HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: ARIZONA, SOUTH CAROLINA, TENNESSEE, TEXAS, & VIRGINIA DUAL ELIGIBLE INTEGRATION PROPOSALS

HMA ROUNDUP: OHIO PROTESTS FILED BY FIVE OF SIX UNSUCCESSFUL MCO BIDDERS; CARESOURCE TO SELL MICHIGAN PLAN; NEW YORK GOVERNOR CUOMO SIGNS EXECUTIVE ORDER FOR HEALTH INSURANCE EXCHANGE; GEORGIA MEDICAID MCO RFP TIMELINE UNDER EVALUATION; COLORADO UPDATE ON ACC PROGRAM; ILLINOIS GOV. TO UNVEIL BUDGET PROPOSAL TOMORROW; MACPAC MEETING TOMORROW

OTHER HEADLINES: MAXIMUS TO ACQUIRE POLICY STUDIES INC.; SXC TO ACQUIRE CATALYST HEALTH; FLORIDA COUNTIES SUE STATE OVER MEDICAID PAYMENT REQUIREMENT

DUAL ELIGIBLE DEMONSTRATION PROPOSAL CALENDAR UPDATED

APRIL 18, 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: ARIZONA, SO. CAROLINA, TENNESSEE, TEXAS, & VIRGINIA DUAL ELIGIBLE INTEGRATION PROPOSALS

This week, our *In Focus* section briefly reviews the flurry of dual eligible integration proposals released for public comment in the past week. Arizona, South Carolina, Tennessee, Texas, and Virginia have all unveiled their plans to bring a combined 590,000 dual eligible lives into capitated managed care plans beginning in 2014. Below, we highlight the key points of each proposal - target population and market opportunity, key milestone dates, and the incumbent Medicaid market.

Arizona

Target Population

Arizona is targeting the majority of the statewide dual population, with 115,065 out of 119,697 duals eligible for the integration demonstration. Approximately 10,000 of these dual eligible members are Native American and will be able to enroll, but will not be passively enrolled unless currently enrolled in a Medicaid MCO. More than 95 percent of Arizona's dual population is eligible for participation in the Medicare-Medicaid integrated Demonstration, and more than 87 percent will be passively enrolled.

Financial Model & Market Opportunity

Care for dual eligibles will be integrated under the capitated model, with managed care plans entering into a three-way contract with the state of Arizona and federal CMS. Arizona will enroll duals into existing managed care plans, with three separate managed care populations being enrolled under the dual integration demonstration dependent on their current program enrollment (see Incumbent Market Landscape below). As mentioned above, all but the 10,000 Native American duals will be passively enrolled.

Timeline

Arizona Duals Integration	Date
Submit Final Proposal to CMS	May, 2012
Maricopa Co. RBHA* RFP	July, 2012
Acute Care RFP	November, 2012
Maricopa Co. RBHA* RFP Award	January, 2013
Acute Care RFP Awards	March, 2013
Implementation	January 1, 2014

*Regional Behavioral Health Authorities

Incumbent Medicaid Market Landscape

There are three separate Arizona dual populations covered under the dual integration proposal. The long term care (LTC) managed care population, the acute care managed care population, and the severe mental illness (SMI) population in Maricopa County. The following tables show the current Medicaid landscape for managed LTC and managed acute care.

LTC Managed Care Plan	March Enrollment	%	Duals
Mercy Care LTC	10,545	38%	
EverCare Select (UnitedHealth)	7,343	26%	
Bridgeway Health Solutions (Centene)	4,904	18%	
SCAN-LTC	2,616	9%	
Navajo	1,469	5%	
Gila River	241	1%	
Hopi	186	1%	
Pasqua Yaqui	162	1%	
White Mt. Apache	132	0%	
Three other plans (<100 lives each)	198	0%	
Totals	**27,796**		**21,000**

Source: State Enrollment Data, March 2012.

The Medicaid acute care managed care contracts are set to expire in September 2013. The state is currently preparing an RFP, tentatively to be released in November 2012, for acute care for all Medicaid enrollees. Those plans awarded acute care MCO contracts will serve the dual acute care population of roughly 77,000 lives.

Acute Care Managed Care Plan	March Enrollment	%	Duals
Mercy Care Plan (Aetna)	291,092	27%	
AP/IPA (UnitedHealth)	241,390	22%	
Phoenix Health Plan	188,494	17%	
Health Choice	177,931	16%	
University Family Care (UPH)	69,991	6%	
Maricopa Health Plan (UPH)	51,696	5%	
Care 1st Arizona	47,624	4%	
Bridgeway Health Solution (Centene)	16,846	2%	
DES Foster Care	10,955	1%	
Totals	**1,096,019**		**77,000**

Source: State Enrollment Data, March 2012.

Behavioral health benefits for individuals with SMI are currently carved-out of managed care contracts. AHCCCS is seeking to rebid the Regional Behavioral Health Authorities (RBHA) contract in Maricopa County, also set to expire in September 2013. An RFP is tentatively set to be released on July 1, 2012, with contract awards announced in January, 2013. Roughly 7,000 individuals with SMI in Maricopa County are dual enrolled in Medicaid and Medicare. AHCCCS has proposed that the awarded Maricopa County RBHA also serve as a health plan under the Demonstration. Accordingly, these requirements are being incorporated into the RFP process for a new Maricopa County RBHA contract, which will be effective October 1, 2013.

Link to Proposal:

http://www.azahcccs.gov/reporting/Downloads/Integration/Duals_DemoProposalDraftFINAL4_17_12.pdf

South Carolina

Target Population

South Carolina intends to enroll all dual eligibles who are over the age of 65, do not reside in a nursing facility, and are not enrolled in one of the state's waiver programs. (The excluded waiver populations would include individuals enrolled in the Home and Community Based Services (HCBS) Waiver). The state proposes to divide the population into four geographic regions, enrolling residents of the first two regions in January 2014, the third in July 2014, and the fourth and final region in January 2015. The regions will be prioritized for enrollment based on their concentration of dual eligible lives.

Financial Model & Market Opportunity

South Carolina is pursuing the capitated model and will engage with managed care entities to be known as coordinated and integration care organizations (CICOs) under a three-way contract with federal CMS. Individuals will be passively enrolled into CICO plans with a 90-day opt-out. The state is looking for plans that will serve all four geographic regions. With a full enrollment of 68,000 in 2015, we estimate an annual market opportunity for this population of roughly $1.6 billion, based on a Medicare PMPM of $1,300 and a Medicaid PMPM of $700[1], for a combined PMPM of $2,000.

Timeline

South Carolina Duals Integration	Date
Submit Final Proposal to CMS	May 26, 2012
State/CMS Issue RFP	October 29, 2012
RFP Awards Announced	July 30, 2013
Contracts Signed	September 30, 2013
Implementation – First Two Regions	January 1, 2014
Implementation – Third Region	July 1, 2014
Implementation – Fourth Region	January 1, 2015

Incumbent Medicaid Market Landscape

Managed Care Plan	April Enrollment	% Total
Absolute Total Care (Centene)	86,891	14%
BlueChoice Health Plan	66,040	11%
First Choice/Select Health (AmeriHealth Mercy)	231,255	37%
UnitedHealthcare Community Plan	67,934	11%
HMO total	**452,120**	**72%**
PCCM/Other	172,599	28%
Managed Care Total	**624,719**	

Source: State Enrollment Dashboard, April 2012.

Link to Proposal:

https://msp.scdhhs.gov/scdue/sites/default/files/SCDuEProposal_DRAFT%20PUBLIC.pdf

[1] CMS, *Medicaid Statistical Information System (MSIS) State Summary Datamart*, FY 2009 data.

Tennessee

Target Population

Tennessee has proposed to serve all statewide dual eligible beneficiaries, excluding those enrolled in a Program of All-Inclusive Care for the Elderly (PACE) plan, an estimated 136,000 lives in total. The program, to be built upon the existing TennCare statewide managed care plan, will be known as TennCare PLUS, with an implementation date of January 2014.

Financial Model & Market Opportunity

Dual eligibles would be enrolled in managed care plans under a three-way capitated contract with the state and federal CMS. All duals in the demonstration are currently enrolled in one of four managed care plans for their Medicaid benefits. During an open enrollment period, existing dual eligibles may select a new MCO to receive their Medicaid and Medicare benefits. If no selection is made, they will remain in their current MCO plan. New dual eligibles will be passively enrolled into a plan after the implementation date.

Timeline

Tennessee Duals Integration	Date
Three-Way Contracts Signed	TBD
Open Enrollment Begins	October 15, 2013
Open Enrollment Ends	December 7, 2013
Implementation	January 1, 2014

Incumbent Medicaid Market Landscape

Managed Care Plan	Nov 11 Enrollment	% Total	Duals	% Total
UnitedHealthcare	562,006	46%	64,827	48%
BlueCare	403,780	33%	48,989	36%
Amerigroup	199,238	16%	20,880	15%
TennCare Select	46,089	4%	1,388	1%
Managed Care Total	**1,211,113**		**136,084**	

Source: State Enrollment Data, Nov. 2011. Duals Data from Dual Integration Proposal, April, 2012.

Link to Proposal:

http://www.tn.gov/tenncare/forms/dualsdemo.pdf

Texas

Target Population

The Texas Health and Human Services Commission (HHSC) has proposed to enroll dual eligibles in existing STAR+PLUS service areas. These nine regions will cover 214,500 of the state's 328,500 dual eligible lives, a little over 62 percent of all duals statewide. STAR+PLUS is a program built upon the state's STAR Medicaid managed care plan, providing long-term care services to elderly and disabled Medicaid beneficiaries. The proposal also excludes those dual eligibles receiving care in certain institutional care settings and those enrolled in a waiver program aside from the STAR+PLUS waiver.

Financial Model & Market Opportunity

HHSC is pursuing implementation through the capitated model. The proposal indicates a need to enroll individuals mandatorily in the same managed care plan for both Medicaid and Medicare benefits. However, if CMS is unwilling to agree to this, HHSC proposes passively enrolling individuals in the Medicare special needs plan (SNP) of their Medicaid managed care plan, with the ability for the enrollee to opt out. In addition to the incremental impact of the Medicare benefits, the demonstration will also carve-in nursing home services to the existing Medicaid managed care benefits.

Timeline

Texas Duals Integration	Date
Submit Proposal to CMS	May 31, 2012
Three-Way Contracts Finalized	February 1, 2013
Plan Readiness Review Completed	July 31, 2013
Begin Enrollment Process	November 1, 2013
Implementation	January 1, 2014

Incumbent Medicaid Market Landscape

The table below details March enrollment in the STAR+PLUS program only and does not include the broader STAR program enrollment numbers.

Managed Care Plan	March Enrollment	% Total	Duals
Bexar	**46,909**		**25,331**
Amerigroup	9,048	19%	
Molina Healthcare	9,554	20%	
Superior HealthPlan (Centene)	28,307	60%	
Dallas	**53,896**		**28,057**
Molina Healthcare	33,281	62%	
Superior HealthPlan (Centene)	20,615	38%	
El Paso	**23,144**		**15,139**
Amerigroup	10,307	45%	
Molina Healthcare	12,837	55%	

Harris	**96,711**		**50,391**
Amerigroup	42,910	44%	
Molina Healthcare	13,806	14%	
UnitedHealthcare	39,995	41%	
Hidalgo	**71,485**		**42,596**
HealthSpring	16,324	23%	
Molina Healthcare	30,000	42%	
Superior HealthPlan (Centene)	25,161	35%	
Jefferson	**17,063**		**8,239**
Amerigroup	8,449	50%	
Molina Healthcare	8,472	50%	
UnitedHealthcare	142	1%	
Lubbock	**10,427**		**7,143**
Amerigroup	5,035	48%	
Superior HealthPlan (Centene)	5,392	52%	
Nueces	**19,974**		**11,720**
Superior HealthPlan (Centene)	11,380	57%	
UnitedHealthcare	8,594	43%	
Tarrant	**30,456**		**15,684**
Amerigroup	27,008	89%	
HealthSpring	3,448	11%	
Travis	**18,826**		**10,028**
Amerigroup	11,422	61%	
UnitedHealthcare	7,404	39%	
All Service Areas	**388,891**		**214,328**
Amerigroup	114,179	29%	
Molina Healthcare	107,950	28%	
Superior HealthPlan (Centene)	90,855	23%	
UnitedHealthcare	56,135	14%	
HealthSpring	19,772	5%	

Source: TX Enrollment Broker Report, March 2012. Duals Data from Dual Integration Proposal, April, 2012

Link to Proposal:

http://www.hhsc.state.tx.us/medicaid/dep/docs/Proposal-for-Integration-of-Care-for-Dual-Eligibles.pdf

Virginia

Target Population

Virginia has proposed to enroll duals over 21 years of age, who are not institutionalized and are not enrolled in HCBS waivers. This covers 56,884 out of 102,784 duals statewide, a little over 55 percent of the statewide dual eligible population. Currently, the dual eligible population is excluded from participating in the state's Medicaid managed care program, which enrolls close to 620,000 Medicaid lives. Virginia, like many other states, has proposed a delayed implementation timeline of January 2014.

Financial Model & Market Opportunity

Virginia is seeking to procure an unspecified number of managed care entities through a competitive RFP process and three-way contract with the state and federal CMS. The proposal indicates the state's desire to institute a passive enrollment with opt-out option. Additionally, the state, with CMS approval, wishes to require a six-month lock-in to an individual's managed care plan. Based on an enrolled population of 56,000 dual eligibles and an estimated Medicaid PMPM of $1,020[2], we can conservatively estimate the Medicaid-only market opportunity of this RFP at more than $685 million, not including the impact of the Medicare benefit.

Timeline

Virginia Duals Integration	Date
Submit Proposal to CMS	May, 2012
RFP Released	October, 2012
Plan Selection Completed	July, 2013
Three-Way Contracts Signed	September, 2013
Enrollment Period Begins	October 15, 2013
Implementation	January 1, 2014

Incumbent Medicaid Market Landscape

Managed Care Plan	Jan. Enrollment	% Total
Anthem HealthKeepers Plus	235,726	38%
CareNet by Southern Health (Coventry)	29,865	5%
Optima Family Care	152,175	25%
Virginia Premier	147,501	24%
Amerigroup Community Care	46,757	8%
MajestaCare	5,446	1%
Total Managed Care	**617,470**	

Source: State Enrollment Data, January 2012.

Link to Proposal:

http://dmasva.dmas.virginia.gov/Content_atchs/altc/altc-icp1.pdf

[2] CMS, *Medicaid Statistical Information System (MSIS) State Summary Datamart*, FY 2010 data.

HMA MEDICAID ROUNDUP

Colorado

HMA Roundup – Joan Henneberry

Health Care Policy and Financing officials updated their Medical Services Board on April 13, 2012 on the Accountable Care Collaborative. This is the first year of the pilot program which contracts with seven Regional Care Coordination Organizations (RCCO) to serve Medicaid clients throughout the state of Colorado. The state budgeted to enroll 123,000 clients this fiscal year and has exceeded that number; almost 126,000 clients have enrolled and receive case management through RCCOs. Over 1,700 practitioners are serving clients. The state is beginning to analyze utilization and claims data to determine the outcomes from this first year; they must demonstrate budget neutrality and cost effectiveness in order to expand to additional clients and populations in FY2013. The State Data Analytics vendor (Treo Solutions) has begun calculating the performance of the RCCOs and provides those data back to the RCCOs and their network providers monthly. The primary goals of the ACC effort are to reduce inappropriate visits to emergency departments; reduce hospital readmissions; and reduce the use of inappropriate high cost imaging. The Department reported that dividing the state into seven regions was a starting point and that over time they expect adjustments in both the number and geographic boundaries of regions – perhaps having even fewer regions to make sure there are enough clients to make the case management investments cost effective.

The Department also reported that they have held five large stakeholder meetings in the past 10 months to talk about how to better serve the dually eligible population; Colorado received one of the CMS planning grants and they post their next draft plan on their website the week of April 16. The Department will submit their plan to CMS in May and if approved by CMS, will begin enrolling duals in RCCOs early 2013.

The Assistant Secretary for Aging at HHS, Kathy Greenlee, announced the creation of the Administration for Community Living (ACL), a realignment and creation of a new Operating Division, bringing together the Administration on Aging (AoA), the Office on Disability (OD) and the Administration on Developmental Disabilities (ADD) to form a single agency charged with developing policies and improving supports for seniors and people with disabilities. Ms. Greenlee will serve as Administrator of the Administration for Community Living. Henry Claypool will continue to serve as Senior Advisor on Disability Policy to the HHS Secretary, as well as take on the role of Principal Deputy Administrator of the Administration for Community Living.

In the news

- **Colo. GOP rejects health law passed by their own**

  Colorado Republicans aren't happy with a health care law promoted by some of their own leaders in the state Legislature. In a platform resolution whose results were announced Monday, Republicans at the state GOP convention voted overwhelmingly to seek repeal of the Colorado Health Benefits Exchange. (Denver Post)

Florida

HMA Roundup – Gary Crayton

The Florida Association of Health Plans submitted feedback to the state's Medicaid agency (AHCA) on the long term care data book that was released last month. Comments centered primarily on the consistency of reporting across eligibility and service categories in order to ensure accurate analysis ahead of the July ITN release date.

In the news

- **Association of Counties to Sue Over New Medicaid Law**

  The Florida Association of Counties said it will challenge a new Medicaid law that's expected to cost local taxpayers millions. The association on Thursday announced it'll sue in the coming weeks. The case will be filed in state Circuit Court in Tallahassee. The new law will require counties to pay more than $300 million in disputed billings owed to the state-federal health care program. The counties contend they are being made to pay for mistakes by the state's electronic billing system. The law's supporters said the counties simply are trying to avoid payment. (The Ledger)

- **Scott-signed bill will hurt counties' credit, Wall Street says**

  Just last summer, Gov. Rick Scott was bubbling with good news, hailing the state's suddenly improved credit rating when Standard & Poor's boosted Florida's outlook from negative to positive. The agency touted the spending cuts he'd imposed. But legislation Scott signed into law last month has had the opposite effect on Florida counties — which learned this week that Moody's Investor Services has said HB 5301 will have "negative credit implications" for them. Palm Beach County already expects to lose almost $8 million in state health care dollars under the bill, which the Florida Association of Counties condemns as a strong-arm tactic by the state. Under the bill, state lawmakers agreed to reduce revenue sharing with counties by $70.5 million, part of a move to recover $325.5 million in Medicaid debt over five years. (Palm Beach Post)

Georgia

HMA Roundup – Mark Trail

Medicaid Redesign Update

Last week, the Department of Community Health (DCH) Deputy Commissioner Blake Fulenwider gave a brief update on Georgia Medicaid Redesign.

The DCH final Redesign recommendation was scheduled to go public in late April 2012 with the RFP release set for July 2012. However, **DCH sees the need for additional time to develop the Redesign recommendation is now reassessing the timeline.** The need for additional time is due to:

- Stakeholders wish to extend time to analyze and discuss plans/options.
- Ongoing task force meetings
- Speed of financial projections and actuarial analysis.

- Uncertainty about ACA impacts given the imminent ruling on ACA by the U.S. Supreme Court.
- Further evaluation of stakeholder proposals submitted to DCH.

Mr. Fulenwider noted that the revised timeline will be limited by the January 2014 ACA Medicaid expansion, the June 2014 CMO contract expiration, the need for sufficient time to procure and implement, and the FY 2013 cut of $250,000 to the Navigant contract.

In the news

- **Medicaid, PeachCare cope with cash problem**

  Georgia's Medicaid and PeachCare programs are tight on cash. The cash-flow problem has prompted the Department of Community Health to ask medical providers and insurers to give the agency some flexibility on payments. The agency is about one month behind in payments to the three care management organizations that oversee care for more than 1 million Medicaid and PeachCare members. The CMOs agreed to the payment lag. Community Health has also asked hospitals for early delivery of their ''provider tax,'' a payment that, by increasing federal dollars for the program, helps fund Medicaid and raises reimbursements for providers. Hospitals are also getting their final payment from the state for the disproportionate share program a little later than normal. (Georgia Health News)

Illinois

HMA Roundup – Jane Longo / Matt Powers

Chicago public radio station WBEZ reported that Governor Pat Quinn would be announcing his budget proposal on Thursday, April 19, aimed at filling a $2.7 billion budget gap in the state's Medicaid program. Governor Quinn's budget announcement scheduled for last Wednesday was delayed until after another meeting of the Legislative Medicaid Advisory Committee, which occurred Tuesday, April 17. In other news, the state's proposal to integrate care for dual eligibles was submitted to CMS and is posted on their website for a 30-day comment period.

Illinois Care Coordination and Budget Timeline – Key Dates and Milestones

Date	Care Coordination	Budget/Medicaid Cuts
January 2012	***Phase I RFP Released*** Complex Adults, no MCOs	
February 2012	75 LOIs received	***Gov. Address, Feb. 22.*** Call for $2.7B in Medicaid cuts.
March 2012		HFS released menu of possible cuts and associated savings.
April 2012	***Dual Integration RFP*** To be released April 30 (tentative) ***Phase II RFP Release*** Complex Children	***Gov. Budget Proposal*** April 19, 2012
May 2012	***Phase I RFP Due May 25, 2012***	Legislative Scheduled Sessions ends May 31, 2012

June 2012 through August 2012	***Dual Integration RFP Winners*** To be announced July 1, 2012 ***Medicaid MCO RFP*** Summer 2012, may be delayed	If nothing passes, Legislature moves to extended session with two-thirds majority required to pass a law..
January 2013	***Phase I, Phase II, Duals*** Go live January 1, 2013 ***Medicaid MCOs*** Depends on possible delay	

NOTE – all elements in the table are estimates and subject to change

In the news

- **Medicaid group strains for $2.7 billion in cuts**

  As state leaders push for a prompt agreement on where to cut a breathtaking $2.7 billion from Illinois' Medicaid program, the two Republicans and two Democrats designated to come up with a deal are confronting fundamental differences, including over a proposal to resurrect a cigarette tax increase as a way to soften the blow. While a final list of cuts hasn't been determined, coming into focus are possible points of agreement on reductions in spending for the health insurance program for nearly 3 million poor and disabled Illinois residents, according to interviews with committee members and committee background materials obtained by The Associated Press. The group met again Tuesday, April 17. (Herald Times Reporter)

Michigan

HMA Roundup – Esther Reagan

Flint-based McLaren Health Plan says it has reached an agreement to purchase CareSource Michigan, an MCO contracted with the State to serve about 34,500 Medicaid members in 31 Michigan counties. McLaren currently serves about 80,000 Medicaid members in 30 counties. Service areas for the two MCOs have some overlap. If the purchase is approved, McLaren's service area will expand to 53 of the state's 83 counties and give it the second largest geographic coverage in the state. Meridian Health Plan serves Medicaid members in 66 counties.

New York

HMA Roundup – Denise Soffel

On April 12, Governor Andrew M. Cuomo issued an Executive Order to establish a statewide Health Exchange. The executive order did not provide many details regarding the future structure of the exchange other than the following broad parameters:

- The Exchange shall, among other things, facilitate enrollment in health coverage and the purchase and sale of qualified health plans in the individual market in this state, and enroll individuals in health coverage for which they are eligible in accordance with federal law.
- The Exchange shall, among other things, take such actions necessary to enable eligible individuals to receive premium tax credits and cost-sharing reductions and to

enable eligible small businesses to receive tax credits, in compliance with all applicable federal and state laws and regulations.

- The Exchange shall, among other things, become financially self-sustaining by January 1, 2015, as required by the Affordable Care Act.

The NYS legislature approved a $132.6 billion spending plan on March 30 for the fiscal year beginning April 1, 2012. As part of the previous year's budget, the state's Medicaid program is operating under a global cap that limited the growth in Medicaid spending to a 4 percent annual rate of growth. The FY 2013 Medicaid budget is actually lower than the current year's spending of $54.2 billion by $200 million. Despite increases in Medicaid enrollment, spending has remained under the cap. The budget extends the Medicaid Savings Allocation plan, which grants the Commissioner "super powers," giving him the authority to unilaterally cut Medicaid spending should the rate of growth exceed the cap, through 2014.

New York is one of the few states that has imposed significant cost-sharing on localities, a responsibility that has been gradually shifting back to the state over the last several years. The enacted budget included a provision that will further shift responsibility for increases in Medicaid costs away from the counties and fully onto the state. This shift will occur over the next three years. Post-2015, the state will assume responsibility for increases in Medicaid costs, and county Medicaid spending will be frozen at the 2015 level.

Two additional counties, Schuyler and Steuben, have adopted a mandatory Medicaid managed care program. Schuyler County has 3,800 Medicaid enrollees; Steuben County has 19,000. Currently two managed care plans are operating in each of those counties, Fidelis and Excellus. Two plans that had been operating there as partial capitation plans (Southern Tier Pediatrics and Southern Tier Priority) have closed, and their members are being transitioned to one of the two plans. Fifty-one counties plus the 5 boroughs of New York City are now operating a mandatory Medicaid managed care program; only seven counties remain voluntary.

CMS approved New York's request to end exemptions from mandatory enrollment for a number of additional populations, effective April 1, 2012. This includes individuals enrolled in Chronic Illness Demonstration Programs (550), individuals with ESRD (1500), homeless individuals (15,000), and low-birth-weight babies (50-60/month). CMS has not yet approved mandatory enrollment for duals requiring long-term care into MLTCs, so implementation of that program is delayed.

Amerigroup's acquisition of Health First should be finalized by May 1. They have reported minimal changes in the provider network, and anticipate minimal disruption as members transition to the new plan.

Healthy New York, a state-subsidized insurance program for low-income individuals and small businesses, has stopped enrollment in its standard plans effective January 2012. The change is a result of increased health care costs and flat funding for the program. Healthy New York is now accepting enrollment only in its high-deductible plan, which requires $1,200 in out-of-pocket payments ($2,400 for families) before coverage begins. Those currently enrolled in the standard plan are allowed to maintain their current coverage.

Ohio

HMA Roundup – Alicia Smith

The deadline for filing protests to the recent Medicaid managed care RFA contract awards was this past Monday and five of the six plans that were denied contracts filed: Amerigroup, Centene, Coventry, Molina and Wellcare. All but Coventry have existing Medicaid managed care operations in the state. The process and timeline for evaluating the appeals is not codified but we believe the Ohio Department of Job and Family Services will pursue an expedited review given its stated intention of implementing the new contracts on January 1, 2013.

In the news

- **Bidders protest Medicaid contracts**

  In protests filed yesterday with the state agency, several firms said that state officials miscalculated scoring on bid applications so badly that it cost them business. They asked that the results be tossed out or recalculated. Such protests are common but generally have little impact on contract awards. However, Barclays, the London-based banking and financial-services company, noted in an analysis conducted on behalf of some of the bidders that Ohio's results were more unusual than most. The state virtually shut out a few of the bidders in some categories, indicating some confusion between the state and those seeking the billions of dollars worth of work, Barclays said. Some losing companies said that their competitors submitted false information about their experience in other states, which altered the outcome. (The Columbus Dispatch)

United States

HMA Roundup – Lillian Spuria

MACPAC will hold its next public meeting on April 19th from 10:30 am–12:30 pm and 1:30 pm–4:30 pm in the National Guard Association Hall of States (One Massachusetts Avenue, NW). The agenda is listed below. Note that Melanie Bella, Director of the Medicare Medicaid Coordination Office will be speaking from 11:30- to 12:30.

10:30-11:30 am	Session 1: Assistant Secretary for Planning and Evaluation (ASPE) research agenda in Medicaid and CHIP Richard Kronick, PhD, Deputy Assistant Secretary, Office of Health Policy, ASPE Staff contact: Lois Simon, Principal Analyst
11:30-12:30 pm	Session 2: Update on Medicare-Medicaid Coordination Office activities Melanie Bella, Director, Medicare-Medicaid Coordination Office Staff contact: Christie Peters, Principal Analyst
12:30-1:30 pm	Adjourn for Lunch
1:30-2:30 pm	Session 3: Chapter review: Access to care for non-elderly adults Chris Peterson, Director of Eligibility, Enrollment and Benefits Peter Cunningham PhD, Senior Fellow and Director of Quantitative Research

2:30-3:15 pm	Session 4: Chapter review: Data for measuring access Lois Simon, Principal Analyst
3:15-3:30 pm	Break
3:30-4:15 pm	Session 5: Review of MACStats, June 2012 April Grady, Principal Analyst
4:15-4:30 pm	Public comment
4:30 PM	Adjourn

In the news

- **Community Health Centers Under Pressure to Improve Care**

  Hundreds of the nation's nearly 1,200 federally funded community health centers fall short on key quality of care measures, according to federal data analyzed by KHN and USA Today. The centers' performance most often lagged national averages on helping diabetics keep their blood sugar under control and screening women for cervical cancer. Federal officials point out that patients at the nation's community health centers sometimes get better care. For example, three out of four centers performed significantly better than the national average in helping hypertensive patients keep their blood pressure under control and more than four in 10 do significantly better at making sure women get timely prenatal care. (Kaiser Health News)

- **Fate of health law's Medicaid expansion hinges on how much doctors get paid**

  The success of the healthcare reform law's massive Medicaid expansion could hinge on new regulations that are expected as early as next week. While the 20 million people who will gain subsidized coverage on the new insurance exchanges have gotten most of the attention, President Obama's health law also expands Medicaid and the Children's Health Insurance Program to 17 million low-income families starting in 2014. Medicaid, however, is already straining to care for the more than 58 million already in the program because it doesn't pay doctors enough to participate. (The Hill)

- **Nursing homes say it's time for states to undo Medicaid cuts**

  States should boost their Medicaid spending as the economy improves and their budgets begin to grow back, the nursing home industry said Friday. Many states made significant Medicaid cuts in 2009 and 2010, to help keep their spending in line with falling tax revenues. But after those two years of decline, every state saw its tax revenues increase last year, according to data released Thursday by the Census Bureau. Nursing homes said states should restore Medicaid funding as their budgets continue to improve. The president of the American Health Care Association said states underfunded nursing homes by more than $6 billion last year. (The Hill)

- **As Supreme Court weighs health care reform, contractors await their fate**

  Government contractors are involved in every aspect of setting up the new health insurance exchanges — the "marketplaces" for health plans that the Affordable Care Act established. But depending on the outcome of March's Supreme Court case, which will be revealed in June, the exchanges — along with the rest of the law — may be scrapped, leaving some health insurance contractors uncertain about the end result of their labor. (Washington Post)

- **States' tax revenue rose 8.9 percent in last fiscal year**

  The severe fiscal problems that crippled state budgets and sparked brutal political battles in the wake of the recession are easing, as state tax revenue rose substantially last year, the Census Bureau reported Thursday. State tax collections were up 8.9 percent in the fiscal year that in most states ended last June. The improvement spanned the country, with all 50 states reporting an increase in tax collections — something just 11 states experienced during the previous fiscal year. (Washington Post)

OTHER HEADLINES

District of Columbia

- **Chartered Health names new chairman**

  D.C. Chartered Health Plan Inc. has named former CareFirst BlueCross BlueShield executive David Wolf its new chairman, just days after Jeffrey Thompson stepped down. Thompson is subject of a federal investigation into campaign finance violations. Chartered Health is the District's largest Medicaid managed care administrator. (Washington Business Journal)

Kansas

- **KanCare waiver request to be ready soon, officials say**

  The waiver application needed for Gov. Sam Brownback's proposed Medicaid makeover is nearly complete and could be filed with federal officials before the month is up, Brownback administration officials said today. Still unclear, an administration source said, was whether public hearings on the waiver application would be required in order to satisfy new federal regulations governing Medicaid 1115 waiver applications. (Kansas Health Institute)

Massachusetts

- **Report: Mass. Health Law No 'Budget Buster'**

  Outside Massachusetts, talk show hosts and politicians frequently blast the state's health coverage law as a "budget buster." hat's just one of the myths the Massachusetts Taxpayers Foundation (MTF) hopes to debunk with a report out Friday. The facts will help. Michael Widmer, president of the MTF, says the state has spent just $91 million more a year since 2006 to cover the uninsured, than it was spending before the law passed. The sum amounts to 1.4 percent of the state budget. (Kaiser Health News)

- **Different Takes: How Massachusetts Can Control Health Care Costs**

  With the state law's anniversary this week and the cost-control legislation still percolating in the statehouse, Kaiser Health News asked the governor, as well as Massachusetts Hospital Association President Lynn Nicholas, Massachusetts' Health Care For All's Paul Williams and Massachusetts Medical Society's Lynda Young about their views on what's been accomplished in the past six years and their take on how the state might tackle this next wave of policy challenges. Their perspectives follow. (Kaiser Health News)

- **Partners in talks to acquire South Shore Hospital**

  Partners HealthCare System Inc. is in talks to acquire South Shore Hospital in Weymouth, one of the largest remaining independent hospitals in the Boston area, in a deal that would reshape the competitive landscape in the region's health care market, according to two health care professionals who have been briefed by the parties on the negotiations. The 318-bed regional hospital serves a swath of Southeastern Massachusetts stretching from Quincy to Taunton to Cape Cod. Representatives from both organizations acknowledged Wednesday that they are discussing ways to expand a clinical alliance between South Shore and Partners-owned Brigham and Women's Hospital, but would not confirm they are talking about a full merger under which the Weymouth hospital would become part of the Boston-based Partners system. (Boston Globe)

Missouri

- **Missouri committee asked to review Medicaid contracts**

  Missouri lawmakers plan to investigate Medicaid contracts after a company's recent lawsuit challenging the awarding of a managed care contract. Senate President Pro Tem Rob Mayer wants the Government Accountability Committee to review the competitive bidding process used by the state Office of Administration. Mayer requested the inquiry this week. That comes after Molina Healthcare sued the state claiming it violated competitive bidding laws in awarding a contract earlier this year to Centene Corp. instead of Molina. Meanwhile, the Missouri Supreme Court appointed a new judge Friday to preside over the Molina lawsuit. The high court chose retired St. Louis County Circuit Judge Bernhardt Drumm after retired Boone County Judge Frank Conley recused himself. (KY3 News)

New Hampshire

- **Executive Council Has More Questions on Medicaid Managed Care**

  State and Managed Care company officials met today with the executive council to discuss the contract that would change the state's Medicaid Program. The councilors have serious concerns, and many questions. The $2.2 billion dollar proposed contract is the biggest in the history of the state. Supporters say Managed Medicaid would streamline services for the some 130,000 people in the program. Health-care providers worry the new contract may hurt their patients and their business. (New Hampshire Public Radio)

New Jersey

- **Medicaid On Schedule to Bring Managed Care to Behavioral Services**

  New Jersey's ongoing Medicaid reform -- which seeks to save money while improving quality of care -- will reach its next critical deadline July 1, 2013. That's when more than 60,000 adults with psychiatric illnesses, addictions, and other behavioral health problems will be enrolled in a managed care program. Shifting behavioral health to managed care is among dozens of Medicaid changes New Jersey is seeking via the comprehensive Medicaid waiver DHS submitted in September to the federal Centers for Medicare and Medicaid Services. The state is awaiting a decision from CMS. Assuming that

federal agency green lights the waiver, the state plans to solicit proposals for an ASO by July 1. There will be just one ASO chosen, and it will coordinate behavioral health for adult Medicaid patients. (NJ Spotlight)

Oregon

- **National Medicaid companies want in on the Oregon Health Plan; lawmakers cry foul**

  The state's new health care reforms, slated to kick in by August, are supposed to blaze new ground for the nation, using locally based groups of Oregon providers, hospitals and clinics to save money while offering innovative, high-quality care for the neediest. Now, two national health care companies that serve Medicaid patients in other states want to take advantage of the new law to do business in Oregon, causing lawmakers to cry foul. Centene Corporation of Missouri and United Healthcare of Minnesota are among about 50 groups, companies and nonprofits that submitted letters of intent to form coordinated care organizations for the Oregon Health Plan. The state spends more than $3 billion a year in state and federal funds to care for 650,000 low-income people. Oregon's reforms, passed in 2011 and earlier this year , do not ban out-of-state or for-profit firms from qualifying as care organizations. Whether a firm meets standards won't be decided by state officials until applications are submitted and reviewed starting this month. (Oregon Live)

COMPANY NEWS

- **REACH Health Secures Series B Funding**

  Reach Health Inc., an Alpharetta, Georgia-based provider of telemedicine technology solutions for hospitals, has raised $4 million in Series B funding. Return backers include Council Capital, BIP Opportunities Fund and C&B Capital. (Reach Health News)

- **Tritrax Healthcare Services combines with Jordan Health Services**

  Jordan Health Services, a Mount Vernon, Texas-based portfolio company of Palladium Equity Partners, has acquired Tritrax Healthcare Services, a provider of home healthcare services to geriatric patients in the Dallas/Ft. Worth area. No financial terms were disclosed. Ancor Capital Partners was the primary seller. (www.jhsi.com)

- **SXC Health to buy Catalyst Health for $4.4B**

  SXC Health Solutions Corp. said Wednesday that it plans to buy competitor Catalyst Health Solutions Inc. for about $4.4 billion in cash and stock in an acquisition that catapults the Lisle, Illinois-based company into the top tier of the pharmacy benefits management sector and marks the continued consolidation of the industry. (Chicago Tribune)

- **MAXIMUS Signs Definitive Agreement to Acquire Policy Studies Inc. for $67 Million Cash**

  MAXIMUS announced today that it has signed a definitive agreement to acquire Policy Studies Inc. (PSI), a government health and human services provider. The acquisition is expected to strengthen MAXIMUS' leadership in the administration of health and human services programs across the United States. For more than 25 years, Denver-based Policy Studies Inc. has supported government clients in the administration of public programs that include public health insurance programs, such as Medicaid and the Children's Health Insurance Program (CHIP), welfare-to-work services, and child support enforcement. (MAXIMUS News Release)=

- **Blues Plans, Lumeris Partner to Acquire Nation's Largest Real-Time Health Care Communication Network**

  Three of the nation's leading Blue health plans that work with more than 70,000 physicians and hospitals to deliver care to more than 11 million people announced today they are partnering with health IT provider Lumeris Corp. to acquire NaviNet. NaviNet is the nation's largest real-time communication network for physicians, hospitals and health insurers. Lumeris and the three Blues—Highmark, Horizon Blue Cross Blue Shield of New Jersey (Horizon) and Independence Blue Cross (IBC)—have signed an agreement to acquire NaviNet for an undisclosed price. (Lumeris News Announcement)

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
April, 2012	Arizona Duals	Demo Proposal released	120,000
April 18, 2012	Ohio Duals	RFP Released	115,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 27, 2012	Massachusetts Duals	RFP Released	115,000
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
June 4, 2012	Massachusetts Duals	Proposals due	115,000
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

DUAL INTEGRATION PROPOSAL STATUS

Below we provide an ongoing look at states as they progress toward implementation dual eligible integration demonstrations in 2013 and 2014..

State	Model	Duals eligible for demo	Released by State	Date	Submitted to CMS	Date	Deadline for Plans to submit applications	3-way contracts signed	Open enrollment ends	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012			N/A[+]	Spring 2013	N/A	1/1/2014
California*	Capitated	800,000	X	4/4/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Colorado	MFFS	59,982	X	4/13/2012			N/A	N/A	N/A	1/1/2013
Connecticut	MFFS	57,568	X	4/9/2012			N/A	N/A	N/A	12/1/2012
Illinois	Capitated	172,000	X	2/17/2012	X	4/11/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Idaho	Capitated	17,219	X	4/13/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	2/16/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Michigan	Capitated	198,644	X	3/5/2012			5/24/2012	TBD	TBD	7/1/2013
Minnesota	Capitated	93,165	X	3/19/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
North Carolina	MFFS	222,151	X	3/15/2012			N/A	N/A	N/A	1/1/2013
New York	Capitated	460,109	X	3/22/2012			TBD	TBD	TBD	1/1/2014
Ohio	Capitated	122,409	X	2/27/2012	X	4/2/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012			N/A	N/A	N/A	7/1/2013
Oregon	MFFS	68,000	X	3/5/2012			N/A	N/A	N/A	1/1/2013
South Carolina	Capitated	68,000	X	4/16/2012			TBD	9/20/2012	TBD	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012			TBD	TBD	TBD	1/1/2014
Texas	Capitated	214,500	X	4/12/2012			TBD	TBD	TBD	1/1/2014
Virginia	Capitated	56,884	X	4/13/2012			TBD	TBD	TBD	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012			TBD	TBD	TBD	1/1/2014
Washington	Capitated	115,000	X	3/12/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Wisconsin	Capitated	17,600	X	3/16/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013

**Duals eligible for demo based on approval of 10 county expansion.*

[+] Acure Care Managed Care RFP Responses due January 2013; Maricopa Co. Behavioral RFP Responses due October 2012. Duals will be integrated into these programs.

HMA RECENTLY PUBLISHED RESEARCH

Webcast: Proven Steps To Clinical Efficiency

Sharon Silow-Carroll, Managing Principal

April 9, 2012: When hospitals seek to enhance value in care delivery, their goal is two-fold: improve quality while using resources as effectively as possible. Bill Santamour of Hospitals & Health Networks (H&HN) talks with Sharon Silow-Carroll of Health Management Associates (HMA) about four hospitals that have successfully done just that by better managing service lines, harnessing data and technology and rethinking clinical staffing. **(H&HN Magazine - Link to Webcast)**

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

The Women's College of the University of Denver's Leadership Salon - Is consensus possible? A conversation on health care policy.

Joan Henneberry, Panelist

April 19, 2012

Denver, Colorado

Venture Behavioral Health Regional Integrated Care Summit - Pathways to Medicaid Health Homes and Safety Net ACOs

Alicia Smith, Presenter

Pat Terrell, Presenter

Terry Conway, MD, Presenter

April 19, 2012

Kalamazoo, Michigan

2012 Spring State of the State - State Health Reform: Implications of the Supreme Court Decision

Joan Henneberry, Keynote Speaker

April 24, 2012

Denver, Colorado

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

AcademyHealth Annual Research Meeting – Health Insurance Exchanges: Progress to Date

Joan Henneberry, Panel Facilitator

June 25, 2012

Orlando, Florida