HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: FLORIDA GOVERNOR'S BUDGET PROPOSES HOSPITAL PAYMENT RESTRUCTURING

HMA ROUNDUP: CALIFORNIA UPDATES TIMEFRAME OF DUAL ELIGIBLE DEMONSTRATION PROGRAM; FLORIDA RELEASES LONG TERM CARE RFI; MASSACHUSETTS DUAL ELIGIBLE DRAFT RFP RELEASED; NEW YORK PHASE ONE HEALTH HOME APPLICANTS APPROVED; TEXAS WAIVER APPROVED BY CMS; PENNSYLVANIA CASELOADS CONTINUE TO DECLINE; CALIFORNIA EXCHANGE DRAFT RFP EXPECTED NEXT WEEK

OTHER HEADLINES: WASHINGTON RFP RESPONDENTS ANNOUNCED; LOUISIANA HEALTH PLANS PASS READINESS REVIEW; CMS RELEASES FINAL CO-OP RULES; NEW YORK HOME CARE COMPANIES SCRUTINIZED

RFP CALENDAR: NEW HAMPSHIRE PROPOSALS DUE FRIDAY

DECEMBER 14, 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: FLORIDA GOVERNOR'S BUDGET PROPOSAL – HOSPITAL IMPACT

This week, our *In Focus* section highlights a key component of Governor Rick Scott's budget proposal – the implementation of a new Medicaid hospital payment methodology. The Governor's budget aims to provide major funding increases to Florida's public schools, offset by several proposals amounting to significant cuts in funding appropriated for hospital payments. The most significant of these proposals is a "rate band" payment methodology with the following three goals:

1. Streamline and simplify the rate-setting process;
2. Adjust the methodology so that inefficient hospital operating procedures will negatively affect the hospital's reimbursement rate; and
3. Lower the overall rates.

In addition to the rate band payment proposal, the Governor's budget also includes limits on payments for hospital inpatient days for non-pregnant adults, limits on payments for emergency room visits for non-pregnant adults, limits on services in the Medically Needy program, and a HMO rate reduction.

Rate Band Payment Methodology

The rate band proposal would create groups, or bands, of hospitals offering a similar line of service. These bands would then be paid flat rates based on weighted averages of costs and Medicaid days. Hospitals would be grouped into one of 10 categories.

Rate-Band Groupings	# of Hospitals	Inpatient Rates	Outpatient Rates	Total Loss in Payments
Children's Hospitals	3	$ 1,834.71	$ 113.62	$ (78,160,777)
Statutory Teaching Hospitals	9	$ 1,507.50	$ 155.31	$ (334,235,149)
15+ Percent Charity	17	$ 1,160.93	$ 112.39	$ (179,748,252)
Specialty Hospitals	4	$ 1,548.59	$ 227.22	$ (23,165,323)
Community Hospital Education Program (CHEP)	6	$ 1,108.19	$ 148.45	$ 319,995
Rural Hospitals	27	$ 1,174.62	$ 67.78	$ (25,004,826)
Long-Term Care Acute Care Hospitals	18	$ 690.25	$ 112.53	$ (377,719)
Rehabilitation Hospitals	14	$ 416.82	$ 43.78	$ (1,024,282)
General Acute Care Hospitals	128	$ 659.87	$ 72.96	$ (473,921,040)
Out-Of-State Hospitals (within 50 mi. of border)	16	$ 586.16	$ 81.58	$ (4,480,244)
Total Impact				**$ (1,119,797,615)**

Source: AHCA analysis, by hospital and county, December 2011

The total impact on hospitals will be a net loss in payments of more than $1.1 billion. In the analysis above, prepared by AHCA, the only hospitals to gain under the rate band payment system would be those six hospitals in the Community Hospital Education Program (CHEP), and their gains are relatively small. The Florida Hospital Association is preparing its own assessment of the impact of the rate band methodology and intends to release a comparison of the two analyses in the coming days.

Below we highlight the top ten hospitals in terms of total loss in payments. These ten hospital account for nearly half of the net total loss in payments across all hospitals.

Hospital	Rate Band	Total Loss in Payments	
Jackson Memorial Hospital	Statutory Teaching Hospital	$	(186,519,669)
Shands Teaching Hospital	Statutory Teaching Hospital	$	(76,967,633)
Memorial Hospital	15+ Percent Charity	$	(52,141,262)
Broward General Hospital	15+ Percent Charity	$	(43,507,695)
All Children's Hospital	Children's Hospital	$	(40,878,624)
Tampa General Hospital	Statutory Teaching Hospital	$	(40,442,900)
Miami Childrens Hospital	Children's Hospital	$	(36,245,543)
Baptist Of Miami	General Acute Care Hospital	$	(31,197,007)
Shands Jacksonville	Statutory Teaching Hospital	$	(28,967,651)
St. Joseph's Hospital	15+ Percent Charity	$	(24,729,739)
Total		**$**	**(561,597,723)**

Source: AHCA analysis, by hospital and county, December 2011

Inpatient Days Limits

The Governor's budget includes a provision that would limit hospital inpatient days for non-pregnant adults to 23 days per year. This change would go into effect on July 1, 2012. Medicaid currently covers 45 hospital inpatient days per year. The net impact of this change would result in state savings of more than $156 million.

Limits to Emergency Room Visits

The Governor's budget also includes savings of $12.2 million as a result of limiting payments for emergency room visits, again for non-pregnant adults only. Emergency room visits will be limited to 12 per fiscal year. There is currently no limit in place.

Cuts to Medically Needy Program

The Governor's budget includes $48.5 million in cuts to the Medically Needy Program. Individuals who are not eligible for full Medicaid benefits because their income or assets are over program limits may qualify for the Medically Needy Program. Individuals enrolled as Medically Needy must have a certain amount of medical bills each month before Medicaid can be approved. The top areas of service cuts under the proposal are hospital insurance benefits ($12.9 million), home health services ($6.6 million), and patient transportation ($5.7 million).

Health Maintenance Organization Rate Reduction

Finally, the Governor's budget includes a reduction of $30.8 million to HMO providers. The reduction in reimbursement rates is a result of reducing Medicaid reimbursement rates for inpatient and outpatient hospital rates and clinic services as of September 1, 2011.

For more information or for further analysis on individual hospital impacts of the proposals above, please do not hesitate to contact us:

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HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

The California Health Benefit Exchange, California Department of Health Care Services (DHCS), and the Managed Risk Medical Insurance Board (MRMIB) are soliciting stakeholder feedback related to the development of policies for marketing, eligibility, enrollment, and retention for the millions of Californians who will be eligible for coverage under the Affordable Care Act in 2014. As part of this effort, the State is launching a competitive procurement for an IT system integrator. The selected vendor will design, develop, and implement a system that will support the operations of the Exchange and the enrollment and eligibility processes for Medi-Cal and Healthy Families. A draft RFP is scheduled for release on December 20, 2011, with a final RFP expected January 18, 2012, and contract awards on April 17, 2012. Link

DHCS also announced an updated timeline for its Dual Eligibles Demonstration and site selection process. The details are described in the table below:

Activity	Approx. Timeframe	Activity
Release of draft site selection criteria	Mid to Late December	Previously, the goal had been to release final site selection criteria by year's end. Given the complexity of the issues, the goal is to now release draft criteria for comment.
Comment period on criteria and incorporation of comments	Early to Mid-January	Harbage Consulting will compile site selection criteria comments, and DHCS will make any changes as needed. A public meeting will be held in Sacramento in early January on the criteria.
Release of final site selection criteria and beginning of selection process	Late January to Early February	Final set of site selection criteria released. A second public meeting will be held on LTSS in Sacramento. A proposer conference will also be held.
Applications due	Mid to Late February	Site applications are due, likely with sites having a two- to three-week window for completion.
Announcement of sites selected for demonstrations under SB 208*	Mid to Late March	DHCS will announce sites selected to participate in the Demonstration, as authorized under SB 208.

DHCS releases draft Demonstration Proposal for 30-day state comment period	Mid to Late March	The site selection criteria are not the same as California's Demonstration Proposal. The Proposal will outline operations of the Demonstration and will be subject to a 30-day comment period. Town Hall meetings will be held in Sacramento and each county selected.
DHCS closes state comment period and updates draft duals Demonstration Proposal	Mid to Late April	DHCS will have incorporated comments on the Proposal, as needed, and will hold a public presentation discussing changes made during the comment period.
Submission of draft Demonstration Proposal to CMS and beginning of 30-day federal comment period	Late April or Early May	DHCS will submit the Duals Proposal to CMS, which will have a formal 30-day public comment period.

In the news

- **Audit faults state health officials on Medi-Cal oversight**

  State health officials have failed to adequately or promptly review the finances of publicly funded managed-care plans responsible for serving millions of Medi-Cal recipients, according to a report released Tuesday by California's state auditor. The state departments of Managed Health Care and Health Care Services also didn't conduct timely medical checks, intended to ensure that Medi-Cal recipients receive high-quality care. According to the audit, the Department of Managed Health Care was "chronically late" in completing its financial reviews, taking an average of 200 days, "seriously lessening their value as an oversight tool." The managed-care department also didn't recognize that some plans' administrative expenses were incorrectly categorized as medical expenses. One plan miscategorized $5.3 million of administrative costs as medical expenses, the report states. The audit occurred at the request of state Sen. Michael Rubio (D-East Bakersfield). The senator's office was concerned about healthcare plans having much higher balances of unspent state revenue than required by law. Auditors found that was the case, raising concerns about whether the plans were not spending what they should on providing medical care. The managed-care plans, however, said they kept the reserves high to ensure continuity of services to Medi-Cal recipients, the report states. (Los Angeles Times)

- **Physicians in California sue over new Medicaid pay cuts**

  The California Medical Assn. has sued the state Dept. of Health Care Services and the federal Dept. of Health and Human Services for cutting doctors' Medicaid rates by 10%. The pay cuts will harm patients already hit by a lack of available medical care, says the Nov. 21 suit, which was joined by the California Dental Assn. and other associations. The cut is the most recent conflict in a long-running battle between doctors and the state over pay under its Medicaid program, Medi-Cal. State lawmakers issued several rounds of cuts beginning in 2008, which health professionals sued several times to block. The U.S. Supreme Court is examining whether doctors have standing to sue over those cuts. (American Medical News)

Florida

HMA Roundup – Gary Crayton

In addition to the buzz surrounding Governor Scott's budget proposal, this week also saw the release of a request for information (RFI) related to the Managed Long-term Care invitation to negotiate (ITN) that is scheduled for release in mid-2012.

Specifically, the RFI seeks information from entities with direct experience in the managed health and long-term care industries about best practices and innovations in business models and service delivery for Medicaid managed care. The Agency for Health Care Administration (AHCA) is also interested in experiences with comparable programs in the commercial market and in other state Medicaid programs. AHCA will consider information gathered from responses to this RFI in preparing the ITN for statewide Medicaid Long-Term Care Managed Care, which is scheduled for release no later than July 1, 2012. The due date for the RFI was originally posted to be January 3, 2012 but our sources indicate it will be pushed back to January 10, 2012.

In the news

- **Continuation of Florida's Medicaid managed-care program close to approval**

  Federal officials could be close to approving a continuation of Florida's Medicaid managed-care pilot program, but some hospitals are balking at new requirements that could cost them millions of dollars. The requirements center on part of the pilot known as the Low Income Pool, which funnels $1 billion a year to hospitals and other health providers that serve large numbers of poor and uninsured patients. As part of continuing the pilot, the federal government would require that Florida carve out $50 million of the $1 billion for new or stepped-up programs aimed at improving the quality of care for low-income people. Federal officials also would place similar requirements on 15 hospitals that receive the most Low Income Pool money. Phil Williams, a top Florida Medicaid finance official, said Tuesday that the federal government has made clear it plans to include the requirements in any continuation of the pilot program. (News-Press)

- **Studies point to flaws in Florida's Medicaid managed care**

  Like many other states in fiscal duress, Florida sliced a large portion of its Medicaid budget this fiscal year, primarily by cutting payments to hospitals, nursing homes and other health care providers. Next year, Governor Rick Scott wants to double the size of reductions to the federal-state program — again by cutting provider fees. Within the next two years, however, the Republican governor expects to shave billions from the state budget is a statewide expansion of a five-county managed care pilot. The state Medicaid office sought approval for the plan in August and a decision by the U.S. Department of Health and Human Services is expected soon. But two new reports suggest the federal government may need some answers before it approves Florida's plan. Georgetown University's Health Policy Institute – which has been studying Florida's Medicaid managed care experiment since it was launched — predicted the state's proposed $10 monthly premium for Medicaid recipients would result in 800,000 low-income parents and children dropping the coverage. In addition, the authors point to a

proposed $100 co-payment for any use of an emergency room that doesn't involve an emergency. That is sure to raise some federal concerns. No other state has proposed such a high fee for low-income Medicaid beneficiaries. In another study, the Florida Center for Fiscal and Economic Policy, a consumer group, asserts that Medicaid beneficiaries in the managed care pilot program had a harder time making appointments with doctors after the program began than before it. The report – which analyzed claims data from January 2008 through December 2010 — found that the number of primary care visits per person was "alarmingly worse" under some private health plans. (Stateline)

Georgia

HMA Roundup – Mark Trail

On December 8, Georgia Department of Community Health (DCH) Director Jerry Dubberly announced that Peach State Health Plan (Centene) has been approved to go statewide beginning in January 2012. Amerigroup's application is still pending.

Also last week, the DCH board elected not to move forward with a planned rate cut of 0.5% to physicians, dentists and other providers participating in Medicaid and PeachCare. The proposed cut was estimated to save $13.9 million and did not apply to hospitals, nursing homes, home and community–based services, federally qualified health centers, rural health clinics or hospice providers.

The DCH Board's care management committee met to review issues around provider access and performance improvement. Dubberly discussed concerns about member access to care and how to increase provider participation in Medicaid. The access reports were presented and can found at link. We note that DCH is attempting to lessen the administrative burden on providers through the consolidation of forms and procedures across the CMOs and with the MMIS vendor.

Medicaid Redesign is on schedule to release its first report on redesign strategy on January 17, 2012 (DCH has released goals and strategies to guide them, which are shown in the tables below)

Medicaid Redesign - Initiative Goals & Strategies

Goals for Medicaid and PeachCare for Kids® Redesign		Weighting
1	Enhance appropriate use of services by members	33%
2	Achieve long-term sustainable savings in services	33%
3	Improve health care outcomes for members	34%
Goals - Weighted Total		100%

Strategies for Medicaid and PeachCare for Kids® Redesign		Weighting
1	Gain administrative efficiencies to become a more attractive payer for providers	20%
2	Ensure timely and appropriate access to care for members within a reasonable geographic area	20%
3	Ensure operational feasibility from a fiscal and administrative oversight perspective	20%
4	Align reimbursement with patient outcomes and quality vs. volume of services delivered	18%
5	Encourage members to be accountable for their own health and health care with a focus on prevention and wellness	18%
6	Develop a scalable solution to accommodate potential changes in member populations as well as potential changes in legislative and regulatory policies	4%
Strategies - Weighted Total		100%

Finally, the State of Georgia's net tax collections for the month of November totaled $1.35 billion, an increase of $88 million or 7% compared to November 2010. Through five months of FY2012, net revenue collections totaled $6.7 billion year-to-date, an increase of $427.5 million or 6.8% compared to YTD November FY2011. Individual Income Tax collections for November totaled $679 million, up from $662 million in November 2010, for an increase of $17 million or 2.6%. Net Sales and Use Tax collections for November totaled $451 million, up from $393 million in November 2010, for an increase of $58 million or 14.8%. Corporate Income Tax collections for November rose by $4.1 million or 65%, up from $6.4 million in November 2010.

Massachusetts

HMA Roundup – Tom Dehner

Massachusetts' Office of Medicaid released a draft RFP for the State Demonstration to Integrate Care for Dual Eligibles. The demonstration program would cover 115,000 dual eligibles aged 21-64 statewide. Of this total, 13.3% receive long-term care support in institutional settings, 17.4% receive LTC support in home and community based settings and 69.3% receive no LTC support. Total spending on the non-aged duals is projected to be $3.85 billion in 2011.

Under the Demonstration, MassHealth and CMS will use combined Medicaid and Medicare funding to contract with Integrated Care Organizations (ICOs) using a blended capitation financial arrangement to provide integrated, comprehensive care for dual eligible adults under age 65. The ICOs will be accountable for the delivery and management of all covered medical and long-term services and supports (LTSS) for enrollees, including behavioral health services. Implementation is scheduled for December 2012.

Currently, Massachusetts administers a voluntary integrated managed care model for dual eligibles called Senior Care Options. Participating plans include United/Evercare, Senior Whole Health, Commonwealth Care Alliance and Navicare/Fallon. Total enrollment in the program is roughly 20,000 lives.

Michigan

HMA Roundup – Esther Reagan

Yesterday, House Republicans removed language in a supplemental appropriations bill that would have allowed the State to accept a $9.8 million federal grant to continue the planning and development of the State's health insurance exchange, the MIHealth Marketplace. The bill will head back to the Senate, where it was already passed, in the new year.

New York

HMA Roundup – Denise Soffel

On November 1, 2011, the New York State Department of Health (NYSDOH) received 61 Health Home applications to serve the 10 counties in Phase 1. All applications were reviewed by a broad multidisciplinary team representing many perspectives, including the NYS Department of Health's Offices of Health Insurance Programs, Health Information Technology and the AIDS Institute; the NYS Office of Mental Health; the NYS Office of Alcohol and Substance Abuse Services; and the NYC Department of Health and Mental Hygiene. This week, New York announced conditional approval of its Phase 1 Medical Health Homes. Twenty one applicants were approved for the 10 Phase 1 counties, which include the Bronx, Brooklyn, Schenectady and the Northern Region (Clinton, Essex, Franklin, Hamilton, Warren, Washington counties). While a number of health plans applied to be the lead applicant, the State made the decision to favor provider-led applications. The Department of Health is requiring that health plans contract through an approved State Designated Lead Health Home to provide their members with Health

Home services. The Department has decided that health plans should only directly provide health home services in areas where such approved capacity is insufficient as determined by the State. The link below provides the list of approved applicants as well as the managed care plans approved for participation. Link

Phase 2 applications are due February 1, 2012, for an estimated start date of April 2012. Fifteen counties are included in Phase 2: Albany, Erie, Manhattan, Monroe, Orange, Putnam, Queens, Rensselaer, Richmond (Staten Island), Rockland, Saratoga, Suffolk, Sullivan, Ulster, Westchester.

Phase 3 applications are due April 21, 2012, with implementation scheduled for July 1, 2012. Phase 3, the final phase of implementation, includes 36 Counties: Alleghany, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Columbia, Cortland, Delaware, Fulton, Genesee, Greene, Herkimer, Jefferson, Lewis, Livingston, Madison, Montgomery, Niagara, Ontario, Oneida, Onondaga, Orleans, Oswego, Otsego, Schoharie, Schuyler, Seneca, St. Lawrence, Steuben, Tioga, Tompkins, Wayne, Wyoming, Yates.

The NYS Medicaid Redesign Team held its final meeting on December 13. Four working groups presented their final recommendations, all of which were approved by the full MRT. The MRT final report is due to Governor Cuomo by December 31. The MRT recommendations are only advisory; the Governor and his staff will review all the work of the MRT and evaluate it for inclusion in the fiscal year 2012-13 budget. The four workgroups presenting their recommendations were: Basic Benefit Review, Workforce Flexibility and Scope of Practice, Payment Reform and Quality Measurement, and Affordable Housing.

Although the MRT has officially finished its work, it is expected that some of the work groups will continue to meet as implementation of their recommendations moves forward. Specifically, Commissioner Mike Hogan has expressed a desire to keep a behavioral health stakeholder group in place to advise him as the department of Mental Health implements Behavioral Health Organizations, and develop the next steps for behavioral health redesign and reorganization.

Materials from the final meeting of the MRT can be found here: Link

The MRT also received an update on the Medicaid global cap. New York enacted a two percent global cap on Medicaid expenditures as means of closing this year's budget gap. Actual spending through October 2011 was $124.7 million over projected spending, which represents about 1.3 percent of total Medicaid spending. Jason Helgerson, the NYS Medicaid Director, reported a steady increase in Medicaid enrollment, which creates additional pressure on program expenditures. Medicaid enrollment reached 4,991,840 enrollees at the end of October 2011, an increase of 101,500 enrollees (2.0 percent) since April 2011.

In the news

- **New York State scrutinizes Medicaid benefits**

  New York State's Medicaid program could stop covering health care treatments whose effectiveness is not supported by data, if the state implements the recommendations of the Medicaid Redesign Team work group on benefits. Tuesday, the MRT recommended that the guiding principle for deciding whether Medicaid should cover a treatment should be evidence of its efficacy. The state Health Commissioner said the state should invest in treatments that, while costly, would save money in the long term. These include tobacco-cessation counseling by dentists, obesity counseling, podiatry for adult diabetics, lactation counseling and the nurse family partnership program, where nurses visit first-time mothers. The added costs of covering the benefits will not be part of the Medicaid global cap. (Crain's New York)

- **Aiding Disabled, Nonprofits Rake in State Money**

  The New York Times examines the financial gains many non-profit home health care companies have experienced due to low-cost care and favorable rates paid to these companies by the state. (New York Times)

- **State rolls out first phase of 'health homes'**

  Meeting its mandate to find better and more cost-effective ways to manage care for Medicaid patients and others with multiple medical and behavioral health problems, the state Department of Health approved its first round of "health home" organizations. These Phase I designations are for Brooklyn and the Bronx. Twenty-one of 61 applicants were conditionally approved. Each will get capitated payments for coordinating the care of these patients, including appropriately referring them to behavioral health organizations and others. The state's plan is to eventually put all such patients into managed care. But for the near future, the goal is to find patients who are "lost" to the health system, avoid unnecessary use of emergency rooms, and educate patients on taking better care of themselves—such as taking their medications. Part of the long-term plan involves having electronic health records for all patients. The full list of Home Health approvals and schedule for future awards is at www.health.ny.gov. (Crain's New York)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Enrollment figures reported by the Department of Public Welfare (DPW) indicate that program attrition accelerated in November as the State continues to review current caseloads. Specifically, counties are closing eligibility cases for beneficiaries that are not returning their redetermination paperwork at renewal. Over 150,000 beneficiaries have been culled from the rolls since August, with the majority being adults. A recent editorial in a local paper suggested the issue may in part be related to slower processing on the part of the State due to layoffs.

	Total		Adults		Children	
	Monthly Number	% Change Over Prev. Month	Monthly Number	% Change Over Prev. Month	Monthly Number	% Change Over Prev. Month
July 2010	2,223,452	1.3%	1,103,455	1.4%	1,119,997	1.2%
Aug.	2,236,299	0.6%	1,111,421	0.7%	1,124,878	0.4%
Sept.	2,219,392	-0.8%	1,103,776	-0.7%	1,115,616	-0.8%
Oct.	2,238,902	0.9%	1,114,371	1.0%	1,124,531	0.8%
Nov.	2,250,188	0.5%	1,120,763	0.6%	1,129,425	0.4%
Dec.	2,255,181	0.2%	1,124,348	0.3%	1,130,833	0.1%
Jan. 2011	2,264,663	0.4%	1,131,388	0.6%	1,133,275	0.2%
Feb.	2,270,369	0.3%	1,136,397	0.4%	1,133,972	0.1%
Mar.	2,298,582	1.2%	1,150,253	1.2%	1,148,329	1.3%
Apr.	2,310,026	0.5%	1,156,538	0.5%	1,153,488	0.4%
May	2,306,596	-0.1%	1,157,294	0.1%	1,149,302	-0.4%
June	2,312,862	0.3%	1,162,500	0.4%	1,150,362	0.1%
July 2011	2,331,009	0.8%	1,171,404	0.8%	1,159,605	0.8%
Aug.	2,333,807	0.1%	1,172,672	0.1%	1,161,135	0.1%
Sept.	2,302,066	-1.4%	1,158,897	-1.2%	1,143,169	-1.5%
Oct.	2,271,176	-1.3%	1,140,876	-1.6%	1,130,300	-1.1%
Nov.	2,180,612	-4.0%	1,062,884	-6.8%	1,117,728	-1.1%

Pennsylvania General Fund collections of $1,719.4 million for the month of November were $63.3 million, or 3.5%, below the official estimate. Fiscal year 2011-12 collections of $9,374.7 million were below the official estimate by $345.3 million, or 3.6%.

In the news

- **UPMC, Highmark to drop access to Walgreen**

  Walgreen, the largest operator of drugstores nationwide, will no longer be available at in-network rates for members of UPMC Health Plan starting January 1, 2012. UPMC Health Plan is the No. 2 health insurer in the region, with about 1.5 million members, most of whom have pharmacy benefits. And Highmark Inc., the region's largest health insurer, will begin a two-year transition of its 2.5 million members with pharmacy access to a new network that does not include Walgreen or Target Corp. pharmacies, the insurer said on Monday. There are about 35 Walgreen stores and about a dozen Target stores with pharmacies in the region. Highmark's pharmacy network allows access to about 61,000 retail pharmacies across the country. By dropping Walgreen and Target, Highmark's network will drop to about 52,000 pharmacies after two years. (Pittsburgh Live)

Texas

HMA Roundup – Dianne Longley

Texas received CMS approval for an 1115 waiver submitted earlier this year. The waiver was necessary to enact several new cost-saving initiatives the Texas legislature authorized in an effort to meet a $5 billion budget shortfall. The "Healthcare Transformation Waiver" authorizes the expansion of Medicaid managed care throughout the state for both STAR and STAR+PLUS populations and creates a new Delivery System Reform Incentive Payment (DSRIP) program that restructures and preserves the State's Upper Payment Limit (UPL) funding.

Modeled after the California DSRIP, the State will allocate waiver savings payments to two sub-pools: an Uncompensated Care Pool will defray the costs of care provided to uninsured patients, and the DSRIP will support coordinated care and quality improvements. To qualify for DSRIP funding, hospital districts and counties providing Texas' state share of Medicaid waiver matching dollars will form regional health partnerships to design five-year coordinated plans that will improve access to and quality of care for eligible populations. The proposals must include regional health assessments and potential improvements; outline projects and interventions that support delivery system reforms tailored to local community needs; and identify project goals, milestones, metrics and expected results. The State will be responsible for monitoring and evaluating projects to ensure funding is used efficiently and effectively.

Typically when a state expands managed care, federal rules result in a reduction of funding to hospitals under the UPL program. The five-year waiver will allow the State to continue receiving federal funds that are critical to hospitals treating uninsured individuals while also allowing the managed care expansion. The State estimated that UPL funds for fiscal year 2011 will total $2.7 billion. Texas Department of Health and Human Services Commissioner Tom Suehs stated, "It was critical we maintain those payments for our hospitals, but we also want to make sure we know how those tax dollars are being spent; our reform plan does both. Our plan ensures hospitals serving the most uninsured patients and providing the best services will get the most funding."

In the news

- **Administration Ties Medicaid Managed Care Expansion To Performance**

  The managed care industry's growing role in Medicaid got a boost Monday when the Obama administration approved Texas' plan to shift one million additional recipients into private health plans by 2013. The approval is the latest signal the administration will give broad leeway to states to expand managed care in Medicaid if they meet performance measures showing they are improving care. Currently, about half the 60 million people in Medicaid, the state-federal program for the poor, are covered by private managed care plans that have promised to coordinate care and hold down spending. The Centers for Medicare and Medicaid Services (CMS) has been pushing to make states and hospitals more accountable for how they use federal Medicaid dollars. The federally approved plan for Texas is also being closely watched by other states because

of how it changes --and potentially increases --Medicaid payments to hospitals that treat the poor. The Texas approval comes one year after the Obama administration approved a similar managed care expansion in California. There, too, the administration allowed hospitals to tap into supplemental Medicaid funds if they met certain performance measures. (Kaiser Health News)

- **Texas Health and Human Services Commission Offers Christus Health**

  Texas Health and Human Services Commission has announced a new health care option, Christus Health Plan. According to a release, the plan will be available on March 1, 2012 to current Medicaid (STAR) and Children's Health Insurance Program (CHIP) participants in the Nueces Service Area. The group said Christus Health Plan provides assistance to uninsured families who are eligible for Medicaid or CHIP. Current Coastal Bend STAR and CHIP participants will begin receiving enrollment packages in mid-December detailing the new Christus Health Plan. This package will include information about the plan, how to participate, and how to start receiving its benefits. Eligible participants are encouraged to sign-up for the Christus Health Plan by February 10, 2012. Services will begin March 1, 2012. (Insurance News Net)

- **Texas Gets Approval for Cost-Saving Medicaid Improvements**

  Texas this week received approval from the Centers for Medicare and Medicaid Services (CMS) for a waiver that allows the state to expand Medicaid managed care while preserving hospital funding, provides incentive payments for health care improvements and directs more funding to hospitals that serve large numbers of uninsured patients. HHSC applied for the waiver earlier this year to identify innovative, state-based solutions to Texas' health care needs. Under the waiver, communities and hospitals will form regional health partnerships that support more localized health care solutions. The partnerships will identify ways to improve health services that address the specific needs of their region in order to qualify for incentive payments. These projects will be monitored and measured to ensure the funding is used efficiently and effectively. (Texas HHS News Release)

- **Medicaid waiver could be boon for Texas hospitals**

  The federal government on Monday granted Texas a waiver that could mean billions more in Medicaid dollars to hospitals over the next few years in return for having them work together to provide better care for the poor. State lawmakers cut deeply into the Medicaid budget this year, in part by requiring all Texas Medicaid patients to be enrolled in private health maintenance organizations for their doctor care. In recent years, patients in most urban areas were covered by HMOs, while patients in many rural counties and the Rio Grande Valley had their doctor bills paid directly by Medicaid. The problem was, enrolling everyone in managed care plans threatened to violate the terms of an existing waiver that paid hospitals separately and at much higher rates - equal to what Medicare pays. To get that extra money for hospitals, local tax funds are put into a state pool to draw down more federal funds. The new plan could lead to even more money for hospitals - as much as $6.2 billion in the final year of the five-year waiver, up from about $2.8 billion this year. But it would require hospitals in each region to work together to improve care for the poor. (Houston Chronicle)

Washington

HMA Roundup – Julie Johnston

On December 8, the Washington Health Care Authority announced that seven health plans submitted bids on a 2012-13 contract that will provide managed care for more than 700,000 Medicaid clients and Basic Health subscribers.

The seven health plans were:

1. Amerigroup Washington, Inc. (new bidder)
2. Columbia United Providers (incumbent plan)
3. Community Health Plan of Washington (incumbent plan)
4. Coordinated Care Corporation Inc. (Centene - new bidder)
5. Molina Healthcare of Washington Inc. (incumbent plan)
6. Premera Blue Cross of Washington (new bidder)
7. UnitedHealthcare (new bidder)

We note that three incumbent plans, Asuris (4,219 lives), Regence (38,867) and Kaiser Foundation Health Plan (930) did not submit bids. It is interesting to see Premera pursuing this contract after having sold its Medicaid business to Molina in 2004. The State intends to announce the winners by mid-January.

In the news

- **1 of 7 state residents lacks health insurance**

  The number of people in Washington state without health insurance has risen sharply since the end of 2008 and is expected to reach 1 million by the end of the year, according to a new report from state Insurance Commissioner Mike Kreidler. About 14.5 percent of state residents — most of them working-age adults — have no coverage, and many more are underinsured, the report says. In 31 of 39 counties, the percentage of uninsured grew over the past two years. Meanwhile, hospitals and health-care providers across the state are spending about $1 billion per year on uncompensated care, which includes both charity cases and bad-debt write-offs. Those losses ultimately are passed along to those who have insurance, adding an estimated $1,017 to an average family's annual premium, the report says. The $1 billion includes a 36 percent increase in charity-care costs from 2008 to 2010. (Seattle Times)

OTHER HEADLINES

Louisiana

- **All Five Health Plans ready to launch BAYOUHEALTH**

DHH Secretary Bruce D. Greenstein announced that all five Health Plans contracted to manage care under the BAYOU HEALTH program have passed their operational and systems readiness review, and each has been certified as having an adequate provider network in the first region of the state to roll out BAYOU HEALTH. Operational and systems readiness reviews were conducted by DHH's BAYOU HEALTH staff to ensure that the Plans are fully prepared to manage health care for some 865,000 Medicaid and LaCHIP recipients. The reviews examined each Plan's ability to handle everything from case management and claims payments, where applicable, to member grievances and fraud prevention. In total, Prepaid Plans had to prove readiness on 906 different factors, and Shared Savings Plans had to show readiness on 788 factors. Each Plan also had to show they have contracted with an adequate network of doctors, including specialists, where applicable and other providers, for the first region of the state to go live, which is the four-parish New Orleans and five-parish Northshore areas - known as Geographic Service Area A (GSA A). GSA A goes live on Feb. 1 with member enrollment beginning Thursday, Dec. 15. The Plans will also have to show network adequacy in each subsequent GSA before they launch, which will occur in 60-day increments following GSA A. (BAYOUHEALTH News)

New Jersey

- **NJ's Comprehensive Medicaid Waiver on Track but Still Several Months Out**

New Jersey's request to overhaul its $11 billion Medicaid program via what's known as a "comprehensive waiver" from the federal government is on track but could take several more months to complete, according to a federal official overseeing the waiver request. The state proposes shifting Medicaid's 30,000-plus nursing home and assisted living residents into managed care. Four managed-care companies, including a division of the state's largest health insurer, Horizon Blue Cross Blue Shield of New Jersey, already deliver Medicaid services under contract with the state to the majority of Medicaid's 1.3 million members. The waiver also seeks federal approval to launch Medicaid Accountable Care Organizations, modeled on work started nine years ago in Camden by Dr. Jeffrey Brenner, executive director of the Camden Coalition of Healthcare Providers. The coalition brings the city's three hospitals, its physician practices, and other social and medical services together to improve preventive care for those with chronic conditions. (New Jersey Spotlight)

North Carolina

- **Delays, overruns plague NC Medicaid claims project**

North Carolina Republican lawmakers grilled state Medicaid leaders Tuesday about delays in replacing the government health program's claims processing system, which has faced operational hurdles since the project first began almost eight years ago. The system's launch is running nearly two years behind schedule. State auditors also estimate it will cost more than double the originally projected amount because of expand-

ed contract expenses and the expense of keeping the current aging system running with its longtime vendor. The state's Medicaid Management Information System Office is working with Computer Sciences Corp., which has a contract to overhaul and operate the new processing system. Medicaid processes eight million claims a month involving more than 70,000 providers. The original contract, announced in late 2008 and awarded to Computer Sciences Corp., was estimated at $265 million. The system was supposed to be up and running this year. (Canadian Business)

Utah

- **Few surprises in governor's health policy agenda**

  The Governor's budget recommendation, released this week, is asking for $57.2 million to cover anticipated growth in the low-income health program Medicaid and $2.2 million for the Children's Health Insurance Program (CHIP). And he's setting aside $9 million to fund a Legislature-driven health reform experiment to move some Medicaid recipients into managed care networks known as Accountable Care Organizations (ACOs). If approved by the federal government, the experiment would pay ACOs a lump sum per patient. Any losses at the end of the year would be absorbed by the ACOs, which would also share in any leftovers. Advocates for the poor are generally pleased by the recommendations, but are angling to use some of this year's $280 million surplus to restore dental services. (Salt Lake Tribune)

Wisconsin

- **Delay in Medicaid changes approval may cut coverage for 53,000**

  The federal government said Friday it likely won't meet Wisconsin's Dec. 31 deadline for approving Medicaid changes. The state responded by repeating its request for a prompt decision, saying it wants to avoid cutting coverage for 53,000 adults. On Nov. 10, the state asked the agency to approve key parts of its plan to trim $554 million over two years from Medicaid, the state-federal health plan for the poor. This year's state budget law said lack of approval by Dec. 31 would require ending BadgerCare Plus coverage in July for 53,000 adults who earn more than a third above the federal poverty level. That's about $30,000 a year for a family of four. Approval of the state's proposals, meanwhile, would cause nearly 65,000 people to leave or be turned away from BadgerCare Plus and other Medicaid programs, the nonpartisan Legislative Fiscal Bureau said. That's mostly because of higher premiums, a required switch to employer insurance and changes in eligibility. The state also wants to shift 263,000 people into a lower-cost plan with fewer benefits. (Wisconsin State Journal)

United States

- **December 8, 2011: HHS issues final CO-OP rules**

  HHS issued final rules for the establishment of the Consumer Oriented and Operated Plan, or "CO-OP" program. CO-OPs are non-profit private health insurers whose boards of directors are composed of plan members. Organizations seeking to establish a CO-OP can apply for low-interest loans to fund start-up costs and meet solvency requirements, with quarterly application deadlines through December 31, 2012. The first round of applications were due October 17, 2011. (Link to final rules)

- **December 7, 2011: CMS releases study on health care spending by state**

  A CMS study of health care spending by state found the gap is broadening between the highest-spending and lowest-spending states, with the highest-spending states ranging from 133 to 136 percent of the average. The states with the highest spending in 2009 were Massachusetts, Alaska, Connecticut, Maine, Delaware, New York, Rhode Island, New Hampshire, North Dakota, and Pennsylvania. The lowest-spending states were Utah, Arizona, Georgia, Idaho, Nevada, Texas, Colorado, Arkansas, California, and Alabama. (Link to study)

PRIVATE COMPANY NEWS

- **CareSource to add 150 Ohio jobs**

  CareSource said Monday it will create 150 more jobs statewide as it strives to meet a state push to improve the performance of Medicaid managed-care plans. The hiring also lays the foundation for the Dayton-based nonprofit to expand beyond its traditional Medicaid base. CareSource is moving partly to a "community-based care management model" meant to improve the health of the 1 percent of its members deemed at highest risk. Those Medicaid members are among the highest users of health care services and the most costly to the state Medicaid program, budgeted at $18.8 billion this fiscal year. CareSource, which now covers about 10 percent of insured Ohioans and through November had 2011 revenues of $2.5 billion, plans to implement the new model by July 1. (Dayton Daily News)

- **HMS Awarded Third Party Liability Contract by the State of Louisiana**

  HMA, a wholly owned subsidiary of HMS Holdings Corp., announced today that is has been awarded a contract by the State of Louisiana, Department of Health and Hospitals, to provide third party liability identification and recovery services. HMS will also perform data matches and insurance verifications to ensure that the state's third party eligibility resource file remains current, and will also administer the Louisiana Health Insurance Premium Payment program (LaHIPP). The contract extends through June 30, 2014. HMS has been providing third party liability and cost avoidance services to Louisiana since 1985. During that time, HMS's cost avoidance efforts have resulted in millions in savings and recoveries for Louisiana. Over the course of the most recent contract term from 2008 – 2011, HMS recovered $118.1 million for the State and cost avoided an additional $275.6M, for a net benefit to Louisiana of $393.7M. (Business Wire)

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. We note that New Hampshire proposals are due Friday.

Date	State	Event	Beneficiaries
December 13, 2011	Missouri	Proposals due	425,000
December 16, 2011	New Hampshire	Proposals due	130,000
January, 2012	California (Central Valley)	Evaluation (delayed)	N/A
January 1, 2012	Virginia	Implementation	68,000
January 15, 2012	New Hampshire	Contract awards	130,000
January 17, 2011	Hawaii	Contract awards	225,000
January 17, 2012	Washington	Contract awards	800,000
January 18, 2011	Pennsylvania	Proposals due	465,000
January 31, 2012	Kansas	Proposals due	313,000
January 31, 2012	Ohio	RFP Released	1,650,000
February 1, 2012	Louisiana	Implementation (GSA A)	255,000
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
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
July 1, 2012	Georgia	RFP Released	1,500,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 15, 2012	California (Central Valley)	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA Recently Published Research

Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012

Vernon K. Smith, Managing Principal
Eileen Ellis, Managing Principal
Kathleen Gifford, Principal

For the 11th consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) present their budget survey of Medicaid officials in all 50 states and the District of Columbia. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data for FY 2011 and FY 2012. (Link to report)

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 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. The findings were informed, in part, by the perspectives of a group of Medicaid pharmacy administrators convened by the Foundation in May 2011. (Link to report)