HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MEDICAID BUDGET UPDATE – MID-YEAR FY 2012, LOOKING TO FY 2013

HMA ROUNDUP: FLORIDA SENATE BUDGET AMENDMENT INCORPORATES PRIMARY CARE RATE BOOST; GEORGIA TASK FORCES REVIEWING MEDICAID REDESIGN RECOMMENDATIONS; INDIANA RELEASES MEDICAID DENTAL BENEFITS MANAGEMENT RFI; PENNSYLVANIA PROPOSES BLOCK GRANTS FOR COUNTIES

OTHER HEADLINES: ALASKA HIRES EXCHANGE DESIGN CONSULTANT; ILLINOIS GOV. CONSIDERS EXECUTIVE ORDER TO ESTABLISH EXCHANGE; KENTUCKY HEALTH SECRETARY RESIGNS; VERMONT MULLS BIG DECISIONS ON HEALTH CARE OVERHAUL

HMA WELCOMES: JO ANN LAMPHERE – WASHINGTON, D.C.

FEBRUARY 15, 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: MEDICAID BUDGET UPDATE – MID-YEAR FY 2012, LOOKING TO FY 2013

This week, our *In Focus* section contains excerpts of the key takeaways from ***A Mid-Year State Medicaid Budget Update for FY 2012 and A Look Forward to FY 2013***, published Monday, February 13, 2012, by the Kaiser Commission on Medicaid and the Uninsured. This report was prepared by Vernon Smith, Kathleen Gifford and Michael Nardone from Health Management Associates, as well as Robin Rudowitz and Laura Snyder from the Kaiser Commission on Medicaid and the Uninsured.

This report, based on structured discussions in November 2011 with the Executive Board of the National Association of Medicaid Directors (NAMD) and survey questions e-mailed to all 50 states and DC in December 2011 and January 2012, provides a mid-fiscal year 2012 update on state Medicaid issues, augmenting the findings from the most recent comprehensive Medicaid budget survey report published in October 2011.

The full report is available on the Kaiser Family Foundation website: (PDF - 9 pages)

Background

As states prepared their budgets for FY 2012, almost all continued to experience the on-going effects of the Great Recession including high unemployment and depressed state revenue collections. At the same time, states were forced to dramatically increase FY 2012 state spending for Medicaid by an average of 28.7% largely to replace temporary Medicaid federal stimulus funds that expired in June 2011. However, compared to 2011, adopted budgets for FY 2012 assumed total Medicaid spending growth of only 2.2% (a near record low) as well as slower enrollment growth. Even within tight FY 2012 budgets, states continue to plan and implement a number of high priority initiatives, including the integration of care for duals (those eligible for Medicaid and Medicare) and health care reform-related activities.

Key Takeaways – Mid-Year FY 2012

For FY 2012, the majority of states are experiencing Medicaid spending and enrollment growth equal to or below original growth projections, and 10 states reported mid-year Medicaid cuts.

- Medicaid enrollment and spending pressure is moderating in many states in 2012 compared to 2011 with a number of states experiencing trends below original growth projections. While the recession is still driving overall enrollment and spending growth for Medicaid, putting overall pressure on state budgets and Medicaid, some lower than expected enrollment projections are easing pressure to implement additional cost containment measures.
- While more than half of the states reported a 50-50 chance of a FY 2012 budget shortfall at the beginning of the fiscal year, 10 states (California, Colorado, Louisiana, Maine, Maryland, North Carolina, Pennsylvania, Tennessee, Washington and West Virginia) reported mid-year Medicaid budget cuts to close FY 2012 budget

gaps. These mid-year cuts include additional benefit and provider rate restrictions. The Patient Protection and Affordable Care Act (ACA) "maintenance of eligibility" requirements generally prohibit states from restricting Medicaid eligibility or tightening enrollment procedures until 2014. While most of the states reported targeted changes, two states (Maine and Washington) are considering a range of significant cuts to help address state budget shortfalls:

- **Maine.** The governor has proposed additional cuts in his supplemental biennial budget, including: provider rate reductions, eligibility reductions for parents, elimination of coverage for childless adults, elimination of coverage of nearly all optional benefits (therapy, podiatry, dental among others), limitations on outpatient hospital visits and hospital admissions, pharmacy-related changes.
- **Washington.** Washington State legislators must close a $1.4 billion budget gap in the FY 2011-2013 biennial state budget. Medicaid and related reductions under consideration include the following recommendations made by Governor Gregoire in her 2011-2013 supplemental budget proposal:
  - Elimination of the Basic Health Plan that delivers health care to 35,000 low-income individuals.
  - Provider rate cuts affecting: critical access hospitals, school-based Medicaid services, developmental disability community residential providers, and home care agencies.
  - Benefit reductions, including: elimination of routine dental care for persons with developmental disabilities, long-term care clients and pregnant women; increasing the level-of-care requirements for personal care services; elimination of the Adult Day Health program; utilization management for mental health services; and elimination of medical interpreter services.
  - Imposition of nominal cost sharing for prescription services, non-emergent client transportation, non-emergent emergency room visits and physician services for Medicaid clients.

Looking ahead, state interest in initiatives for duals remains high and states continue to move forward with the implementation of health reform.

- Medicaid Directors expressed support and enthusiasm for the new integration opportunities for duals made available to states by the Medicare-Medicaid Coordination Office and were hopeful that the integration initiatives will result in improved care for duals and budget savings for states. However some Directors suggested that a short timeline would make it difficult to ensure a smooth transition for enrollees.
- In the most recent annual budget survey, 38 states indicated plans to take advantage of new enhanced federal matching funds for eligibility systems. Nationally, 28 states have qualified for Exchange Establishment grants and 18 states have either passed legislation to establish an exchange or have plans to do so. In the dis-

cussion with the Medicaid Directors, most reported that progress on updating and modifying eligibility systems was underway; however, fewer states reported actions to adopt authorizing legislation or establish governing boards for exchanges. A few states reported completion of substantial planning activities and a few Directors said that their states were waiting for the resolution of pending litigation before moving forward with additional planning and implementation efforts.

A Look Forward to FY 2013

States continue to grapple with the lingering effects of the Great Recession on state revenues and Medicaid spending, although many states are beginning to see signs of economic improvement. While most have avoided the need for additional mid-year budget cuts, a few states have yet to close budget gaps for FY 2012. The outlook for 2013 and beyond remains difficult with continued pressure to find Medicaid cuts, although few options for additional savings remain. At the time of the discussion:

- Tennessee reported that the governor has already asked all state agencies to prepare to reduce FY 2013 budgets by 5 percent.
- California officials were hoping to achieve savings from dual eligible and managed long term care initiatives.
- Texas reported plans for a top down medical policy review of the amount, duration and scope of all benefits to identify savings for both mandatory and optional services.

Medicaid remains front and center in state budget discussions as governors release proposed budgets for FY 2013.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

Richard Chambers, the CEO of CalOptima, announced this week that he will be leaving the organization in early April to become President of Molina Healthcare California in Long Beach. CalOptima is the county organized health system (COHS) in Orange County where it covers 424,000 Medi-Cal beneficiaries.

In the news

- **Getting a Head Start on Medi-Cal Expansion**

  Counties started enrolling people into the Low-Income Health Program in July 2011, and four months later (at the most recent count in November) about 260,000 Californians were enrolled in it. The goal is to fashion a smooth transition into the insurance expansion provisions of the Affordable Care Act when they go into effect on Jan. 1, 2014. (California Healthline)

- **Inmate advocates question state's commitment to prison healthcare**

  The judge who called California's medical care of inmates cruel and unusual punishment has ordered a plan to return control to the state. But inmates question if improvements will continue without U.S. supervision. State statistics show that prison deaths considered preventable or likely to have been preventable dropped from 18 in 2006 to five in 2010, a 72% decrease. Spending on inmate healthcare jumped from $948 million before the receiver arrived to a peak of nearly $2.3 billion in the 2008-09 fiscal year. Prison medical spending is projected at almost $1.8 billion in Brown's proposed budget for the next fiscal year, which begins in July. (Los Angeles Times)

Florida

HMA Roundup – Elaine Peters

Wednesday evening the Senate budget committee passed the Senate budget proposal which will be voted on by the full Senate next week. As a reminder, the Senate budget includes the following proposals:

- 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. We estimate there are approximately 400,000 MediPass members in the 31 counties where this proposal would be applicable.
- $17M increase in KidCare/CHIP funding.

Assuming the bill is passed out of the Senate next week, we expect the budget will be moved into conference committee in the last week of February.

A noteworthy amendment that was passed by the Senate budget committee provides for $438M in additional federal fund dollars for physician payment increase effective January 1, 2013. This appropriation relates to the ACA provision that primary care physician rates be raised to Medicare levels as of January 1, 2013 (using exclusively federal funds).

In the news

- **Feds deny part of Fla. Medicaid proposal**

  Federal CMS officials said the state could not impose $10 monthly premiums on Medicaid beneficiaries. CMS also denied the state's proposal to charge $100 co-pays for any non-emergency ER visits, according to a letter sent Thursday. Federal health officials said the fees violated several statutes designed to protect nearly 3 million of state's most vulnerable. Officials at Florida's Agency for Health Care Administration said they were disappointed with the CMS decisions, but said they would continue to work with the federal agency on other key elements and they are confident statewide expansion can move forward. (Miami Herald)

- **State Senate proposes $87 million cut in mental health, substance-abuse programs**

  Grappling with the need to close a $2 billion budget gap, a Senate proposal would make deep cuts in funding for adult mental health and substance-abuse programs, and entirely eliminate support for some of them. The proposal would slash overall state spending on adult mental health and substance-abuse treatment by about 40 percent, or $87 million. The Senate proposal differs greatly from the budget passed last week by the House, which called for an additional $32 million in treatment funds. The Senate plan has been criticized by providers, who stand to lose millions of dollars in state funding, and by law-enforcement officials who warn there will be a trickle-down effect that could drain state resources. (Miami Herald)

- **Senate budget cuts lead to mental health, hospital concerns**

  The Senate released a health budget proposal Wednesday that calls for deep cuts in mental-health and substance-abuse programs and includes a complicated plan that hospitals fear could cost them hundreds of millions of dollars. The $30 billion proposal, however, would shield nursing homes from Medicaid cuts, increase funding for programs that serve developmentally disabled people and boost spending on child-protective investigators. Senate Health and Human Services Appropriation Chairman Joe Negron, R-Stuart, said the proposal includes a total of $390 million in general-revenue cuts for the upcoming 2012-13 fiscal year. It also includes key differences from a House health and human-services budget plan that is expected to be approved Thursday by the full House. As an example, the Senate proposal would cut $63.3 million from adult mental-health programs and $23.2 million from adult substance-abuse programs. The House would not make those cuts. (News-Press)

Georgia

HMA Roundup – Mark Trail / Megan Wyatt

The state has convened two task forces to review and gather input on the Medicaid redesign recommendations report prepared by Navigant Consulting and released in January. One task force will involve medical provider groups while the other will focus wholly on the aged, blind and disabled (ABD) population. These task forces are scheduled to meet in a closed session with the Department of Community Health and the Navigant consultants and provide feedback on the report's recommendations by the end of February. The state is then likely to make a decision on Medicaid redesign sometime in April.

The state also recently released a notice of intent to award (NOIA) for the Medicaid eligibility system redesign procurement. Five bidders are qualified to bid as "prime" on the procurement, while another two are qualified to bid as subcontractors. The five bidders qualified as prime are Accenture, Deloitte, HP, IBM, and Northrop.

As a final note, the legislature is roughly halfway through their session scheduled to end in mid to late March.

In the news

- **Health exchange idea faces uncertain future**

  Early in January, the Republican leadership in the General Assembly declared the door was shut this year on any bill to set up a health insurance exchange in Georgia. The decision surprised many, because an advisory committee, appointed by Gov. Nathan Deal, had recommended in December that such an online insurance marketplace for small businesses be created. Deal's spokesman cited the uncertainty over the fate of the federal health reform law as a reason to wait. The law, also known as the Affordable Care Act, requires that health insurance exchanges be operational in the states by 2014, but it could be overturned before that happens. But Rep. Pat Gardner (D-Atlanta), a member of the exchange panel, sees no need to wait. She has introduced an exchange bill anyway. She acknowledges that her bill has little to no chance of moving anywhere. She speculates that lawmakers' fear of Tea Party opposition has killed momentum for legislation. (Georgia Health News)

- **Task forces to discuss report on Medicaid**

  State officials are creating two task forces to gather input on a consulting firm's report on the future of Georgia's Medicaid and PeachCare programs. One task force will involve medical provider groups, including representatives of hospital and physician organizations. The second grouping will review the Navigant report's recommendation to revamp services for the ''aged, blind and disabled'' populations. (Georgia Health News)

- **Atlanta Medical Center, South Fulton Medical Center seek consolidation**

  Atlanta Medical Center and financially ailing South Fulton Medical Center announced Wednesday that they will seek state permission to consolidate the two hospitals. Both hospitals are owned by the Tenet Healthcare Corp. A two-campus Atlanta Medical Center would become one of the largest hospitals in the state with 798 beds. (Atlanta Journal Constitution)

Indiana

HMA Roundup – Cathy Rudd

The State issued an RFI for responses from potential contractors experienced in providing dental benefits management (DBM) services. The RFI will evaluate the feasibility of implementing a DBM program for Indiana Medicaid. There has been an indication that the State may limit the subsequent RFP to only those bidders who responded to the RFI.

Link to RFI website: http://www.in.gov/idoa/proc/bids/rfi-12-87/

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The State Insurance Commissioner testified at the agency's budget hearing Tuesday that the Insurance Department would hold a public hearing on the Highmark reorganization and WestPenn/Allegheny General acquisition in Pittsburgh on April 17, 2012, and would close the public record 30 to 60 days after the hearing. A decision is expected within 30 to 60 days after closing the public record, meaning a decision would come, at the latest, in mid-August.

The impact of proposed Medicaid budget reductions to hospitals and nursing homes mentioned in last week's HMA Weekly Roundup, whether rate reductions or cost-containment strategies, remains unclear. However, the State has indicated an openness to suggestions from the provider community.

Gov. Corbett's budget proposal included a move to provide bundled "block grant" payments for several health and human services related state funding streams to counties. This may be part of a broader strategy to push for a Medicaid block grant from CMS in the future.

In the news

- **County: State budget has positive aspects**

  Delaware County Councilman John McBlain said Wednesday he was encouraged by an aspect of Gov. Tom Corbett's budget proposal that would allow counties more flexibility in the area of human services. Corbett said his $27.1 billion budget proposal includes "use of block grants to give counties and school districts the flexibility to adjust to their own, unique needs." McBlain said he was encouraged by the overall concept of allowing county officials more flexibility to direct funds where they believe would be most beneficial. At the same time, he noted that county officials are still looking into the specifics of the state budget in terms of dollars spent. Similarly, county Executive Director Marianne Grace said the county is encouraged by greater flexibility, but needs more specifics on what this means in terms of funding. (Delaware County Daily Times)

- **Needy patients facing double setback**

  Set against proposed 30 percent cuts in state higher education funding, Gov. Tom Corbett's proposed 4 percent cut in Medicaid reimbursements looks reasonable enough. But for Pennsylvania nursing homes this cut would follow an 11.1 percent decrease in Medicare reimbursement imposed in October by the federal Centers for Medicare and Medicaid Services. As a result, individuals on Medicaid could find it more difficult to find a nursing home that will accept them. Nursing homes are already losing $19.23 per Medicaid resident per day according to the Pennsylvania Health Care Association/Center for Assisted Living Management. (Pittsburgh Post-Gazette)

- **West Penn Allegheny reports $34 million loss last year**

  The losses continue to mount at West Penn Allegheny Health System, which on Thursday reported a net loss of $34.1 million in the last three months of 2011. In the same period a year earlier, the financially troubled hospital system showed a net loss of $1.4

million, according to its most recent financial report. While Highmark is investing in the health system now, the acquisition still requires approval from the Internal Revenue Service, the state Insurance Department, the state Attorney General's Office and Allegheny County Orphan's Court. State officials have estimated the process could take at least a year, but Highmark and West Penn Allegheny have lobbied for approval in half that time. West Penn Allegheny's loss was driven by a 7 percent drop in revenue as fewer patients sought treatment at its hospitals. The health system recorded revenue of $387.3 million for the October-December quarter, down from revenue of $417.8 million in the same quarter the year before. (Pittsburgh Live)

United States

HMA Roundup – JoAnn Lamphere

On Monday, President Obama's election year budget was unveiled. The Administration's 2013 proposed budget presents a $3.8 trillion spending plan, with a slight delay in deficit reduction. Medicare and Medicaid, and other health programs, are generally protected with proposed changes ("improvements") that will save $364 billion over the next ten years. The proposed budget embraces the preservation and implementation of the Affordable Care Act and its guaranteed subsidies by providing resources to build state capacity and infrastructure, and funds for the federally facilitated Exchange ($864 million).

The proposed Department of Health and Human Services $76.4 billion budget calls for more than $200 billion in Medicare cuts to hospitals, skilled nursing facilities, and other post-acute providers, as well as pharmaceutical companies. To help improve the financial stability of the Medicare program, higher income Medicare beneficiaries (defined as $85,000 for individuals) would pay higher Part B and Part D monthly premiums starting in 2017. New Medicare beneficiaries would be charged a co-payment for certain home health services they receive (in 2017). To increase Medicare program integrity, the proposed budget invests $610 million to implement activities that reduce payment error rates, targeting high risk services and supplies.

Medicaid proposals unveiled this week are not new: the Medicaid provider tax threshold that states have used would be reduced in 2015; a single blended matching rate for Medicaid and Children's Health Insurance program spending is proposed to replace the myriad and complex array of matching formulas that confound states and the health sector (in 2017); and Disproportionate Share Hospital allotments would be re-based.

At this stage, the outlook for these federal budget proposals is uncertain. The proposals provide a framework for policy deliberations in a highly volatile year and, given election uncertainties, it could again be December before final decisions are made.

OTHER HEADLINES

Alaska

- **Alaska Takes Biggest Step Yet Toward Exchange**

  Last month, the administration of Gov. Sean Parnell, a Republican, hired Public Consulting Group to study the state's options for setting up an exchange. The state is spending $200,000 on the contract with the Boston-based firm. Alaska has opposed the federal health law and was the only state that chose not to even apply for a $1 million grant the federal government was passing out to states to plan a health insurance exchange. (Kaiser Health News)

Connecticut

- **Malloy to add funds to private human service providers, nursing home "right-sizing"**

  The health and human services portions of Malloy's proposed budget adjustments include money to support an effort to move people out of nursing homes, fund nursing homes that consider providing long-term care to people leaving prisons and state institutions, add three childhood vaccines to the state's program and offer the first funding boost in five years to private human services providers. The administration also intends to move ahead with plans to seek permission from the federal government to add enrollment restrictions and scale back benefits in a Medicaid program for low-income adults without minor children, a move that has drawn criticism from advocates and some key lawmakers. Of about $120 million in savings built into the budget adjustments, more than $40 million come from changes to Medicaid. (CT Mirror)

Illinois

- **Quinn mulls executive order for health insurance exchange**

  Gov. Pat Quinn is weighing whether to use an executive order to jump-start planning for Illinois' health insurance exchange, a move that could rankle both state legislators and business groups. In an apparent sign of impatience with the slow-moving Illinois General Assembly, a spokeswoman for the governor said the administration may use the order to create the "skeleton" of an exchange, which would allow staff to push forward with planning efforts. That option immediately drew criticism from the executive director of the Health Care Council of the Illinois Chamber of Commerce, as well as Rep. Frank Mautino, a Democrat from downstate Spring Valley who has been at the center of negotiations about the exchange. (Crain's Chicago)

- **Quinn's Medicaid goal faces hurdles**

  Two weeks ago, the Civic Federation of Chicago warned that the twin perils of rising pension and Medicaid costs could result in the state of Illinois facing a backlog of nearly $35 billion in unpaid bills in five years. Last week, in a speech at the Union League Club in Chicago, Gov. Pat Quinn put a price tag on the savings he wants to see from Medicaid. "We are going to have to reduce the amount we send on Medicaid by probably over $2 billion this year," Quinn said. With Quinn scheduled to deliver his budget speech in a little less than two weeks, rank-and-file lawmakers are already holding dis-

cussions about what a $2 billion cut in the state's giant Medicaid program will mean and who it will affect. (Aledo Times Record)

Kansas

- **Kan. lawmaker: Fear shouldn't stop Medicaid change**

  Kansas shouldn't let fear of change prevent it from overhauling Medicaid, an influential legislator said Tuesday, as Gov. Sam Brownback's administration stuck with plans to let private companies manage the $2.9 billion program starting next year. House Appropriations Committee Chairman Marc Rhoades, a Newton Republican, responded to criticism that the Brownback administration is moving too quickly to make massive changes in the state's health coverage for the poor, the disabled and elderly. Rhoades said the state can't sustain its current Medicaid program because of rising costs. Brownback's administration plans to issue three contracts this year for the Medicaid program. Each contract would start Jan. 1, 2013, and each company would operate statewide, giving Medicaid clients a choice of coverage. The administration expects to award the contracts this summer. Potential contractors had until Jan. 31 to submit the technical details of their proposals to the state, and they have until Feb. 22 to submit the rest of their materials. Fifteen companies qualified to bid by attending a mandatory state conference for potential contractors in December, but the state's largest health insurance company, Blue Cross and Blue Shield of Kansas Inc., announced last week that it will not submit a proposal. (CBS News)

Kentucky

- **Beshear Confident Medicaid Managed Care Problems Will Be Resolved**

  Governor Steve Beshear says the problems with Kentucky's new Medicaid Managed Care system will be resolved. Beshear pushed for the managed care system last year to take some of the administrative burden of Medicaid off of the state. But earlier this week, doctors, pharmacists and hospital officials told lawmakers there were significant problems with the system. Specifically, care providers are owed millions of dollars in claim payments and have struggled to get pre-authorizations for procedures and medications. Beshear noted similar complaints and issues when Passport Health went live more than a decade ago. (WFPL.org)

- **Medicaid firms try to explain drug system**

  Executives with three companies hired to run Kentucky's new Medicaid managed care system encountered anger and exasperation Monday as they tried to address a growing number of complaints and explain to legislators how they cover prescription costs. Under the Medicaid plan before managed care, the formula was provided to pharmacists, who said they knew what they would be paid. Now, they said, they don't find out what a company will pay for a specific drug until they file claims. And too often, they say, it's less than they paid to buy the drug. Two of the three companies also have cut the dispensing fee — a payment meant to cover the pharmacy's actual costs of filling the prescription. The prior Medicaid program paid $4.50 to $5 per prescription, but only Kentucky Spirit continues that rate, the pharmacists said. (Courier-Journal)

- **Head of Kentucky family services agency quits**

  Janie Miller, secretary of the state Cabinet for Health and Family Services, resigned Tuesday after a controversial tenure directing the agency that oversees the state's Medicaid, child welfare, social services, public health, programs for the elderly and other human services. Miller's resignation comes as the cabinet is under fire over several controversies — including its refusal to fully comply with a judge's order to release records in cases of child abuse deaths, and mounting problems with the state's new Medicaid managed care system. (Courier-Journal)

Louisiana

- **Aetna challenges health-care pacts**

  Aetna Better Health on Thursday asked a state district court to throw out contracts awarded to three private companies involved in the state's new health-care delivery system for the poor. The Aetna "petition for judicial review" comes a day after the state rolled out the first phase of the "Bayou Health" program in a region that includes Livingston, Tangipahoa, Washington and the New Orleans area. The three contested companies are among five chosen to take over $2.2 billion of the state's Medicaid business. The three-year pacts are worth in excess of $6 billion. Aetna wants to nullify contract awards that went to Amerigroup Louisiana, Louisiana Healthcare Connections Inc. and United Healthcare of Louisiana. It wants the court to require the state Department of Health and Hospitals to solicit new proposals. Aetna was an unsuccessful proposer and has objected to the contract awards in both administrative and court filings as it pressed for information related to the decisions. (The Advocate)

Mississippi

- **Proposed Medicaid Changes Could Effect Enrollment**

  Mississippi lawmakers are looking at ways of trimming and cutting the cost of the state's Medicaid program. Currently 1 in 4 Mississippi is on Medicaid. At least two bills have been introduced in the legislature, controlling who gets on Medicaid and how they stay on, including one to test Medicaid recipients for nicotine. Under the bill people who fail a nicotine test could stay on the program if they enter a smoking cessation program, if not, they could lose their eligibility for one year. Another bill has been filed in the senate to require Medicaid recipients to re-enroll every six months, instead of once a year. (Mississippi Public Broadcasting)

New York

- **Gov. Andrew Cuomo's Medicaid plan draws praise**

  In a show of bipartisan support Wednesday, Republican and Democratic politicians alike cheered a Democratic governor's proposals to ease Medicaid cost growth for counties and save all public employers money by creating a new pension tier for future workers. Under the proposal, the state would gradually absorbs the future cost increases in the counties' share of Medicaid beginning in 2013 and would effectively cap counties' Medicaid costs by 2015. (Times Herald-Record)

Tennessee

- **StoneCrest partners with AmeriGroup**

  HCA's TriStar Health announced last week that Amerigroup Real Solutions will now provide its enrollees with access to healthcare services at the TriStar Family of Hospitals in Middle Tennessee, which includes StoneCrest Medical Center in Smyrna. All TriStar hospitals throughout Middle Tennessee will now be considered in-network providers of Amerigroup. (DNJ.com)

Utah

- **Angst over federal health law could hurt home-grown fixes**

  A dozen health bills surfaced last week, with most amounting to political posturing. But health industry lobbyists and advocates for the poor are fretting about a few they say could derail a home-grown plan for reforming Medicaid, and its promise of better, cheaper health care for all. Backed by health industry leaders and unanimously approved by the Legislature last year, the 91-page blueprint would pay providers to keep patients healthy and out of hospitals, instead of just paying for tests and treatments. It envisions handing Medicaid over to Accountable Care Organizations (ACOs), managed care networks that would be paid lump monthly sums per patient. If an ACO spends more than allotted for care and prescription drugs, it absorbs the loss. If it spends less, it gets a share of the leftovers. (Salt Lake Tribune)

Vermont

- **Vermont looks at models for standardized health coverage**

  State officials have determined that one of three health insurance plans currently sold in Vermont will become the model for the benefits plan offered to small employers and individuals buying health insurance beginning in 2014. By early March, the Green Mountain Care Board is expected to select among an MVP Health Care plan, a Blue Cross & Blue Shield of Vermont health maintenance organization plan and Cigna's package for state employees. All three plans offer benefits in most of the 10 categories of coverage that federal law defines as "essential benefits." (Burlington Free Press)

- **Phase in? Or big plunge? Vermont Legislature debates the health exchange program**

  Vermont lawmakers have been weighing whether to make the state's exchange the only place where private insurers could sell to individuals and small employers beginning in 2014 and whether to include employers with 50-100 workers in the first wave to use the exchange or have them wait until 2016. Early last week, Gov. Peter Shumlin and the Democratic leaders of the House and Senate signaled support for a phased in process. (Burlington Free Press)

Wisconsin

- **Limits on state's Family Care program draw critics**

  Cost-saving measures proposed by Gov. Scott Walker's administration to Family Care programs for frail elderly and people with disabilities are coming under fire by critics who say the changes could hurt those the program is meant to help. One County Executive called for lawmakers to approve a measure that would lift an enrollment cap on

the Family Care program that was approved as part of the 2011-'13 state budget. The cost-saving moves were proposed by the state Department of Health Services to help pay for an anticipated surge in enrollments once the cap is lifted. (Journal Sentinel Online)

United States

- **Success of health reform hinges on hiring 30,000 primary care doctors by 2015**

  Decades of research have confirmed that more specialists leads to more specialty care, which leads to a more expensive system. Now, with the passage of the Affordable Care Act, tens of millions of previously uninsured Americans will be looking for a primary-care doctor. It is no exaggeration to say that the success of the health-care law rests on young doctors choosing to do something that is not in their economic self-interest. The surprise of the health-care overhaul, at least thus far, is that so many young doctors are cooperating. The number of American medical students matching into primary care residencies jumped 20 percent between 2009 and 2011, according to the Association of American Medical Colleges. (Washington Post)

- **Obama administration defends healthcare Medicaid law**

  In a written brief filed with the U.S. Supreme Court, the attorneys disagreed with the argument by 26 states that have challenged the law that the Medicaid expansion was unprecedented and will impose a significant, onerous financial burden on the states. The states had said that by threatening a loss of federal funds, Congress unconstitutionally coerced them into expanding their Medicaid programs. The states said they have no real alternative but to keep participating in Medicaid. A federal judge and a U.S. appeals court ruled against the states. The administration urged the Supreme Court to uphold the appeals court's ruling. The Supreme Court has scheduled three days of oral arguments in the legal battle over the healthcare law for March 26-28, with an election-year ruling expected by the end of June. (Reuters)

- **President's Spending Plan Spares Health Care Entitlements, But They'd See Big Changes**

  The Obama administration's fiscal 2013 budget proposal seemingly charts a far different path for Medicare and Medicaid than many Republican plans, as it would preserve both as entitlement programs. The proposal calls for more than $200 billion in Medicare cuts to hospitals, skilled nursing facilities and other "post-acute providers," and pharmaceutical companies. Medicare would change in other ways as well. Starting in 2017, beneficiaries with higher incomes would pay sharply higher Part B and Part D monthly premiums than other beneficiaries. The current income thresholds for paying those premiums would drop from the current figure of $85,000 in annual income to $80,000. The higher premiums they pay would be raised 15 percent. And the income thresholds would not be adjusted for inflation until fully one-quarter of the Medicare population was paying the higher premiums. As for Medicaid, states would be less able to pump up federal matching payments by raising provider taxes. The budget proposal also calls for "a single blended matching rate for Medicaid and Children's Health Insurance Program spending to replace the current complicated patchwork of matching formulas starting in 2017." Critics of this approach say having a single rate

would make it much easier for Congress to dial down how much the federal government sends to the states for Medicaid over time. And Sen. John D. Rockefeller, IV, D-W.Va., said the approach would lead to an end of the Children's Health Insurance Program. (CQ Healthbeat)

PRIVATE CO. NEWS

- **Clayton-based Centene reaps millions cutting government health costs**

  As the nation's fourth-largest Medicaid manager, Centene processes about 2 million medical claims a month and oversees health spending for about 1.8 million people in a dozen states. About 78 percent of Centene's enrolled patients are children. However, Centene and its competitors are advancing into one of the highest-cost areas of health care: serving the aged, the blind and the disabled poor, including those who qualify for both Medicaid and Medicare, the federal program for seniors. In the last decade, Centene has moved aggressively into several new states including Georgia, Texas and Louisiana, but has not held the primary Medicaid contract in its home state of Missouri since 2006. Both revenue and profit have steadily climbed, with Centene in 2011 posting revenue of $5.2 billion and profit of $111 million. It expects to surpass $7 billion in revenue in 2012, reaching up to $10 billion in revenue in the next few years. (STL Today)

- **Amerigroup has new deal with TriStar**

  Amerigroup Real Solutions has established a new agreement with HCA's regional TriStar Health System through which Amerigroup enrollees will have access to the TriStar network of hospitals and facilities. The agreement became effective last Tuesday. (Nashville Post)

- **Ministry Health Care assumes control of Affinity Health System**

  Ministry Health Care is taking over Affinity Health System. Ministry and Wheaton Franciscan Healthcare had been co-sponsors of Affinity since 1996. Today's announcement means that Ministry will become the sole sponsor of Affinity. Affinity operates a network of three hospitals, 26 clinics and a medical group that includes nearly 300 providers in the Fox Valley. Ministry runs hospitals in Marshfield, Stevens Point, Weston and several other communities. (WSAU.com)

- **Welsh Carson's NaviHealth Acquires SeniorMetrix**

  Private equity backed NaviHealth has acquired SeniorMetrix, a Nashville-based provider of data-driven clinical decision-support solutions to the post-acute healthcare markets. Brentwood Capital Advisors acted as exclusive financial advisor to SeniorMetrix. (PEHub)

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 WELCOMES…

Jo Ann Lamphere, Principal – Washington, D.C.

On Monday, February 13th, Jo Ann Lamphere joined HMA as a Principal in the DC office. Jo Ann comes to HMA from AARP where she has served as the Director of Government Affairs for the State Health & Family Team. In this role, Jo Ann led state-level strategy development and a team of legislative experts to support AARP's overall advocacy vision and its fifty-three state offices. Her responsibilities included providing ongoing technical and political expertise to state offices for health reform campaigns, Medicaid state waiver design, managed long term care, and legislative and regulatory analysis. Prior to joining AARP, Jo Ann spent six years at The Lewin Group as a Senior Consultant, and directed research projects and analyses designed to improve coverage and health care payment policies at the national and state levels. Earlier in her career, Jo Ann served as Senior Associate at the Alpha Center (now AcademyHealth), as a Research Associate in the University of North Carolina's Department of Health Policy and Administration, as a Senior Manager at the New England Medical Center, and as a Program Director and Principal Analyst at the New York State Department of Health. Jo Ann earned her Bachelor of Science degree at Pennsylvania State University, her Master of Science degree at S.U.N.Y. at Stony Brook, and her Doctorate in Public Health at Columbia University.

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

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