
HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup Trends in State Health Policy

IN FOCUS: GEORGIA MEDICAID REDESIGN CONSULTANT RECOMMENDATIONS

HMA ROUNDUP: ILLINOIS RELEASES PHASE 1 CARE COORDINATION RFP; FLORIDA HOUSE BUDGET PROPOSES PROVIDER RATE CHANGES; NEW YORK GOVERNOR'S BUDGET PROPOSAL CALLS FOR CAP ON EXECUTIVE COMPENSATION FOR STATE CONTRACTORS

OTHER HEADLINES: CMS RELEASED ADDITIONAL GUIDANCE REGARDING DUAL ELIGIBLE INTEGRATION DEMONSTRATIONS; HAWAII AWARDS MEDICAID MANAGED CARE CONTRACTS; ILLINOIS OKAYS NURSING HOME TAX; WHITE HOUSE RELEASES HEALTH INSURANCE EXCHANGE PROGRESS REPORT

HMA WELCOMES: GREG BUCHERT, LOS ANGELES

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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: GEORGIA MEDICAID REDESIGN CONSULTANT RECOMMENDATIONS

This week, our *In Focus* section reviews the recommendations provided to the Georgia Department of Community Health (DCH) by Navigant Consulting in its Friday, January 20, 2012 report. Navigant was contracted by DCH to review the existing Medicaid program in Georgia and provide recommendations, based on both a national scan of best practices across Medicaid systems, as well as an evaluation of the Georgia Medicaid environment. Below we provide a brief overview of the current Medicaid landscape in Georgia, and highlight the key recommendations and overall direction of the Navigant report.

Georgia Medicaid

The Georgia Families program provides Medicaid managed care coverage to over 1.1 million beneficiaries. WellCare has a roughly 50 percent market share of these enrollees, with Amerigroup and Centene roughly splitting the remainder. Until earlier this month, WellCare was the only plan authorized to participate in the Georgia Families program statewide. As of January 1, 2012 Centene began serving members across the state and Amerigroup is also working toward that goal. Accordingly, we would expect the market share distribution across each of the three plans to gradually become more balanced over time.

Currently, the Georgia Families program is limited to the TANF and CHIP populations. Aged, blind, and disabled (ABD) Medicaid enrollees remain in the fee for service delivery system. This includes dual eligible beneficiaries that are high utilizers of behavioral health services, long-term care services, and home and community-based services (HCBS). In FY 2010, Georgia spent \$2.2 billion (combined state/federal) on Medicaid managed care.

Managed Care Plan	Enrollment (Aug. 2011)
Amerigroup	262,954
Peach State (Centene)	296,678
WellCare	556,518
Total	1,116,150

Source: *Georgia Families CMO Flash Report, August 2011* ([Link to report](#))

Navigant Recommendations

The report prepared by Navigant considered a wide range of options for the design of the state's Medicaid program, and has recommended the movement toward full carve-in of all Medicaid populations and benefits into a managed care structure. Specifically, Navigant scored each of the following options against their ability to meet the state's objectives on a scale of 1 to 9, with a 9 representing the greatest likelihood of the option achieving the objective. Below we list the options considered and how they scored relative to the evaluation criteria:

- Current delivery system: 3.8

- FFS for all members: 2.0
- Primary care medical home model: 4.8
- Enhanced primary care case management: 4.7
- ACO model: 4.8
- Georgia Families Plus: 7.2
- HSA with high deductible health plan: 4.6
- “Commercial style” managed care: 8.2
- Free market purchasing: 6.0

We note that the model receiving the highest score was the “commercial style” managed care option. This construct incorporates approaches that have become more prevalent in the employer sponsored health insurance marketplace such as higher out of pocket costs and increased use of member incentives. Importantly, “commercial style” managed care refers to the benefit design type under consideration rather than the potential type of managed care organization the state would seek.

Navigant’s recommendations combined aspects of the models listed above to form new delivery system structures that build on one another. We note that at the heart of each of Navigant’s recommendations is Medicaid managed care for all beneficiaries and covering all services (Georgia Families Plus). This is described in Option 1 below. Options 2-4 build off of this framework by incorporating some free market principles but would require federal waivers that may or may not be viable.

Option 1: Georgia Families Plus

With this option, DCH would enroll all populations, including children in foster care, dual eligibles and individuals who are aged, blind and disabled, in an enhanced Medicaid managed care program called Georgia Families Plus. Additionally, all services would be carved in, including behavioral health, transportation, dental, LTC and HCBS waiver services. This Georgia Families Plus program would add 357,000 lives to managed care plans, as well as open up the full \$7.2 billion in annual Medicaid spending to a capitated managed care structure.

Georgia Families Plus would:

- Incorporate value-based purchasing
- Further encourage use of medical homes, for example, through Patient Centered Medical Homes (PCMHs)
- Reduce administrative complexities and burdens for providers and members
- Increase patient compliance through incentives and disincentives
- Increase focus on health and wellness programs and preventive medicine
- Continue to build upon current efforts to focus on quality
- Carve in more services (such as transportation) and populations (such as people who are aged, blind and disabled)

Navigant cites several key advantages and disadvantages to this plan:

Advantages	Disadvantages
Statewide option	Requires federal waiver to mandate enrollment of certain populations, could delay implementation
Builds upon existing Georgia Families infrastructure	Initiatives to encourage appropriate patient behavior may be unenforceable
Providers and members familiar with managed care	Stakeholders opposed to Georgia Families may view as a “tweak” to current program
Options for care management for LTC population and others with chronic conditions	Administrative burden may be high initially – new contracting and monitoring approach, infrastructure for value-based purchasing
Tools available to address inappropriate service utilization	
Delegates provider monitoring and oversight to CMOs	
Provider contracts provide ability for vendors to hold providers accountable for performance	
Budget predictability	
DCH can hold CMOs accountable for quality and financial outcomes	
Full-risk contracts incentivize eliminating fraud, waste, abuse	

The report suggest that, by making some significant changes to the current Georgia Families program to focus more on outcomes, administrative ease for providers and increased and appropriate monitoring and oversight of contractors, DCH has an opportunity to improve care for members currently served through Georgia Families as well as individuals currently in the fee-for-service (FFS) delivery system who do not have access to care management services or other benefits of managed care.

Option 2: Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program

- This option would start with the implementation of Georgia Families Plus as described above, and then build off of it by incorporating certain techniques employed in the commercial managed care market that are designed to increase member engagement.
- Among the tools used by commercial managed care plans that would be encouraged under this model are copayments, deductibles, HRAs, incentive payments and prizes and other creative strategies.
- Navigant acknowledges that the vast majority of these tools – most notably copayments and deductibles – are not permitted in Medicaid for certain populations and services without seeking federal waiver authority

Option 3: Georgia Families Plus Transitioning to “Commercial Style” Managed Care Program that Requires Use of ACOs and PCMHs

- This option would start with the implementation of Georgia Families Plus with “commercial style” incentives.
- The only difference between Option 2 and Option 3 is that participating care management organizations (CMOs) would be contractually required to include ACOs and PCMHs in their provider networks.
- The belief underlying this option is that requiring inclusion of ACOs and PCMHs in provider networks may help to move the Medicaid program to a more patient-centered model that involves teams of providers sharing responsibility for care of the whole person.
- In addition to the need for waivers described above, this model would also be constrained by the need to develop integrated, patient-centered provider systems with the capacity to absorb high volumes of Medicaid beneficiaries.

Option 4: Georgia Families Plus and Free Market Health Insurance Purchasing

- This option would start with the implementation of Georgia Families Plus.
- Over time, the model would evolve to something similar to a voucher program where beneficiaries would be allocated a fixed amount of funding from the state with which they would be allowed to purchase a health insurance plan from a series of options offered in state-designed marketplace.
- Insurers would offer the standard Medicaid benefit package as one of their products.
- DCH would not contract directly with health plans and would not process claims.
- Medicaid members would be given a credit with which to purchase a standard Medicaid benefit insurance product from a certified insurer.
- There would be an annual enrollment period each calendar year, and enrollees would be locked in to their selected health plan for the entire calendar year.
- Medicaid would no longer pay claims or operate a FFS program or other infrastructure for members who participate in this free market program.
- Navigant acknowledges that there are significant limitations to the model described in option 4 including the need for federal approval to implement a model that does not currently exist and “which may not be appropriate for all Medicaid members.” In addition, under this model, DCH would cede some or all of its oversight authority over the health plans raising concerns over access to care and network adequacy among others.

In summary, expanded Medicaid managed care under Georgia Families Plus serves as the foundation of Navigant’s recommendations with the other three options building upon the model with emerging contracting approaches that have not historically been employed in Medicaid programs. Accordingly, we view Option 1 as being the most like-

ly recommendation to be considered by the legislature this year and expect the debate over moving forward with it to begin soon.

Importantly, the Navigant report did not address a number of other significant issues related to the implementation of the program including how many health plans will be selected to participate in the expanded program. In our opinion, given the magnitude of the expansion considered here, we would expect the state to move from contracting with three plans statewide to contracting with between four and six CMOs.

Dual eligibles

We note that while Navigant mentions the dual eligibles throughout the report, the analysis falls short of recommending an integrated care and financing model for duals other than to include them in Georgia Families Plus. The report does suggest that the state should evaluate the integration models being proposed by CMS. The report also speaks favorably toward the Medicare Advantage Special Needs Plan (SNP) model and suggests that DCH consider requiring CMOs participating in Georgia Families Plus offer Special Needs Plans to any dual eligible members they enroll.

Impact on Managed Care Market

In FY 2009, Georgia Medicaid served 94,000 aged and 258,000 blind/disabled beneficiaries with a combined \$3.7 billion in FFS payments.¹ While a significant portion of the aged Medicaid population falls into the dual eligible category, there are more than 150,000 non-dual eligible blind/disabled beneficiaries accounting for more than \$2 billion in Medicaid FFS payments.²

With the added inclusion of behavioral health, LTC, and HCBS services, as well as non-emergency transportation and pharmacy, the implementation of the Navigant recommendations could easily add in excess of \$4 billion in annualized spending to the managed care market.

We also note that the framework recommended by Navigant encourages the enrollment of the Medicaid expansion population in managed care in 2014. It is estimated that an additional 550,000 Georgia residents will gain eligibility for Medicaid in 2014 under the Affordable Care Act, bringing the total enrollment in managed care to 2 million once the program is implemented, almost twice the current level of enrollment with total annual expenditures likely exceeding \$8 billion per year, versus approximately \$2.5 billion in Medicaid managed care today.

Timeline for Medicaid Redesign

Assessment - Completed

- August - December 2011, completed.

Recommendation - Underway

- January 2012, posting of Strategy Report.

¹ Medicaid Statistical Information System (MSIS) State Summary Datamart, FY 2009. Available at: <http://msis.cms.hhs.gov/>

² Medicaid Statistical Information System (MSIS) State Summary Datamart, FY 2009. Available at: <http://msis.cms.hhs.gov/>

- January – April 2012, review and analysis of the Strategy Report.
- February 29, 2012 deadline for submitting detailed feedback, comments, questions
- April 2012 – Finalization of the Redesign Model.

Procurement – Later in 2012, 2013

- April – July/August 2012, procurement planning.
- July/August 2012, procurement documents to be posted.
- January 2013, contract award to successful vendor(s).

Implementation – Planned for Early 2014

- January/February 2014, implementation begins.

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Elaine Peters

The House Budget for FY 2012-2013 was released this past week. Some of the major Medicaid related issues of note are:

- **Nursing Home Rates** - Reduces funds by \$76.1 million resulting from a reimbursement rate reduction of 2.5 percent over the prior year estimated spending. This reduction includes the impact to hospice rates.
- **Hospital Inpatient Rates** - Reduces funds by \$230.7 million resulting from a reimbursement rate reduction of 7.0 percent over the prior year estimated spending. Stand-alone children's and rural hospitals are exempted.
- **Hospital Outpatient Rates** - Reduces funds by \$60.9 million resulting from a reimbursement rate reduction of 7.0 percent based upon prior year estimated spending. Stand-alone children's and rural hospitals are exempted.
- **HMO Rate Reduction** – Reduces funds by \$85.5 million resulting from the pass through impact to managed care rates due to the reduction in hospital inpatient and outpatient services.
- **Nursing Home Diversion Rate Reduction** – Reduces funding by \$14.2 million based on a 4 percent actuarial adjustment. These savings have been reinvested back into the nursing home diversion program and other waivers.
- **Hospital Buy Back** – Provides an increase of \$108 million trust (\$45.6 million IGTs) for hospitals to buy back current and historical rate reductions through the use of intergovernmental transfers (IGTs).
- **Developmentally Disabled Waiver** – Provides an increase of \$65.1 million to support waiver services for the developmentally disabled.

In the news

- **House starts looking at Medicaid cuts**

The House released an initial health and human-services budget proposal Tuesday that would chop hospital Medicaid rates by \$291 million next year and trim a series of benefits for low-income Floridians. But the \$29.8 billion proposal also would take steps such as increasing funding for child-protection investigators, stabilizing the finances of the deficit-plagued Agency for Persons with Disabilities and shielding from cuts the Medically Needy program for people with debilitating illnesses. The proposal is a first step as the House prepares to approve its version of a 2012-13 budget and, ultimately, to negotiate a final spending plan with the Senate. Health and human-services programs play a critical role in the budget, as lawmakers look to close an overall shortfall that has been estimated as high as \$2 billion. A key issue in the negotiations likely will be hospital Medicaid rates, which were cut by \$510 million to help balance the current fiscal year's budget. The House proposal rejects a plan by Gov. Rick Scott to overhaul – and more deeply slash – hospital funding, but it still calls for a 7 percent rate reduction. ([Orlando Sentinel](#))

- **Lawmakers seek alternatives to Scott's hospital budget cuts**

Gov. Rick Scott's controversial plan to cut \$1.9 billion in Medicaid payments to Florida hospitals may not win backing in the Legislature this year. But legislative leaders and the governor agree they need to overhaul the way hospitals are paid to take care of Florida's poorest and sickest residents. And ultimately it will mean less money for the hospitals, which were hit with a \$510 million rate cut this year. Sen. Joe Negron, chairman of the Senate budget subcommittee that oversees health care spending, cited the cuts that hospitals, nursing homes and other health care facilities endured in the last year as the state struggled through an ongoing budget crisis. Negron said his committee would be charged with finding \$850 million in health care reductions this year as lawmakers try to write a new \$66 billion state budget at same time trying to find an additional \$1 billion for schools while also agreeing not to raise taxes or fees. It means hospitals as well as other health care and social service programs will face more cuts in the new budget year, which begins in July. Negron also said while he had reservations about Scott's hospital plan, it would remain under consideration as the Senate develops its budget in the next few weeks. The House has already rejected Scott's proposal. ([HTPolitics.com](#))

- **Florida lawmakers consider tough law to protect assisted living facilities**

Senate Committees this week unveiled dual bills to target abuse and neglect in Florida Assisted Living Facilities (ALFs). Among the proposals, the state would:

- Strip the license of any home where a resident dies from abuse or neglect. Under current law, the agency can impose much weaker sanctions – or do nothing at all.
- Slap the maximum fines on homes caught abusing or neglecting residents to death, without resorting to making settlements.

- Dramatically increase the qualifications for ALF administrators, from a high school diploma to a college degree with coursework in health fields or two years of experience caring for residents.
- Impose criminal penalties for caregivers and administrators who falsify medical and other ALF records.
- Allow family members of residents to install so-called "Granny Cams" in rooms to help detect caregiver abuse, as long as relatives sign agreements to respect the privacy of others.
- Allow residents to appeal a home's decision to force them out, giving residents the chance to remain at the home until a hearing is held.

While the bills are supported by some of Florida's most powerful senators — including Ronda Storms, a Republican who chairs the Children, Families and Elder Affairs Committee — they are expected to draw opposition from industry leaders and some House members. ([Tampa Bay Times](#))

- **Legislators introduce bill to set up health insurance exchange**

Senate Bill 1640 and House Bill 1423 would provide the intent to “establish a state-level health benefits exchange by a certain date; providing minimum functions for such exchange; establishing the Florida Health Benefits Exchange Legislative Study Committee to consider and make recommendations regarding the establishment of the exchange; providing that the act is null and void if that part of federal law requiring an exchange is repealed or replaced.” Just this week, the government released a report documenting the progress 28 states and the District of Columbia have made in creating their state health insurance exchanges. The study noted that Florida is one of two states that has refused to even use a \$1 million federal grant to begin planning for and researching an exchange. ([Florida Independent](#))

- **Waiting list: dilemma for Medicaid**

Florida's unfolding plan to keep elderly and disabled Medicaid patients out of nursing homes through the use of HMOs faces a huge obstacle: The state already has a long waiting list for the kinds of home- and community-based services those patients need. And there is no state money on the table to address it. An analysis of the project released last week cited the waiting list as just one of several challenges facing Florida's plan to move all Medicaid patients into HMOs and other managed-care networks starting next year. The research team from Georgetown University concluded that the state may not have allocated enough time or money to "assure smooth transitions for a very vulnerable population." Also, the researchers said, the project may fail to accomplish one of its essential elements: saving money. It all depends on how the program, under the joint direction of the Agency for Health Care Administration and Department of Elder Affairs, is carried out. ([Health News Florida](#))

Illinois

HMA Roundup – Jane Longo / Matt Powers

On Monday, the Department of Health and Family Services (HFS) released the Phase I RFP for the Care Coordination Innovations Project. The solicitation is for Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCNs) for seniors and adults with disabilities. During the RFP development process, one concern continually raised was on the issue of voluntary enrollment. It should be noted that the final RFP locks enrollees into their CCE or MCCN after 90 days of enrollment. The RFP and Performance Measure Specifications are available on the state's Care Coordination Innovations Project [website](#). A mandatory letter of intent is due on February 29, 2012, with final responses due May 25, 2012.

In the news

- **U.S. OKs increase in nursing home tax to bring in more Medicaid money**

Federal authorities have approved a nursing home bed tax that will allow Illinois to collect more than \$100 million a year in new Medicaid money that officials say will be used to boost facility staffing levels and implement other safety reforms mandated by a landmark 2010 overhaul, the Tribune has learned. Gov. Pat Quinn, who is expected to announce the federal approval Tuesday, pushed hard for the tax as a way to hire more state inspectors and finance other reforms in Illinois' troubled long-term care system without dipping into the state's already-depleted coffers. ([Chicago Tribune](#))

Massachusetts

HMA Roundup – Tom Dehner

Children's Hospital Boston and Blue Cross Blue Shield of Massachusetts have reached a deal under which Children's and its doctor groups will accept global payments. This is one of several similar deals BCBS is striking with major providers (including Partner's recently). The Children's Hospital deal is unique, however, in that specialty providers have not been thought likely to agree to a global payment structure. The added fact that Children's receives almost no Medicare payments adds an additional element of interest to the story.

In the news

- **Patrick Outlines Initiatives in State Of The State Address**

To address the rising cost of health care, the governor once again called on the Legislature to pass a bill he filed last year aimed at cost containment. While the governor wants the Legislature to take up health care cost containment before they debate the state budget, both Senate President Therese Murray and Speaker Robert DeLeo indicated it may take more time. Lawmakers don't have a lot of time to act on all of the governor's initiatives: legislative rules say they must finish up work on major bills by July 31. ([WBUR.org](#))

New York

HMA Roundup – Denise Soffel

Executive Order on State-Funded Administrative Costs and Executive Compensation

On January 18 Governor Cuomo issued an executive order addressing executive compensation and operations. The order states that no less than 75 percent of state-funded financial assistance or state-authorized provider operating expense payments should be used to provide care and services for New Yorkers. This number increases 5 percent each year until April 2015, when it should remain at no less than 85 percent. Looking to rein in the use of public money to pay what he called excessive salaries, Gov. Cuomo's executive order also places a \$199,000 limit on the amount of state funds that contractors can use to pay executives. Organizations that contract with the state to provide services including health care may still pay their executives higher amounts, but the state will reimburse the provider only up to the stated amount. Agencies affected by this order include the Office for People with Developmental Disabilities, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, Office of Children and Family Services, Office of Temporary and Disability Assistance, Department of Health, Office for the Aging, Division of Criminal Justice Services and the Office of Victim Services.

More on Governor Andrew Cuomo's Executive Budget

While health care was not the major focus of this year's budget, it includes a number of items of interest. Many proposals included in the budget emerged from the Medicaid Redesign Team. The budget does not propose any significant cuts to Medicaid, but the global spending cap that was approved last year remains in place. The spending cap provides the Commissioner of Health with the authority to unilaterally make spending cuts should spending exceed the four percent cap. Some other provisions in this year's budget are discussed below.

Supportive Housing

One of the working groups of the Medicaid Redesign Team addressed issues related to the lack of affordable housing and its impact on Medicaid beneficiaries. Several of the work group's recommendations are included in this year's budget. The budget proposes establishing a formal mechanism for setting aside savings related to reductions in inpatient and nursing home capacity that can be used to fund housing development. This reinvestment of Medicaid savings would provide financing for supportive housing.

Assisted Living

The MRT Work Group on Affordable Housing also recommended changes to the Medicaid Assisted Living Program (ALP) to allow for greater flexibility in the program. One proposal would allow an ALP with multiple certified home health agencies and Long Term Home Health Care Programs, providing greater flexibility for the ALP. Another proposal delinks expanding the number of ALP beds with concomitant reductions in nursing home bed capacity, allowing for the expansion of ALP beds through a modified Certificate of Need process.

Consumer-Directed Personal Care Program (CDPAP)

The MRT work group on managed long-term care recommended establishing a work group to advise the Department on the integration of self-directed program models, including the consumer directed personal assistance program (CDPAP), into MLTC. The Governor's budget went one step further, and would require that all managed care plans and MLTCs offer consumer-directed personal care.

Payment Reform

Two initiatives are included in the Governor's budget. Essential Community Provider Network designation (a new initiative that would provide short-term funding) and Vital Access Providers (which provides ongoing rate enhancement) are designed to provide additional financial support to essential safety net providers, ensuring access to care for patients in underserved communities. Essential Community Provider Networks would be eligible to receive short-term funding to achieve defined operational goals such as a facility closure, merger, integration or reconfiguration of services. This proposal is designed to provide support to hospitals, nursing homes, health centers and home care agencies during a time of significant restructuring and payment reform. VAP funds help provide a sufficient funding source to aid in the smooth transition of service within communities and to provide reinvestment capital for new investment paradigms.

Pennsylvania

HMA Roundup - Izanne Leonard-Haak

The Office of the Budget released their 2011-2012 mid-year budget report this past week. Included are two items of note related to the state's health care agencies. First, The Department of Public Welfare created a new Office of Program Integrity earlier this year. The new office is tasked with several responsibilities aimed at reducing welfare fraud, waste and abuse. Second, in a preliminary look at the 2012-2013 budget, there is nearly \$1 billion in increased mandatory spending projected, \$400 million of which is in Medical Assistance and Long-Term Care.

In the news

- **Doctors at Erie practice accused of unnecessary medical procedures**

A doctor who was formerly employed by an Erie cardiology practice associated with UPMC and who represents the interests of the U.S. government is suing the practice and the hospital system alleging that doctors profited by performing unnecessary medical procedures. The complaint alleges that at least five doctors in the Medicor Associates practice defrauded the federal government by billing Medicaid for procedures that were not medically necessary. It also alleges that the Hamot Medical Center, which was taken over by UPMC and became UPMC Hamot last year, paid kickbacks and gave the doctors sham contracts to ensure referrals for cardiac procedures. ([Pittsburgh Post-Gazette](#))

OTHER HEADLINES

Arkansas

- **Panel OKs additional Medicaid funds in DHS budget**

Lawmakers endorsed Gov. Mike Beebe's proposed \$114.3 million increase in Medicaid funding today with assurances that the additional funding would shore up existing programs, not start new ones. Medicaid would get the bulk of \$163 million in new funding under the proposal, which also calls for a \$2.9 million increase in the DHS budget for the State Hospital and a \$56.6 million increase in funding for public education. ([Arkansas News](#))

California

- **PACE program a new approach to senior health care**

On Lok, which provides coordinated medical and day care services, was developed in the early 1970s and became the model for the Program of All-inclusive Care for the Elderly, or PACE, a state and federally funded program designed to help frail seniors stay in their homes. State budget woes that threaten seniors and disabled people, in addition to growing interest from state and federal government to provide better and less costly care, have caused policymakers to take a closer look at programs like On Lok. To be eligible for PACE, enrollees have to be 55 or older and meet the criteria for admission to a skilled nursing facility. That means they must need help with basic living tasks or have a terminal illness, dementia or a condition that has required multiple medications or frequent emergency visits. A Medicare advisory commission late last year acknowledged the potential of PACE and recommended some changes, such as expanding eligibility to people under 55 who need nursing-home-level care. California is home to five PACE organizations - two of which are in the Bay Area - that operate 18 centers. In addition to On Lok, which has eight centers in San Francisco and one in San Jose, the Center for Elders' Independence serves some 450 seniors in the East Bay at its four locations in Berkeley and Oakland. ([San Francisco Chronicle](#))

- **Federal judge continues to block California's cuts to in-home care**

A federal judge will continue blocking millions of dollars in cuts to in-home care for the elderly and the disabled, parties to a lawsuit over the services said last Thursday. U.S. District Judge Claudia Wilken had temporarily halted the cuts in December. The \$100 million in reductions to home aid, built into the state budget in case revenue did not match projections, were to have kicked in this month. The judge, who presided over a hearing on the matter in Oakland on Thursday, said she was prepared to keep the cuts at bay, according to both sides. Melinda Bird, senior counsel for the advocate group Disability Rights California, said Wilken directed the parties to reach a settlement. ([Los Angeles Times](#))

- **Calif. hopes for end to court oversight of prisons**

Most of the prison system's core functions, from the care of mentally ill inmates to housing juvenile offenders, have been under the authority of federal and state courts for years. But the state appears to be emerging from more than a decade of lawsuits af-

ter a federal judge said last Tuesday he is preparing to end court oversight of inmate medical care. That has the potential to end a long-running battle between the state and federal courts that led to a U.S. Supreme Court challenge and a revamping of the nation's largest state prison system. Reforming that part of prison operations has cost California billions of dollars and led critics to say it created a system that provides convicts with better health care than many of the taxpayers who are paying to house them. [\(AP\)](#)

Georgia

- **Georgia budget offers breathing room for medical segment**

Gov. Deal's budget eliminates some of the budget tricks included in the previous budget, including deferred payments. The next fiscal year will contain 12 months of payments again. Deal even recommends that the Legislature put in enough money to cover some growth, which is important because medical inflation and enrollment growth combine to raise the cost yearly for Medicaid. The state has kept its medical inflation, 5.2 percent, below the national average, 7.3 percent. While the yearly national payment per covered person was roughly \$6,000 in 2009, Georgia's was around \$4,000, the second lowest among 16 states in the Southeast. Another change Deal is recommending is reversing a 0.5 percent cut in the reimbursement rate providers got when the current budget took effect. Nursing homes will get a second bump as the state adopts new cost estimates upon which reimbursement rates are based. Deal is including \$20 million to replace funds Congress had supplied temporarily to tide states over during the worst of the recession. His added money also accounts for the cost of allowing 21,000 state workers to enroll their children in the PeachCare for Kids program for the poor. [\(The Augusta Chronicle\)](#)

- **Health care spikes worry Ga. lawmakers**

The House and Senate appropriations committees met jointly last week to get broad overviews of the money demands of the state's largest agencies while the rest of the General Assembly was in recess. Monday, the House Appropriations Committee's subcommittees began weeks of in-depth hearings to pore over the details of what Gov. Nathan Deal has recommended spending in each area. Deal asked every agency to cut 2 percent of its expenditures next year, but he's also calling on legislators to make big boosts in health care. For the Department of Community Health, he wants \$437 million added next year and for the balance of the current fiscal year to cover rising health costs and the growing enrollment in the insurance plans for state workers, teachers and the poor. That includes enrolling the children of 21,000 state employees in the PeachCare for Kids insurance plan for children from low-income families. [\(The Augusta Chronicle\)](#)

Hawaii

- **QUEST RFP Awards Announced**

The Med-QUEST Division is pleased to announce that it has finalized the procurement process for the QUEST program. The Division is awarding contracts to five health plans:

- AlohaCare
- HMSA QUEST (BCBS)
- Kaiser Foundation Health Plan
- 'Ohana Health Plan (WellCare)
- United HealthCare Community Plan

All of the health plans will be providing services to QUEST members Statewide except for Kaiser Foundation Health Plan that has chosen to focus their efforts on the islands of Oahu and Maui. The health plans will start provision of services to QUEST members on July 1, 2012. ([QUEST Procurement Website](#))

Kansas

- **Republican legislator seeks delay of governor's Medicaid plan**

Backed by advocates for Kansans with developmental disabilities, a Republican legislator on Monday urged Gov. Sam Brownback to delay his proposal to privatize Medicaid. Sen. Dick Kelsey joined a chorus of comments that the move toward managed care was going too fast and had too many unresolved issues. He noted the request for proposals from managed care companies elicited 1,100 questions from the bidders. ([LJWorld](#))

- **Governor hints at money targeted for waiting-list problem**

Gov. Sam Brownback on Friday hinted that he would support using a portion of the savings from his proposed elimination of the state's earned income tax credit to reduce long-standing waiting lists for services for the disabled. Today, more than 4,800 developmentally disabled adults and children are on waiting lists for Medicaid-funded services in community-based programs. About 1,600 of those are receiving some services but waiting for others. At least 3,250 people with physical disabilities are waiting for services. The Brownback administration has proposed doing away with the earned income tax credit and using the \$90 million in resulting savings to underwrite other programs for the poor, including a \$30 million expansion of the standard income tax deduction for low- and modest-income families; \$30 million to be spent on assistance for needy families; and \$30 million added to the state's Medicaid program. ([Kansas Health Institute](#))

Kentucky

- **Legislative Committee Issues Subpoenas to Medicaid Providers**

The Program Review and Investigations Committee voted this week to authorize subpoenas to Kentucky's three new managed care providers over reimbursement rates to independent pharmacies. Passport, based in Louisville, is exempt from the subpoena. At its weekly meeting, the committee heard testimony from independent pharmacy owners who said two managed care providers were squeezing them too tight by drastically cutting reimbursements. It is believed that Passport and Kentucky Spirit are not the two providers referenced. Even so, Kentucky Spirit will be sent a subpoena to testify. ([WFPL News](#))

Mississippi

- **Hospitals won't try to kill Medicaid tax**

The leader of the Mississippi Hospital Association says his group won't fight renewal of a tax his members pay to help fund Medicaid. The association protested in 2009 when then-Gov. Haley Barbour pushed for the hospital tax. Now, the association's president and CEO, Sam Cameron, says the tax gives hospitals something very important - predictability in their expenses. The tax is set to expire June 30 unless lawmakers renew it this session. Officials say the hospital tax generates about \$200 million a year, and that money is multiplied with the federal match. Gov. Phil Bryant, who took office Jan. 10, said he supports renewing the hospital tax because the state can't afford to replace the Medicaid money that would be lost if the tax disappears. ([Hattiesburg American](#))

North Carolina

- **Even with savings, HHS chief frets about Medicaid**

Health and Human Services Secretary Lanier Cansler got some good news as he prepares to leave his job at the end of the month. The news was about cost savings associated with a nationally-recognized health care initiative for the state designed to manage better outcomes for Medicaid consumers. An outside actuary estimated a cumulative \$984 million in Medicaid savings from 2007 to 2010 from the nonprofit Community Care of North Carolina networks. The networks help 1.2 million patients with treatments for chronic and special conditions, ensure they aren't overprescribed drugs and encourage them to go to a primary-care doctor, not the emergency room. But with a projected \$150 million Medicaid shortfall this year, a larger shortfall next year and a projected one-third increase in enrollees in 2014 because of the federal health care law, Cansler sounds justified in worrying about the overall Medicaid program's long-term finances. For an agency that will spend almost \$13 billion in federal and state funds this year, \$1 billion over four years remain just one piece of the Medicaid savings puzzle. ([MSNBC](#))

Texas

- **Impact of Medicaid Cuts May Devastate Patients, Texas Pharmacies & Small Businesses**

Texas pharmacy groups are warning that Texas' planned move to managed care for pharmacy services on March 1st of 2012 will have a devastating impact on the state's community pharmacies and on the poor they serve. This warning comes as the Texas House of Representatives committee on Public Health is scheduled to meet this week to discuss managed care. Under managed care, pharmacy reimbursements will no longer be set by the state, but by pharmacy benefit managers (PBMs). PBMs have already offered some pharmacies a dispensing fee of as low as \$1.35 plus a very low reimbursement for the drug. That represents a reduction of more than 80 percent from recent rates and nearly 90 percent below the actual cost of dispensing prescriptions, according to The Perryman Group, a Texas research firm. Legislative budget writers rejected a 27 percent cut just last year which many believed would threaten the viability of community pharmacies. ([Texas Insider](#))

Utah

- **Utah's Medicaid overhaul partially rejected by feds**

The federal government buys into the core principle of Utah's ambitious Medicaid overhaul: steering patients into managed care networks. But officials have rejected key pieces of the plan and asked the state to regroup. However, moving patients into Accountable Care Organizations (ACOs) was "essentially OK'd," said CMS regional spokesman Mike Fierberg. Backed by health industry chieftains and unanimously approved by the Legislature, the overhaul was pitched as a way to preserve Utah's low-income health safety net, which is taking up a greater share of the budget. It envisions handing Medicaid over to ACOs, managed care networks that would be paid lump monthly sums per patient. If an ACO spends more than allotted for care and prescription drugs, it absorbs the loss. If it spends less, it gets a share of the leftovers — similar to old HMOs of the '90s. At issue for federal officials were some of the more controversial elements, such as allowing ACOs to charge patients higher co-payments than is currently allowed. ([Salt Lake Tribune](#))

Vermont

- **State releases report on single-payer plan**

Officials in the process of overhauling Vermont's health care system released a 21-page report on how the state will implement a single-payer plan within the next three to five years. The Green Mountain Care Board and governor's administration released its Strategic Plan for Vermont Health Reform last week. It proposes a guide for the state to implement the plan of Gov. Peter Shumlin, a first-term Democrat, to expand and improve health insurance coverage in Vermont. ([Brattleboro Reformer](#))

United States

- **Senate Watchdog Targets High-Prescribing Medicaid Docs**

Iowa Republican Charles Grassley sent letters to 34 states Monday asking what steps they had taken to investigate doctors whose prescribing of antipsychotics, anti-anxiety drugs and painkillers to Medicaid patients far exceeds that of their peers. The request is a follow-up to a 2010 letter Grassley sent all states that requested statistics on top prescribers of these drugs. His letter to Ohio notes that the top prescriber of the anti-psychotic Abilify wrote 13,825 prescriptions in 2009 – about 54 prescriptions per weekday. Ohio paid \$6.7 million for that those prescriptions, state officials reported to Grassley. The biggest prescriber of another anti-psychotic, Seroquel, wrote 18,890 scripts at a cost of \$5.7 million. Grassley wrote the tally would amount to nine prescriptions per hour. ([ProPublica](#))

- **Financial alignment models update**

This week, CMS' Office for Medicare and Medicaid Coordination plans disseminated additional materials regarding capitated financial alignment demonstrations for dual eligibles. The draft plan guidance will be released through the CMS Health Plan Management System (HPMS) along with other supporting material.

For more information on the content of the materials, please contact Greg Nersessian at gnersessian@healthmanagement.com

- **Building a business with unwanted customers**

Nationally, dentists shy away from treating Medicaid patients. Many complain that this patient population has a far higher no-show rate than patients with private insurance, according to a May 2011 report called "The State of Children's Dental Health" from the Pew Center on the States. Those empty chairs eat at profits. However, Newark, N.J.-based Dental Kidz has developed a business model around this population, focusing on volume to drive profitability, despite reimbursements that average well below costs nationwide - 33 states reimbursed under 60.5 cents for every dollar a dentist charged, according to a Pew Center study. The clinic sees between 180 and 200 new patients per month. The company made \$1.6 million in revenue for 2011, up from \$500,000 at the end of 2009. Profit margins have also increased, up from 24% in 2009 to 47% this past year. The most expensive part of the business is actually its staff, which accounts for 40% of Dental Kidz's overall expenditures. ([Fortune](#))

- **State of the state speeches calendar**

Stateline has compiled a timeline of all state Governor's State of the State speeches. Those that have already occurred include full text and video, where available. Many speeches so far have addressed Medicaid reform and cost containment initiatives, ACA implementation progress, and general state budget updates. Available at: ([Stateline](#))

- **Medicaid anti-smoking program saved big money, study says**

Numerous studies have shown that investments in programs aimed at helping people quit smoking reap significant long-term reductions in health care costs. Now new data suggests that states may not have to wait so long for the returns. According to a study

conducted by George Washington University, a Massachusetts Medicaid program saved \$3 in Medicaid hospitalization expenses for every dollar it invested in a comprehensive smoking cessation counseling and treatment program – and the savings accrued in the first 16 months of the program. While not all Medicaid patients who underwent the treatment were able to quit smoking permanently, the group as a whole had far fewer hospital admissions for cardiovascular problems than it did before entering the program. According to the report, the annual medical savings attributable to even a brief reduction in smoking was \$571 per participant, far outweighing the \$183-per-person cost of the program. ([Stateline](#))

- **Building a health insurance marketplace one step at a time**

Less than a year from now, states will have to prove to Washington that they are capable of running a health insurance exchange on their own, or the federal government will create one for them. The way it looks now, only a handful of states are likely to make that deadline. One small group of states – led by Maryland, Washington, Oregon, Rhode Island and California – is running significantly ahead of the rest. Statutes have been enacted to create the exchanges and the basic decisions about how to run them have already been made. The full list of states that have established legal authority for the exchanges is: California, Colorado, Connecticut, Hawaii, Maryland, Massachusetts, Nevada, Oregon, Rhode Island, Utah, Vermont, Washington, and West Virginia. ([Stateline](#))

- **White House 2012 Progress Report: States Are Implementing Health Reform**

This report summarizes the actions taken by States to establish Exchanges and focuses on examples of the legislation and executive actions, public meetings, and other activities undertaken by States across the country to create these new health insurance marketplaces. It profiles ten States that cut across the spectrum of geography, demographics, and political leadership. The States profiled are not necessarily the States most advanced in establishing an Exchange; instead, they illustrate the diversity of approaches and progress being made. ([WhiteHouse.gov PDF](#))

PRIVATE COMPANY NEWS

- **WellCare's 'Ohana Health Plan Selected to Serve Hawaii's QUEST Medicaid Program**

WellCare Health Plans, Inc. today announced that the Hawai'i Department of Human Services awarded 'Ohana Health Plan ('Ohana), a health plan offered by WellCare Health Insurance of Arizona, Inc., a contract to serve Hawaii's QUEST Medicaid program. 'Ohana is one of five health plans selected to serve approximately 230,000 beneficiaries across the state. Beneficiaries of the QUEST program include low-income individuals, families and children who are not aged, blind or disabled. Services are expected to begin on or about July 1, 2012, and 'Ohana will coordinate medical, behavioral and pharmacy services with a focus on improving health care access and the quality of care. The award is conditioned on the execution of a definitive contract. 'Ohana currently serves approximately 26,000 Hawai'i residents through its Aged, Blind, and Disabled Medicaid and Medicare Advantage Plans. ([WellCare News Release](#))

- **Magellan Health Services and Phoenix Health Plan Announce Joint Venture Development Agreement**

Magellan Health Services, Inc. and VHS Phoenix Health Plan, LLC, a subsidiary of Vanguard Health Systems, Inc., announced that they have entered into a joint venture development agreement pursuant to which they will form a joint venture to bring together their significant behavioral health and medical management capabilities to manage integrated care in a holistic manner to better serve individuals with serious mental illness (SMI) in the state of Arizona. The joint venture, to be called Magellan of Arizona, Inc., will respond to a request for proposal (RFP) that is expected to be released by the state of Arizona in 2012 to manage behavioral health services for the general Medicaid population and integrated behavioral and physical health care for recipients with serious mental illness in Maricopa County. The RFP will likely address management services for the population currently served in Maricopa County by Magellan under its current contract which is set to expire on September 30, 2013. ([Magellan Health News 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.

Date	State	Event	Beneficiaries
January 27, 2012	Virginia Behavioral	Proposals due	265,000
February 1, 2012	Louisiana	Implementation (GSA A)	255,000
February 22, 2012	Kansas	Proposals due	313,000
February 27, 2012	Ohio	LOIs due	1,650,000
February 28, 2012	Nebraska	Contract awards	75,000
March	New Hampshire	Contract awards	130,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
March 19, 2012	Ohio	Proposals due	1,650,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
April 9, 2012	Ohio	Contract awards	1,650,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	100,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July/August, 2012	Georgia	RFP Released	1,500,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
October 1, 2013	Florida	LTC enrollment complete	100,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA WELCOMES...

Greg Buchert, Principal – Los Angeles, CA

Greg Buchert joins HMA as a Principal in our new Los Angeles office. Greg is a well-known and highly regarded health care executive in Southern California, and comes to us from CalOptima, where he has served for the last six years as the plan's Chief Operating Officer (COO). CalOptima is a large, public, managed care program in Orange County, California, serving over 400,000 Medicaid, Medicare, and CHIP members. As the COO, Greg provided leadership and strategic direction for operational units including Contracting, Information Services, Project Management, Customer Service, Provider Operations, Claims, Compliance, and Strategic Planning. Prior to his role as COO, Greg served as CalOptima's Medical Director and led Strategic Program Development, during which time he was responsible for the development and implementation of medical management programs to promote the delivery of high quality patient care. Earlier in his career, Greg served as Vice President/Administrative Director at La Veta Pediatric Medical Group, as a Pediatrician, Pediatric Emergency Physician, and Medical Director at the Children's Hospital of Orange County, and as Associate Director, Emergency Department and Medical Director, Off-Site Units at the Children's Hospital of Oakland. Greg earned his Bachelor of Arts degree at Tufts University, his Masters of Public Health at Tulane University, and his Doctor of Medicine at Tulane University. He served as Pediatric Intern and Resident at Tulane University School of Medicine, and as Pediatric Resident and Chief Resident at the Children's Hospital of Oakland.

HMA RECENTLY PUBLISHED RESEARCH

Commonwealth Fund - Why Not the Best? Series: Eliminating Central Line Infections and Spreading Success at High-Performing Hospitals

Sharon Silow-Carroll, Managing Principal

Jennifer Edwards, Managing Principal

One of the most common types of health care-associated infections is the central line-associated bloodstream infection (CLABSI), which can result when a central venous catheter is not inserted or maintained properly. About 43,000 CLABSIs occurred in hospitals in 2009; nearly one of five infected patients died as a result. This report synthesizes lessons from four hospitals reporting that they did not experience any CLABSIs in their intensive care units in 2009. Lessons include: the importance of following evidence-based protocols to prevent infection; the need for dedicated teams to oversee all central line insertions; the value of participating in statewide, national, or regional CLABSI collaboratives or initiatives; and the necessity for close monitoring of infection rates, giving feedback to staff, and applying internal and external goals. The report also presents ways these hospitals are spreading prevention techniques to non-ICU units and strategies for preventing other health care-associated infections.

Read the case studies from the four hospitals:

- [Bronson Methodist Hospital](#) of Kalamazoo, Michigan;

- Englewood Hospital and Medical Center of Englewood, New Jersey;
- Presbyterian Intercommunity Hospital of Whittier, California; and
- Southern Ohio Medical Center of Portsmouth, Ohio.

Comparative performance data for these and other hospitals can be found on WhyNotTheBest.org.

[Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012](#)

Vernon K. Smith, Managing Principal

Eileen Ellis, Managing Principal

Kathleen Gifford, Principal

For the 11th consecutive year, the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) present their budget survey of Medicaid officials in all 50 states and the District of Columbia. The annual survey tracks trends in Medicaid spending, enrollment and policy initiatives with data for FY 2011 and FY 2012. ([Link to report](#))