HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: WISCONSIN'S MAINTENANCE OF EFFORT WAIVER PROPOSALS

HMA ROUNDUP: CALIFORNIA RECONSIDERS PROCUREMENT STRATEGY FOR DUAL ELIGIBLES; FLORIDA INPATIENT RATES FINALIZED; NEW YORK PHARMACY CARVE-IN BEGAN OCTOBER 1, AS DID MIGRATION OF NEW ELIGIBILITY GROUPS INTO MANDATORY MANAGED CARE; NEW YORK MANAGED BEHAVIORAL HEALTH ORGANIZATIONS SELECTED

OTHER HEADLINES: SUPREME COURT HEARS ORAL ARGUMENTS IN CALIFORNIA RATE CUT CASE; WASHINGTON PHYSICIANS SUE OVER MEDICAID BENEFIT LIMITS; TRIPLE-S AWARDED PUERTO RICO MEDICAID CONTRACTS; NURSING HOMES BRACE FOR CUTS IN FLORIDA, INDIANA

RFP CALENDAR: NEBRASKA RURAL MCO RFP ADDED

OCTOBER 5, 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: WISCONSIN'S WAIVER REQUEST, OTHER MEDICAID REFORMS

This week, our In Focus sections reviews a package of Medicaid savings proposals unveiled on September 30, 2011 by Wisconsin's Department of Health Services (DHS). The proposals are required under Act 32, the state's FY 2011-2013 biennial budget, which directed DHS to identify nearly $445 million in total Medicaid savings, in addition to other projected increases in expenditures. In total, the package of Medicaid savings proposed exceeds $550 million in total funds, and nearly $220 million in general purpose revenue in FY 2013. At the core of the proposed savings is a federal waiver request pertaining to the maintenance of effort (MOE) provisions established under the Affordable Care Act (ACA). Below we review the waiver proposal, as well as several other significant proposals included in the package.

Maintenance of Effort Waiver

DHS officials have indicated the intent to submit a Section 1115 Waiver Demonstration Project to waive the MOE provisions under the ACA. The MOE provisions prohibit states from making changes to eligibility standards, methodologies, or procedures that are more restrictive than those in place on March 23, 2010. The DHS proposal notes, however, that ACA permits states to lower eligibility for non-disabled, non-pregnant adults to 133% FPL if the state is in an economic emergency. The MOE waiver is intended to allow DHS to implement a series of eligibility changes in order to avoid making a unilateral eligibility reduction that could disenroll more than 53,000 individuals in BadgerCare Plus and BadgerCare Plus Core programs. BadgerCare Plus provides Medicaid services through managed care plans to pregnant women, children, parents and childless adults up to 200% FPL. According to DHS, the following changes to eligibility standards are intended to reestablish Medicaid "as a safety-net for those low-income families who do not have access to private health insurance offered through employers and the individual market." Some key elements of the Wisconsin's MOE Waiver request include:

- **Eligibility standardization** – Allows the state to restrict eligibility for Medicaid under the following scenarios:

    If individual(s) have access to employer-based health insurance and the employee contribution of the premium is less than 9.5% of household income. 9.5% of income is the definition of "affordable health care" under the ACA.

    - If individual(s) are currently covered under a major insurance policy when the household contribution to the premium is less than 9.5% of household income.

- **Failure to pay** – Allows the state to prohibit Medicaid enrollment for twelve months for any individual who fails to pay a BadgerCare Plus premium or has been disenrolled for failure to pay.

- **Household income redetermination** – Allows the state to include all adults living in the household, excluding grandparents, in household income determination. This would likely result in a higher household income level for households that include extended family and other adults outside of the immediate family.
- **Eliminate retroactive eligibility** – Allows the state to end the current practice allowing BadgerCare Plus enrollees to receive coverage for services up to three months prior to application and enrollment.
- **Increased premium flexibility** – Allows the state the flexibility to increase premiums up to 5% of family incomes for families above 150% FPL. The purpose of this flexibility is to reduce financial differences between government and private coverage.
- **Presumptive eligibility** – The state is developing a real-time Medicaid eligibility determination system on top of an existing Medicaid online eligibility and enrollment system that the waiver indicates is far more advanced than most states. When the real-time eligibility determination system is implemented, the state requests the freedom to end the practice of presumptive eligibility, whereby an individual is presumed eligible for up to 45 days while the state makes and eligibility determination. As a result, the state may end up paying Medicaid claims for hospital and other health care services for individuals who do not end up being eligible.
- **Real-time eligibility termination** – In addition to the presumptive eligibility changes above, a real-time eligibility determination system can be used to determine the precise date when eligibility ends. The state is requesting flexibility to disenroll individuals closer to the actual date of ineligibility. Currently, enrollees remain under Medicaid coverage through the end of the month.
- **Young adult eligibility restriction** – The ACA allows for children to remain on their parents insurance plan through age 26. This waiver allows for the state to mandate that Medicaid eligible adults ages 19-26 be prohibited from enrolling in Medicaid if able to remain on their parent's health insurance plan.

Other Notable Medicaid Reforms in the Sept. 30 Announcement

Family Care provides long-term care services for adult Medicaid eligible individuals who are elderly, physically disabled, and individuals with developmental disabilities. Family Care and its related programs also include the Program for All-Inclusive Care for the Elderly (PACE). As of July 1, 2011, enrollment in the Family Care program was capped at 43,500 enrollees. Between 2005 and 2010, Family Care expanded from 5 to 53 counties, while program expenditures increased from roughly $250 million to more than $930 million. Although enrollment is capped, the Legislature has provided $25 million for emergency enrollment for individuals with urgent need for long-term support services. The enrollment cap will be maintained at 43,500 enrollees until needed program and policy changes can be identified and implemented.

Other proposals in the announcement include:

- Creating medical homes to better track and coordinate participants' medical visits, and to encourage coordination to prevent health care costs from escalating. DHS indicates that Michigan's largest insurer, Blue Cross Blue Shield, saved $65 million to $70 million last year through its medical homes program.
- Linking hospital reimbursements to new performance standards.
- Monitoring whether enrollees with private insurance are using it before turning to Medicaid coverage.
- Developing a project with federal officials to recoup money lost through erroneous eligibility determinations for the disabled.

Next Steps

DHS stressed that these proposals have been developed based on input from consumers, providers, advocates, and members of the public, including town hall meetings conducted across the state last spring. The Medicaid reform package is posted on the DHS website and public hearings will be announced in the near future, seeking further input on the proposals. However, the state is on a tight timeframe for the MOE waiver, which requires federal approval before December 31, 2011, or DHS will be required to take action to reduce eligibility to 133% FPL to meet the mandated savings under the biennial budget act. The Wisconsin DHS is headed by former CMS administrator Dennis Smith.

HMA Medicaid Roundup

California

HMA Roundup – Jennifer Kent

The United States Supreme Court has begun hearing oral arguments in the *Douglas v. Independent Living Center,* a suit filed by several health care providers after California cut its Medicaid payment rates by 10 percent. At issue is whether or not the state violated federal law requiring payments sufficient to assure access to and quality of care in implementing the cuts (which an appeals court has blocked). A decision in the case is not anticipated until the Spring of 2012.

Regarding the plan to transition dual eligible beneficiaries into managed care delivery systems, the California Department of Health Care Services (DHCS) had originally announced that it would conduct a Request for Information process (completed in June 2011) to be followed by a formal Request for Proposal by October 2011. Since the issuance of the July 8, 2011 CMS State Medicaid Director letter, DHCS has modified its schedule and has instead announced that it will be doing "site selection" in order to identify the counties where the program will be piloted.

Under the current schedule, the DHCS estimates that its timeline will be:

September-October 2011	Develop criteria for site selection process
November 2011	Open public meetings to inform site-selection criteria
December 2011	DHCS announcement of site selection criteria
Winter 2012	DHCS receives and evaluates applications DHCS Director announces demonstration sites Open public meeting
Spring/Summer 2012	Work with selected demonstration sites, CMS, Mercer and others to finalize pilot development
November/December 2012	Operationalize demonstration sites

With this revised schedule, the DHCS is no longer pursuing a state RFP. On September 16, the DHCS sent a letter to CMS announcing its interest in participating in both financial models as detailed in the July 8 CMS letter. It is anticipated that the DHCS will be required to participate in the joint procurement as detailed in the CMS letter. We believe that the DHCS Director will announce the "sites" and then invite plans and other qualified organizations to apply for participation. We believe this will be with CMS participation and approval.

Florida

HMA Roundup – Gary Crayton

Florida inpatient hospital rates were finalized on Friday, September 30, 2011. Managed care rates will likely be finalized in the next week or two, with an update call between AHCA and the health plans scheduled for Monday, October 10, 2011. As a reminder, the preliminary non-reform rates were calculated to be down 0.4% (average rate across all regions) for the upcoming fiscal year by the state's actuarial firm, Milliman. We anticipate that the finalized rate will be modestly higher based on the final hospital rates.

In the news

- **HP Signs $172M Renewal to Manage Florida's Medicaid Management Info System**

  HP Enterprise Services has signed a three-year $172 million renewal extension contract with the Florida Agency for Health Care Administration to manage the state's Medicaid management information system. HP will help the state transition to a managed care environment and keep a lid on costs in its preparation for pending program changes. This includes implementing federal HIPAA 5010 requirements and supporting the move to ICD-10 procedure coding. The agreement extends HP's contract through June 2016. The company has supported the agency since 2008. (ExecutiveBiz)

- **Nursing homes brace for cuts**

  An 11.4 percent cut in Medicare payments to U.S. nursing homes takes effect this month, which, combined with a 6.5 percent rollback in state Medicaid reimbursements, will leave some Florida facilities with no way to meet payroll expenses. Patients and their families can expect to see diminishing staff and disappearing amenities, from

group therapy to housekeeping. But even more alarming, operators say, is the prospect of no beds available for the sickest patients, who need the highest — and most costly — levels of nursing. As a result, hospitals will likely be forced to keep more people who could be cared for more comfortably and economically in nursing homes. This, critics say, amounts to both shortsighted fiscal planning and bad medicine. The national Medicare cut, announced in May, is intended to recover expenses from 2010, when a new payment formula was deemed overly generous. But Florida nursing homes, especially, have relied on the extra money to help cover losses on their Medicaid patients. An unknown number of homes are expected to close unless some government funds are restored in time. (Herald-Tribune)

Illinois

HMA Roundup – Matt Powers / Jane Longo

The Illinois Health Benefits Exchange Legislative Study Committee is expected to make recommendations to the General Assembly by Thursday, October 6. The committee's report is expected to include recommendations about how to structure and pay for the exchange, as well as how to monitor it once it's up and running.

As a reminder, there is a meeting scheduled for October 13, 2011 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.

In the news

- **Hospital budget approved, but fight continues**

  A committee of the Cook County Board on Monday approved an $827-million budget for the Cook County Health and Hospitals System, but the proposal likely will face tough scrutiny before it can be adopted. After a fierce, six-hour public hearing, the finance committee approved a health system budget that asks county taxpayers for a subsidy of $35 million more than Cook County President Toni Preckwinkle has said she will allow. The health system budget for the 2012 fiscal year, which begins Dec. 1, must still be approved by the Cook County Board of Commissioners. (Crain's Chicago)

- **GOP accuses Quinn administration of dragging heels on Medicaid changes**

  In January, Illinois lawmakers passed a series of Medicaid reforms that they said could save the state up to $774 million over the next five years. However, federal regulators later said Illinois couldn't proceed with two of the changes, which deal with how the state verifies the eligibility of Medicaid recipients to receive aid. Some Republican lawmakers now say Democratic Gov. Pat Quinn's administration isn't being aggressive enough in challenging that ruling and implementing other reforms. (Willowbrook Suburban Life)

Indiana

HMA Roundup – Catherine Rudd

HHS rejected Indiana's proposal to use the Healthy Indiana Plan as the basis for its health benefits exchange on the grounds that it is too early to know if the HIP complies with federal statutes since those have not been established yet. The letter does not preclude the state from resubmitting the request at a later date.

In the news

- **Nursing homes fear funding cuts**

  Reimbursement cuts by state and federal health insurance programs will disproportionately hurt Northwest Indiana nursing homes and dramatically reduce their ability to provide quality skilled nursing care, several local facility operators said, while predicting layoffs, service cuts and even home closures. Local nursing home administrators said the cuts will lead to smaller staffs and threaten access to nursing home care for needy and vulnerable Medicaid recipients. However, while there is widespread agreement that those cuts could impact nursing home revenues and even hurt financially troubled homes, state regulators and even advocates disputed the severity of the harm. Beginning in October, the Centers for Medicare and Medicaid Services — the federal agency that funds Medicare — will cut Medicare reimbursement to nursing homes for some services by more than 11 percent. Earlier this year the Indiana Families and Social Services Administration, the state agency charged with administering Indiana's Medicaid program, announced that beginning in July 2011 it would implement a 5 percent across the board cut in reimbursements to Hoosier nursing homes. (Chicago Sun Times)

New York

HMA Roundup – Denise Soffel

The following changes became effective Saturday, October 1, 2011.

Pharmacy Benefit Carve-In

Beginning October 1, 2011, Medicaid and Family Health Plus enrollees will have their pharmacy benefit paid through their health plans. Until now, pharmacy had been carved out of the Medicaid managed care contracts. Plans are now allowed to establish their own formularies and prior authorization processes. However, plan formularies must include all categories of prescription drugs on the state Medicaid fee-for-service list of reimbursable drugs. Plans will also be required to maintain an internal and external review process for exceptions. There is no change in beneficiary co-pay amounts.

Changes to Medicaid Managed Care Exemptions and Exclusions

As part of the state's goal of moving away from fee-for-service care within the Medicaid program, most of the categories for exemption or exclusion from the mandatory Medicaid managed care program are eliminated. These changes only apply to the non-dual-eligible population; dual-eligibles remain outside the mandatory Medicaid managed care program (although they can choose to enroll in MLTC or Medicaid Advantage plans).

Once enrolled, all services covered by the member's managed care plan must be accessed through participating providers. Categories no longer outside Medicaid managed care include:

- Individuals with HIV (already mandated in NYC, now the mandate includes the entire state), about 1,200 individuals.
- Individuals with serious/persistent mental illness (SPMI) and children with Serious Emotional Disturbance (SED) who are not eligible through SSI - about 12,000 individuals.
- A number of categories that affect small numbers of individuals, including those temporarily residing out-of-home district (college students); those speaking a language that no Medicaid managed care plan offers; pregnant women seeing FFS non-network providers; and individuals with chronic illnesses seeing a specialist provider who does not participate in any Medicaid managed care plan.

On September 28, 2011 Bob Myers of the New York State Office of Mental Health gave a presentation on the implementation of behavioral health organizations (BHOs) in the state. The program is divided into two phases. Phase 1, which is scheduled to be completed by January 1, 2012, involves non-risk contracts with BHOs in five regions to cover behavioral health services for non-elderly adults and children. The plans that have been selected and are currently negotiating contracts with the state are:

- New York City Region: Optum Health
- Hudson River Region: Community Care Behavioral Health
- Central Region: Magellan Behavioral Health
- Western Region: New York Care Coordination Program
- Long Island - Final determination not yet been made

In phase two of the program, all beneficiaries in the state will receive care through one of 3 structures – Integrated Delivery System (a large provider network), Special Needs Plan, which integrates both physical and behavioral health care services, or a BHO. At this time, the BHO contracts will convert to risk bearing arrangements. Phase two is scheduled for July 2013.

In the news

- **Advocates fear consequences of Medicaid prescription-drug changes**

  Starting Saturday, pharmacy benefits for three million Medicaid recipients will be switched over to managed-care plans, part of an ongoing state process to overhaul the health care program for the poor. Patient-advocacy groups have tried unsuccessfully to get the date pushed back, claiming the state Health Department hasn't done a good job of informing roughly three million New Yorkers who are affected by the change, and people's health is at risk. Another change that has advocates concerned is physicians and other providers no longer will have the authority to place patients on medications that aren't on insurers' lists of covered drugs. (The Ithaca Journal)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Two major players in the Western Pennsylvania health care market continue to be at odds over their future relationship. Earlier this Summer Highmark, the major health insurer in Western Pennsylvania, announced plans to Purchase West Penn Alleghany Health System (WPAHS). Ever since, the University of Pittsburgh Health System (UPMC), the largest hospital and provider network in the region, has refused to negotiate on a continuation of its contract with Highmark. The contract is due to expire in the summer of 2012.

Initially, the announcement by Highmark of its plan to purchase the financially ailing WPAHS was greeted by the press and public with enthusiasm. However, once UPMC refused to negotiate with Highmark, things turned sour very quickly. Highmark consumers have expressed concerned they will no longer have access to UPMC's hospitals and extensive provider network. UPMC claims that Highmark becomes a competitor once Highmark owns a hospital. UPMC has signed agreements with Highmark competitors, giving United, Aetna and HealthAmerica/Coventry access to UPMC hospitals and providers that was previously denied or very limited. UPMC is recommending consumers switch to a Highmark competitor, including the UPMC Health Plan, to maintain in-network access to UPMC hospitals and providers.

Pennsylvania legislators have stepped in to pressure the two organizations to reach an amicable resolution. Two hearings have already been held and at least three more are scheduled. In terms of oversight, at a minimum the Health Department will have to approve the change in ownership of the WPAHS hospitals. Additional state and federal approvals could be required as there are non-profit issues related to both organizations.

Tim Costa, the Executive Deputy Secretary of the Pennsylvania Department of Public Welfare, reported that the department's program for persons with intellectual disabilities was in very poor financial condition. At a September 28, 2011 hearing before the Pennsylvania Senate Public Health and Welfare Committee, Costa blamed the problems with the Office of Developmental Programs on poor financial oversight and changes resulting from a transition from a county-based system to a centralized state approach. He noted that "waste and excess crept into the system arguably as a result of providers taking advantage of the generous reimbursement policies and the limitations on fiscal governance put in place." The department plans to release new regulations for the Office of Developmental Programs later this year.

Finally, three appointments were announced last week. Bonnie Rose will assume the position of Deputy Secretary for the Office of Long Term Living. Former State Representative Beverly Mackereth will be the new Deputy Secretary for the Office of Children, Youth and Families and Blaine Smith will be the new Deputy Secretary for the Office of Mental Health and Substance Abuse Services.

United States

HMA Roundup – Lillian Spuria

Presentations from the MACPAC meeting that was held Sept. 22-23 2011 in Washington, DC were posted last week. Topics included linking payment to quality in Medicaid, and care coordination for high-cost, high-need populations. (Link to presentations)

In the news

- **Analysis: States lobby against Medicaid cuts in Congress**

  With billions of dollars in Medicaid spending at risk in Congress, states are forming a loose confederacy to oppose any federal cuts that could damage state budgets already awash in red ink. Lobbyists say governors, legislators and other state officials, Republican and Democrat alike, have found common ground in a push to convince a special congressional deficit panel that White House-backed Medicaid cuts totaling $41 billion will only weaken a system that already struggles to deliver care to 60 million beneficiaries. (Reuters)

OTHER HEADLINES

Arizona

- **As Medicaid program expires, Arizona looks for federal OK of new plan**

  The state is negotiating with federal officials on a scaled-back program that state officials say is needed because of Arizona's financial straits. The state wants permission to make cuts that will affect patients, providers and insurers, in an effort to trim up to $500 million in state spending for Medicaid. The program's current five-year Medicaid waiver officially expired Friday, but federal officials at the Center for Medicare and Medicaid Services have granted an extension of at least two weeks while negotiations continue. (Cronkite News)

Arkansas

- **GOP, state chamber at odds on health insurance exchange grant**

  The head of the Arkansas State Chamber of Commerce says the business organization is disappointed that the state declined to apply for a multimillion-dollar federal grant to fund planning for a state health insurance exchange. The deadline to apply for the grant was Friday. Gov. Mike Beebe said the state did not apply because of opposition from Republican state legislators. The state previously received a $1 million federal grant to fund planning for the exchange, which under the federal Patient Protection and Affordable Care Act must be operational by Jan. 1, 2014. The federal government will set up exchanges for states that choose not to create their own. (Arkansas News)

Connecticut

- **State Awards Health Care Contract To Nonprofit**

  The state announced Thursday that Community Health Network of Connecticut, Inc. , won the right to negotiate a contract expected to be worth between $70 and $73 million in the first year alone. The Wallingford-based nonprofit beat out Anthem Blue Cross and Blue Shield, Iowa Foundation for Medical Care in partnership with Qualidigm, and AmeriChoice of Connecticut, Inc. which is owned by UnitedHealthCare, to win a five-year contract to administer health care coverage for nearly 600,000 low-income children, families, seniors, and adults with disabilities. Community Health Network of Connecticut, Inc. (CHN) will take over the entire Medicaid population starting on Jan. 1. Awarding the contract was the first step in moving the state away from a Managed Care Organization model to a model where the state will assume the risk. The move is expected to save the state "tens of millions" of dollars. (CTNewsJunkie.com)

Idaho

- **Health exchange, new regulations could increase Medicaid enrollment by 100,000**

  A new health insurance program could mean that 100,000 more Idahoans would end up with government-paid health coverage. That was the sentiment Idaho Department of Health and Welfare Director Dick Armstrong shared with members of the House Health and Welfare Committee at a special meeting in the Capitol Thursday. Armstrong told committee members that the online portal created by the exchange would integrate private and government health insurance options and that low income Idahoans would be directed to taxpayer-funded coverage plans. According to department forecasts, the exchange would likely bring 100,000 new participants. More than 233,000 Idahoans, or about 15 percent of the Gem State population, are already on Medicaid. If, in fact, 100,000 people do join Idaho's Medicaid system in 2014, more than 22 percent of the population would be on the program. (Idaho Reporter)

Kentucky

- **Medicaid funds allegedly misused: U of L doctors used $4.8 million in Medicaid money for bonuses**

  Doctors at the University of Louisville medical school used about $4.8 million in state Medicaid funds to pay themselves "financial bonuses" — money that was supposed to be used for indigent care, state Sen. Tim Shaughnessy says. And they used another $5.2 million for an electronic records system that would make U of L doctors eligible for additional bonuses from the federal government, according to new details of a controversial transaction that Shaughnessy said he recently obtained from Attorney General Jack Conway's office. A spokeswoman for Conway said Wednesday that the office determined only that the $4.8 million was compensation for U of L doctors. But Shaughnessy insisted that Conway's staff described the money as "bonuses" at a recent meeting. (Courier-Journal)

Massachusetts

- **Doctors: We aren't ready for global payments**

  A new survey from the Massachusetts Medical Society reveals interesting divisions among doctors over plans to hold down health care spending -- and perhaps some words of warning for lawmakers. More than half -- 58 percent -- of the 1,100 doctors who responded to the society's survey this year said they would not voluntarily agree to treat patients under so-called global payments. Global payments, which are considered one of the best hopes for saving money on medical care, put providers on a monthly per-patient budget for care. That's a big change from the current fee-for-service system, which allows doctors and hospitals to bill for each separate service rendered to a patient, with few limits on the number of services. Primary care doctors were more accepting of global payments than specialists; just 32 percent of specialists said they would voluntarily participate in the system. These responses may be instructive for legislators, who are working to finalize legislation that could include strong incentives for global payments. They may have to be ready to mandate the change to a new payment system and provide financial assistance with the transition, or at least be prepared for an intense educational campaign to bring doctors around. (Boston Globe)

Michigan

- **Patterson wants county to opt out of Snyder's health insurance rules**

  A new law limiting public employer contribution to health benefits has two Republicans at odds — namely Gov. Rick Snyder and Oakland County Executive L. Brooks Patterson. Patterson is asking the county commission to opt out of the new public health insurance requirements signed into law by Snyder Tuesday. The new law signed by the governor places limits on public employer contributions to health insurance, but also allows a local governing body to opt out of the requirements with a two-thirds vote. A resolution to allow the county to opt out of the requirements is expected to be introduced to the Board of Commissioners Wednesday, and then proceed through the committee process. Patterson said the law was signed by the governor just five days after the county passed its own three-year budget. The new fiscal year begins Oct. 1, and Patterson said county taxpayers will bear "additional significant costs" for its open enrollment for employees (Daily Tribune)

Montana

- **Schweitzer calls for universal health care**

  Gov. Brian Schweitzer said Wednesday he will ask the U.S. government to let Montana set up its own universal health care program, taking his rhetorical fight over health care to another level. Like Republicans who object to the federal health care law, the Democratic governor also argues it doesn't do enough to control costs and says his state should have more flexibility than the law allows. But Schweitzer has completely different plans for the Medicare and Medicaid money the federal government gives the state to administer those programs. The popular second-term Democrat would like to create a state-run system that borrows from the program used in Saskatchewan. He said the Canadian province controls cost by negotiating drug prices and limiting nonemergency procedures such as MRIs. Schweitzer said the province's demographics

and economy are similar to Montana in several ways - yet its residents live longer while spending far less on health care. A Republican state senator heavily involved in crafting GOP measures aimed at undermining the federal health care law said he will have to see Schweitzer's specific proposal before passing judgment. (Billings Gazette)

Nebraska

- **Nebraska issues RFP for Medicaid Managed Care Physical Health Service**

  The State of Nebraska is issuing a Request for Proposal for the purpose of selecting one or two Qualified Contractors to Provide Medicaid Managed Care Physical Health Service through a Managed Care Organization for the counties not currently served by physical health managed care. Letters of intent are due November 3, with a proposal due date of December 6, 2011.

Puerto Rico

- **Triple-S Management Awarded Five Regions of Puerto Rico Medicaid Plan**

  Triple-S Management Corporation (NYSE: GTS), one of the leading managed care companies in Puerto Rico, announced today that on October 1, 2011, the Puerto Rico Health Insurance Administration (ASES) notified its subsidiary Triple-S Salud that it has been selected to administer healthcare services for the Metro North, North, San Juan, Northeast and West regions of the Puerto Rico Government's health insurance program (Medicaid), known as MiSalud, for a 20-month term commencing November 1, 2011. This selection also includes minors under custody of the Department of the Family and victims of domestic violence. The MiSalud program currently services approximately 840,000 members in these regions. (PR Newswire)

Texas

- **HCA May Face Big Revenue Hit If Feds Approve Texas Medicaid Waiver Plan**

  Private Texas hospitals, including at least 21 facilities owned by the publicly traded Hospital Corporation of America, could see a plunge in supplemental Medicaid payments if a state proposal to revamp its health care program for the poor is approved by the federal government. HCA, the nation's largest for-profit hospital chain, drew $657 million in supplemental Medicaid payments from Texas in 2010, making it especially vulnerable. The payments – about one-quarter of all state-paid hospital financing -- support public hospitals and those that treat high numbers of uninsured and Medicaid patients. They're also used to induce other private hospitals to care for the poor, expanding the reach of the health care safety net. But some powerful backers of the Texas proposal say not enough of the funds are reaching the poor, going instead to finance hospital construction projects and pad the bottom line of big companies and health systems. (Kaiser Health News)

Washington

- **Doctors sue state over limits on ER visits**

  A group of doctors filed a lawsuit Friday to stop a new Washington state rule limiting Medicaid patients' visits to emergency rooms for routine health care. It limits payment to three visits a year for any of the 700 diagnoses the state says are typically not emergencies, including chest pain, abdominal pain and early-pregnancy hemorrhage — conditions doctors argue must be evaluated because they could in fact prove to be genuine emergencies. (Seattle Times)

Wisconsin

- **Jail health care change denounced**

  Milwaukee County Sheriff David A. Clarke Jr.'s planned privatization of medical care for jail inmates is inadequate and should be stopped, according to the court-appointed overseer of the jail. Clarke announced in June his intention to award a contract for jail medical services to Armor Correctional Health Services, a Florida firm, saying the move would save the county about $1.5 million a year. The contract would cover medical services at both the jail and the County Correctional Facility-South in Franklin. (Journal Sentinel Online)

PRIVATE COMPANY NEWS

- National Healing Corp. and Diversified Clinical Services, both wound care management companies and both based in Florida, will merge.

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. This week, we added the dates associated with Nebraska's Medicaid managed care RFP and note that proposals are due Friday for the Hawaii Quest program.

Date	State	Event	Beneficiaries
October 7, 2011	Hawaii	Proposals due	225,000
October 15, 2011	New Hampshire	RFP 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
December 6, 2011	Nebraska	Proposals due	60,000
January 1, 2012	Virginia	Implementation	68,000
January 15, 2012	New Hampshire	Contract awards	N/A
January 17, 2012	Washington	Contract awards	800,000
January 31, 2012	Ohio	RFP Released	1,650,000
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
February 28, 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
July 1, 2012	Nebraska	Implementation	60,000
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 WELCOMES…

Janet Olszewski – Lansing, MI

On October 4th, Janet Olszewski joined HMA as a Principal in our Lansing office. Most recently, Janet served as the Director of the Michigan Department of Community Health where she led the agency responsible for Medicaid and health coverage programs, mental health and substance abuse programs (including the operation of five psychiatric hospitals), public health activities, and the regulation of health professions and facilities. She held this position for all eight years of Governor Granholm's administration. Prior to that, Janet was the Director, and then Vice President of Government Programs and Regulation for M-Care, a health plan in Michigan. At M-Care, Janet directed the implementation of the Medicare and Managed Care program and two state products: a Medicaid plan and the Kids Care Program (a state funded managed care program for chronically ill children). Earlier in her career, Janet was the Director of the Quality Improvement and Customer Services Bureau and the Director of the Managed Care Quality Assessment and Improvement Division, both in Michigan's Department of Community Health. She also served in positions of increasing responsibility in the Michigan Department of Public Health, and started her career in the Michigan Office of Services to the Aging. Janet has served on numerous boards and commissions in recent years, and in 2010 was honored by the Association for State and Territorial Health Officers with the Presidential Meritorious Service Award. Janet earned her Bachelor of Arts degree at Boston University, and her Masters in Social Work at the University of Michigan.

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 moni-

tor 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)

UPCOMING HMA APPEARANCES

Ohio Association of Community Health Centers Fall Conference

Alicia Smith, presenter
October 11, 2011

Columbus, Ohio

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

American Evaluation Association: "A Mixed-Methods Approach to Understanding the Impact of Requiring Citizenship Documentation for Medicaid Enrollment."

Caroline Davis, speaker

November 3, 2011

Anaheim, California