HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MICHIGAN DUAL ELIGIBLE INTEGRATION PROPOSAL

HMA ROUNDUP: NEW YORK TO RELEASE DUAL INTEGRATION PROPOSAL MARCH 22; FLORIDA HOSPITAL RATE CUTS FINALIZED; CALIFORNIA DUAL INTEGRATION APPLICATIONS RELEASED; TEXAS PHARMACY CARVE-IN IMPLEMENTED; HMA RECORDS GLG WEBCAST ON STATE BUDGETS, MCO EXPANSION, AND CALIFORNIA DUALS RFS

OTHER HEADLINES: KENTUCKY AUDITOR RECOMMENDS BEHAVIORAL HEALTH CARVE-OUT FROM MCOS; KANSAS ADVOCATES OPPOSE BEHAVIORAL HEALTH CARVE-IN AS MEDICAID REDESIGN MOVES FORWARD; NEBRASKA AWARDS MEDICAID MCO CONTRACTS TO COVENTRY, AMERIHEALTH; NEW JERSEY POSTPONES MEDICAID LTC CHANGES WITHOUT FEDERAL WAIVER; NEW MEXICO, WASHINGTON, WYOMING MOVE FORWARD ON EXCHANGES; IDAHO UNLIKELY TO SET UP OWN EXCHANGE

RFP CALENDAR: DUAL INTEGRATION DATES FOR ARIZONA, MICHIGAN, NEW YORK ADDED; TIMELINE FOR MARICOPA CO. (ARIZONA) BEHAVIORAL HEALTH RFP

MARCH 7, 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: MICHIGAN DUAL ELIGIBLE INTEGRATION PROPOSAL

This week, our *In Focus* section reviews Michigan's proposal to integrate care for dual eligible Medicare-Medicaid beneficiaries. Unlike other state dual eligible integration proposals that limit the population included either geographically or by age (including Ohio, Michigan and Illinois), Michigan has proposed a phased approach, beginning in 2013 and continuing through 2014, that integrates care for all dual eligibles statewide – more than 211,000 lives in total. The proposal, released on Monday, March 5, kicks off a 30 day public comment period. The state intends to incorporate public comments into a final proposal to the federal Centers for Medicare and Medicaid Services (CMS) by April 26, 2012.

Key Proposal Elements

Beginning in July 2013, the state proposes to roll out enrollment in the first of three geographic regions. Through a quarterly phased approach over the following year, the state will enroll all dual eligible individuals in all geographic regions by June 30, 2014. In each geographic region, dual eligible individuals will be enrolled in the following order:

Q1: Non-elderly with disabilities, persons with serious mental illness (SMI) or substance abuse disorder, and non-nursing facility older people.

Q2: Nursing facility residents; MI Choice Waiver enrollees.

Q3: Persons with intellectual and developmental disabilities (ID, DD).

Dual eligibles will be passively enrolled in an integrated care organization (ICO) with a two-month plan selection period. Additionally, during this two-month period, individuals may opt out of the integrated care demonstration. The state defines an ICO as an insurance-based or provider-based health organization contracted to, and accountable for, providing integrated care to persons eligible for both Medicare and Medicaid.

One important aspect of the proposal is that behavioral health benefits will be carved-out of ICO contracts and provided by a separate entity. During the enrollment process, beneficiaries will be assessed based on their need for specialty services, which will be provided under separate state contracts through a prepaid inpatient health plan (PIHP). PIHPs will cover mental health and substance abuse services for those with a specialty level of need for behavioral health and ID/DD supports and services. Michigan Medicaid spent more than $843.6 million on behavioral health and DD services for dual eligibles in 2008.

Market Opportunity

In the draft proposal, the state provided detail on the dual eligible population of nearly 200,000 in 2008. Table 1 below provides population and utilization distributions, as well as Medicaid and Medicare per-member per-month (PMPM) spending. The state also noted that this population increased to more than 211,000 as of March 2011.

Enrollment in Table 1 below is presented in a hierarchical order, meaning that enrollees were only counted in one category, based on their status as of the end of 2008. Enrollees were assigned to the first applicable category, even though they may have received services from other categories.

Table 1: Medicare and Medicaid PMPM Costs by Client Category

Population	Number	Medicaid PMPM	Medicare PMPM	Total PMPM
DD - Habilitation Supports Waiver	5,499	$5,774	$1,201	$6,975
DD non-waiver	10,554	$2,521	$1,023	$3,544
Adults w/ Mental Illness	24,120	$1,279	$1,708	$2,986
MiChoice HCBS Waiver Enrollees	6,815	$2,867	$3,097	$5,964
Nursing Facility Residents	31,150	$4,377	$2,840	$7,217
Adult Home Help Recipients	27,909	$533	$2,561	$3,094
End Stage Renal Disease	2,293	$610	$8,212	$8,822
Other Disabled	47,657	$918	$1,142	$2,060
Other Aged	42,647	$329	$1,508	$1,837
Total	**198,644**	**$1,411**	**$1,899**	**$3,310**

Source: Michigan Proposal, data from 2008

The state provided the following points of analysis on the population data:

- Most of the cohorts in the hierarchy include a sizeable number of individuals. The patterns of service utilization vary greatly among the cohorts. The implication is that the integrated care plan and the competencies of the ICOs may require development of multiple models of care planning and service coordination and delivery.
- Individuals with intellectual/developmental disabilities receive most of their services from Medicaid. In addition to receiving extensive support services from Medicaid, their Medicare costs are lower than average. In particular, their use of Medicare-financed acute physical health care services is only about half the per capita level for the entire dual eligible group.
- Individuals needing nursing facility level of care who are enrolled in the MI Choice HCBS waiver receive more Medicare services than Medicaid. By contrast, nursing facility residents receive significantly more Medicaid than Medicare services. They are also the oldest cohorts of dual eligible enrollees, accounting for more than half of those over the age of 85.
- For individuals with ESRD (End Stage Renal Disease) and for "other" aged individuals, Medicare is the predominant provider of services.
- For adults with mental illness, Medicare spending exceeds Medicaid spending. This is in part due to the fact that Medicare pays for acute psychiatric care for this cohort and Part D covers most of their psychiatric medications.
- "Other" disabled individuals receive slightly more than half of their services from Medicaid.

Table 2 below provides total monthly Medicare and Medicaid spending by provider category.

Table 2: Medicare and Medicaid Monthly Costs by Provider Category

Provider Category	Monthly Medicaid $	Monthly Medicare $	Monthly Total $
Practitioners/Carriers	$1,896,256	$70,298,796	$72,195,052
Inpatient Hospital	$2,831,527	$142,482,947	$145,314,474
Outpatient Hospital	$1,616,624	$43,566,757	$45,183,381
Pharmacy	$1,314,163	$44,573,191	$45,887,354
Durable Medical Equipment (DME)	$2,576,856	$12,524,641	$15,101,497
Home Health	$60,840	$19,005,225	$19,066,065
Hospice	$12,107,258	$13,625,835	$25,733,093
Skilled Nursing Facility (SNF)	$158,028,196	$31,109,265	$189,137,461
MI Choice	$9,076,546	$0	$9,076,546
Home Help	$13,838,066	$0	$13,838,066
Medicaid HMO	$3,616,716	$0	$3,616,716
Payments to PIHPs	$71,930,614	$0	$71,930,614
Other	$1,487,230	$0	$1,487,230
Total	**$280,380,892**	**$377,186,657**	**$657,567,549**

Source: Michigan Proposal, data from 2008

With more than 211,000 dual eligibles as of early 2011, and monthly PMPM spending for combined Medicare and Medicaid services of more than $3,300, we estimate an annual market potential of more than $8 billion when all individuals are enrolled by mid-2012, of which roughly 90 percent will be through the ICOs and 10 percent will be through the PIHPs.

Current Market Overview

Michigan has a high Medicaid managed care penetration rate, with more than 1.2 million lives enrolled in Medicaid managed care organization plans (MCOs). Michigan spent more than $3.9 billion on Medicaid managed care in FY 2010. Combined, United, Molina, and Michigan-based Meridian cover close to 750,000 lives, more than 60 percent of all Medicaid MCO enrollees. The remaining 480,000 managed care lives are spread among 11 other MCOs.

Table 3: Michigan Medicaid MCO Enrollment

Medicaid Health Plan	Enrollment (Feb. 12)	Percent of Total
Meridian/Health Plan of Michigan	292,644	24%
UnitedHealthcare GLHP	241,829	20%
Molina Healthcare of Michigan	211,289	17%
McLaren Health Plan	76,797	6%
Midwest Health Plan	74,833	6%
HealthPlus Partners, Inc.	66,157	5%
Priority Health Gov. Programs, Inc.	64,082	5%
Total Health Care	52,426	4%
OmniCare Health Plan (Coventry)	45,381	4%
CareSource Michigan	34,488	3%
Upper Peninsula Health Plan	29,323	2%
BlueCaid of Michigan	18,799	2%
PHP of Mid-Michigan-FamilyCare	18,035	1%
Pro Care Health Plan	2,097	<1%
Total	**1,228,180**	

Source: State Enrollment Files

Michigan has an existing structure of eight Medicare Advantage Special Needs Plans (SNPs) offering coordinated benefits to dual eligible Medicare individuals. However, enrollment in these plans amounts to just over 6 percent of the targeted dual eligible population under the integrated care proposal. Molina and United combined cover more than 10,500 out of 12,800 SNP enrollees, roughly 82 percent of all SNP lives in the state. Meridian, the other top Medicaid plan in terms of enrollment, also operates a SNP, enrolling just 172 lives.

Table 4: Michigan Medicare Advantage Special Needs Plan Enrollment

Special Needs Plan (SNP)	SNP Type	Medicare Membership (Feb. '12)	Percent of Total
Molina Healthcare	Dual Eligible	7,151	55.8%
UnitedHealthcare	Dual Eligible	3,414	26.7%
Fidelis SecureCare	Institutional	856	6.7%
CareSource	Dual Eligible	485	3.8%
Midwest Health Plan	Dual Eligible	460	3.6%
Upper Peninsula Health Plan	Dual Eligible	210	1.6%
Meridian Health Plan	Dual Eligible	172	1.3%
Fidelis SecureCare	Dual Eligible	57	0.4%
Total		**12,805**	

Source: State Enrollment Files

Beginning in October 2011, Michigan began allowing dual eligibles to enroll in a Medicaid MCO for their Medicaid services. Also, dual eligibles receiving their Medicare services from a SNP were passively enrolled in that SNP for their Medicaid services but received notification that they could "opt out" of the SNP. As of February 2012, a total of 15,292 dual eligibles were enrolled in Medicaid MCOs for their Medicaid services (and are included in the 1.2 million Medicaid enrollees listed above). Detailed data for the 14,518 dual eligibles enrolled in a Medicaid MCO in January 2012 indicates that dual eligible SNP plans predominate.

Table 5: Dual Eligible Enrollment in Michigan Medicaid MCOs

Medicaid Health Plan	Dual Eligible SNP?	Medicaid Dual Eligible Membership (Jan. '12)	Percent of Total
Molina Healthcare of Michigan	Yes	5,907	40.7%
UnitedHealthcare Community Plan	Yes	3,414	26.7%
Meridian Health Plan of Michigan	Yes	1,942	13.4%
Priority Health Gov Programs		633	4.4%
McLaren Health Plan		503	3.5%
Midwest Health Plan	Yes	372	2.6%
CareSource MI	Yes	343	2.4%
HealthPlus Partners, Inc		336	2.3%
Upper Peninsula Heallth Plan	Yes	278	1.9%
Total Health Care		262	1.8%
OmniCare		196	1.4%
BlueCaid		120	0.8%
PHP FamilyCare		91	0.6%
ProCare Health Plan Inc		20	0.1%
Total		**14,518**	

Source: State Enrollment Files

The combination of a strong managed care presence in the Michigan Medicaid market, coupled with major Medicaid plans already operating dual eligible SNPs, may set the state up well for a transition to managed care for all dual eligible enrollees. Additionally, those Medicaid plans already operating a SNP in the state may have a competitive advantage in the procurement process.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein

Last week, the state released the applications submitted in response to its Request For Solutions (RFS) for a Dual Eligibles Demonstration. These are not necessarily winning applications, however, because the Department has not yet announced the four initial demonstration counties. The state's intent, however, is to increase the number of counties to ten, per the proposed state budget, motivating more plans to apply. There will not be an official procurement process. Below we highlight a few notable observations from the RFS applications.

- Anthem did not file an application for Contra Costa County, losing the potential to serve 22,500 beneficiaries.
- Anthem has a letter of commitment from Health Net for Alameda.
- Anthem plane to subcontract with Independent Living Systems, Addus and Univita to provide long term care services and supports.
- Neither Health Net nor Anthem filed an application in Sacramento County (leaving 45,000 beneficiaries on the table). Only Molina filed for this county, which means that Sacramento will almost certainly not be chosen as a pilot county.
- Health Net mentions Molina, Brand New Day, Alta Med and Heritage Provider Network as plan partners/providers.
- Health Net indicates that it will continue to delegate or contract with provider groups for all risk.
- Kaiser, with 60,000 dual members in California, did not file applications for either Sacramento or San Diego counties for which they have a Medi-Cal contract.

Last Friday, March 2, HMA Principal, Jennifer Kent led a discussion regarding California's RFS for an integrated delivery model for Medicare-Medicaid eligibles. A webcast replay of the call is available at: **(GLG Research - Link to Webcast)**

In the news

- **Ventura County seeks to keep healthcare plan audit a secret**

  The Medi-Cal Managed Care Commission hires a consultant to investigate complaints about late payments and poor management, but seeks to use attorney-client privilege so results will be confidential. Complaints about alleged late payments and poor management prompted the Department of Health Care Services to request that auditors step in and examine the plan's financial condition and claims practices. Gold Coast Health Plan was launched last year to switch an estimated 110,000 Ventura County Medi-Cal beneficiaries into an HMO-style healthcare plan. Previously, doctors and hospitals were free to charge Medi-Cal directly on a fee-for-service basis. The Ventura County Medi-Cal Managed Care Commission, which operates the plan, voted last

week to approve a $450,000 contract with BRG, a Berkeley consulting firm, to conduct a three-month review. (Los Angeles Times)

- **Four Sacramento area counties prepare for early test of Obama's health care overhaul**

  All four Sacramento-area counties are joining a program that will insure tens of thousands of residents who have been without coverage, more than a year before federal health care changes kicks in. For county governments and health care providers, the Low-Income Health Program is a chance to get a head start and work out some of the kinks in a new and complicated system – one that must emerge by Jan. 1, 2014, but remains largely unformed. (Sacramento Bee)

- **To stay fiscally healthy, state's hospitals want fewer patients**

  To survive the unprecedented challenges coming with federal healthcare reform, California hospitals are upending their bedrock financial model: They are trying to keep some patients out of their beds. Hospital executives must adapt rapidly to a new way of doing business that will link finances to maintaining patients' health and impose penalties for less efficient and lower-quality care. It's too soon to know precisely how the changes will affect patients. But experts say more will be treated in clinics and doctors' offices than in hospitals. And when they are admitted, their hospital stays could be shorter. (Los Angeles Times)

Florida

HMA Roundup – Gary Crayton

With the House and Senate finalizing an agreement on the state budget, hospitals will see a lower-than-expected rate cut in 2012-2013. The budget adds in additional funding for 2012-2013, resulting in an effective rate cut to hospitals of 5.64 percent. This compares to original House proposal of 7.0 percent. Nursing home rates are also down 1.25 percent. The House and Senate settled on a limit of six emergency room visits per year. Additionally, the legislature directed the Medicaid agency to transition to a DRG payment system for inpatient hospital rates in 2013-2014. This will be a legislative issue beginning next year with a study likely to be released before then. DRGs would have a positive financial impact for hospitals with low per-diems, and a negative impact for those hospitals with high per-diems.

In the news

- **State budget negotiators plan $350 million in cuts for hospitals, nursing homes**

  Hospitals and nursing homes are targeted to lose about $350 million in funding as House and Senate negotiators worked tonight toward completing a $70 billion state budget. The 5.6 percent Medicaid rate cut for hospitals and 1.25 percent reduction for nursing homes frees cash which helps bolster a $1 billion increase in dollars for public schools that budget-writers have already agreed will be a central part of spending this election year. (Palm Beach Post)

- **Medicaid billing fight could cost Florida counties**

  Florida counties stand to lose nearly $300 million in state revenue over the next few years, a punishment of sorts for what the state says are unpaid Medicaid bills. But counties say much of what the state categorizes as delinquent bills are actually erroneous charges created by a faulty state billing system, and that the state's decision to collect is masking a ploy to shift additional costs to local governments. Led by the Florida Association of Counties, local officials are begging legislators for a fix as House-Senate budget negotiations commence. Under the controversial proposal, the state would withhold revenue sharing dollars from counties equal to a portion of the delinquent bills as well as any future payments counties owe under the Medicaid program. Currently, counties are allowed to dispute the amounts they owe and pay what they think is fair. (Tampa Bay Times)

Georgia

HMA Roundup – Mark Trail / Megan Wyatt

The public comment period on the Medicaid redesign options report closed at the end of February. However, stakeholder groups will continue to advocate for their positions while the state finalizes its redesign plans that are expected to be announced in late April.

Today (Wednesday, March 7), is the deadline for the House to pass the state budget bill and send it to the Senate for action. Below is a list of Medicaid/PeachCare (CHIP) budget impacts in the House Appropriations Committee recommendation:

- Fully funds 12 months of Care Management Organization (CMO) capitation payments in FY 2013. However, the SFY 2012 budget only funds 11 months of CMO capitation payments. This means that the CMOs continue to lag one monthly payment behind.
- The House, as required by the Accountable Care Act (ACA), reflects a $75 million increase in federal funds to increase certain primary care rates to 100 percent of Medicare effective January 2013.
- The Governor's recommendations increased the Nursing Home Provider Fee to fund a nursing home rate increase resulting from updating from the 2006 cost report to the 2009 cost report for rate setting purposes. The House further increases the Nursing Home Provider Fee to support an update to the 2010 cost report. The impact on the fee amount is not available.
- The House increases the Governor's proposed state savings from $4.2 million to $8.1 million due to increased efforts to identify inappropriate and medically unnecessary service utilization.
- The House cut $12.8 million in general funds from the FY 2013 budget in anticipation of FY 2012 reserves. Note – this cut could pose cash flow issues for Medicaid in FY 2013. The total funds impact of the cut is $35 million.

In the news

- **Atlanta's Grady Hospital Chief Sees Major Threat In Medicaid Cuts**

  Grady Memorial Hospital is the biggest safety-net hospital in Georgia, treating many low-income and uninsured patients from Atlanta and around the state. It ended 2011 with a loss of about $25 million, CEO John Haupert says, and has trimmed staff and found other ways to cut costs. It also faces significant reductions in funding from federal, state and local programs. In this interview with Kaiser Health News, Haupert expresses concern at the additional financial risk placed on providers under a greater expansion of managed care in the state, as proposed by the Navigant Medicaid redesign report. (Kaiser Health News)

New York

HMA Roundup – Denise Soffel

The five largest Medicaid managed care plans grew in membership between January 2011 and January 2012 and now collectively account for 60 percent of Medicaid managed care and Family Health Plus enrollment in New York state. The biggest gainer was Fidelis, which added 80,000 members and is the state's largest plan, with an 18.6 percent share of the total state market, according to an analysis of State Department of Health data by GNYHA. The nearest competitor was Healthfirst, a provider-owned plan, with a 13.8 percent share. Two plans, Affinity and HIP, lost membership. Statewide, combined enrollment in Medicaid managed care and FHP rose by almost 200,000 enrollees, a gain of 6.1 percent, during the period. Total managed care membership is now 3.5 million New Yorkers, with about a third of the enrollment growth fueled by a 3.1 percent increase in New York City enrollment.

On the dual eligibles integration front, the State is preparing a draft proposal for a joint state and federal demonstration to test full integration for dual eligibles. The draft proposal will be published for public comment on March 22, 2012.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Nursing home and disability advocates are opposing Medicaid cuts in Governor Tom Corbett's proposed budget and changes being implemented by the Department of Public Welfare (DPW). The Governor's budget would cut $100 million in nursing home reimbursements. This comes on the heels of Medicare cuts already straining nursing home finances. Disability advocates were also protesting the consolidation of financial management services organizations vital to Medicaid beneficiaries receiving home and community based services. As mentioned in a previous Roundup, DPW is consolidating the number of financial management services organizations from 37 down to only one to three organizations statewide.

This week, Pennsylvania Secretary of Revenue Dan Meuser reported the state collected $1.7 billion in General Fund revenue in February, which was $15.6 million, or 0.9 percent, more than anticipated. Fiscal year-to-date General Fund collections total $15.5 billion, which is $481.6 million, or 3 percent, below estimate.

In the news

- **Revive adultBasic health insurance plan, Corbett urged**

  Looking at an increasingly costly program with a long waiting list, Gov. Tom Corbett decided adultBasic's costs kept mounting faster than the revenue to support it and let the program die. For most of the state's 40,000 other adultBasic enrollees, the end of the program left them with three choices: Try to fit under the state Medicaid guidelines, enroll in another program that was four times more expensive and provided less coverage, or go without insurance. That was, for most, a poor set of choices, advocates and state legislators said last week on the anniversary of the program's expiration. They called for Corbett to revive adultBasic. (The Morning Call)

- **Pa. welfare secretary defends proposed funding cuts, program rollbacks**

  In his budget blueprint for the fiscal year beginning in July, Corbett is proposing roughly $620 million in cuts and savings to human services programs. They include eliminating cash payments to poor adults, cutting aid by 20 percent for county-run social service programs, and reducing reimbursements to hospitals and nursing homes serving the poor. Those changes come on top of reports that 89,000 children have been dropped from the state's Medicaid rolls since August, and the administration's plan to impose an assets test, come May, on people seeking to receive food stamps. Welfare Secretary Gary Alexander maintains that as long as state revenues grow at lackluster rates in a tight economy, Pennsylvanians cannot sustain public welfare costs growing 9 to 10 percent annually. (Philadelphia Enquirer)

Texas

HMA Roundup – Dianne Longley

Despite concerns from the pharmacist community and a court challenge, the Texas Health and Human Services Commission (HHSC) proceeded with the implementation of the managed care expansion as originally scheduled on March 1, 2012, including the planned carve-in of pharmacy services. However, the public challenge of the pharmacy carve-in in the South Texas regions may cause HHSC to reevaluate the impact of the carve-in, given pharmacists' reliance on Medicaid payments in the region. For the time being, all pharmacy claims are being processed through the managed care plans' pharmacy benefit managers.

In the news

- **New Medicaid rules hurt independent pharmacies**

  A new state law reduces by 80 percent how much pharmacies get reimbursed for filling prescriptions for customers who rely on Medicaid, the government-funded insurance that serves about 3.3 million poor and disabled Texans. The new Medicaid prescription drug program is expected to save up to $100 million over the next two years by hiring private companies, pharmacy benefit managers, to pay out the lower rates and negotiate the cheapest possible drug prices. (Texas Chronicle)

- **Texas Lawmakers Working to Reform Medicaid**

  A joint oversight committee made up of House and Senate members met Wednesday morning to hear from the state's top public health officials and stakeholders on the process they'll pursue to cut as many strings as possible from federal funding for the entitlement program that serves the state's poorest adults and children. The state is facing a problem much larger in scale compared with other states. Nearly 26 percent — or 6.5 million — of the state's residents are uninsured. In 2014, the Affordable Care Act will require all Texans to sign up for health benefits (though the state estimates about 9 percent will still fall through the cracks and remain uninsured). Medicaid is expected to increase from 3.5 million to 5.7 million beneficiaries. To deal with the increase in demand, the state is pursuing changes on two fronts. On the one hand, they are moving forward with the federal government's recent approval of an 1115 waiver, which will allow the state to try proven or new approaches to delivering care. However, there are strict requirements that any plan the state presents be budget-neutral and maintain current coverage levels. The interim group is also figuring out ways to implement SB 7, a bill passed during last summer's special session that directs the Health and Human Services Commission to pursue a waiver that would give the state more freedom to change Medicaid eligibility requirements, encourage the use of private benefits, establish co-payments and health-savings programs, offer vouchers and make patient care more cost-effective. (Texas Tribune)

OTHER HEADLINES

Arkansas

- **Republican lawmakers unhappy with lack of action on Medicaid**

  The fiscal 2013 budget that legislators approved Friday received a number of "no" votes in the House and Senate, a reflection of the frustration some felt with what they saw as a lack of action during the fiscal session on the state's looming Medicaid crisis. State human services officials said last week that the state Medicaid budget could see a shortfall as high as $400 million in fiscal 2014. (Arkansas News)

District of Columbia

- **As feds investigate Jeff Thompson, D.C. looks for new Medicaid contractor**

  D.C. Mayor Vincent Gray's administration will soon officially seek a new Medicaid contractor, a development that comes two days after FBI agents raided the home and offices of Jeff Thompson, the owner of the city's largest Medicaid managed care company. The Department of Health Care Finance expects to receive a finalized solicitation back from the District's contracting and procurement experts "in days" and put its request for proposals "on the street shortly thereafter," according to agency Director Wayne Turnage. The solicitation will seek a third insurance company to join Thompson's D.C. Chartered Health Plan Inc. and UnitedHealthcare Community Plan as the risk-bearing administrators of Medicaid for about 70 percent of the District's 200,000 Medicaid recipients. (Washington Business Journal)

Idaho

- **Idaho-run health insurance exchange won't happen, legislative leaders say**

  "We've never been able to get critical mass [of legislative votes] to introduce a bill" to create a state-run health insurance exchange, said House Speaker Lawerence Denney during a meeting with reporters Tuesday. Idaho must obtain a federal stamp of approval for its plans by 2013 or the exchange will default to a federal one. If the state-run exchange were approved, it would have to be up and running by 2014. Idaho could still design an independent exchange — one that isn't up to snuff with federal requirements — using its own money. But that exchange wouldn't come with premium-subsidy features, so most people likely would end up using the federal exchange. (Idaho Statesman)

Illinois

- **Aetna Better Health and IlliniCare Health PlansPartner With General Medicine, P.C.**

  Aetna Better Health and IlliniCare Health Plan, health plans that provide management services to the Illinois Department of Healthcare and Family Services' Integrated Care Program for older Adults and Adults with Disabilities, have contracted with General Medicine, P.C. to manage the program's physician and nurse practitioner services (SNFist) for members residing in nursing home and long-term care facilities. (Insurance News)

Kansas

- **Advocates for developmentally disabled continue opposition to KanCare carve-in**

  Advocates for Kansans with developmental disabilities must continue pressing against Gov. Sam Brownback's plan to include long-term care for the disabled as part of his administration's Medicaid makeover, opposition leaders said during a forum here Wednesday evening. The administration is in the process of negotiating contracts with managed care companies, of which three will be chosen to direct Medicaid services statewide. Brownback officials have said they want to launch the new system on Jan. 1, 2013. (Kansas Health Institute)

Kentucky

- **Kentucky auditor recommends changes in Medicaid program**

  State Auditor Adam Edelen recommended Wednesday that the state consider removing mental-health services from its new Medicaid managed care system, citing an especially high number of complaints about access to care and medication. The recommendation is among 10 that Edelen proposed to address problems with the managed care system the state launched Nov. 1 in an effort to save money. The problems include delays or the denial of medical care to patients and late payments, or in some cases none at all, to health-care providers. (Courier-Journal)

Maryland

- **Senate budget subcommittees make first cuts: higher ed and Medicaid**

  Senate budget subcommittees Monday began their decisions to approve or reject recommendations from the Department of Legislative Services. The Subcommittee on

Health and Human Services approved $63 million in proposed General Fund reductions for Medicaid in fiscal 2013 — but rejected a recommendation to scrap the administration's proposed $16 million increase in physician reimbursements for medical coding and management. (Maryland Reporter)

Mississippi

- **Half of All Mississippi Kids Could Soon Be On Medicaid or CHIP**

  New research shows that the recent health care overhaul could mean a growing number of Mississippi kids will get their health insurance through the government. MPB's Jeffrey Hess reports child welfare advocates see the expansion as good news for the health of Mississippi's youngest residents. When the law takes full effect in 2014, it will bring with it an expansion of Medicaid which could bring more of Mississippi's kids into the program. Georgetown University health policy analyst Welsey Prater says that change could mean more than half of Mississippi's kids will be covered under Medicaid or CHIP. (Mississippi Public Broadcasting)

Nebraska

- **Nebraska Awards Medicaid Managed Care Contracts to Coventry, AmeriHealth**

  Effective July 1, 2012, the Department of Health and Human Services, Division of Medicaid and Long-Term Care (MLTC) is expanding the physical health managed care program statewide. MLTC is contracting with two (2) health plans to manage physical health services for clients in the 83 counties not currently served by Physical Health Managed Care. See page four of this bulletin for a listing of counties and health plans coverage. The two health plans servicing the statewide expansion counties are: Coventry Healthcare of Nebraska, Inc. (Plan name: Coventry Cares); AmeriHealth Nebraska, Inc. (Plan name: Arbor Health Plan). (DHHS Provider Bulletin)

New Hampshire

- **Hospitals buoyed by ruling in Medicaid reimbursement suit**

  A federal judge has handed a partial victory to Dartmouth-Hitchcock Medical Center and nine other New Hampshire hospitals in their lawsuit against the state health commissioner over reductions in Medicaid reimbursements, finding a "strong case" that the state's cuts failed federal mandates to provide minimal medical care for its neediest citizens. In a pair of rulings on Friday, U.S. District Judge Steven J. McAuliffe ordered the state to properly notify the public and hold hearings about reimbursement rates that were dramatically lowered in 2008. The notice must be given within 15 days from Friday's ruling, to be followed by a 30-day comment period. (Foster's Daily Democrat)

- **Judge orders NH to explain Medicaid cuts**

  A federal judge is ordering the New Hampshire Department of Health and Human Services to follow federal procedures when setting Medicaid reimbursement rates. In a 31-page order Friday, Judge Steven McAuliffe said the state has not properly notified the public or held required hearings on proposed reimbursement rate cuts. His order stems from a federal lawsuit filed last year by Dartmouth-Hitchcock Medical Center and nine other New Hampshire hospitals. They allege the state has failed to give prop-

er notice on reimbursement rate changes and that reimbursements have been inadequate. (Boston Globe)

- **Medicaid Grant Money To Help Home Based Services**

  New Hampshire will be the first state in the country to receive new Medicaid grant money to help seniors and people with disabilities remain in their homes. The state will receive $26.5 million over three years through the Affordable Care Act. The goal is to help states shift from institutional care to home and community-based services. (NHPR.org)

New Jersey

- **Lacking Medicaid Waiver, NJ Postpones Overhaul of Long-Term Care**

  Massive changes to the state's long-term care program will be delayed at least six months, as officials continue to await the federal government's approval to their request to change how nursing homes and home care are reimbursed under Medicaid. The state has asked the feds for a Comprehensive Medicaid Waiver, which will allow them to encourage more of New Jersey's elderly to remain in their homes for a longer period of time, rather than force them to move to a nursing home. The program was initially scheduled to begin July 1, 2012, at which time 30,000 Medicaid nursing patients were to be put under a private managed-care umbrella, as opposed to directly working with the Medicaid. State officials are now targeting January 2013. (NJ Spotlight)

New Mexico

- **State moves forward on health insurance exchange**

  New Mexico is taking a step this week toward setting up a health insurance exchange, one of the cornerstones of the nation's new health care system. Several firms are expected to submit competing bids Thursday for a contract to install the computer framework for the proposed statewide exchange. Using $24 million in federal funds it won in November and shooting for an ambitious schedule, New Mexico hopes to award a contract by early May and to begin enrolling New Mexicans in the exchange by October 2013. (Santa Fe New Mexican)

Oregon

- **Oregon Gov. Kitzhaber signs health care overhaul bill; promises to improve care, reduce costs**

  Oregon's new health care law would allow officials to assign certain Medicaid patients caseworkers to manage all aspects of a client's care, from medical to dental to mental, with the goal of eliminating redundant tests and procedures and reducing expensive hospital stays. Proponents say if all 50 states adopt the approach, it would save the federal budget more than $1.5 trillion over the next 10 years — $300 billion more than Congress' failed "super committee" was trying to save over the same span. (Washington Post)

South Carolina

- **South Carolina floats Medicaid plan**

  South Carolina taxpayers would pay an extra $29 million next year for health insurance for 70,000 poor and disabled children under a state House budget proposal designed as a test run for enacting President Barack Obama's controversial health care law. The 70,000 children are among those 500,000 SC residents. In 2007, lawmakers made the children eligible for Medicaid. But for a variety of reasons – poor outreach efforts, a lack of knowledge – the children never were enrolled. (The State)

Washington

- **Wash. Senate passes health care exchange bill**

  The Senate has approved a bill to foster the implementation of the insurance exchange associated with the federal health care overhaul. The measure passed Thursday on a near party line 27-22 vote, with one Republican voting in support. The House passed the bill last month, but because the Senate amended the measure it now heads back to the House for concurrence. (Seattle Times)

Wyoming

- **Wyoming House passes health insurance exchange bill**

  The Wyoming House passed a bill Tuesday to continue the study of a health insurance exchange for the state on a 50-8 roll call vote. The bill, which previously passed the Senate, continues the steering committee study of an exchange for Wyoming and requires a report to the Legislature by October 1. The bill also adds to the committee one member each from the Araphoe and Shoshone Indian tribes who are residents of the Wind River Indian Reservation. Gov. Matt Mead supports the steering committee's preliminary recommendation of a state-run insurance exchange. (Casper Star-Tribune)

United States

- **Medicaid waivers pave way for reform**

  Millions and millions of dollars in Affordable Care Act grants aren't the only way the Obama administration is helping states prepare for health care reform. Some states are also bringing in billions through Medicaid waivers. California, which embraced health care reform early on, received a $39 million exchange grant last summer — chump change compared with the nearly $10 billion in federal Medicaid money the Golden State is slated to receive under its waiver. Texas Gov. Rick Perry, a staunch opponent of the ACA, won approval for a waiver that could bring in $12 billion to help the state's hospitals and vulnerable populations. Some stakeholders and lawmakers in Texas have argued the waiver lays an important foundation for 2014, when nearly 2 million residents will become eligible for Medicaid in a state that's had the highest rate of uninsured citizens in the country. (Politico)

- **Some Republican governors wary of House GOP's Medicaid reform proposals**

  Several Republican governors are raising concerns with a House GOP Medicaid reform proposal that's expected to be reintroduced shortly. The Republican budget that the House approved last year would have replaced the Medicaid program with a block

grant that gives states more flexibility to run their programs while cutting federal funding for the health program for low-income Americans. Budget Committee Chairman Paul Ryan (R-Wis.) is expected to propose a similar approach again when he releases his FY 2013 budget this month or next. A couple of former Republican governors however told The Hill this past week that the block grant proposal may not work for their states. (The Hill)

- **High health-care costs: It's all in the pricing**

  There is a simple reason health care in the United States costs more than it does anywhere else: The prices are higher. There are many possible explanations for why Americans pay so much more. It could be that we're sicker. Or that we go to the doctor more frequently. But health researchers have largely discarded these theories. And some economists warn that though high prices help explain why America spends so much more on health care than other countries, cutting prices is no cure-all if it doesn't also cut the rate of growth. After all, if you drop prices by 20 percent, but health-care spending still grows by seven percent a year, you've wiped out the savings in three years. (Washington Post)

- **Former Governors Recommend Reforms to Medicaid Waivers**

  The Governors' Council made six recommendations that they say would bring more transparency to the waiver process and reduce the administrative burden for states. Generally, they called for setting clear parameters and developing templates that would ensure states know what to include in their applications in order to gain approval. They urged a more timely process; reviews are supposed to take 90 days, but CMS often extends the period with further questions. One Tennessee waiver took a year to be approved. The governors also recommended establishing a mechanism that would allow waivers that have proven successful to become permanent or semi-permanent. For example, TennCare is built on various waivers. But every five years, Tennessee must reapply, despite the fact that the program couldn't function without the waivers. Vermont saved more than $260 million over five years with its Global Committment to Health initiative, but still faced uncertainty when reapplying for a waiver. (Governing Magazine)

COMPANY NEWS

- **EmblemHealth: No 2012 Conversion**

  EmblemHealth will not seek to convert to a for-profit this year. According to a source close to EmblemHealth, the company, parent to GHI and HIP, did not want to be caught in the middle of the fight over conversion proceeds between the state and New York City. Market conditions for a conversion also aren't ideal. The state's executive budget says that it "assumes no proceeds from a health care conversion in FY 2012, but counts on proceeds of $250 million in FY 2013 and $300 million in FYs 2014 and 2015." A spokeswoman for EmblemHealth said in a statement that the company "remains committed to its conversion to for-profit status at the appropriate time and under appropriate financial and economic conditions."

- **CompCare expands contract with L.A. Care**

  Comprehensive Care Corp. added 42,000 covered lives as part of its contract with L.A. Care. The deal expanded the original 2011 contract between CompCare and L.A. Care, the nation's largest public health plan, a statement said. Under the original contract, CompCare managed behavioral health benefits for the plan's Healthy Families, Healthy Kids and Medicare Advantage members in the Los Angeles County area. L.A. Care recently added members under the In-Home Support Services Workers Health Care Program, which allows individuals who are disabled to receive in-home care. The addition more than doubles the number of lives CompCare manages for the program, the statement said. (Tampa Bay Business Journal)

- **Universal American Completes Acquisition of APS Healthcare**

  Universal American Corp. (NYSE: UAM) today announced that it has completed its acquisition of APS Healthcare, a leading provider of specialty healthcare solutions primarily to Medicaid agencies. (Universal American Press Release)

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. Dual eligible integration dates for Arizona, Michigan, and New York are included, as well as the Arizona behavioral health RFP for Maricopa County.

Date	State	Event	Beneficiaries
Mid to late March	California Dual Eligibles	Site Selection	500,000
March 19, 2012	Ohio	Proposals due	1,650,000
April, 2012	Arizona Duals	Demo Proposal released	120,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
April 2, 2012	Ohio Duals	RFP Released	122,000
April 9, 2012	Ohio	Contract awards	1,650,000
April 13, 2012	Massachusetts Duals	RFP Released	115,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 30, 2012	Illinois Duals	RFP Released	172,000
May 11, 2012	Ohio Duals	Proposals due	122,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 15, 2012	Illinois Duals	Proposals due	172,000
June 20, 2012	Florida CHIP	Contract awards	225,000
July 1, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	90,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Contract awards	115,000
July 31, 2012	Illinois Duals	Contract awards	172,000
July/August, 2012	Georgia	RFP Released	1,500,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
January, 2012	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	172,000
January 1, 2013	Massachusetts Duals	Implementation	115,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid to late March	California Dual Eligibles	Implementation	500,000
January 1, 2013	Ohio Duals	Implementation	122,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
July 1, 2013	Michigan Duals	Implementation	211,000
October 1, 2013	Florida	LTC enrollment complete	90,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000
January 1, 2014	New York Dual	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA RECENTLY PUBLISHED RESEARCH

Webcast: Medicaid Budgets and California's Dual Eligible RFS

Vernon Smith, Managing Principal

Jennifer Kent, Principal

On Friday, March 2 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)**

A Mid-Year State Medicaid Budget Update for FY 2012 and A Look Forward to FY 2013

Vernon Smith, Managing Principal

Kathleen Gifford, Principal

Michael Nardone, Principal

This report, based on structured discussions in November 2011 with the Executive Board of the National Association of Medicaid Directors (NAMD) and survey questions e-mailed to all 50 states and DC in December 2011 and January 2012, provides a mid-fiscal year 2012 update on state Medicaid issues. The report augments the findings from the most recent comprehensive Medicaid budget survey report published in October 2011.

Link to Kaiser Family Foundation Report (PDF, 9 pages)