HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: ILLINOIS PHASE I CARE COORDINATION INITIATIVE RFP

HMA ROUNDUP: FLORIDA SENATE BUDGET PROPOSAL CALLS FOR FURTHER INPATIENT REDUCTIONS; CALIFORNIA TRAILER BILL OUTLINES MEDICAID MANAGED CARE EXPANSION PLANS; NEW YORK RECEIVES CMS APPROVAL FOR HEALTH HOMES; TEXAS UPL HEARINGS UNDERWAY; PENNSYLVANIA GOVERNOR'S BUDGET RELEASED; WASHINGTON ANNOUNCES COUNTY AWARDS TO SELECTED MANAGED CARE PLANS

OTHER HEADLINES: PROVIDER PAYMENT ISSUES PLAGUE KENTUCKY MEDICAID MANAGED CARE PROGRAM; BCBS KANSAS BACKS OFF MEDICAID BID; HEALTH INSURANCE EXCHANGE DEVELOPMENTS IN ILLINOIS, MINNESOTA AND VIRGINIA

RECENTLY PUBLISHED RESEARCH: *"ON THE VERGE: THE TRANSFORMATION OF LONG TERM SERVICES AND SUPPORTS"*

FEBRUARY 8, 2012

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: ILLINOIS PHASE I CARE COORDINATION INITIATIVE RFP

This week, our *In Focus* section reviews the Phase I procurement under the Illinois Care Coordination Innovations Project. The Phase I RFP is the first step in a transition toward more managed care and care coordination in the State's Medicaid program. The Medicaid reform law, passed by the Legislature last year, requires that at least 50 percent of the individuals covered under Medicaid be enrolled in a care coordination program by January 1, 2015. Illinois has significant Medicaid enrollment in the Illinois Health Connect primary care case management (PCCM) program but has very low traditional managed care penetration, particularly for a state of its size. Illinois enrolls less than 250,000 Medicaid lives in traditional MCO plans, between a voluntary MCO program and the new Integrated Care Program, which enrolls aged, blind, and disabled (ABD) beneficiaries in the Chicago suburbs. The Phase I RFP will target high-cost, high-utilization Medicaid recipients and seeks to encourage partnerships between providers, community agencies, and other non-HMO entities to propose innovative care coordination strategies for this population. In the coming months, a Phase II RFP will be released, targeting traditional managed care plans and the broader Medicaid population.

Phase I RFP Summary

The Phase I RFP is seeking applicants to provide coordinated Medicaid services to seniors and adults with disabilities (including long-term care populations, those with serious mental illness, HCBS Waiver populations, and Dual Eligibles).

This RFP is not open to traditional managed care organizations; however MCOs may partner to provide back office services under one of the following care coordination partnerships, as defined by the RFP:

- **Care Coordination Entity (CCE):** A CCE is a collaboration of providers and community agencies, governed by a lead entity, that receives a care coordination payment in order to provide care coordination services for its enrollees.
- **Managed Care Community Network (MCCN):** A MCCN is an entity, other than a Health Maintenance Organization, that is owned, operated, or governed by providers of health care services within Illinois and that provides or arranges primary, secondary and tertiary managed health care services under contract with the Department exclusively to persons participating in programs administered by the Department.

CCE Reimbursement Model

Those interested in applying as CCEs are offered three models for financial reimbursement; entities may select one of the models or a combination of more than one. First, CCEs can receive a care coordination fee for each enrolled member, full payment of which is dependent on meeting specified quality and care coordination measures. Second, a CCE may operate under a shared savings model, with savings (relative to Medicaid spending trends) split between the CCE and the state/federal government. Last, and strongly encouraged by the RFP, is the development of new and innovative payment

models. Regardless of the reimbursement method proposed for care coordination services, all medical services will remain under a fee-for-service (FFS) payment structure, with the CCE receiving only care coordination funds.

MCCN Reimbursement Model

For MCCNs, the State, in conjunction with its independent actuary, will set actuarially sound capitation rates for services that are at-risk. There will not be a bidding process to set rates. A MCCN may pay for non-covered services within the capitation rate set by the Department. As with the CCE model, payment of the full capitation rate is subject to the MCCN meeting specified quality measures. Performance and quality measures have been provided along with the RFP. However, we note that the State has noted that some of these measures are still in development and yet to be finalized. A link to the quality and performance measures is provided: (Quality Measures Specifications)

Matchmaking Service

The Department has provided a unique "matchmaking" service on its website, through which interested parties can post a description of what they offer to a CCE or MCCN partnership and what type of entities they are seeking as partners. As of February 8, 74 interested parties have posted on the site, (available here).

Timeline and Scoring Criteria

Questions on the RFP and procurement process must be submitted to the Department, through the HFS website, by this Friday, February 10. A mandatory letter of intent (LOI) is due by February 29, 2012. The LOI is a prerequisite to receiving any Medicaid claims data from the state on a target population. Final proposals are due on May 25, 2012 at 2:00 p.m.

In public Medicaid Advisory Committee (MAC) meetings leading up to the RFP release the State has indicated that the number of CCEs and MCCNs selected will depend on the quality of responses. The scoring methodology for the RFP is summarized below.

CCE and MCCN Evaluation Categories	Maximum Points
Governance Structure, Scope of Collaboration, and Leadership	250
Populations/Geography	100
Care Coordination Model	450
Health Information Technology	200

Link to RFP: (PDF, 59 pages)

Link to Quality Measures: (PDF, 82 pages)

Link: (Matchmaking Site)

Link: (HFS Care Coordination Homepage)

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

The Department of Health Care Services recently released additional detail regarding the Governor's proposal to expand the dual integration pilots up to 10 counties in California. As proposed last month, the budget assumes the expansion of the dual pilot counties to include up to 800,000 duals by the end of 2013 and state savings of $678 million. The additional detail included a fact sheet and "trailer bill language," which is typically released after the proposed budget and reflects the statutory language that the Legislature will need to adopt to implement the budget. This language should be viewed as the initial starting point of negotiations between the Governor, the Legislature, and stakeholders and will not likely be adopted in its current form. In addition, any approval for expansion won't be forthcoming until the budget is approved and enacted, which will not be until June or July 2012. Some of the highlights of the proposed language include:

- The Department is seeking a mandatory lock-in of six-months for all duals after they are enrolled in a demonstration site. If the lock-in is not approved by CMS, beneficiaries will be allowed to return to Medicare FFS. The Department is additionally proposing to require all duals to be mandatorily enrolled in Medi-Cal Managed Care plans in order to receive Medi-Cal Services.
- The Department is proposing to extend managed care throughout California, and after the implementation of statewide managed care, it will include duals in addition to other populations that are currently served in the state's Fee-For-Service system.
- While the Department asserts that plans will have increasing responsibility for behavioral health services in years 2 and 3 of the Demonstration, counties will continue to have a role in the assessment of beneficiaries for the In-Home Supportive Services program.
- If the Legislature fails to enact the proposed dual expansion, the mandatory enrollment of duals into Medi-Cal managed care, and the inclusion of long-term supports and services into managed care, the Director of the Department is authorized to defer payments to Medi-Cal managed care plan in the final month of the state fiscal year 2012-13.

In the news

- **New county program broadens health care access**

  Path2Health is projected to provide an additional 2,600 uninsured adult residents with health care coverage. It does this chiefly by easing eligibility rules set by a predecessor plan, the County Medical Services Program, or CMSP. Key changes include raising income caps — which largely eliminates deductibles that officials say have prevented people from joining — and dropping a rule that excluded anyone with more than $2,000 in assets. (Press Democrat)

Florida

HMA Roundup – Gary Crayton / Elaine Peters

On Wednesday, February 8th, the Florida state Senate introduced its FY 2012/13 budget. While we are still reviewing the details and evaluating the potential impact across constituents, we highlight the following items:

- Hospital funding is reduced by 9.5% statewide in order to fund the HMO portion of the rate related to hospital exemptions and buy backs. The mechanism used to enforce the reduction, however, will have disproportionate impacts across hospitals. Approximately half of the hospitals will be exempt from the cut. As such, while the overall reduction in the inpatient line item is 9.5%, the impact on the hospitals that are not exempt from the cut will be larger. Of the half that are subject to the cut, a subset will be able to "buy back" the rate reduction by contributing the state share of spending through an intergovernmental transfer. The remaining hospitals will absorb the rate reduction without the ability to offset it through buy backs. We note that the House budget proposal called for a 7% rate reduction to hospitals.
- ER visits limited to six per year. This compares to the House proposal which was 12 ER visits per year.
- Medipass (PCCM) eliminated in any county where there are already two managed care plans effective October 1, 2012.
- $17M increase in KidCare/CHIP funding.

In the news

- **71 Percent of Florida Voters Oppose Medicaid Reimbursement Cuts to Hospitals, New Poll Shows**

  Seventy-one percent of Florida voters say Medicaid is an important program that should be maintained and oppose the deep reimbursement cuts to Florida's hospitals that Governor Rick Scott and legislative leaders are proposing this session, a new poll shows. Voters say they are most concerned that additional reimbursement cuts will force hospitals to eliminate specialized healthcare services such as trauma care, advanced care for newborn babies, burn units and outpatient clinics. The poll also found that 72 percent of voters oppose Governor Scott's proposal to reduce the number of days that Medicaid patients can be hospitalized annually from 45 to 23 days. After 23 days, hospitals would no longer receive Medicaid reimbursement for these patients. The poll of 800 registered Florida voters was conducted January 9-13 on behalf of the Safety Net Hospital Alliance of Florida (SNHAF). (Sacramento Bee)

- **Jackson Health System will announce "significant" layoffs in about two weeks**

  Jackson Health System plans to "right-size" its organization with "significant" layoffs, Chief Executive Carlos Migoya said Friday. Though he refused to give specifics, he said managers are examining each department to see where reductions make sense without hurting the quality of patient care. Patient volume has dropped, partly be-

cause of shorter average lengths of stay and partly because more patients are getting out-patient treatment rather than being admitted to the hospital. (Miami Herald)

- **Hospitals dodge budget cuts**

  Spending cuts to health programs will be less than half as much as forecast in the Senate budget, that chamber's health-spending chief announced last week. Now, the Senate Subcommittee on Health and Human Services Appropriations will have to cut only $390 million from current spending levels, rather than the more-draconian $850 million that had originally been assigned, said Sen. Joe Negron, chair of the panel. Negron said hospitals and nursing homes' Medicaid pay rates may be touched only lightly, if at all. Instead, Negron said, he intends to eliminate behavioral-health programs that are not performing up to expectations. (Health News Florida)

Georgia

HMA Roundup – Mark Trail / Megan Wyatt

On Friday, February 3, the Georgia House passed HB 471, the AFY 2012 appropriation bill. Overall, the House budget makes very few adjustments to the Governor's budget for Medicaid/CHIP, DBHDD and DHS, with the exception of the Low-Income Medicaid (LIM) Medicaid Budget. The House budget cuts $15.1 million state funds ($44 million total funds) to reflect projected benefit need. This cut amounts to a 1.4 percent reduction to LIM. (Link to House Budget Office documents)

In the news

- **Budget Forecast for 2014**

  Gov. Nathan Deal is projecting a deficit of $320 million for fiscal 2014. The state Constitution requires lawmakers to balance the budget each year. Fiscal experts told Democratic lawmakers at a hearing Monday that means the state will have to trim vital services again next year without additional revenue. Deal's 2013 spending plan is up about $900 million from the current fiscal year. But the added revenue only pays for the normal increases in government services. Alan Essig of the non-partisan Georgia Budget and Policy Institute says the budget's current size will keep the state treading water. (Georgia Public Broadcasting)

Illinois

HMA Roundup – Matt Powers / Jane Longo

This week, *Crain's Chicago* reported that State Rep. Frank Mautino on January 30 introduced a bill in the Illinois General Assembly to establish a health insurance exchange. According to the article, HB 4141 is likely to serve as the vehicle for the upcoming debate over the structure of Illinois' health insurance exchange. The bill's language mirrors an amendment to another bill that Mautino introduced last year. The new bill is currently in the House Rules Committee.

In the news

- **Illinois governor says he wants to cut $2 billion from the state's Medicaid budget**

  Gov. Pat Quinn previewed some tough budget choices Tuesday, saying he wants to cut $2 billion from the state's Medicaid budget to help solve the state's fiscal woes. That amounts to about 14 percent of total spending. Reforming Medicaid won't be easy, particularly in an election year. Last year, Quinn proposed cutting payment rates for providing care under the Medicaid program, which would have meant a reduction in what state government owes. But state legislators did not approve it. The state has paid some current Medicaid costs out of future budgets, and there has been buildup of late payments. The backlog of unpaid Medicaid bills is expected to reach $1.8 billion by the end of the fiscal year. (Chicago Tribune)

- **GOP lawmakers: Quinn administration request for Cook County Medicaid growth should be dropped**

  Two Republican state lawmakers on Thursday said it would be hypocritical for Gov. Pat Quinn to seek expansion of a health insurance program for low-income adults in Cook County at a time Illinois faces billions in unpaid bills and needs statewide Medicaid reforms. The lawmakers said there are hundreds of millions of dollars in cost-saving reforms that were approved by the Legislature last year but not carried out. The reform package, which included requiring income and residency verification for Medicaid applicants, put a moratorium on expanding Medicaid eligibility. (The Republic)

New York

HMA Roundup – Denise Soffel

NY Receives Approval for Health Homes

New York's Medicaid State Plan Amendment for Phase I Health Homes was approved by CMS, with an effective date of January 1, 2012. The State is working on guidance that will describe how existing care management programs can bill for patients they are already serving. The State will also be providing the new provider-led health homes with a list of members eligible for health home enrollment in February so that health homes can begin outreach and engagement. Managed care plans are in the process of contracting with approved Phase 1 provider-led health homes so they will be able to assign their members into health homes effective March 2012.

The State has also posted the criteria by which it will be evaluating its health home goals. The State has five goals for its health home initiative, listed below. Details about the quality measures that will be used can be found on the Health Department web site at: (Link to PDF)

> Goal 1: Reduce utilization associated with avoidable (preventable) inpatient stays
>
> Goal 2: Reduce utilization associated with avoidable (preventable) emergency room visits
>
> Goal 3: Improve outcomes for persons with mental illness and/or substance use disorders

Goal 4: Improve disease-related care for chronic conditions

Goal 5: Improve preventive care

State Psychiatric Hospital Closure Announced

The Office of Mental Health (OMH) has announced the closure of Kingsboro Psychiatric Center (KPC) in Brooklyn. This was one of the recommendations of the Medicaid Redesign Team (MRT) as part of its Health Systems Redesign working group. The MRT recommended that OMH should close the inpatient service of KPC and, working with the Department of Health, redirect resources to community-based behavioral health services that would function in collaboration with Brooklyn hospitals. The report noted that KPC provides intermediate psychiatric hospital care for fewer than 240 admissions each year, and that the length of treatment for patients at KPC is the longest in the state for this level of care. The MRT report goes on to argue that "Conversion of a majority of the high cost KPC inpatient beds into intensive community treatment and support services would be well-timed with the implementation of the Medicaid health home initiative in the borough. Improved coordination, coupled with expanded service availability, will significantly reduce the burden on Brooklyn's emergency rooms and inpatient services." Current services at Kingsboro include:

- Comprehensive, integrated services 24 hours per day for hospitalized patients,
- 24-bed Crisis Residence for patients who have been discharged but need to have arrangements completed for residence placement,
- 48-bed Transitional Residence,
- 65-bed Family Care Program with certified homes in the community,
- Community-based outpatient clinics located in Canarsie and Williamsburg

These services will be consolidated with South Beach Psychiatric Center in Staten Island. OMH anticipates that this will result in a net reduction of inpatient beds, along with expansion of other State-operated residential and outpatient services in Brooklyn. Kingsboro's closure will take nine to 12 months.

More on the Executive Budget

Consistent with Governor Cuomo's commitment to transparency in government, the NYS Medicaid Director, Jason Helgerson, provided two opportunities to learn more about the Medicaid issues addressed in the Governor's budget. On February 1 Helgerson conducted a webinar for consumer stakeholders that focused on budget proposals coming from three of the MRT work groups. He also discussed the status of planning for the health insurance exchange.

The webinar can be viewed through a link on the MRT web site.

While the webinar did not provide an opportunity for Q & A, Helgerson did provide for a back and forth on February 3 when he hosted the first-ever Twitter session focused on New York's Medicaid budget. Over the course on an hour, Helgerson responded to a number of questions on a wide range of topics including the possibility of a new federal

1115 waiver, the future of MRT recommendations that do not appear in the budget, scope of practice laws, and charity care payment and policy.

Managed Long-term Care Plans Consumer Satisfaction Survey

The New York State Department of Health announced that, according to a customer satisfaction survey of enrollees in Medicaid managed long-term care plans (MLTCs), enrollees rate their plans highly. The survey by IPRO concludes that 85 percent of enrollees rated their managed long-term care plans (MLTCs) good or excellent. Ninety-one percent would recommend their plan to a friend, and 84 percent have said the plan helped them and their families manage their illness better. Ratings of plan communication were also high with 85 percent indicating that the plan explains services clearly, and 98 percent reporting that they were treated with politeness and respect. It is perhaps not surprising that consumer satisfaction is so high, as participation in MLTCs is completely voluntary at this point, and anyone who is not satisfied can choose to leave the program.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Pennsylvania Governor Tom Corbett announced his proposed budget for FY 2012-13 on February 7. In presenting his budget, Corbett emphasized his commitment to not increase taxes. The result is a proposed state general fund budget for FY 12-13 of $27.14 billion, which is more than $20 million below the FY 2011-12 budget. Medical Assistance, including long-term living, makes up 23.4 percent of the general fund budget proposal for Pennsylvania in FY 2012-13.

Notable changes (and state general fund savings) in the Governor's proposed budget include:

- The redirection of $59 million in Tobacco Settlement Fund revenues from the Health Research program to offset long-term care costs.
- The transfer of fee-for-service program funding to the mandatory capitation program to expand HealthChoices (an initiative that is already moving forward with the recent procurement for New East and New West).
- An increase of 4.4 percent in the Children's Health Insurance Program to $101.6 million.
- A projected savings of $319.3 million from the elimination of cash benefits provided through the General Assistance program and from revisions to the eligibility criteria for Medical Assistance benefits provided the General Assistance population.
- $59 million in savings generated from a reduction to provider reimbursement rates or alternative provider cost containment for hospitals and nursing homes (details not yet available).
- $50 million in savings generated through the implementation of an automated audit system to identify waste, fraud and abuse for provider payments, and intensive case management of high–cost consumers enrolled in Medical Assistance.

- $10 million in savings from increasing the monthly premium rate paid by Medical Assistance for Workers with Disabilities (MAUD).
- $10 million in savings generated from maintaining recipients enrolled through the hospital application process in the fee-for-services program until after redetermination (expected to save on capitation payments).

The total operating funding proposal for FY 12-13 including state general funds, federal funds, lottery funds and other funding sources is $63.3 billion. For more information on the proposed Pennsylvania State Budget, please see the following:

(Link to Current and Proposed Commonwealth Budgets)

In the news

- **PA to Cut Medicaid-Related Financial Services**

  Consolidating its financial management services for Medicaid recipients, the PA Department of Public Welfare may drastically cut the number of organizations that offer financial help, according to a news release. In Pennsylvania, the DPW has 37 such organizations that offer financial management services, but that number could be cut to as few as three as early as April. (Roxborough-Manayunk Patch)

- **West Penn Allegheny Health System's turnaround tied to buy**

  West Penn Allegheny Health System will be profitable in two to three years if the financially troubled hospital network can be quickly acquired by health insurer Highmark Inc., Dr. Keith Ghezzi, the health system's interim CEO, said on Thursday. Highmark, the state's largest health insurer, has committed to giving the health system $475 million in grants and loans. Highmark CEO Dr. Kenneth Melani said in November that West Penn Allegheny could be profitable in two years if state regulators approve the acquisition by June. (Pittsburgh Live)

Texas

HMA Roundup – Dianne Longley

There has been a great deal of activity and focus lately on the implementation of the State's Health Transformation Waiver, particularly on the changes to upper payment limit (UPL) hospital funding. Under the Healthcare Transformation waiver, funding is redirected to uncompensated Medicaid and indigent care, as well as redesign investments to improve care, create a coordinate health system, and contain costs.

Under the waiver, trended historic UPL funds and additional new funds are distributed to hospitals through two pools. The Uncompensated Care (UC) pool will reimburse costs of care provided to individuals who have no third party coverage for the services provided by hospitals or other providers. The UC pool begins in the first year of the waiver. The Delivery System Reform Incentive Payments (DSRIP) will support coordinated care and quality improvements through regional health partnerships (RHPs) to transform care delivery systems. DSRIP will begin in the later years of the waiver. All told, the waiver program will provide an additional $29 billion to hospitals over a five-year period (2012-2016).

In the news

- **Texas A&M team helps craft Medicaid care formula**

  The Department of State Health Services recently began using an assessment form created by a team of Texas A&M System researchers to better evaluate how much home care is required for children with special needs covered by Medicaid. The new forms were developed to more effectively determine the number of personal care services hours families should receive, and also to make the programs more accessible to low-income families whom researchers say often aren't aware of the available services or the level of their child's needs. (The Eagle)

- **Prisons consider switch to local hospitals for convict care**

  State prison officials are poised for the first time in 18 years to contract directly with someone other than a state university to provide medical care for Texas convicts. Officials confirmed to the American-Statesman on Friday that an agreement has been reached for Huntsville Memorial Hospital to provide nine emergency-care beds on the second floor of its hospital, and that negotiations are under way for the hospital to operate an emergency room and specialty care clinic inside the Estelle Unit east of town. In addition, talks are under way for two other hospitals in Northeast Texas — Palestine Regional Hospital and the University of Texas at Tyler Health Sciences Center — to provide inmate health care. (Statesman)

Washington

HMA Roundup – Julie Johnston

The Health Care Authority announced this week the regional service areas tentatively assigned to the five health plans selected earlier as apparently successful bidders on a proposal to provide managed care for up to 800,000 Medicaid clients and Basic Health subscribers. The contracts take effect July 1, 2012, and extend through 2013. The number of counties tentatively awarded to the bidders varied considerably.

- Coordinated Care Corporation (Centene) was listed in all 39 counties in the state.
- United HealthCare was listed in every county except one (Clark County).
- Molina was omitted from only four counties (Island, Jefferson, Klickitat, and Wahkiakum counties).
- Community Health Plan was listed with 32 of 39 counties.
- Amerigroup was listed with 22 out of 39 counties.

In the news

- **State Medicaid to quit paying for ER visits deemed unnecessary**

  Intent on cutting state budget health-care costs, Medicaid officials say the program will no longer pay for any medically unnecessary emergency-room visits, even when patients or parents have reason to believe they're having an emergency. The rules would block payment for ER visits for about 500 different conditions. They would apply to all adults and children on Medicaid, with no exceptions, such as someone being brought

in by ambulance or from a nursing home, or when patients have neurological symptoms or unstable vital signs. The new rules are to begin April 1, but a statewide group of emergency doctors, backed by the Washington State Medical Association and the Washington State Hospital Association, are pressing lawmakers to stop the plan, arguing it would shift costs to hospitals and ER doctors and deny care to people with real emergencies. (Seattle Times)

OTHER HEADLINES

Connecticut

- **Health reform choice: For those just above Medicaid limit, private insurance or a state-run plan?**

  Connecticut legislators, administrators, and health advocates are weighing the option of developing a basic health plan. For people earning just above the Medicaid eligibility threshold, states have two options. One is to have them buy coverage through the health insurance exchange, a state-based marketplace that is expected to sell mostly private insurance plans. People just above the Medicaid threshold would get federal subsidies to help cover their costs. Alternatively, the state could create a basic health program to cover people earning between 133 percent and 200 percent of the poverty level, who then wouldn't be eligible for the exchange. The federal government would give the state 95 percent of what it would have spent on subsidies for those adults to buy coverage. Effectively, it's a choice between using private coverage or a state-run plan. (The CT Mirror)

Kansas

- **Kan. gov. issues Medicaid order, fills Cabinet job**

  Gov. Sam Brownback appointed a social worker and former legislator Friday as secretary of the state's largest social services agency and outlined a plan to reorganize it and two other departments as part of a larger effort to overhaul the state's Medicaid program. Brownback announced Friday that former state Rep. Phyllis Gilmore will lead the Department of Social and Rehabilitation Services, starting Monday. The governor also released the text of an executive order that he plans to sign Monday, shrinking SRS so that it can focus on services for children and families, removing it from involvement with the $2.9 billion Medicaid program, which provides health coverage to the poor, disabled and elderly. (Washington Examiner)

- **Blue Cross of Kansas won't bid to be Medicaid managed-care contractor**

  Blue Cross of Kansas, the state's largest insurer, has decided not to submit a proposal to the state to be a Medicaid contractor. Governor Brownback has made Medicaid privatization a centerpiece of his plans for reforming state government. The administration last week applied to the federal government for a waiver to change the state's Medicaid system. Democratic Rep. Jim Ward said Blue Cross' decision brings into question the financial feasibility of the governor's plan. (The Wichita Eagle)

Kentucky

- **Health care officials detail big problems with Medicaid managed care**

  Health care officials from throughout Kentucky described massive problems Wednesday with the state's new Medicaid managed care system. Several officials who spoke Wednesday said they believe the three private companies — CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky, all affiliated with national chains outside the state — may be deliberately stalling payments. The Kentucky Hospital Association said hospitals across the state are owed millions of dollars in unpaid claims since managed care took effect three months ago. Health officials who spoke Wednesday said they have no such complaints about Passport Health Plan, a non-profit Medicaid managed care entity that provides service to about 170,000 Medicaid patients in Jefferson and 15 surrounding counties. (Courier-Journal)

- **Auditor asks firms running Medicaid for data on claims payments**

  Spurred by growing complaints about three companies hired to run Kentucky's new Medicaid managed care system, state Auditor Adam Edelen is asking for data to show how well they are processing and paying claims. Edelen and state lawmakers have been inundated by complaints from health care providers that claims for reimbursement have been wrongly rejected, delayed or simply ignored since the state hired the three companies Nov. 1 to manage most Medicaid services outside the Louisville region. Some providers say they have had to borrow money to pay office expenses and employees because of claims-processing problems. Others have said they fear going out of business. (Courier-Journal)

Maine

- **LePage blasts lawmakers again on DHHS budget**

  Gov. Paul LePage, in his strongest words to date, criticized lawmakers Monday for drastically altering his initial budget proposal to cut $220 million from the Department of Health and Human Services and for putting forward a new plan "full of gimmicks and built on false savings." Instead of dealing with a $220 million shortfall for 2012 and 2013, lawmakers are addressing $140 million in MaineCare cuts to pay the state's bills through June. The biggest sticking point with the governor seemed to be the proposal to eliminate noncategoricals, or childless adults, from MaineCare eligibility. That is not included in the latest plan, although lawmakers said there is an idea to remove some of the noncategoricals but not all. (Bangor Daily News)

Minnesota

- **Minnesota Plans For Exchange, Even Without New Law**

  Minnesota's Democratic Gov. Mark Dayton said last week that at some point — not necessarily this year — authorization will be needed from the state legislature to open a Minnesota exchange for business. But he also suggested that much work could be done ahead of legislative action. Dayton referred to the federal deadline of Jan. 1, 2013, when all states are supposed to present their exchanges to the federal government for certification. Certification means that the exchange is adequate under the law and the federal government won't impose its own exchange on a state. Minnesota Commerce

Commissioner Michael Rothman said nothing in the federal health care law requires states to pass legislation to set up their state health insurance exchanges. He said the federal review will be based on other benchmarks. (Kaiser Health News)

Mississippi

- **Bryant aims to stretch Medicaid by payment changes**

Gov. Phil Bryant wants to reform Mississippi's Medicaid program so that it doesn't cost any more state money next year. Program officials were expecting costs to increase by 16 percent. The essence of making funds stretch is changing how the state pays hospitals to care for Medicaid patients. That group is mostly poor children, but includes some parents, disabled adults, and senior citizens. Medicaid will cost Mississippi $763 million this year. Democratic lawmakers are questioning whether Bryant is just camouflaging cost cutting, which could mean less care for patients or less money for hospitals. (Hattiesburg American)

South Dakota

- **Molina Medicaid Solutions' Issues Ease**

Molina Medicaid Solutions may show signs of improving, but to local Medicaid providers, the company still has a ways to go. In 2010, Idaho placed Molina in charge of handling claims and issuing payments for Medicaid reimbursement in the state. Almost immediately, health care companies began reporting multiple delayed payments, causing severe financial stress for many providers. Now, a 2011 audit by Idaho's Office of Performance Evaluations shows that Molina's satisfaction among state Medicaid providers has almost tripled over the past year. (Magic Valley Times-News)

Tennessee

- **Health department puts inspection reports of nursing homes online**

With a prod from the federal government, the state Health Department has posted on its web site thousands of pages of inspection reports on licensed nursing homes across the state. The posting marks the state's effort to come into compliance with a little known provision of the new federal health care reform law, known formally as the Affordable Care Act. The law set a Jan. 1 date for states to come in to compliance. (The Tennessean)

Utah

- **Utah explores continuous enrollment for Medicaid**

Legislation to streamline Medicaid applications was unanimously endorsed by a committee on Thursday. HB98 would permit the Utah Department of Health to explore letting some Medicaid recipients maintain their health benefits for a year, even if they experience a change in income or family status. Currently, clients must re-apply each month. Doing so was pitched as a move to cut the costs of "churning" — people going on and off Medicaid rolls — and to improve access for low-income Utahns. It also is critical if, as proposed, hospital groups are going to be held financially responsible for patient outcomes under a plan to steer Medicaid patients into managed care groups known as Accountable Care Organizations. (Salt Lake Tribune)

Virginia

- **Senate committee expected to vote on setting up health exchange**

  A Virginia Senate subcommittee is poised today to begin making decisions about health-care reform that the House of Delegates decided not to tackle. The three-member panel is expected to vote on a revised version of legislation that would set up a health insurance exchange as a new division of the State Corporation Commission that would be financed initially by the federal government and later by assessments on insurers. The bill incorporates provisions from two measures favored by health-care advocates who want the exchange to be a new, quasi-governmental entity that is more accessible to consumers than the industry-oriented SCC. (Richmond Times-Dispatch)

Wyoming

- **Wyoming Gov. Mead: Fix $37 million Medicaid shortfall**

  Gov. Matt Mead said Tuesday his highest budget priority is replacing the $37 million shortfall in the Wyoming Department of Health's Medicaid budget. The money is needed to make up for discontinued federal stimulus money. The governor and the Legislature have both asked state agencies to prepared budgets with 2, 5 and 8 percent reductions. (Billings Gazette)

United States

- **Study: Health Law's Tax On Insurers Will Take Bite Out Of Medicaid**

  The Affordable Care Act calls for a new tax on health insurers' premium revenue — intended to help pay for expansion of coverage to 32 million uninsured Americans. But the tax will be paid by all insurers, including those that contract with states to provide coverage to recipients of Medicaid, the state-federal health insurance program for the poor. Under federal law, that fee must be paid by the Medicaid program, meaning that state and federal governments must pick up the tab. A report released today by the actuarial firm Milliman Inc. said the tax will cost the Medicaid program between $36.5 billion and $41.9 billion over 10 years. At least $13 billion will be borne by states, and at least $23.5 billion by the federal government, based on the state-federal Medicaid matching formula, according to the report paid for by the Medicaid Health Plans of America, which represents private health plans that cover people on Medicaid. According to the America's Health Insurance plans, the tax overall would generate at least $73 billion from 2014-2019. (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.

Date	State	Event	Beneficiaries
February 22, 2012	Kansas	Proposals due	313,000
February 24, 2012	California Dual Eligibles	Applications due	N/A
February 27, 2012	Ohio	LOIs due	1,650,000
February 28, 2012	Nebraska	Contract awards	75,000
March	New Hampshire	Contract awards	130,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
Mid to late March	California Dual Eligibles	Site Selection	N/A
March 19, 2012	Ohio	Proposals due	1,650,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
April 9, 2012	Ohio	Contract awards	1,650,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	90,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July/August, 2012	Georgia	RFP Released	1,500,000
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
January 1, 2013	Ohio	Implementation	1,650,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
October 1, 2013	Florida	LTC enrollment complete	90,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA Recently Published Research

AARP - On the Verge: The Transformation of Long Term Services and Supports

Jenna Walls, Senior Consultant

Kathy Gifford, Principal

Many states are undergoing or are about to undergo a dizzying array of long-term services and supports (LTSS) transformations. The lagging economy and increased demand for publicly funded LTSS are placing pressure on state policymakers to find solutions. As a result, many states either have or plan to implement Medicaid Managed LTSS, with 12 states having existing programs and another 11 with plans for implementation. At least 28 states are focusing on improved integration of care for people who are eligible for both Medicare and Medicaid. Many states used the economic downturn as an opportunity to balance services from institutional to noninstitutional settings, with 27 states reporting that their home and community-based services census increased from fiscal year (FY) 2010 to FY 2011 and 31 states reporting expected increases from FY 2011 to FY 2012.

Link to AARP Brief (PDF, 2 pages)

Link to Full Research Report (PDF, 57 pages)

HMA Upcoming Appearances

AARP Public Policy Institute - On the Verge: The Transformation of Long-Term Services and Supports: Medicaid LTSS Transformations

Jenna Walls, Speaker

February 14, 2012

Webinar

American Health Lawyers' Association: Long Term Care and the Law Conference

Eliot Fishman, Speaker

February 27-29, 2012

Phoenix, Arizona

UIC College of Nursing Grand Rounds Series: Basics of Billing & Coding for APNs

Linda Follenweider, Presenter

March 7, 2012

Chicago, Illinois