HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MASSACHUSETTS DUAL ELIGIBLE INTEGRATION PROPOSAL

HMA ROUNDUP: ILLINOIS RELEASES DUAL-ELIGIBLE INTEGRATION PROPOSAL; GEORGIA GOV. PROPOSES MID-YEAR MEDICAID CUTS; ILLINOIS GOV. CALLS FOR $2.7B IN MEDICAID CUTS; PENNSYLVANIA PROPOSES MEDICAID STATE PLAN AMENDMENTS

OTHER HEADLINES: MISSOURI AWARDS MEDICAID MANAGED CARE CONTRACTS; CALIFORNIA LEGISLATIVE ANALYSIS GROUP CALLS FOR HALT TO MEDICAID MANAGED CARE EXPANSION; US SUPREME COURT WILL NOT HEAR CALIFORNIA PROVIDER RATE CUT CASE; ARIZONA SUPREME COURT UPHOLDS MEDICAID ENROLLMENT FREEZE

HMA WELCOMES: MIKE FAZIO – BOSTON, MA

RFP CALENDAR: FLORIDA RELEASES CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) RFP

FEBRUARY 22, 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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Contents

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IN FOCUS: MASSACHUSETTS DUAL ELIGIBLE INTEGRATION PROPOSAL

This week, our In Focus section reviews Massachusetts' State Demonstration to Integrate Care for Dual Eligible Individuals, released February 16, 2012. The state proposes a comprehensive benefit package and combined Medicaid and Medicare funding stream to cover dual eligible individuals between ages 21 and 64. The elderly dual eligible population is not included in the new initiative because Massachusetts already has integrated care for dual eligible individuals aged 65 and older. The table below lays out Senior Care Options plans and enrollments currently serving the over-65 dual eligible population.

Senior Care Options Plan	Enrollment (Aug. 2011)
Senior Whole Health	7,865
Evercare (UnitedHealthcare)	7,865
Commonwealth Care Alliance	3,442
Navicare (Fallon)	829

A draft demonstration proposal was posted on the Executive Office of Health and Human Services website in early December 2011. This final proposal incorporates public comments from providers, health plans, and other stakeholders based on the draft proposal. This proposal must be approved by CMS prior to the state's drafting and release of an RFP.

Proposal Overview

Out of nearly 275,000 dual eligible beneficiaries in the state, roughly 110,000 are between the ages of 21 and 64 and eligible for the demonstration based on 2008 data. The state estimates that approximately 115,000 will be eligible when the program goes live on January 1, 2013. These non-elderly dual eligible individuals would be served under a statewide capitated three-way contracting model, as proposed by CMS' Center for Medicare and Medicaid Innovation (CMMI) in a July 2011 letter to state Medicaid Directors. Under the three-way contracting model, the state and federal CMS will jointly contract with an unspecified number of managed care entities, referred to in the proposal as Integrated Care Organizations (ICOs). The non-elderly dual population in Massachusetts accounted for roughly $2.6 billion in combined Medicare and Medicaid services in 2008.

The following are some additional key takeaways from the final proposal:

- Under the three-way capitated contract, ICOs will receive an actuarially developed, prospective, risk adjusted, blended global rate for the full continuum of benefits they provide to an enrollee. Both Medicare and Medicaid will contribute to the total base global rate for the range of covered services, but these contributions will not be directly aligned with payment for particular services. (Medicare will not pay solely for Medicare services and Medicaid will not pay solely for Medicaid services.)
- MassHealth proposes a voluntary opt-out enrollment process, with no lock-in period so that members can change ICOs or select the FFS option. The Demonstration will require a sufficient volume of enrollees over the Demonstration period to at-

tract enough ICOs to give members choice, and allow evaluators to adequately assess the effectiveness of the innovations.

Target Population Data

The integration proposal provides detailed data on the target population. The data is from CY 2008, but the proposal indicates that the state has entered into a data-sharing agreement with CMS that will allow access to more current data. As the table below indicates, 35% of the population to be included in this demonstration have severe mental illness, including 70% of the beneficiaries enrolled in institutional settings.

CY 2008	Total	Receiving LTSS Institutional Setting	Receiving LTSS Home/Community-Based Setting	No LTSS
Beneficiaries Under Age 65	109,636	14,620	19,072	75,944
		13%	*17%*	*69%*
Beneficiaries with Severe Mental Illness (SMI)	38,247	10,246	6,858	21,143
		27%	*18%*	*55%*
Percent of Beneficiaries with SMI	35%	70%	36%	28%

The table below illustrates the PMPM cost of each of the primary eligibility categories to be covered under the demonstration, broken out by funding source (Medicare vs. Medicaid). As one might expect, the eligibility categories that are associated with less intensive institutional or HCBS services tend to make up a significant portion of the Medicare expenditures for non-elderly duals, but a smaller percentage of the Medicaid costs. For example, non-waiver individuals residing in the community made up 88.0 percent of the total population and accounted for 74.9 percent of Medicare spending but only 32.6 percent of Medicaid spending; about one-third of this group (32,874 out of 96,522) had a SMI diagnosis. On the other hand, individuals that experienced extended episodes in institutional facilities made up 5.3 percent of the total population, yet accounted for over 20 percent of Medicare spending and nearly 30 percent of Medicaid spending; 39.8 percent of this institutional population had a diagnosis of a substance use disorder. HCBS waiver enrollees made up 6.7 percent of the total population, and accounted for 38.8 percent of total Medicaid spending; 79.5 percent of HCBS waiver enrollees had a developmental disability.

CY 2008		Total	Non-Waiver	Institutional	HCBS Waiver
Total Duals 21-64	***Beneficiaries***	**109,636**	**96,522**	**5,794**	**7,320**
	Medicare PMPM	$1,092	$934	$4,158	$718
	Medicaid PMPM	$1,080	$403	$5,752	$5,890
Developmental Disabilities	***Beneficiaries***	**17,965**	**10,315**	**1,829**	**5,821**
	Medicare PMPM	$1,234	$1,103	$3,744	$700
	Medicaid PMPM	$3,557	$888	$8,851	$6,526
Serious Mental Illness (SMI)	***Beneficiaries***	**38,247**	**32,874**	**3,561**	**1,812**
	Medicare PMPM	$1,484	$1,176	$4,523	$1,071
	Medicaid PMPM	$1,175	$583	$3,997	$6,038
Substance Abuse Disorders	***Beneficiaries***	**30,837**	**28,206**	**2,305**	**326**
	Medicare PMPM	$1,631	$1,350	$4,998	$1,638
	Medicaid PMPM	$745	$480	$3,330	$4,880
Chronic Physical Conditions	***Beneficiaries***	**45,420**	**39,779**	**3,796**	**1,845**
	Medicare PMPM	$1,835	$1,511	$5,374	$1,587
	Medicaid PMPM	$1,035	$475	$4,403	$5,993
3+ Acute Inpatient Admits / year	***Beneficiaries***	**6,275**	**3,916**	**2,188**	**171**
	Medicare PMPM	$5,904	$5,417	$6,782	$5,814
	Medicaid PMPM	$2,467	$940	$4,921	$5,961

It is also interesting to note that there is a substantial reduction in spending between institutional and HCBS settings for beneficiaries of all categories, but that the savings accrue almost entirely to the Medicare program. In fact, in many cases, Medicaid spending is actually higher for HCBS waiver services than for institutional care. For example, for individuals chronic physical conditions, Medicare spending on those enrolled in HCBS programs, is $1,587 PMPM as opposed to $5,357 for those in an institutional setting (a 70% differential). By contrast, Medicaid spending is actually 36% higher ($5,993 versus $4,403) for those in HCBS programs versus institutional care. In our opinion, this dynamic creates a powerful incentive for states to pursue the integration model that has been proposed by the CMMI which allows the states to share in the total savings to both programs.

Timeline

The proposal indicates a target date for an RFP release of April 13, 2012. ICO awards would then be announced July 30, 2012. This timeline is not likely to slip, due to the need to enroll Medicare beneficiaries in late 2012 for an implementation date of January 1, 2013.

HMA Medicaid Roundup

Florida

HMA Roundup – Gary Crayton / Elaine Peters

With the Senate expected to pass their budget this week, next week a conference committee is expected to meet to iron out the differences between the House and Senate budgets. The three major health care issues are the Medicaid hospital rate cuts, the elimination of MediPass, and mental health cuts. The House cuts are, in general, less severe than those proposed by the Senate budget.

Also this week, the state issued an RFP for the 225,000 children covered under the Healthy Kids CHIP program. Details are included in our RFP calendar on page 20.

Georgia

HMA Roundup – Mark Trail / Megan Wyatt

The recommendation made in the Medicaid redesign report, prepared by Navigant, that all aid categories go into full risk managed care is generating debate amongst stakeholders including some opposition from the Georgia Hospital Association. Interestingly, disability advocacy groups aren't as opposed but are expressing caution. Feedback from the public, advocacy groups, and the two state task forces must be received by the end of February. The state will announce the official decision in April about what the new system design will be.

On Tuesday February 21, 2012 the Georgia Senate Appropriation Committee (SAC) passed HB 471 – its recommendation for the AFY 2012 appropriation bill. The full Senate will take up the bill for consideration this week.

Overall, the SAC makes significant adjustments to the AFY 2012 budget and to Medicaid specifically. First, because revenues were flat in January 2012, the Governor has revised down his AFY 2012 general fund revenue projection by $47,188,929 or 0.29% as reflected in the SAC recommendation. It is important to note that in Georgia the Governor sets the revenue projection for the fiscal year – not the General Assembly.

The Governor proposes to make up for the lost revenue by cutting Medicaid as reflected in the SAC recommendation. Specifically:

- Eliminates $82.2 million in state general funds which had been intended to restore funding of the 12th month of care management capitation payments for AFY 2012 ($75.6M in Low Income Medicaid (LIM) and $6.6M in PeachCare).
- Adds back $35 million of the capitation cut "to maintain the projected LIM expenses". This item is related to the House AFY 2012 cut of $15,127,330 state funds ($44 million total funds) to reflect projected benefit need. The SAC eliminates this cut and adds an additional $19.3 million in state funds to LIM (for a $35 million state fund increase).

- To clarify, the Governor recommended and the SAC agreed to cover the $47 million revenue loss by eliminating $82 million in funding for 12 months of CMO cap payments and then adding the left over $35 million to the LIM program.

In the news

- **Drug tests, 'personal growth' for those who need help?**

  Proposed mandates requiring drug tests and "personal growth" activities for parents and others who apply for public assistance in Georgia ran into resistance Monday in the state Senate, although not enough to derail them. The drug-test mandate of Senate Bill 292 would be for anyone applying for Medicaid or for the federal Temporary Assistance for Needy Families (TANF) program. The bill would make applicants pay for the tests. If they tested positive, they would be banned from receiving benefits for a set amount of time, starting at one month for the first positive test. Senate Bill 312 would mandate "personal growth" activities for TANF parents as well as food stamp applicants. This would include working toward a GED or high school diploma, receiving technical training, attending self-development classes or enrolling in adult literacy classes. The program would operate as a pilot in five unnamed counties and exempt anyone who worked at least 30 hours a week. Officials with the state Department of Human Services, however, said the program would add expenses as their budget faced state cuts and caseworkers were already overburdened. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Matt Powers / Jane Longo

Today, Wednesday, February 22, Governor Pat Quinn gave his budget address to the legislature, as well as released several high-level budget documents on the state's website. In his address, he called for cuts of $2.7 billion from the Medicaid program. Quinn called for a combination of liability reductions, modernized eligibility standards, utilization controls, rate reductions, acceleration of integrated managed care, and coordination of long-term care programs.

The Department of Health and Family Services (HFS) released a proposal for public comment to integrate care for individuals eligible for both Medicare and Medicaid under a managed care program. This is one in a series of initiatives undertaken by the State of Illinois through its Innovations Project. A link to the proposal is available here: (PDF). Additionally, HFS will hold a stakeholder meeting on the proposal on Thursday, February 23, 2012, in both Chicago and Springfield.

In the news

- **Illinois tightens Medicaid without federal approval**

  Illinois has been debating the "maintenance of effort" requirement, which expressly prohibits states from doing anything that would reduce the number of people who qualify for Medicaid, with officials in Washington for nearly a year now and has decided not to wait any longer for a final answer. Starting March 1, the state plans to implement new Medicaid enrollment restrictions, which include electronic cross-checks on residency and income data. According to Medicaid agency estimates, the new proce-

dures will eliminate thousands of current beneficiaries and save the state more than $1 million. The state will use existing data sources to verify the accuracy of Medicaid applications, including records from food stamps and welfare, the Social Security Administration, the Illinois Secretary of State and the state department of employment security. If residency can't be verified by the data, the Medicaid agency will then require applicants to provide an alternate form of verification. (Stateline)

- **Medicaid use skyrockets in the suburbs as potential cutbacks loom**

  The number of suburban residents enrolled in Medicaid has skyrocketed in recent years, even as Gov. Pat Quinn takes aim at funding for the health care program for the poor. Suburban enrollment in the Medicaid program has risen drastically since the state's 2006 fiscal year: 89 percent in DuPage County, 76 percent in Kane, 103 percent in McHenry, 73 percent in Lake, 84 percent in Will, and 19 percent in Cook County, including Chicago, according to data from the Illinois Department of Healthcare and Family Services. That's far higher growth than in the state as a whole, where the number of people enrolled in Medicaid has risen 30 percent in the same period — forcing the state to pay more and sacrifice funding for schools and other programs. In his budget address on Wednesday, Quinn is expected to call for large cuts to Medicaid spending to help deal with the state's dismal finances. Medicaid, which costs the state $15 billion, is one of Illinois' largest expenses. (Daily Herald)

- **Hospital chief: More taxes, not $2B Medicaid cut**

  Trimming Illinois' Medicaid spending is one of the stickiest problems lawmakers will consider this year, but Gov. Pat Quinn's proposal to cut $2 billion is a blunt approach that would hurt the Illinois economy and cost 19,000 jobs, according to the head of Illinois' influential hospital lobby. In an interview with The Associated Press, Illinois Hospital Association chief Maryjane Wurth said the unsustainable costs of providing health services to the state's poor is a problem that deserves a thoughtful, multi-year approach, not a crisis approach. And her association is proposing alternatives to steep Medicaid cuts, such as increasing revenues through higher cigarette taxes and taxing junk food and soda. Quinn, who will deliver his budget address Wednesday, has said he wants to cut $2 billion from Medicaid – about 14 percent of total spending on a health care program that covers 2.7 million poor and disabled Illinois residents. The hospital association will "vigorously" fight any cuts to Medicaid payments to hospitals, Wurth said. Such payment cuts could result in the closure of struggling hospitals, leaving Illinois with more "health care deserts," such as in East St. Louis, which already lost its only hospital. (Daily-Chronicle)

Michigan

HMA Roundup – Esther Reagan

Governor Rick Snyder's budget, across all departments, assumes expenditure of $48.2 billion / $9.2 billion General Fund/General Purpose (GF/GP), a proposed increase in GF/GP expenditure of 3.0 percent. The proposed Department of Community Health (DCH) appropriation assumed expenditure of $15.0 billion Gross / $2.8 billion GF/GP, a change 3.3 percent Gross and -3.5 percent GF/GP. While the recommendation allocates less GF/GP to support DCH in FY 2012-2013, this proposal may be best characterized as an effort to expand financial support for health coverage programs. The appropriation funds several expansions in Medicaid covered services, mandates increases in Medicaid provider reimbursement rates and funds new (unspecified) public health efforts.

Assumed program savings in the appropriation are not generated through reductions in ongoing Medicaid provider rates, Medicaid covered services or mental health and public health programs but through assumed efficiencies in Medicaid provider payment and reduced costs associated with State employee health benefit changes. The most significant reduction in GF/GP comes from the ability to reduce Medicaid Health Maintenance Organization (HMO) rates since the 6 percent State use tax on Medicaid HMOs is being replaced by a 1 percent claims tax. This adjustment affects only the component of the HMO rate for the cost of taxes and will not impact the payment rates for covered services. It should be noted that changes in budget boilerplate will reduce available Medicaid funding to some hospitals. Provided below is a summary of the major changes included in the proposed Executive Recommendation.

Medicaid Changes

- Medicaid Caseload Utilization and Inflation Adjustment: The recommended appropriation assumed continued increases in Medicaid program caseload and makes adjustments for increased utilization and inflation costs: $108.7 million Gross / $39.2 million GF/GP
- Assumed Medicaid Payment Recovery Savings: The recommended appropriation assumed savings through reductions in inappropriate Medicaid provider payments. Savings are assumed through new contracts with vendors to identify unclaimed hospital credit balances and payables, third party liability data matches, retrospective overpayment detection, and increased Office of Inspector General staff. -$32.8 million Gross / -$10.7 million GF/GP
- Assumed Medicaid Pharmacy Savings: The recommended appropriation assumed reductions in Medicaid pharmacy costs through initiatives to improve prescribing for behavioral health drugs and for greater utilization of generic injectable drugs. -$6.5 million Gross / $2.2 million GF/GP
- Medicaid Program Expansions: The recommendation proposed the following Medicaid expansions:
    - A new requirement for the Medicaid and MIChild programs to cover new therapies for children with autism spectrum disorders $34.1 million Gross / $10.1 million GF/GP,

- An expansion of the Healthy Kids Dental program to additional counties $25.0 million Gross /$8.4 million GF/GP,
- Expansion of the MIChoice Home and Community-Based Waiver program $7.5 million Gross / $3.4 GF/GP,
- Addition of a new PACE site in Berrien County (no net cost or savings), and
- Restoration of the Medicaid adult chiropractic benefits $900,000 Gross / $300,000 GF/GP.

- Medicaid Provider Rate Increases: The recommendation funded the ACA mandated increase in Medicaid primary care rates to 100 percent of the Medicare level, assumed a 1.5 percent increase in HMO rates in compliance with actuarial soundness requirements and funded an increase in non-emergency transportation rates. $330.3 million Gross / $16.9 million GF/GP
- Medicaid Disproportionate Share Hospital (DSH) Funding: The recommendation restored DSH funding allocated to the Wayne State University Psychiatric residency program, increases provider-tax funded DSH payments to eligible hospitals and increased DSH payments for special indigent care agreements. $25.4 million Gross / $0.0 GF/GP
- One-Time Boilerplate Funding: The recommendation did not continue one-time funding to hospitals for Graduate Medical Education ($17.3 million Gross) and special payments for rural and sole community hospital providers ($29.5 million Gross). Failure to continue this funding represents a net reduction in hospital reimbursement of $46.8 million. New one-time funding was assumed for upgrades to the Michigan Medicaid CHAMPS computer system.

Mental Health Changes

- Prepaid Inpatient Health Plan (PIHP) Actuarial Soundness: The recommendation funded a 1.25 percent increase in capitation rates provided to PIHPs for the provision of mental health services to Medicaid eligible individuals. $27.8 million Gross / $9.3 million GF/GP

Public Health / Aging Services

- Health and Wellness Initiatives: The recommendation provides $1.0 million for new health and wellness initiatives. It is not yet clear how this money would be used. This funding is further enhanced by one-time dollars available through budget boilerplate. $1.0 million Gross / $1.0 million GF/GP
- Aging Grant Increases: The recommendation provides additional funding for grants for aging options counseling, Alzheimer's and dementia and elder abuse prevention initiatives. $850,000 Gross / $850,000 GF/GP
- One Time Boilerplate Funding: The recommendation did not continue one-time funding for the Healthy Michigan Fund ($3.0 million) and but did allocate $5.0 million for unspecified health and wellness initiatives and provided additional funding for laboratory services ($200,000).

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

On February 18, 2012, the Pennsylvania Department of Public Welfare issued 5 notices of its intent to amend its Medicaid State Plan and current regulations using a special authority granted by the Pennsylvania General Assembly at the time the FY 2011-12 State Budget was passed. The special authority was granted to help ensure that the Department could take the necessary unspecified cost containment actions to ensure that its expenditures for FY 2011-12 did not exceed the aggregate amount approved by the General Assembly. Most notably, the special authority enables the Department to move more quickly than usual to implement the changes by bypassing the normal regulatory review process. The notices satisfy the public comment requirements. Most of the announced changes take effect April 1, 2012. Savings for FY 2011-12 are estimated at $29.9 million (state and federal). However, the savings are expected to increase significantly in subsequent fiscal years when the changes are in effect for a full 12 months. Of the items listed below the largest share of savings is associated with normalizing reimbursement for HCBS services (#4 and #5).

The most significant changes include:

1. **Copayment Increases –** In the future, Medicaid copayments will be tied to the Consumer Price Index for all Urban Consumers (CPI-U). The Department also is eliminating the practice of reimbursing consumers whose co-payments exceed set amounts in any given 6 month period.

2. **Newborn Payments** - Currently the Department makes one payment for the inpatient care related to the mother's delivery and another for the newborn. Under the change, there will be a single payment for the inpatient care related to the mother's delivery of a normal newborn. In the event the newborn stays in the NICU or experiences other complications not associated with newborn care, the hospital will receive a separate payment for the delivery and newborn care.

3. **Pharmacy Payments –** The dispensing fee paid to pharmacies under the fee for service program will be $2 for prescriptions for compensable, non-compounded legend and non-legend drugs and $3 for compensable compounded prescriptions. The current dispensing fee is $4. Also rather than paying the full dispensing fee when a third party payer makes payment, the Department will only pay $0.50 to cover the pharmacy's cost to transmit the claim to the Medicaid program for secondary payment.

4. **LTL Home and Community Based Services –** The Department currently pays for many Long Term Living Home and Community Based Services (HCBS) through a locally negotiated rate between providers and public and private local entities. The change will create two payment methods for the payment of services under the LTL HCBS programs. The first method will establish a fee schedule of rates for the provision of a service. The second payment is for a small portion of HCBS that have traditionally been reimbursed for the actual cost. The Department will continue to reimburse the actual cost of the good or service. The

new regulation will specify provider qualifications and sanctions, as well as conflict free service, quality management and risk management requirements.

5. **Developmental Programs Community Based Services** – This regulation will continue cost based rate and fee schedule methodologies put in place effective July 1, 2011 and extended on November 12, 2011 and specifies that a limited number of goods and services provided in the Developmentally Disabled (DD) programs (vendor goods and services) are reimbursed for the actual cost. In addition, the regulations will specify DD provider qualifications and sanctions, as well as training, quality management and back-up plan requirements.

On February 21, 2012, Brian Duke, Pennsylvania's Secretary Aging, testified that the Pennsylvania Lottery funded pharmaceutical programs for elderly, PACE and PACE Net, would not be affected by the reduction in the Pharmacy Dispensing fee recently proposed for the Medicaid Program in Pennsylvania. In testimony at a State Senate 2012-13 Budget Hearing, Duke gave the response as several Senators expressed concern over the proposed Medicaid change saying that it would drive consumers to mail order pharmaceutical suppliers and, in turn, drive local pharmacies out of business. Duke also reported that there would not be a reduction in services or persons covered under the PACE program despite a $35 million proposed budget reduction. He explained that the savings would come from administrative efficiencies and from changes in Medicare Part D. Over 300,000 low income elderly Pennsylvanians, who are not eligible for Medicaid, receive prescriptions through the PACE or PACE Net programs.

Duke reassured the Senators that Pennsylvania is still committed to the rebalancing of long term care services noting that much progress has already been made. Comparing today's distribution with FY 2008-09 when 64% of those needing long term care services were treated in nursing homes and 36% in home and community based services; Duke reported that the split today is 58% in nursing facilities and 42% using community based services. Duke also confirmed one Senators report that 1 in 12 Pennsylvania residents have Alzheimer's or a related diagnosis.

In the news

- **County commissioners express concern about proposed state budget cuts**

  York County commissioners are concerned about proposed cuts in the state budget proposal that Gov. Tom Corbett unveiled last week. According to a statement that commissioners released on Wednesday the proposal would cost the county about $4.5 million for human services programs. In addition, a proposed cut in Medicaid reimbursement rates would increase the county's cost to operate Pleasant Acres Nursing and Rehabilitation Center by an estimated $940,000 annually. Commissioners said they like a proposal by Corbett to distribute money via "block grants." (York Daily Record)

- **Penn State's Thon raises record $10.69M**

  The Penn State University annual THON dance marathon was held over this past weekend to benefit the Four Diamonds Fund, which helps children with cancer. The largest student-run philanthropy in the country raised a $10.6 million beating last year's mark by over a million dollars. (GoErie.com)

OTHER HEADLINES

Alabama

- **Alabama Plans to Close Most Hospitals for Mentally Ill**

  Alabama will shut down most of its mental health hospitals by the spring of 2013 in a sweeping plan to cut costs and change how the state's psychiatric patients receive treatment, state officials announced on Wednesday. (New York Times)

Arizona

- **Arizona Supreme Court allows cuts to AHCCCS to stand**

  The Arizona Supreme Court on Wednesday declined to review an appeal challenging cuts to the state's Medicaid program, letting stand an enrollment freeze that has locked thousands of poor residents out of government-paid health insurance. An estimated 100,000 childless adults will lose Arizona Health Care Cost Containment System coverage this fiscal year. The state has turned away an untold number since a lower-court judge allowed the cap to take effect in July. The high court's decision effectively ends the case, which centers on a 2000 voter- approved measure that expanded the AHCCCS population. However, it lets stand an Appeals Court ruling that effectively said the budget cuts violated the measure, Proposition 204, but the court couldn't force the Legislature to obey the law. (Tucson Citizen)

- **Arizona prisons in health-care quandary**

  The Arizona Department of Corrections, under orders to privatize its troubled prison health-care system, faces a questionable choice. The department is expected shortly to award a three-year contract to provide medical and mental-health care for the nearly 34,000 inmates in Arizona's 10 state-run prisons. Lawmakers adopted legislation two years ago and revised it last year, requiring Corrections to privatize the health-care system regardless of whether it saves money. But the choices are between two companies with checkered records (Corizon Inc. of Brentwood, TN; Wexford Health Sources Inc. of Pittsburgh, PA) and a third company that has no track record in correctional health care, Centurion LLC, a unit of Centene Corporation. (AZ Central)

California

- **LAO: Brown's Expansion of Managed Care Pilot Would Be 'Premature'**

  Gov. Jerry Brown's plan to rapidly expand a four-county pilot program that shifts individuals eligible for both Medi-Cal and Medicare into managed care plans is "premature," according to a report from the non-partisan Legislative Analyst's Office, California Watch reports. Medi-Cal is California's Medicaid program. According to LAO estimates, the state has about 1.9 million so-called dual eligibles. After reviewing Brown's plan, LAO said state lawmakers should reject the expansion of the pilot program "before the results from the demonstration have been properly evaluated, but proceed instead with the four-county demonstration." (California Healthline)

- **Supreme Court sends back California Medicaid cuts case**

  The high court said on Wednesday that after it heard oral arguments in the case on October 3, federal government officials approved the state's statutes as consistent with federal law. Justice Stephen Breyer said in the majority opinion the case was sent back to a U.S. appeals court based in California to determine whether the recipients and providers may sue in light of the changed circumstances of the federal government's approval. In sending the case back, the justices set aside a ruling by the appeals court that had blocked the cuts for violating federal law. The case involved a plan by California's lawmakers in 2008 to slash Medicaid payments to doctors, hospitals and other medical providers to help reduce the state's massive budget deficit. (Reuters)

- **Working Out the Details of the Exchange**

  With a June deadline looming for submitting its Level II implementation grant, California's exchange board finds itself grappling with some of the hard questions and sticky details around creation of the Health Benefit Exchange. The exchange board will consider cost-sharing with qualified health plans,, and will expand its scope of inquiry to include vision and dental. The exchange issued a SHOP (Small-Business Health Options Program) solicitation last week. Bids are due at the end of February. The board will soon post information giving the relative cost of the benchmark plans for essential health benefits. (California Healthline)

- **Adult Day Care Transition Gets Another Month**

  The state's move on Friday to shift the transition date for Adult Day Health Care elimination by a month was borne of a request by CMS, according to officials from the Department of Health Care Services. Advocates say the delay may be due to the scattered nature of the state's transition so far. DHCS has been busy implementing the conditions of its lawsuit settlement over eliminating ADHC as a Medi-Cal benefit. The state agreed to create a new program, Community Based Adult Services, which will provide many of the same services. The optional ADHC benefit had been slated for elimination on Feb. 29. That date has now been moved to Mar. 31. The CBAS program is expected to launch Apr. 1. The smooth transition of one program into the other is dependent, in part, on the assessments of 35,000 current ADHC beneficiaries -- a group of mostly elderly Californians who generally have multiple medical conditions, numerous medications and are at-risk of admission to a nursing home. (California Healthline)

- **10 counties expand medical coverage for low-income residents**

  Los Angeles County adds about 114,000 people to its Healthy Way program. The state hopes to enroll as many as possible before the federal government takes over the program in 2014. 10 California counties have expanded medical coverage to more than 250,000 people who were previously uninsured, according to new state data. They are among 47 counties participating in the state's Bridge to Reform program, which provides health coverage for low-income residents and enables them to receive free care at their local public clinics and hospitals. (Los Angeles Times)

Indiana

- **Ind. Senate panel OKs state withdrawal from Medicare, Medicaid**

A Senate committee on Wednesday approved legislation authorizing the governor to withdraw Indiana from Medicare, Medicaid and nearly all federal health programs. House Bill 1269 permits the governor to enter into a health care compact with other states that will enable each state to regulate the provision of health care at the state level but pay for it with federal funds. The nonpartisan Legislative Services Agency estimates Indiana would have to pay $15 billion a year to maintain the federally supported health programs that Hoosiers now receive, though federal funds are expected to cover that cost if the interstate compact is approved by Congress. (Northwest Indiana Times)

Kentucky

- **Kentucky Medicaid managed-care firms acknowledge problems**

Executives with three managed-care companies hired to run most of the state Medicaid program acknowledged Wednesday that there have been significant problems since they took over Nov. 1 and said they are committed to fixing them. Lawmakers have faced a growing chorus of complaints from health-care providers about chronically late payments, bungled claims processing and constant battles over new rules that require services once routinely covered by Medicaid to be "pre-authorized" to guarantee payment. (Courier-Journal)

Louisiana

- **Federal Agency Approves Medicaid Contract**

A proposed $185 million contract with a firm to handle Louisiana's Medicaid claims processing has been approved by the federal government's health agency. The Advocate reports state health agency officials have been waiting for months for the U.S. Center for Medicare and Medicaid Services to agree to Louisiana's deal with CNSI, the Maryland company that won the bid. (KTBS.com)

Maine

- **Health and Human Services head offers to help Maine change Medicaid**

Health and Human Services Secretary Kathleen Sebelius told members of the U.S. Senate Finance Committee on Wednesday that she has told Maine Gov. Paul LePage what the state's options are to change Medicaid and offered to send a team to help the state craft a plan that will pass federal muster. LePage has proposed closing a $220 million, two-year shortfall in the state's Department of Health and Human Services budget by overhauling MaineCare, the state's version of the federal Medicaid program, to bring it closer to national averages for public health benefits. His plan would drop 65,000 people from coverage, tighten eligibility requirements and cut services. A portion of his proposed cuts would require federal waivers that Democrats and HHS have said likely would not be granted. (Bangor Daily News)

Minnesota

- **Bachmann joins state lawmakers seeking Medicaid audit**

  U.S. Rep. Michele Bachmann said she plans to introduce a federal bill similar to one recently introduced in the Minnesota Legislature to require independent audits of health maintenance organizations. The push began last week when Minnesota lawmakers heard that one HMO returned $30 million it said the state overpaid it. That left questions of whether other insurers also may have received too much government money. (Echo Press)

- **Feds investigate Minnesota's handling of Medicaid**

  The federal government is investigating how Minnesota administers Medicaid health insurance coverage for poor people, but few details are available on the nature of the inquiry, a leading state health official said. The probe came to light at a hearing that focused on transparency and rate-setting around the state's health care coverage for poor Minnesotans. The state will spend about $3.3 billion on Medicaid this year, and $3.6 billion next year. The program provides coverage for about 733,000 Minnesotans, and the majority of recipients have their care managed by private health maintenance organizations. Gov. Mark Dayton told Minnesota Public Radio he welcomed the investigation and his administration has nothing to defend. (Austin Daily Herald)

- **Legislative auditor to review HMO process for setting rates**

  Minnesota's legislative auditor says he will seek a new review of the rate-setting process for HMOs providing services to Medicaid patients. The move comes a day after the human services commissioner told lawmakers that federal authorities are investigating the state's Medicaid program. Auditor Jim Nobles said it is time to determine if the Department of Human Services is receiving the financial data it needs to oversee the managed care plans and whether the department is using that data effectively. (Minnesota Public Radio)

New Hampshire

- **House gives preliminary OK to health care compact**

  An effort intended to free the state from the mandates of the federal health care overhaul received preliminary approval in the New Hampshire House Wednesday. The bill would create an interstate compact that would place all health care programs under the member states' control, including federal programs like Medicare and Medicaid, while enabling the states to continue receiving federal funding. The House voted 253-92 in favor of the bill. The bill would effectively supersede any federal health care laws. This includes the Patient Protection and Affordable Health Care Act. (Boston Globe)

New Jersey

- **Grapevine: Insurer unsure on N.J.**

  Word on the street is that AmeriHealth New Jersey is trying to get out of the Garden State market by selling its state license, according to two sources connected to the health insurance world. One source said AmeriHealth's parent company, Independ-

ence Blue Cross, is looking to focus more on the Philadelphia market under its new president and CEO, Daniel J. Hilferty. (NJ Biz.com)

- **Federal officials signal they may agree to Gov. Christie's Medicaid change**

  The Christie administration got welcome budget news Friday as federal officials signaled they were close to accepting the governor's plan to dramatically change the Medicaid program and save $300 million in state funding this year. But precisely how the administration will allow Gov. Chris Christie to achieve that savings remains a matter of negotiation, state and federal officials said. The federal government last fall said it did not have the authority to repay New Jersey $107.3 million for decades of federal costs the state had picked up. Christie anticipated the savings for the current budget year, which runs through June 30. Friday's letter that U.S. Centers for Medicare and Medicaid Services director Cindy Mann sent to Human Services commissioner Jennifer Velez did not mention specifically the $300 million savings the governor anticipates, or the notice it sent to New Jersey last fall. (NJ.com)

New Mexico

- **New Mexico proposes to overhaul Medicaid program**

  Gov. Susana Martinez's administration is proposing to overhaul a program that provides health care to a fourth of the state's population. One of the goals of the planned revision is to slow the rate of growth in Medicaid, which accounts for 16 percent of this year's state budget and costs New Mexico taxpayers nearly $1 billion. The state proposes to require "co-pays" for Medicaid recipients who go to an emergency room for routine medical care and for using a brand name drug when a generic drug is available. The fee will be $3 for brand name drugs but won't apply to certain drugs used to treat mental health conditions. The fees for using an emergency room will vary according to a person's income, but could range from $6 to $50. A key element of the overhaul calls for using fewer health care contractors to provide a broader range of medical services through managed care. Behavioral health services will no longer operate separately but will be part of the main consolidated Medicaid plan. Long-term health care services to the developmentally disabled will remain separate, however. (Boston Globe)

Ohio

- **New Healthcare Initiative Launched in Ohio**

  Ohio Governor John Kasich recently launched an initiative to shift Ohio's healthcare payment system from a volume-based business model to one based on value and performance. The Office of Ohio Health Plans (Ohio Medicaid) has begun to work with Catalyst for Payment Reform (CPR), a non-profit organization that helps employers and other healthcare purchasers get better quality, less expensive health care. Ohio Medicaid is the first state Medicaid program to partner with CPR, Kasich said. (Compensation.BLR.com)

Tennessee

- **TennCare Restricts Nursing Home Coverage, Could Save $15 Million**

  The state of Tennessee's Medicaid managed care program, TennCare, is looking to save millions of dollars by restricting what qualifies people for long-term nursing care, reports local WCYB news. At least $15 million could be saved in the state institutes "tougher new standards" for who's eligible to enter a nursing home. Currently, an individual with one activity of daily living deficiency (ADL) can be admitted into a facility through the TennCare program. The new proposal, however, changes that requirement to four ADLs by next year. (Senior Housing News)

Texas

- **Central Health OKs budget for new HMO but won't let public see it**

  The budget for a health maintenance organization supported by Travis County taxpayers is being kept under wraps, at least for now. Central Health, the tax authority that oversees care for low-income Travis County residents, approved the budget for Sendero Health Plans after a closed-door session Wednesday night. Central Health officials said they believe the spending plan for Sendero, including the total cost, can be withheld from the public for competitive reasons. Sendero is one of four Medicaid HMOs the Texas Health and Human Services Commission approved last year for Central Texas, and the only one that's public, backed by nearly $34 million in taxpayer dollars. It launches March 1 as part of a state plan to control escalating costs for Medicaid, the federal-state program that provides health coverage to the indigent. (Statesman)

- **Opinions Mixed as Managed Care Comes to Valley**

  Managed health care services, which had been the subject of a recent moratorium in three Rio Grande Valley counties, will soon be available for Medicaid patients in those counties and the rest of the Valley. On March 1, Medicaid patients living in what the Texas Health and Human Services Commission classifies as the Hidalgo Service Area will be eligible for the services, in which private organizations receive set monthly payments from the state to provide health services for patients. The Hidalgo Service Area includes Starr, Duval, Jim Hogg, McMullen, Webb, Willacy and Zapata counties, as well as Hidalgo, Cameron and Maverick counties, which had previously banned managed care. Advocates of managed health care say the program has proven to be cost-effective in parts of the state where it has been implemented. But others say that managed care will not meet the unique needs of the Valley. (Texas Tribune)

- **Pharmacies sue over Medicaid cuts**

  Texas TrueCare Pharmacies, the state's largest group of independent pharmacies, on Friday filed a federal lawsuit in Austin to delay planned cuts in Medicaid. Texas TrueCare was joined in the suit by four pharmacies and two parents whose children receive Medicaid benefits. They allege the Texas Health and Human Services Commission has failed to establish reasonable standards for the reimbursement of pharmacy claims under Medicaid managed care. (My San Antonio)

- **Medicaid change will affect almost all recipients in Rio Grande Valley**

  The rollout on March 1 of managed-care Medicaid for the Rio Grande Valley and beyond is expected to affect more than 400,000 Medicaid clients in a 10-county service area. They were asked to enroll in managed-care plans by last Friday. The change has been criticized by a group of Valley pharmacists who said their Medicaid reimbursements would go down, potentially passing the cost on to clients. (The Brownsville Herald)

Washington

- **State denies Medicaid provider's appeal**

  The state Health Care Authority has declined Columbia United Providers' appeal to continue serving 47,000 Clark County Medicaid patients. The appeal was CUP's response to a state decision that may force local Medicaid patients to find new doctors and leave 80 CUP workers unemployed. As a result of the state's decision, CUP officials said the organization will pursue legal action. The state Health Care Authority last month selected five health insurance plans that appear to have successfully bid to provide Medicaid services to Washington residents. The selected insurance plans will manage care for the state's Healthy Options and Basic Health members, who are mostly low-income women and children. Columbia United Providers, a Vancouver-based group which has provided those services in Clark County since 1994, was not selected. CUP filed a formal protest to the decision on Feb. 3. The Health Care Authority, after an internal review, determined CUP's protest lacked merit and upheld its earlier action. CUP was notified of the decision Friday. (The Columbian)

- **House Republicans propose state budget eliminating Basic Health Plan**

  House Republicans on Friday released a supplemental budget proposal that makes nearly $840 million in cuts to state programs and doesn't include a sales-tax increase for voters to consider, as suggested by Gov. Chris Gregoire. The Republican plan includes the elimination of the Basic Health Plan, which provides health insurance for the poor, and Disability Lifeline, a welfare and health-care program for unemployable adults who aren't covered by federal Social Security benefits. Democrats in the House oppose those cuts. In total, about $230 million would be saved by eliminating 51 programs. Majority Democrats, who ultimately decide what the budget will look like, are expected to unveil their plan next week. (Seattle Times)

Wisconsin

- **Proposed state Medicaid changes gain some support from feds**

  The federal government Wednesday confirmed its support of some proposed changes to Wisconsin's Medicaid program but said more details are needed before it can grant approval. The state has proposed cutting $554 million over two years from the $7.5 billion-a-year Medicaid program. The changes would cause 65,000 people, nearly half of them children, to leave or be turned away from Medicaid, the nonpartisan Legislative Fiscal Bureau said. Another 263,000 people would be shifted into lower-cost plans with fewer benefits. (Wisconsin State Journal)

COMPANY NEWS

- **Coventry Health Care Announces Missouri Managed Care Award**

  Coventry Health Care, Inc. announced today that it has received notification from the State of Missouri of an award to provide services for the State's Medicaid managed care program known as MO HealthNet Managed Care. The statewide award covering the Eastern, Central, and Western Managed Care Regions is consistent with Coventry's current market-leading statewide presence and incorporates the membership which was recently acquired as part of the Family Health Partners transaction. The new contract is scheduled to commence on July 1, 2012 and is one year in duration with two potential extension periods. (Coventry Health Care)

- **Molina Healthcare Loses Missouri Contract**

  Molina Healthcare Inc. shares fell Tuesday after the Medicaid managed care provider said it had lost a key contract in Missouri, and thus was lowering its full-year earnings guidance. Molina said that revenue from Missouri represented 4.7 percent of the company's totals as of Dec. 31. The company is scheduled to report fourth-quarter results on Thursday. (Los Angeles Business Journal)

- **Centene Corporation Awarded Missouri Managed Care Contract**

  Centene Corporation announced today that its subsidiary, Home State Health Plan, has been selected to contract with the Office of Administration for Missouri to serve Medicaid beneficiaries in the Central, Eastern and Western Managed Care Regions of the state. Approximately 427,000 beneficiaries are eligible to receive services under the MO HealthNet Managed Care program in 54 counties. This award represents the 16th state in which Centene has healthplan/hybrid operations. (Centene Press Release)

- **CVS details government probes into Medicaid claims**

  CVS Caremark Corp. said Friday federal and Texas officials have pressed the company for information about the way its prescription-drug-management plans process Medicaid claims. The company said the federal Office of the Inspector General and Texas attorney general each had filed requests, according to a filing made Friday with the U.S. Securities and Exchange Commission. The disclosures come after CVS's retail-pharmacy division last year agreed to pay $17.5 million to resolve allegations it submitted inflated prescription claims to the government by billing the Medicaid programs for more than what CVS was owed in some states. (Market Watch)

- **Meridian Health Plan to Serve Iowa Medicaid Population**

  Meridian Health Plan has been selected by the State of Iowa to provide managed Medicaid health services to beneficiaries through a contract with the Iowa Department of Human Services (IDHS). (Bradenton Herald)

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 have added the Florida CHIP RFP which was announced earlier this week.

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
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
April 25, 2012	Florida CHIP	Proposals due	225,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 20, 2012	Florida CHIP	Contract awards	225,000
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
October 1, 2012	Florida CHIP	Implementation	225,000
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…

Mike Fazio, Senior Consultant – Boston, MA

On Monday, February 20th, Mike Fazio joined HMA as a Senior Consultant in the Boston office. Mike comes to HMA from Children's Hospital Boston where he has served as Manager of Managed Care Finance and Strategy. In this role, Mike has been responsible for the development and implementation of the hospital's managed care strategy and contract operations, including negotiating multi-million dollar contracts with local and national insurers, Medicaid managed care organizations and government programs; interpreting and reporting changes in managed care market trends and legislative initiatives to senior leadership; developing financial forecasting models and strategy recommendations to support network development initiatives with physician practices, community hospitals, and other key partnerships; and development of pricing strategies and operationalizing revenue cycle initiatives. Prior to his time at Children's Hospital Boston, Mike was a Consultant with Public Consulting Group in Boston. Mike earned his Bachelor of Science degree at the University of New Hampshire.

HMA RECENTLY PUBLISHED RESEARCH

A Mid-Year State Medicaid Budget Update for FY 2012 and A Look Forward to FY 2013

Vernon Smith, Managing Principal

Kathleen Gifford, Principal

Michael Nardone, Principal

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.

Link to Kaiser Family Foundation Report (PDF, 9 pages)

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

"The Changing Face of Medicaid: A Profile of the 2014 Medicaid Population and Interventions That Work"

Linda Follenweider, Presenter

February 28, 2012

Live webcast, http://MedicaidTalk.com

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

Linda Follenweider, Presenter

March 7, 2012

Chicago, Illinois