HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup Trends in State Health Policy

IN FOCUS: WASHINGTON DUAL ELIGIBLE INTEGRATION PROPOSAL

HMA ROUNDUP: DUAL ELIGIBLE INTEGRATION DEVELOPMENTS IN NEW YORK, COLORADO; GEORGIA MEDICAID REDESIGN DECISIONS EXPECTED LATE APRIL; PENNSYLVANIA CONTRACT AWARDS STILL PENDING

OTHER HEADLINES: CMS RELEASES HEALTH INSURANCE EXCHANGE REGULATIONS; CONGRESSIONAL REPUBLICANS PREPARE MEDICAID REFORM PROPOSALS; MOLINA PROTESTS MISSOURI AWARD

RFP CALENDAR: OHIO MCO PROPOSALS DUE MARCH 19; WISCONSIN DUAL ELIGIBLE PROPOSAL TO BE RELEASED MARCH 16; NEW YORK DUAL ELIGIBLE PROPOSAL TO BE RELEASED MARCH 22

MARCH 14, 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: Washington Dual Eligible Integration Proposal

This week, our *In Focus* section reviews the state of Washington's proposal to integrate care for dual eligible individuals. Washington was one of fifteen states to receive dual eligible demonstration grant funding from the Centers for Medicare and Medicaid Services (CMS) over an eighteen-month planning period. While the states we have reviewed in previous weeks (Massachusetts, Ohio, Michigan) have taken straightforward approach for integrating care for dual eligibles through traditional managed care plans, the Washington Health Care Authority, which oversees the state Medicaid and Basic health programs, as well as several other state health care programs, is proposing a three-fold strategy:

1. Implementing health homes for high-cost, high-risk dual eligible beneficiaries, under a managed fee-for-service structure, where financial integration capitated model does not exist (Begins January 1, 2013).
2. Using a fully financially integrated model through managed care health plans, in selected counties (Begins January 1, 2013).
3. Supporting a modernization of the current delivery system, implementing three-way contracting between health plans, the State, and Federal CMS for full capitation of Medicaid and Medicare payments, coupled with performance measures and incentive pools (Begins January 1, 2014).

Key Proposal Highlights

The three strategies listed above serve to allow the state to test different models of integration under a demonstration period. During a stakeholder engagement period that led to the design of this proposal, several key themes emerged that were integrated into the three-strategy approach. The geographic diversity and population distribution of the duals across a large state, coupled with significant variation in provider networks across the state, require multiple models of care integration, at least in the demonstration phase. Additionally, there was a strong push from the stakeholder community to test different models of care coordination for dual eligibles without "flipping the switch" on statewide managed care enrollment for the dual population.

Strategy 1 – Health Homes

Under the first strategy, the state will certify entities to serve as health homes for dual eligible beneficiaries, providing a set of services and functions to facilitate care integration. A qualified health home will be an entity that is comprised of a network of community based providers, including primary care clinics, hospitals, health plans, community mental health centers, local safety net providers, long term care and independent living, and other providers who serve the high-cost, high-risk dual eligibles population. Appendix F of the state's proposal includes a draft health home qualification process. Washington will be seeking a Medicaid State Plan Amendment under section 2703 of the Affordable Care Act (ACA) to implement intensive care management through health homes. The proposal indicates that the health homes strategy will go live on January 1, 2013.

The proposal also indicates that individuals enrolled in the state's Program of All-Inclusive Care for the Elderly (PACE) will continue to receive their care coordination through their PACE provider.

Finally, the proposal notes that the Strategy 1 model will likely become unsustainable after the first eight quarters of enhanced federal matching funds for health home services, unless negotiation with CMS allows for options with Medicare funding, potentially under Strategy 3, or through shared savings or service fees.

Strategy 2 – Full Financial Integration Through Health Plans

Washington recently concluded a joint procurement that combined the state's Medicaid managed care program, Healthy Options, with the Washington Basic Health plan, a subsidy program for low-income residents not eligible for Medicaid. As a note, Washington Basic Health is not a "basic health plan" created under the Affordable Care Act, however the state has moved towards qualifying for enhanced federal matching funds for Washington Basic Health as a basic health plan under the law. These contracts go live on July 1, 2012. Under Strategy 2, the state intends to leverage the recently-completed procurement process to implement fully integrated capitated services for dual eligibles. The state will select plans to participate in a request for selection process, targeted to begin in May 2012. Health plans will provide services including medical, mental health, chemical dependency, and long term services and supports. Additionally, plans are encouraged to offer supplemental benefits, to be identified in the procurement.

Developmentally disabled (DD) individuals will be included in the model, but those services provided to individuals under the state's 1915(c) waiver will be carved out of the capitation. Currently, the state is unable to serve all DD beneficiaries under the waiver, and Strategy 2 will explore if managed care implementation will aid the state in delivering services to more DD individuals.

County selection will be dependent on a variety of criteria and assessment of readiness to implement on January 1, 2013, including agreement by the county legislative authority and a dual eligible population of more than 5,000 individuals in the county or multi-county service area.

Dual beneficiaries in the counties selected will be given the opportunity to choose to participate with an available health plan. However, if no choice is made, duals will be passively enrolled in a plan with the opportunity to opt-out after a 90-day retention period. As with Strategy 1, participation of PACE individuals will be fully optional, with no passive enrollment.

Strategy 3 – Modernized Delivery System

This third approach goes beyond the Managed FFS and Capitated models proposed by CMS in its July 2011 "Dear State Medicaid Directors" letter for dual integration demonstration models. Under a three-way contract between the state, CMS, and health plans, this strategy would combine all medical care, along with Medicare skilled nursing facility (SNF) services, and Medicare outpatient mental health services under a single contract. Participating health plans would be subject to quality withholds tied to performance targets. Additional financial incentives would be put into place to promote care coordina-

tion. This strategy would allow for home health services to be continued for duals when the enhanced federal match expires.

The implementation of Strategy 3 is targeted for January 1, 2014, a full year after the implementation of Strategies 1 and 2.

Target Population

As of December 2011, there were approximately 115,000 full benefit dual eligibles in Washington. By January 2013, this number is expected to increase to nearly 123,000. The tables below come from the state proposal, and detail the number of individuals, both under and over age 65, in various categories of service and their annual Medicaid-only spending. We note that the PMPM values provided do not equal total spending divided by clients served divided by twelve months, and we are seeking more information on reconciling the numbers presented below.

Duals Under Age 65	Clients Served		Medicaid Spending	
	Total	%	Total	PMPM
Long Term Services and Supports (LTSS)	12,571	23.80%	$225,655,141	$430.38
Alcohol/Substance Abuse	2,461	4.70%	$5,221,329	$9.96
Developmental Disabilities (DD)	9,864	18.70%	$448,498,765	$855.41
Mental Health (non-state hospital)	16,521	31.30%	$79,001,616	$127.07
Total Population	**52,807**			

Source: Washington Dual Integration Demonstration Design Proposal, March 12, 2012

Duals Age 65 and Older	Clients Served		Medicaid Spending	
	Total	%	Total	PMPM
Long Term Services and Supports (LTSS)	41,067	60.50%	$810,290,432	$1,201.31
Alcohol/Substance Abuse	183	0.30%	$475,058	$0.70
Developmental Disabilities (DD)	974	1.40%	$51,273,184	$76.02
Mental Health (non-state hospital)	7,490	11.00%	$26,146,094	$19.02
Total Population	**67,884**			

Source: Washington Dual Integration Demonstration Design Proposal, March 12, 2012

The data presented by the state determines the following conclusions based on the current dual eligible population:

- 79 percent (roughly 91,000 of 115,000 duals) use long-term services and supports
- 28 percent (more than 32,000 of 115,000 duals) have an indication of serious mental illness
- 7 percent (8,000 of 115,000 duals) have an indication of a substance use problem
- 6 percent (nearly 7,000 of 115,000 duals) received services for developmental disabilities
- 9 percent (more than 10,000 of 115,000 duals) received only medical services with no indication of need for LTSS or DD services, or indication of serious mental illness or a substance use problem

These findings point to the critical role that community-based non-medical service providers are likely to play in improving health outcomes for high-risk dual eligible clients.

Additionally, the proposal makes the following observations on the developmental disability population:

- The current system of supports for people with developmental disabilities reaches 63 percent of the 38,000 Washington residents with a qualifying developmental disability.
- About 18,000 are under age eighteen and 20,000 are eighteen or older.
- About 14,000 people or 37 percent wait for services to be available.
- Of the people served approximately 24,000 live in the community; most with their families.
- Fewer than 900 people live in one of the five Residential Habilitation Centers (RHCs).
- In the next decade the number of Washington residents with a developmental disability is projected to increase to 51,000.

Forecasted January 2013	Overall Total Dual	LTSS in institutional settings	LTSS in community settings
Individuals age 65+	69,629	12,507	31,358
Individuals under age 65	53,207	1,913	10,273
Individuals with SMI	47,295	5,425	22,582
Overall total	**122,836**	**14,420**	**41,631**

Source: Washington Dual Integration Demonstration Design Proposal, March 12, 2012

Market Opportunity

While the state only provides Medicaid spending data for the dual eligible population, we can roughly estimate the additional Medicare spending for the current dual enrollees. Medicaid spending for the roughly 115,000 current duals is approximately $2 billion annually. Based on other state proposals to CMS that included both Medicaid and Medicare spending data for duals (Michigan and Massachusetts) in which spending on duals was roughly split between Medicaid and Medicare, we can conservatively estimate a full combined spend for this population to be approximately $3 to $4 billion. However, it is unknown at this time in how many counties the state will award managed care health plan contracts. We do note that the top six counties in terms of dual eligible beneficiaries (King, Pierce, Snohomish, Spokane, Clark, Yakima) account for nearly 68 percent of the statewide dual population, and each county has a dual population of more than 5,000, a requirement under the county selection criteria.

Current Market Overview

Washington currently enrolls roughly 700,000 Medicaid lives in Medicaid managed care plans, with Molina and Community Health Plan, a local plan, combining for roughly 81 percent of all enrolled lives. However, as noted in the section below, the state recently

awarded contracts in a joint procurement combining the Medicaid managed care program (roughly 700,000 lives) and the state's Basic Health Program for non-Medicaid low-income individuals (roughly 40,000 lives). These awarded contracts go live on July 1, 2012.

Plan Name	Enrollment	% of Total
Molina Health Care of Washington	340,972	48%
Community Health Plan	232,281	33%
Columbia United Providers	59,038	8%
Regence Blue Shield	38,839	6%
Group Health Cooperative	20,891	3%
Various Native American Orgs	5,971	1%
Asuris Northwest Health	4,512	1%
Kaiser Foundation Health Plan	1,120	<1%
King County Care Partners	221	<1%
Total Managed Care Enrollment	**703,845**	

Source: State Enrollment Data

There are five organizations offering SNP plans in the state of which four are dual eligible SNP, one is chronic care SNP and one is an institutional SNP. Community Health Plan, Molina and UnitedHealthcare also secured contracts in conjunction with the recent Medicaid re-procurement.

Plan Name	SNP Type	Enrollment	% of Total
Community Health Plan	Dual Eligible	5,168	37%
Molina	Dual Eligible	4,291	31%
UnitedHealthcare	Dual Eligible	2,429	17%
Group Health Cooperative	Chronic Care	1,358	10%
UnitedHealthcare	Institutional	681	5%
Humana	Dual Eligible	111	1%
Total SNP Enrollment		**14,038**	

Source: CMS

Medicaid/Basic Health Procurement

As mentioned above, Washington's Health Care Authority announced last month the regional service areas tentatively assigned to the five health plans selected earlier as apparently successful bidders on a proposal to provide managed care for up to 800,000 Medicaid clients and Basic Health subscribers. The contracts take effect July 1, 2012, and extend through 2013. As noted above, Molina and Community Health Plan combine for 81 percent of the current managed care market. The number of counties tentatively awarded to the bidders varied considerably.

- Coordinated Care Corporation (Centene) was listed in all 39 counties in the state.
- United HealthCare was listed in every county except one (Clark County).
- Molina was omitted from only four counties (Island, Jefferson, Klickitat, and Wahkiakum counties).

- Community Health Plan was listed with 32 of 39 counties.
- Amerigroup was listed with 22 out of 39 counties

Timeline

Date	Strategy 1 Health Homes	Strategy 2 Managed Care
May 2012	Health home requirements finalized	Procurement information issued
June 2012	Begin qualifying home health entities	Plans submit integrated benefits packages
July 2012	State Plan Amendment submitted	Plans selected by state and CMS
October 2012		Plan enrollment begins
January 2013	Health home services begin	Integrated coverage begins

Contract development for the delivery system modernization in Strategy 3 will begin in November 2012, with interested plans asked to submit a letter of intent in February 2013. A procurement is expected to be issued in in April 2013, with awards in June 2013, enrollment in October 2013, and selected plans going live in January 2014.

HMA Medicaid Roundup

Colorado

HMA Roundup – Joan Henneberry

On March 2 2012, Colorado Medicaid? released a second draft of its demonstration model to integrate care for dual eligibles. The draft proposal, which is still under development, outlines Colorado's plan for leveraging the state's Accountable Care Collaborative (ACC) program structure to develop an integrated financing and care delivery model. The model outlined by the Colorado Department of Health Care Policy and Financing is meant to be consistent with CMS' proposed managed fee for service (MFFS) option, though federal guidance on that delivery model has been limited. By way of background, Colorado's ACC program, which began enrolling members in May 2011, is not a capitated managed care model. Instead, the ACC program builds off of the state's fee for service delivery system. The ACC uses a regional approach to service delivery through a collaborative effort between three organizational structures:

- Regional Care Collaborative Organizations (RCCOs) are responsible for ensuring comprehensive care coordination by developing a robust provider network, supporting care providers and providing medical management and care coordination services. There are seven RCCOs in the state.
- Primary Care Medical Providers (PCMPs) provide comprehensive primary care for beneficiaries participating in the ACC program and coordinate services across specialties.

- Statewide Data and Analytics Contractor (SDAC) are responsible for building a data repository and providing data to RCCOs and PCMPs.

Colorado's dual eligible proposal seeks to leverage this existing program infrastructure to cover the 69,787 dual eligible beneficiaries in the state. Dual eligibles would be passively enrolled into the RCCOs which would then be responsible for coordinating care delivery across all acute and long term care service providers including the managed behavioral health organizations. Payment to the RCCOs under the dual eligible demonstration model would be fee-based with the Department setting the per member per month (PMPM) amount. While it hasn't yet released its formal proposal for 30 day comment, Colorado anticipates receiving approval from CMS this year for January 2013 implementation.

In the news

- **State of Colorado selects Integrated Community Health Partners to improve health care for Medicaid Members in Southern Colorado**

  The State of Colorado's Department of Health Care Policy and Financing, which oversees the state's Medicaid services, has launched a new program to better serve Medicaid members. Dubbed the Accountable Care Collaborative (ACC), the ACC will offer better access to health care while at the same time, reduce unnecessary or duplicate services. The ACC program is statewide and is comprised of seven Regional Care Collaborative Organizations (RCCO's). Integrated Community Health Partners (ICHP) was chosen to serve as the RCCO for Region 4. Region 4 covers southern and southeastern Colorado, including Pueblo, La Junta, Canon City and Alamosa. ICHP is a partnership that includes ValueOptions, Inc. (Fowler Tribune)

Georgia

HMA Roundup – Mark Trail / Megan Wyatt

On Monday March 12, 2012 the final version of the Georgia FY 2012 Appropriation Bill (HB 741) was passed by the Georgia General Assembly. While it looks as if there were relatively minor cuts to Medicaid, there are actually fund transfers out of Medicaid that could create year end cash flow issues for the DCH. The impact will depend on Medicaid enrollment trends and drug rebate performance.

The state is wrapping up the comment period on the Medicaid redesign report, soliciting additional input from consumer groups. With the comment period essentially complete, the state will be finalizing how to present the chosen redesign options, likely near the end of April 2012. This keeps the redesign on track for a procurement to be issued in July or August of 2012.

In the news

- **Deal: February revenues up 7 percent**

  Georgia's net tax collections for February 2012 totaled $765 million, an increase of nearly $50 million or 7 percent compared to February 2011. With eight months of FY2012 now completed, net revenue collections totaled almost $10.6 billion year-to-date, an in-

crease of $471 million or 4.7 percent compared to the same period last year. (Rome News-Tribune)

New York

HMA Roundup – Denise Soffel

The NYS Department of Health is soliciting input on its draft proposal for the Dual Eligible Integration Demonstration. The proposal, tentatively called Fully Integrated Dual Advantage program (FIDA), envisions moving all dual-eligibles in eight target counties into fully integrated systems of care. The capitated benefit would include all physical health services, all long-term services currently available through Medicare Advantage, additional services currently offered by various home and community-based waiver programs, and behavioral health. The three-year demonstration program is scheduled to begin passive enrollment of dual-eligibles in the fall of 2013, with service delivery beginning in January 2014.

During a webinar on March 13 2012, Mark Kissinger of the NYS Department of Health Division of Long-Term Care highlighted some areas where decisions still remain, and reiterated the Department's interest in feedback about the planned demonstration. Still unresolved is what the criteria will be used to select Medicare Advantage plans to participate in FIDA. The state has not decided whether a partially capitated MLTC can align with a Medicare Advantage plan as a FIDA plan, or whether the two arms have to be a single corporate entity. How behavioral health will be incorporated, whether through the newly established Behavioral Health Organization, or through some other mechanism, is also undecided.

The webinar can be replayed through a link on the Medicaid Redesign Team website. Slides from the webinar are also available. The slides include a list of all proposed services to be covered by the FIDA plans, including those that are in addition to current Medicare Advantage plans. (Link to Webinar)

The draft demonstration proposal will be published on March 22, 2012 and the state will be soliciting public comment during a 30-day comment period. Comments can be submitted through the MRT MLTC link at mltcworkgroup@health.state.ny.us.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The state held a Managed Care Subcommittee Meeting last week, however there was no news announced regarding the timing of announcement of winning bidders for the managed care expansion into the New East and New West regions.

Additionally, providers have continued to come out publicly in opposition to Governor Corbett's proposed hospital cuts.

In the news

- **Risperdal has role in J&J probe by U.S.**

  The top 10 prescribers in Pennsylvania's system that year wrote 9,557 Risperdal scripts costing Medicaid $1.76 million, according to figures provided by a state official to U.S. Sen. Charles Grassley (R., Iowa), who has pushed for disclosure of such information and the relationship between doctors and pharmaceutical companies. The numbers raised questions for Grassley, and Pennsylvania officials sent letters to scores of doctors emphasizing the need for safety in prescribing antipsychotic drugs. Twelve were suspended, dropped from Medicaid, or are under investigation. The numbers also play a role in the U.S. Department of Justice's efforts to fight health care fraud. In the case of Risperdal, the Justice Department is negotiating with Johnson & Johnson, whose Janssen subsidiary makes the drug, to address allegations that the company illegally promoted it to doctors and through Medicaid programs. (Philadelphia Inquirer)

- **State budget cuts loom for hospitals**

  The threat of millions of dollars in state budget cuts to medical-assistance funding might make it difficult for hospitals to continue offering services that are typically the costliest to provide. Gov. Corbett's proposal includes a 4 percent reduction - equal to about a $26.9 million - in fee-for-service rates to general acute care, psychiatric and rehabilitation hospitals, according to Paula Bussard, senior vice president of policy and regulatory services at the Hospital & Healthsystem Association of Pennsylvania. Other proposed budget cuts will affect supplemental Medicaid payments to hospitals who offer certain types of care, including trauma, burn, obstetric and neonatal services, Ms. Bussard added. These services are especially critical for communities and expensive to sustain, and the increased payments from Medicaid help hospitals continue to provide them, she explained. (The Times-Tribune)

- **PA Health Care Association Releases Data That Shows Nursing Home Funding Cuts**

  The Pennsylvania Health Care Association (PHCA) today released data that shows the impact -- by county and by legislative district – of the $102 million cut in Medicaid funds proposed for the commonwealth's nursing homes. In October 2011, Pennsylvania nursing home sustained a nearly $300 million annual cut that was the result of a new federal Medicare rate rule. The recent passage of federal legislation to extend the payroll tax cut is being paid for, in part, by cuts in Medicare payments to nursing homes. Pennsylvania nursing homes will see $46.4 million in cuts over the next three years as a result of this legislation. The failure of the debt super committee late last year to reach an agreement triggers another $500 million in cuts starting in 2014 to the commonwealth's nursing homes. A chart that illustrates the state Medicaid cuts by county is available at http://www.phca.org/docs/budgetcutscounty.pdf. (PHCA)

Other Headlines

California

- **More People May Be Eligible for Adult Day Services**

  It looks like a much higher percentage of them than previously estimated will be eligible to receive the new benefit called Community Based Adult Services. Department of Health Care Services Director Toby Douglas originally said he expected about 50% of current ADHC patients to qualify for the new program. ADHC will be eliminated as a Medi-Cal benefit on Mar. 31 and the CBAS program starts Apr. 1. Now it looks like 70% to 80% of those receiving the ADHC benefit will qualify for CBAS, according to Catherine Blakemore, executive director of Disability Rights California, which is monitoring the state's assessment and placement of ADHC patients. However, tensions are running high over three DHCS transition plans: the conversion of seniors and persons with disabilities to managed care; the transition of care for those who have been receiving ADHC services and now will get either the equivalent CBAS program or enhanced case management; and the demonstration project to convert dual eligibles to managed care. (California Healthline)

- **Patients suffer as state overhauls Medi-Cal, advocates say**

  Patients who are being moved into Medi-Cal managed care plans as part of a major statewide policy shift are facing life-threatening obstacles to getting needed care, according to patient advocates who testified in a legislative oversight hearing. An attorney, doctor and lobbyist pleaded with lawmakers on Wednesday to slow the pace of a program overhaul that they say has knocked patients off organ transplant waiting lists or upended care that kept chronic diseases under control. The changes are part of a wide-ranging plan that is meant to improve care and cut costs in the state's Medi-Cal program, California's version of Medicaid. In June, the first wave of Medi-Cal patients moved to managed care plans. The effort is planned to extend to about 1.2 million seniors who are covered by both Medicare and Medi-Cal and projected to save the state a billion dollars within five years. (California Watch)

Connecticut

- **Connecticut Weighs Its 'Nurses Only' Medication Policy For Homebound Seniors**

  Connecticut, like every state trying to reduce health care spending, is looking closely at how it cares for people with chronic conditions. Gov. Dannel Malloy has promised to move more than 5,000 poor and disabled patients out of nursing homes in five years. But the Democratic governor says there's an expensive obstacle in the way -- Connecticut law says nurses have to give medications to people in the Medicaid system living at home, and that costs a lot of money. The state legislature is now considering a plan to allow trained home care aides -- who now cost half what nurses do -- to administer medications while working under a nurse's supervision. (Kaiser Health News)

Florida

- **Anonymous warnings sent to Medicaid elderly**

  Someone is sending warning letters to elderly Medicaid patients about the state's plan to move them all into managed care. The Agency for Health Care Administration, which includes Medicaid, issued a press release Wednesday about the letters, warning they could needlessly alarm elderly and disabled Medicaid patients. At the request of Health News Florida, AHCA released one of the letters. The letter, signed by an unnamed "deeply concerned Florida resident," alerts the recipient to the state's plan for a Statewide Medicaid Managed Care program, passed by the Legislature in 2011 and pending federal permission. (Health News Florida)

- **Medicaid cut would hit Florida's poorest patients, hospitals**

  Doctors and hospitals treating Florida's poorest patients face significant pay cuts in the state's nearly final budget. Legislators will vote by Friday on a $70 billion budget that includes $304 million less to reimburse hospitals. A Florida Hospital Association analysis released Wednesday projects the state's hospitals will receive $323 million less for treating poor children, pregnant women and disabled adults in 2013. This second consecutive year of Medicaid cuts will force hospitals to quickly decide what services to reduce or eliminate, said Kimberly Guy, chief operating officer at St. Joseph's hospitals for women and children, where the cuts could total $7.3 million. (Tampa Bay Online)

Idaho

- **Idaho House: Private insurers should set up exchange**

  House members voted 49-13 to encourage private insurers to establish their own health insurance exchange, rather than having federal or state governments set one up as envisioned by the 2010 federal health care overhaul. Rep. Bob Nonini of Coeur d'Alene said Monday he doesn't think Idaho lawmakers have enough time to pass exchange legislation, with just two weeks left in the 2012 Legislature. Nonini, an insurance salesman, told lawmakers that he felt obligated to offer this alternative - especially since he's such an outspoken foe of a publicly-run exchange. This non-binding resolution now goes to the Senate. (Idaho Statesman)

- **Idaho could see $1.9 billion Medicaid budget next year, a $103 million total increase**

  Members of the Joint Finance-Appropriations Committee (JFAC) concluded their work for the year Friday by setting a $1.9 billion Medicaid budget. The budget includes an increase in state money for the second year in a row due to the loss of funding elsewhere. The spending plans also calls for funds to reform Idaho's Medicaid eligibility system. Overall, the Medicaid budget, including state, dedicated and federal funds, will jump $103 million next fiscal year if the full House and Senate approve the plan. State spending for the program is set to spike by $38 million, due mostly to the expiration of some self-imposed taxes from hospitals and other care facilities. That jump in spending represents an 8.9 percent state funds hike. Lawmakers set forth $474 million in state spending on Medicaid for 2013. (Idaho Reporter)

Iowa

- **Senate approves overhaul of mental health system**

  Iowa's mental health system would be subjected to statewide standards, and six regional hubs rather than the state's 99 counties would coordinate the services under an overhaul approved Monday by the Senate. The measure, approved on a 32-18 vote, seeks to ensure all Iowans get similar services. Services would still be done at the local level, but supporters said the regionalized approach would be an improvement from the current system, where the quality of care can vary widely from county to county. The proposal would cost $42 million in the first year. The measure sent to the House doesn't include funding. (Des Moines Register)

Kansas

- **Committee to examine KanCare**

  The House Health and Human Services Committee is scheduled to hold hearings next week on a bill that would exempt long-term care services for the developmentally disabled from the managed care provisions in KanCare, Gov. Sam Brownback's Medicaid reform plan. The panel also will hear testimony on a bill to require an annual evaluation of the state's Medicaid managed care contractors. The hearings may coincide with the introduction of a resolution in the House, urging the governor to delay KanCare's start by six months. The resolution already has been introduced in the Senate. (Kansas Health Institute)

Louisiana

- **Senators take first crack at state Medicaid overhaul**

  Lawmakers have raised questions and offered some skepticism the past two years, as the Department of Health and Hospitals put together the networks known collectively as Bayou Health. Today, Wednesday, March 14, the Senate Health Committee will get its first opportunity to question officials from Health Secretary Bruce Greenstein's agency about how the program is going. Some physicians and other health-care providers have reported having trouble getting their claims paid by the managed-care firms that won contracts to run the new system. The Senate hearing, scheduled for 1 p.m., could be the first opportunity for those practitioners to air their grievances. (NOLA.com)

Maine

- **DHHS chief expects feds will want Medicaid funds back**

  Maine will likely have to repay the federal government for providing Medicaid coverage to as many as 19,000 ineligible patients during the past year and a half, Health and Human Services Commissioner Mary Mayhew said today. Mayhew said she spoke to federal officials today about the latest problem with MaineCare's troubled computerized eligibility and claims systems. She also briefed lawmakers for a second day, answering questions about what the computer problem will cost the state and why the Legislature was not notified sooner. Mayhew said the claims system that was launched in the summer of 2010 never communicated properly with the existing eligibility system. Between Septeber 2010 and January 2012, an estimated 19,000 MaineCare enrol-

lees were sent letters telling them they were no longer eligible for coverage. But those same people still had active MaineCare cards and accounts and could have continued to receive coverage for medical services. (Morning Sentinel)

Massachusetts

- **Religious, business leaders support aggressive cap on health cost increases**

Religious and business leaders in Massachusetts called Tuesday for state lawmakers to rein in health spending more aggressively than House Speaker Robert A. DeLeo has proposed, but groups representing doctors and hospitals warned that slowing spending too sharply could be harmful. The Greater Boston Interfaith Organization, which has provided a significant consumer voice throughout the state's health care overhaul, said Tuesday night that DeLeo's proposal to cap health care cost increases at about 3.7 percent annually, a number comparable to the yearly growth in the state's economy, was insufficient. The religious group contends instead that the annual increase in health costs should be capped at two percentage points less than the increase in the gross state product, a measure of overall economic growth. A major business group, Associated Industries of Massachusetts, also came out Tuesday in support of the same growth limit. (Boston Globe)

Michigan

- **Agreement signed to take Marquette General Hospital private**

Marquette General Hospital would become Michigan's second largest privately-run acute-care hospital under an agreement it has signed with Duke LifePoint Healthcare. The hospital board this week signed a memorandum of understanding to join the company, which is a joint venture between Duke University and LifePoint Hospitals, a Brentwood, Tenn., firm with 53 U.S. hospitals. Marquette General is the largest regional hospital in the Upper Peninsula, with 315 beds, 200 doctors and 2,400 employees. For the next two to four months, the hospital and the company will negotiate an agreement, which would have to be reviewed by the Michigan Attorney General's office. The acquisition proposal calls for Duke to make financial commitments to improve care. The Detroit Medical Center, owned by Vanguard Health Systems, another private Tennessee hospital company, is Michigan's largest privately-owned hospital. (Detroit Free Press)

Minnesota

- **Minnesota bill to change HMO Medicaid requirements advances**

A state House committee advanced a bill Tuesday that would eliminate a requirement for nonprofit health plans to participate in the state's Medicaid program. The change would amount to a fundamental shift in how Minnesota buys health insurance for low-income and disabled residents who rely on the program, which is jointly funded by the state and federal government. Currently, the majority of Medicaid recipients in the state have their care administered by managed care organizations, including nonprofit HMOs. (Twin Cities Pioneer Press)

- **UCare's $30 million payment to Minnesota questioned**

  A $30 million payment to Minnesota coffers last year by one of the state's nonprofit health plans is coming under renewed scrutiny after an influential U.S. senator on Thursday questioned whether part of that largesse belongs to the federal government. U.S. Sen. Chuck Grassley, R- Iowa, sent letters to Gov. Mark Dayton, the Department of Justice and four HMOs saying he wanted to gain "a better understanding of the nature of the $30 million 'donation'" made by UCare. "I am particularly concerned about evidence I received which appears to suggest that the funds returned by UCare were tailored in a way to avoid returning any of said funds to the federal government," wrote Grassley, the ranking member of the U.S. Senate Judiciary Committee. UCare, which covers taxpayer-funded insurance for low-income and disabled Minnesotans on Medicaid, returned the money to the state saying it had excess profits in its reserves. The state was facing what it believed was a $5 billion budget at the time. (Star Tribune)

Mississippi

- **Miss. Medicaid funding challenge getting steeper**

  The state Medicaid agency told House members Wednesday that without changes, it now needs almost $884 million for the budget year that begins July 1. That's up from the $870 million that the agency had previously requested. Gov. Phil Bryant is only asking lawmakers for the current year's funding of $763 million for Medicaid, part of an austere budget request that would cut funding for most other agencies. (SunHerald)

Missouri

- **Molina Healthcare files protest over Centene contract**

  California-based Molina Healthcare has filed a formal protest with Missouri's Office of Administration following the award last month of a contract to Centene Corp. to provide Medicaid managed care services in Missouri. The Centene contract was a loss for Molina, which covered around 78,000 members in Missouri as of Sept. 30, 2011. Molina officials believe the state made "procedural and substantive errors" in the bidding process, leading to "unexpected and unjustifiable" results, according to the protest's executive summary. Molina began providing Medicaid managed care services in Missouri in 1995 and is the state's second-largest managed care provider. The company's contract with the state expires June 30, 2012. (St. Louis Business Journal)

New Jersey

- **Medicaid cuts create grim diagnosis for privately run health facilities**

  As counties ready their budgets, they are confronting some daunting balance sheets, colored red by continual cuts to Medicaid that have made operating nursing homes a precarious proposition. Some counties are reducing staff, some are raising taxes while others are washing their hands of the healthcare business altogether. And there is a growing concern that if publicly-run nursing homes disappear, there will be fewer beds for Medicaid patients because privately-run facilities cannot operate at a loss. New Jersey has about 28,000 Medicaid patients in long-term care facilities. (NJ.com)

North Carolina

- **Medicaid deadline jeopardizes residents of adult care homes**

  Thousands of families could soon be scrambling to find care for relatives living in the state's adult care homes if the state continues to violate federal rules. The federal government has given the state Department of Health and Human Services until April 30 to have an approved Medicaid plan for people receiving personal care services. State officials acknowledge that they won't meet the deadline and are working for an extension. If the state doesn't get the extra time, thousands of people in adult care homes could be turned out because their full costs won't be paid - about 20,300 people on Medicaid receive personal care services in adult care homes and about 25,500 receive in-home services. People receiving personal care at home would lose their services, too. (News Observer)

Ohio

- **MetroHealth wants to create Medicaid subsidy program for uninsured**

  The MetroHealth System hopes to use $72 million in subsidies from Cuyahoga County taxpayers over the next two years to reduce the region's uninsured by record numbers. The safety-net health system, with help from state regulators, recently submitted a proposal to the U.S. Centers for Medicare & Medicaid that would allow MetroHealth to create a special Medicaid program for low-income people who aren't currently eligible for the federal health insurance program for the poor. (Cleveland Plain Dealer)

Tennessee

- **TennCare hospital reimbursements vary widely**

  Some Tennessee hospitals are questioning why they should continue paying a self-imposed tax to prop up the state's Medicaid program because competitors are getting back much more in reimbursements while they lose money treating TennCare patients. Hospital executives were shocked to learn that insurance contractors for TennCare, the state health-care program for the poor, were paying more than four times as much to some hospitals as to others for outpatient procedures. In some cases, the disparities amounted to millions of dollars — enough to make or break a hospital's budget. The tension threatens to fracture a carefully negotiated alliance that keeps the state from losing hundreds of millions of dollars in federal matching money. (The Tennessean)

Texas

- **State Cuts Squeezing the Elderly Poor and Their Doctors**

  On Jan. 1, the state reduced its share of co-payments for such patients. Because the rule took effect on Jan. 1, patients were unlikely to have met their deductible. And while Medicare usually pays 80 percent of the costs of services, including office visits and checkups, Texas no longer covers remaining co-pays if they exceed Medicaid rates. Dr. C. Bruce Malone, the president of the Texas Medical Association, warned lawmakers in November that such cuts would cause physicians to stop taking both Medicaid and Medicare patients and lead to a minimum 20 percent reduction in revenue. The Legislature directed the state's Health and Human Services Commission last year to cut the

Medicaid budget by $3 billion over two years, including savings of $475 million for this single change. (New York Times)

West Virginia

- **Medicaid worries loom as W.Va. budget work begins**

  Medicaid is expected to be a recurring topic as the West Virginia Legislature completes a new state budget this week. Meeting in extended session, a House-Senate committee will review Gov. Earl Ray Tomblin's bid to keep pace with the state-federal health care program by banking funding for future use. The governor's $11.6 billion spending plan for the budget year that begins July 1 includes $132 million in new state funds for Medicaid, said Budget Director Mike McKown. But around $32 million of that is meant to serve as surplus for the following budget year. Tomblin updated his proposed budget twice since first delivering it to the Legislature in January, and added money for Medicaid each time. During the just-completed regular session, the Democrat also had lawmakers add at least $27 million to the current budget. Officials expect those funds to roll over unspent into the upcoming budget. (Herald-Dispatch)

United States

- **CMS names participants in Medicaid emergency psychiatric care project**

  The Centers for Medicare & Medicaid Services will provide up to $75 million in federal Medicaid matching funds to 11 states and the District of Columbia to test whether reimbursing private psychiatric hospitals for emergency services improves care while reducing costs and the burden on general acute-care hospital emergency departments. Alabama, California, Connecticut, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington state, West Virginia and Washington, D.C. will participate in the Patient Protection and Affordable Care Act demonstration, which will reimburse inpatient psychiatric facilities for emergency care provided to Medicaid enrollees aged 21-64. (AHA News)

- **Rules For New Insurance Marketplaces Give Insurers Clout**

  Insurers and other industry representatives will get to fill as many as half the seats on the governing boards for state health insurance exchanges, under final rules for the marketplaces issued today by the Department of Health and Human Services. At least one seat must be reserved for a consumer representative. The long-awaited rules are likely to disappoint consumer advocates, but they may also frustrate insurers who had sought to prevent the governing boards from imposing requirements on plans beyond what is included in the 2010 health care law. HHS left that possibility in place. (Kaiser Health News)

- **Backup plans if individual mandate is struck down**

  If the U.S. Supreme Court strikes down health reform's individual mandate and leaves the rest of the law in place, the backup plan could be automatic enrollment in your employer's health insurance, a lot like the way you get signed up for the 401(k) plan. It's an idea that could even appeal to Rep. Paul Ryan — it's straight out of the health reform alternative he sponsored in 2009. The Patients' Choice Act proposed setting up auto-enrollment procedures at emergency rooms and state departments of motor vehi-

cles and through state tax returns and workplaces. People would have been enrolled in private plans being sold on state exchanges. Although the bill allowed individuals to opt out, research has shown that auto-enrollment, particularly in the case of individual retirement accounts, has successfully boosted participation from people who wouldn't take the initiative on their own. (Politico)

- **In high-risk insurance, enrollment lags and costs soar**

  One of the most popular provisions of the Affordable Care Act — cheap insurance plans for people with medical conditions that prevent them from getting coverage anywhere else — has run into a couple of snags. Though nearly everyone agrees a lifeline for sick people is needed, these new so-called high-risk insurance plans have attracted fewer than 50,000 — far less than the 375,000 Congress anticipated. At the same time, the costs of health care services for each member are more than twice as much as projected. According to a new report from the U.S. Department of Health and Human Services, the estimated per-member claims cost for 2012 is $29,000. That compares to $13,000 per person for those enrolled in existing state-run high risk pools, which federal estimates were based upon. (Stateline)

- **Republicans float dueling Medicaid reform bills**

  House Republicans are floating dueling Medicaid reform bills as Budget Committee Chairman Paul Ryan (R-Wis.) prepares to unveil his own proposal in the coming weeks. Leaders of the conservative Republican Study Committee will introduce legislation on Wednesday that gives states maximum flexibility to run the program as they see fit. The "State Health Flexibility Act" would combine Medicaid and the Children's Health Insurance Program (CHIP) into a single block grant, while reducing federal spending on the two programs by $1.8 trillion over 10 years by freezing spending at current levels. The bill would allow states to determine eligibility, benefits, provider reimbursement rates and many other aspects of the program. That makes it incompatible with the healthcare reform law, which calls on the Medicaid programs of all 50 states to cover everyone up to 133 percent of the federal poverty level. Separately, Energy and Commerce member Bill Cassidy (R-La.) has been touting his own Medicaid reform proposal, which would replace the current open-ended federal matching rate system for states with a per patient, per month budget depending on the characteristics of each state's patient population. (The Hill)

Company News

- **ILS Appoints to Board**

  Independent Living Systems, a provider of care to the elderly and special needs populations has appointed four new members to its board of directors. The new appointments include Michael Leavitt, chairman of Leavitt Partners and former secretary of the US department of health and human services; Jay Rosen, health policy and economics expert at Health Management Associates; and health care investors Ann Lamont of Oak Investment Partners and Ruben King-Shaw of Mansa Capital. (PE Hub)

- **CalOptima Names Interim CEO**

  To provide stability and leadership for CalOptima during the national search for a Chief Executive Officer, Michael Engelhard, CalOptima Chief Financial Officer, will become Interim CEO upon the early April departure of Richard Chambers. The CalOptima Board of Directors announced this interim appointment after their March Board meeting on March 1, 2012. (CalOptima News Release)

- **Amerigroup is now in the entire state of Georgia**

  Amerigroup Community Care serves members in the Georgia Families programs, including Medicaid, PeachCare for Kids and Planning for Healthy Babies. Amerigroup began operations in June 2006 in the Greater Atlanta area. In September 2006, services were extended to other areas of the state, including Savannah, Augusta, Gainesville and Dalton. Beginning February 2012, Amerigroup services will be available statewide. (MyAmerigroup.com)

- **Horizon NJ Health Rates as New Jersey's Top Medicaid Managed Care Plan**

  Horizon NJ Health, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey, is the highest rated Medicaid managed care plan among all of the state's participating Medicaid plans. According to the NJ FamilyCare/Medicaid "HMO Performance Report" released last month, Horizon NJ Health received a 92% overall performance score, the highest of all New Jersey's Medicaid managed care plans and the only plan to improve its overall score from previous reports. The NJ FamilyCare/Medicaid "HMO Performance Report" for 2010 provides information on the quality of each health plan's performance that includes the quality of care provided to clients, client satisfaction levels in their health plans and the performance of internal operations of all plans. (Market Watch)

RFP Calendar

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
Mid to late March	California Dual Eligibles	Site Selection	500,000
March 16, 2012	Wisconsin Dual Eligibles	Proposal released	TBD
March 19, 2012	Ohio	Proposals due	1,650,000
March 22, 2012	New York Dual Eligibles	Proposal released	TBD
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, 2012 HMA Principals Vernon Smith and Jennifer Kent hosted a conference call in conjunction with the Gerson Lehrman Group (GLG). On the call, Vernon provided an update on state Medicaid budgets and the expansion of Medicaid managed care while Jennifer led a discussion of California's request for solutions (RFS) for an integrated delivery model for Medicare-Medicaid eligibles. A webcast replay of the call is available at: **(GLG Research - Link to Webcast)**

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)