HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: OHIO DUAL ELIGIBLE INTEGRATION PROPOSAL

HMA ROUNDUP: FLORIDA BUDGET NEARS COMPLETION; DUAL ELIGIBLE INTEGRATION ACTIVITY IN MICHIGAN, ILLINOIS, NEW YORK; PENNSYLVANIA CONSIDERS MLTC PROGRAM;

OTHER HEADLINES: HHS AWARDS $229 MILLION IN HEALTH INSURANCE EXCHANGE GRANTS TO TEN STATES; OREGON MEDICAID REDESIGN BILL PASSES CLEARS LEGISLATURE; WELLCARE WHISTLEBLOWER SETTLES; HHS DENIES STATE CO-PAY PROPOSALS; ILLINOIS BUDGET PROPOSALS FALL SHORT OF TARGETED SAVINGS

RFP CALENDAR: ILLINOIS, MASSACHUSETTS, OHIO DUAL ELIGIBLE RFPS ADDED

FEBRUARY 29, 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: OHIO DUAL ELIGIBLE INTEGRATION PROPOSAL

This week, our *In Focus* section highlights the key points in Ohio's proposal to CMS to integrate care for dual eligible Medicaid-Medicaid enrollees. The demonstration program, known as the Ohio Integrated Care Delivery System (ICDS), will provide dual eligible enrollees with all Medicaid and Medicare services, including long term supports and services (LTSS). The ICDS will build upon a Medicaid managed care program that has, since 2006, mandated enrollment of aged, blind, and disabled (ABD) Medicaid beneficiaries. However, those dual eligible individuals enrolled in both Medicaid and Medicare have, until now, been excluded from managed care. Governor Kasich's administration, and the Governor's Office of Health Transformation have made the ICDS a top priority for this year despite not being awarded a dual eligible transformation grant through CMS. Instead, the administration is pursuing the capitated model, made available to states through a July 2011 letter to state Medicaid directors, to integrate care for dual eligible enrollees.

A link to the Proposal is available here: (PDF - 59 pgs.)

Target Population

The ICDS will not, at least initially, be a statewide program. Instead, the State has targeted seven regions of three to five counties each. In all, these seven regions encompass 122,409 out of 196,369 dual eligible enrollees statewide. The target population is limited to full benefit dual eligible enrollees. Those individuals eligible for the Medicare Savings Program will be excluded. Additionally, the following dual eligible populations will be excluded as well:

- Dual eligibles with intellectual disabilities (ID) and other developmental disabilities (DD) served through an IDD 1915(c) HCBS waiver or an ICF-IDD.
    - However, those ID and DD dual eligibles not served under a waiver may opt into the ICDS program.
- Dual eligibles enrolled in the Program for All-Inclusive Care for the Elderly (PACE).
- Dual eligibles under the age of 18.

Additionally, Medicare-Medicaid enrollees with severe or persistent mental illness (SPMI) will be included in the ICDS program. The Ohio Medicaid program is currently working with CMS on a Medicaid state plan amendment to create Medicaid Behavioral Health Homes for all individuals in the Medicaid program with SPMI. The assumption in this proposal is that the state plan amendment will be approved and the Health Home program will be implemented in October 2012. Ohio is proposing that ICDS health plans be required to contract with the Medicaid Behavioral Health Homes. However, individuals with SPMI will not be required to change to a new provider for behavioral health services.

Ohio has conducted preliminary analyses of Medicaid spending for the ICDS target population. It is estimated that in FY 2011, Ohio Medicaid spent approximately $3.7 billion providing services to Medicare-Medicaid Enrollees in the ICDS target population. Of this total, $2.3 billion (62 percent) was for Medicaid-covered nursing home stays, while approximately $900 million (another 24 percent) was spent for PASSPORT and other home and community-based services. The remaining $500 million (14 percent) was spent on Medicare cost-sharing services and other Medicaid benefits not available through the Medicare program. Thus, in all, 86 percent of Medicaid spending for the target population is for Long-Term Services and Supports, either in institutional or community-based settings. More detailed analysis of current Medicaid spending for the target population will be developed through the rate development process.

Ohio Medicaid Managed Care Plans	Enrollment (Dec. 2011)	Market Share
CareSource	865,430	52.8%
Molina	246,503	15.0%
Buckeye/Centene	158,491	9.7%
Unison/UnitedHealth	119,259	7.3%
WellCare	100,529	6.1%
Paramount	93,835	5.7%
Amerigroup	55,107	3.4
Total	**1,639,154**	

Source: Ohio Department of Job and Family Services

Six of the seven selected regions have at least four Medicare Advantage plans currently serving enrollees. The seventh region has at least three plans. All eligible Medicare-Medicaid enrollees in the seven regions will be enrolled in the ICDS program beginning January 1, 2013.

Ohio Dual Eligible Special Needs Plans	Enrollment (Feb. 2012)	Market Share
UniteHealthcare	9,382	74.2%
CareSource	1,221	9.2%
WellCare	1,110	8.8%
Centene	761	6.0%
Humana	113	0.9%
Molina	55	0.4%
Total	**12,642**	

Source: CMS

Program Design and Enrollment

Individuals will be required to choose one of the two ICDS plans in a region. Thus, if an eligible enrollee is currently enrolled in a SNP that is not one of the ICDS plans, the individual will be disenrolled from the SNP and given the choice of one of the ICDS plans.

Enrollment in the ICDS Program will be mandatory for Medicaid-covered benefits. For Medicare-covered benefits, Ohio proposes to implement an "opt out" enrollment pro-

cess. If eligible participants elect to opt out of the ICDS program for their Medicare-covered benefits, they will remain enrolled in the ICDS program for their Medicaid-covered services. There will no longer be a fee-for-service Medicaid option in the ICDS program target regions for ICDS participants. If individuals fail to notify the State of their plan selection choice, they will be automatically enrolled in one of the two plans available in their region.

Once enrolled in one of the two ICDS plans, individuals will be offered the option of switching plans twice a year—on July 1 and January 1. There is no "lock in" provision on the Medicare side, so that individuals can disenroll from ICDS plans for their Medicare-covered benefits at any time.

Timeline

Milestone	Date
Request for Applications (RFA) released	**April 2, 2012**
RFA Responses Due	**May 11, 2012**
Contract Awards	**July 30, 2012**
Enrollment Begins	**January 1, 2013**

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

Last Wednesday's U.S. Supreme Court decision the Medi-Cal rate provider cut lawsuit to refer the case back to the 9th Circuit Court allows the existing injunctions on implementing California's rate reductions to continue and sets the stage for further challenges in the lower courts. The Court did not grant the state's request that it find that providers did not have standing in federal court to litigate rates and therefore could not bring lawsuits against states. The key issue in moving forward will be the provider's ability to effectively challenge CMS' approval of any rate cuts in the lower courts under the administrative procedures act. The 9th Circuit will review California's rate reductions post CMS approval of these reductions. We note that a federal District Court in California has already enjoined the state from moving ahead with CMS approved rate reductions. The 9th Circuit the court decision leaves the door open for a potential challenges of CMS approved rate decreases, additional litigation under the Supremacy Clause on any rate reductions that states in the 9th Circuit implemented before CMS approves the rate reductions, and the 9th Circuit's decision that rate studies conducted by the state as part of any rate reduction must consider the provider's cost of providing care as defined in the orthopedic lawsuit decision.

In the news

- **Jerry Brown presses Obama on Medi-Cal, meets with labor**

  Gov. Jerry Brown continued to press President Barack Obama today for authorization to enact further cuts to Medi-Cal to help balance California's budget, even as the administration showed no sign of relenting and complained about the severity of state budget cuts in other areas. The Obama administration recently denied Brown's bid to charge Medi-Cal recipients co-payments for prescription drugs, doctor visits and other services. After meeting privately with Health and Human Services Secretary Kathleen Sebelius on Sunday, Brown said there are "some legal issues being raised about our ability to require co-pays." He said Sebelius told him there may be other ways to reduce Medi-Cal costs but did not suggest any, in particular. (Sacramento Bee)

- **State health chief vows changes to Sacramento County dental program**

  The state's Medi-Cal chief, under pressure to improve dental care for Sacramento's poor children, pledged this week to implement changes so kids won't have to wait months to receive treatment for painful, rotted or broken teeth. In response to concerns raised by Senate President Pro Tem Darrell Steinberg, D-Sacramento, Toby Douglas outlined the steps that the state Department of Health Care Services will take to ensure that the more than 110,000 Sacramento County children with Medi-Cal get "high quality and timely" dental care. He promised quicker resolution to complaints from patients and said the department will get tougher on dental plans that fail children, either by withholding payments or by terminating their contracts. (Sacramento Bee)

- **Hearing Examines States' Behavioral Health Restructuring**

  The state has big plans for restructuring the behavioral health system in California. State legislators held a rare four-committee joint hearing this week to hear about the details of that reorganization, and to raise concerns about it. The state is moving to eliminate the Department of Mental Health, essentially folding it into the Department of Health Care Services. According to state HHS undersecretary Michael Wilkening, almost all the functions of the current Department of Alcohol and Drug Programs also will shift to DHCS. (California Healthline)

- **Supreme Court lets providers continue suing to stop Medi-Cal cuts**

  A years-long legal fight over cuts in California's multibillion-dollar healthcare program for the poor took another twist Wednesday as the U.S. Supreme Court kicked the case back to a lower court. The high court's 5-4 decision allows medical providers to continue suing to stop the cuts, which would lower reimbursement rates for doctors who participate in the state's Medi-Cal program. But it did not affirm the lower court's decision to block the reductions, leaving the state another opportunity to argue for the right to implement them to help balance its depleted budget. For now, the state will continue paying the higher reimbursement rate as it evaluates the justices' action, according to officials in Gov. Jerry Brown's Department of Finance. Without a ruling for one side or the other, both sides claimed victory. (Los Angeles Times)

Florida

HMA Roundup – Gary Crayton

The legislature is in the final stages of its budget negotiations this week as the session ends on Friday, March 9. The three key issues from a healthcare standpoint, as we have highlighted in the past, continue to be:

- Hospital rates - The House proposed a 7 percent reduction while the Senate proposed a much steeper cut for hospitals that are receiving payments above a certain ceiling (exemptions and buybacks). Based on comments from Sen. Joe Negron late last week, it appears the Senate is moving to the House position.
- ER visits – The Senate has proposed a cap of six ER visits per beneficiary per year; the House has proposed 12. This issue has not been resolved as of this date.
- Elimination of MediPass – The Senate has proposed eliminating MediPass (PCCM) in counties where there are at least two MCOs currently operating. Opponents believe this would create an additional administrative burden on the Medicaid Agency (AHCA) at a time when it is preparing the invitations to negotiate (ITNs) for the upcoming long term care and acute care programs, which would eliminate the MediPass program upon implementation.

With respect to the managed care expansions, news reports indicate that the State will be required to incorporate a minimum MLR into the structure of its program as opposed to the experience rebate methodology the legislature preferred. Additionally, we note that there is language in the current bill that clarifies the benefit that a Florida-based plan would receive in the upcoming ITN. Specifically, a plan is eligible for the highest number of points if it has all or substantially all of its operational functions performed in the state. The second highest number of points shall be awarded to a plan that has a majority of its operational functions performed in the state. Operational functions include corporate headquarters, claims processing, member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration.

In the news

- **Legislators reject 'anti-free market' Medicaid push by GOP contributors**

  A proposal to force Florida hospitals into contracts with Medicaid managed care plans was defeated on two fronts in the House and Senate on Tuesday, despite a push by two of the state's most politically connected HMO operators. But the measure was fiercely opposed by hospitals, who warned that it would reverse attempts to rely on the market to drive the price of the contracts, as expected last year when legislators passed the landmark Medicaid reform. (Miami Herald)

- **Florida may use medical loss ratio after all**

  For months, Republican lawmakers resisted the idea. But Monday, a House committee acknowledged that the federal government likely will require Florida to set a minimum standard for how much money Medicaid HMOs spend on medical care. The House Health & Human Services Committee approved a bill that allows the state Agency for

Health Care Administration to use what is known as a "medical loss ratio," as Florida seeks federal approval of a proposal to enroll almost all Medicaid beneficiaries in managed-care plans. (Jacksonville Business Journal)

- **Ready for conference? Senate approves $70.7 billion budget**

  With a bipartisan vote, Florida Senate on Thursday teed up a $70.7 billion budget for negotiations with the House. The Senate's 2012-13 budget is about $1.5 billion larger than its House counterpart. Unlike the House, the Senate plan sweeps $265 million from the Lawton Chiles Endowment. It asks local governments to pick up a greater share of hospital funding and for universities to rely on cash balances for a year to withstand a funding reduction of nearly $400 million. In its current form, the Senate's spending plan would save nearly $219 million in general revenue by shifting Medicaid hospital reimbursements to intergovernmental transfers, a move that could amount to a cut for hospitals if local hospital districts do not make up the lost revenue. However, Senate Health and Human Services Appropriations Subcommittee Chairman Joe Negron said he had met considerable pushback from public hospitals and intended to back away from that change in favor of a straightforward rate reduction, likely equal to or less than the 7 percent House is proposing. The Medicaid conforming bill would also gain an estimated $77.5 million in general revenue by docking sales tax revenue transferred to local governments. The move is intended to recoup 85 percent of unpaid Medicaid bills the state says are owed by county governments. In future years, the proceeds from this change would be used to replenish the Chiles fund. (The Florida Current)

Illinois

HMA Roundup – Matt Powers / Jane Longo

The Department of Health and Family Services (HFS) held a stakeholder meeting on the dual eligible integration proposal released last week, as well as provided updates on some other State issues.

On the budget and payment cycle front, the State is currently paying bills on average 120 days after receipt. News outlets have begun using dire language that the Medicaid program is on verge of collapse. Last Wednesday, HFS Director Julie Hamos went through budget cut options. All potential cuts - including eligibility, optional services and rate cuts – aren't enough to achieve the $2.7 billion in Medicaid cuts prescribed in Governor Quinn's budget address last week. The Department did indicate that better care management, while not a panacea, could bring budget savings.

In the news

- **Hospital group to take charity tax exemptions fight to Illinois Legislature**

  State Senate Majority Leader James Clayborne Jr., D- East St. Louis, has agreed to sponsor the Illinois Hospital Association's proposal, which would overrule a two-year-old Illinois Supreme Court decision that tightened the requirements for nonprofit institutions to be exempt from property taxes. The proposal by the 200-member IHA would expand the definition of charity in the state's Property Tax Code to include not only free medical care to the indigent but also programs and losses that hospitals incur treat-

ing patients under Medicaid, whose reimbursement fees are well below market rates, according to a copy of the proposed legislation obtained by Crain's. The current method to determine a hospital's eligibility for property tax exemption involves weighing several factors, including whether an institution dispenses charity to all who need and apply for it. Under the IHA's proposal, nonprofit hospitals likely won't have any trouble qualifying as charitable. (Crain's Chicago)

- **Glasses, wheelchairs on Illinois Medicaid cut list**

  A menu of possible cuts prepared by Quinn's administration includes few dollar figures and those numbers don't add up to $2.7 billion. That's because specific dollar amounts for various options are still being calculated for the bipartisan legislative working group, Quinn senior health adviser Michael Gelder said Thursday, a day after the governor said Medicaid "is on the brink of collapse" in his budget address. But what's clear, Gelder said, is that lawmakers will have to choose everything on the list of possible Medicaid cuts to get to the $2.7 billion proposed by Quinn. For example, all the listed options short of cutting payments to hospitals, doctors and pharmacies add up to only $1.9 billion, he said. Rate cuts to providers are needed to reach the target. (Quad City Times)

Massachusetts

HMA Roundup – Tom Dehner

Earlier in February, the state announced the re-launch of the Business Express program. The state's eight leading health insurance carriers are now offering health plans to small businesses through the Massachusetts Health Connector's Business Express program. Business Express is a solution for small businesses that enables an easy apples-to-apples comparison of plans. All Medicaid and non-Medicaid plans are now participating in the plan. The eight health insurance carriers now offering high-quality plans through Business Express are Blue Cross Blue Shield of Massachusetts, BMC HealthNet Plan, CeltiCare Health Plan, Fallon Community Health Plan, Harvard Pilgrim Health Care, Health New England, Neighborhood Health Plan and Tufts Health Plan. Until now, there had been limited carrier participation in the program since its original launch two years ago

Michigan

HMA Roundup – Esther Reagan

From HMA's Michigan update:

The number of Medicaid beneficiaries dually eligible for Medicare auto-assigned to the Medicaid HMOs in February was 8,677; the number of duals voluntarily enrolling in the HMOs was 6,615. Every HMO has duals enrolled although the numbers vary dramatically across plans.

The Michigan dual eligible proposal is expected to be released next week.

On February 21, 2012, DCH Director Olga Dazzo testified before the House Appropriations Subcommittee on Community Health to provide an overview of Governor Rick

Snyder's Executive Budget Recommendations for DCH, and on February 28th, Medicaid Director Steve Fitton also provided testimony.

New York

HMA Roundup – Denise Soffel

New York State Dual Eligible Initiatives

Mandatory Enrollment of Duals into MLTCPs

The Medicaid Redesign Team (MRT) proposed a reform in Medicaid LTC financing and service delivery that was enacted in the FY 2012 budget. The change requires that a subset of LTC recipients—those who are 21 years of age or older, are dually eligible for Medicare and Medicaid, and require more than 120 days of community-based long-term care—will be enrolled in a Managed Long Term Care (MLTC) plan or a care management entity called a "care coordination model" (CCM). A CCM will provide the same minimum benefit package, including care management, as MLTC Partial Capitation plans, although CCMs may differ from MLTC Partial Capitation plans in their sponsorship, and the State will not hold them to the same reserve requirements in the near term.

Enrollment in the program initiative affects different groups in different ways. Mandatory enrollment includes dual eligibles over age 21 receiving community-based long term care services for over 120 days. Voluntary Enrollment includes dual eligibles ages 12- 21 in need of community-based long term care services for over 120 days (voluntary), and dual eligibles ages 18-21 assessed as nursing home eligible.

The following individuals are excluded from the program:

- Nursing Home Transition and Diversion Waiver participants;
- Traumatic Brain Injury waiver participants;
- Assisted Living Program participants;
- Dual eligibles that do not require community based long term care services.

Mandatory enrollment of duals into MLTCPs or CCMs is scheduled to be phased in geographically. The program would begin in NYC, beginning in New York County (Manhattan). It would cover all of NYC by February 2013. Subsequent phases would be timed as plan capacity is established. The program start-up, initially scheduled for April 1, 2012, has been postponed awaiting CMS approval. The tentative roll-out is:

Phase II – Nassau, Suffolk, Westchester (January 2013)

Phase III – Rockland, Orange (June 2013)

Phase IV – Albany, Erie, Onondaga, Monroe (December 2013)

Phase V – other counties with capacity (June 2014)

Phase VI – currently excluded groups, contingent upon development of appropriate programs and reimbursement models

CCM guidelines developed by the MRT require that payments to MLTCPs and CCMs be risk-adjusted, based on the functional impairment level and acuity of CCM members,

possibly including "functional status, cognitive status, diagnoses, demographics, or other measures found to be correlated to increased cost of services." The State is also considering employing a risk corridor model to mitigate plan risk under mandatory enrollment. The risk corridor model would be a temporary mechanism to adjust for differences between premium revenue and actual service use until new enrollees' costs are reflected in premium base rates. Under the model, plans would be fully exposed to losses or gains up to specific percentages of premium revenue. Beyond these percentages, the State would mitigate risk by absorbing either 50 percent or 100 percent of plans' losses or gains, depending on the variance from the premium revenue.

Dual Eligible Demonstration Initiative

NYS's Dual Integration Planning contract application is due to CMS in April 2012, with a January 2014 start date. The demonstration would begin by passively enrolling dual eligibles who are part of the MLTCP initiative into a Medicare plan, preferably one that is linked to the long term care plan. They intend to begin with the Phase I and Phase II counties (NYC, Nassau, Suffolk, Westchester). Individuals will have the ability to opt out of the Medicare plan if they choose. Plans participating in the demonstration will be required to cover a comprehensive benefit package that includes Medicare services, including Part D; and Medicaid services, including all long term care and behavioral health services, which could be provided through the plan or contracted with a Behavioral Health Organization.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

During testimony before the Pennsylvania Senate Appropriations Committee on February 28, Welfare Secretary Gary Alexander noted that 80 percent of the Department's budget is controlled by the federal government. He explained that the federal maintenance of effort (MOE) provisions, in particular, were making it difficult for the Department to meet its budget targets. Sec. Alexander confirmed that the State recently sent a letter to CMS requesting relief from the MOE requirements including requesting that the State be allowed to raise the bar on who gets into nursing homes. He explained that this should help the Department in its efforts to shift a greater percentage of people into home and community based services. Sec. Alexander also reported that the Department was looking to build on its LIFE program (the capitated Living Independently for Elderly program). Commenting that providers in this "very successful program" had offered to take a decrease in reimbursement, he reported that the program saved between $5 and $7,000 when compared to nursing home care. The Secretary also said he is favorably inclined to support a capitated long term care model that would expand the MCO model across a broader population base to include duals. He indicated he hoped to have a proposal along these lines in the next three to six months. In addition, Sec. Alexander said the State was planning to expand its shared living program in the next fiscal year.

Additionally, it was announced that Pennsylvania received $33.8 million in federal Exchange grant funding. According to the State, the grant funding will be used for the following:

1) conducting extensive insurance market analyses;

2) establishing advisory groups;

3) determining the regulatory framework and contractual relationships needed to facilitate the development of a marketplace;

4) making decisions regarding governance;

5) developing and implementing a comprehensive plan to efficiently and effectively interface necessary government-operated programs;

6) developing a technical roadmap for the development of infrastructure or technology modifications, and, where appropriate, initiating these modifications;

7) determining necessary resources to perform financial accounting and reporting, and where appropriate, implementing financial and business operations;

8) developing and implementing a program integrity plan;

9) mitigating possible adverse selection;

10) determining target areas for focused consumer assistance;

11) performing an evaluation of needed business operations/functions.

OTHER HEADLINES

Alabama

- **Alabama Gov. Bentley seeks to trim child health insurance**

Gov. Robert Bentley has asked the federal government to let him lower the number of children who can qualify for ALL Kids, the state's public health insurance plan for children, because of a budget crunch. The program covers children from families at 300 percent of poverty and below; Bentley asked to lower that threshold to 200 percent of the poverty level. ALL Kids this year covers about 84,000 children and of those, about 15,800 are between 200 percent and 300 percent of poverty. Although the federal government picks up 78 percent of the cost of ALL Kids, Bentley said he asked the U.S. Department of Health and Human Services to allow the eligibility change because the state can't afford its 22 percent share. (AL.com)

Arkansas

- **Ark. Medicaid shortfall could hit $400M in 2013**

Arkansas' shortfall in its Medicaid program in 2013 will be even higher than officials expected and could hit $400 million, the state's Department of Human Services said Thursday. DHS spokeswoman Amy Webb said officials now estimate the Medicaid program will face between a $350 million and $400 million shortfall in the budget year that begins July 1, 2013. Officials had originally estimated the program would need at least $250 million in additional money that year. Webb said officials revised their estimates on the expected deficit over the past few weeks, and said the estimate was changed after budget hearings began in January. (CBS News)

Colorado

- **Colorado gets another $17.9 million to start health insurance exchange**

  The U.S. Department of Health and Human Services Wednesday awarded Colorado another $17.9 million to firmly establish the insurance exchange at the heart of national health reform. The second round of insurance exchange grants will allow the state board to hire more staff and contract with all-important tech and benefits vendors to shape the online guts of the plan. (Denver Post)

Connecticut

- **State seeking nursing home to take sick, disabled prisoners**

  Like many states, Connecticut has a growing population of older prisoners whose care, officials say, could be provided less expensively outside prison. The state already has legal mechanisms to parole inmates who are "physically incapable of presenting a danger to society," but they're rarely used, and Department of Correction staff often struggle to find nursing homes willing to take prisoners who could be paroled if suitable placements were available. In seeking to contract with a nursing home for about 95 beds, Connecticut officials say they're hoping to develop a workable pipeline when the number of people expected to use it is relatively small, rather than relying on case-by-case efforts to find beds for sick or disabled inmates when there are more in the system. (CT Mirror)

Idaho

- **Budget committee clears money to ready Medicaid for exchange**

  The Joint Finance-Appropriations Committee approved $4 million in funding to ready Idaho's Medicaid system for integration with an online exchange portal. Most of the money, about $3.6 million in all, comes from a federal match program. The state is asked to pay 10 percent of the costs, or about $400,000 of the initial allocation. (Idaho Reporter)

Kansas

- **Kansas, Missouri unlikely to meet deadline on health care**

  Kansas and Missouri are almost certain to miss an end-of-the-year deadline for establishing a key component of the nation's health care law — health insurance "exchanges" where individuals and businesses can compare and purchase coverage. The health law requires states to establish the framework for their exchanges by the end of this year, or tell the federal government they aren't interested. For months, experts in both states have been working quietly to figure out how to meet that Dec. 31 deadline. But conservative Republican lawmakers — concerned that the exchanges are an implicit endorsement of President Barack Obama's Affordable Care Act — have blocked further implementation of the exchanges. Those delays, experts said, mean Kansas and Missouri won't have their exchanges ready for federal government review by January 2013. (The Kansas City Star)

- **Brownback's Medicaid reform program lures five insurer bids**

  Five insurance companies have submitted bids to participate in KanCare, Gov. Sam Brownback's effort to remodel the state's Medicaid program. Announced Wednesday, the five are competing for three spots to oversee the program. The five are WellCare of Kansas, Sunflower State Health Plan (Centene), United Health Care, Coventry Health Care of Kansas, and Amerigroup. Kansas' largest health insurer, Blue Cross and Blue Shield of Kansas, announced earlier this month that it would not participate, saying the program would require significant changes to its business model. (BizJournals)

Kentucky

- **Medicaid managed-care problems mount, advocates tell panel**

  Problems with the state's new Medicaid managed-care system continue to mount, causing serious disruptions in care for people with mental illness, advocates told the Senate Health and Welfare Committee last Wednesday. Wednesday's hearing was one of several this legislative session in which doctors, pharmacists, hospital executives and others have expressed increasing frustration over late payments, bungled claims processing and delays in advance approval now required for many medical procedures and prescription drugs. While many of the complaints Wednesday focused on mental health care, others who testified described medication problems they said could be life threatening. (Courier-Journal)

Minnesota

- **Minnesota House committee advances bill seeking independent audits of nonprofit HMOs**

  Just a few weeks after learning of a federal investigation of the state's Medicaid program, a state House committee on Tuesday passed a bill to require annual independent financial audits for nonprofit HMOs that manage the care for most of the state's Medicaid beneficiaries. In addition to audits, the bill introduced by Rep. Steve Gottwalt, R-St. Cloud, would require that health plans give the state detailed data about the health care services provided to beneficiaries. It also would prohibit the actuarial firm that advises the state in evaluating health plans from also providing services to the HMOs. (Twin Cities Pioneer Press)

Missouri

- **Mo. changing rules for Medicaid `spend down' plan**

  Some low-income seniors and people with disabilities in Missouri could have to pay more out of their pockets to qualify for Medicaid coverage under changes being initiated after the state realized it was running afoul of federal rules. About 24,000 Missouri residents qualify for Medicaid _ even though their income is higher than the program's federal limits _ by "spending down" the difference between their monthly income and the federal eligibility limit. They do that in one of two ways _ sending the state a cash payment, sort of like a monthly insurance premium, or by submitting medical bills that show they spent that excess income on medications and treatments. (STL Today)

New Jersey

- **Health insurance exchange in works**

  New Jersey will receive a $7.7 million federal grant to help plan a state health insurance exchange, as mandated by federal health care reform, the Department of Health and Human Services announced Wednesday. The state will decide by June 29 whether to establish the exchange itself or let the federal government do it, he said. That is the deadline to apply for grants that are to be used to actually set up the state exchanges. Meanwhile, the Legislature is taking steps to define what type of insurance exchange New Jersey will have. A measure sponsored by Assemblyman Herb Conaway passed the Assembly Health Committee earlier this month and awaits a vote by the full Assembly. (NorthJersey.com)

Oklahoma

- **Oklahoma urged to form its own health insurance exchange**

  A joint legislative committee issues a final report suggesting the state consider using Utah's program. State must have plans in place for exchange by Jan. 1 or risk the federal government coming in and setting up a program. The mostly Republican Joint Committee on Federal Health Care Law, which met several times last year, suggested the state begin taking steps to establish a system similar to the one in Utah, which was established before the national health care law was written. (News OK)

Oregon

- **Major health reform bill passes with bipartisan vote in Oregon House**

  A health reform bill long in the making passed the House floor today, setting the stage for a massive overhaul of the Oregon Health Plan. Senate Bill 1580 passed by a vote of 53 to 7, setting guidelines for groups of hospitals, clinics and other providers to manage spending and care for the roughly 600,000 low-income people in the Medicaid-funded program. (Oregon Live)

Texas

- **Health Leaders Say They're Ready for Federal Reforms**

  On Monday, state officials at a joint meeting of the House Insurance and Public Health committees told lawmakers that Texas is ready to move forward with the Affordable Care Act next month, regardless of whether the U.S. Supreme Court strikes down parts or all of it. Lawmakers remain concerned over how Texas will fund the expected increase in Medicaid patients. The Health and Human Services Commission predicts that by the end of 2014, Medicaid will expand from 3.5 million beneficiaries to 4.7 million. HHSC is still calculating the actual cost to taxpayers, but it could be as much as $27 billion over the first 10 years, with the federal government paying for nearly all the cost of the new law in the first two years. For now, HHSC is complying with new requirements meant to improve the integrity of the entitlement enrollment process by increasing audits, identifying overpayments and increasing reimbursements to primary care physicians, among other measures. (Texas Tribune)

- **Medicaid overhaul could be beneficial to Central Texas health care**

  Central Health expects to play the lead role in coordinating the Medicaid overhaul in up to eight Central Texas counties. It will assist hospitals, health care organizations and local governments with complicated changes already moving down the track. On Friday, Central Health will host a meeting of Central Texas organizations affected by the overhaul. The Central Health board met in special session Saturday to discuss the changing health care landscape but took no action. The part of the discussion aimed at helping finance a medical school and a proposal to rebuild the public hospital it owns, University Medical Center Brackenridge, took place in closed session. (The Statesman)

Vermont

- **Vt. governor defends health care exchange**

  With the Vermont House poised to debate the next big step on the road to what Gov. Peter Shumlin hopes will be single-payer health care, the governor on Wednesday defended his proposed requirement that employees of small businesses get health insurance through a state-backed insurance market known as a health care exchange. Shumlin said about 96,000 Vermonters working for the 16,000 employers in the state with payrolls of 50 or fewer workers would be able to compare health plans, their benefits and costs on a website. The companies would have the option of continuing to offer employment-based health insurance — and get federal subsidies to do so — or let their employees buy federally subsidized health insurance on their own. His comments came as minority Republicans were drafting amendments to change key parts of the legislation. (Houston Chronicle)

Washington

- **Medicaid Cuts Rile Doctors**

  A plan by Washington state's Medicaid agency to stop paying for certain emergency-room visits is prompting pushback from hospitals and doctors, who say they will be stuck with bills for vital care they often are legally required to provide. The new cuts, set for April 1, focus on about 500 diagnoses including common infections, mild burns, strains and bruises. If an enrollee comes to an emergency room and is diagnosed with one of these conditions, the Washington Medicaid program won't pay the hospital and doctors. (Wall Street Journal)

United States

- **At-Risk Patients Gain Attention of Health Insurers**

  As the new federal health care law aims to expand care and control costs, the people in the medical 1 percent are getting more attention from the nation's health insurers. Many insurance executives say they are already developing programs to better address the needs of these patients. The insurers often work with employers that are self-insured to manage their workers' medical conditions, and companies are already demanding they do what they can to control costs. Insurance companies will be required to enroll millions of new customers without the ability to turn them away or charge them higher premiums if they are sick. They will prosper only if they are able to coor-

dinate care and prevent patients from reaching that top 1 percent, said Daniel Malloy, an executive at IMS Health. (New York Times)

- **Many States Take a Wait-and-See Approach on New Insurance Exchanges**

  States are lagging in the creation of health insurance exchanges, the supermarkets where millions of consumers are supposed to buy subsidized private coverage under President Obama's health care overhaul. Many states are waiting for a Supreme Court decision or even the November election results, to see whether central elements of the new law might be overturned or repealed. But that will be too late to start work. By Jan. 1, 2013, the Obama administration will decide whether each state is ready to run its own exchange or whether the federal government should do the job instead. (New York Times)

- **Governors split over effects of Obama's health-care law**

  The National Governors Association's health committee met Sunday morning in a downtown Washington hotel with the goal of recommending ideas to cut states' health-care costs for needy residents. Republicans and Democrats, as expected, disagree heartily about whether the health-care reform law is worth its benefits to state residents — or creates more harm by overburdening state budgets. (Washington Post)

- **Life, With Dementia**

  Dementia in prison is an underreported but fast-growing phenomenon, one that many prisons are desperately unprepared to handle. It is an unforeseen consequence of get-tough-on-crime policies — long sentences that have created a large population of aging prisoners. About 10 percent of the 1.6 million inmates in America's prisons are serving life sentences; another 11 percent are serving over 20 years. New York has established a separate unit for cognitively impaired inmates and uses professional caregivers, at a cost of about $93,000 per bed annually, compared with $41,000 in the general prison population. Pennsylvania and other states are giving mental health workers special dementia training. But some struggling prison systems, including those in Louisiana and California, are taking a less expensive but potentially riskier approach. They are training prisoners to handle many of the demented inmates' daily needs. (New York Times)

COMPANY NEWS

- **WellCare Announces Leadership Team Appointments**

  WellCare Health Plans, Inc. today announced the appointment of Daniel R. Paquin as president, National Health Plans. In addition, Lisa G. Iglesias has been named senior vice president, general counsel and secretary. Both executives will report to chief executive officer Alec Cunningham. Mr. Paquin joined WellCare on February 27, 2012. Ms. Iglesias joined WellCare in February 2010 as vice president and assistant general counsel, and has been serving as WellCare's acting general counsel since September 2011. (WellCare Press Release)

- **WellCare: Free at last?**

  After holding out for years, the chief whistleblower in the long-running case against WellCare Health Plans has removed his objection to a settlement of civil fraud charges with the federal government and nine states. In a filing in Tampa federal court on Thursday, Sean Hellein said he intends to sign the agreement that WellCare announced last May it had negotiated with the Civil Division of the US Justice Department. In filings with the Securities and Exchange Commission, WellCare has said the settlement amount is $137.5 million. WellCare will pay an additional $35 million if there is a "change in control" of the company within three years of the settlement signing, the U.S. Attorney's Office in Tampa said Friday. Of the total, Florida would receive about $23 million, according to previous filings. Florida Medicaid's major HMO contractors were WellCare subsidiaries during the time of the alleged fraud, 2005 to 2007. (Health News Florida)

- **Roxborough Memorial Hospital has new owner**

  A fast-growing California hospital chain has purchased Roxborough Memorial Hospital in Philadelphia, giving the 137-bed institution its third owner since 2002. Prime Healthcare Services, of Ontario, Calif., near Los Angeles, said Wednesday that it bought the hospital from Solis Healthcare L.L.C. but did not say what it paid. Prime Healthcare, a for-profit company founded in 2001 by its chairman, Prem Reddy, a cardiologist, already owned or managed 15 hospitals, 14 in California and one in Texas. (Philly.com)

- **Steward seeks law change, plans layoffs for Landmark**

  Steward Health Care System has completed the purchase application for Woonsocket's fiscally troubled Landmark Medical Center and has submitted plans that include layoffs, a name change and $30 million in investment and upgrades for the facility. The for-profit health care chain, however, must first pass the strict guidelines set forth in the Hospital Conversions Act, the legislation that guides the purchase of health care facilities in the state. And nearly nine months after submitting the winning bid for Landmark, Steward, which oversees 10 hospitals in neighboring Massachusetts, is seeking to alter HCA to eliminate the waiting period for buying more hospitals in Rhode Island. Steward representatives have said the outcome of the bill, H-7283, which

would waive the three year requirement for additional acquisitions, could affect their decision to move forward with the Landmark deal. (The Valley Breeze Newspapers)

- **WellCare Launches the CommUnity Commitment to Address Social Needs and Reduce Access Barriers to Health Care**

  WellCare Health Plans, Inc. recently launched a new social safety net services initiative, The CommUnity Commitment, during an open house event in Louisville, Kentucky. The CommUnity Commitment is an innovative approach to addressing health plan members' social needs, which if left unaddressed could become barriers to accessing health care. Through this effort, WellCare is building partnerships and connecting health plan members with community organizations that offer support in meeting basic social needs, including assistance with food, housing, transportation, utilities and more. WellCare's catalog of available social services, also known as the social safety net, will be compared to public health data to identify gaps developed as a result of increased needs. WellCare's grassroots councils will review collected data and identify ways to resolve these gaps. The information will then be used to jointly develop community health needs assessments with stakeholders such as public health departments, hospitals, primary care physicians and others, following an approach centered on evidence-based and outcomes-oriented strategies. (WellCare Press Release)

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. Dual eligible integration RFPs for Illinois, Massachusetts, and Ohio.

Date	State	Event	Beneficiaries
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 2, 2012	Ohio Duals	RFP Released	122,000
April 9, 2012	Ohio	Contract awards	1,650,000
April 13, 2012	Massachusetts Duals	RFP Released	115,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 30, 2012	Illinois Duals	RFP Released	172,000
May 11, 2012	Ohio Duals	Proposals due	122,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 15, 2012	Illinois Duals	Proposals due	172,000
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 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Contract awards	115,000
July 31, 2012	Illinois Duals	Contract awards	172,000
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
January 1, 2013	Illinois Duals	Implementation	172,000
January 1, 2013	Massachusetts Duals	Implementation	115,000
January 1, 2013	Ohio Duals	Implementation	122,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
October 1, 2013	Florida	LTC enrollment complete	90,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA Recently Published Research

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. The report augments 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

Kathleen 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

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

Linda Follenweider, Presenter

March 7, 2012

Chicago, Illinois