HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS UPDATES DUAL ELIGIBLE INTEGRATION GUIDANCE & TIMELINE

HMA ROUNDUP: CALIFORNIA DEMONSTRATION SITES ANNOUNCED, DUAL INTEGRATION PROPOSAL RELEASED; ILLINOIS RELEASES MMIS, ENROLLMENT BROKER PROCUREMENTS; PENNSYLVANIA NEW EAST AND NEW WEST MANAGED CARE AWARDS STILL PENDING; FLORIDA TO EVALUATE SHIFTING TO DRG-BASED REIMBURSEMENT SYSTEM FOR HOSPITALS; COLORADO LAUNCHES TELEHEALTH INITIATIVE

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HMA WELCOMES: LINDA TROWBRIDGE – BAY AREA, CA

APRIL 4, 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: CMS UPDATES DUAL ELIGIBLE INTEGRATION GUIDANCE & TIMELINE

This week, our *In Focus* section looks at the updated guidance on dual eligible integration, released March 29, 2012 by the Centers for Medicare & Medicaid Services (CMS). In January 2012, CMS released an initial round of guidance regarding dual eligible integration demonstrations, providing information on payment principles, key dates, and network adequacy determinations. The March 2012 round of guidance provides additional information on Medicare plan selection requirements, programmatic design for joint Federal and State review of plans, key principles of oversight and monitoring, and requirements for Medicaid plans to submit data to the Medicare Plan Finder. Additionally, CMS has provided an updated timeline with additional detail on key actions in the dual eligible integration demonstration process. In addition to the CMS guidance updates, we have provided an up-to-date timeline on where states are in the process to implement dual eligible integration demonstrations in 2013.

Dual Integration Background

In a letter to state Medicaid directors, issued Friday, July 8, 2011, CMS expressed interest in working with state Medicaid agencies by offering two financial models for integrated care for dual eligible Medicaid and Medicare beneficiaries. These payment and financing models are intended to promote better care and align incentives for improving care, as well as lower costs to States and the federal government.

For more details on the State Medicaid Directors (SMD) letter, please refer to our July 13, 2011 *In Focus* section available on our website at this link. On January 4, 2012, our *In Focus* provided an overview of which states submitted letters of intent to CMS and what model or models those states were pursing. Key elements of the two models include

- Under the **Capitated Model**, states, CMS, and health plans will enter into a three-way contract, under which managed care plans will receive a blended capitated rate for the full continuum of benefits provided across both Medicare and Medicaid. Blended rates will be set to target aggregate savings to both states and the federal government. CMS indicated that managed care plans will be required to meet established quality thresholds. Health plan contracts will be awarded through a joint procurement by states and CMS, and the SMD letter indicates a preference toward plans that have demonstrated the capacity to provide Medicaid and Medicare services to plan enrollees.
- Under the **Managed FFS Model**, CMS will establish a retrospective performance payment system, under which states will receive performance payments based on Medicare savings net of federal Medicaid costs. This model requires upfront investment in care coordination, with savings determinations made by the CMS Office of the Actuary.

Updated CMS Guidance

Capitated Model Plan Selection Criteria

Plans interested in participating in Capitated Financial Alignment Demonstrations will ultimately be selected through a joint procurement conducted through the states, either through a RFP or application process. The following Medicare components of the plan requirements were included in the January 2012 CMS guidance:

- Approval of a unified formulary consistent with Part D and Medicaid;
- Approval of a medication therapy management program (MTMP) consistent with Part D requirements;
- Approval of an integrated plan benefit package that meets the minimum requirements for Part D drugs, Medicare-covered items and services, Medicaid-covered items and services, and any required demonstration-specific items and services;
- Approval of a demonstration-specific application, including demonstration of adequate access to providers and pharmacies for Medicare drug and medical benefits; and

This updated guidance from CMS also indicates that past plan performance will be included in the selection criteria. CMS will not consider an organization eligible if it is currently under a Medicare enrollment and/or marketing sanction. In addition, CMS will consider an organization's previous performance in the Medicare program for purposes of allowing passive enrollment (automatically or mandatorily enrolling eligible individuals with an opt-out period).

CMS will use two mechanisms for assessing an organization's Medicare performance: (1) the Past Performance Review methodology; and (2) the "low performing" icon. Managed care entities that are considered an outlier based on the Past Performance Review methodology and/or have a "consistently low performing" icon on the Medicare Plan Finder website can still qualify to offer a demonstration plan but will not be eligible to receive any new passive enrollments. These entities will only be able to enroll members that voluntarily select their plan or are already enrolled in either their existing Medicaid or Medicare plan in the market.

Updated Timeline

The following timeline was of dates and events and deadlines is provided in the updated guidance released last week:

Date	Event/Deadline
Ongoing – Summer 2012	States submit demonstration proposals that are evaluated against Standards and Conditions. States and CMS negotiate MOU for proposals that meet the Standards and Conditions.
April 2, 2012	Latest date for Interested plans to submit their Notice of Intent to Apply (NOIA).
April 30, 2012	Part D formulary submissions due to CMS for interested organizations that are submitting a new formulary (e.g., those that have not submitted a formulary for CY 2013 for non-demonstration plans).
April – July 2012	Interested organizations are selected through a CMS-State joint selection process. The CMS portions of the joint plan selection requirements will be consistent with guidance documents. CMS and States review and select participating plans.
May 14, 2012	Part D formulary crosswalk requests due to CMS for interested organizations that have already submitted a non-demonstration plan formulary for CY 2013 and intend to utilize that previously submitted formulary for their demonstration plans.
May 24, 2012	Deadline for interested organizations to submit a Capitated Financial Alignment Demonstration Application.
June 4, 2012	Submission deadline for interested organizations' proposed plan benefit packages (including all Medicare and Medicaid benefits for demonstration plans).
June – July 2012	CMS and States review submitted plan benefit packages.
July 30, 2012 (target date)	CMS and State portions of the demonstration joint plan selection process for CY 2013 completed.
Late July - September 2012	CMS and State conduct readiness reviews for selected plans. CMS and States jointly confirm readiness requirements have been met.
September 17, 2012 (target date)	Roll-out of MA and Part D plan landscape documents, which include details (including high-level information about benefits and cost-sharing) about all available Medicare health and prescription drug plans for CY 2013.
September 20, 2012 (target date)	Three-way contracts among selected plans, States, and CMS must be finalized and signed no later than this date.
October 15 – December 7, 2012	MA and Part D Annual Coordinated Election Period.
January 1, 2013	Enrollment effective date.

State Progress Update

Below we have summarized the progress of states in developing dual eligible integration proposals for enrollment dates in 2013. Several states interested in the capitated model are proposing to begin plan enrollment in 2014, and are on a longer timeline. These states are not described in the table below but include New York, Arizona and South Carolina. We note Tennessee has not released a demonstration proposal yet for 2013 implementation, but we expect a proposal to be released soon. California released its proposal for public comment today, April 4, 2012.

State	Released by State	Date	Submitted to CMS	Date	Deadline for Plans to submit applications	3-way contracts signed	Open enrollment ends	Enrollment effective date
California	X	4/4/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Illinois	X	2/17/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Massachusetts	X	12/7/2011	X	2/16/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Michigan*	X	3/5/2012			5/24/2012	9/20/2012	TBD	7/1/2013
Minnesota	X	3/19/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Ohio	X	2/27/2012	X	4/2/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Washington	X	3/12/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Wisconsin	X	3/16/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013

**Michigan proposed an enrollment effective data of 7/1/13*

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

The breaking news in California is that the following four counties were selected to be the first four to participate in the state's dual eligible demonstration program:

- Los Angeles (Health Net, L.A. Care): approximately 375,000 duals
- Orange (CalOptima): approximately 74,000 duals
- San Mateo (Health Plan of San Mateo): approximately 35,000 duals
- San Diego (Community Health Group, Health Net, Molina Healthcare and Care1st): approximately 74,000 duals

California also released its demonstration proposal for a 30-day comment period wherein it states its intention to implement in six additional counties if it receives legislative authorization. The six additional counties are Alameda, Contra Costa, Riverside, Sacramento, San Bernardino and Santa Clara. California plans is to implement the demonstration program beginning January 1, 2013 and will have a potential enrollment of 800,000 duals by the end of 2013. The state, if authorized, will enroll all 1.1 million duals statewide by 2015.

We also note that last week, the California Department of Healthcare Services (DHCS) released guidance related to how existing dual eligible Special Needs Plans (D-SNPs) will be contracted going forward. Specifically, the state is strongly encouraging all D-SNPs to subcontract with one or more of the demonstration plans in the pilot counties where they operate so that their existing Medicare members' care will not be disrupted. To the extent that a subcontracting arrangement can't be negotiated, DHCS will enter into a MIPPA-compliant contract with the D-SNP for a one year period (without the opportunity of renewal) with the understanding that the organization will subsequently reach an agreement with the demonstration plan(s) or will lose their D-SNP enrollment. These one-year MIPPA contracts will also not include any compensation from the state. Additionally, the D-SNP must agree that its enrollment won't exceed 105% of its base as of March 2012 at any point during the year.

In the news

- **Ironing Out Details of Duals Conversion**

  State officials met with stakeholders in Sacramento yesterday to answer questions and work out the final details of the duals demonstration project -- an ambitious plan to enroll an estimated 700,000 dual-eligible Californians in 10 counties into Medi-Cal managed care. Enrollment will be mandatory for beneficiaries eligible for both Medi-Cal and Medicare. Jane Ogle, deputy director of health care delivery systems at the Department of Health Care Services, was quick to point out that beneficiaries would keep their own physician, even if that physician is not in the Medi-Cal network, and that beneficiaries have the power to opt out of the demonstration project, if they want.(California Healthline)

- **Gov. Brown's administration wants health care change, with or without federal law**

  Gov. Jerry Brown's administration vowed Thursday to continue pushing forward elements of the federal health care overhaul in California, even if the U.S. Supreme Court strikes it down. If the court does rule the federal law unconstitutional, state Health and Human Services Secretary Diana Dooley said California should at least consider enacting its own universal health care legislation, including requiring every Californian to buy insurance. At issue is whether Congress can require people to buy insurance and, separately, whether lawmakers overstepped in pressuring states to expand Medicaid coverage. In 2010, California, amid urging from the White House, became the first state in the nation to enact legislation establishing a public health insurance marketplace to implement the Affordable Care Act. The insurance exchange is expected to serve more than 2 million Californians beginning in 2014, many of them now uninsured residents who do not qualify for existing public health care or cannot afford coverage on the open market. (The Sacramento Bee)

- **Medi-Cal Officials Assess Gold Coast Health Plan's Assignment Procedures**

  The Ventura County Medi-Cal Managed Care Commission has formed a committee to study how beneficiaries covered by Gold Coast Health Plan have been assigned to clinics and physicians. Medi-Cal is California's Medicaid program. Concerns about the assignment process were raised in a draft report by an external auditor. Commissioners said they will not be able to assess the implications of the plan's assignment procedures until they obtain more information on how and why beneficiaries were directed to certain health care providers. (California HealthLine)

Colorado

HMA Roundup – Joan Henneberry

Colorado Medicaid has made Telehealth services available to Medicaid clients meeting specific program eligibility criteria. Telehealth enables the remote collection of vital signs such as weight, temperature, blood glucose levels, blood pressure, pulse and lung functions. Studies have shown telehealth services to reduce hospital readmissions. Though particularly impactful for those beneficiaries in rural areas who may lack access to a health care provider, the program is not limited to rural clients.

The state launched the Adults Without Dependent Children (AwDC) Program on April 1, 2012. AwDC will provide Medicaid benefits to 10,000 eligible adults, ages 19 through 64, who are at or below 10% of the Federal Poverty Level (FPL), do not have a Medicaid-eligible dependent child living in the home and who are ineligible for Medicare and other Medicaid programs. All applicants determined eligible between April 1, 2012 and May 15, 2012 will participate in a randomized member selection process. The initial selection process is limited to 10,000 clients. A waitlist will be implemented for those not included in the initial selection.

In the news

- **Colo. budget written, heads for debate in House**

A Colorado budget with better-than-expected funding for education, colleges and seniors will be introduced in the House next week, where lawmakers will vote on a proposed $8 billion spending plan. Budget writers finalized the budget Friday after some tension in recent months over whether to fund a property tax break for seniors and a debate over benefits for state employees and payroll reductions to Colorado agencies. (The Denver Post)

Florida

HMA Roundup – Gary Crayton

Governor Scott signed HB 5301 into law this past week. The bill contains several impactful measures to the state Medicaid program. One of the major components of the bill is the provision which directs AHCA to evaluate a transition to a Medicaid payment system based on DRG codes. The bill does not lay out a timeline for the exploration of this payment system transition.

In the news

- **Gov. Rick Scott signs Medicaid billing changes; may cost counties $326 million**

  Against the wishes of counties and tea party leaders, Gov. Rick Scott signed a controversial bill into law Thursday that will change the way counties are billed for Medicaid costs and could set up a legal showdown. If nothing changes, counties could be forced to pay the state an additional $325.5 million in the coming years in disputed Medicaid bills. Scott took the unusual step of submitting a letter to the Secretary of State's office explaining why he signed the bill, HB 5301. Scott acknowledged the counties' concerns and vowed to work with them to resolve years of disagreements with the Agency for Health Care Administration on how much they owe for Medicaid. (Miami Herald)

- **Scott signs Medicaid bill opposed by Fla. Counties**

  Gov. Rick Scott promised steps will be taken to make sure counties' Medicaid bills are accurate Thursday as he signed legislation requiring them to pay nearly $300 million in disputed past-due billings. Scott signed the measure (HB 5301) over objections from county officials who had urged him to veto it. They contend they are being overcharged due to mistakes by the state's electronic billing system. The bill's sponsors argued that counties simply have refused to pay their fair share because their budgets are being pinched by hard economic times. Counties are required to pay a share of the costs for their residents who are enrolled in the state-federal health care program for low-income and disabled patients. (WDBO.com)

- **Doctors fight over Universal HMO**

  Two doctors who are among Florida's most aggressive fund-raisers for the Republican Party have had a nasty falling-out over control of an HMO. Dr. Zachariah P. Zachariah, a prominent Broward cardiologist, has filed suit against Dr. Akshay Desai, the chairman and CEO of Universal Health Care. Universal, founded in 2002, is a fast-growing Medicare HMO based in St. Petersburg. Desai was recently named finance chairman for the Republican Party of Florida. Zachariah is raising money for a Senate candidate and for the presidential campaign. Zachariah's suit says Desai cheated him out of a seat

on the Universal board and diluted the value of his holdings by issuing 57 million additional shares of common stock without his knowledge or consent. (HealthNews Florida)

- **Magic Johnson Enterprises invests in Simply Healthcare Plans**

  Magic Johnson Enterprises bought a minority stake in Miami-based Simply Healthcare Plans, which announced the launch of a Medicaid plan for people with HIV and AIDS. NBA Hall of Famer Earvin "Magic" Johnson is a major advocate for the disease, which he has had since 1991. Since retiring for good in 1996, Johnson has been involved in multiple business ventures. That includes the recent purchase of the Los Angeles Dodgers and a deal to acquire the Intracoastal Mall in North Miami Beach in a deed in lieu of foreclosure. Now he's a minority investor in and board member of Simply Healthcare, which runs Medicaid, Medicare and Healthy Kids managed care plans with more than 65,000 members. (South Florida Business Journal)

Georgia

HMA Roundup – Mark Trail

The legislative session has completed, and much attention has turned to the state's Medicaid managed care redesign process. The state's current plans are for the Department of Community Health (DCH) to release its redesign proposal by the end of April at which time its consulting firm, Navigant, will begin to draft the managed care RFP. The RFP is expected to be released in the July/August timeframe with contracts signed by January 2013. We note that implementation is not scheduled until January 2014 giving DCH some flexibility in case the process is delayed. We continue to believe the state will transition the ABD population into the managed care model, consistent with Navigant's recommendation, and that it will select 4-6 plans for the expanded program.

In the news

- **Lawmakers get update on Medicaid restructuring**

  The current timeline for a decision on restructuring Georgia Medicaid may not be feasible, a state official indicated to lawmakers Wednesday. Blake Fulenwider, deputy commissioner of the Department of Community Health, also told House lawmakers that financial projections on the leading options for a Medicaid revamp have not yet been worked out. (Georgia HealthNews)

- **Integrated Eligibility Portal Simplifies Program Application Process**

  An aggressive undertaking to simplify enrollment in Medicaid and other state programs is underway in Georgia. A new web-based eligibility system for application to multiple social services is under development with goals to streamline the eligibility process for consumers, eliminate redundant data entry for case workers, and reduce duplicate client information shared by multiple social services. The Georgia Department of Community Health (DCH) is the lead agency on the project and is working with the Department of Human Services, the Department of Public Health and the Georgia Technology Authority. The new Integrated Eligibility System (IES) will allow

consumers to apply online and obtain eligibility for programs like Medicaid, TANF, SNAP (formerly Food Stamps) and WIC through a single web portal.

Illinois

HMA Roundup – Jane Longo / Matt Powers

There continues to be significant discussion around the budget deficit and the call for $2.7 billion in Medicaid cuts. The Department of Healthcare and Family Services (HFS) has developed a list of $1.9 billion in optional services that could be eliminated or reduced, including $814.7 million in adult pharmaceuticals, impacting approximately 675,000 Medicaid patients. HFS stresses, however, that these are not the department's recommendations, but merely a menu of options. As of yet, no legislation has gained any momentum to address the budget shortfall in Medicaid. The legislative session is set to end May 31, with any legislation after that date requiring a two-thirds majority vote, rather than a simple majority.

HFS released two procurements last week. The first, for an MMIS replacement, is for a staffing vendor to provider project management, business services, technical and Medicaid experts to the state as they build an MMIS to replace the 30-year old system in use today. This will occur in two phases that may be spread out over 10 years. The first phase is to build two MMIS subsystems – Pharmacy Point of Sale and Drug Rebate – over a one year period. The second phase will be over a four year period and will involve rebuilding all other MMIS components. The evaluation scoring will be 50% responsiveness and 50% price. Deadline for vendor questions is April 13, 2012. Proposals are due May 4, 2012 at 2:00 pm CT.

The second procurement is for a Client Enrollment Broker. The contract for the current CEB with AHS expires June 30, 2012. This procurement is for current CEB duties with expansion as a result of the state's various procurements to increase care coordination enrollment. AHS is expected to bid to retain this contract ($5.2 million value for state FY12). Evaluation scoring will be 70% responsiveness and 30% price. Deadline for vendor questions is April 11, 2012. Proposals are due May 9, 2012 at 2:00 pm CT.

In the news

- **Urban hospitals propose Illinois Medicaid plan**

  A coalition of Chicago-area hospitals that serve the poor called on Illinois officials to go after more federal money before cutting their Medicaid funding. Leaders of the Association of Safety-Net Hospitals released a plan Wednesday that aims to bring Illinois' Medicaid program $1.4 billion closer to a balanced budget. They said the state could bring in $110 million more each year in Medicaid money from the federal government than it does now. (Washington Examiner)

- **Chicago's Mercy Health joining Novi-based Trinity hospital system**

  The Chicago-based Mercy Health System has become part of Trinity Health, the Novi-based Catholic health care system said Monday. The affiliation with Trinity Health, finalized Sunday, will help Mercy Hospital in Chicago survive, the two nonprofit groups said in a statement. Trinity Health has shared some services with Mercy Health since

2009. In November, the two health systems agreed to work more closely together to cut costs and improve service at Mercy Hospital, receiving the necessary regulatory and board approvals. (The Detroit News)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Despite predictions from Pennsylvania State management that there would be an announcement on the winning bidders in Pennsylvania's Medicaid managed care expansion by the beginning of April, no information has been released. A recommendation has been on the Secretary of Welfare's desk for two weeks. Admittedly, this procurement poses some tough decisions for the state. Earlier, the state confirmed there were 9 bidders overall interested in the procurement for the New East (290,000 lives) and New West (174,000 lives), with 7 submitting proposals for each zone. However, the state has indicated that they will award the contracts to "no more than 3 offerors per zone." While the state has not announced who the bidders are, companies who signed in at the pre-proposal conference include Aetna Better Health Coventry Cares (Health America), Blue Cross/Blue Shield of North East PA (NEPA), Gateway, Geisinger Health Plan, AmeriHealth Mercy, Universal American/APS, United Healthcare and UPMC for You. In total, the annual market opportunity represents approximately $1.8 billion.

The Pennsylvania Department of Revenue released the March 2012 collections earlier this week indicating that the overall General Fund collections exceeded expectations by about 2.4 percent for a grant total of $4.1 billion. The year-to-date collections for the General Fund are about 1.9 percent below estimate.

Finally, we provide an update on the implementation of electronic health records in Pennsylvania. As of Tuesday, March 27th, 3,018 Eligible Professionals either began or completed their Pennsylvania Medical Assistance Provider Incentive Repository (MAPIR) application. 108 Eligible Hospitals either began or completed their Pennsylvania MAPIR application. To date, the state has made payments of $46,884,627 for Eligible Professionals and $62,524,145 for Eligible Hospitals.

In the news

- **Moody's downgrades Highmark Inc. outlook**

  Moody's Investors Services has downgraded its outlook on the credit rating for Highmark Inc. following the announcement that the company's president and chief executive officer was placed on unpaid administrative leave. Moody's changed the outlook on the company's insurance financial strength rating and senior unsecured debt rating from stable to negative following the departure of Highmark Inc. CEO Kenneth Melani, who stepped down following charges in connection with a fight a week ago with an employee's husband. (AP)

OTHER HEADLINES

Arizona

- **Hospital association drops AHCCCS lawsuit: Group to work with lawmakers on funding**

  The Arizona Hospital and Healthcare Association has dropped a lawsuit challenging payment cuts from the state's Medicaid program. The hospital group in November sued the Arizona Health Care Cost Containment System to reverse a 5 percent cut in hospital payment rates. Rather than pursue the court case, Arizona Hospital and Healthcare Association President and CEO Laurie Liles said her group would seek to work with lawmakers to restore hospital funding rates.The state's hospitals grappled with a 75 percent surge in patients seeking charity care during the fourth quarter of 2011 as more uninsured patients crowded hospital emergency rooms. The stagnant economy, AHCCCS coverage cuts to childless adults and the Medicaid payment cuts all have pressured hospitals' finances (Arizona Republic)

- **Arizona prisons' health care to be run by Pa. company**

  Arizona's Department of Corrections awarded a $349 million, three-year contract Tuesday to privatize health care for prison inmates that will cost the state $5 million a year more than it spent in 2011. The contract to privatize prison health care -- originally pushed by Rep. John Kavanagh as a way to save the state money -- was awarded to privately held Wexford Health Sources Inc. of Pittsburgh. Wexford, which has previously lost contracts for poor service and was implicated in a 2008 payoff scandal in Illinois, bid $116.3million a year. Arizona spent $111.3 million last fiscal year on correctional health-care services for nearly 34,000 inmates in 10 state prisons. (Arizona Central)

Hawaii

- **Feds Reject Hawaii's 10-Day Medicaid Hospital Limit**

  The Obama administration has rejected Hawaii's proposal to limit most adult Medicaid recipients to 10 days of hospital coverage per year, which would have been the strictest in the nation. Instead, Hawaii has been approved to implement a 30-day hospital coverage limit starting July 1, state and federal health officials say. Exempted from the limit are children, pregnant women, those undergoing cancer treatment, the elderly and the blind and disabled. The Centers for Medicare and Medicaid Services is still mulling a proposal from Arizona last September to limit adult Medicaid patients to 25 days of hospital coverage a year. (Kaiser Health News)

Idaho

- **Idaho takes aim at prison health care report**

  The Idaho Department of Correction is telling a federal judge that a scathing report about health care at a Boise-area prison isn't accurate and doesn't reflect current conditions at the lockup. Dr. Marc Stern was appointed as a special master in the case and ordered by the federal court to examine the medical and mental health care provided at the prison as part of a lawsuit between inmates and the state. U.S. District Judge B.

Lynn Winmill has said he will use Stern's findings to help him decide whether to end the 30-year-old lawsuit or continue overseeing operations at the prison. (Idaho Statesman)

Kansas

- **KanCare 'carve out' killed on House floor**

  Advocates for the developmentally disabled have clamored to be excluded from the governor's Medicaid managed care plan for months. An amendment that would have done that failed to get an up-or-down vote on the House floor Thursday. The amendment, introduced by Rep. Jim Ward, D-Wichita, was sent back to committee by a vote of 69-54, despite Ward's pleas that it be heard and voted on. (Kansas Capitol Journal)

Louisiana

- **BAYOU HEALTH Goes Live in Capital Area, Acadiana and South Central Louisiana April 1**

  The Louisiana Department of Health and Hospitals launches the second phase of its historic transformation of the Medicaid program April 1, as the second Geographic Service Area (GSA) of the State goes live with BAYOU HEALTH, an improved Medicaid health care service delivery program. BAYOU HEALTH is the State's new approach to coordinating care for nearly 900,000 Medicaid and LaCHIP recipients. Its focus is on improved access to quality health care and better health outcomes for recipients. Under BAYOU HEALTH, DHH has contracted with five Health Plans - Amerigroup RealSolutions, Community Health Solutions, LaCare, Louisiana Healthcare Connections and UnitedHealthcare Community Plan -- that are responsible for coordinating health care for their members.

Minnesota

- **HMO profits cap means nearly $8 million for Minnesota**

  A cap on HMO profits instituted in Minnesota last year will generate about $8 million for state government, a number that could grow. That's the early conclusion from filings being submitted to regulators this week by the state's nonprofit health plans. In a filing Monday, April 2, Minneapolis-based UCare said it expects to return $7,977,270 million to the state, a sum that represents the amount of excess earnings that UCare received last year through its contracts with Minnesota. (Twin Cities Pioneer Press)

New Jersey

- **NJ Program Aims to Keep Seniors Out of Nursing Homes**

  A New Jersey healthcare program known as Global Options, which helps seniors age in place rather than nursing homes, is earmarked for a big boost in funding under Gov. Chris Christie's proposed 2013 budget. It's part of the sweeping changes in long-term care underway in New Jersey, a topic that drew 19,000 senior citizens via telephone and the Internet to a virtual town hall last week with State Health Commissioner Mary E. O'Dowd and Human Service Commissioner Jennifer Velez. New Jersey is moving forward with its push to help seniors remain in their homes and communities and avoid nursing homes for as long as possible. (New Jersey Spotlight)

New York

- **Troubled Firm Wins Health Exchange Bid**

  The company the Cuomo administration has hired to design a state health-insurance exchange has been dogged by critical audits and lawsuits in the U.S. and abroad. The state Department of Health awarded the five-year contract to Virginia-based Computer Sciences Corp. in mid-March, state officials said. Its main duty will be developing a major local element of President Barack Obama's medical care overhaul: an online New York marketplace of insurance plans. Gov. Andrew Cuomo is expected to create the exchange through an executive order soon, putting New York among 14 states that have approved one. (WSJ)

Ohio

- **Details emerge on Ohio's health plan**

  The state's plan to streamline medical care for some of its sickest, most expensive and difficult to treat patients includes changes designed to eliminate unnecessary health tests, prevent medication errors and keep people healthier and out of emergency rooms. The proposal for those enrolled in both Medicaid and Medicare could end up being a model for other states, said Ohio officials who drafted the plan. The officials are expected to send the details on Monday to the federal government, which must sign off on the changes. (AP)

- **Regulator Orders Hospitals to Undo a Merger**

  The Federal Trade Commission has blocked an Ohio hospital merger in a closely watched case that could slow the consolidation of health care providers around the country. In the Ohio case, the commission ruled that the merger of the ProMedica Health System and St. Luke's Hospital would "substantially lessen competition" in the Toledo area, allowing the hospitals to charge higher prices. ProMedica had argued that the merger would advance the type of collaboration promoted by President Obama under the new health care law. The commission rejected this argument. The ruling serves notice that such cooperation runs the risk of being seen by regulators as anti-competitive behavior in violation of antitrust law. (The New York Times)

Utah

- **The Ensign Group Acquires Utah Home Health and Hospice Company**

  The Ensign Group, Inc. announced today that an Ensign subsidiary has acquired Zion's Way Home Health and Hospice, a well-regarded home health and hospice agency based in St. George, Utah, with branch offices in the cities of Kanab, Utah and Page, Arizona. The acquisition was effective as of April 1, 2012. Zion's Way was founded in 2005 by Shirley Bagby, a fixture in Southern Utah's healthcare community, and will be operated by a subsidiary of Cornerstone Healthcare, Inc., Ensign's home health and hospice-based portfolio subsidiary. (prnewswire.com)

Texas

- **County hospital chief optimistic about challenge**

  As CEO of one of the nation's largest public health systems and leader of a multibillion-dollar project with the potential to change the way Texans get medical care, Lopez is under new scrutiny from his peers. The Texas Health and Human Services Commission tapped Lopez to oversee the creation of a regional plan, part of a complicated project known as the Medicaid 1115 waiver, intended to determine who gets paid - and how much - for providing charity care. Hospitals that historically have received the most federal money for treating people without health insurance are not guaranteed to do so under the new rules. Lopez kicked off the first planning meeting in February with a promise that he won't try to enrich the hospital district at the expense of other hospitals and clinics. (Houston Chronicle)

- **Public, private Texas hospitals spar over Medicaid**

  Texas' public hospitals are asking the state to make some taxpayer money now spent on Medicaid care instead pay for the uninsured, a group that soon may be mostly illegal immigrants. The proposal, under consideration by the Texas Health and Human Services Commission, is pitting public and private hospitals against each other for hundreds of millions of dollars allocated annually in a supplementary Medicaid program. The public hospitals argue the program favors private hospitals. (Houston Chronicle)

Washington

- **Gregoire suspends plan to limit Medicaid emergency-room visits**

  A plan by the state Medicaid program to stop paying for emergency-room visits for all conditions deemed "nonemergency" — set to go into effect Sunday — has been suspended by Gov. Chris Gregoire pending the outcome of budget negotiations under way in the state Legislature. Gregoire stopped the Medicaid plan from going into effect, noting growing legislative support for a less-drastic alternative. The alternative plan is a modified version of a proposal offered by emergency-room doctors and hospitals, Brown said. Pressed by a shrinking budget, Dr. Jeff Thompson, chief medical officer for the state Medicaid program, said "overuse and abuse" of emergency rooms cost the state at least $21 million a year. (The Seattle Times)

National

- **MedPAC Agenda April 5-6, 2012**
  Thursday, April 5, 2012
  CMS demonstrations for dual-eligible beneficiaries (Christine Aguiar, Carlos Zarabozo)
  9:30 AM – 10:30 AM
  Ronald Reagan Building
  1300 Pennsylvania Avenue, NW
  Washington, DC 20004

- **Justices Debate Medicaid Expansion, Which Branch Should Settle Severability Question**

  Liberal and conservative justices at the Supreme Court on Wednesday sharply questioned lawyers on whether it's their job or Congress' responsibility to decide what will happen to the rest of the health care law if the court decides to strike down the individual mandate. Later on Wednesday in an afternoon session devoted to whether the law's Medicaid expansion is constitutional, the court's liberal wing attacked an argument by 26 states that the health care law has unconstitutionally coerced them into serving millions of uninsured once the law goes into effect in 2014. (CQ HealthBeat)

- **Medicaid gets Harder to Tap**

  Families hoping to use Medicaid to help pay for long-term care are facing tougher restrictions—though some states are getting stricter than others. Medicare doesn't cover much in the way of long-term care. That falls primarily to Medicaid, the jointly funded state and federal program intended for the poor. The program now is shouldering 40% of the country's long-term-care spending, according to the Kaiser Family Foundation. To be eligible for Medicaid in most states, you generally can have no more than $2,000 in cash and investments, along with a house and a car. States are in charge of qualifying people needing long-term care for Medicaid, working within federal rules, and that leaves room for different interpretations. (WSJ)

- **Health Exchanges Have Fans in Some States**

  A handful of states say they are planning to press ahead and voluntarily implement a key part of the 2010 federal health-care law even if it is wiped out by the Supreme Court. The Obama administration's law faced three days of skeptical questions from the court's conservative majority this past week, increasing the odds that part or all of the law will be struck down. The justices met Friday for their weekly conference, where they were expected to take a preliminary vote and decide how to issue their written opinions on the case. (WSJ)

COMPANY NEWS

- **Dallas firm to upgrade N.M.'s Medicaid IT system**

  Affiliated Computer Services Inc. of Dallas has won a state contract potentially worth $100 million to administer the computerized claims system for Medicaid, the government's low-income health insurance program that covers one of every four New Mexicans. The firm will earn roughly $15 million a year to make upgrades to an IT system that pays tens of thousands of claims each week. The claims are submitted by medical providers who treat New Mexico's more than 550,000 Medicaid recipients. Among the upgrades Affiliated will be responsible for making are strengthening the IT system's fraud abuse detection system and improving the system's Internet portal. State officials hope an easier-to-use way to access the system from the Internet will give Medicaid recipients the opportunity to select the managed-care companies they want to administer their coverage. (Insurance News)

- **Integrated Healthcare Model Outperforms Traditional Fee-for-Service in Caring for Individuals with Medicare and Medicaid**

  A new Avalere Health study released today shows that SCAN's integrated care model, which provides coordinated care for dual eligibles through the Medicare Advantage program, results in fewer hospital stays or readmissions than a group of similar beneficiaries receiving care under traditional fee-for-service. According to the study, healthcare quality can be improved and considerable dollars can be saved by delivering coordinated, integrated care to "dual-eligible" individuals. Dual eligible refers to those individuals who qualify for both Medicare and Medicaid/Medi-Cal. (Market Watch)

- **Molina Healthcare sues over Medicaid contract**

  In February, Centene Corp. of Clayton was one of three companies chosen to handle benefits and claims for 427,000 Medicaid clients in 54 counties, including Boone. Centene was the only new provider selected in the bid process. The lawsuit challenging the award was filed by Molina Healthcare Inc., which handles 80,000 clients and has held a contract since Missouri implemented managed care for Medicaid in 1995. (Columbia Missouri Daily Tribune)

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
Early April	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	Louisiana	Implementation (GSA B)	315,000
April 9, 2012	Ohio	Contract awards	1,650,000
April 13, 2012	Massachusetts Duals	RFP Released	115,000
April 16, 2012	Ohio Duals	RFP Released	115,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 30, 2012	Illinois Duals	RFP Released	172,000
May 18, 2012	Kansas	Contract awards	313,000
May 25, 2012	Ohio Duals	Proposals due	115,000
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	New York LTC	Implementation	200,000
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
September 20, 2012	Ohio Duals	Contracts finalized	115,000
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
February 1, 2013	Ohio Duals, NW, NC, EC	Implementation	35,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
April 1, 2013	Ohio Duals, NE	Implementation	32,000
May 1, 2013	Ohio Duals, C, WC, SW	Implementation	48,000
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 Welcomes…

Linda Trowbridge, Principal – Bay Area, CA

Linda comes to HMA with nearly 30 years of hospital experience, most recently with Kaiser Permanente, where she served the last seven years as the Executive Director of the Continuum for Northern California. In this role, Linda was responsible for establishing strategic, financial, and operational direction and performance for services managed through the continuum of care and for efficiencies in the hospitals. This included managing a $2.2 billion budget, and leading a team of 2,000 to serve 10,000 patients per day at 21 medical centers, 19 home health and hospice agencies, and through hundreds of contracted providers. Prior to her most recent assignment, Linda served as the Continuing Care Leader for the North East Bay for Kaiser Permanente. Earlier in her career, Linda was the Regional Vice President for Strategic Planning and Business Development for the St. Joseph Health System in northern California and also the CEO of St. Joseph Home Care. She earned her Masters degree in Business Administration at San Francisco State University, and her Bachelor of Arts degree at the University of Colorado.

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