HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: WASHINGTON MEDICAID MCO RFP

HMA ROUNDUP: FLORIDA DRAFT RATES DOWN SLIGHTLY; GEORGIA RECEIVES FUNDING FOR ELIGIBILITY SYSTEM REPLACEMENT; ILLINOIS CONTINUES TO WORK TOWARD CARE COORDINATION MODEL; INDIANA CUTS DISPENSING FEE

OTHER HEADLINES: HEALTH INSURANCE EXCHANGE UPDATES IN ILLINOIS, RHODE ISLAND AND MICHIGAN; MICHIGAN GOVERNOR SIGNS CLAIMS TAX LEGISLATION; ALABAMA, UTAH EXPLORE MEDICAID ELIGIBILITY FOR PRISONERS; MACPAC HEARING SEPT. 22-23, DUAL ELIGIBLE HEARING

PRIVATE COMPANY NEWS: HEALTH ALLIANCE PLAN ANNOUNCES INTENT TO ACQUIRE MIDWEST HEALTH PLAN; SUMMIT PARTNERS HAS ACQUIRED A MAJORITY STAKE IN CARECENTRIX,

SEPTEMBER 21, 2011

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: WE REVIEW THE WASHINGTON RFP AND NON-DUAL ABD EXPANSION

This week, our *In Focus* section reviews the Washington RFP to rebid roughly 740,000 lives under the state's Healthy Options Program and Basic Health Plan. Additionally, the RFP expands managed care coverage to non-dual eligible Medicaid individuals who are aged, blind, or disabled (ABD). Healthy Options provides fully-capitated managed care services to Temporary Assistance to Needy Families (TANF) and Children's Health Insurance Program (CHIP) clients. These 700,000 lives represent roughly 60% of the state's total Medicaid and CHIP population. The Basic Health Plan provides basic health services to roughly 40,000 low-income individuals. Below we review the current managed care market in Washington, summarize the key points of the RFP, and provide detailed information on the state's ABD population to be covered under the expansion.

Current Market Landscape

A breakdown of managed care plan enrollment in Washington as of September 2011 is provided below. Molina currently covers nearly half of the current Healthy Options population, with Community Health Plan being the only other significant player in the current market.

	Sep-11	% of Total
Molina Healthcare of Washington	334,240	47.8%
Community Health Plan of Washington	235,906	33.7%
Columbia United Providers	58,392	8.3%
Regence Blue Shield	38,867	5.6%
Group Health Cooperative	20,584	2.9%
Asuris Northwest Health	4,219	0.6%
Kaiser Foundation Health Plan	930	0.1%
King County Care Partners	253	0.0%
Other	5,946	0.9%
Total Washington	**699,337**	

Source: http://hrsa.dshs.wa.gov/HealthyOptions/NewHO/Provider/HOEnrollmentdata.htm

RFP Review

The RFP seeks to rebid the existing contracts serving the 740,000 Healthy Options and Basic Health Plan individuals, as well as the roughly 115,000 non-dual ABD lives[1] in the state. The department will award contracts by service area, with three plans selected for each urban county (King and Spokane counties), and two plans selected to serve each of the other counties. Plans must offer both Healthy Options and Basic Health Plans in a service area.

[1] Medicaid Statistical Information System State Summary Datamart. FY 2009.

The RFP requires a rate proposal for each bidder. The rate proposal is divided into three parts as detailed below:

1. **Basic Health Plan:** The state will set a rate for each service area for the Basic Health Plan. This rate will be the same for all bidders.
2. **Healthy Options TANF/CHIP:** The state will establish minimum and maximum rates. A bidder's proposed rate must fall within this range.
3. **Healthy Options ABD:** The state will establish a maximum rate and a target rate, but will not set a minimum rate. Bidders proposing rates below the target rate will be required to provide additional information about rate-setting assumptions. Additionally, inpatient hospital services at Certified Public Expenditures (CPE) hospitals are excluded from the covered benefits for this population.

New bidders entering a Healthy Options service area in which they have not had a contract in the previous twelve months will receive 50% of the assignments in the service area. This only applies to the auto-assignment of individuals who do not select a managed care plan for themselves.

Scoring criteria is included in the table below. We note that bidders must achieve an average score of at least 75% for all scoring criteria exclusive of the rate proposal section. Although rate scores dominate the scoring criteria at 40% of the total, a bidder must achieve minimum average scores across the remaining 60% of the scoring metric.

Scoring Criteria	%
Rates	40%
Access to Care and Provider Network	14%
Care Management	14%
Quality Assurance/Performance Improvement	14%
Utilization Management/ Service Authorization/ Grievance System	8%
Program Integrity	8%
Integrated Care/Understanding Changing Landscape of Managed Care	2%

Non-Dual ABD Population

The non-dual aged, blind, and disabled population in Washington includes roughly 115,000 individuals. Their inclusion in the RFP is significant, as non-dual ABD populations are traditionally in poor health, with high utilization and high medical costs. They are generally physically or mentally disabled or both, and unemployed. Below we breakdown non-dual ABD Medicaid spending from FY2009:

Washington Medicaid Spending – Non-Dual ABDs, FY2009

Category of Service	% of Total
All Services	100%
Inpatient Hospital Services	24%
Prescribed Drugs	20%
Personal Support Services	14%
Outpatient Hospital Services	7%
Physician Services	7%
Nursing Facility Services	3%
All Other Services	25%

Source: Medicaid Statistical Information System State Summary Datamart. FY 2009. *Spending numbers are rounded.*

As noted above, the RFP excludes inpatient hospital services for the non-dual ABD population when those services are provided by a certified public expenditure (CPE) hospital. This exclusion is significant, as inpatient hospital services amounted to roughly 24% of all FY2009 spending on non-dual ABDs in Washington.

Market Opportunity

We estimate a market opportunity of roughly $1.5 billion for the rebid of existing Healthy Options and Basic Health contracts. With 740,000 lives this is roughly a blended PMPM of $170. The Healthy Options Non-Dual ABD population expansion can be conservatively estimated at nearly $830 million, with 115,000 covered lives and a PMPM of $600. In total, the total value up for bid in this RFP exceed $2.3 billion.

HMA Medicaid Roundup

Florida

HMA Roundup – Gary Crayton / Dyke Snipes

Comments are due this Friday, September 23, on the non-reform rates distributed last week. Overall, rates are essentially flat, down -0.4%, but with significant variation by geographic area; rates adjustments varied from a decrease of 7.0% to an increase of 5.0%. The state will meet with plans on Friday, at which time plans will likely make their case on problems with the preliminary rates. As part of a continued change to the rate-setting process, these rates are based less on a fee-for-service approach, and based more on encounter and financial data. As previously reported, the preliminary rates for reform counties were up significantly. When finalized, the state will likely begin paying these rates in November. It is unclear as of yet whether adjustments for September and October will be paid retroactively or through prospective rate adjustment.

In the news

- **Medicaid HMO hires former state agency chief as a consultant**

  Sunshine State Health Plan has contracted with a former chief of a state agency to help further establish the company's managed long-term care networks and position it as a player in the state's new mandatory Medicaid-managed care program. Sunshine State HMO lobbyist Steve Madden confirmed that the managed care plan has hired former Department of Business and Professional Regulation Secretary Charlie Liem as a consultant. Former Gov. Charlie Crist appointed Liem Department of Business and Professional Regulation secretary in July 2010 to the position Liem had held on an interim basis since November 2009. Gov. Rick Scott did not reappoint Liem to lead the department, which regulates more than 1 million businesses in the state, including Realtors. It was Liem's understanding of long-term care and Medicaid spending issues, though, that attracted Sunshine State Health Plan, Madden said. (Florida Current)

- **Medicaid Reform Pilot extension faces hurdles**

  The Agency for Health Care Administration today told a Florida Senate health committee that the federal government has concerns over an absent medical loss ratio in Florida's Medicaid Reform Pilot, as well as the future of Low Income Pool dollars in the state. Right now, the federal government is considering extending the state's Medicaid Reform Pilot, which operates in a handful of counties. According to a briefing by, the federal government is looking to "phase out" Low Income Pool (aka LIP) money for the state. This "sunset provision" is part of a nationwide effort to get rid of LIP money in time for implementation of the Affordable Care Act. LIP money is used to reimburse hospitals that provide services to low-income and uninsured people. AHCA also told committee members that the Centers for Medicare and Medicaid Services is asking for a medical loss ratio, absent in the state's current Medicaid Reform Pilot. This "85/15" requirement mandates that providers spend 85 percent on services and 15 percent on administration. (Florida Independent)

Georgia

HMA Roundup – Mark Trail

Although there was good news last week on the state revenue front - up 9.1% year-over-year, as reported last week – Georgia's unemployment rate is still at roughly 10%. This is despite the GeorgiaWorks plan, which provides a weekly transportation stipend in exchange for part-time unpaid employment. 25% of program participants end up being hired by their employer. This continued rate of high unemployment could pose problems for future revenues due to a high reliance on personal income taxes.

The state received federal approval for $1 million in funding for eligibility system replacement and redesign, for which the state will hire a consultant. There is likely to be a quick turnaround on this, as the eligibility system is intended to be the backbone of the Medicaid and Exchange structure, as well as handle eligibility determinations for other state programs. However, cost-sharing requirements on eligibility system redesign may make it difficult for the state to receive 90/10 federal match on the entire process, as the

higher match is offered only for Medicaid eligibility system redesigns and not for the re-design of additional eligibility systems.

Managed care plans received initial rates from the state last week. The general consensus is that plans are satisfied with the rates as written currently.

The non-emergency medical transportation contract award is still outstanding.

There is an Exchange committee meeting scheduled for Thursday, September 22. The committee sent a report to the Governor's office on September 15, but it is not known when or if that report will be released to the public.

Illinois

HMA Roundup – Matt Powers / Jane Longo

At a Medicaid Advisory Committee meeting on Friday, September 16, the Director indicated that a progress report on the Medicaid reform law would be released that day at the House Appropriations-Human Services Committee, and that the Department has just created an agency-wide Project Management office to coordinate the numerous projects associated with Medicaid reform. That progress report was submitted on September 15. Additionally, HFS will host a public meeting regarding the Care Coordination Innovations Project on October 13, 2011 at the State of Illinois center in Chicago. This event is thought to give the Department a better idea of what kind of interest exists for providing care coordination services related to the Phase 1 and Phase 2 care coordination issues that they have been discussing. It appears that the Department is seeking input in how to craft the future RFP.

In the news

- **Report: Health-benefits exchange could cost up to $89 million annually**

  A health insurance exchange would cost Illinois $57 million to $89 million a year to operate and could be funded through a tax on all insurance companies offering coverage in the exchange, according to a report released Friday. It's unknown whether the proposed assessment would be passed on to consumers. The assessment would be equivalent to between 2.2 percent and 3.4 percent of premiums paid for each person covered through the exchange, or $8.90 to $13.50 per member per month, according to the report from Wakely Consulting Group and Health Management Consultants. The exchange is expected to be created by the Illinois General Assembly and begin operating in January 2014 as part of the federal Affordable Care Act. The exchange initially would serve 486,000 people, the report estimates. The number of people enrolled would ramp up to more than 1 million people by 2016, and 73 percent of the enrollees would receive federal subsidies to help them afford premiums and out-of-pocket costs, the report says. The 12-member study committee is expected to dissect the report's proposals when it meets Wednesday, September 21, in Chicago. (State Journal-Register)

Indiana

HMA Roundup – Cathy Rudd

As noted last week, the state tried to implement a cut in the Medicaid pharmacy dispensing fee from $4.90 to $3.00, but was blocked by a temporary restraining order in response to a suit filed by a pharmacists and their association. That court decision has since been reversed and the rate cut will proceed as planned. It is not known whether the pharmacists will appeal.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The state issued a reminder to providers in a September "Quick Tips" notice regarding the transition to X12 v5010 transaction codes. The notice reminded providers of the requirement for Pennsylvania providers or their transaction clearinghouse to be certified as of January 1, 2012 in order to be able to continue submitting Medicaid claims. A link to the Pennsylvania Quick Tips notice can be found here.

In the news

- **Pa. considering shift in Medicaid payments to help cut rising expenses**

  Pennsylvania is considering paying Medicaid recipients as much as $200 as an incentive to visit higher-quality and lower-cost hospitals and doctors. Experts say the strategy has never been tried by other states. Gary Alexander, the state's secretary of public welfare, said his agency hoped to launch the plan by early next year to help control rising expenses in the $30 billion Medicaid program. After his talk at a conference sponsored by the industry group America's Health Insurance Plans, Alexander told Kaiser Health News that his incentive plan would initially apply to the nearly one million Medicaid recipients still in traditional fee-for-service Medicaid. Later, he said, it could be expanded to more than 1.2 million in private Medicaid managed-care plans, which predominate in the Philadelphia area. Alexander said he did not believe the state would need to get approval from the federal government for the incentive program, although other Medicaid officials disagreed. Interestingly, neither the Pennsylvania Hospital & Health System Association nor the chair of the state's Medicaid advisory board said they knew of the incentive plan. (Philadelphia Inquirer)

- **Commonwealth of Pennsylvania Awards Two Medicaid Contracts to HMS**

  HMS, a wholly owned subsidiary of HMS Holdings Corp., announced today that it has been awarded two contracts by the Commonwealth of Pennsylvania Department of Public Welfare (DPW) to provide review and recovery services for the Commonwealth's Medical Assistance (Medicaid) program. Under the first contract, HMS will provide third party liability data exchange and recovery services, including data match, cost avoidance, and recovery billings. HMS will also provide financial overpayment reviews and recovery services under a subcontract. These contracts run for four years, with the option to renew for two additional two-year periods. (MarketWatch)

United States

HMA Roundup – Lillian Spuria

President Obama unveiled his deficit reduction plan this week, which includes several provisions impacting the Medicaid program. We detail the major impacts to Medicaid below and the estimated 10-year savings associated with each proposal:

- Reduce Medicaid provider tax threshold to 3.5% by 2017 ($26.3 billion)
- Apply a blended matching rate to Medicaid/CHIP in 2017 ($14.9 billion)
- Amend modified adjusted gross income (MAGI) to include Social Security benefits ($14.6 billion)
- Limit Medicaid reimbursement of durable medical equipment ($4.2 billion)
- Rebase Medicaid disproportionate share hospital (DSH) payments in 2021 ($4.1 billion)

In the news

- **Dual-eligibles hearing Sept. 21**: the Senate Finance Committee will hold a hearing on dual Medicare-Medicaid eligibles, a $300 billion/year business largely untapped by Managed Care, Sept. 21 at 10am.
- **MACPAC Meeting Sept. 22-23, Washington DC**: Topics include linking payment to quality in Medicaid and care coordination for high-cost, high-need populations
- **States, unhappy with health-care overhaul, look to form compact**

  State governors and legislators opposed to the federal health-care law are considering a novel approach to escape its provisions: joining an "interstate compact" that would replace federal programs - including Medicare and Medicaid - with block grants to the states. To date, legislation has been drafted or introduced in 14 states and brought to the floor by lawmakers in at least nine. Three Republican governors - in Georgia, Oklahoma, and Texas - have signed the compact into law, while Governor Jay Nixon of Missouri, a Democrat, let the compact become law without signing it. Supporters say they hope to get 40 states to put it on the legislative calendar in 2012. If a significant number of states pass the compact, supporters plan to submit it to Congress for approval in the same way that the body approves interstate compacts regulating commerce, transportation, and resource conservation and development. (Boston Globe)

- **Medicaid Audit Program Launched**

  Two years after starting the Medicare Recovery Audit Program, the Department of Health and Human Services has launched a similar program to crack down on Medicaid waste, fraud and abuse. HHS published a final rule for the Medicaid Recovery Audit Program this week. Created under the healthcare reform legislation, the program is designed to help states identify and recover improper Medicaid payments. As in the ongoing Medicare effort, independent auditors will be paid a contingency fee out of any improper payments they recover. HHS is projecting that the Medicaid audits of provider organizations could save as much as $2.1 billion over the next five years, of which $900 million will be returned to the states. The Medicare audit effort is on a pace

to grow from recovering roughly $75 million in 2010 to nearly $670 million in 2011. The auditors review claims after payments have been made using automated review processes and detailed reviews of medical records and other documentation. (GovInfo Security)

OTHER HEADLINES

Alabama

- **Legislators: State could save millions if prison officials seek Medicaid funding for inmates**

  Republican and Democratic lawmakers in Alabama, who have not agreed on much in recent months, are questioning why the state prison system is not seeking reimbursement for medical treatment of Medicaid-eligible prisoners -- a change they believe could save the state millions during tough economic times. The prison commissioner in Mississippi, Christopher Epps, told the Montgomery Advertiser his state has saved $10 million through the program since implementing it in 2009 and that Mississippi has fewer inmates than Alabama. State legislators have pushed corrections officials and the administrations of Gov. Robert Bentley and former Gov. Bob Riley to adopt the program, in which a vendor qualifies eligible inmates for Medicaid reimbursements. (Montgomery Advertiser)

Louisiana

- **Baton Rouge judge refuses to block the state from signing health care contracts**

  A Baton Rouge judge has refused to block the state from signing contracts with three private insurance companies chosen to take part in Louisiana's new health-care delivery system for the poor. The Advocate reports Judge William Morvant rejected arguments from an attorney for Aetna Better Health Inc. — which failed to get some of the business — that Aetna will be irreparably harmed if the state is allowed to move forward with the three winning proposals. Those companies are Louisiana Healthcare Connections Inc., AmeriHealth Mercy of Louisiana Inc. and AmeriGroup Louisiana Inc. On a related legal front, state District Judge Todd Hernandez ruled Tuesday that the winning proposals submitted by Louisiana Healthcare Connections, AmeriGroup and United Healthcare of Louisiana Inc. must be released to the public. Those companies filed separate lawsuits against DHH to block the release of their proposals, claiming the documents contain trade secrets and proprietary information. (The Republic)

- **Audit finds millions in improper payments by Louisiana for Medicaid providers**

  From 2005 to 2010, Louisiana's health agency paid more than $4.32 million in improper claims by Medicaid vendors who provide in-home and community-based care to elderly and disabled patients, according to a new state audit. In fiscal 2005, the amount was $161,638. The annual figure peaked at $1.66 million in fiscal 2010. The audit reviewed billing activity in three service areas: the Long-Term Personal Care Services Program; the Elderly and Disabled adults waiver program; and the New Opportunities waiver program. Auditors attributed the errors primarily to an inadequate system of tracking

services and scrutinizing claims submitted by Medicaid vendors. The report also criticized the Department of Health and Hospitals for not doing a better job of screening providers and noted that the agency's process for certifying Medicaid vendors is not yet in compliance with new standards set by the 2010 federal health insurance overhaul. (NOLA.com)

Massachusetts

- **Steward Health Takes Insurer Role**

  Massachusetts hospital operator Steward Health Care System LLC will launch a new insurance plan that requires consumers to use it for nearly all routine health-care needs, a sign of health-care providers' growing interest in such products. Steward, owned by Cerberus Capital Management LP, plans to work with the nonprofit Tufts Health Plan to create Steward Community Choice, which will be aimed at small businesses and is expected to go into effect Jan 1, assuming regulatory approval. (Wall Street Journal)

- **Insurer in deal to curb its rates**

  Partners HealthCare System Inc. is close to reaching an agreement with Blue Cross Blue Shield of Massachusetts that could provide relief to tens of thousands of insurance customers by slowing the rate of their premium increases, potentially by nearly a quarter of a billion dollars. A preliminary understanding calls for Partners hospitals to accept $80 million less in reimbursements annually for the next three years under a new contract, according to business and government officials briefed on their plans. The officials spoke on condition of anonymity because they weren't authorized to discuss the plans. Employers and individuals who buy Blue Cross insurance covering Partners hospitals would still pay more under the proposed contract, but the increases would not be as much as they would have been otherwise. Annual premium increases that were projected at 5 to 6 percent for 2012 through 2014 would be pared to between 2 and 3 percent, for a total savings of about $240 million during that period. (Boston Globe)

Michigan

- **Michigan governor signs health care claims tax into law**

  Michigan Gov. Rick Snyder on Tuesday signed into law legislation, S.B. 348, that will impose a new 1% tax on paid health care claims. The tax will be paid starting Jan. 1, 2012, by insurers that provide fully insured plans and by third-party claims administrators in the case of self-funded plans. The tax, which is intended to help fund Michigan's Medicaid program, will be paid quarterly starting April 30, 2012. The tax is intended to generate $400 million in annual revenues for the state. If the revenue collected exceeds that amount, insurers and TPAs would receive a credit against their assessments due the next year. Other states that have similar taxes include Maine, which is phasing out its tax, Massachusetts and New York. (Business Insurance)

- **Administration Lays Out Details Of State Health Exchange**

  Governor Rick Snyder would urge the state to move forward with a health care exchange with or without a federal mandate, an administration official told a joint House

committee meeting Thursday. The idea behind the exchange would be to set up an online marketplace where people could shop for the health insurance coverage that suits them best. They would be able to compare plans and rates from various providers, as they would if they were shopping online for hotels or airfare. Mr. Snyder delivered his special message on health and wellness, in which he proposed setting up the state's health care exchange under the Affordable Care Act through a nonprofit organization. The Michigan Association of Health Plans, which represents 17 health insurance companies, supports the direction the administration is heading. Mr. Snyder favors the state setting up a nonprofit entity that will oversee and run the exchange, rather than doing nothing and have the federal government come in and force its plan on the state. The nonprofit would be run by a seven-member board appointed by the governor, and would also have an advisory committee. The goal is to not create more government or bureaucracy, but a lean operation that makes it easier for individuals and small businesses to compare their health care options. (Gongwer News)

New York

- **State-run Medicaid on table**

Lawmakers may not be returning to the Capitol until January, but some of them are already plotting out their priorities -- including a push to get New York state to take over county Medicaid costs. Noting that the health insurance program for the poor consumes an average 45 percent of county property tax levies, a bipartisan group of lawmakers on Monday put forth a plan to freeze the local share and begin phasing out the counties' contribution toward the $53 billion program. Medicaid costs have long been a bone of contention between counties and the state. But the debate has several new twists this year, most notably the 2 percent property tax cap that counties will be operating under, and Gov. Andrew Cuomo's move to limit the overall growth in Medicaid spending. The tax cap, which can be overridden by a 60 percent majority, means that counties would have to cut other services such as veterans' programs, police patrols and road repairs in order to pay for Medicaid costs -- which have historically grown beyond 2 percent. (Times Union)

Rhode Island

- **RI governor signs order creating health exchange**

Gov. Lincoln Chafee (CHAY'-fee) has signed an executive order establishing in Rhode Island a health insurance exchange of the sort that's at the center of President Barack Obama's federal health reform. Chafee on Monday issued the order calling for the exchange, which is an insurance marketplace for individuals, families and businesses, and announced his appointments to its board. Chafee said the exchange, which is expected to enroll Rhode Islanders by late 2013, will allow more people in the state to obtain affordable health coverage. Rhode Island will apply this month for federal funding to develop the exchange. (Boston Globe)

Texas

- **Texas And Feds Agree 'In Principle' On Medicaid Overhaul**

  Texas officials received a long awaited thumbs up from the federal government on a proposed overhaul of the Texas Medicaid program this week, according to a letter obtained by Kaiser Health News. The letter, dated Sept. 14 from federal Medicaid director Cindy Mann, said her agency has "reached agreement in principle" on the Texas plan to expand Medicaid managed care across the state and create funding pools to finance hospital infrastructure and quality improvement programs. The new funding pools are essentially a workaround to keep money flowing to hospitals that would otherwise be canceled out by the managed-care expansion. Hospitals have expressed concern over whether the proposal would meet approval at the federal level. The Texas Health and Human Services Commission had initially sought approval by Sept. 1, to quell hospitals' concerns before an initial managed care expansion began on that date. The Centers for Medicare and Medicaid Services said in the letter that it could not promise a date for final approval, but indicated that it could come as early as Sept. 30 (Kaiser Health News)

Utah

- **Feds give Utah's Medicaid overhaul mixed reviews**

  Utah's plan for reforming Medicaid is getting mixed reviews from the Obama administration. Like many states, Utah is looking to redesign its Medicaid program to contain costs. A blueprint submitted in July for federal approval calls for moving Medicaid patients into managed care networks that would pay providers to keep patients healthy, instead of for more tests and treatment. The meat of the proposal — its payment reforms — has been well received, said Utah Medicaid Director Michael Hales. But officials with the Centers for Medicare and Medicaid Services (CMS) have indicated they don't support a controversial provision that would impose higher co-payments and deductibles on pregnant women and children enrolled in the low-income insurance program. The charges — $40 deductibles and co-payments ranging from $15 for inappropriate use of emergency rooms to $220 for hospital stays — would far exceed what's allowed now. They are supposed to encourage patients to take responsibility for their health, but national child advocacy groups fear they will cause some to forgo needed care. (Salt Lake Tribune)

- **Utah explores extending Medicaid to inmates**

  Utah health officials are exploring expanding the state's Medicaid program to cover inmates' hospital stays and doctors' office visits. Inmates have traditionally been barred from the state-federal health insurance program, which caters to the poor and disabled. Currently, the Department of Corrections contracts directly with the University of Utah's hospital and clinics for procedures that cannot be handled at the prison infirmary, and the state picks up the tab. Moving inmates onto Medicaid would shift most of the funding burden onto the federal government, explained state Medicaid director Michael Hales on Thursday at an advisory board meeting. (Salt Lake Tribune)

Virginia

- **Carilion Clinic adds program for Medicaid patients**

  As the state prepares for an influx of new Medicaid recipients, Carilion Clinic has been approved to add a second insurance product to its portfolio to help meet those needs. Carilion's newly created MajestaCare plan is one of six Medicaid managed care insurance plans recently approved by the state to begin operating in Southwest Virginia in 2012. The Virginia Department of Medical Assistance Services also approved plans offered by Amerigroup Community Care, Anthem HealthKeepers Inc., CareNet-Southern Health, Optima Family Care and Virginia Premier Health Plan. Those five plans already operated elsewhere in the state, with Virginia Premier being the only previous plan to serve Medicaid patients in Southwest Virginia. Carilion Chief Financial Officer Don Lorton said Friday that he expects enrollment in MajestaCare to be significantly higher than the enrollment in Carilion's managed care plan for the Medicare population. About 575 people are enrolled in Carilion's Medicare Advantage plan, he said. (Roanoke Times)

Washington

- **Washington State limits emergency department visits for Medicaid patients**

  Washington State will limit Medicaid patients to three non-emergent emergency department visits per year effective Oct. 1. The state says this benefit limit will save $72 million per year in state and federal funds, while opponents say it will endanger some of the state's most vulnerable citizens. As part of this plan, Washington State's Health Care Authority (HCA), which administers Medicaid, has created a list of 700 diagnoses that will be treated as non-emergent for Medicaid patients, including chest pain, shortness of breath, miscarriage and abdominal pain. The American College of Emergency Physicians (ACEP) opposes the plan and is urging the Centers for Medicare & Medicaid Services to reject the list, saying it will jeopardize the most vulnerable members of society, including children. (Healthcare Finance News)

PRIVATE COMPANY NEWS

- **Health Alliance Plan Announces Intent to Acquire Midwest Health Plan**

  Health Alliance Plan (HAP) announces today a definitive agreement to acquire Midwest Health Plan (MHP), a for-profit Medicaid HMO with 74,000 members based in Dearborn, Mich. The acquisition is pending federal and state regulatory approvals. HAP intends to maintain MHP as a separate, wholly owned subsidiary under the proposed agreement. Dr. Mark Saffer, the founder of MHP, will maintain his position as President. Midwest Health Plan will continue to operate under the same name in its Dearborn headquarters. MHP members' access to providers, coverage and service will continue uninterrupted. No job losses are anticipated at either company as a result of the acquisition. This acquisition will favorably position HAP and MHP to compete in the growing Medicaid market. Michigan's Medicaid program, which today serves about 1.5 million persons, is expected to reach 2 million individuals by 2014 under expanded eligibility standards in the Patient Protection and Affordable Care Act. The

strategic alliance also gives HAP and MHP an increased footprint in serving the "dual eligible" population, those individuals who are eligible for both Medicare -- which HAP provides -- and Medicaid. (Market Watch)

- **HealthWyse**, a Wilmington, Mass.-based provider of clinical and financial software to home healthcare and hospice providers, has raised an undisclosed amount of growth equity funding from **Housatonic Partners**. www.healthwyse.com
- **Summit Partners** has acquired a majority stake in **CareCentrix**, an East Hartford, Conn.-based provider of home health benefits management services to the managed care industry, from **Water Street Healthcare Partners**. No financial terms were disclosed. Water Street will retain a minority equity position. www.carecentrix.com

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. Washington's RFP timeline has been added to the calendar.

Date	State	Event	Beneficiaries
September 15, 2011	Nebraska	RFP Released	60,000
September 15, 2011	Kentucky RBM	Contract awards	N/A
September 29, 2011	Washington	Bidders conference	800,000
October 1, 2011	Kentucky	Implementation	460,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 1, 2011	Kentucky RBM	Implementation	N/A
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 7, 2011	Hawaii	Proposals due	225,000
October 15, 2011	New Hampshire	RFI Released	N/A
October, 2011	Pennsylvania	RFP Released	565,000
November 14, 2011	Hawaii	Contract awards	225,000
November, 2011	Pennsylvania	Proposals due	565,000
December 1, 2011	Hawaii	Implementation	225,000
December 2, 2011	Washington	Proposals due	800,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 15, 2012	New Hampshire	Contract awards	N/A
December 2, 2011	Washington	Contract awards	800,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
Early 2012	Nebraska	Contract awards	60,000
April 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
September 1, 2012	Pennsylvania	Implementation - New West Zone	270,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	295,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

HMA Recently Published Research

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

Vernon K. Smith, Managing Principal

Kathleen Gifford, Principal

Dyke Snipes, Principal

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

Links to the report and presentations below:

Link to report: (PDF)

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

NGA Center for Best Practices: State Health Insurance Exchanges and Children's Coverage: Issues for State Design Decisions

Tom Dehner, Managing Principal

Caroline Davis, Senior Consultant

Lillian Spuria, Principal

As states consider implementation options under the Affordable Care Act, they face a series of critical decisions that will affect the design of Insurance Exchanges. Many of those decisions have the potential to affect health insurance options for children and how they obtain and retain coverage.

This issue brief was developed based on input during a daylong meeting hosted by the National Governors Association Center for Best Practices. Participants at the meeting included state government officials, general health care experts, federal representatives, and individuals from nonpartisan health policy institutions. (Link to brief)

Upcoming HMA Appearances

Nixon Peabody - Investing in Health Care: Current Challenges and Opportunities

Greg Nersessian, featured speaker

October 19, 2011

Boston, Massachusetts