HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: STATES SUBMIT DUAL ELIGIBLE INTEGRATION LETTERS OF INTENT

HMA ROUNDUP: FLORIDA MANAGED CARE RATES FINALIZED; GEORGIA OPENS CHIP TO STATE EMPLOYEES' CHILDREN; NEW YORK ACHIEVES MEDICAID SAVINGS; NEW YORK MANAGED CARE RATES FINALIZED; PENNSYLVANIA UPDATES HOSPITAL READMISSION POLICY

OTHER HEADLINES: GEORGIA ISSUES EXCHANGE RFI; NEW YORK ADVISED TO CONSIDER FOR-PROFIT HOSPITALS; MICHIGAN MULLS CONVERTING BLUES TO FOR-PROFIT STATUS; LOS ANGELES COUNTY EXPANDS COVERAGE

UPCOMING APPEARANCES:

VERNON SMITH: DEUTSCHE BANK HEALTH CARE POLICY DAY. OCT. 13, WASHINGTON, D.C.

DONNA STRUGAR-FRITSCH: NATIONAL CONFERENCE ON CORRECTIONAL HEALTH CARE. OCT. 18, BALTIMORE, MD

GREGORY NERSESSIAN: NIXON PEABODY – INVESTING IN HEALTH CARE. OCT. 19, BOSTON, MA

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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: STATES SUBMIT DUAL ELIGIBLE INTEGRATION LOIS

In December 2010, the Centers for Medicare and Medicaid Services (CMS) announced the State Demonstrations to Integrate Care for Dual Eligible Individuals, a competitive solicitation for proposals to design person-centered models that coordinate primary, acute, behavioral and long-term supports and services for Medicare-Medicaid enrollees. In reviewing the initial state proposals for dual integration projects, CMS has confirmed that a key factor in the implementation of care integration and care coordination models for dual eligible individuals will be the ability to test and apply new payment and financing models.

In a letter to state Medicaid directors, issued Friday, July 8, 2011, CMS offered two financial alignment models for dual eligibles (now referred to as Medicare/Medicaid eligibles or MMEs) that the federal government has developed for the consideration of state Medicaid agencies: risk-based capitation and managed fee-for-service (FFS). These payment and financing models are intended to promote better care, align incentives for improving care, and lower costs to both states and the federal government. Interested states were asked to submit a letter of intent (LOI) to CMS by October 1, 2011. The letters of intent were non-binding, but meant to indicate to CMS the state's interest in discussing the options further. In the discussion below, we briefly describe each of the models, identify the states that responded and summarize a few of the models proposed in the LOIs.

Capitated Model

The first proposal put forth in the CMS letter is intended to take advantage of state experience in utilizing capitated managed care models within the Medicaid population. CMS notes that, of the current dual eligible care coordination systems, the most integrated programs utilize a capitated funding arrangement, citing the success of the Program of All Inclusive Care for the Elderly (PACE) and managed long-term care programs in Medicaid.

Under this design model, states, CMS, and health plans will enter into a three-way contract, under which managed care plans will receive a blended capitation rate for the full continuum of benefits provided across both Medicare and Medicaid. Blended rates will be set to target aggregate savings to both states and the federal government. CMS states that managed care plans will be required to meet established quality thresholds. Plans will be bid through a joint procurement by states and CMS, with a preference toward plans that have demonstrated the capacity to provide Medicaid and Medicare services to plan enrollees. The model promotes a "passive enrollment" model in which members are automatically enrolled in an integrated care plan but have the option to opt-out if they so choose.

There are a number of key issues that will have to be worked out with respect to this model as the states begin their discussions with CMS. For example, many states have certain benefits, such as mental health services or pharmacy benefits, carved out of their managed care programs. It is unclear if CMS would allow such arrangement to exist in a model that is intended to be fully integrated. Also, some states have already implement-

ed Medicaid long term care programs (MLTC). Will those states be allowed to integrate the full breadth of dual eligible services into those contracts without having to issue a joint RFP? To what extent will Medicare Advantage administrative and regulatory requirements be applied to integrated plans, possibly favoring MA Dual Eligible Special Needs Plan (DE SNP) options. What rate setting approaches will be utilized and how will risk adjustment be addressed? We look forward to sharing insights on this process as we learn of them

Managed FFS Model

The second financial model proposed in the letter to state Medicaid directors builds on the existing FFS delivery system, expanding on the foundation of care coordination many states have already built into their Medicaid FFS payment systems. CMS highlights primary care delivery systems with a heavy focus on care coordination, such as accountable care organizations (ACOs) and Medicaid health home models.

Under a managed FFS model, CMS will establish a retrospective performance payment system, under which states will receive performance payments based on Medicare savings net of federal Medicaid costs. This model requires upfront investment in care coordination by the states, with savings determinations made by the CMS Office of the Actuary. This model may prove appealing to states that have already invested in their Medicaid care coordination infrastructure, as well as states that have historically been less inclined to pursue arrangements within the capitated managed health care plan structure.

Summaries of Selected State LOIs

In a blog post on HealthCare.gov, dated October 12, 2011, Melanie Bella, Director of the CMS Medicare-Medicaid Coordination Office, indicated that 37 states have responded with LOIs indicating an interest in exploring the proposed care coordination models. The LOI deadline begins a 15-month window within which states must work with CMS to design and implement a new payment and financing model by the end of 2012. For states pursuing the capitated model, this means we could expect to see CMS and states jointly issuing RFIs and RFPs for managed care plan bids in early to mid-2012.

The 37 states submitting LOIs are:

Alaska	**Idaho**	**Massachusetts**	**North Carolina**	**Texas**
Arizona	**Illinois**	**Michigan**	**Ohio**	**Vermont**
California	**Indiana**	**Minnesota**	**Oklahoma**	**Virginia**
Connecticut	**Iowa**	**Missouri**	**Oregon**	**Washington**
Delaware	**Kansas**	**Montana**	**Pennsylvania**	**Wisconsin**
D.C.	**Kentucky**	**Nevada**	**Rhode Island**	
Florida	**Maine**	**New Mexico**	**South Carolina**	
Hawaii	**Maryland**	**New York**	**Tennessee**	

Below we have summarized several state LOIs.

Arizona

Arizona Health Care Cost Containment System (AHCCCS) is proposing to work with CMS to develop an integrated program for full dual eligible elderly and physically disabled members enrolled in the Arizona Long Term Care System (ALTCS) in two counties:

Maricopa and Pima. The proposed capitated program would incorporate Medicare benefits with the ALTCS program, which currently provides medical, long-term care and behavioral health services. Roughly 16,000 of the 19,000 elderly and physically disabled ALTCS enrollees in Maricopa and Pima counties are currently eligible for Medicare. These two counties have been selected for their high percentage of dual eligible enrollees as well as high rates of utilization of health services.

California

The California Department of Health Services (DHS) responded with interest in both the capitated and managed fee-for-service models. Initially, DHS intends to pursue the capitated model, but would like to reserve the ability to pursue the managed fee-for-service model in the future. The DHS LOI indicates that both community advocates and Medi-Cal managed care plans expressed significant interest in this demonstration project at a recent conference on integrating care for dual eligibles.

Florida

Florida's Agency for Health Care Administration (AHCA) submitted a "non-binding" LOI to CMS to participate in the dual eligible integration payment demonstration. The letter indicates that Florida has not yet made a final decision on participation. AHCA is interested in learning more about the demonstration payment models and indicated that if Florida does participate, it will be consistent with the principles outlined in the CMS letter to state Medicaid directors.

Michigan

The Michigan Department of Community Health (MDCH) LOI indicates the State's intention to pursue a capitated model for dual eligibles. The integrated system will include primary, acute, LTC, pharmacy, and behavioral health services, including services for individuals with developmental disabilities. A model of care coordination will be implemented to remove inefficiencies and duplicative services under current service delivery systems. As indicated in Michigan's application for dual eligible integration funding earlier this year, MDCH proposes combining Medicaid and Medicare funding streams at the state level and developing a rate structure for managed care plans covering all services for the dual eligible population. MDCH intends to begin implementation of a phased-in program by the end of 2012, targeting areas initially with the greatest degree of readiness. Implementation readiness will be determined by a procurement process in early 2012.

Oregon

The Oregon Health Authority (OHA) indicated its intent to work with CMS to pursue the Oregon Integrated and Coordinated Health Care Delivery System for Dual Eligible Individuals. Oregon anticipates pursuing the capitated model approach, and the letter indicates that it would be a statewide program. Plans will provide services covered by Oregon's Medicaid program and Medicare Parts A, B, and D. However, certain services, such as long-term care supports and services, mental health drugs specified in state Medicaid statutes, and certain residential treatment services for beneficiaries with severe mental illness, will be provided by the State outside the blended Medicare-Medicaid capitation rate. Plans will begin providing services under a joint state-federal Medicare-Medicaid

capitation structure on July 1, 2012, in areas of the state where plans have been certified as having the. The letter does not provide detail on a procurement process or timeline.

Pennsylvania

Pennsylvania's Department of Public Welfare (DPW) responded in an LOI with its intent to implement a demonstration for dual eligibles and to evaluate both the capitated and managed fee-for-service models. The demonstration would integrate primary, acute, behavioral health, and long-term supports and services, with a phased-in statewide implementation approach. The first phase of implementation would likely begin in early 2013.

Texas

Texas Health and Human Services Commission (HHSC) indicated in its LOI response that the State will pursue the capitated model for dual eligible integration within the STAR and STAR+PLUS programs. The model will be implemented in the STAR+PLUS program in urban areas, and in the STAR programs in rural counties. The LOI outlines the following key elements of the proposed demonstration:

- All core Medicare and Medicaid services for an individual will be provided through a single plan, including a comprehensive pharmacy benefit.
- Medicaid and Medicare enrollment will be mandatory with an opt-out provision.
- The demonstration will include person-centered medical homes to address the needs of individuals with multiple chronic conditions or severe mental health conditions.
- A single care coordinator will develop plans of care for an individual based on beneficiary choice and will facilitate access to community-based care whenever possible.
- The demonstration will utilize quality management strategies and measurements unavailable in the current Medicare FFS model.

HHSC is targeting an implementation date of December 2012. The LOI provides no details on a procurement process or timeline.

Vermont

Vermont's Agency of Human Services contends, in its LOI response, that Vermont is uniquely positioned to coordinate services and streamline financing for dual eligibles. Currently 22,000 dual eligibles are enrolled in the State's Medicaid managed care entity (MCE) health plan. Since all dual eligibles are already enrolled in the MCE, Vermont proposes to use the current system to serve the dual eligible population under an integrated demonstration program. The State targets an implementation date of December 2012. The proposed Vermont Dual Eligibles program would feature the following components:

- Serve all Vermonters statewide who are dually eligible;
- Provide the full range of Medicare and Medicaid services with the addition of enhanced benefits, designed to maintain individuals at home and in the community;
- Integrate the existing delivery system (primary, acute, long term care, behavioral);

- Capitate rates with incentives to promote delivery of comprehensive care;
- Realize savings that would be shared with Medicare through a pre-arranged formal agreement between the State of Vermont and CMS, using a transparent mechanism for accountability;
- Enroll participants automatically; employ an easy "opt-out" mechanism;
- Retain consumers' existing physician. (Physician participation in both Medicaid and Medicare is 95%-96% in Vermont);
- Utilize Vermont's existing MCE Grievance and Appeals Process; and
- Ensure high quality service delivery through comprehensive and coordinated oversight by the State of Vermont.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Gary Crayton

Final managed care rates were communicated to health plans in a conference call on Monday. The final non-reform rates will be increased 1.3% compared to the preliminary estimate of a 0.4% reduction. These are the average rates across all regions, so plan-specific outcomes will depend on each plan's enrollment distribution across regions. Over 85% of Florida Medicaid managed care enrollees are in the non-reform program. As we mentioned last week, the increase in the non-reform rates is primarily driven by a calculation of inpatient rates that was higher than previously estimated. Reform rates will be increased by a high single digit/low double digit percentage.

In the news

- **Florida's Budget Shortfall to Top $1.3 Billion, State Economists Project**

  Florida's slow recovery, tied with global economic uncertainty, has smacked the state in its bank account. State economists remain "cautiously hopeful" the United States, and with it Florida, will avoid a second recession as they look at a $1.3 billion revenue shortfall for next year. The drop is expected to go deeper Monday when the revenue estimating conference reviews revised Medicaid cost numbers. The revision was needed because revenues declined sharply in August and September. For the current year, the state's projected end-of-the-current-budget-year surplus was shifted from $1.5 billion to $900 million. The shortfall means when legislators meet in January for the start of the regular session, they will have that much less money to play with as they craft the 2012-13 budget than they did when putting together the current year's $69 billion budget. (Sunshine State News)

- **Florida to launch its own health insurance marketplace**

  Florida, which is fighting to overturn the federal health overhaul, is preparing to launch an insurance marketplace early next year that looks like a distant cousin of the ones being created under the federal law. Florida's version aims to give small business-

es — those with 50 or fewer employees — an online tool where they can easily shop for health plans offered in their county. The idea, backers say, is to entice employers who otherwise wouldn't offer coverage. Florida will be the third state — and by far the largest — with an insurance exchange, following Massachusetts and Utah. The Florida program is a public-private partnership. (Washington Post)

Georgia

HMA Roundup – Mark Trail

Georgia Governor Nathan Deal announced last week that the State continues to experience strong revenue growth. Specifically, the Governor reported that September 2011 collections were up $80.6 million, or 5.6%, from September 2010. This is the fifth straight quarter of net revenue growth over 3.8%.

Additionally, Georgia state employees will have the option of enrolling their children in the state's CHIP program, PeachCare for Kids. The State expects that approximately 40,000 children will transition from the state employees' health plan to PeachCare for Kids. United and CIGNA administer the state employees' contract.

In the news

- **Report: Work remains, but Georgia's mental health overhaul significant**

  Georgia has made significant strides in moving the developmentally disabled and mentally ill out of state mental hospitals and into community settings -- despite notable gaps in care, a new report shows. Over the past eight months, the state's efforts include placing 192 developmentally disabled people -- who have lifelong mental or physical impairments that often prevent them from living on their own -- into homes with no more than four people. Under the agreement, the state also aims to provide community-based support to 9,000 mentally ill individuals. Overall, it plans to spend $72 million in the first two years alone. (Atlanta Journal Constitution)

- **RFI Alert: Establishment and Operation of a Statewide Health Information Exchange**

  The Georgia Department of Community Health (DCH) is seeking information from the Vendor Community for the establishment and operation of a statewide health information exchange (HIE). This HIE will incorporate not only the effective use of electronic health records among participating eligible health care professionals and hospitals, but also allow for the seamless interface between the public, payors, and labs networks, insuring HIPAA and Privacy Standards are met for all concerned. DCH may or may not proceed with an RFP for this project. Questions are due October 13, 2011, with proposals due October 21, 201.

Illinois

HMA Roundup – Matt Powers / Jane Longo

As a reminder, there is a meeting scheduled for tomorrow, October 13, hosted by the Department of Health and Family Services (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 gather input on how to craft the RFP.

Indiana

HMA Roundup – Catherine Rudd

On October 5, Indiana released a Request for Proposals to solicit pharmacy benefit management (PBM) services. Pharmacy services are currently carved out of MCO contracts, and the State plans to continue with that approach. Claims processing is also currently carved out (and handled by HP), but the solicitation will carve that service back into the PBM's duties. Other significant duties of the PBM will include: day-to-day operations of the pharmacy benefit, prior authorization, call center operations, auditing, rate setting and management of federal and state supplemental rebate programs. The State plans to award two contracts. The first contract will be for design, development and implementation (DDI). Implementation must be completed by June 30, 2013. The second contract will be for an operational period of four years from DDI completion. There may be two one-year renewals (at the State's option) of the second contract, for a total of six years. The incumbent PBM is ACS. Proposals are due November 18, 2011.

Michigan

HMA Roundup – Esther Reagan

The State announced the timeline for its integrated care workshops, a series of meetings with various stakeholders to develop recommendations for pursuing integrated care coordination for dual eligibles. The workshops begin on November 9, 2011 and are divided into four work groups:

1. Care Coordination and Assessment
2. Education, Outreach, and Enrollee Protections
3. Performance Measurement and Quality Management
4. Service Array and Provider Network

In the news

- **Lawmakers weigh privatizing Blues**

  The Michigan legislature is weighing reviewing Blue Cross Blue Shield of Michigan's non-profit status, which would lead to a debate over converting the nonprofit insurer into a for-profit company, current and former state lawmakers say. The legislative review is being sparked in part by federal health care reform and Gov. Rick Snyder, who last month said it is time to take a "fresh look" at Blue Cross' special legal and regulato-

ry requirements in an effort to encourage competition, lower costs and access to high-quality care. The Blues control 70 percent of the state's health insurance market, with 4.3 million customers in Michigan. The nonprofit also receives annual state tax breaks worth about $79 million, but is the only insurer in Michigan required to provide health insurance to those who are sick. Converting the Blues to a for-profit could strip the nonprofit of its insurer of last resort duty, increase competition and, some insurance experts say, lead to lower rates for consumers. (Detroit News)

- **State Needs To Move On Health Exchange, Legislators Told**

  Michigan officials need to move with some dispatch to enact a health exchange in order to ensure the federal government does not impose an exchange on the state, members of both the House Health Policy committees were told Thursday by insurance company executives. But Republicans questioned why the government should set up such an exchange at all. They also asked what it would take for insurance companies to create an exchange with no government interference. (Michigan Gongwer News)

- **Legislators set to begin work on creating state health exchange**

  Gov. Rick Snyder wants the state to create its own health exchange that would meet the requirements of the Affordable Care Act, rather than opt to let the federal government do it for Michigan and impose a "one size fits all" approach. The law requires states to create a health exchange by 2014. Snyder, in his recent health care message to the state, said he strongly supports the idea, regardless of the mandate in the federal law. He urged lawmakers to enact legislation by Thanksgiving to create a "customer-oriented" health exchange that "makes a better market for us in a way that people can understand their health care (and) insurance choices, their options, the availability of things and an easier way to buy and shop." (MLive.com)

New York

HMA Roundup – Denise Soffel

The Medicaid Redesign Team (MRT), established by Governor Cuomo as part of his 2012 Executive Budget, met in Albany last week. The MRT was tasked with finding spending cuts to meet the current year's fiscal plan, as well as to develop longer-term strategies for reducing Medicaid spending.

The executive budget set a Global State Medicaid spending cap that limits total Medicaid spending growth to the rate of the long-term medical component of the CPI (currently 4%). The Medicaid spending cap is $15.3 billion in 2011-12 and $15.9 billion in 2012-13. If spending rises by more than 4%, the Health Department, in conjunction with the Department of Budget, is empowered to enact spending cuts to meet the cap.

The MRT is declaring success in controlling Medicaid expenditures. While enrollment in Medicaid has increased over the last six months, spending has actually declined. Monthly data on Medicaid expenditures by category are now available on-line.

To help manage Medicaid spending, the Department of Health is now using Salient Management Company's Medicaid Visual Data Mining system. The Department is very enthusiastic about this tool and gave an extensive demonstration of the software during

the meeting. The program allows cash tracking by sector and allows the department to analyze spending on a real-time basis.

Jason Helgerson, NYS Medicaid Director, stated that he believes the MRT will save the federal government more than $18 billion in Medicaid expenditures over the next five years. The State is now preparing a waiver to submit to CMS that would allow New York to keep a portion of those savings to reinvest in Medicaid to further redesign the program through targeted investment priorities.

In other news, managed care rates went into effect on October 1. The rates are retroactive to the beginning of the state fiscal year, April 1, 2011. The rates reflect the carve-in of pharmacy and personal care services, as well as an across-the-board rate cut.

Additionally, the Public Health and Health Planning Council approved Lenox Hill's application to create a freestanding emergency department at the former site of St. Vincent's Hospital, the first such facility in New York. The application, from North Shore-LIJ Health System, must now be approved by the state health commissioner. The facility, which will be known as the Lenox Hill Hospital Comprehensive Care Center, is expected to open in 2014.

In the news

- **Berger: NY should consider publicly traded hospitals**

  While the Medicaid Redesign Team's Brooklyn task force won't have enough time by its November deadline to make specific recommendations on how facilities should reconfigure, it will be parsing any voluntary proposals that hospitals and other providers submit. But time is running out, and so far, no providers have submitted proposals. At the task force's most recent public meeting, the door was opened for-profit operators who can inject capital into providers. That includes publicly traded companies, the Team later confirmed. (Crain's New York)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The Department of Medical Assistance has extended the review period for all inpatient admissions from 14 days to 30 days effective July 1, 2011. The Department's readmissions policy stipulates:

- If the readmission is for the treatment of conditions that could or should have been treated during the previous admission, the Department shall make no payment in addition to the hospital's original DRG payment. If the combined hospital stay qualifies as an outlier, an outlier payment shall be made.
- If the readmission is due to complications of the original diagnosis and the result is a different DRG with a higher payment, the Department shall pay the higher DRG payment rather than the original DRG payment.
- If the readmission is due to conditions unrelated to the previous admission, the Department shall consider the readmission as a new admission for payment purposes.

OTHER HEADLINES

Arizona

- **Arizona Medicaid cuts: Key portions of plan rejected by U.S. officials**

  The Centers for Medicare and Medicaid Services OK'd some of Arizona's proposals to reduce the state's financial burden. But federal health officials rejected other key pieces: The state will not be allowed to impose a smoking fee or cap enrollment for low-income parents, a move that would have left an estimated 30,000 people uninsured in the first year. Agency director Cindy Mann said the state failed to show that freezing enrollment for poor parents would do anything more than save money, which is not reason enough to allow an exception to Medicaid standards. The rejected proposals amount to $52 million in savings the state had been relying on to help reduce a budget shortfall. Gov. Jan Brewer and lawmakers cut the Arizona Health Care Cost Containment System, the state's Medicaid program, by about $500 million to help balance the fiscal 2012 budget. Another $40 million in planned savings has been delayed indefinitely. (AZ Central)

Arkansas

- **Insurance chief: May be too late for state-run health exchange**

  State Insurance Commissioner Jay Bradford said today that it may be too late for Arkansas to create and fully implement its own health insurance exchange. Bradford said he may now recommend to the Legislature a hybrid exchange program that is run by the federal government but gives the state regulatory oversight. The hybrid insurance exchange is an option for states that don't want to create their own and don't want to defer that responsibility to the federal government. (Arkansas News)

California

- **L.A. County expands no-cost healthcare**

  In one of the largest expansions of health coverage to the uninsured, Los Angeles County is enrolling hundreds of thousands of residents in a publicly funded treatment program and setting the stage for the national healthcare overhaul. The county hopes to register as many as 550,000 patients and is assigning them to medical clinics for services at no cost to them. At the same time, the county is transforming its healthcare system to be less focused on acute care and more on primary care. The changes are expected to reduce costs, streamline care and attract patients. (Los Angeles Times)

Kansas

- **Colyer: Medicaid changes won't narrow eligibility**

  A plan for overhauling Kansas' Medicaid program will push to cut the state's nursing home population and reorganize agencies, but won't narrow eligibility requirements to reduce the number of people covered, Lt. Gov. Jeff Colyer said Thursday. Colyer said the administration will release its plan by the end of October. The lieutenant governor discussed the broad outlines of the Medicaid plan during an interview with The Associated Press, saying it will be designed to tackle a "fragmented" system for providing

care for the elderly and disabled and poor families. He said Brownback's administration will ask the federal government for a "global waiver" of Medicaid rules to give the state as much flexibility as possible. (LJ World)

Massachusetts

- **Medicaid waiver entangled in safety net in Massachusetts**

  The extension of the Medicaid waiver that allows Massachusetts to operate its landmark health care reform has hit a roadblock over funding for "safety net" providers, who are facing a growing demand for care even though the state's coverage expansion was supposed to limit their burden of caring for the poor. The waiver, which was part of the framework for the state reform, has been extended since June 30, when the current three-year agreement with the Centers for Medicare & Medicaid Services was set to expire. Renewal is on hold as Massachusetts and CMS try to settle federal payments to the safety net institutions, according to sources who have been briefed on the closely guarded negotiations. (Politico)

- **Athol Hospital Sees Vanguard Deal As Key To Future**

  Athol Memorial Hospital made headlines recently when it was ranked one of the best hospitals in the country by The Joint Commission, a nonprofit hospital accreditation organization, joining five other Massachusetts institutions. The 25-bed hospital intends to remain small, but not independent. It's in the process of being acquired by Vanguard Health Systems, the owner of Saint Vincent Hospital in Worcester and MetroWest Medical Center in Framingham and Natick. That will mean becoming a for-profit hospital, assuming the change meets with state approval. (Worcester Business Journal)

Virginia

- **Virginia's Medicaid payouts seen needing more oversight**

  Virginia needs to massively improve how it monitors payments in its Medicaid program, according to a report released Tuesday by the General Assembly's investigative arm. Local social services departments that mistakenly enroll people who should not be eligible pose the largest risk to improper payments in Virginia's Medicaid program, costing the state between $18 million and $263 million in fiscal 2009, according to a report presented Tuesday by the Joint Legislative Audit and Review Commission (JLARC). The wide range was attributable to the fact that analysts found many cases in which recipients were terminated from the program because of a lack of necessary documentation, though it was possible they were eligible at the time they applied, the report said. Analysts said part of the problem with the enrollment errors was that processes and standards for determining Medicaid eligibility are outdated and inconsistent throughout the state. (Washington Times)

Wisconsin

- **Madison County pushes state to cover Medicaid costs**

  Madison County officials are pushing the state legislature to pass a bill that will gradually transfer the financial responsibility of Medicaid from counties to the state. The county is estimated to spend $11.3 million next year on mandatory Medicaid costs, a portion of the $7.3 billion counties across the state contribute. The board unanimously

passed a resolution at its meeting Tuesday morning voicing its support of the bill and denouncing steadily increasing and unreasonable Medicaid costs. A new bill currently in Senate committees would put an immediate freeze on Medicaid contributions from counties and call for a gradual consumption by the state of all non-federal Medicaid costs during an eight-year span. (Oneida Dispatch)

United States

- **Medicaid explained: How would lower provider taxes affect state budgets?**

  The Obama administration's current deficit reduction proposal, now before the so-called congressional "Super Committee," includes a variety of measures designed to roll back federal Medicaid spending. But one — a lower cap on the taxes that states charge hospitals, nursing homes and other health care organizations — would have the biggest potential impact on state budgets. In its overall Medicaid proposal, the administration is calling for a $72 billion reduction in federal payments to states over a 10-year period starting in 2014. That's $28 billion less than the administration proposed to cut earlier this year during debt ceiling negotiations. In the current proposal, an estimated $26.3 billion of the reduction would come from lowering an existing cap on state provider taxes. Currently, these taxes cannot exceed 5.5 percent of a health care organization's revenues. The administration's proposal would gradually lower that ceiling to 3.5 percent over a ten year period starting in 2014. (Stateline)

- **Administration Scales Back Expansion Of Community Health Centers**

  Rather than handing out $250 million to establish new patient care sites to serve more than 2 million additional people as originally expected, the Obama administration gave $29 million to 67 nonprofit organizations that will serve an additional 286,000 patients. The funding cut was a result of a federal budget compromise in March to keep the government open. That agreement reduced federal spending by nearly $80 billion, including a $600 million trim in funding for ongoing operations at existing health centers. To make sure current centers did not have to reduce services, the Obama administration diverted some of the $11 billion set aside in the health overhaul law for health center expansion initiatives and instead used it to keep the existing centers operating at current levels. In addition, to free up money to help with existing operations, the administration scrapped plans to distribute $335 million to health centers to boost medical, dental, pharmacy and vision services. Advocates are concerned that future congressional spending cuts could slow efforts to build health center capacity by 2014, when the health law will begin expanding coverage to 32 million uninsured. (Kaiser Health News)

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 highlight an updated timeline related to the Hawaii Quest procurement.

Date	State	Event	Beneficiaries
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 18, 2011	Hawaii	Proposals due	225,000
November, 2011	Pennsylvania	Proposals due	565,000
December 1, 2011	Kentucky RBM	Implementation	N/A
December 2, 2011	Washington	Proposals due	800,000
December 6, 2011	Nebraska	Proposals due	75,000
December 23, 2011	Hawaii	Contract awards	225,000
January 1, 2012	Virginia	Implementation	68,000
January 15, 2012	New Hampshire	Contract awards	N/A
January 16, 2011	Hawaii	Implementation	225,000
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	75,000
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	75,000
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 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)

UPCOMING HMA APPEARANCES

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