HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: OHIO DUAL ELIGIBLE INTEGRATION RFP

HMA ROUNDUP: PENNSYLVANIA ANNOUNCES MEDICAID MCO EXPANSION AWARDS; FLORIDA MANAGED LTC ATTRACTS LOIS; ILLINOIS GOV. PROPOSES MEDICAID BUDGET REDUCTIONS

OTHER HEADLINES: WASHINGTON, D.C. ISSUES MEDICAID MCO RFP; KANSAS LAWMAKERS IN PUSH TO DELAY DEVELOPMENTALLY DISABLED ENROLLMENT IN MEDICAID MCOS; NEW HAMPSHIRE FURTHER DELAYS MCO AWARD ANNOUNCEMENT; STATES MAY TURN TO SPECIAL SESSION FOR EXCHANGE LEGISLATION

DUALS CALENDAR UPDATED: HAWAII ADDED

APRIL 25, 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

ATLANTA, GEORGIA • AUSTIN, TEXAS • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS • COLUMBUS, OHIO
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
OAKLAND, CALIFORNIA • SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

Edited by:
Gregory Nersessian, CFA
212.575.5929
gnersessian@healthmanagement.com

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

IN FOCUS: OHIO RELEASES DUAL ELIGIBLE INTEGRATION RFA

This week, our In Focus section reviews the Ohio Integrated Care Delivery System Demonstration (ICDS) Request for Applications (RFA), released on Tuesday, April 24, 2012 — the first of three dual integration RFPs we expect to be released in the coming weeks, along with Massachusetts and Illinois. This solicitation comes on the heels of Ohio's controversial Medicaid managed care awards announced earlier this month. We reviewed the state's proposal, issued for public comment, in our February 29, 2012 Weekly Roundup.

RFA Requirements

The RFA lays out several mandatory requirements that must be met for the state and CMS to consider an application. Specifically, an applicant must:

- Be a current Ohio Medicaid managed care plan or, as a company or part of a corporate family, serve at least 100,000 lives across all lines of business and all states.
- Currently maintain an approved Medicare Advantage Plan contract with CMS in at least one state.
- Have submitted a non-binding notice of intent to apply (NOIA) to CMS by April 2, 2012. Details on the NOIA were contained in a CMS memo issued January 25, 2012.
- Meet all requirements set forth in the March 29, 2012 CMS memo providing additional guidance. We reviewed this CMS memo in our April 4, 2012 Weekly Roundup. Among other criteria, this round of guidance set forth exclusions for plans with low performance ratings.
- Meet minimum electronic data interchange (EDI) experience requirements, as detailed in the RFA.

Target Population

The State has targeted implementation for seven regions of three to five counties each. In all, these seven regions encompass 122,409 out of a total 196,369 dual eligible enrollees statewide. The target population is limited to full benefit dual eligible enrollees — individuals eligible for the Medicare Savings Program are excluded. Additionally, the following dual eligible populations will be excluded as well:

- Dual eligibles with intellectual disabilities (ID) and other developmental disabilities (DD) served through an IDD 1915(c) HCBS waiver or an ICF-IDD. However, those ID and DD dual eligibles not served under a waiver may opt into the ICDS program.
- Dual eligibles enrolled in the Program for All-Inclusive Care for the Elderly (PACE).
- Dual eligibles under the age of 18.

Market Opportunity

In our initial write-up of Ohio's proposal, we provided the state's preliminary analyses of Medicaid spending for the ICDS target population —an estimated $3.7 billion in FY 2011. This equates to a Medicaid PMPM of roughly $2,500. The inclusion of Medicare benefits will add significantly to the total spending for this population.

Current Medicaid Market

As we reported in the previous two weeks, Ohio announced Medicaid managed care awards earlier this month. Of the incumbent plans listed in the table below, Molina, Centene, WellCare and Amerigroup were not awarded new contracts. These four plans represent a sizeable portion of current Medicaid managed care enrollment, serving more than 550,000 out of 1.6 million total Medicaid lives. WellCare, Centene, and Molina also operate Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) in Ohio, which would position them well to apply to serve the broader dual eligible population.

Ohio Medicaid Managed Care Plans	Enrollment (Dec. 2011)	Market Share
CareSource	865,430	52.8%
Molina	246,503	15.0%
Buckeye/Centene	158,491	9.7%
Unison/UnitedHealth	119,259	7.3%
WellCare	100,529	6.1%
Paramount	93,835	5.7%
Amerigroup	55,107	3.4%
Total	**1,639,154**	

Source: Ohio Department of Job and Family Services

Six of the seven selected regions have at least four Medicare Advantage plans currently serving enrollees. The seventh region has at least three plans. All eligible Medicare-Medicaid enrollees in the seven regions will be enrolled in the ICDS program beginning January 1, 2013.

Ohio Dual Eligible Special Needs Plans	Enrollment (Feb. 2012)	Market Share
UnitedHealthcare	9,382	74.2%
CareSource	1,221	9.2%
WellCare	1,110	8.8%
Centene	761	6.0%
Humana	113	0.9%
Molina	55	0.4%
Total	**12,642**	

Source: CMS

Scoring Criteria

The scoring criteria included in the RFA and described in the table below highlight the importance of meeting CMS requirements. Included in the mandatory criteria are the state requirements noted above and the requirements put forth by CMS in the January and March 2012 guidance memoranda.

Application Criteria	Max. Points	%
Applicant Information & Attestation/Acknowledgement	Mandatory	-
Applicant's Contract/Compliance Experience	20,000	20%
Clinical Performance	25,000	25%
Care Coordination	30,000	30%
Provider Relations and Incident Management	5,000	5%
Innovative Payment Methods	20,000	20%
Total	**100,000**	**100%**

RFA Timeline

Each interested plan must have already submitted a non-binding notice of intent to apply (NOIA) to CMS by the April 2, 2012 deadline and begun to prepare its Medicare Advantage submission, either by itself or in partnership with a Pharmacy Benefit Manager (PBM) in order to fulfill all critical Part D requirements, including a formulary, Medication Therapy Management Program (MTMP), a pharmacy network, and a Part D package. If an interested Applicant did not submit a NOIA to CMS by April 2, 2012, it will not be eligible to participate in the ICDS program in 2013.

RFA Timeline	Date
RFA Released	April 24, 2012
Deadline for online Q&A submission	May 1, 2012
Letter of Intent (LOI) due	May 14, 2012
RFA Responses due	May 25, 2012
Applicants submit benefit package to CMS	June 4, 2012
Notification of scoring results	June 18, 2012
Deadline to file protest	July 2, 2012
Three-way contracts signed	September 20, 2012
Enrollment implementation begins	January 1, 2013

HMA Medicaid Roundup

Florida

HMA Roundup – Gary Crayton

The following plans submitted letters of intent to apply for the Medicaid managed long-term care RFP. As noted in the table, these LOIs are non-binding.

SMMC LTC Program Non-Binding Letters of Intent		Regions of Interest										
Plan Name	Letter Of Intent Submitted	1	2	3	4	5	6	7	8	9	10	11
Aetna Better Health	4/18/2012	√		√			√	√	√			
American Eldercare	3/26/2012	√	√	√	√	√	√	√	√	√	√	√
Amerigroup	3/27/2012	√	√	√	√	√	√	√	√	√	√	√
AvanteGroup	4/11/2012			√	√			√		√		
Brevard Alzheimer's Foundation Inc.	4/18/2012							√				
Catholic Health Services	4/11/2012										√	√
Ganot Capital LLC	4/11/2012			√	√			√	√	√	√	
Florida Healthcare Plus, Inc.	4/14/2012						√	√				√
Humana	4/16/2012	√	√	√	√	√	√	√	√	√	√	√
Miami Jewish Health Systems	4/3/2012										√	√
Molina	4/18/2012	√			√	√	√	√		√	√	√
Neighborly Care Network	3/29/2012					√	√	√		√	√	√
Prestige Health Choice	4/11/2012						√		√			√
Simply Healthcare	4/17/2012	√	√	√	√	√	√	√	√	√	√	√
Sunshine State Health Plan	3/28/2012	√	√	√	√	√	√	√	√	√	√	√
Tri-County Life Care	4/3/2012							√		√	√	
Universal	3/23/2012				√	√	√	√	√	√	√	√
United	4/16/2012	√	√	√	√	√	√	√	√	√	√	√
WellCare	3/30/2012	√	√	√	√	√	√	√	√	√	√	√
Worldnet Services Corp.	4/18/2012	√			√			√				√

Source: AHCA

In the news

- **Health plans line up for new Florida Medicaid system**

  Preparing for Florida's shift to a statewide Medicaid managed-care system, 20 health companies and organizations are interested in competing for contracts to serve seniors who need long-term care. Potential bidders faced a deadline last week to submit non-binding letters of intent that signaled their interest in the long-term care program, as the state Agency for Health Care Administration gets ready to move forward with a lengthy contracting process. Those expressing interest ranged from major managed-care industry players, such as Humana and WellCare, to smaller regional organizations, such as Brevard Alzheimer's Foundation Inc., and Miami Jewish Health Systems. The list of potential bidders only reflects health plans interested in the long-term care portion of a statewide managed-care system. AHCA has not sought similar letters of

intent for plans hoping to serve the broader Medicaid population, such as children and women. (News-Press)

- **Budget would delay statewide Medicaid managed care for dentistry**

  The state budget and an implementing bill signed this week by Gov. Rick Scott would delay the phasing in of Medicaid managed care plans for dentistry, but Scott made clear he would support the plans in the future. The language would require the agency to continue allowing dentists to bill for Medicaid patients under the traditional fee-for-service system in areas outside Miami-Dade County, but would expire in July 2013. The Agency for Health Care Administration announced it was delaying the statewide implementation of the managed care system after the language was approved by the Legislature. (The Florida Current)

- **Jackson Health System reveals a few details on strategic plan**

  In the midst of the largest layoffs in Jackson Health System's 94-year history, the new chief strategy officer offered some thoughts Thursday to the governing board on ways to create revenue for the troubled system — while county commissioners demanded a closed-door meeting to hear specifics. Jeffrey Crudele, who took over the strategy job two weeks ago after the sudden death of Donn Szaro, gave board members timetables for some ideas — such as hiring 100 primary care physicians in the next three years — but he said that these were just initial thoughts, not a complete strategic plan. (Miami Herald)

Illinois

HMA Roundup – Jane Longo / Matt Powers

Governor Quinn released his Medicaid budget proposal late last week, seeking to close a $2.7 billion budget gap that has forced delayed payments to providers. The Governor's budget includes the following savings, cuts, and additional revenues:

- Cuts, reductions and efficiencies totaling $1.35 billion
- Rate reductions to providers totaling $675 million
- A $1 per pack increase in the cigarette tax totaling $337.5 million
- Federal matching funding from the increased cigarette tax totaling $337.5 million

The Illinois Department of Health and Family Services (HFS) posted a notice on Friday, April 20, 2012, regarding the Phase I Care Coordination project. Due to budgetary constraints, HFS will limit contracts to no more than ten organizations in Cook County, and no more than ten organizations outside of Cook County. There were a total of 75 LOIs received by the state from providers and other organizations seeking to become care coordination entities (CCEs) or managed care coordination networks (MCCNs) to serve the Medicaid seniors and persons with disability (SPD) population. Further, the state will not be including Medicare shared savings for those SPD enrollees who are dual eligible. Last, the deadline for CCE and MCCN applications has been delayed from May 25, 2012 to June 15, 2012. The limit on the total number of CCE and MCCN organizations selected

and the exclusion of Medicare shared savings from CCE and MCCNs may cause many organizations that submitted an LOI to drop out of the procurement.

Illinois Care Coordination and Budget Timeline – Key Dates and Milestones

Date	Care Coordination	Budget/Medicaid Cuts
January 2012	***Phase I RFP Released*** Complex Adults, no MCOs	
February 2012	75 LOIs received	***Gov. Address, Feb. 22.*** Call for $2.7B in Medicaid cuts.
March 2012		HFS released menu of possible cuts and associated savings.
April 2012	***Phase I RFP Delayed*** ***Dual Integration RFP*** To be released April 30 (tentative) ***Phase II RFP Release*** Complex Children	***Gov. Budget Proposal*** April 19, 2012
May 2012		Legislative Scheduled Session ends May 31, 2012
June 2012 through August 2012	***Phase I RFP Due June 15, 2012*** ***Dual Integration RFP Winners*** To be announced July 1, 2012 ***Medicaid MCO RFP*** 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*** Go live January 1, 2013 ***Medicaid MCOs*** Depends on possible delay	

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

In the news

- **Coordinated care program aims to save Medicaid millions**

  Funded solely through a charitable grant from Chicago's Comer Science and Education Foundation and launched at the end of February, the Medical Home Network focuses primarily on low-income women and children who seek medical attention in emergency rooms and return home, often with no medical follow-up and limited understanding of how to use the health care system. Those savings, applied across about 170,000 patients in Chicago's South and Southwest sides covered by a new program called the Medical Home Network, could amount to up to $22 million in 2012, officials said. While merely a ripple in the state's nearly $15 billion in annual Medicaid spending, Illinois officials are watching the nonprofit program closely, hoping the results point the way to more coordinated and efficient care across the state. (Chicago Tribune)

New York

HMA Roundup – Denise Soffel

MLTC Rate-Setting

The NYS Office of Long-Term Care provided a briefing on managed long term care (MLTC) mandatory enrollment, rate-setting and risk corridors. The rate-setting process is bifurcated between those currently enrolled in MLTC plans and those who are newly enrolling. For individuals currently enrolled in an MLTC plan the rate-setting process is unchanged. Rates are based on regional prices that are then risk-adjusted. The assessment score of each individual member of a plan are cumulated to generate an acuity score that is specific to that plan. This year's rates should be out in a couple of weeks. For new populations that will be subject to the mandatory enrollment, both those that are nursing home certifiable and for those that are not, the state is working with Mercer to develop new rates. They expect to complete this by July 1. For all new enrollments (post-January 1, 2012), the state will apply a rate corridor to mitigate risk to plans. They recognize that a large new population will be coming into the MLTC system, and do not think the experience of the current population is sufficient to establish rates with the necessary degree of confidence. The rate corridor is being structured with both an upside and a downside: the state will share both gains and losses. The state describes it as a prudent plan. They recognize that large numbers of people will be entering the MLTC program who are new to the system, and for whom no assessment scores exist. Since they have no clear picture of the people who will be moving into the program they are establishing the risk corridors to allow for a smooth launch of the risk bearing model. They have assured the MLTC plans that they will stay afloat during this transition. As MLTCs generate cost efficiencies, savings will be returned to the state. The risk corridors will stay in place for one year, and then will be re-evaluated.

NYS describes the MLTC program as a mature program. The mandatory program will lead to a tripling of the size of its business, talking it from a $1.5 billion program to a $5 billion program. They also noted that enrollment into MLTC plans has risen significantly in the last several months, to about 3,000 new enrollments per month.

NYS recognizes that this is a significant change for Medicaid beneficiaries. They are working to develop strategies to provide meaningful consumer information to beneficiaries, but acknowledge significant resource restraints limit what they can do.

Nursing Home Benefit and Mandatory Enrollment

Medicaid enrollees residing in nursing homes have been excluded from enrollment into a managed care plan. Ending that exclusion, originally planned for October 2012, has been delayed, probably until October 2013. Mandatory enrollment of Medicaid-only (not dual-eligible) beneficiaries residing in nursing homes into mainstream Medicaid managed care plans will not begin until then. Ending the nursing home exclusion is part of the state's move to add long-term care services into the Medicaid managed care benefit. Personal care was moved into the benefit in 2011; nursing home care will be moved over in 2013. Once the nursing home benefit is moved into the managed care plan benefit, Medicaid beneficiaries residing in a nursing home will be required to select a managed care plan. Further, Medicaid beneficiaries enrolled in a mainstream Medicaid managed care plan

who experience a need for nursing home care will have to obtain that care through their managed care plan, and use a facility that is part of their plan's network.

In the news

- **NY audits fault $42 million in Medicaid payments**

  State auditors say data problems and information delays at New York's Medicaid claims processing system have caused $36 million in improper payments and another $6.3 million in overpayments. State Comptroller Thomas DiNapoli said Wednesday that $3.2 million has been recouped and the health department says it has changed practices. An audit of Medicaid managed care plans for three years, examining premium payments for "dual-eligible" enrollees who are also in Medicare or other federal programs, says there were unnecessary payments on behalf of 45,000 people due to delays in posting Medicare data and then removing those people from managed care plans. A second audit noted actual and suspected overpayments during six months when eMedNY processed approximately 174 million claims resulting in payments to health care providers of about $25 billion. (Wall Street Journal)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Successful bidders in the state's Medicaid managed care expansion were announced at the Medical Assistance Consumer Subcommittee today, Wednesday, April 25. Successful bidders to serve lives in the New West region, implementation September 1, 2012, are AmeriHealth, Gateway, UPMC, and Coventry. Successful bidders in the New East region, implementing March 1, 2013, are AmeriHealth, Geisinger, and Coventry.

We also note that a "dual demonstration initiative" is also on the agenda for a Thursday, April 26 meeting. Up until now, Pennsylvania has not made public any intention to participate in the dual eligible demonstration initiative for either 2013 or 2014.

OTHER HEADLINES

Arkansas

- **Ark. set to roll out Medicaid changes in July**

  State officials say they're on track for a July launch of an effort to change the way Arkansas's Medicaid program pays for services. Department of Human Services Director John Selig, state Medicaid Director Andy Allison and Surgeon General Joe Thompson on Thursday updated lawmakers on the state's Medicaid payment reform initiative. The state plans on moving from a fee-for-service model to one where it pays for "episodes" of care rather than each individual treatment. The state will begin rolling out the reforms in six areas in July. (Today's THV)

California

- **Los Angeles Is Betting On One Crusading Doc To Turn Public Health System Around**

  Kaiser Health News profiles Dr. Mitch Katz, director of the Los Angeles County's Department of Health Services. Katz oversees LA's public hospitals and clinics, the health care of last resort for millions of low-income Angelenos. He has 22,000 employees and a $3.7-billion dollar budget. Los Angeles, the nation's second largest city with some 2 million uninsured residents, has long had one of the most disorganized systems. (Kaiser Health News)

- **California To Overhaul 30-Year-Old Medicaid Computer System**

  California is developing a complex computer system, called Health Enterprise, to replace the system that currently handles Medi-Cal billing, according to a letter from State Auditor Elaine Howle, Capitol Weekly reports. Affiliated Computer Services -- the contractor handling MMIS -- will develop the new system under its current $1.7 billion contract with the state, which runs until at least 2016. (iHealthBeat)

- **Analysis says Calif. prison medical costs too high**

  As the state prepares to resume control of inmate medical care, it must find ways to reduce costs that are triple the national average, the nonpartisan Legislative Analyst's Office said Thursday. The federal receivership that has been in place since 2006 has greatly improved the medical care of state prison inmates but also has caused costs to soar, according to the report. California spends $16,000 per inmate for health care services, compared to an average of $5,000 in other states. The analysis was released less than two weeks before the state and attorneys representing inmates must report to a federal judge with recommendations on when the receivership should end and whether it should maintain some oversight role. (Fresno Bee)

Colorado

- **House Approves Bill Aimed At Overhauling Colorado's Medicaid System**

  The House gave initial approval to a bill aimed at overhauling Colorado's Medicaid payment system. Under the bill Medicaid payers and the state health department will create pilot programs to restructure the payment system. (CBS Denver)

District of Columbia

- **D.C. seeks bids for new Medicaid contract**

  The Department of Health Care Finance on Tuesday issued a request for proposals to solicit bids for the District's Medicaid and HealthCare Alliance programs. The RFP seeks three contractors to take over the programs beginning May 2013, and it adds one additional contractor for the last year of the current contract, which begins May 1. The D.C. Council is currently deciding whether to extend the contracts for the two existing companies. Current contractor D.C. Chartered Health Plan Inc. has managed the majority of D.C.'s Medicaid patients for more than a decade. Chartered's D.C. Healthcare Systems Inc. is currently owned by Jeffrey Thompson, whose home and office were raided in March as part of a federal corruption investigation into campaign contributions. Sources have said Chartered will not win a new managed care contract if Thompson remains owner or remains connected to the company. The other contractor, UnitedHealthcare Community Plan, has shown increasing losses since 2008, its first full year administering insurance plans on behalf of the District, prompting questions as to whether it will bid for the job in the future. (Washington Business Journal)

Kansas

- **Kansas House majority leader plans to seek delay of Medicaid reform for developmentally disabled**

  Lawmakers say that House Majority Leader Arlen Siegfreid plans to try to delay including services for people with developmental disabilities in Gov. Sam Brownback's plan to contract with insurance companies to manage Medicaid services. The move would be one of several attempts by lawmakers to delay or remove services for people with developmental disabilities, such as autism and Down syndrome, from inclusion in the KanCare system. Democratic and Republican lawmakers believe the majority leader's proposal will be accepted and added to the budget being debated this week. The budget proviso would delay inclusion of long-term services for people with developmental disabilities in Brownback's Medicaid makeover until January 2014. (The Wichita Eagle)

Louisiana

- **Audit finds more problems with Louisiana Medicaid home-care programs**

  Home health services financed by the Louisiana Medicaid program remain plagued by claims fraud and other personnel problems, this time centered on workers who are related to their patients, according to a recent analysis by state auditors. Legislative Auditor Daryl Purpera's office last year documented six years of irregularities that resulted in $4.32 million in improper payments to Medicaid vendors who provide in-home and community-based care to elderly and disabled patients. The new follow-up audit involves 2010 claims from 25 workers. All the cases involved patients that had family members serving as their direct-care provider. (NOLA.com)

Minnesota

- **Minn. to give feds $15M in Medicaid cash**

  The state of Minnesota has agreed to share with the federal government about half of a controversial $30 million payment from the HMO, UCare. The decision is a reversal from the state's long-held position that the money was a donation and the state could keep all $30 million. That position has prompted inquiries from Congress, and a joint hearing on Minnesota's Medicaid program is scheduled for later this week. (Minnesota Public Radio)

Missouri

- **Medicaid chief says suit could devastate**

  Missouri's Medicaid chief fears a "nuclear scenario" of "mass confusion" and "turmoil" if a judge blocks the state's new Medicaid insurance plans for which hundreds of thousands of low-income residents can begin enrolling today, according to a deposition obtained by The Associated Press. The two-month open-enrollment period for the Medicaid managed care program is proceeding as planned, despite a lingering lawsuit from a spurned insurer seeking to halt registration and re-start bidding for the $1.1 billion of contracts. A hearing on a preliminary injunction request is scheduled for April 27, and coverage under the revised insurance plans is scheduled to begin July 1. In a deposition obtained by the AP, MoHealthNet Division Director Ian McCaslin warned of dire consequences if the lawsuit is successful and the judge grants an injunction. (Columbia Tribune)

New Hampshire

- **Council puts off Medicaid contract vote**

  The vote to contract out New Hampshire's Medicaid program was delayed again last week, as the state's executive councilors sought more assurances that providers of long-term care will have a say in how the new system is implemented. The five-member, all-Republican council tabled the bill for a second time after putting off a vote last month to take more time to review the contracts, which would be among the largest in the state's history. The state is prepared to pay three private organizations a combined $2.2 billion over three years to manage care for all of its Medicaid populations. (Concord Monitor)

New Jersey

- **Healthcare Reform Changing How NJ Will Receive Medicaid Dollars**

  New Jersey hospitals will see major changes in funding regulations in 2014, when the federal government plans to change how it delivers Medicaid dollars. Funding will be distributed based on how efficiently hospitals deliver care and the quality of that care. Initially up for grabs is the $128.3 million in annual federal Medicaid matching dollars for two programs -- graduate medical education, which helps fund residency programs to train doctors, and the Hospital Relief Subsidy Fund, which subsidizes costly programs such as HIV/AIDS and tuberculosis care. (NJ Spotlight)

Texas

- **CHOP, partner in talks to build an outpost in San Antonio**

  Children's Hospital of Philadelphia is in talks to build an outpost in San Antonio, Texas, in partnership with publicly traded Vanguard Health Systems Inc., a Tennessee company that owns the Baptist Health System in that city. Children's and Vanguard Health are expected within 60 days to complete a formal proposal for University Health System and the University of Texas Health Science Center, a hospital and medical school in San Antonio that for years have been exploring options for creating a comprehensive children's health-care network for that metropolitan area. (Philadelphia Inquirer)

National

- **Medicaid Fraud to Get Scrutinized**

  With the federal government trying to cut costs and crack down on fraud, a congressional panel this week will set its sights on the Medicaid program, which last year paid out nearly $22 billion in error or fraudulent claims. The April 25 hearing from the House Oversight and Government Reform Committee is just the latest in a series that Congress has had recently targeting federal program that have high "error rates" in payments, such as Medicaid. These errors can be outright fraud or clerical mistakes that ended up costing the federal government $115 billion last year. (Stateline)

- **10 States With Medical Loss Ratio Requirements for Medicaid MCOs**

  Currently, under the Patient Protection and Affordable Care Act, all health insurers must meet a medical loss ratio requirement, which is the amount of total revenue an insurer must spend on patient care and quality improvement as opposed to administrative costs and profits. Health insurers in large group markets must meet the MLR standard of 85 percent, while small group and individual market insurers must have an MLR of 80 percent. Here are the 10 states that have MLR requirements for Medicaid MCOs, with the MLRs in parenthesis: Arizona (84 percent); Hawaii (91.5 percent or 93 percent, depending on the plan); Illinois (80 percent); Indiana (85 percent); Maryland (85 percent); New Jersey (80 percent); New Mexico (85 percent); Ohio (85 percent); Virginia (92 percent); Washington (80 percent). (Becker's Hospital Review

- **Health Exchange Special Sessions Could Be Called**

  Some statehouses could reopen in the fall if the U.S. Supreme Court upholds most or all of the Affordable Care Act (ACA) this summer. With about half of states not taking action on their state health insurance exchanges before the court rules, legislators might be forced to return to their state capitols for special sessions to complete work on the online marketplaces. Officials in North Dakota, Tennessee and Virginia confirmed to *Governing* that the possibility of a special session has been floated in those states. Given these early examples, it seems the idea could become popular among Republican-controlled states that want to avoid having a federal-run exchange. (Governing Magazine)

- **States' Revenues Rise Above Peak Levels after Two Straight Years of Growth**

  States' tax collections grew for the eighth straight quarter at the end of 2011, for the first time topping peak revenue levels seen at the beginning of the Great Recession, according to Rockefeller Institute research and Census Bureau data. States' tax revenues grew by 3.6 percent in the fourth quarter of 2011 compared to a year ago. The gains were 3.0 percent and 7.4 percent higher than during the same quarters of 2007 and 2008, respectively. Nonetheless, tax collections in 17 states remain lower in the final quarter of 2011 than they were four years before. (Rockefeller Institute)

COMPANY NEWS

- **Liazon Secures $18.2m for Expansion and New Products**

  Liazon, a private health benefits exchange, has closed $18.2 million in new funding to expand nationwide and develop new products. Bessemer Venture Partners and Fidelity Biosciences led the round with follow-on funding from existing investors Bain Capital Ventures and Rand Capital, SBIC. Founded in 2007, Liazon has offices in Buffalo, N.Y., New York City and Waltham, MA. (PE Hub)

- **Veritas Capital to Buy Healthcare Unit from Thomson Reuters in $1.25 Bln Deal**

  Thomson Reuters said Monday that it has agreed to sell its healthcare business to Veritas Capital in a deal valued at $1.25 billion. The transaction, subject to regulatory approval, is execpted to close in the next few months. The Healthcare business provides data, analytics and performance benchmarking solutions and services to hospitals, health systems and employers. Veritas has obtained financing for the deal. Morgan Stanley and Allen & Co. advised Thomson Reuters. (PE Hub)

- **H.I.G. Growth Partners' Co Acquires South Bay Mental Health Center**

  H.I.G. Growth Partners' portfolio company, Community Intervention Services has completed the acquisition of South Bay Mental Health Center. Headquartered in Brockton, MA, South Bay was founded by Dr. Peter Scanlon in 1986 as a single facility focused on delivering outpatient mental health services to children and families. (PE Hub)

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
Late April	Pennsylvania	Contract awards	465,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 27, 2012	Massachusetts Duals	RFP Released	115,000
April 30, 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	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
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
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	Date	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	4/11/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Idaho	Capitated	17,219	X	4/13/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	2/16/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Michigan	Capitated	198,644	X	3/5/2012			5/24/2012	TBD	TBD	7/1/2013
Minnesota	Capitated	93,165	X	3/19/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
North Carolina	MFFS	222,151	X	3/15/2012			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	4/2/2012	5/25/2012	9/20/2012	12/7/2012	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012			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			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Wisconsin	Capitated	17,600	X	3/16/2012			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 while using resources as effectively as possible. Bill Santamour of Hospitals & Health Networks (H&HN) talks with Sharon Silow-Carroll of Health Management Associates (HMA) 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)**

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)**

Upcoming HMA Appearances

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