be "split" between the Exchange and Medicaid. However, the financial structure of the BHP, which gives states 95% of what BHP enrollees would have received in subsidies on the Exchange, creates significant risk and uncertainty for Illinois. The report analyzes risks and benefits of the BHP in detail. Financial modeling demonstrates wide variation in net state costs depending on premium levels in the Exchange. The implementation of a BHP in Illinois may simplify coverage and coordination and mitigate the movement between Medicaid and the Exchange, referred to as "churning." However, uncertainty in eligible populations makes modeling difficult and could lead to increased risk. Additionally, there could be adverse effects on the Exchange because it would be left with a smaller enrollment pool.

HMA Medicaid Roundup

California

HMA Roundup – Jennifer Kent

California submitted a letter of intent (LOI) to CMS in response to the State Medicaid Directors letter regarding integrated care plan options for dual eligibles. The state intends to pursue the capitated model but is also considering the managed FFS model as an option for future implementation.

In the news

- **California issues RFP for MMCD Actuarial Rate Development**

  The State of California Department of Health Care Services, Office of Medi-Cal Procurement is conducting an RFP to acquire actuarial services in the area of capitation rate-setting methodologies for the Medi-Cal Managed Care program. Letters of Intent are due on October 14, 2011, with Proposals due on November 18.

Florida

HMA Roundup – Gary Crayton

Managed care rate negotiations continued this past week. As a reminder, Florida's Agency for Healthcare Administration (AHCA) proposed Reform rates for Duval and Broward county that were in the low double digit range. At a meeting held late last week, the state's actuaries (Mercer) maintained that these rates are unlikely to be materially revised going forward. Centene and Molina have the most market share in the Reform program, with 56% and 18% of the enrollees respectively. The non-reform rates were reduced by 0.4% for FY2012, though that is the statewide average. There is considerable variation by region. For example, rates in Region 2 were reduced by 7%, while rates in Region 9 were increased by 5%. For a breakdown of rate increases and plan enrollment by region, please contact us. With respect to the non-reform rates, our sense is that the rate negotiations are ongoing, with the health plans taking issue with the actuaries' methodology of using utilization rates based on plan encounter data while relying on fee-for-service rates for the unit cost input. Typically plans are able to offset higher-than-FFS rates to providers with lower utilization.

Additionally, AHCA provided an update to the legislature last week regarding the status of the waiver extension. This waiver extension refers only to the state's existing program design, which needs to be federally approved for renewal before the state can begin negotiating with CMS over its plans to pursue a statewide expansion of managed care starting in 2012. There are two sticking points related to the waiver renewal. First, CMS is insisting that Florida include a minimum loss ratio (MLR) in its contracts with the health plans. Florida's legislature considered this option earlier this year but rejected it in favor of an experience rebate methodology as is in place in Texas, where CMS recently renewed the state's waiver. It is unclear why CMS is insisting on a minimum MLR in Florida but did not do so in Texas. The other unresolved issue relates to the low-income pool, where CMS wants to approve the program only through December 31, 2013, while the state wants it extended through June 30, 2014. The half year difference equates to approximately $500 million. AHCA suggested in its presentation that negotiations are ongoing regarding the LIP extension but that CMS is not likely to back down on its insistence on a minimum MLR.

Finally, Governor Scott released a list of his legislative priorities for the upcoming year. On the list are a bill to allow for the sale of health insurance across state lines and a bill to make changes to the assisted living facility (ALF) industry based on the recommendations of the ALF task force.

In the news

- **Florida Health Care Administration trying to recoup $4 million from firm managing Medicaid mental-health services**

  Contending that not enough money was spent on patient care, the state Agency for Health Care Administration is trying to recoup $4 million from a firm that manages Medicaid mental-health services. Tampa-based Florida Health Partners Inc. challenged the agency in cases filed last week in the state Division of Administrative Hearings. The dispute centers on whether Florida Health Partners in 2006 met a requirement that it spend 80 percent of the money it received --- known as a "medical loss ratio" --- on caring for Medicaid patients. AHCA contends that the firm fell substantially below the 80 percent threshold in the Tampa and Orlando areas. Under state law, Medicaid mental-health firms have to pay back the difference if they spend less than 80 percent. (Palm Beach Post)

- **South Broward public hospitals prosper as Miami-Dade's struggle**

  While many South Florida governments are slashing expenses to try to balance budgets, the government hospitals of South Broward are doing so well that they are improving services while cutting their tax rate by 41 percent. The four public hospitals in the Memorial Healthcare System can reduce their tax rate because they have brought in $232 million the past two fiscal years, by attracting paying patients while keeping costs down. In contrast, Miami-Dade's Jackson Health System has lost $337 million over that same time. The financial success in Broward led the board of the South Broward Hospital District, which oversees the Memorial healthcare facilities, to vote Monday evening to reduce its 2012 property tax from $1.27 per $1,000 of taxable property value to 75 cents per $1,000 — meaning the owners of a $275,000 home could see their hospital taxes drop from $318 to $187. (Miami Herald)

- **Jackson Health System expects to lose about $85 million this year**

  Jackson Health System expects to finish its fiscal year, which ends Friday, with "11 or 12 days of cash on hand," Chief Financial Officer Mark Knight told the governing board Monday at its monthly meeting. Most successful public hospitals average about 160 days of cash to pay bills. The number might have been lower had the state not assured him that on Thursday it will make a large payment to Jackson in special Medicaid funding. For the fiscal year, Knight now anticipates the system will finish with a loss of around $85 million. In fiscal 2011, Jackson lost $93 million. In fiscal 2009, it was $244 million. Jackson executives hope to reduce future losses by shrinking the JMH Health Plan, which lost $27 million this fiscal year. (Miami Herald)

- **Feds to state: Medical loss ratios are coming to Florida**

  State officials told legislators on Wednesday that the federal government will require health maintenance organizations in five counties to meet medical loss ratio requirements. The move is angering Republican legislators since they specifically rejected the concept earlier this year when they adopted a statewide Medicaid managed care program. Medical loss ratios, which require that health plans spend a certain percentage on patient care, are a key component of the controversial federal health care reform. (The Florida Current)

Georgia

HMA Roundup – Mark Trail

The Georgia Health Insurance Exchange Advisory Committee met on September 22, 2011. This is significant because the state has until now resisted, at least publically, complying with the requirements of the Affordable Care Act (ACA). Among the takeaways from the meeting were that the state should design an exchange that could survive even if the ACA is ruled unconstitutional and that it be designed in such a way as to improve the economic viability of small businesses in Georgia, where only 47% of small businesses offer employer-sponsored insurance. For more information on the topics discussed at last week's meeting, please contact us.

Also worth noting, Georgia received CMS approval for a 90% match on costs related to hiring a consultant to do planning for a new eligibility system. It is expected that the new system will be the backbone for determining eligibility for Medicaid, CHIP, and subsidies associated with the health insurance Exchange and other social support programs (TANF, SNAP etc).

Finally, Medicaid HMO rates were delivered to the plans last week. We are not hearing reports of dissatisfaction with the rates.

Illinois

HMA Roundup – Matt Powers / Jane Longo

The legislative Study Committee held a meeting on September 21, 2011, to discuss the exchange report discussed in detail above. Based on its findings, the committee is scheduled to make recommendations to the General Assembly by September 30.

The next significant legislative event on the horizon is an October 13 public meeting, hosted by HFS, to discuss the Care Coordination Innovations Project. This event is expected to give the Department a better idea of what kind of interest exists for providing care coordination services. Our sense is that the state will be seeking to assess interest in the RFP and input in how to craft the RFP.

Finally, according to a recent budget report, the state will be $8.3 billion short on June 30, 2012, if no actions are taken. The report suggested the bulk of the shortfall will be filled by delaying payments to vendors.

New York

HMA Roundup – Denise Soffel

The planned roll-out of the health homes project has been delayed. The state has decided to pursue the initiative in three phases, rather than all at once. The first phase will begin in January 2012 (rather than November 1 as originally planned). Applications for Phase 1 are due November 1. Thirteen counties will be included in Phase 1 based on the Department of Health evaluation of their readiness and the number of LOIs received. The counties selected also reflect a mix of upstate/downstate and urban/rural areas.

By way of background, the health homes project is designed to better coordinate care for higher-cost populations by paying a care coordination fee to an integrated care delivery team that applies together but with one organization serving as the lead applicant. Lead applicants to the health homes project can be one of three entities: a community-based organization, a hospital, or a managed care plan. The best proposals include all of these entities in their network. The Department reiterated that the care coordination fee should be shared among partners based on their relative effort for the patient.

Patients will be assigned to health homes. The Department is working with the managed care plans to develop the assignment algorithm. They are using attribution and loyalty data to inform assignment. The first wave of assignments will be those patients least connected to the health care system and most at risk of hospitalization.

Individuals are being assessed and scored using three metrics:. (1) Clinical risk groups capture severity and chronicity of illness (but not behavioral health issues). (2) Predicted hospitalizations is based on work done by John Billings at NYU. (3) Behavioral health indicators will also be considered. In all cases the state will be looking for existing relationships with providers—ambulatory, medical and behavioral.

Case management rates will be calculated based on three criteria: caseload variation, the cost of case management services, and patient-specific acuity. In the future, the state hopes to incorporate functional status data into the rate calculations. They recognize that clinical acuity does not translate into the need for care management; homelessness, education, and other social factors are probably as important. The average statewide rate is $100 PMPM, but it is over $300 for some patient groups. The final rates will be adjusted for a wage equalization factor to pay more in the downstate region and less upstate.

In the news

- **Nursing homes claim they were illegally shortchanged of Medicaid funding by Cuomo administration**

  A group of nearly three dozen nursing homes is suing the state, claiming they were illegally shortchanged of crucial Medicaid funding by Governor Cuomo's administration. The lawsuit against the state Health Department, filed recently in Albany Supreme Court, seeks to throw out a change in the Medicaid funding formula enacted earlier this year that cuts this year's money and recoups payouts from the past two years. (NY Daily News)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Last week, Pennsylvania submitted a letter of intent (LOI) to CMS in response to the State Medicaid Directors letter regarding integrated care plan options for dual eligibles. The state is considering both the capitated model and the managed FFS model. .The LOI enables the state to sit down and talk to CMS about what flexibility Pennsylvania has to build on or modify the various existing delivery options available in Pennsylvania. Among the state-specific questions likely to be discussed are:

- Whether or not CMS will allow for behavioral health services to be carved out of the integrated care plan (BH services are currently carved out in Pennsylvania).
- Whether or not CMS will support an option that would allow the state to award the integrated option under any of its existing service delivery contracts without having to go through a new procurement process as is outlined in the SMD letter.
- What are the implications for the under 21 duals which are currently included in the Pennsylvania's managed care and enhanced primary care case management contracts .

Also, Beginning October 1, 2011, the state will officially eliminate paper notifications to providers regarding changes in the Medicaid program. Instead, providers will be notified of changes through one of three options

- Receiving an email notification of new bulletins from PROMISe
- Receiving email notifications of new bulletins from a Listserv
- Receiving no notification and obtaining bulletins by checking the website

Finally, the state has changed the threshold for early refills of prescription drugs to less than 15% of the dispensed drug remaining which compares to the previous threshold of less than 25%.

In the news

- **Demise of Pennsylvania Plan For Low-Income Adults Leaves Many Uninsured**

  Six months after Pennsylvania terminated adultBasic, the state-funded health plan for low-income adults, many of the nearly 41,000 former enrollees who lost their coverage at the end of February likely have been left uninsured. About 40% have enrolled in either Medicaid or the limited benefit Blue Cross Blue Shield plan that was opened to them, according to data provided by the Pennsylvania Insurance Department. Some of the remaining 23,000 individuals who lost their coverage may have found other options, but the insurance department believes many are accessing free or reduced-cost care through community health centers. (Kaiser Health News)

United States

HMA Roundup – Lillian Spuria

Responses to the State Medicaid Directors letter regarding integrated care plan options for dual eligibles are due on October 1, 2011. So far, we know that Pennsylvania, California and Arizona have submitted LOIs.

Also, a MACPAC meeting was held Sept. 22-23 in Washington, DC.. Topics included linking payment to quality in Medicaid, and care coordination for high-cost, high-need populations. Presentations have not yet been posted.

In the news

- **Health-Care Costs May Become Biggest State Expense, Fitch Says**

  Rising health-care costs, especially Medicaid, are set to become the biggest challenge for U.S. state budgets and may eclipse education spending over the next decade, Fitch Ratings said. Federal spending cuts and implementation of the 2010 health-care bill will represent "a major concern for states," Fitch said in a report today. Medicaid is likely to be a target of the congressional supercommittee charged with finding $1.2 trillion in budget cuts, the ratings company said in a Sept. 21 report. Medicaid represents the biggest share of federal aid to states, according to Fitch. President Barack Obama's 2009 stimulus program cushioned state budgets from increasing enrollment and costs for Medicaid, the health-insurance program for the poor, Fitch said. From October 2008 to June of this year, the legislation provided an estimated $103 billion to the states. The funds helped offset $50 billion in increased costs associated with an additional 6 million Medicaid participants. (Bloomberg)

- **Debt panel eyes dual Medicare/Medicaid patients**

  Government health benefits for some 9 million of the sickest and poorest U.S. citizens will come under scrutiny from the congressional "super committee" seeking to cut the nation's debt. These are Americans who qualify for both the Medicare and Medicaid programs for the elderly and the poor, based on their disability, age and low income. Medicare- and Medicaid-eligible patients represent about 15 percent of enrollees in Medicaid but account for 39 percent of program costs. They also account for 16 percent of Medicare enrollees and 27 percent of program costs. The super committee panel, with six members from each party, is taking a look at proposals to reduce spending on this group, a congressional aide said. President Barack Obama is proposing shifting federal drug reimbursements for this group to lower Medicaid rates rather than paying the higher Medicare prices, a move strongly opposed by the pharmaceutical industry. Insurance companies and states are pressing for policy changes to encourage more use of managed care which would in turn encourage less costly forms of treatment, from closer scrutiny on the need for specific services to incentives for preventive care. (Reuters)

- **Barrasso supports opt-out bill on Medicaid**

  U.S. Senator John Barrasso has joined South Carolina Senator Lindsey Graham in introducing a bill that would allow states to opt out of the Obama administration's Medicaid expansion. The two Republicans note that Medicaid in its current form is crushing the states financially. They say the expansion called for under the new health care law will exacerbate the problem. Barrasso says President Barack Obama's one-size-fits all health care policy is not the right prescription for all states. He says states deserve to have the flexibility, freedom, and choice to make decisions about how best to help the people in their own states. (Billings Gazette)

- **State budget cutting prompts worries by nation's children's hospitals**

  State lawmakers are slashing Medicaid payments to children's hospitals as part of their efforts to close budget gaps. Medicaid accounts for about half of children's hospitals' revenues. Even small cuts, like the 3% payment reduction Florida lawmakers enacted

this spring, will severely strain budgets, advocates say. Meanwhile, cuts to physician training programs have some children's advocates worried that there will not be enough pediatricians and specialists to provide care. That is particularly true in Texas, where the children's population is growing and hospitals already struggle to fill slots. Conversely, Ohio, California, and other states with aging populations are seeing a decline in the number of children, even as hospitals invest billions in new facilities and payments are trimmed. (Bellingham Herald)

- **Medicaid claims audits to begin in January**

  Physician and hospital organizations praised several changes federal health officials made to an earlier proposed version of a new Medicaid claims audit program authorized by the health system reform law. The Centers for Medicare & Medicaid Services on September 14 released a final rule detailing implementation of the Medicaid Recovery Audit Contractor program, based on a similar Medicare program in operation nationwide. The Medicare RACs have come under fire from physicians for what doctors have termed aggressive auditing tactics, prompting some critics to label them "bounty hunters." The Department of Health and Human Services estimates that Medicaid RACs will save the program $2.1 billion over the next five years, of which $900 million will return to states. States must implement Medicaid RACs by January 1, 2012, according to the final rule. (American Medical News)

- **National Association of Medicaid Directors letter to Supercommittee**

  The National Association of Medicaid Directors released a letter addressed to the Supercommittee members on September 22, urging them to consider constructive changes in the Medicaid program that will reduce costs while increasing access and improving the quality of the care provided without a negative fiscal impact on states. The letter proposes allowing states greater flexibility in the areas of managed care, management of dual eligible members, and establishing appropriate incentives to drive quality outcomes among providers and enrollees in all types of delivery systems. Link to Letter (PDF)

OTHER HEADLINES

Arizona

- **Side effect of mental-health cuts: Job losses**

  As much as the state's behavioral health system has suffered cutbacks over the past year, it is about to suffer more. Agencies that treat Arizona's mentally ill and provide substance-abuse treatment face a double whammy. The state's Medicaid program soon will again reduce the amount it pays for services. And a 30-year-old class-action lawsuit that ensured state-funded treatment for the seriously mentally ill may be nearing its demise. The latest round of payment reductions, spurred by a need to balance the state budget, has forced care providers to lay off hundreds of mental health workers statewide. Hundreds more layoffs are expected in the months ahead. (AZ Central.com)

Maine

- **Maine lawmakers worried about federal audits of DHHS**

  Members of the state Legislature's budget-writing Appropriations Committee are worried several federal audits of the Maine Department of Health and Human Services now under way could cost the state tens of millions of dollars. The two most significant audits of DHHS in terms of potential liability to the state are school-based services for children and what are called private nonmedical institutions. The state's formal response to the federal concerns is due next month. There have been several discussions with officials at the Center for Medicaid Services about the federal position that many of the private nonmedical institutions services are not eligible for the reimbursement the state has been getting from the federal government. (Bangor Daily News)

Massachusetts

- **State to penalize hospitals that readmit too many patients**

  Starting next month, the state plans to cut Medicaid payments to 24 hospitals that it says have higher-than-average rates of readmitting patients. When a patient returns to the hospital soon after going home, it can mean that the hospital provided inadequate instructions on taking medications or failed to follow-up on problematic test results. By docking the pay of hospitals that readmit high numbers of patients within 30 days of discharge, state officials hope to push hospitals to better coordinate patients' care after they leave the hospital. Massachusetts Medicaid officials, who plan to reduce reimbursements to these hospitals by 2.2% , estimate the program will save $5.2 million in the fiscal year that begins October 1. The Massachusetts Hospital Association said the plan is unfair. (Boston Globe)

Minnesota

- **Twin Cities poor told to switch state health plans**

  More than 70,000 Twin Cities residents enrolled in state health insurance programs will need to select a new health plan this fall. The changes stem from a new program at the Minnesota Department of Human Services designed to save money in the Medical Assistance and MinnesotaCare health programs by putting managed care contracts out for competitive bids. This year, Governor Mark Dayton called on his administration to implement competitive bidding for HMOs in the seven-county metro area to test whether such a program can reduce overall costs. Currently, five HMOs have contracts with the state to manage the public programs in some or all of the seven counties. But next year, at least two and possibly three of those options will not be available in some of the counties. The switch to competitive bidding was announced this spring in the midst of legislative scrutiny surrounding HMO profits from the public programs. Health plan operating income from state health programs came in at $130.8 million for 2010, up from $98.7 million in 2009. While some beneficiaries in some metro counties could see fewer HMO choices for 2012 than in the past, they still will have at least two options. (TwinCities.com)

New Jersey

- **New Jersey backs off Medicaid cuts**

  New Jersey Governor Chris Christie removed proposed Medicaid cuts and co-payments from a Medicaid waiver request after an uproar from Democrats, consumer advocates, and others. The state will maintain Medicaid eligibility for parents—up to 133% of the federal poverty level—under a revised waiver proposal the New Jersey Department of Human Services submitted on September 9 to federal Medicaid officials. The state also will scrap a $25 hospital emergency department co-pay initially proposed for nonemergency conditions. The state had considered asking the federal government for permission to reduce Medicaid eligibility for parents to 27.5% of the federal poverty level, or $5,100 for a family of three, according to details the agency released in early June. The state anticipates that Medicaid physician fees will increase as it moves more Medicaid enrollees into managed care. These plans are expected to pay physicians more than the existing average Medicaid fee-for-service rate of 41% of Medicare rates, according to the waiver proposal. (American Medical News)

Texas

- **Valley Health Providers Oppose Managed Care**

  Texas officials are facing a chorus of discontent as a result of their plans to bring managed care to South Texas. The state is in the process of switching over 425,000 people currently covered by Medicaid to private insurance. If Medicaid now covers a person's medical bills, a private insurance company will start making decisions about what treatments and services are covered under the individual's plan. This is scheduled to start March 1. The state hopes to save $300 million over two years by making this change. Officials say this new system has worked in other parts of the state. But people who run Valley health care companies say this spells trouble for businesses. They say it is also bad news for patients. Pharmacists, home health care providers, and hospital officials are all voicing serious concern. (KRGV.com)

- **Perry's Medicaid plan secret: Dems like it**

  Less than a year ago, Texas Governor Rick Perry publicly floated dropping out of Medicaid to cut spending, but now the state is quietly revamping the health care safety net for the poor in a way that even some Democrats can get behind. The Medicaid proposal, which came up in Thursday's Republican presidential debate, could prove increasingly inconvenient for Perry's presidential campaign narrative. The state gained tentative federal approval to begin rolling out the proposal that, in its own words, would prepare the health system "to serve newly insured individuals … in 2014," when the federal ACA that Perry forcefully opposes expands health coverage. Federal officials said in a September 14 letter they had reached "agreement in principle" with the state on the Medicaid plan, which would waive some federal laws to reshape the way hospital care for the poor is financed. The idea is to reroute federal funds the state would otherwise lose—an undesired consequence of expanding managed care—to subsidize hospitals' uncompensated care costs. The plan would also finance projects to help the uninsured, such as new clinics. Final approval could come as soon as September 30. (Politico)

Washington

- **Washington to limit Medicaid emergency room visits**

  Washington state is preparing to limit Medicaid coverage of emergency room visits for non-emergency care, hoping to save millions of dollars each year. State officials have notified clients that they will get coverage for only three of those visits each year starting Saturday. Additional visits will not be covered, and patients may be billed for that care. "Non-emergency" ailments, according to the state, include everything from blisters to headaches to chest pain. Supporters tout the cost savings, while critics argue the new restriction will force patients to try to diagnose themselves before getting needed medical help. (Seattlepi.com)

Wisconsin

- **State launches website on Medicaid savings**

  State officials unveiled the website Monday to detail how they will achieve hundreds of millions of dollars in unspecified savings for state health programs for the poor but laid out few of their actual plans to do it. Governor Scott Walker's administration has now been working on those plans privately for the better part of this year. The website will allow the public to give input on the savings plans for Medicaid programs, which provide everything from medical care for poor children to nursing home care for the elderly. But so far only a few proposals have been posted, with Department of Health Services spokeswoman Stephanie Smiley saying she expected the agency to post many more in the coming weeks. (Journal-Sentinel)

PRIVATE COMPANY NEWS

- **Humana Announces Agreement to Acquire MD Care**

  Humana Inc. (NYSE: HUM) announced today that it has signed an agreement to acquire MD Care, a California-based Medicare Advantage HMO with approximately 15,000 members in Southern California. Terms were not disclosed. MD Care was founded in 2007 and offers Medicare beneficiaries a choice of plans with comprehensive and value-added alternatives to traditional Fee-for-Service Medicare, including Medicare Advantage medical plans, Medicare Advantage prescription drug plans (include medical and drug coverage), and Medicare Advantage special needs plans. MD Care's members reside in four Southern California counties: Los Angeles County, Orange County, San Bernardino County, and Riverside County. MD Care's 2010 revenue was $155 million. The transaction is subject to both federal and state regulatory approvals and is expected to close in late 2011. (Humana News Release)

- **Tunstall Healthcare Group**, which is backed by **Charterhouse Capital Partners**, has agreed to buy **American Medical Alert Corp.** Tunstall is paying $8.55 a share cash, or $82.3 million for AMAC. New York-based ACAM provides telecare/telehealth solutions like remote patient monitoring devices and emergency response systems. **Jefferies** advised Tunstall while **Houlihan Lokey** served as financial advisor to AMAC. More here…

RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order. Arizona's ALTCS implementation begins on October 1. As a reminder, Centene and Unitedhealth won new business in that reprocurement.

Date	State	Event	Beneficiaries
September 29, 2011	Washington	Bidders conference	800,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 3, 2011	Kentucky RBM	Proposals due	N/A
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 7, 2011	Hawaii	Proposals due	225,000
October 15, 2011	New Hampshire	RFI Released	N/A
October, 2011	Pennsylvania	RFP Released	565,000
November 1, 2011	Kentucky RBM	Contract awards	N/A
November 1, 2011	Kentucky	Implementation	460,000
November 14, 2011	Hawaii	Contract awards	225,000
November, 2011	Pennsylvania	Proposals due	565,000
December 1, 2011	Kentucky RBM	Implementation	N/A
December 1, 2011	Hawaii	Implementation	225,000
December 2, 2011	Washington	Proposals due	800,000
January 1, 2012	Virginia	Implementation	30,000
January 15, 2012	New Hampshire	Contract awards	N/A
January 17, 2012	Washington	Contract awards	800,000
February 1, 2012	Louisiana	Implementation (GSA A)	892,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
Early 2012	Nebraska	Contract awards	60,000
April 1, 2012	New York LTC	Implementation	200,000
February 1, 2012	Louisiana	Implementation (GSA B)	892,000
February 1, 2012	Louisiana	Implementation (GSA C)	892,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	270,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	295,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA Recently Published Research

Managing Medicaid Pharmacy Benefits: Current Issues and Options

Vernon K. Smith, Managing Principal
Sandy Kramer, Senior Consultant

This report examines reimbursement, benefit management and cost sharing issues in Medicaid pharmacy programs. The analysis, conducted by researchers from the Foundation's Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, focuses on the potential of several measures recently highlighted by HHS Secretary Kathleen Sebelius to reduce Medicaid pharmacy costs and is informed, in part, by the perspectives of a group of Medicaid pharmacy administrators convened by the Foundation in May 2011 to discuss current Medicaid pharmacy issues. (Link to report)

A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey

Vernon K. Smith, Managing Principal
Kathleen Gifford, Principal
Dyke Snipes, Principal

This 50-state survey, conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, provides a comprehensive look at state Medicaid managed care programs, documenting their diversity, examining how states monitor access and quality, and exploring emerging efforts to improve care, including managed long-term care and initiatives targeted toward dual eligibles. The survey was released September 13, 2011, at a public briefing at the Kaiser Family Foundation's Washington, D.C. office.

Links to the report and presentations below:

Link to report: (PDF)

Link to presentations: (.WMV Video); (.MP3 Audio)

NGA Center for Best Practices: State Health Insurance Exchanges and Children's Coverage: Issues for State Design Decisions

Tom Dehner, Managing Principal
Caroline Davis, Senior Consultant
Lillian Spuria, Principal

As states consider implementation options under the Affordable Care Act, they face a series of critical decisions that will affect the design of Insurance Exchanges. Many of those decisions have the potential to affect health insurance options for children and how they obtain and retain coverage.

This issue brief was developed based on input during a daylong meeting hosted by the National Governors Association Center for Best Practices. Participants at the meeting included state government officials, general health care experts, federal representatives, and individuals from nonpartisan health policy institutions. (Link to brief)

UPCOMING HMA APPEARANCES

California Oral Health Access Council - Examining the Impact of Adult Dental Cuts on Utilization and Expenditures

Lisa Maiuro, speaker

September 28, 2011

Sacramento, California

NJ Association of Mental Health Agencies - The Medicaid Health Home Care Coordination Benefit: Implications for Behavioral Health Providers in New Jersey.

Eliot Fishman, speaker

October 3, 2011

Mercerville, New Jersey

Deutsche Bank Health Care Policy Day

Vernon Smith, speaker

October 13, 2011

Washington, D.C.

National Conference on Correctional Health Care: Health Care Reform, Medicaid, and Inmates

Donna Strugar-Fritsch, speaker

October 18, 2011

Baltimore, Maryland

Nixon Peabody - Investing in Health Care: Current Challenges and Opportunities

Greg Nersessian, featured speaker

October 19, 2011

Boston, Massachusetts