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HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: NEW YORK DUAL ELIGIBLE INTEGRATION PROPOSAL

HMA ROUNDUP: SITE SELECTION FOR CALIFORNIA DUAL ELIGIBLE DEMONSTRATION DELAYED; FLORIDA LONG-TERM CARE RATE BOOK RELEASED; GEORGIA, NEW YORK BUDGETS FINALIZED

OTHER HEADLINES: SUPREME COURT JUSTICES DEBATE CONSTITUTIONALITY OF AFFORDABLE CARE ACT; FLORIDA JUDGE ORDERS MEDICAID TO COVER AUTISM THERAPY; NEBRASKA MEDICAID MANAGED CARE CONTRACT AWARDS; ILLINOIS GRAPPLES WITH BUDGET SHORTFALL; STATE HEALTHCARE OFFICIALS IN ALABAMA, NEW MEXICO RESIGN, AS DOES HEAD OF COVENTRY MEDICAID DIVISION

RFP CALENDAR: PENNSYLVANIA MANAGED CARE CONTRACT AWARDS IMMINENT

MARCH 28, 2012

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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IN FOCUS: NEW YORK DUAL ELIGIBLE INTEGRATION PROPOSAL

This week, our *In Focus* section reviews New York's dual eligible integration proposal. The New York State Department of Health has proposed a fully-integrated managed care program, which will be known as the Fully-Integrated Duals Advantage (FIDA) program. New York, like several other states, is initially planning a geographically focused demonstration project in eight counties—Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester—with a goal of enrolling all dual eligibles into the FIDA program by January 2015. The proposal builds on an initiative already underway in New York to enroll dual eligible individuals with long-term supports and services (LTSS) needs into the state's Managed Long Term Care Program (MLTCP) in the same eight counties. Below we highlight some of the key elements of the proposal, including the proposed enrollment phases, and review the current MLTCP marketplace.

Key Proposal Highlights

New York is pursuing the capitated model, as outlined in the July 8, 2011 CMS letter to State Medicaid Directors. This model requires a three-way contracting process between the state, Federal CMS, and health plans. The state also plans to develop financial performance-based incentives to reward improvements in quality of care. New York does not contract with managed care plans through RFP procurement but rather through an application process. There is no indication of a limit to the number of plans New York may contract with under the FIDA program.

The proposal only focuses on the eight counties listed above but accounts for more than 460,000 estimated dual eligibles out of roughly 755,000 statewide, more than 60 percent. These counties are also the focus of a 2011 law requiring enrollment of all dual eligibles over 21 years of age and requiring more than 120 days of community-based LTSS into an MLTCP plan. The first wave of enrollment begins this summer in New York City, with the remaining counties to follow. As mentioned above, New York intends to build on this MLTCP expansion to the dual population, as many MLTCP plans either are integrated Medicare and Medicaid plans or are well-positioned to offer an integrated plan. The proposal notes that more than half of the state's partially capitated MLTCP plans are owned by a parent organization that operates a Medicaid Advantage plan in the state.

New York has proposed passive enrollment in which individuals may opt out of their FIDA plan, but re-enrollment will be limited to twice a year during January and July. Enrollees will be able to select a FIDA plan or will be automatically assigned to one by an independent enrollment broker. Those individuals opting out of FIDA plan enrollment will remain with their MLTC plan. Dual eligibles would be passively enrolled into the FIDA program in a phased approach:

> **Phase 1:** Beginning January 1, 2014, dual eligibles in the eight initial counties who are receiving community-based LTSS and are enrolled in the mandatory MLTC program will be passively enrolled into a FIDA plan. Duals enrolled in the state's Program of All-Inclusive Care for the Elderly (PACE) plans will not be passively en-

rolled but may elect to enroll in a FIDA plan. There are close to 3,200 PACE plan enrollees in the eight-county region out of approximately 460,000 total duals.

Phase 2: Beginning January 1, 2015, the remaining dual eligible population, that is, those not receiving LTSS, will be passively enrolled in a FIDA plan. Those duals enrolled in a Medicaid Advantage plan would be enrolled in a FIDA plan with the assistance of an enrollment broker. To prevent disrupting access or care, enrollment brokers will enroll duals into a FIDA plan operated by the individual's current Medicaid Advantage plan, wherever possible. Non-Medicaid Advantage duals, currently receiving Medicaid services through the fee-for service (FFS) structure, will be passively enrolled into a FIDA plan. However, those opting out of a FIDA plan will still be transitioned away from FFS and into a Medicaid Advantage or Medicaid managed care plan beginning in 2015.

The program will require federal waivers for a number of program components, including Medicare rules for passively enrolling the eligible population into plans, provision of an integrated appeal process, and rules limiting the frequency of plan changes within the FIDA program.

Target Population

The State has proposed to serve the approximately 460,000 dual eligibles in the eight county region of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester counties. The population is largely over the age of 65, with just over 100,000 individuals between ages 21 and 65. Roughly 45 percent of those over 65 are receiving LTSS, compared with roughly 17 percent of those below age 65.

	Overall	LTSS in institutional settings	LTSS in HCBS settings
Overall total	**460,109**	**54,164**	**123,880**
Individuals age 65+	356,256	49,420	110,102
Individuals under 65	103,853	4,744	13,778
Serious Mental Illness (SMI)	75,956	20,796	21,112

Source: State Data, December 2010. Provided in Dual Integration Proposal.

Based on a fully-enrolled population of 460,000 dual eligibles, we can estimate the overall market opportunity of this population at more than $13 billion in Medicaid spending alone, based on a Medicaid per member per month (PMPM) cost of $2,400.[1] The inclusion of Medicare benefits could push annual spending for this population above $20 billion.

[1] PMPM cost based on FY 2009 data from Medicaid Statistical Information System (MSIS) State Summary Datamart. Centers for Medicare & Medicaid Services. http://msis.cms.hhs.gov

Current Market Overview

New York's MLTCP plans enroll roughly 44,000 beneficiaries as of March 2012, with close to 43,000 of those enrolled in the eight county region for the dual integration proposal. Enrollment in the MLTCP partial capitation program is spread across 10 different health plans, some national, and some local.

MLTCP Plans (Partial Capitation)	County	Enrollment
Amerigroup	**Total**	**1,446**
	New York	*1,446*
CCM Select	**Total**	**3,824**
	New York	*3,784*
	Westchester	*40*
Elderplan	**Total**	**5,120**
	New York	*5,120*
Elderserve	**Total**	**5,323**
	Nassau	*38*
	New York	*5,202*
	Suffolk	*16*
	Westchester	*67*
GuildNet	**Total**	**7,827**
	Nassau	*487*
	New York	*6,887*
	Suffolk	*453*
HHH Choices	**Total**	**1,285**
	New York	*1,285*
Independence Care Systems	**Total**	**2,018**
	New York	*2,018*
Senior Health Partners Inc.	**Total**	**3,615**
	New York	*3,615*
VNS Choice	**Total**	**10,329**
	New York	*10,329*
Wellcare	**Total**	**2,051**
	New York	*2,051*
Total MLTC (Partial Capitation)*		**42,838**

**Roughly 1,100 additional enrollees in counties outside the eight initial dual eligible counties.*
Source: New York Monthly Medicaid Managed Care Enrollment Report, March 2012

Within the eight county region, there are two MLTCP PACE plans, enrolling just under 3,200 individuals. These PACE enrollees may opt out of enrollment in a FIDA plan, as noted above in the proposal summary.

MLTCP PACE Plans	County	Enrollment
Archcare Senior Life	**Total**	**206**
	New York	*206*
Comprehensive Care Mgmt	**Total**	**2,974**
	Nassau	*24*
	New York	*2,726*
	Suffolk	*66*
	Westchester	*158*
Total MLTC PACE*		**3,180**

**Roughly 1,000 additional enrollees in counties outside the eight initial dual eligible counties.*
Source: New York Monthly Medicaid Managed Care Enrollment Report, March 2012

The proposal indicates that those FIDA plans whose parent company also operates a Medicaid Advantage plan will likely retain those dual eligibles beneficiaries they currently enroll. Three of the eight target counties (New York, Suffolk, Westchester) currently have Medicaid Advantage plans in operation, enrolling nearly 6,200 beneficiaries.

Medicaid Advantage Plans	County	Enrollment
Affinity	**Total**	**284**
	New York	*284*
ElderPlan	**Total**	**11**
	New York	*11*
Fidelis	**Total**	**1,372**
	New York	*1,372*
GHI	**Total**	**608**
	Suffolk	*7*
	Westchester	*28*
	New York	*573*
HIP of Greater New York	**Total**	**1,431**
	Suffolk	*77*
	Westchester	*8*
	New York	*1,346*
Liberty Health Advantage	**Total**	**481**
	New York	*481*
Managed Health	**Total**	**177**
	Westchester	*2*
	New York	*175*
MetroPlus	**Total**	**199**
	New York	*199*
Touchstone/Prestige	**Total**	**1,439**
	Westchester	*72*
	New York	*1,367*
United HealthCare	**Total**	**189**
	New York	*189*
WellCare	**Total**	**4**
	Westchester	*2*
	New York	*2*
Total Medicaid Advantage*		**6,195**

**Roughly 1,000 additional enrollees in counties outside the eight initial dual eligible counties.*
Source: New York Monthly Medicaid Managed Care Enrollment Report, March 2012

Next Steps and Timeline

The public comment period for the dual integration proposal runs through April 20, 2012. The state will begin the plan selection process in April 2013, with plan selection to be completed by July 30, 2013. October 1, 2013 will begin the enrollment process, with FIDA plans going live on January 1, 2014.

HMA Medicaid Roundup

California

HMA Roundup – Jennifer Kent

The announcement of county site selections for the dual eligible integration demonstration has been pushed back several weeks. The announcement is now set for "early April."

In the news

- **Court Denies Request To Allow Medi-Cal Pay Cuts While Lawsuit Continues**

  Last week, the 9th U.S. Circuit Court of Appeals denied California's request to allow proposed Medi-Cal cuts to take effect while a lawsuit involving the cuts is litigated. In February, U.S. District Court Judge Christina Snyder granted a preliminary injunction to block a 10% cut to Medi-Cal reimbursement rates. A DHCS spokesperson said the courts' decision was "disappointing but not unexpected." (California Healthline)

Florida

HMA Roundup – Gary Crayton

In advance of issuing a procurement for the managed long-term care program, AHCA released the long-term care (LTC) managed care data book last week. The agency anticipates release of the procurement no later than July 1, 2012. For State fiscal year 2010-2011, the combined home and community-based services (HCBS) and non-HCBS population was roughly 89,100 full-time equivalent (FTE) members (based on combined member months). The HCBS population numbered close to 34,900 FTEs (418,605 member months) at spending of more than $426 million, with PMPM costs of $1,017. The non-HCBS population numbered roughly 54,200 FTEs (650,680 member months) at spending of nearly $3 billion, with PMPM costs of $4,610. In total, the full population spent more than $3.4 billion in SFY 2010-2011. The data book is available at: (ahca.myflorida.com)

In the news

- **Judge orders Medicaid to cover autism therapy**

  In a case that could jolt Medicaid programs across the country, a federal judge in Miami has ordered Florida officials to cover behavioral therapy for autistic children. Her order applies to more than 8,000 low-income children in Florida who are enrolled in Medicaid. In her oral order late Friday following four days of testimony, according to a lawyer who was there, the judge called it "one of the most important cases I have ever heard." She issued a permanent injunction giving Medicaid just seven days to notify all physicians who screen youngsters in Medicaid and all community behavioral health programs that the therapy -- called "Applied Behavior Analysis" -- would now be covered. (Health News Florida)

Georgia

HMA Roundup – Mark Trail / Megan Wyatt

The legislature has authorized the Department of Community Health to submit a Federal 1115 Waiver to pursue implementation of the Medicaid redesign proposals. This is a major step forward in the Medicaid redesign process. As we have previously reported, a final Medicaid redesign plan is expected to be released in late April.

The Georgia General Assembly passed the final FY 2013 Appropriations Act (HB 472) on March 27, 2012. The FY 2013 budget is $19.3 billion state funds and $39.5 billion total funds for Georgia state government. This budget represents an $800 million increase in spending over the prior fiscal year. The next step is final approval from Georgia Governor Nathan Deal.

New York

HMA Roundup – Denise Soffel

The New York State budget was finalized earlier this week. Governor Cuomo had included the establishment of the Health Insurance Exchange in his budget proposal. Republicans who control the State Senate objected, and the Exchange was not included in the final budget agreement. Where that leaves things remains unclear. The Governor is considering establishing an Exchange via executive order.

In the news

- **NY eyes $18 bln of Medicaid savings to be split with U.S.**

  By the end of 2012, the state plans to ask the federal government to give it a waiver that will let it run the program more flexibly and allow it to start reaping these savings. Much of the savings would be achieved by switching to managed care, with clinics, for example, paid annual sums for each patient they care for instead of getting a fee for each service they provide. New York's $53 billion-a-year Medicaid program, which provides health insurance for the elderly, impoverished and disabled, is the nation's biggest and most generous. The state's share is about $15.3 billion, while New York's counties pick up the rest. Last year, increases in the cost of Medicaid were capped at about 4 percent. The previous year, Medicaid's cost was estimated to have gone up around 13 percent. In the new budget that starts on April 1, Governor Andrew Cuomo proposed having the state take over administering the program for the counties, and cutting their cost increases to zero over a three-year period. (Reuters)

- **State Faults Care for the Disabled**

  Nearly 300,000 disabled and mentally ill New Yorkers face a “needless risk of harm” because of conflicting regulations, a lack of oversight and even disagreements over what constitutes abuse, according to a draft state report obtained by The New York Times. The report was commissioned by Gov. Andrew M. Cuomo in response to a Times investigation last year into problems of abuse, neglect and fraud in state homes and institutions for the developmentally disabled. In 2010, the number of abuse accusations at large institutions overseen by the State Office for People With Developmental Disabilities outnumbered the beds in those facilities. (New York Times)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Joan Morgan of the Bureau of Managed Care Operations announced that a recommendation on the Healthchoices expansion is on Secretary Alexander's desk for approval and a decision is expected by the end of March

The Pennsylvania Health Law Project (PHLP) and Philadelphia Legal Services (CLS) recently co-authored comments critical of proposed legislation to establish a state-based Exchange in Pennsylvania. Their comments came in reaction to a conceptual draft released by the Pennsylvania Insurance Department in late January 2012. The comments were prefaced with an appreciation that the Department was moving forward with plans to create an Exchange that is unique to Pennsylvania. Pennsylvania has been slow to consider establishment of an Exchange under the Governor Tom Corbett Administration, as the Governor has taken an active role in challenging the legality of the Patient Protection and Affordable Care Act (ACA).

In a letter dated February 14, 2012, the advocates took particular exception to the proposals to allow establishment of multiple private Exchanges as well as more than one Exchange per geographic area. Citing Section 1311(d)(1) of the ACA, "An Exchange shall be a governmental agency or nonprofit entity that is established by the State", the comments asserted that the proposed Pennsylvania language was inconsistent with ACA as it would allow Exchanges to be run by private for profit companies. Also citing Section 1311(f)(2) of the ACA, " each such Exchange serves a geographically distinct area", the comments challenged the language in the Pennsylvania draft that would require the Department to "certify any entity meeting license and certification requirements…to operate as an Exchange".

The comments challenge other concerns emanating from the proposal to allow multiple private Exchanges, including issues related to accountability, data sharing and data management, consumer transitions between private and public health insurance programs, and consumer choice and literacy. Most pointedly, the comments noted the additional level of complexity inherent in the Insurance Department's proposal, as consumers would first need to choose an Exchange before deciding among many qualified health plans. For a complete text of the comments see:

http://www.phlp.org/wp-content/uploads/2012/03/CLS-PHLP-Comments-to-PID-Exchange-Legislation-Conceptual-Draft.pdf

In the news

- **Health-Care Rivals Battle For Patients in Pittsburgh**

  In Pittsburgh, the acrimonious battle between Highmark, the region's most powerful health insurer, and UPMC, the dominant health-care provider, is drawing national attention as a test case on the impact of consolidation in the health-care industry. At the heart of the dispute is Highmark's effort to acquire a financially troubled local hospital group, West Penn Allegheny Health System, as the centerpiece of what it says will be a lower-cost and more efficient health-care operation. UPMC, which has its own insurance arm as well as 19 area hospitals and 3,240 doctors, says it doesn't want to bolster a

company it now considers a direct rival. It has vowed not to sign a new contract to treat patients covered by Highmark, which would mean those patients generally would pay high out-of-network rates to use UPMC hospitals and doctors. (Wall Street Journal)

- **Pennsylvania's Employment Situation for February 2012**

  Pennsylvania's seasonally adjusted unemployment rate was 7.6 percent in February, unchanged from the January rate. Pennsylvania's unemployment rate was below the U.S. rate of 8.3 percent, and has been below the U.S. rate for 46 consecutive months, and at or below the U.S. rate for 64 consecutive months. The state's unemployment rate was down 0.4 percentage points from February 2011. Pennsylvania's seasonally adjusted civilian labor force – the number of people working or looking for work – was up 6,000 in February to 6,389,000. Resident employment was up 10,000 to 5,906,000, and the number of unemployed residents fell 3,000 to 483,000. Pennsylvania's labor force was 15,000 below its February 2011 level. (Pennsylvania News Release)

Other Headlines

Alabama

- **Ala. Medicaid Commissioner resigns**

  Dr. Bob Mullins is out as the Commissioner of Alabama's Medicaid Agency. A spokes-person for the Medicaid Agency released a statement Monday afternoon announcing Mullins' resignation. It is effective April 30. (WAFF News)

Arizona

- **Arizona moves forward on health law**

  Arizona has secured two federal grants worth nearly $31 million to lay the ground-work for an Arizona-based health-insurance exchange. Some conservative legislators have been critical of the Republican governor's efforts to plan a state-run exchange, but Brewer's advisers see it as a practical way to put Arizona's imprint on part of the health law that, if upheld, will have far-ranging impact on consumers, businesses and the economy. The biggest expense in Exchange planning would be a $16.4 million grant for a software vendor to build the framework for the exchange, and that contract will not be awarded before the Supreme Court rules on the federal health-reform law. The Governor's administration said it wants to certify as many qualified health plans as possible to ensure a robust exchange that attracts a cross-section of health insurers. The more insurers that participate in the exchange, the more likely consumers will get a better rate for health insurance. (AZ Central)

District of Columbia

- **UnitedHealthcare loses $15 million on D.C. Medicaid in 2011**

  UnitedHealthcare Community Plan, the smaller of D.C.'s two Medicaid managed care contractors, lost $15 million on $181 million in revenue in 2012, its fourth consecutive money-losing year, according to an annual report recently filed with District insurance regulators. The company, a subsidiary of Minnesota-based UnitedHealth Group Inc. , has shown increasing losses since 2008, its first full year administering insurance plans on behalf of the District. (Washington Business Journal)

Idaho

- **Senate votes to restore Medicaid funding**

  Senate lawmakers have approved a 5.7 percent increase to the Medicaid budget, which also restores previously slashed services for the disabled. The Senate voted 29-4 Monday to approve the nearly $2 billion budget, which also reinstates three cuts to disabled services accounting for $1.5 million. The funding includes $1.2 billion from the federal government, with the state chipping in $474 million. (Idaho Statesman)

Illinois

- **Safety-net hospitals propose cuts to Illinois Medicaid spending**

  A group of seven Chicago-area safety net hospitals has a plan to slice $1.4 billion in Medicaid spending, an amount just over half what Gov. Pat Quinn last month said should be cut from the federal-state program's budget. The proposal, which combines maximizing revenues to Medicaid and controlling enrollment in the program, would not mean reductions in reimbursement rates to providers or cuts in services for patients, according to the Association of Safety-Net Hospitals. The safety net hospitals' proposal includes collecting from the federal government up to $220 million associated with current Health and Family Service Department programs, and saving between $400 million and $1.2 billion by removing an estimated 100,000 to 300,000 people currently enrolled in Medicaid who don't meet eligibility requirements. (Crain's Chicago)

- **Medicaid cuts, property tax battle a stress test for many hospitals**

  Children's Memorial Hospital would be faced with a $37 million to $50 million hole in its budget. Norwegian American Hospital could be forced to close. Swedish Covenant Hospital's chief executive says the entire health care system in Illinois would be pushed to the verge of collapse. A confluence of proposed cuts to the state's Medicaid program and the specter that some hospitals may be forced to start paying millions each year in property taxes has Illinois hospitals on their heels. (Chicago Tribune)

- **Rush University back in UnitedHealthcare network for first time since 2000**

  For the first time in nearly 12 years, patients insured by UnitedHealthcare of Illinois Inc. will have access to Rush University Medical Center and three other regional hospitals that belong to The Rush System for Health network. The multiyear agreement, to be announced Monday, reunites the state's No. 2 insurer, a division of Minnetonka, Minn.-based UnitedHealth Group Inc., and Rush, Chicago's fourth-largest hospital

based on patient revenue, after the two parted ways in December 2000 over a dispute about reimbursement rates and other issues. (Chicago Tribune)

- **Medicaid drugs become target for Illinois cuts**

  The search for Medicaid savings might drive some lawmakers to examine drug spending. Medications for 2.7 million poor and disabled Illinoisans now cost the Medicaid program more than $1 billion annually. But cutting back on drug spending could end up creating higher costs in other areas of health care. Lawmakers want to avoid those unintended consequences and the resulting outcry from health advocates. (Crain's Chicago)

- **Necessary but impossible cuts face IL in Medicaid spending**

  Gov. Pat Quinn has a dilemma. The state constitution requires him to balance his budget. The governor figures he can find $2.7 billion in savings through cuts to the state's Medicaid program. The costs of failure are huge, and few think the governor will succeed. Even those cuts would simply hold Medicaid spending flat, and wouldn't begin to address the $2 billion the state owes in overdue Medicaid bills. If the Legislature can't agree on cuts, Medicaid eventually will squeeze other areas of the state budget, including education and public safety. On top of that, the state will wind up with $21 billion in overdue Medicaid bills by 2017, according to the Civic Federation, a budget watchdog based in Chicago. A working group has been convened to present possible solutions to the state's ballooning Medicaid costs. The working group's findings are due by mid-April. (Statehouse News Online)

- **Illinois Senate to meet on Medicaid options**

  A Chicago Democrat has said he's calling a bipartisan meeting because it's crucial for Democrats and Republicans to learn about Medicaid together and to cooperate on solutions to preserve the program. Medicaid covers health care for nearly 3 million Illinois residents and costs $14 billion a year in state and federal funds. Facing growth in Medicaid obligations, Illinois has repeatedly paid some of the program's costs out of future budgets, contributing to a buildup of late payments to doctors, pharmacies and nursing homes. The backlog of unpaid Medicaid bills is expected to reach $1.8 billion by the end of the current fiscal year. (NECN.com)

Nebraska

- **Nebraska Awards Medicaid Expansion Contracts to Coventry, AmeriHealth**

  Effective July 1, 2012, the Department of Health and Human Services, Division of Medicaid and Long-Term Care (MLTC) is expanding the physical health managed care program statewide. MLTC is contracting with two health plans to manage physical health services for clients in the 83 counties not currently served by Physical Health Managed Care. The two health plans servicing the statewide expansion counties are Coventry Healthcare of Nebraska, Inc. (Plan name: Coventry Cares) and AmeriHealth Nebraska, Inc. (Plan name: Arbor Health Plan). (Nebraska DHHS Bulletin)

New Hampshire

- **Council puts off managed care decision**

  New Hampshire's executive councilors indicated yesterday they are likely to put off a vote until next month on whether to contract out the Medicaid program to private organizations. After putting the program out to bid, state health officials selected three out of six total applicants to receive a combined $2.2 billion to operate Medicaid in New Hampshire as the system is rolled out in phases over the next three years. A dozen organizations - including AARP New Hampshire, the Children's Alliance, the New Hampshire Hospital Association and Granite State Independent Living - sent a letter to the executive council last week requesting more time for public review of the proposed contracts. (Concord Monitor)

- **New Hampshire Awards Medicaid Contracts to Boston Medical, Centene, Meridian**

  Last Friday, New Hampshire announced Medicaid RFP awards to Boston Medical Health Plan (regional nonprofit), Centene, and Meridian. Boston Medical received top scores and will receive 50 percent of enrollees. Centene and Meridian will split the remaining lives at 25 percent each. MCO contract documents layout budgeted contract spending over the three contract years FY2013-2015, with Centene and Meridian set to receive $95 million in annual revenue during year one, $225 million in year two and $236 million in year three. Boston Medical will receive $191 million in year one, $450 million in year two, and $472 million in year three. Aetna, who previously held a primary care case management (PCCM) contract with the state, did not receive a contract award. (NH MCO Contract Funding - PDF)

New Mexico

- **Health care official resigns over perceived lag in progress**

  An Albuquerque doctor tasked by Gov. Susana Martinez's administration to help administer a cornerstone of the nation's federal health care law in New Mexico resigned this week, citing resistance from top officials to move forward. Dr. Dan Derksen resigned Monday as director of the New Mexico Office of Health Care Reform. In an interview Friday, Derksen, a lifelong Republican, said there had been a shift in policy and that he had lost the battle over "policy approach and implementation" within the administration about the timeline for building a New Mexico health insurance exchange, which is meant to help more people obtain health insurance. (Santa Fe New Mexican)

Washington

- **Governor signs insurance exchange bill into law**

  Gov. Chris Gregoire on Friday signed into law a bill setting rules for insurers preparing for the state's online insurance exchange. The exchange measure was opposed in the Legislature by most Republicans, who say it is unnecessary for the state to go further in setting rules for the exchange beyond what the federal government has done, particularly while many specifics of health care reform remain unresolved and the Supreme Court has yet to weigh in. (Wenatchee World)

National

- **In Court, Sharp Questions on Health Care Law's Mandate**

  Predicting the result in any Supreme Court case, much less one that will define the legacies of a president and a chief justice, is nothing like a science, and the case could still turn in various directions. But the available evidence indicated that the heart of the Affordable Care Act is in peril. The court's decision is expected by June, and much may change as the justices deliberate and exchange draft opinions in the coming months. (New York Times)

- **Medicaid ruling could have far-reaching impact**

  The court is spending most of its health law oral arguments on questions pertaining to the individual mandate. Later, the court will devote the sixth and final hour to Medicaid expansion. And even though court-watchers are not expecting a precedent-shattering ruling on the question, the fact that the court is addressing this element of the health law signals that the justices are taking it seriously. A broad ruling by a conservative majority in June against Medicaid could shake the shared legal foundation of landmark legislation, including unemployment benefits, the Civil Rights Act and the Clean Air Act. And that, said George Washington University's Sara Rosenbaum, would "completely change the balance of power of federalism." (Politico)

- **Contingency Plans Are Few if Court Strikes Down Insurance Requirement**

  If the court invalidates the insurance requirement, the White House and a divided Congress would be left to pick up the pieces. Their first steps toward finding alternatives to reduce the number of uninsured in the country — nearly 50 million, or one in six Americans — would depend heavily on how far the Supreme Court goes, and on the balance of power in Washington after the November elections. So long as the court does not invalidate the entire law, many other components — and the taxes to pay for them — could remain in place even if the mandate and related insurance regulations are struck down. They include a vast expansion of Medicaid eligibility and the establishment of health insurance exchanges, offering subsidized coverage to those with low incomes, both scheduled to start in 2014. (New York Times)

- **Health Executives Unfazed by Supreme-Court Debate**

  Insurance companies and hospital chains brushed off concerns Tuesday the Supreme Court could strike down a requirement in the health-care law that would create millions of newly insured customers. Health insurers have perhaps the most at stake of any sector touched by the case. The court is considering whether a requirement that most Americans eventually carry insurance or pay a fee violates the Constitution. The individual mandate is expected to expand insurance to about 30 million Americans. Shares of major health insurers traded down as reports emerged that Justice Anthony Kennedy, a possible swing vote in the case, skeptically questioned the main attorney defending the provision. He suggested the government faced a heavy burden in defending the requirement, though he later posed tough questions of challengers of the law. Insurers stocks' regained ground after the law's challengers took their turn responding to the justices' questions. (Wall Street Journal)

- **Important Update for Health Care Innovation Challenge**

  From the CMS Innovation Center: *"We received approximately three thousand applications, representing tens of thousands of clinicians, information technology entrepreneurs, medical suppliers, health centers, hospitals, community-based organizations and individual citizens from every corner of the nation. As we continue to process and review these proposals, **we recognize that a diligent and thorough process means that final determinations of awards will not be possible by March 30, 2012, as stated in the Funding Opportunity Announcement. Therefore, the anticipated award date for this opportunity will be delayed by several weeks.** We apologize for the inconvenience this may cause, but will continue to work as efficiently as possible to process all applications under review in a timely manner. Please note, that no determination will be made regarding a second round of funding until the first round of awardees have been announced."*

- **Health Law Accelerates Industry Changes**

  Kaiser Health News highlights an accelerated trend of changes across the health care industry, including increased hospital mergers and sales, health plans focusing increasingly on contracting with Medicaid and Medicare, and a rapid adoption of health information exchange and technology upgrades. (Kaiser Health News)

- **Implications Are Far-Reaching in States' Challenge of Federal Health Care Law**

  A major issue in the Supreme Court battle over the new health care law is whether Congress can force states to make a huge expansion of Medicaid, to add millions of low-income people to the rolls. States say the federal law is unconstitutionally coercive because all their Medicaid money would be at risk if they flout the new requirement. The states' argument has implications that go far beyond health care. It raises questions about Congress's ability to attach conditions to federal grants to the states for other purposes, like education, transportation, law enforcement and protection of the environment. (New York Times)

- **Feds To Test Paying For Medicaid Patients With Psychiatric Emergencies**

  A group of states is testing whether Medicaid patients who seek emergency psychiatric care at private psychiatric hospitals are better off if the federal government picks up part of the costs. Right now, the federal government does not help states pay for inpatient psychiatric care for many Medicaid patients—a longstanding policy meant to discourage states from cost-shifting to the federal government and institutionalizing patients. But many advocates and officials believe the policy is discriminatory and has become a barrier to treatment. For example, patients in need of psychiatric care can land in the emergency rooms of regular hospitals, which may be overburdened or unable to offer them proper treatment—a problem that is exacerbated by cuts to states' mental health budgets that reduce the availability of services. If the federal government paid inpatient psychiatric facilities to treat Medicaid patients, those problems could be lessened, they say. (Kaiser Health News)

COMPANY NEWS

- **HMS Awarded Recovery Audit Contractor (RAC) Contract by the State of Nevada**

  HMS, a wholly owned subsidiary of HMS Holdings Corp., announced today that it has been awarded a contract by the Nevada Department of Health Care Financing and Policy (DHCFP) to serve as the State's Recovery Audit Contractor (RAC). Under the terms of this contract, HMS will perform services outlined in the RAC portion of the Affordable Care Act, including identifying and recovering unnecessary or inappropriate Medicaid payments for services. The contract extends through December 31, 2016. (MarketWatch)

- **WellCare Announces Final Resolution of Whistleblower Claims**

  WellCare Health Plans, Inc. announced that the settlement agreements, which resolve the pending inquiries of the Civil Division of the United States Department of Justice (Civil Division) and the United States Attorneys' Offices for the Middle District of Florida and the District of Connecticut, are now effective. These settlements are related to four qui tam complaints filed by relators against WellCare under the whistleblower provisions of the False Claims Act. The final relator, who recently withdrew his objection to the settlement, has executed the federal settlement agreement, making the resolution effective today. (WellCare News Release)

- **Centene opens office in Sandy Springs; brings 75 jobs**

  Centene has opened an office in Sandy Spings, Georgia, and will create 75 jobs. Centene's new office will serve the PeachCare for Kids program, which provides health care to Georgia children through the age of 18 who do not qualify for Medicaid and live in households with incomes at, or below, 235 percent of the federal poverty level. (Atlanta Business Chronicle)

- **Thomson Reuters puts health unit back on block: sources**

  News and information company Thomson Reuters Corp has resumed an auction of its healthcare unit after shelving the process last year due to tough market conditions, sources familiar with the situation said. More than one bidder is vying for the unit, which provides data, analytics and other services related to the industry to companies, government agencies and healthcare professionals, one of the sources said. (Reuters)

- **Missouri Care Awarded New Contract**

  Missouri Care, an Aetna health plan that administers benefits for MO HealthNet Managed Care members, has been selected to administer services in the Central, Eastern and Western regions of the state. Approximately 426,000 beneficiaries are eligible to receive services under the MO HealthNet Managed Care program in 54 counties. (Aetna News Release)

- **CFO, CMO and a senior VP exit Blue Cross Blue Shield**

  Three high-level executives have left Blue Cross and Blue Shield of Minnesota less than five weeks after new CEO Kenneth Burdick officially took the helm.The departing executives are Pamela Sedmak, chief financial officer; Dr. Gregory Gilmet, chief medical

officer; and Kathleen Mock, senior vice president of marketing and public and health affairs. A spokesman for the Eagan-based insurer on Thursday offered no other information about the departures. (Star Tribune)

- **Coventry Senior VP Resigns**

  On March 16, 2012, John J. Stelben resigned as Senior Vice President, Medicaid Health Plans of Coventry Health Care, Inc. effective as of March 17, 2012.

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
End of March	Pennsylvania	Contract awards	465,000
Early April	California Dual Eligibles	Site Selection	500,000
April, 2012	Arizona Duals	Demo Proposal released	120,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
April 2, 2012	Ohio Duals	RFP Released	122,000
April 9, 2012	Ohio	Contract awards	1,650,000
April 13, 2012	Massachusetts Duals	RFP Released	115,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 30, 2012	Illinois Duals	RFP Released	172,000
May 11, 2012	Ohio Duals	Proposals due	122,000
May 18, 2012	Kansas	Contract awards	313,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 15, 2012	Illinois Duals	Proposals due	172,000
June 20, 2012	Florida CHIP	Contract awards	225,000
July 1, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	90,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Contract awards	115,000
July 31, 2012	Illinois Duals	Contract awards	172,000
July/August, 2012	Georgia	RFP Released	1,500,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
January, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	172,000
January 1, 2013	Massachusetts Duals	Implementation	115,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
January 1, 2013	Ohio Duals	Implementation	122,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
July 1, 2013	Michigan Duals	Implementation	211,000
October 1, 2013	Florida	LTC enrollment complete	90,000
January 1, 2014	New York Dual	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
February 1, 2014	Georgia	Implementation	1,500,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000

HMA Recently Published Research

Webcast: Medicaid Budgets and California's Dual Eligible RFS

Vernon Smith, Managing Principal

Jennifer Kent, Principal

On Friday, March 2, 2012 HMA Principals Vernon Smith and Jennifer Kent hosted a conference call in conjunction with the Gerson Lehrman Group (GLG). On the call, Vernon provided an update on state Medicaid budgets and the expansion of Medicaid managed care while Jennifer led a discussion of California's request for solutions (RFS) for an integrated delivery model for Medicare-Medicaid eligibles. A webcast replay of the call is available at: **(GLG Research - Link to Webcast)**

Upcoming HMA Appearances

CMS Medicaid HITECH Conference – New Medicaid Staff HIT Orientation

Izanne Leonard-Haak, Presenter

April 10, 2012

Baltimore, Maryland

19th Annual Princeton Conference: States' Role in Health Care Reform: Possibilities to Improve Access and Quality – How are States Progressing in Setting Up State-Based Exchanges?

Jennifer Kent, Presenter

May 24, 2012

Princeton, New Jersey

AcademyHealth Annual Research Meeting – The Impact of the ACA on State Policy: Early Findings

Jennifer Edwards, Panel Facilitator

June 25, 2012

Orlando, Florida