HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: NEW HAMPSHIRE MEDICAID MANAGED CARE RFP

HMA ROUNDUP: OPPOSITION MOUNTS TO PROPOSED CALIFORNIA RATE CUTS; FLORIDA PREPARES FOR BUDGET SHORTFALL; MICHIGAN REVENUE COLLECTIONS IMPROVE

OTHER HEADLINES: MEDICAID MANAGED CARE CONSOLIDATION CONTINUES WITH ACQUISITIONS BY AMERIGROUP, COVENTRY; MISSOURI HEALTH HOME FOR CHRONICALLY ILL APPROVED; KANSAS CONSIDERS MEDICAID MANAGED CARE RFP

UPCOMING EVENTS: KAISER COMMISSION ON MEDICAID AND THE UNINSURED RELEASE FINDINGS OF 11TH ANNUAL 50-STATE BUDGET SURVEY CONDUCTED BY HMA, OCTOBER 27, 2011

HMA WELCOMES: STEVE PERLIN, CHICAGO, ILLINOIS

OCTOBER 26, 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: New Hampshire Medicaid Managed Care RFP

We thank Jaimie Bern in HMA's Boston office for this week's review of the New Hampshire Medicaid managed care Request for Proposals (RFP). New Hampshire will be implementing a Medicaid managed care program for the first time beginning July 1, 2012 with approximately 140,000 Medicaid and CHP enrollees expected to be covered upon full implementation. The RFP covers all populations and covered services except for limited benefit enrollees and spend down categories. In SFY 2011, total Medicaid expenditures in New Hampshire were $5.4 billion. Centene indicated interest in pursuing the opportunity on its 3Q11 earnings conference call and we expect the RFP to be competitive.

Background

- New Hampshire Department of Health and Human Services (DHHS) issued an RFP for Medicaid Care Management Services in the context of significant budgetary shortfalls in the state and growing Medicaid expenditures.
  - A $67 million shortfall is estimated for SFY12.[1]
  - $1.43 billion or 27.6% of state spending is accounted for by Medicaid.
- With growing budget concerns, the Legislature passed SB 147, which:
  - Directed DHHS to "develop a comprehensive statewide care management program for all Medicaid enrollees, which would focus on improving the value, quality, and efficiency of services provided in the Medicaid Program, stimulate innovation, and generate savings for the Medicaid program."
  - Called for DHHS to select fully at-risk bidders to provide managed care services with target implementation date of the Care Management Program on July 1, 2012.
- DHHS identifies the following Care Management Program goals[2]:
  - Improve beneficiary health
  - Reimburse based upon outcomes
  - Support continuity of care
  - Ensure access to primary care and prevention
  - Promote shared decision making
  - Improve budget predictability
  - Assure compliance with federal and state law
  - Prepare for 2014 ACA Medicaid expansion (estimate an additional 50,000 Medicaid beneficiaries expected)
  - Achieve savings of $16M in General Fund

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[1] Presentation to DHHS Stakeholder Council Meeting by Nick Toumpas, Commissioner, New Hampshire DHHS, August 29, 2011, available at http://www.dhhs.state.nh.us/ocom/documents/StakeholderCouncilPresentation.pdf.

[2] Ibid

- DHHS identifies the following activities which will be the source of savings:
    - Increase timely access to primary care
    - Implement single point of accountability for care coordination
    - Better manage transitions between sites of care
    - Reduce avoidable hospital admissions and readmissions
    - Reduce emergency department use for primary care
    - Improve compliance with recommended care
    - Reduce duplication of tests
    - Enhance integration of public health

Highlights of RFP

Target populations

- Average monthly Medicaid enrollment for SFY2011 -- 132,900
- Medicaid eligibility categories: low-income children and their parents, pregnant women, the elderly, and people with disabilities
- In the process of converting CHIP to Medicaid – 8,500 covered in SFY2011 (HB2 requires DHHS to submit a State Plan Amendment to implement CHIP upon implementation of the Care Management Program)

Contract Term (Section 1.3)

- Contracts intended to be effective July 1, 2012
- Initial term will be 24 months
- May offer up to three additional one-year extensions

Covered Services (Section 3.1)

- Covered services include a fairly comprehensive set of Medicaid State Plan services, including prescription drugs

Transition to Care Management Program (Section 3.2)

- DHHS proposes a three phase implementation of populations into the program:
    - Phase 1 – implemented in Year 1 (targeted for July 1, 2012)
        - Includes all Medicaid populations except Excluded populations
        - Duals will be allowed to voluntarily opt out
        - Excluded populations – Members with VA benefits, QMB/SLMB (no Medicaid duals)
    - Phase 2 – implemented 12 months following implementation of phase 1
        - Will be seeking CMS waiver for mandatory enrollment of duals
        - Will be adding in home and community-based waiver populations and long-term care services
    - Phase 3 – implemented on January 1, 2014
        - Add in expanded ACA population

Pharmacy Management (Section 3.3)

- DHHS describes the prescription drug benefit as "carved in" but MCOs will not have complete freedom to administer the benefit:
  - DHHS and its PBM will continue to administer the following:
    - Preferred Drug List (PDL), and
    - OBRA 90 rebate and supplemental rebate programs, including rebates for MCO pharmacy claims using encounter data provided to DHHS
  - MCOs will be invited to participate on the State's Drug Utilization Review Board that oversees the PDL
  - MCOs will otherwise administer the pharmacy benefit (i.e., pay claims, conduct prior authorizations (PA), operate medication adherence programs)

MCO Choice / Assignment

- Members will be offered a choice of two or three MCOs
- First year assignment methodology:
  - DHHS will review fee-for-service claims to determine a usual primary care provider
    - If provider is under contract with one MCO, member will be assigned to that MCO
  - If provider is under contract with more than one or no usual provider is identified, the MCO with the highest RFP technical score will be assigned 50% of auto-assigned members:
    - MCO with highest technical score will be assigned 1st member
    - MCO with 2nd highest score will be assigned next member
    - MCO with highest technical score will be assigned next member
    - MCO with 3rd highest technical score will be assigned next member

Payment Reform (Section 3.9)

- Each MCO will be required to develop a plan that promotes value-based payment or other innovative partnerships with providers, including incentives to share in savings, if appropriate
- DHHS will approve the plan and negotiate an incentive program equal to 1% of capitation revenue or penalize the MCO based on performance against its approved plan

RFP scoring (Section 4.1)

- Technical score: 70%
- Cost score: 30%

Procurement Timetable

Procurement Timetable	Item Action Date
Release RFP	10/15/2011
Mandatory Letter of Intent	10/26/2011
RFP Technical Proposal Conference	1:00-5:00pm 11/03/2011
RFP Cost Proposal Conference	1:30-4:30pm 11/17/2011
Technical and Cost Bids due at DHHS by 4:00pm	12/16/2011
Anticipated selection of successful Bidder	1/15/2012
Contract execution	3/08/2012
Anticipated start of contract	7/01/2012

Other Resources

DHHS website – Care Management Program page
http://www.dhhs.state.nh.us/ocom/care-management.htm

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

News flow continues to focus on the pending decision by CMS on proposed rate cuts in California. Most recently, the California Pharmacists Association (CPhA) sent a letter to CMS Administrator Donald Berwick, M.D., outlining why proposed cuts by the California Department of Health Care Services (DHCS) violate federal law and will result in pharmacists being forced out of the program. For pharmacists, these cuts would result in a 15 percent reduction in Medi-Cal prescription payments. According to Jon Roth, Chief Executive Officer of CPhA. "When presented with the facts that Medi-Cal would no longer cover the cost of the drug and pharmacist's services, seven-in-ten (72%) would decline to fill Medi-Cal prescriptions." We expect a decision by CMS in the near future.

In the news

- **778 Assessments a Day To Meet Deadline**
  When the state eliminated adult day health care (ADHC) as a Medi-Cal benefit, DHCS announced it would do a complete health risk assessment of all ADHC patients to better determine their health needs. Assessments started on October 1, and there is a 45-day deadline in place. That means all 35,000 assessments need to be completed by November 15, or more than 5,000 completed assessments every week -- or 778 every day, seven days a week. During the first week of the assessment project, some patient data were not available. The company doing most of the assessments is APS, Inc., a care management contractor. (California Health Line)

Florida

HMA Roundup – Gary Crayton

A recent economic update provided to the Florida legislature by the Office of Economic and Demographic Research (OEDR) indicated mixed results related to the state's economy. State tax collections for SFY 2010-2011 finished $139.1 million above the forecasted level, however preliminary results for the first quarter of the current fiscal year indicate a shortfall from the overall estimate of approximately $106 million. The shortfall was attributable to weak economic conditions including suppressed employment growth and the stalled housing recovery. As a result, the OEDR projects that General Revenue needs for SFY 2012-2013 are greater than estimated collections by approximately $1.2 billion, including discretionary reserve strengthening of $1 billion. The Senate is considering some additional issues that may bring the budget gap up to $2b.

In the news

- **Jackson Health System sells Medicaid plan to Fernandez-owned company**

  Jackson Health System's board agreed Wednesday to negotiate the sale of its failing Medicaid insurance business to Simply Healthcare, a new insurer whose main investor is a close friend of Jackson's chief executive, Carlos Migoya. Migoya told the board he was friends with several Simply Healthcare shareholders, but it was the only company that had offered any money to take over the 12,000 Medicaid recipients in the JMH Health Plan, which consists of insurance HMOs offered by the system. The Medicaid portion consists of many high-risk patients that contributed to plan losses of $14.3 million so far this calendar year. Under the proposed deal, Simply Healthcare will pay Jackson up to $2.5 million and absolve Jackson of a potential $3 million more in losses. Until Simply Healthcare came along, Jackson planned to abandon the Medicaid business without any payment. (Miami Herald)

Michigan

HMA Roundup – Esther Reagan

The State of Michigan is expecting to finish Fiscal Year (FY) 2010-2011 with a surplus and how those funds will be allocated is expected to be an interesting debate. The House Fiscal Agency estimated revenues for the year will be about $285 million above the May Revenue Estimating Conference forecast ($140 million in the general fund and $145 million in the School Aid Fund). The Senate Fiscal Agency's estimates were higher; $431 million above the May forecast ($158.3 million in the general fund and $272.9 million in the School Aid Fund). Governor Rick Snyder is quoted as saying the state should "be thoughtful and cautious" about how the funds are used and, given the tenuous nature of the current national and international economy, perhaps wait until the January Revenue Estimating Conference before making any decisions.

Texas

HMA Roundup – Dianne Longley

The Texas Health and Human Services Commissioner Tom Suehs announced changes to the agency's managerial structure. Charles Bell, Deputy Executive Commissioner for Health Services is retiring. Billy Milwee, currently the state's Medicaid director, will assume that title with responsibility for Medicaid and CHIP. HHS will bring on Dr. Mark Chassay, currently the Head Team Physician and Chief Medical Officer at UT-Austin, to fill the new position of Deputy Executive Commissioner of Health Policy and Clinical Services. According to the agency, Chassay "will focus on coordinating health and clinical policy across the health and human services system to ensure a coordinated approach to medical policy." A spokesperson said the new position reflects the desire of Suehs to have someone in place who could coordinate health policy across all the HHS enterprises including issues like ensuring a sufficient provider base or the use of restraints and psychotropic drugs.

OTHER HEADLINES

Alabama

- **Alabama Medicaid commissioner overseeing construction of statewide medical records program**

  Alabama's Medicaid Agency is creating a program called One Health Record, which aims to create a system that allows physicians to access a patient's medical history -- from previous treatments to current medications -- quickly and easily. The moves come in advance of the implementation of the ACA, which pushes for upgraded health information technology. The system should launch April 1, 2012, with a goal of full implementation by January 1, 2013. The hope is that the system will allow physicians to make better decisions on treatment and cut back on duplicated services and errors, leading to better health outcomes and cost savings. A $10.5 million federal grant is funding the project to build the network. Michigan-based vendor Thomson Reuters is creating the infrastructure for One Health Record. (The Republic)

Arizona

- **US renews scaled-back Arizona Medicaid program**

  The federal government is reauthorizing Arizona's newly scaled-back Medicaid program for another five years. The reauthorization awarded Friday accepts cost-cutting changes to the programs, including enrollment freezes and new copayment requirements that federal officials either previously accepted or indicated that they would. Some other changes proposed by the state either were scaled back or rejected outright. The current Arizona budget required Gov. Jan Brewer's administration to reduce state spending on the Medicaid program by approximately $500 million to help close a $1.1 billion shortfall. A major portion of the state's savings plan is an additional cut in payment rates for hospitals and other providers to save a projected $190 million in the current fiscal year. Federal officials say they're considering that separately. (KSWT News)

Arkansas

- **Arkansas Signs $70 Million Medicaid Contract Extension with HP**

  HP Enterprise Services today announced the Arkansas Department of Human Services (DHS) Division of Medical Services has extended its long-time service agreement with HP to manage the state's Medicaid program. The $70 million, 27-month contract will assist the state in preparing for healthcare reform and other pending changes while helping align Medicaid expenses with state revenues. As the fiscal agent for Arkansas since 1985, HP provides systems support and business process outsourcing services for the state's Medicaid Management Information System (MMIS). HP will assist the state by implementing the American Recovery and Reinvestment Act HITECH electronic health record incentives and federal HIPAA 5010 requirements. (Market Watch)

Connecticut

- **State Contractor Selection Questioned**

  The state Department of Social Services has received protests from two unsuccessful bidders as it seeks to award a multimillion-dollar contract to run a statewide, non-emergency medical transportation program for hundreds of thousands of Medicaid recipients — including low-income and elderly people — beginning next January. One of the protests involves a claim by a non-profit transportation-service company of bias, based on a state official's choice of words in an email. (Hartford Courant)

Kansas

- **Brownback officials: Medicaid managed care contract being drafted**

  Kansas welfare chief Rob Siedlecki told a legislative panel today that his agency has no plans to cut Medicaid provider rates this fiscal year. But he gave no similar assurance for the coming year. And Dr. Robert Moser, secretary of the Kansas Department of Health and Environment, which oversees the state's Medicaid program, said he couldn't yet rule out provider cuts as a possibility for fiscal 2013, which begins July 1, 2012. Moser told the committee that the administration is looking at shifting more Medicaid patients into managed care programs and that the reform plan also would focus on stronger or "targeted" case management and other methods to bring down costs. He cautioned it would take time to achieve savings of $200 million or $400 million. In response to questions from legislators, the Cabinet members told the committee members that the administration is in the process of developing a contract that would expand managed care in the Medicaid program. (Kansas Health Institute)

Massachusetts

- **Most in Massachusetts want state push on health costs**

  Most Massachusetts residents want their state government to take action to reduce high healthcare costs that they blame on drug and insurance companies charging too much, a survey showed on Friday. Eighty-eight percent of the 1,000 Massachusetts residents questioned in the poll in September said the state government should take "major action" to address rising costs. Only 48 percent expressed confidence that the state government could take steps to reduce future healthcare costs, with Democrats more confident than Republicans. Asked for reasons why costs are so high, survey respond-

ents cited drug companies and insurance companies charging too much money, as well as waste and fraud in the healthcare system, hospitals charging too much, and people not taking good care of their health. The poll, conducted by the Harvard School of Public Health for the Blue Cross Blue Shield of Massachusetts Foundation, found that 78 percent of respondents viewed the high cost of healthcare as either a crisis (25 percent) or a major problem (53 percent). (Reuters)

Minnesota

- **Governor touts $242 million saving in state health insurance programs**

Minnesota Gov. Mark Dayton claimed the first major success of his drive to improve government efficiency Thursday, saying a competitive-bidding process for state health insurance programs will save $242 million in the next two years. It was the first and likely largest cost-saving initiative in what the Democratic governor said will be a series of changes as part of what he's calling "Better Government for a Better Minnesota." The health care savings Dayton touted come from a pilot program in which Medicaid lives in the seven-county Twin Cities area were put out to bid. About $180 million of the $242 million in savings is attributable to the bidding process. The savings already are figured into the current biennial budget. (TwinCities.com)

Missouri

- **Missouri is first to implement 'health homes' for patients with chronic illnesses**

Beginning next year, Missouri will take a new approach to serving Medicaid and Medicare enrollees with mental health, substance abuse and other chronic conditions. These dual eligible residents will be served through what's known as a "health home" model, a model supported by the ACA. In a health home, providers -- ranging from primary-care doctors to counselors – coordinate behavioral and physical health services to meet all the patients' needs. The Center for Medicare & Medicaid Services announced Missouri's new approach in a conference with reporters last week. The agency said Missouri would be the first state in the nation to move to the health home model. Cindy Mann, Director of the Center for Medicaid and State Operations, provided no information about the number of Missourians that would be served by the new program or the costs. She expressed confidence that the approach would save money, citing research showing patients tend to get better care and more coordinated care at a lower cost through health homes. She also noted that the state would have to put up less money for care coordination services under this program. Typically, states are required to contribute a 40 percent match for Medicaid services. But this program requires Missouri to spend only 10 percent of its money for designated care coordination services, with the federal government providing 90 percent. Rhode Island and Oregon also are seeking to set up a health-home plan similar to Missouri's. (St. Louis Beacon)

New York

- **Two Major Hospital Groups in City Explore a Partnership**

Two of New York City's major hospital organizations are exploring a partnership that would give them a large share of the city's patients and make them a formidable rival for other city hospitals in tough economic times. A partnership between Continuum

Health Partners and NYU Langone Medical Center could alter the balance of power in New York City health care. It could also complicate efforts to control health care costs: with reduced competition, the hospitals could gain clout in negotiating rates with insurance companies, potentially driving up costs for employers and employees across the region. Executives at both organizations confirmed the partnership discussions on Thursday, while saying that they were still preliminary and that the details of how such a relationship would be structured — whether it would be a merger or short of that — remained to be worked out. (New York Times)

Pennsylvania

- **Clinics are key to health care, Pennsylvania state senator says**

  A legislative hearing was held Tuesday regarding a Republican proposal to expand community health clinics. The hearing was held by state Sen. Ted Erickson, R-Delaware County, who is hoping to spur action on a bill he's pushed for several years, and who highlighted the urgency to address a large uninsured population that's growing because of job losses. Cheri Rinehart, president of the Pennsylvania Association of Community Health Centers, said the state could help the centers by expanding a grant program that's been the state's main vehicle for helping the centers, but which funded only five of 43 recent applications. She said the state also could help by reducing administrative burdens, creating an uncompensated care fund — she said the centers provided $88 million in uncompensated care in 2009 — and increasing state payment for delivering babies. State payments to clinics average about $120 per birth, while regular providers receive about $1,200. (Penn Live)

- **Insurance exchange inching forward**

  The state Insurance Department is waiting on a report from the consulting firm KPMG before it makes its final recommendations to Gov. Corbett about establishing a health insurance exchange, a key component of the Obama administration's health care reform law, an insurance department official told an audience of businesspeople Friday. The department's recommendation to Corbett will not be public, but the KPMG report and other documents supporting its decision will be posted online. (The Morning Call)

- **Highmark, West Penn agree on terms of acquisition**

  Highmark Inc. and West Penn Allegheny Health System have reached a verbal agreement on the terms and conditions of the insurer's planned acquisition of the region's second-largest hospital network, the Tribune-Review has learned. Board officials at both organizations need to sign the agreement before it becomes official and can be forwarded to state regulatory agencies. It is unclear when the signing will take place, but an announcement could come in about a week. Highmark's acquisition of West Penn Allegheny, announced June 28, aims to preserve the parent company of Allegheny General Hospital and five other suburban hospitals. The system reported a loss from operations of $48.8 million for the nine months ended March 31. Highmark, the state's largest health insurance company with about 3 million customers in Western Pennsylvania, will spend about $475 million on the ailing hospital network. (Pittsburgh Live)

South Carolina

- **SC Medicaid agency may add 70,000 kids to program**

The director of South Carolina's Medicaid agency wants to make it easier for low-income children who already qualify for health care coverage to enroll, saying Monday it's a conservative step toward meeting a huge unfunded liability looming in 2014. Director Tony Keck is requesting an additional $35 million from the state in his 2012-2013 budget proposal, submitted to Gov. Nikki Haley earlier this month. Nearly $30 million of that would pay to add an estimated 70,000 children to Medicaid rolls by streamlining the application process. Officials estimate up to 89,000 children in South Carolina without health insurance qualify for a Medicaid program that covers only those 18 and under. Legislators passed a law in 2007 increasing eligibility – allowing parents' incomes to be 200 percent of the federal poverty level, up from the state's previous 150 percent cap. CMS has provided a sizable financial incentive to encourage states to streamline Medicaid and CHIP applications in the manner proposed by South Carolina. (The Sun News)

Tennessee

- **TN nursing homes face cuts**

Nursing homes in Tennessee may have to lay off staff because they will lose another 4.25 percent in funding from TennCare. The state's Medicaid program said Friday it would implement the cut January 1. It comes on the heels of a reduction for the same amount that occurred July 1. Dentists, transportation providers, lab and X-ray services and home health agencies also are affected. Staffing is the only place nursing homes can cut back, said Jesse Samples, executive director of the Tennessee Health Care Association. Labor accounts for 70 percent of costs, he said, while the other 30 percent are for fixed costs. TennCare initially budgeted the latest 4.25 percent reduction but held off implementing it in hopes of receiving $82 million from the federal government. The state agency recently learned it probably won't be getting that money. Tennessee and other states are owed because of an error the Social Security Administration made over a 35-year period. The program nationwide assigned people to Medicaid programs when they qualified for Medicare. The error involved about 300,000 cases, TennCare said. (The Tennessean)

Virginia

- **Va. officials to meet about setting up health-insurance exchange**

The Virginia General Assembly wants a head start on how to set up a health-insurance exchange amid uncertainty about the federal law that requires that the entity be created. The commerce and labor committees of both legislative houses will meet November 15 for a joint briefing by Secretary of Health and Human Resources Bill Hazel, point man on health-care reform for Gov. Bob McDonnell. McDonnell opposes the Patient Protection and Affordable Care Act signed into law by President Barack Obama last year, but the governor and key legislators want to be sure that the state runs the exchange, not the federal government. How best to do it remains the question for the legislature, which is waiting for an overdue report by the governor's Health Care Reform Initiative Advisory Council and a better sense of the deadline for making key de-

cisions under the federal law. The council delivered the report to the governor and his policy office on Friday, but the administration won't make it public until transmitting the document to members of the assembly. (Richmond Times-Dispatch)

West Virginia

- **Health overhaul may trim costs for state prisons**

The state Division of Corrections could save up to $2 million a year in inmate medical care costs when new federal health care laws take effect in 2014. Provisions in the Patient Protection and Affordable Care Act that passed last year overhaul eligibility requirements for Medicaid to include individuals who make less than 133 percent of the federal poverty level, regardless of whether they have children. While this expansion means states eventually will have to spend significantly more to fund their portion of the Medicaid program, part of the rule change may trim costs in state corrections programs. The Division of Corrections spends about $18 million each year on inmate health care. In-house prison services are contracted out to private health care providers. Wexford Medical Services, a Pittsburgh, Penn.-based firm, currently holds that contract. (Charleston Daily Mail)

Wisconsin

- **Residents voice concerns about proposed BadgerCare cuts**

The Department of Health Services hosted a town-hall meeting last Friday on the state's plan to trim an estimated $554 million over two years from the BadgerCare Plus and Medicaid budget. The plan, released earlier this month, includes dozens of proposed changes in the programs that provide health coverage to about one in five people in Wisconsin. The changes are designed to close the state's budget shortfall while maintaining coverage for people. The temporary cap on enrolling in Family Care generated the most comments Friday. Several speakers noted that the waiting lists were beginning to grow. One of the most controversial proposals is to limit the benefits of an estimated 215,000 people now covered by BadgerCare Plus. That program covers families with children younger than 19 and household incomes below 200% of the federal poverty level. The proposed changes will be reviewed by the Legislature's Joint Finance Committee and also will require the federal government's approval. (Journal Sentinel)

United States

- **Inspector general report faults oversight of Medicaid prescription drug program**

Not one of 14 states recently audited had adequate controls in place to ensure that all of its Medicaid drug expenditures complied with federal law, according to a new Health and Human Services Office of Inspector General report. The potential cost to state and federal taxpayers: almost $260 million. The report found many drugs were ineligible for coverage, and faulted the federal Centers for Medicare and Medicaid Services (CMS). (The Hill)

- **FMAP Calculation and MAGI Conversion Activities Announcement**

On October 20th, CMS released new information about its efforts to develop methodologies for FMAP calculation and MAGI conversion according to changes made by the

Affordable Care Act. HHS recently awarded a contract to RAND, in collaboration with the State Health Access Data Assistance Center (SHADAC) and the National Conference of State Legislatures (NCSL), to help CMS with the technical aspects of this work. According to CMS' announcement, they will be evaluating and refining the methodologies proposed by CMS to make the MAGI approximations and to distinguish "newly eligible" from currently eligible individuals for the purposes of FMAP claiming.

- **Pilot states sought for testing FMAP, MAGI Conversion**

  In its October 20th email, CMS notified states about an opportunity to participate in the testing of the feasibility of methodologies for FMAP calculation and MAGI conversion. More information about this opportunity will be forthcoming.

- **More states limiting Medicaid hospital stays**

  A growing number of states are sharply limiting hospital stays under Medicaid to as few as 10 days a year to control rising costs. Arizona, which last year stopped covering certain transplants for several months, plans to limit adult Medicaid recipients to 25 days of hospital coverage a year, starting as soon as the end of October. Hawaii plans to cut Medicaid coverage to 10 days a year in April, the fewest of any state. Both efforts require federal approval, which state officials consider likely because several other states already restrict hospital coverage. (USA Today)

- **House to vote on Rep. Black bill paring down health law's Medicaid expansion**

  The House will vote next week on legislation that will prevent as many as one million middle-income Americans from becoming eligible for Medicaid under the ACA. The Medicaid eligibility bill, sponsored by Rep. Diane Black (R-Tenn.), is the last bill on the leader's weekly schedule. It cuts the deficit by about $13 billion over 10 years and is expected to pass with bipartisan support. The ACA currently counts only the taxable portion of Social Security benefits when calculating Medicaid eligibility, allowing up to a million middle-income early retirees to potentially be eligible for a program meant to help low-income people. Black's bill would replace the healthcare law's Modified Adjusted Gross Income with the more restrictive eligibility standard for federal assistance programs. (The Hill)

- **Government triples money recovered from Medicaid scams**

  The federal government has more than tripled the amount of money it has recovered through efforts to stop Medicaid fraud in the past six years, records show. In 2004, the government gained $573 million through fraud prosecutions, compared with $1.85 billion in 2010, according to records from the Department of Health and Human Services inspector general's office. That was spurred by a 57% increase in the amount of grant money to state Medicaid Fraud Control Units (MFCUs) from $131 million to $205.5 million. Much of the money comes as the Obama administration, with bipartisan help in Congress, has increased spending on anti-fraud programs. Recent examples include a requirement in last year's health care law for electronic records systems for all medical professionals who provide health care for Medicaid and Medicare patients, as well as a proposed rule released on the Federal Register October 6 requiring state MFCUs to better monitor their own activities to show they are effective. (USA Today)

PRIVATE COMPANY NEWS

- **Coventry Health Care Agrees To Purchase Business Of Children's Mercy's Family Health Partners**

  Coventry Health Care announced today that it has signed a definitive agreement to purchase the business of Children's Mercy's Family Health Partners, a Medicaid health plan that is operated by Children's Mercy Hospital, Kansas City. Family Health Partners has approximately 210,000 Medicaid members in total with approximately 155,000 members in Kansas and 55,000 members in Missouri and annual revenue of more than $450 million. Upon completion of this transaction, Coventry will serve nearly 900,000 Medicaid recipients across 10 states and more than 1.5 million public and private members in its seven-state Midwest region. In addition, Coventry and Children's Mercy Hospital have entered into a long-term provider relationship as part of the definitive agreement. (Coventry Health Care)

- **Amerigroup To Expand New York Presence**

  Amerigroup Corporation (NYSE: AGP) announced today that it has signed an agreement to purchase substantially all of the operating assets and contract rights of Health Plus, one of the largest Medicaid managed care companies in New York. Health Plus, established in 1984 by Lutheran Medical Center, currently serves approximately 320,000 members in New York State's Medicaid, Family Health Plus and Child Health Plus programs, as well as the federal Medicare program. The purchase price of $85 million will be funded through available cash. The transaction is subject to regulatory approvals and other closing conditions and is expected to close in the first half of 2012. Health Plus expects to generate approximately $1 billion of revenue in 2011. (Amerigroup)

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. This week, we highlight the anticipated start date of the Kentucky Medicaid managed care expansion on November 1, the anticipated announcement of the Kentucky RBM contract awards (though that decision has already been delayed multiple times) and the release of the Pennsylvania Medicaid managed care RFP (imminent but exact date uncertain).

Date	State	Event	Beneficiaries
October, 2011	Pennsylvania	RFP Released	565,000
November 1, 2011	Kentucky RBM	Contract awards	N/A
November 1, 2011	Kentucky	Implementation	460,000
November 18, 2011	Hawaii	Proposals due	225,000
November, 2011	Pennsylvania	Proposals due	565,000
December 1, 2011	Kentucky RBM	Implementation	N/A
December 2, 2011	Washington	Proposals due	800,000
December 6, 2011	Nebraska	Proposals due	75,000
December 23, 2011	Hawaii	Contract awards	225,000
January 1, 2012	Virginia	Implementation	68,000
January 15, 2012	New Hampshire	Contract awards	N/A
January 16, 2011	Hawaii	Implementation	225,000
January 17, 2012	Washington	Contract awards	800,000
January 31, 2012	Ohio	RFP Released	1,650,000
February 1, 2012	Louisiana	Implementation (GSA A)	892,000
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
February 28, 2012	Nebraska	Contract awards	75,000
April 1, 2012	New York LTC	Implementation	200,000
February 1, 2012	Louisiana	Implementation (GSA B)	892,000
February 1, 2012	Louisiana	Implementation (GSA C)	892,000
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
July 1, 2012	Nebraska	Implementation	75,000
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 Welcomes…

Steve Perlin – Chicago, IL

We are pleased to announce that Steve Perlin has returned to HMA as of Monday, October 24th as a Principal in our Chicago office. From October 24th through the end of 2011, Steve will divide his time between HMA and his current employer, the Illinois Hospital Association. Steve was previously at HMA for nearly seven years, first as a Senior Consultant and then as a Principal. Steve's work focused primarily on Medicaid special financing arrangements, and he led projects for hospitals and hospital associations across the country. Both before and after his time at HMA, Steve served in senior roles with the Illinois Hospital Association, where his policy, reimbursement, and advocacy work has been invaluable to the association and its members. Steve earned his Bachelor of Science degree at the University of Wisconsin, and his Master of Business Administration degree at The George Washington University.

HMA Recently Published Research

Managing Medicaid Pharmacy Benefits: Current Issues and Options

Vernon K. Smith, Managing Principal
Sandy Kramer, Senior Consultant

This report examines reimbursement, benefit management and cost sharing issues in Medicaid pharmacy programs. The analysis, conducted by researchers from the Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, focuses on the potential of several measures recently highlighted by HHS Secretary Kathleen Sebelius to reduce Medicaid pharmacy costs. The findings were informed, in part, by the perspectives of a group of Medicaid pharmacy administrators convened by the Foundation in May 2011. (Link to report)

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 September 13, 2011, at a public briefing at the Kaiser Family Foundation's Washington, D.C. office.

Links to the report and presentations below:

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

Upcoming HMA Appearances

Press Briefing: Kaiser Commission on Medicaid and the Uninsured's 11th Annual 50-state Medicaid budget survey

Vernon K. Smith, Keynote Speaker

October 27, 2011

Washington, DC

Alliance for Health Reform Luncheon Briefing

Vernon K. Smith, Panelist

October 28, 2011

Washington, DC

American Evaluation Association: A Mixed-Methods Approach to Understanding the Impact of Requiring Citizenship Documentation for Medicaid Enrollment

Caroline Davis, speaker

November 3, 2011

Anaheim, California

Medicaid Health Plans of America Annual Meeting

Vernon K. Smith, Keynote Speaker

November 7, 2011

Washington, DC

National Association of Medicaid Directors Annual Meeting: "The New Eligibility Paradigm"

Vernon K. Smith, Panelist

November 8, 2011

Arlington, Virginia

American Medical Association Council on Medical Service Innovation

Vernon K. Smith, Speaker

November 11, 2011

New Orleans, Louisiana

PhRMA Annual Meeting for State Government Affairs and State Policy

Vernon K. Smith, Speaker

November 15, 2011

Reston, Virginia

NGA National Summit on Government Redesign: "Opportunities for Medicaid Redesign"

Vernon K. Smith, Speaker

December 13, 2011

Washington, DC