HMA

HEALTH MANAGEMENT ASSOCIATES

# *HMA Investment Services Weekly Roundup*
# *Trends in State Health Policy*

**IN FOCUS:** NEW MEXICO'S MEDICAID REDESIGN WAIVER

**HMA ROUNDUP:** HEALTH NET WINS CENTRAL CALIFORNIA RFP; CALIFORNIA "MAY REVISE" TO BE RELEASED MAY 14; NEW YORK SCALES BACK, REFINES DUAL ELIGIBLE DEMONSTRATION PROPOSAL; GEORGIA ANNOUNCES, BUT TEXAS CANCELS, RAC AWARDS; PENNSYLVANIA MEDICAID MCO AWARDS PROTESTED; CMS REFINES DUAL ELIGIBLE APPLICATION REQUIREMENTS, ANNOUNCES FIRST WAVE OF INNOVATION AWARDS AND RELEASES PROPOSED RULE ON MEDICAID PRIMARY CARE RATE INCREASES

**OTHER HEADLINES:** OHIO MEDICAID MCO PROTESTS REMAIN UNDER REVIEW; INSURANCE COMMISSIONER SAYS FEDS TO RUN KANSAS EXCHANGE; OREGON, FEDS AGREE ON FUNDING FOR MEDICAID REDESIGN; KENTUCKY HOUSE SPEAKER CALLS FOR COVENTRY INVESTIGATION

**MAY 9, 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: NEW MEXICO'S MEDICAID REDESIGN WAIVER

This week, our *In Focus* sections looks at the Medicaid redesign waiver, submitted by New Mexico to the Centers for Medicare & Medicaid Services (CMS) on April 25, 2012. New Mexico is proposing to consolidate the numerous federal waiver populations, as well as the fragmented managed care and fee-for-service structure that serves New Mexico's roughly 512,000 Medicaid lives. New Mexico currently contracts with four managed care plans for its traditional Medicaid population, two managed care plans for its dual eligible and nursing facility population, and one additional managed care plan for behavioral health services. As of July, 2010, more than 67 percent of New Mexico Medicaid beneficiaries were enrolled in comprehensive managed care. In addition, the state operates seven additional and separate waiver populations under federal 1915(c) and 1115 waiver authority. The state's plans to consolidate and reorganize the Medicaid program under this new waiver will be known as Centennial Care and includes the following key components:

- Reprocure and reduce the number of Medicaid managed care plans.
- Carve in behavioral health, home and community-based (HCBS) services, and institutional services.
- Dual eligible integration under capitated model.
- Payment reforms including bundled payments and incentives for Medicaid managed care health plans.
- Cost-sharing and co-pays for inappropriate ER use and non-generic drugs.
- Mandatory managed care enrollment for Medicaid-eligible Native Americans.

### Medicaid Managed Care Consolidation

The waiver submission to CMS indicates the state's intention to reduce the number of Medicaid managed care plans from seven to "a smaller, more manageable number."

| | **Salud!** *TANF Medicaid* | **CoLTS** *Dual Eligible, Nursing Facility* | **Behavioral Health** *Salud!, CoLTS, FFS* |
|---|---|---|---|
| SFY2010 Enrollment | 390,571 | 37,555 | 430,969 |
| Managed Care Plans | Blue Cross Blue Shield | Amerigroup | Optum Health |
| | Molina | UnitedHealth | |
| | Lovelace Community HP | | |
| | Presbyterian HP | | |

The Salud! program, as of SFY2010, serves more than 390,000 traditional Medicaid lives. Salud! members are enrolled in plans offered by Blue Cross Blue Shield, Molina, and local plans, Lovelace Community Health Plan and Presbyterian Health Plan. The CoLTS managed long-term care program, as of SFY2010, served more than 37,000 dual eligibles and those with nursing facility level of care needs. CoLTS members are enrolled in plans offered by Amerigroup and UnitedHealth. Individuals in both Salud! and CoLTS with behavioral health needs receive these benefits through a separate behavioral health man-

aged care plan, as do those Medicaid recipients in the fee-for-service population, for a combined Medicaid behavioral health population of roughly 431,000. Optum Health currently holds the behavioral health contract. The total Medicaid population in New Mexico was roughly 512,000 as of January 2012.

## Behavioral Health Carve In

New Mexico's waiver proposal would bring behavioral health services under the managed care umbrella. Contracted MCOs will provide all behavioral health services currently managed by Optum Health under a statewide carve out. In addition, the state is pursuing a behavioral health home model in conjunction with the physical MCOs. The waiver notes that MCOs will be not be permitted to subcontract behavioral health management to a behavioral health organization.

## Payment Reforms and Cost-Sharing

Under the waiver, New Mexico will pilot payment reform projects within the capitated payments structure. The state will test bundled payment rates for adult diabetes and pediatric asthma, as well as bundled rates for urban hospital rates for patients with pneumonia and coronary disease, with a goal of reducing readmissions.

Additionally, the state is requesting waiver authority to implement a co-pay for non-emergency ER visits, as enacted by the New Mexico legislature in 2009. The co-pay amount will be based on an individual's income level. In addition to the ER co-pay, the state has requested a $3.00 co-pay on branded drug prescriptions when a generic is readily available. This co-pay will not apply to psychotropic drugs for the behavioral health population, nor will it apply to the Native American population.

## Native American Mandatory MCO Enrollment

As of January 1, 2000, Native Americans in New Mexico were given the option to opt-in to managed care enrollment through the Salud! program. Under the state's waiver application, the Native American population would be mandatorily enrolled into a managed care plan. Currently, Native Americans who have a nursing facility level of care are required to enroll in the CoLTS program. Of the general Native American Medicaid population, roughly 20 percent have opted-in for Salud! enrollment. As of January 2012, there was a total of 88,319 Native Americans enrolled in Medicaid.

## Waiver Population Exclusions

While New Mexico's waiver applications seeks to bring additional Medicaid lives under managed care plans, several populations will remain fee for service when the waiver is implemented. Those populations are the developmentally disabled, those in intermediate care facilities (in the Mi Via program), low income Medicare recipients receiving cost sharing and premium assistance, as well as the undocumented alien and refugee populations.

## Waiver Implementation Timeline

| Date | Timeline |
|---|---|
| **June - Oct. 2011** | Public stakeholder meetings and subject specific workgroups |
| **Oct. 2011 - Jan. 2012** | Finalize concept paper, "vet" with the Governor, organize internal workgroups to begin putting additional operation details on the design |
| **Feb. 2012 - June 2012** | Submit waiver to the U.S. Center for Medicare and Medicaid Services (CMS), develop Request for Proposals (RFP) for plans, finalize new contract to be used with plans |
| | Procurement on the street mid to late June 2012 |
| **July -Sept. 2012** | Procure new plans and award contracts |
| **Oct.2012 - Sept. 2013** | Prepare for "Go Live" |
| **Jan. 2014** | Implementation |

# HMA MEDICAID ROUNDUP

## *California*

### HMA Roundup – Stan Rosenstein / Jennifer Kent

California announced last week that it has awarded the Central Valley 2-Plan Model Commercial Health Plan RFP to Health Net Community Solutions. The Central Valley Two-Plan RFP included Kern, San Joaquin, Stanislaus, and Tulare Counties. Health Net was already the Commercial Health Plan in Kern, Stanislaus and Tulare counties. Health Net will be replacing Anthem Blue Cross in San Joaquin where it covers approximately 28,000 lives. The new contract will begin January 1, 2013.

The National Senior Citizens Law Center (NSCLC) released a report last week— Assessing the Quality of California Dual Eligible Demonstration Health Plans. The NSCLC reviews quality reports for plans in the four initial dual eligible demonstration counties. According to a DHCS report assessing the quality of health plans in the Medi-Cal Managed Care (MCMC) Program, seven of the eight plans received a global health plan rating of one out of five stars. It's not clear if this report will influence the Legislature's intent to expand the dual eligible demonstration to a total of ten counties in 2013.

Importantly, on May 14 Governor Brown will release the May Revision to the initial budget released in January 2012. We expect that there will be additional savings proposals included in the document as the state's budget deficit has increased from $9 billion to over $11 billion. Regarding the dual eligible proposal, we anticipate that the governor's revised budget will continue to propose the expansion of the state's authority from four counties to between eight and ten counties..

### In the news

- **Risks, Rewards Higher for Managing Dual Eligibles**

  Two kinds of health plans are going after this new batch of customers: commercial insurers, such as Molina Healthcare and Health Net, and public insurers, such as L.A. Care, CalOptima in Orange County, Contra Costa Health Plan and other county-based public plans. A report released last week by National Senior Citizens Law Center pointed to ratings by the state Department of Health Care Services that gave seven of the eight health plans in the dual-eligibles pilot project one out of five stars for overall Medi-Cal performance. Critics said the low performance ratings raise questions about whether the health plans are ready to take on fragile, elderly patients. (CaliforniaHealthline)

- **Sacramento's threadbare medical network for poor getting thinner**

  Once operating six public clinics for the poor and uninsured, Sacramento County now has one. Nonprofit community clinics, which form the backbone of primary care for the poor in other counties, are few and far between. Given the options, the estimated 444,000 Sacramentans who have Medi-Cal or no health insurance at all – nearly a third of all county residents – often struggle to get primary care. More and more, they end up in emergency rooms. (Sacramento Bee)

# *Georgia*

## HMA Roundup – Mark Trail

Governor Deal signed the state's 2013 budget into law this week.

The Georgia Department of Community Health (DCH) announced that it has awarded the Medicaid RAC contract to Meyers & Stauffer.

Governor Deal announced this week that Georgia's net tax collections for the month of April 2012 totaled $1.53 billion, for an increase of $152 million or 11 percent compared to April 2011. Through 10 months of FY2012, net revenue collections totaled nearly $13.3 billion, for an increase of $677 million or 5.4 percent compared to the same period last year.

## In the news

- **Perils in personal care homes**
  Georgia hasn't done enough to rein in an "epidemic" of mistreatment of vulnerable people by personal care home operators, an Atlanta Journal-Constitution investigation has found. Growing demand, combined with a convoluted, overstretched system of oversight, leaves the door open for abuses of elderly, mentally ill or developmentally disabled residents, many experts say. There are about 100 licensed homes for every state inspector, and for years unlicensed homes have operated with impunity. (Atlanta Journal Constitution)
- **Two shots in the arm for Georgia Medicaid**
  Georgia's Medicaid program has received a double dose of good financial news, according to two separate announcements Monday. First, HP said in a news release that federal officials have recently certified Georgia's Medicaid information system. The accreditation by the Centers for Medicare and Medicaid Services ensures that Georgia will receive maximum federal funding for the system's implementation and operations. Extra funding is available retroactively, to the HP system's first day of operation in November 2010. Georgia is expected to get an additional $15 million under that scenario, plus an increased amount from the federal certification date onward. Also Monday, state Attorney General Sam Olens announced that Georgia has joined with other states and the federal government to reach an agreement with Abbott Laboratories to settle civil and criminal allegations that the company illegally marketed the anti-seizure drug Depakote. The $1.6 billion settlement is the second-largest recovery from a pharmaceutical company in a single civil and criminal global resolution, after Pfizer's $2.3 billion settlement in 2009, the Justice Department said. Georgia Medicaid will receive $12.6 million in state and federal dollars; the state portion of that amount is $5.2 million. (Georgia Health News)

# *Illinois*

## HMA Roundup – Jane Longo / Matt Powers

Although the dual integration RFP was reportedly to be released last Friday, May 4, we are not surprised by its continued delay. The state is in the midst of the Phase I care coordination procurement, while preparing for a broader managed care RFP release this summer or fall. In addition, the state is addressing calls for $2.7 billion in Medicaid budget reductions and working toward hospital Medicaid payment reform.

***Illinois Care Coordination and Budget Timeline – Key Dates and Milestones***

| Date | Care Coordination | Budget/Medicaid Cuts |
|---|---|---|
| January 2012 | ***Phase I RFP Released***<br>Complex Adults, no MCOs | |
| February 2012 | 75 LOIs received | ***Gov. Address, Feb. 22.***<br>Call for $2.7B in Medicaid cuts. |
| March 2012 | | HFS released menu of possible cuts and associated savings. |
| April 2012 | ***Phase I Proposal Due Date Delayed*** | ***Gov. Budget Proposal***<br>April 19, 2012 |
| May 2012 | ***Dual Integration RFP Release***<br>Sometime in May | Legislative Scheduled Session ends May 31, 2012 |
| June 2012 through August 2012 | ***Phase I Proposals Due June 15, 2012***<br>***Dual Integration RFP Winners***<br>To be announced July 1, 2012<br>***Phase II RFP Release***<br>Complex Children<br>***Medicaid MCO RFP***<br>Summer 2012, may be delayed | If nothing passes, Legislature moves to extended session with two-thirds majority required to pass a law. |
| January 2013 | ***Phase I, Phase II, Duals***<br>Go live January 1, 2013<br>***Medicaid MCOs***<br>Depends on possible delay | |

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

## In the news

- **Berrios: Delay in hospital tax status cases costing taxpayers millions**

  Illinois Gov. Pat Quinn announced more than two months ago that the state would resume denying tax exemptions to hospitals that operate more like businesses than charities. His action meant hospitals could lose millions of dollars each year. But the state has taken no action on 17 pending tax-exemption applications, despite calls from advocates to make hospitals live up to their missions and the demands of municipal officials who believe they are losing valuable revenue from hospitals that don't deserve tax breaks. A spokeswoman for Cook County Assessor Joseph Berrios said that further delay could mean a lost year of revenue for some taxing districts. The governor's office denies a holdup, saying the decisions are complicated and take time. But the silence from the Department of Revenue raises concerns that the decisions are embroiled in

wider negotiations in Springfield between the state and hospitals, and that the Democratic governor may be feeling pressure from the state's influential hospital industry, a top contributor to political campaigns. (Crain's Chicago)

- **Nursing home supporters rally in Chicago to fight Medicaid cuts**

  Medicaid cuts being considered in Springfield would costs thousands of jobs and threaten care at nursing homes across the state, according to nursing home administrators, health care leaders and elected officials who rallied at the Thompson Center in Chicago Monday. The event was organized by the Health Care Council of Illinois (HCCI), which represents more than 500 nursing homes and rehabilitation facilities across the state of Illinois. The proposed cuts to nursing homes could drastically jeopardize the quality of care for the more than 50,000 people residing in Illinois nursing homes who pay with Medicaid. These cuts put nursing homes at risk for closing, especially some Chicago nursing homes where Medicaid recipients make up more than 90 percent of the resident population. (MarketWatch)

## *Indiana*

### HMA Roundup – Cathy Rudd

IN announced the winning bidder on its data warehouse/decision support system/business intelligence solution RFP – Optum Government Solutions . It is a $32 million contract for 4 years, with options to extend for 2 one year periods.

http://www.in.gov/idoa/proc/recommendations/rfp-12-58.htm

## *Massachusetts*

### HMA Roundup – Tom Dehner

The Massachusetts State Senate released their health care payment reform bill this week, on the heels of the House's bill that was released last week. Both bills set target cost growth rates for health care costs. The Senate bill would peg increases in the rate of health spending to state economic growth, saving more than $150 billion over 15 years. The House bill would require growth rate increases in health spending even lower, .5 percent below the rate of state economic growth by 2016. The Senate bill would encourage, but not mandate, a transition to bundled payments for health insurance providers, while the House bill would establish an independent agency to set requirements for insurers to move away from fee-for-service payments. One point of difference that may prove controversial is the House bill's inclusion of a tax on health care providers with excessive negotiated unit costs which are not demonstrably linked to above-average quality or unique services. These tax funds would be redistributed to distressed hospitals. Both the House and Senate bills aim to expand primary care, electronic health records, and information for consumers on the cost and quality of treatments, and to improve the medical malpractice system. Additionally, the Senate bill includes the Beacon ACO certification process, which would be a voluntary certification process for ACOs that would result in preferential pricing for state health care contracting. The Senate's bill also provides $100 million in funds over five years for prevention and wellness.

### In the news

- **Mass. Senate unveils health care financing bill**

  State Senate leaders are unveiling their version of a health care payment bill they say will help hold the line on soaring costs while dramatically updating how health care is delivered. The Senate bill seeks to peg increases in health care spending to the growth in the state economy. Senate leaders say their plan will result in more than $150 billion in savings over the next 15 years. (Boston Globe)

- **House targets health spending**

  Massachusetts House leaders released a major proposal to curb health care costs Friday, calling for new limits on the fees charged by hospitals and doctors and for creation of an independent agency to monitor medical spending. The lawmakers project their plan would save families an average of $2,000 annually on health insurance premiums. The long-awaited bill would require the health care industry to cut the growth in spending in about half by 2016, so that it is below the growth of the overall Massachusetts economy. (Boston Globe)

## *New York*

### HMA Roundup – Denise Soffel

The New York State Department of Health has updated its schedule and plans for its dual eligible integration proposal. The managed fee-for-service (MFFS) approach would begin in July 2012 and would provide integrated care coordination through Health Homes to dual eligibles that have two or more chronic conditions, HIV/AIDS, and/or one mental health illness and do not require 120 or more days of long-term supports and services (LTSS). The MFFS dual program will facilitate access to, and transition their members in need of, long term care services greater than 120 days to MLTC (where available) or fee-for-service long term care providers.

The Capitated approach would begin in January 2014, would be called FIDA (the Fully-Integrated Duals Advantage program) and would provide a comprehensive package of services to dual eligibles in the eight New York counties of Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester that require more than 120 days of long term supports and services (LTSS).

According to the draft proposal, we estimate each model would encompass approximately 125,000 dual eligibles, versus the state's initial proposal which would have covered 460,000 duals.

### In the news

- **Cuomo Seeking New Agency to Police Care of Disabled**

  Gov. Andrew M. Cuomo, seeking to strengthen the state's chronically weak response to abuse of disabled people who live in publicly financed homes, plans this week to propose creating an agency dedicated to investigating problems with the care of nearly one million vulnerable New Yorkers. The new law enforcement and oversight agency would monitor those in state or private care who have developmental disabilities like autism or cerebral palsy, mental illnesses including schizophrenia, and other condi-

tions, among them traumatic brain injuries, that put them at risk. The agency would employ a special prosecutor and would be granted subpoena power and the authority to convene grand juries, according to a draft plan obtained by The New York Times. (New York Times)

## *Pennsylvania*

### HMA Roundup – Izanne Leonard-Haak

At the Pennsylvania Medicaid Managed Care Delivery System Subcommittee on May 3, Joanie Morgan, the Bureau Director in charge of the HealthChoices expansion procurements, announced that the Department has received several bid protests and is not permitted to move forward with readiness and contracting until the protests are resolved. As reported earlier, Amerihealth Mercy , Coventry, Gateway and UPMC for YOU won the awards for the New West Zone (174,000 lives in 13 counties) targeted for implementation on September 1, 20012. Amerihealth Mercy, Coventry and Geisinger Health Plan won the awards for the New East Zone (290,000 lives in 22 counties) which was targeted for implementation on March 1, 2013. The Department has not shared any particulars regarding what other health plans submitted bids, so we cannot confirm which plans may be behind the protests. The Department did not indicate what impact the protests may have on the current implementation schedules.

### In the news

- **Time, fear, pressure drove Highmark, UPMC deal**

  Highmark Inc. desperately needed time to complete its takeover of West Penn Allegheny Health System. UPMC eagerly wanted to avoid additional government oversight. Those were key points in behind-the-scenes negotiations that brought the health care giants to agreement to extend their contract until the end of 2014, those familiar with the discussions told the Tribune-Review on Thursday. (Tribune-Review)

## *Texas*

### HMA Roundup – Dianne Longley

Texas' Health and Human Services Commission cancelled the RFP for Medicaid RAC services. The contract was originally awarded to CGI, Federal Inc. on February 27, 2012 however that award was suspended on March 19 and the RFP was cancelled on May 8. The state has not revealed why it elected to cancel the contract.

### In the news

- **Parkland hit with new Medicare-Medicaid fraud allegations**

  The U.S. Justice Department has been investigating new allegations that Parkland Memorial Hospital and UT Southwestern Medical Center doctors defrauded the federal government's health insurance programs for the poor and elderly. The investigation came to light Tuesday after a federal judge unsealed a whistle-blower lawsuit. (Dallas News)

- **Lawmakers Hear Update On Medicaid Spending**

  Top officials from state agencies have warned Texas lawmakers that the cost of caring for the state's disabled and poor children and elderly are growing faster than tax revenues. Appearing before a House Appropriation Subcommittee on Monday, the state's Medicaid chief said the program will likely only achieve 88 percent of the savings lawmakers hoped for. Last year the Legislature balanced the budget by forecasting big savings and shorted the program by roughly $4.8 billion. Officials with the Texas Department of Health and Human Services have predicted that lawmakers will need to come up with more than $10 billion to cover the current deficit and increases in the next budget. That could create another crisis next year. Last year the Legislature cut $27 billion in services in the two-year budget. (KERA News)

# *United States*

## HMA Roundup – Lillian Spuria

We highlight three noteworthy announcements/decision by CMS this week:

- CMS has notified states and health plans that organizations interested in becoming an integrated dual eligible plan on January 2013 do not need to include a Model of Care description in their dual eligible integration plan applications. This requirement would have required that all plans interested in participating in dual eligible demonstration submit a detailed description of their care coordination model by May 24, 2012. Interested organizations still need to submit their applications by May 24 but they do not need to include this description. It is not clear when plans will be required to submit this information.
- On Monday May 7, the CMS Innovation Center announced the first batch of preliminary awardees for the Health Care Innovation Awards. These organizations will implement projects in communities across the nation that aim to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP), particularly those with the highest health care needs. Funding for these projects are for 3 years. Twenty six projects received awards totaling $123 million. More awards will be forthcoming as CMS has targeted a total of $1 billion in funding for innovation projects. Awardees are listed here.
- On Wednesday May 8th, CMS released a proposed rule that would implement the Affordable Care Act's requirement that Medicaid reimburse family medicine, general internal medicine, pediatric medicine, and related subspecialists at Medicare levels in CY 2013 and CY 2014. The increase in payment for primary care is paid entirely by the federal government with no matching payments required of States.

## In the news

- **Dual-eligibles pilot program faces rush from states**

  States want to include more than 3 million dual-eligible beneficiaries in a CMS pilot program to overhaul their care and payments. The number is 1 million more than the program was designed for and represents about a third of all that category's beneficiar-

ies, whose care is one of the biggest drivers of the growth in Medicaid costs. A total of 3,176,796 beneficiaries who are eligible for both Medicare and Medicaid were included in 23 applications from states hoping to participate in the financial alignment demonstration integrated-care program, which was supposed to enroll a maximum of 2 million beneficiaries. The pilot aims to test new care and payment models to see if any improve health outcomes and lower costs for this expensive patient population. (Modern Healthcare)

- **Medicaid costs are growing ... slowly?**

  The Kaiser Family Foundation put out new data Friday that Medicaid's per-person costs grew 2.5 percent between 2007 and 2010, significantly slower than the rate of growth in private insurance and a full point lower than overall medical trend. This Kaiser study comes on the heels of a separate analysis, from Bloomberg Government, that found similar results. It showed Medicaid spending, per capita, hovering around $350 per person over the past decade. Spending patterns varied by state, but none showed a clear spike upwards. (Washington Post)

## OTHER HEADLINES

### Alabama

- **Gov. Bentley names Azar Acting Alabama Medicaid Commissioner**

  Gov. Robert Bentley has appointed Stephanie McGee Azar as Acting Commissioner of the Alabama Medicaid Agency effective May 1, 2012. In this role, Azar will coordinate closely with the Governor's Office and with State Health Officer Dr. Donald Williamson, who will continue to lead the transition at Medicaid. While serving as Acting Commissioner, she will continue in her current position of General Counsel with the Agency, a role in which she has served since March 2010. (Alabama Medicaid Agency)

- **Ala. governor promises veto of budget if Medicaid cut**

  Alabama Gov. Robert Bentley said that he will veto the state's General Fund budget if lawmakers do not find an additional $200 million for Medicaid. Bentley and State Health Officer Don Williamson said at a news conference Tuesday that there would be dire effects if the budget for non-education state services is adopted as it passed the House, with only $400 million for Medicaid. Williamson said at least $602 million is needed to fund the program and to continue many vital services. (Modern Healthcare)

### Florida

- **FL hates health law, but plans for it in $700K study**

  While Florida waits to see whether the Supreme Court will kill the Affordable Care Act, a state agency is laying the groundwork to carry it out, just in case. The Agency for Health Care Administration today will answer questions from companies that have shown an interest in competing for a $700,000 study on creating a modern Medicaid information system. The IT system needs to be able to handle not just the current job, but the health insurance exchange called for under the federal health law. Answers to the questions will help guide whether the companies will respond to the bid by the May 22 deadline. The agency plans on awarding the contract by June 12. It wants the study completed by July 30. (Health News Florida)

- **FL passed up $200M for uninsured kids**

  Over the past two years, Florida did such a good job of enrolling uninsured children in KidCare that the state could have qualified for as much as $200 million in federal bonuses – money that could have helped get more children into care. But the state did not take the steps required to get the money. A spokesman for the Florida House said it appears the reason was the cost involved in making changes to certain agency rules. (Health News Florida)

### Kansas

- **Exchange Watch: Praeger Says Kansas to be a Federal Exchange**

  Kansas Insurance Commissioner Sandy Praeger told Politico PULSE on Tuesday that time has all but run out on the possibility that the state might run its own exchange. The legislature still needs to pass authorizing legislation if it wants to avoid the creation of a federal exchange, but other big items are still unresolved - redistricting and

the budget - that would make it hard to get done even if the governor and legislative leaders weren't resisting implementation. The state could still eke out a federal/state partnership exchange, but a federally run exchange seems likely. (Politico PULSE)

## Kentucky

- **Managed-care company tells Baptist Healthcare it wants new contract**

  One of the state's Medicaid managed-care companies has told Baptist Healthcare System that it wants to renegotiate its contract with the chain, which has hospitals in Lexington, Louisville, La Grange, Paducah and Corbin. Coventry Cares notified Baptist Healthcare System on Friday that it wanted to renegotiate, said Ruth Ann Childers, a spokeswoman for Baptist. If an agreement cannot be reached by Nov. 1, when the current contract expires, Coventry has told the health care system that it would allow the contract to expire, Childers said. (Kentucky.com)

- **Stumbo calls for investigation of Coventry Cares**

  House Speaker Greg Stumbo on Thursday called for a close examination of the Medicaid insurance company that wants to terminate its contract with Appalachian Regional Healthcare, saying the insurance company's conduct "borders on Medicaid fraud." Stumbo also criticized ARH, Eastern Kentucky's largest health care provider, for claiming that the contract termination would force it to cut 300 to 400 jobs through a combination of layoffs and reduced hours. (Kentucky.com)

## Louisiana

- **Health and Hospitals, higher education face more budget cuts**

  Higher education and the Department of Health and Hospitals are facing more cuts as administration officials try to square next year's budget with revenue projections. Overall the health agency is looking at $57 million in reductions in state revenue, which will require the state to forgo about three times that much in federal revenue. (NOLA.com)

## Missouri

- **Patients, Providers, Companies Await Medicaid Ruling**

  A main part of Missouri's Medicaid program is at the center of a lawsuit right now. A company that's long contracted with the state to manage Medicaid services for several thousand enrollees alleges the state inappropriately chose new contracts. A Cole county circuit court could rule on the case any day now, with one potential outcome creating problems for the Medicaid program and its enrollment process. The new awards, issued in February and effective July 1, didn't include Molina Healthcare. The company currently manages about a fifth of enrollees in the program (including around 13,000 people in the Western region), and was one of five companies currently with a contract in Missouri. The state instead awarded a new contract to Centene. The other two companies awarded contracts – a subsidiary of Aetna and of Coventry – are already operating in the state. (KCUR.org)

## New Hampshire

- **State Prepares for Massive Shift to Medicaid Managed Care**

  The Executive Council has passed a $2.3 billion contract that will overhaul the state's Medicaid program. Medicaid Managed care could significantly shake up service for some 140,000 N.H. residents. HHS officials believe this reform is critical. (New Hampshire Public Radio)

## Ohio

- **Medicaid contracts bring bevy of allegations**

  Last month, the state awarded preliminary contracts to five health plans — three existing plans and two new ones — to provide services to two-thirds of enrollees in the tax-funded coverage, or about 1.5million Ohioans. Protests filed by five of the six managed-care organizations that lost business paint a picture of widespread deceit and omission, with the Ohio Department of Job and Family Services failing "to take even the most minimal steps to validate or verify the claims made by applicants." (Columbus Dispatch)

## Oregon

- **Ore. governor announces new Medicaid model**

  Oregon's Medicaid system is about to be retooled and the entire nation will be watching. The tentative agreement with the U.S. Department of Health and Human Services provides Oregon with $1.9 billion over the next five years to transform the Medicaid system. The Governor's office estimates the plan will save the state $11 billion by the end of the decade. The transformation centers around the creation of what are called Coordinated Care Organizations or CCO's, which are teams of health care workers from specific geographic areas. Instead of competing against each other, doctors, nurses and other health care providers will team up to work together. Oregon must lower Medicaid costs by at least two percent within two years of the program's implementation. (KGW News)

## Wisconsin

- **State sending letters on Medicaid changes**

  The state is sending out letters to 111,000 low-income Wisconsinites warning them that they could see changes to their state health coverage, including premium increases. The letters are being sent after federal officials announced Friday their approval of plans by Gov. Scott Walker's administration to cut costs in those Medicaid programs. Officials estimate that the plans will lead to more than 17,000 people leaving or being turned away from the state's BadgerCare Plus health programs for the needy. (Journal Sentinel Online)

## COMPANY NEWS

- **Sale of D.C. health-care firm in works**

  D.C. Chartered Health Plan is weighing offers from buyers in an effort to keep $350 million in District government business that officials have said it could lose if the company remains in the hands of owner Jeffrey E. Thompson. Chartered's efforts to reorganize with such a sale could be finalized as early as this week, said people familiar with the matter who were not authorized to speak publicly about the negotiations. The transaction would separate the managed-care firm from Thompson, who recently resigned as board chairman after a March raid on his home and offices in a federal probe into alleged campaign-finance violations. (Washington Post)

- **Insurers WellCare, Amerigroup Benefit From Muted Costs**

  Medicaid-focused insurers WellCare Health Plans Inc. and Amerigroup Corp. reported better-than-expected earnings Wednesday with help from muted health-care costs and growing membership. Amerigroup benefited from what it called "continued moderate medical trends," while WellCare's still high costs in a new Kentucky market were nevertheless better than feared following a competitor's disappointing report last week. The Amerigroup and WellCare announcements were welcome news in a turbulent quarter for the managed-care sector. (Wall Street Journal)

- **Medicaid Health Plans of America Taps AmeriHealth Mercy Family of Companies CEO to Lead Its Board of Directors**

  The board of directors of Medicaid Health Plans of America (MHPA), the leading trade association solely focused on representing Medicaid health plans, appointed Mr. Michael A. Rashid, president and chief executive officer of the AmeriHealth Mercy Family of Companies, as their chairman. Mr. Frank Siano, vice president of business development, Medicaid, at Coventry Health Care will step into Mr. Rashid's former position of vice chair of MHPA's board. (MarketWatch)

## 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-May 2012 | Illinois Duals | RFP Released | 172,000 |
| May 18, 2012 | Kansas | Contract awards | 313,000 |
| May 25, 2012 | Ohio Duals | Proposals due | 115,000 |
| June 1, 2012 | Louisiana | Implementation (GSA C) | 300,000 |
| June 15, 2012 | Illinois Duals | Proposals due | 172,000 |
| June 20, 2012 | Florida CHIP | Contract awards | 225,000 |
| July 1, 2012 | New York LTC | Implementation | 200,000 |
| June 4, 2012 | Massachusetts Duals | Proposals due | 115,000 |
| July 1, 2012 | Arizona - Maricopa Behav. | RFP Released | N/A |
| July 1, 2012 | Washington | Implementation | 800,000 |
| July 1, 2012 | Hawaii | Implementation | 225,000 |
| July 1, 2012 | Florida | LTC RFP released | 90,000 |
| July 1, 2012 | Nebraska | Implementation | 75,000 |
| July 1, 2012 | Missouri | Implementation | 425,000 |
| July 1, 2012 | Virginia Behavioral | Implementation | 265,000 |
| July 15, 2012 | California (Central Valley) | Implementation | N/A |
| July 30, 2012 | Ohio Duals | Contract awards | 122,000 |
| July 30, 2012 | Massachusetts Duals | Contract awards | 115,000 |
| July 31, 2012 | Illinois Duals | Contract awards | 172,000 |
| July/August, 2012 | Georgia | RFP Released | 1,500,000 |
| September 1, 2012 | Pennsylvania | Implementation - New West Zone | 175,000 |
| September 20, 2012 | Ohio Duals | Contracts finalized | 115,000 |
| October, 2012 | Arizona - Maricopa Behav. | Proposals due | N/A |
| October 1, 2012 | Florida CHIP | Implementation | 225,000 |
| November, 2012 | Arizona - Acute Care | RFP Released | 1,100,000 |
| Late 2012 | New Hampshire | Implementation (delayed) | 130,000 |
| January, 2013 | Arizona - Maricopa Behav. | Contract awards | N/A |
| January, 2013 | Arizona - Acute Care | Proposals due | 1,100,000 |
| January 1, 2013 | Georgia | Contract awards | 1,500,000 |
| January 1, 2013 | Kansas | Implementation | 313,000 |
| January 1, 2013 | Florida | TANF/CHIP RFP released | 2,800,000 |
| January 1, 2013 | Ohio | Implementation | 1,650,000 |
| January 1, 2013 | Illinois Duals | Implementation | 172,000 |
| January 1, 2013 | Massachusetts Duals | Implementation | 115,000 |
| February 1, 2013 | Ohio Duals, NW, NC, EC | Implementation | 35,000 |
| March, 2013 | Arizona - Acute Care | Contract awards | 1,100,000 |
| Mid-late March 2013 | California Dual Eligibles | Implementation | 500,000 |
| March 1, 2013 | Pennsylvania | Implementation - New East Zone | 290,000 |
| April 1, 2013 | Ohio Duals, NE | Implementation | 32,000 |
| May 1, 2013 | Ohio Duals, C, WC, SW | Implementation | 48,000 |
| Spring 2013 | Arizona Duals | 3-way contracts signed | 120,000 |
| July 1, 2013 | Michigan Duals | Implementation | 211,000 |
| October 1, 2013 | Florida | LTC enrollment complete | 90,000 |
| January 1, 2014 | New York Duals | Implementation | TBD |
| January 1, 2014 | Arizona Duals | Implementation | 120,000 |
| January 1, 2014 | Hawaii Duals | Implementation | 24,000 |
| February 1, 2014 | Georgia | Implementation | 1,500,000 |
| October 1, 2014 | Florida | TANF/CHIP enrollment complete | 2,800,000 |

## DUAL INTEGRATION PROPOSAL STATUS

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

| State | Model | Duals eligible for demo | Released by State | Date | Submitted to CMS | Comments Due | Deadline for Plans to submit applications | 3-way contracts signed | Open enrollment ends | Enrollment effective date |
|---|---|---|---|---|---|---|---|---|---|---|
| **Arizona** | Capitated | 115,065 | X | 4/17/2012 | | | N/A[+] | Spring 2013 | N/A | 1/1/2014 |
| **California*** | Capitated | 800,000 | X | 4/4/2012 | | | 5/24/2012 | 9/20/2012 | 12/7/2012 | 1/1/2013 |
| **Colorado** | MFFS | 59,982 | X | 4/13/2012 | | | N/A | N/A | N/A | 1/1/2013 |
| **Connecticut** | MFFS | 57,568 | X | 4/9/2012 | | | N/A | N/A | N/A | 12/1/2012 |
| **Hawaii** | Capitated | 24,189 | X | 4/17/2012 | | | TBD | 7/1/2013 | TBD | 1/1/2014 |
| **Illinois** | Capitated | 172,000 | X | 2/17/2012 | X | 5/10/2012 | 5/24/2012 | 9/20/2012 | 12/7/2012 | 1/1/2013 |
| **Idaho** | Capitated | 17,219 | X | 4/13/2012 | | | N/A | 9/20/2012 | 12/7/2012 | 1/1/2014 |
| **Massachusetts** | Capitated | 109,636 | X | 12/7/2011 | X | 3/19/2012 | 5/24/2012 | 9/20/2012 | 12/7/2012 | 1/1/2013 |
| **Michigan** | Capitated | 198,644 | X | 3/5/2012 | X | 5/30/2012 | TBD | TBD | TBD | 7/1/2013 |
| **Minnesota** | Capitated | 93,165 | X | 3/19/2012 | X | 5/31/2012 | 5/24/2012 | 9/20/2012 | 12/7/2012 | 1/1/2013 |
| **North Carolina** | MFFS | 222,151 | X | 3/15/2012 | X | 6/1/2012 | N/A | N/A | N/A | 1/1/2013 |
| **New York** | Capitated | 460,109 | X | 3/22/2012 | | | TBD | TBD | TBD | 1/1/2014 |
| **Ohio** | Capitated | 122,409 | X | 2/27/2012 | X | 5/4/2012 | 5/24/2012 | 9/20/2012 | 12/7/2012 | 1/1/2013 |
| **Oklahoma** | MFFS | 79,891 | X | 3/22/2012 | X | 5/20/2012 | N/A | N/A | N/A | 7/1/2013 |
| **Oregon** | MFFS | 68,000 | X | 3/5/2012 | | | N/A | N/A | N/A | 1/1/2013 |
| **South Carolina** | Capitated | 68,000 | X | 4/16/2012 | | | TBD | 9/20/2012 | TBD | 1/1/2014 |
| **Tennessee** | Capitated | 136,000 | X | 4/13/2012 | | | TBD | TBD | TBD | 1/1/2014 |
| **Texas** | Capitated | 214,500 | X | 4/12/2012 | | | TBD | TBD | TBD | 1/1/2014 |
| **Virginia** | Capitated | 56,884 | X | 4/13/2012 | | | TBD | TBD | TBD | 1/1/2014 |
| **Vermont** | Capitated | 22,000 | X | 3/30/2012 | | | TBD | TBD | TBD | 1/1/2014 |
| **Washington** | Capitated | 115,000 | X | 3/12/2012 | X | 5/30/2012 | 5/24/2012 | 9/20/2012 | 12/7/2012 | 1/1/2013 |
| **Wisconsin** | Capitated | 17,600 | X | 3/16/2012 | X | 5/26/2012 | 5/24/2012 | 9/20/2012 | 12/7/2012 | 1/1/2013 |

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

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

## HMA RECENTLY PUBLISHED RESEARCH

### Webcast: Proven Steps to Clinical Efficiency

**Sharon Silow-Carroll, Managing Principal**

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

## UPCOMING HMA APPEARANCES

### National Patient Advocate Foundation - Spring 2012 Policy Consortium: Is There Enough to Go Around? States Feel the Financial Crunch

**Matt Powers, Presenter**

*May 9, 2012*

*Washington, D.C.*

### 19th Annual Princeton Conference: States' Role in Health Care Reform: Possibilities to Improve Access and Quality – Medicaid: Current and Future Challenges

**Kathy Gifford, Presenter**

*May 23, 2012*

*Princeton, New Jersey*

### *Princeton, New Jersey* 19th Annual Princeton Conference: States' Role in Health Care Reform: Possibilities to Improve Access and Quality – How Are States Progressing in Setting up State-Based Exchanges?

**Jennifer Kent, Presenter**

*May 24, 2012*

*Princeton, New Jersey*

### AcademyHealth Annual Research Meeting – The Impact of the ACA on State Policy: Early Findings

**Jennifer Edwards, Panel Facilitator**

*June 25, 2012*

*Orlando, Florida*

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

**Joan Henneberry, Panel Facilitator**

*June 25, 2012*

*Orlando, Florida*