
HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup Trends in State Health Policy

IN FOCUS: KEY TAKEAWAYS FROM THE KAISER/HMA 50 STATE MEDICAID BUDGET SURVEY

HMA ROUNDUP: PROVIDERS RESPOND TO CMS' APPROVAL OF CALIFORNIA RATE CUTS;
VOLUNTARY ENROLLMENT OF DUAL ELIGIBLES IN MICHIGAN EFFECTIVE NOVEMBER 1;
PENNSYLVANIA EXPLAINS CASELOAD DROP

OTHER HEADLINES: KENTUCKY MEDICAID MANAGED CARE CONTRACTS WENT LIVE NOVEMBER 1; CMS
APPROVES CALIFORNIA RATE CUTS; PROVIDERS FACE ADDITIONAL RATE CUTS IN TENNESSEE

RFP CALENDAR: PENNSYLVANIA NEW EAST, NEW WEST RFP EXPECTED THIS WEEK

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*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: KAISER/HMA 50 STATE MEDICAID BUDGET SURVEY

This week, our *In Focus* section highlights key takeaways from the 50-state Medicaid budget survey report released last Thursday, October 27, by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates. The report, titled *Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends*, was prepared by Vernon K. Smith, Kathleen Gifford, and Eileen Ellis of Health Management Associates, as well as Robin Rudowitz and Laura Snyder from KCMU. The report draws from findings of the 11th annual budget survey of Medicaid officials in all 50 states and D.C. conducted by HMA and KCMU. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data from FY 2011 and FY 2012. The report provides detailed appendices with state-by-state information as well as a more in depth look through case studies of the Medicaid budget and policy conditions of three states (Minnesota, New York, Tennessee).

Link to Report: [\(PDF\)](#)

Link to Executive Summary: [\(PDF\)](#)

Link to Press Release: [\(KFF.org\)](#)

Key Takeaways from the Executive Summary

As a result of the recession, states experienced robust Medicaid spending and enrollment growth in FY 2011, but states are projecting lower growth for FY 2012.

Medicaid spending increased on average by 7.3 percent across all states in FY 2011 – very close to original projections of 7.4 percent growth. For FY 2012, legislatures authorized spending growth that averaged 2.2 percent, one of the lowest rates on record. Eleven states projected actual spending decreases. In some cases, these projections may understate actual spending increases for FY 2012, given that Medicaid officials in over half of the states reported a 50-50 chance of a Medicaid budget shortfall, and almost one-quarter indicated a Medicaid budget shortfall was almost certain for FY 2012. Enrollment growth, which drives spending growth, averaged 5.5 percent in FY 2011, somewhat lower than the 6.1 percent growth rate projected at the start of FY 2011. For FY 2012, states projected that the rate of enrollment growth, on average, would slow to 4.1 percent.

Increased federal assistance through the American Recovery and Reinvestment Act (ARRA) enhanced FMAP reduced the state share of Medicaid costs in FY 2009 and FY 2010, but the expiration of these funds means large increases in state funding for Medicaid in FY 2012.

From October 2008 through June 2011, states received federal fiscal relief from ARRA in the form of an enhanced federal match rate for Medicaid. These funds helped states support state budgets and their Medicaid programs. The ARRA enhanced FMAP reduced the state costs for Medicaid by increasing the federal share, resulting in an average decline in state general fund spending for Medicaid of 4.9 percent in FY 2010, following a drop of 10.9 percent in FY 2009. These were the only two declines in state annual spending for Medicaid in the program's history. As the ARRA enhanced FMAP began to phase

down over the final two quarters of the 2011 state fiscal year, state general fund spending increased on average by 10.8 percent for FY 2011. ARRA funds expired entirely as most states began FY 2012, when federal matching rates returned to statutory calculated levels. As a result, state spending had to be increased to replace the enhanced federal funds, contributing to large increases in state general fund spending for Medicaid of 28.7 percent in FY 2012.

Nearly every state implemented at least one new Medicaid policy to control spending in FY 2011 and FY 2012, but many states also implemented some expansions in eligibility and home- and community-based long-term care.

In FY 2011, 47 states implemented at least one new policy to control Medicaid costs, and 50 states planned to do so in FY 2012. Most states reported program reductions in multiple areas. Highlights of Medicaid policy changes for FY 2011 and FY 2012 include the following:

- The ARRA and ACA maintenance of eligibility provisions prevented states from restricting their Medicaid eligibility standards, methodologies or procedures, and despite tight budgets, many states reported eligibility expansions or enrollment simplifications. Thirty-three states in FY 2011 and 22 states in FY 2012 reported moving forward with positive eligibility changes.
- As in previous years, provider rate restrictions were the most commonly reported cost containment strategy. During economic downturns, states tend to freeze or reduce provider rates but often restore or enhance them when conditions improve. A total of 39 states restricted provider rates in FY 2011, and 46 states reported plans to do so in FY 2012.
- States continue to restrict benefits and implement cost containment strategies focused on prescription drugs. Eighteen states in both FY 2011 and FY 2012 reported eliminating, reducing or restricting benefits. Elimination of, or limits on, dental, therapies, medical supplies and DME and personal care services were most frequently reported.
- There is a notable increase in the number of states raising or imposing new copayments on beneficiaries. Copayments are currently required by most state Medicaid programs for various services, particularly prescription drugs for adults. Five states in FY 2011 and 14 states in FY 2012 increased copayment amounts or imposed new copayments. In contrast, only one state did so in FY 2010. Most copayment changes were for pharmacy and emergency room visits, although a few states, including Arizona, California and Florida, are requesting broader authority through waivers to impose copayments beyond nominal levels and to exempt populations.
- States continue to re-orient the delivery of long-term care to shift care away from institutions and into community settings. Thirty-two states in FY 2011 and 33 states in FY 2012 took actions that expanded LTC services (primarily expanding home- and community-based service (HCBS) programs). Conversely, a total of 14 states in FY 2011 and 11 states in FY 2012 took action to restrict LTC services.

States continue to adopt policies to expand managed care and enhance quality.

Seventeen states in FY 2011 and nearly half (24 states) in FY 2012 reported that they were expanding their managed care programs, primarily by expanding the areas and populations covered by managed care programs. Some states, including Kentucky, Louisiana, New Jersey, New York and Texas, are implementing either new or significant expansions of comprehensive managed care programs. States are also expanding the use of disease and care management programs and patient-centered medical homes to help coordinate care and focus on high-cost and high-need populations. States are using managed care as a vehicle to implement quality and performance strategies, such as tying payment or default enrollment to performance and adding quality measures for reporting.

New initiatives related to systems of integrated, coordinated care to serve dual Medicare–Medicaid eligibles were a top priority in FY 2011 and FY 2012.

The ACA created two new offices (the Medicare-Medicaid Coordination Office and the Center on Medicare and Medicaid Innovation) that are working with states to facilitate new approaches to improve the care for this population. In April 2011, CMS awarded \$1 million in planning contracts to each of 15 states for the development of integrated systems to serve dual eligibles. In July 2011, CMS released guidance that it would assist additional states in developing payment and delivery systems that would facilitate the coordination and integration of care for duals. Many states, including several of the 15 states who received contracts in April 2011, indicated that they had planned to submit proposals. Since the time of the survey, CMS has announced that 37 states have submitted letters of intent related to the opportunities announced by CMS in July 2011.

A number of states are pursuing Section 1115 Medicaid Demonstration Waivers to make program changes not otherwise allowable under federal Medicaid law.

The majority of states with waiver plans reported significant delivery system and/or provider payment reforms for broad or targeted populations, including duals or individuals with disabilities and special health care needs. Some states have approval from CMS for certain program changes or have applications pending; other states are still developing proposals and have not yet submitted formal applications to CMS.

Over the next few years, states will be required to implement significant health information technology (HIT) changes.

Four major HIT initiatives are common across most states, with timelines for implementation that are driven by national deadlines:

- Medicaid Electronic Health Record (EHR) certification and incentive programs
- Major upgrades to claims payment systems
- Updates to the coding system for medical claims
- Implementation of health reform in 2014 requires major Medicaid IT development, particularly for Medicaid eligibility systems and new systems developed for state Health Insurance Exchanges

In addition, states are also using data systems to monitor for fraud and abuse to assure the highest level of fiscal and program integrity.

As states continue to grapple with historically difficult budget conditions, they must also plan for the implementation of the ACA, which envisions new roles for Medicaid and for states.

Under health reform, Medicaid will be expanded to cover nearly all individuals with incomes below 133 percent of poverty, resulting in a large adult expansion in most states. Medicaid officials are playing a lead role in preparing for health reform implementation, in many cases alongside insurance commissioners. While reform presents the opportunity to dramatically reduce the number of uninsured, states identified a number of concerns related to ACA implementation, including the fiscal impact of health care reform, tight implementation timelines, lack of clear federal guidance, limited staff and administrative resources, the need to streamline eligibility and coordinate with new Exchanges, systems and IT issues, provider access issues, and political challenges in states with significant ACA opposition. State officials also discussed some of the issues and questions associated with transitioning to the new Modified Adjusted Gross Income (MAGI) eligibility methodology. (Concerns about MAGI were largely raised prior to the release of a proposed rule on these issues by CMS on August 4, 2011). To help develop new eligibility systems, three-quarters of the states indicated that they would take advantage of the new 90 percent federal match rate for eligibility systems made available under a final CMS regulation adopted in April 2011.

Looking to the future, Medicaid is poised to play a greater role in health care coverage, to lead the way in innovative payment and delivery models, and to remain front and center in state and federal budget discussions.

Despite the intense focus on cost containment efforts due to unrelenting fiscal pressure, Medicaid directors pointed to a range of program improvements and strategies now underway, particularly changes related to care delivery and payment systems. These initiatives are designed to improve the program in the near term and to better position the program for the ACA-required eligibility expansions to cover more low-income Americans. However, as states take on the immediate challenges of running their programs and look to the implementation of health reform, they are raising concerns that federal discussions related to debt and deficit reduction might achieve federal savings by shifting more Medicaid costs to states, thereby compromising their ability to move forward. In many ways, Medicaid programs have proven to be a resilient part of the nation's health care infrastructure, innovating and adapting to opportunities afforded by an evolving health care system and implementing new provisions of federal law while holding down cost increases. The current challenges may appear daunting, but Medicaid directors communicated that they and their programs are poised for a greater role in health care delivery and are committed to assuring access to high-quality care delivered in the most effective manner possible.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

The big news in California this week was the announcement that CMS had approved the proposed 10 percent rate cut to providers retroactive to July 1. Specifically, the following rate changes were approved:

- A 10 percent provider payment reduction on a number of outpatient services, including physicians, clinics, optometrists, therapists, laboratories, dentists, durable medical equipment and pharmacy.
- A new 10 percent provider payment reduction for freestanding nursing and adult sub-acute facilities.
- A 10 percent provider payment reduction and rate freeze for distinct part/nursing facility-B services.

After the California Department of Health Care Services conducted a review of the potential impact that the proposed rate reductions would have on beneficiary access to care, DHCS concluded that there were some areas where an additional 10 percent payment reduction was not advisable. Therefore, DHCS did not move forward with the 10 percent reduction to physician/clinic services for children, home health services or distinct part sub-acute facilities. DHCS is still reviewing some long-term care services to determine if additional proposed reductions should be reduced or if any additional reduction would be appropriate.

The provider community in California has expressed its surprise and dismay about CMS' decision, and it is likely that litigation will continue. As a reminder, the Supreme Court is already hearing a case related to proposed rate cuts that were passed in 2008 but blocked by the ninth circuit court. Managed care companies are likely to pass through the rate cuts to physicians where possible. To the extent that the rate cuts result in reduced access to specialist physicians, however, the site of care for certain services may shift to hospitals, which would adversely impact the managed care organizations.

In the news

- **Advocates, Health Plans, State Eyeing ADHC Hearing**

If a settlement cannot be reached on the elimination of adult day health care (ADHC) in Med-Cal, a federal court hearing is scheduled for Nov. 8. The state is working on a relatively short timeline. It needs to line up other care choices for this population by Dec. 1, when Medi-Cal coverage of ADHC services is set to expire. The state's first step was to offer managed care choices to ADHC beneficiaries, with the intent to shift beneficiaries into managed care programs. The next step -- assessing the health needs of those ADHC beneficiaries -- is more involved. The state set a 45-day window, from Oct. 1 to Nov. 15, to contact and assess all of those 35,000 ADHC beneficiaries. As of Oct. 21, about halfway into the effort, about 3,785 assessments had been completed, Williams said, but that estimate is rough and includes a wasted week where some data weren't

available. Also, Williams said, the pace of those assessments recently picked up and that trend isn't reflected in the total number. If the assessments can be completed on time by Nov. 15, the next challenge is to make some sort of plan for those people before the Dec. 1 elimination date. ([California Healthline](#))

Illinois

HMA Roundup – Matt Powers / Jane Longo

At the next meeting of the Medicaid Advisory Committee (MAC)'s Care Coordination Subcommittee, the committee will consider the HEDIS and HEDIS-like performance measures that will be included in the Innovations Project solicitation. To the extent similar populations are being covered, the State will utilize uniform measures to compare the differing care coordination models. The Subcommittee meeting will be held on Tuesday, November 15, from 10 a.m.-Noon in both Springfield and Chicago.

In the news

- **Health insurance exchange bill moves forward**

Rep. Frank Mautino last week introduced into the Illinois General Assembly a bill that appears to offer answers to some key questions about the exchange, such as the composition of the board that would run it. But the bill leaves open other key points, such as how operations would be funded. Some observers expect the exchange bill to be considered during the General Assembly's fall veto session, which has been dominated by heated debate over an expansion of gambling and the passage of guaranteed electricity rate hikes over Gov. Pat Quinn's objection. Rep. Mautino is also co-chairman of the Illinois Health Benefits Exchange Legislative Study Committee, which last month approved a report about the exchange that some consumer advocates criticized. ([Crain's Chicago](#))

Indiana

HMA Roundup – Catherine Rudd

Indiana issued an RFP for vendors to provide maintenance and modification services to support its current (and ancient) integrated eligibility system for Medicaid, Food Stamps and TANF. A proposal conference was held on 10/27. Bids are due 11/30. Contract will be for a two-year term beginning 4/1/2012, with options to extend for additional two years. Deloitte is the incumbent.

In the news

- **Indiana group for disabled pushes improved services**

More people with intellectual and developmental disabilities could work and live at home under changes recommended in an advocacy group's plan, which also raises the possibility of converting the state's largest agency into a quasi-governmental entity. The Arc of Indiana said its Blueprint for Change, released Tuesday, is the result of 18 months of work by national leaders in the field of developmental disabilities, people with disabilities and professionals in Indiana seeking ways to improve care with shrinking budgets and resources. The core approach of the plan is to find employment

outside the home – whether paid or volunteer work – for even the most severely disabled, while providing families with the resources they need to cope. Part of the plan involves building more flexibility into the state's Medicaid waiver program to redirect funds to families and individuals instead of group homes and nursing homes in return for lower overall spending. As much as \$25 million a year could be saved simply by helping disabled people living on their own to find roommates with whom they can share services. ([Northwest Indiana Times](#))

Michigan

HMA Roundup – Esther Reagan

We previously reported that the Department of Community Health (DCH) had issued a proposed policy that would allow most dual eligibles to voluntarily remain or enroll in Medicaid Health Plans as soon as October 1, 2011. A final policy was issued by DCH on October 1, 2011, announcing the effective date as November 1, 2011, subject to approval of the policy by the federal Centers for Medicare and Medicaid Services (CMS). Details regarding CMS' concerns are unknown.

The Director of Michigan's Department of Licensing and Regulatory Affairs (LARA), Steven Hilfinger, announced on October 27, 2011 that the state has applied for \$9.8 million in federal grant funds to continue development of the MIHealth Marketplace, a health insurance Exchange for Michigan. This second round of grant funds would be in addition to the \$1 million previously received for Exchange planning activities. The state should know in November whether the application was successful. Any federal funds awarded will need to be appropriated by the Legislature. Mr. Hilfinger also announced that another grant application for federal funds, for information technology support, will be submitted in December.

DCH is establishing a work group to study the methodology through which Disproportionate Share Hospital (DSH) funds are paid to hospitals serving Medicaid beneficiaries. Review of the distribution policy will culminate with a report to the legislature by March 1, 2012. The House is considering the policy as well, and several hospitals provided testimony at a recent subcommittee hearing, encouraging a change in the methodology to provide more DSH funds for their facilities.

New York

HMA Roundup – Denise Soffel

On November 1, 2011, the Medicaid Redesign Team (RT) met and submitted final recommendations ([available here](#)), which included the following:

- New York should establish its own health insurance Exchange to best meet the needs of its residents and small businesses. The MRT urged the state to enact authorizing legislation establishing a New York Health Benefits Exchange to allow the state to be deemed "operationally ready" by January 1, 2013. The MRT warned that failure to enact Exchange legislation in a timely manner jeopardizes significant federal funding for the establishment of New York's Exchange, increases the likeli-

hood of a federally run Exchange in New York, impedes Medicaid modernization, and enhances the potential for adverse impacts on the state insurance market.

- The State should develop and implement a plan for more sustainable Medicaid financing that phases out reliance on local taxes (e.g., property taxes). In New York, approximately 30 percent of the non-federal cost of Medicaid is paid through local taxes.
- New York must have one eligibility determination and enrollment system for its Medicaid program and all Medicaid-eligible sub-populations (i.e., over 65, non-MAGI, under 65, MAGI, those who need health care services, and those who need long term care services). While the state may implement this system incrementally for these populations, there must be a plan that sets certain implementation dates for each Medicaid sub-population. These dates should fall within the period during which the federal government will fund the development and implementation of this system at 90 percent FMAP.
- The MRT also outlined a series of principles related to improved care coordination models for the managed long term care program and the behavioral health carve-out.

In the news

- **Medicaid team passes four sets of reform proposals**

Members of the Medicaid Redesign Team yesterday voted to accept proposals from four of its work groups—but only after member Stephen Berger threatened not to vote on one set of proposals because of the costs. At those earlier meetings, MRT members questioned how New York would pay for the sweeping changes and whether hospitals and other providers would be on the hook for cost increases because of the global cap on Medicaid spending. Medicaid Director Jason Helgeson said New York was working on a way to pay for reforms with expensive upfront costs, mentioning again the state's intent to apply for a federal waiver to get Washington to share \$18.8 billion in federal savings. The complete presentation on yesterday's approved proposals is at www.health.ny.gov. (Crain's New York)

- **NY Medicaid auditors save millions on a hunch**

Auditors in the Medicaid Inspector General's Office recently discovered that managed care companies often inaccurately billed the government health program based on where patients got care, not where they lived. That meant some health care providers were getting paid more than the program allowed. Gov. Andrew Cuomo said the error was costing New York taxpayers \$8 million per month. Medicaid's payments to health care providers vary considerably from county to county, mostly to account for differences in the cost of living between places like Manhattan, and rural upstate towns. Many health care providers are in counties with higher reimbursement rates, but they are still supposed to be paid based on where the patient lives. State officials chalk it up as a mistake, or "locator code error," not fraud. But the fix has already saved \$41.3 million in five months — half of it state dollars. The state has recovered another \$16 million. ([Wall Street Journal](#))

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

In testimony before the Pennsylvania House Republican Committee, Tim Costa, the Executive Deputy Secretary of the Department of Public Welfare, provided updated information on the recent decline in Medicaid Assistance eligibility in Pennsylvania. Costa reported that there were more than 154,000 cases overdue for eligibility reviews at the beginning of the fiscal year (July 2011). In addition “there was a backlog of information from data sources that potentially affect eligibility and those items also needed to be reviewed.” Costa emphasized that because of rigorous program integrity efforts to enforce current rules and regulations, the result of the reviews has been the disenrollment of over 100,000 individuals in Medical Assistance. Some of these individuals were recently deceased, had moved out of state, or were no longer eligible to receive these services. Not unexpectedly, Laval Miller-Wilson, executive director of the Pennsylvania Health Law Project, predicted many of those who lost their benefits would wind up reapplying, “It’s a vulnerable population that received these notices,” he said. Nonetheless, the Department has estimated that the closing of these cases will save about \$25.1 million, much of which is the result of a drop in the monthly capitation payments for ineligible persons enrolled in managed care programs.

Costa also provided an update on the cost containment initiatives included in the 2011-2012 Pennsylvania State Budget. The six-prescription-per-month limit for adults is expected to save \$14 million; the Hospital Assessment will bring in \$50 million in new revenue; limits on adult dental services will result in \$20 million in savings; and increased copayments for subsidized child care will produce approximately \$16 million in savings.

Additional savings are expected from a reduction in exceptions in community-based waiver services, implementing or increasing co-payments, and reducing behavioral health managed care investment funds. Another change in the works is drug testing for welfare beneficiaries who have a previous felony drug conviction, which would likely reduce enrollment. Costa said a pilot program in one county was expected to begin in January, with the entire state to follow over the next six to eight months.

OTHER HEADLINES

Florida

- **Finding more filth, abuse, state moves to shut ALFs**

For five months, state regulators have been slapping the state’s harshest actions on dozens of homes, forcing the shutdown of 10 troubled facilities. Prompted by a Miami Herald series showing the state was failing to close bad homes, the Agency for Health Care Administration began cutting state dollars and banning new residents from a dozen facilities. Now, the state is moving to strip the licenses of at least 34 homes – nearly doubling the rate before the crackdown – after finding that residents were in danger. ([Miami Herald](#))

Hawaii

- **\$540M in Medicaid contracts delayed**

The state Department of Human Services has pushed back by a month the start of a new \$540 million Medicaid contract as it waits for federal approval on a host of amendments it made to the request for proposal it issued in August. Sources say delaying the annual contract is not unusual for the department, given the complexities of the procurement process for administering the Medicaid, or QUEST, program in Hawaii. ([Pacific Business News](#))

Kentucky

- **U.S. approves managed care for Kentucky Medicaid**

Federal authorities have given final approval to the state's new Medicaid managed care plans, allowing the program to be launched on Tuesday. Centers for Medicaid and Medicare Services notified Kentucky Friday that it was satisfied that Kentucky is prepared for the transition. The new managed care contractors, selected after a bidding process this year, are Coventry Cares of Kentucky, Kentucky Spirit Health Plan and Wellcare of Kentucky. And Kentucky renewed its contract with its one prior managed care contractor, Passport, which serves Medicaid recipients in Jefferson and 15 nearby counties. Monday's news release said Medicaid recipients who will be covered by one of the three new contractors have received member cards. ([Courier-Journal](#))

Louisiana

- **Louisiana Medicaid program has \$127 million shortfall**

Louisiana's Medicaid program for the poor, elderly and disabled has a nearly \$127 million state funding shortfall, the health department announced Tuesday, saying it would use one-time federal cash and reshuffle other funds to fill much of the gap. The Department of Health and Hospitals also will add new hurdles and tighten prior authorizations for people who want to receive mental health rehabilitation treatment, and DHH will try to slow enrollment in programs that provide home- and community-based services to the elderly and disabled. The agency must close the deficit before the budget year ends June 30. The rates paid to providers for taking care of Medicaid patients won't be reduced to fill the hole. The shortfall is about 5 percent of the state funding in the Medicaid program, and it's caused by growth in Medicaid enrollment and people using more services than expected. ([NOLA.com](#))

Maine

- **Insurer profits at issue in Anthem Health Plans of Maine suit**

A lawsuit challenging Maine's authority over health insurers' profit margins is drawing national attention from state regulators worried about the impact on their power to hold down rate increases. The state's highest court has scheduled oral arguments Nov. 10 on a case brought by a Maine unit of WellPoint, one of the nation's largest health plans. Anthem Health Plans of Maine argues that regulators violated state law and the U.S. Constitution when they reduced requested premium increases in each of the past three years, depriving the company of "a fair and reasonable return." ([Washington Post](#))

Massachusetts

- **Delegation argues for extension of Massachusetts Medicaid waiver**

The Massachusetts congressional delegation today sought to maintain federal funding for the state's safety-net hospitals providing health care for the poor. The letter said renewing the state's waiver would help strengthen Massachusetts' safety-net hospitals and maintain the momentum and ongoing implementation of the state's health care overhaul. The senators and representatives requested that the Centers for Medicare and Medicaid Services keep the funding for Massachusetts safety-net hospitals. A waiver would enable the state to continue its subsidized insurance plans as well as help fund new programs such as ones focused on improving care for children with severe asthma. The money would also enable hospitals and doctors to better coordinate care and reform payment and delivery systems. Massachusetts' previous waiver expired over the summer and the state has been operating under a series of temporary extensions, the latest of which will expire Nov. 30. ([Boston Globe](#))

- **Mass. to revamp health care for disabled adults**

Massachusetts is planning to streamline the way it provides health care to more than 100,000 low-income and disabled adults, who often have trouble navigating a confusing bureaucratic maze of sometimes contradictory regulations. The goal is to both improve quality and cut costs. The adults, including people with mental illness, drug and alcohol addictions, and development disabilities, are enrolled in both Medicaid and Medicare. The state and federally run programs often have different rules and pay for different services. Gov. Deval Patrick's administration will release a draft within two weeks of a plan to enroll most of those patients in a network of providers that would receive one payment to provide all services to a patient, including medical and dental care and support services. ([Boston Globe](#))

Nebraska

- **A first look at health insurance exchange**

Nebraska lawmakers got a peek at the potential skeleton of a state health insurance exchange Friday. But officials with the State Department of Insurance urged them not to proceed with setting up an exchange during next year's legislative session. State Insurance Commissioner Bruce Ramage said too much remains unknown for Nebraska to make a good choice among the options: operating its own exchange; partnering with the federal government on an exchange; or leaving the job entirely to the federal government. He recommended that the decision be delayed until later next year, even if it means lawmakers have to come back in special session. ([Omaha World-Herald](#))

New Hampshire

- **2 Hospitals, Several Medical Offices To Refuse Medicaid**

LRG Healthcare, which operates Lakes Regional General Hospital and Franklin Regional Hospital, announced that its facilities would no longer accept new or existing patients on Medicaid by mid-November. Company officials said financial challenges prompted the decision that will affect more than 3,000 patients. Letters citing unprecedented financial challenges and announcing the decision were sent to patients. LRG

Healthcare officials said a reduction in Medicaid payments and a reduced demand for services due to a weak economy forced them to reduce staff and cut overhead. Officials said they were still operating with a \$4 million loss. ([WMUR.com](#))

North Carolina

- **CenterPoint approved to manage area services**

The state approved CenterPoint Human Services as a Medicaid waiver program and local advocates and officials said they are hoping CenterPoint will improve its responsiveness to local needs by becoming a managed-care organization. The primary goal of the waiver – scheduled to go into effect statewide Jan. 1, 2013 – is combining the management of Medicaid and state funds at the community level to reduce costs and add more accountability and consistency to mental-health reform. The waiver allows local management entities (LMEs) to operate with fewer restrictions on how they manage the mental health, developmental disability and substance-abuse providers and services they oversee. CenterPoint's first application was rejected in July, primarily because a health-care consultant, Mercer, questioned the agency's financial liquidity, information technology and clinical operations. Mercer also said CenterPoint had to improve its mechanisms for detecting provider fraud and abuse. CenterPoint becomes the 10th, and potentially final, LME to gain state approval. It covers Davie, Forsyth, Rockingham and Stokes counties. ([Winston-Salem Journal](#))

- **Different takes on NC Medicaid shortfall argued**

State health regulators told the Legislature's chief oversight committee they're falling short of meeting \$356 million in net reductions for the division that oversees Medicaid, the government-run health care plan for poor children, older adults and the disabled. They said the savings are difficult, if not impossible to come by this year in part due to slow enrollment of the chronically ill in the state's managed-care arm. The state Medicaid agency also must make repayments for accounting errors and improper billings that occurred years ago. Less than half of the more than 40 proposed changes to the state Medicaid program to find savings have yet to be approved by the Centers for Medicare & Medicaid Services, according to a presentation to legislators. ([Business Week](#))

Tennessee

- **Some health care providers facing 4.25% cuts**

The federal government's failure to pay back \$82 million it owes TennCare is sending shudders through some segments of Tennessee's health care industry that now face 4.25 percent cuts in their Medicaid reimbursements. Nursing homes warn that the reductions could lead to layoffs in at least some of the estimated 325 facilities in the state. TennCare managed care organizations such as BlueCross BlueShield of Tennessee also would be affected. Officials with the federal Centers for Medicare and Medicaid Services acknowledge that the state is owed, but said they couldn't return the money without congressional authorization. Absent state or federal action, the cuts are scheduled to take effect Jan. 1. ([Times Free Press](#))

Vermont

- **Report: Universal health care system in Vermont could cost as much as \$9.5B a year by 2020**

New projections by the state of Vermont say a public, universal health care system would cost between \$8.2 billion and \$9.5 billion a year – roughly \$13,000 to \$14,000 per resident – by 2020, but that sticking with the current system based on private insurers would cost even more. Without a health care overhaul approved by lawmakers this year, including a new law that could move Vermont closer than any other state to a single-payer system, costs would surpass \$10 billion by 2020, the report said. Lawmakers asked for the cost estimates by Nov. 1, but they still must determine how to pay for the new system. Officials said residents will get a chance to offer ideas at a series of forums to be held in November and December. No final decision is expected until early 2013. ([Washington Post](#))

Washington

- **Gregoire outlines grim choices for budget cuts**

For the fourth year in a row, Gov. Chris Gregoire on Thursday outlined more than \$1.5 billion in state cuts to health care, social services, prisons and education. The latest round would increase public-school class sizes, eliminate subsidized health care for the working poor and release hundreds of inmates early. The Legislature is to convene in a special session Nov. 28 to start rewriting the \$32.2 billion two-year budget adopted in May. It's now about \$2 billion in the hole. The governor has proposed more than 160 individual cuts ranging from \$100,000 to more than \$100 million. All told, they add up to \$1.65 billion. ([The Seattle Times](#))

- **11,000 may rejoin state's Basic Health plan**

About 11,000 people who were kicked off the state's Basic Health insurance program for the working poor in March because of their immigration status will be allowed to re-enroll after a federal court judge said the state likely had violated their constitutional equal-protection rights. Nearly 1,600 are immigrants who are in the country legally but have been "lawfully present" for less than five years; the others didn't supply information to the state about their resident status in time to avoid being removed from the program. Earlier this year, the state, under budget pressure that nearly shut down the subsidized program, adopted new rules to qualify for federal funds. The new rules required that participants be legal U.S. residents who have been in the country for at least five years. ([Seattle Times](#))

Wisconsin

- **Walker adjusts plan to close \$554 million gap in Medicaid programs**

Gov. Scott Walker's administration tweaked its proposals Monday to close a half billion-dollar budget hole in the state's health plans for the poor as a deadline approaches for deciding whether the state will drop the health coverage of tens of thousands of state residents. The state Department of Health Services made the changes in a 238-page plan being sent for review to the Legislature's budget committee, which is expected to take up the proposal next week. There is a \$554 million estimated deficit in

state and federal money through June 2013 in state Medicaid health programs. In closing that gap and controlling fast-growing costs, Health Services Secretary Dennis Smith has said the state would try to avoid dropping residents with no other options for health insurance. Instead, officials will look at shifting more than 200,000 people into a plan with lower costs but fewer benefits for recipients. To follow through on its plans, the state will need approval by Dec. 31 from the federal government to waive rules that prohibit those sorts of changes. Otherwise, Wisconsin could be forced to drop 53,000 adults from its health plans under a year-end deadline included in the budget law passed this summer by Republican lawmakers and Walker. ([Journal-Sentinel Online](#))

United States

- **CMS Should Plan For Delayed Opening Of Exchanges, Groups Say**

State officials and insurers are urging the Centers for Medicare and Medicaid Services to begin planning for delays in launching some functions of health insurance exchanges under the health care law, saying that short time frames and limited vendor capacity to create the marketplaces make such planning prudent. The National Association of Medicaid Directors said, in a comment on proposed requirements for exchange determinations of Medicaid eligibility, that "for many states the combination of diminished state capacity and limitations on vendor expertise ... present a significant challenge to meeting the statutory deadlines" (CQ Healthbeat)

- **Supreme Court to decide if suits can be filed over Medicaid cuts**

The Supreme Court heard oral arguments earlier this month in *Douglas v. Independent Living*, which asks whether patients and healthcare providers have the right to sue states over proposed Medicaid cuts. Federal law says state Medicaid rates have to be high enough to ensure that patients have access to the care they need. Only the federal government has the explicit legal authority to say whether a state's proposal would violate that requirement. The issue before the Supreme Court is whether private parties can take to the courts when they believe a cut would diminish access and the federal government hasn't made a decision. But the federal government made that determination Thursday, when the Centers for Medicare and Medicaid Services (CMS) approved the 10 percent reductions proposed by California — the same cuts at issue in the Supreme Court case. ([The Hill](#))

PRIVATE CO. NEWS

- Welsh, Carson, Anderson & Stowe has acquired Matrix Medical Network, a Scottsdale, Ariz.-based prospective health assessments for Medicare Advantage health plans. No financial terms were disclosed. Matrix Medical had raised VC funding from firms like Ballast Point Ventures and Spring Bay Capital. www.wcas.com
- Pioneer Behavioral Health said Wednesday that its stockholders approved its planned sale to Acadia Healthcare. The deal was announced in May. Acadia, which operates 19 behavioral facilities around the country, is backed by Waud Capital. The transaction is expected to close on or about Nov. 1. [More here](#)

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. This week, we highlight that Kentucky received approval from CMS to move forward with its Medicaid managed care program which then went live on November 1. As reminder, Centene, Coventry and WellCare are the new entrants into that market alongside Passport Health Plan. We also highlight the Pennsylvania Medicaid managed care RFP is expected to be released imminently but the exact date is uncertain.

| Date | State | Event | Beneficiaries |
|-------------------|-----------------------------|--------------------------------|---------------|
| Imminent | Pennsylvania | RFP Released | 565,000 |
| November 18, 2011 | Hawaii | Proposals due | 225,000 |
| November, 2011 | Pennsylvania | Proposals due | 565,000 |
| December 1, 2011 | Kentucky RBM | Implementation | N/A |
| December 2, 2011 | Washington | Proposals due | 800,000 |
| December 6, 2011 | Nebraska | Proposals due | 75,000 |
| December 23, 2011 | Hawaii | Contract awards | 225,000 |
| January, 2012 | California (Central Valley) | Evaluation (delayed) | N/A |
| January 1, 2012 | Virginia | Implementation | 68,000 |
| January 15, 2012 | New Hampshire | Contract awards | N/A |
| January 16, 2011 | Hawaii | Implementation | 225,000 |
| January 17, 2012 | Washington | Contract awards | 800,000 |
| January 31, 2012 | Ohio | RFP Released | 1,650,000 |
| February 1, 2012 | Louisiana | Implementation (GSA A) | 892,000 |
| March 1, 2012 | Texas | Implementation | 3,200,000 |
| March 1, 2012 | Massachusetts Behavioral | Implementation | 386,000 |
| February 28, 2012 | Nebraska | Contract awards | 75,000 |
| April 1, 2012 | New York LTC | Implementation | 200,000 |
| February 1, 2012 | Louisiana | Implementation (GSA B) | 892,000 |
| February 1, 2012 | Louisiana | Implementation (GSA C) | 892,000 |
| July 1, 2012 | Washington | Implementation | 800,000 |
| July 1, 2012 | Florida | LTC RFP released | 2,800,000 |
| July 1, 2012 | New Hampshire | Implementation | N/A |
| July 1, 2012 | Nebraska | Implementation | 75,000 |
| July 15, 2012 | California (Central Valley) | Implementation | N/A |
| September 1, 2012 | Pennsylvania | Implementation - New West Zone | 270,000 |
| January 1, 2013 | Florida | TANF/CHIP RFP released | 2,800,000 |
| March 1, 2013 | Pennsylvania | Implementation - New East Zone | 295,000 |
| October 1, 2013 | Florida | LTC enrollment complete | 2,800,000 |
| October 1, 2013 | Florida | TANF/CHIP enrollment complete | 2,800,000 |

HMA RECENTLY PUBLISHED RESEARCH

Managing Medicaid Pharmacy Benefits: Current Issues and Options

Vernon K. Smith, Managing Principal
Sandy Kramer, Senior Consultant

This report examines reimbursement, benefit management and cost sharing issues in Medicaid pharmacy programs. The analysis, conducted by researchers from the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, focuses on the potential of several measures recently highlighted by HHS Secretary Kathleen Sebelius to reduce Medicaid pharmacy costs. The findings were informed, in part, by the perspectives of a group of Medicaid pharmacy administrators convened by the Foundation in May 2011. ([Link to report](#))

A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey

Vernon K. Smith, Managing Principal
Kathleen Gifford, Principal
Dyke Snipes, Principal

This 50-state survey, conducted by the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, provides a comprehensive look at state Medicaid managed care programs, documenting their diversity, examining how states monitor access and quality, and exploring emerging efforts to improve care, including managed long-term care and initiatives targeted toward dual eligibles. The survey was released September 13, 2011, at a public briefing at the Kaiser Family Foundation's Washington, D.C. office.

Links to the report and presentations below:

Link to report: ([PDF](#))

Link to presentations: ([.WMV Video](#)); ([.MP3 Audio](#))

UPCOMING HMA APPEARANCES

American Evaluation Association: A Mixed-Methods Approach to Understanding the Impact of Requiring Citizenship Documentation for Medicaid Enrollment

Caroline Davis, speaker

November 3, 2011

Anaheim, California

Medicaid Health Plans of America Annual Meeting

Vernon K. Smith, Keynote Speaker

November 7, 2011

Washington, DC

CMS Webinar: State Medicaid HIT Plan & HIT Implementation Advance Planning Document Community of Practice

M. Reneé Bostick, Facilitator

November 7, 2011

Webinar (State Medicaid HIT Staff Only)

National Association of Medicaid Directors Annual Meeting: “The New Eligibility Paradigm”

Vernon K. Smith, Panelist

November 8, 2011

Arlington, Virginia

American Medical Association Council on Medical Service Innovation

Vernon K. Smith, Speaker

November 11, 2011

New Orleans, Louisiana

PhRMA Annual Meeting for State Government Affairs and State Policy

Vernon K. Smith, Speaker

November 15, 2011

Reston, Virginia

NGA National Summit on Government Redesign: “Opportunities for Medicaid Redesign”

Vernon K. Smith, Speaker

December 13, 2011

Washington, DC