HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: KEY TAKEAWAYS FROM NASBO SPRING 2012 STATE FISCAL SURVEY

HMA ROUNDUP: SCOTUS TO ANNOUNCE ACA DECISION TOMORROW; CALIFORNIA TO VOTE ON BILLS FINALIZING BUDGET CUT IMPLEMENTATION; ILLINOIS ANNOUNCES DUALS RFP BIDDER LIST; AETNA, AMERIGROUP LAWSUITS HALT OH MCO CONTRACT IMPLEMENTATION; OHIO TO ANNOUNCE DUALS RFP SCORING BY END OF MONTH; PENNSYLVANIA NEARS VOTE ON BUDGET

OTHER HEADLINES: KANSAS AWARDS MCO CONTRACTS TO AMERIGROUP, CENTENE, UNITED; FLORIDA PRISON HEALTH PRIVATIZATION FATE UNCERTAIN; OREGON CMS WAIVER NEGOTIATIONS NEAR END

JUNE 27, 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
BAY AREA, 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: KEY TAKEAWAYS FROM NASBO SPRING 2012 STATE FISCAL SURVEY

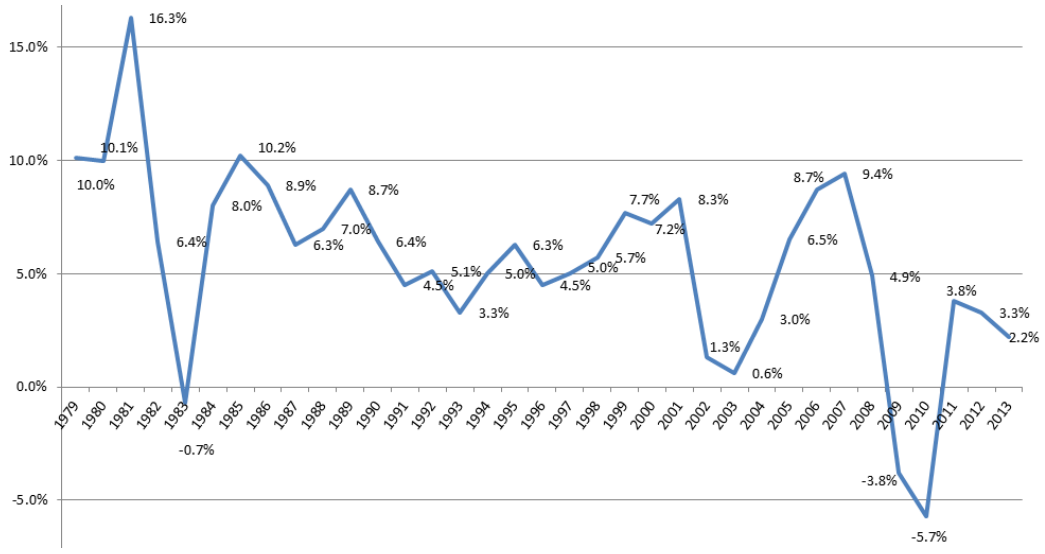
This week, our *In Focus* section highlights some of the key findings of the Spring 2012 *Fiscal Survey of the States*, released June 13, 2012 by the National Governors Association (NGA) and National Association of State Budget Officers (NASBO). Surveys of state budget officers in all 50 states were conducted in March and April 2012. The results in the report focus on the key determinants of state fiscal health – general fund receipts, expenditures, and balances, or "rainy day funds." The report highlights data and state-by-state budget actions by area of spending. Below we summarize the major takeaway points from the report, as well as highlight key findings on Medicaid-specific and other health care budget items. Additionally, we provide a summary table (pg. 5) with many of the state-by-state data items discussed below.

Overall Takeaways

Based on NASBO's survey and evaluation of state governors' recommended budgets, it appears that state fiscal conditions are generally improving, but that states have still not recovered from the fiscal crisis of the past few years.

- Governors' recommended budgets show an overall increase in both general fund expenditures and revenues in FY 2013. However, states may be cautious about the strength of economic recovery.
- While aggregate state revenues will likely be above their pre-recession levels in FY 2013, total general fund (GF) spending will not surpass pre-recession levels.
- FY 2013 will be the third consecutive year of nominal spending increases, following back-to-back declines in GF spending in FY 2009 and FY 2010. However, in the chart below, nominal spending increases have decreased over the past three years on a percent basis.

State Nominal Annual Budget Increases, FY 1979 to FY 2013



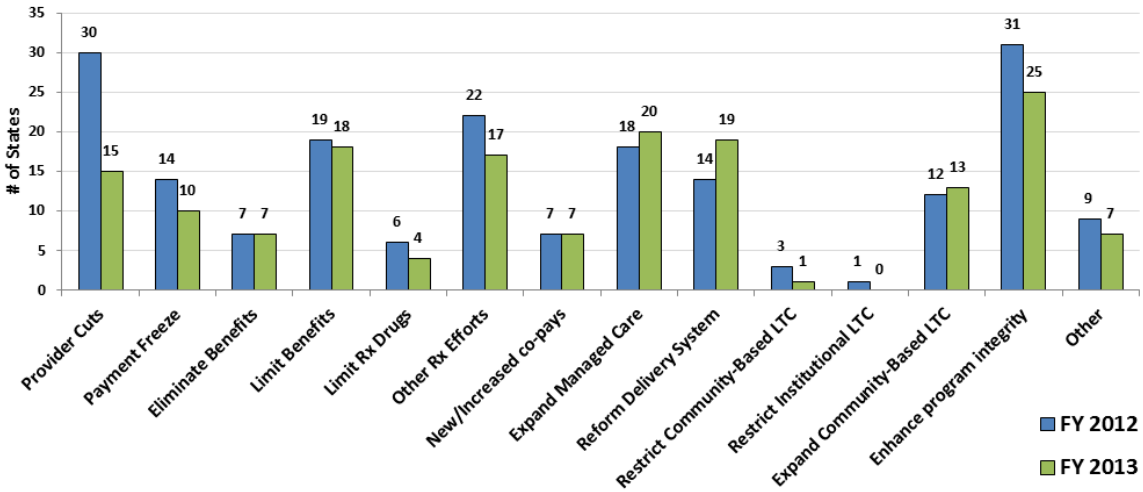
- Twenty-five states are still forecasting lower GF spending in FY 2013 as compared to FY 2008. However, governors in 39 states are recommending higher GF spending in FY 2013 versus FY 2012, a positive sign.
- Twenty-three states are projecting FY 2013 GF revenues still below FY 2008 levels.
- NASBO concludes that state revenue improvement has not been enough to meet the rising demand for state services and spending. States have faced a combined $146.3 billion budget gap in FY 2011 and FY 2012.
- Nineteen states forecast a combined $30.6 billion in budget gaps for FY 2013 so far.

Medicaid-Specific Takeaways

Medicaid represents a significant portion of state GF spending (17.4 percent in FY 2011) and presents a challenge to states in times of fiscal stress when state revenue is down and Medicaid enrollment rises. In the wake of the financial crisis, the federal government provided a significant injection of additional Medicaid funding to states through the American Recovery and Reinvestment Act (ARRA). However, federal spending on Medicaid declined rapidly in the last year due to the expiration of enhanced ARRA matching rates for Medicaid.

- State spending on Medicaid increased by 20.4 percent in FY 2012, while federal spending decreased 8.2 percent.
- Governors' proposed budgets for FY 2013 project a slower rate of growth in state Medicaid spending at 3.9 percent. However, Medicaid spending growth still outpaces overall GF spending growth.
- In both FY 2012 and FY 2013, states have taken or are planning to take various actions to contain Medicaid costs, including provider payment cuts, limiting benefits, delivery system reforms, expanded Medicaid managed care, and enhanced program integrity efforts.

FY 2012 & Proposed FY 2013 Budgetary Actions Aimed at Containing Medicaid Costs



- There is good news for providers, as only 15 states have proposed provider rate cuts in FY 2013, compared to 30 states in FY 2012. In general, FY 2013 proposed Medicaid cost savings represent a transition away from rate cuts and benefit limits, toward long-term strategies such as managed care expansions, delivery system reforms, and program integrity measures.

State budgetary actions aimed at containing Medicaid costs in proposed FY 2013 budgets include:

- **California**: provider taxes, dual eligible demonstration, elimination of some hospital supplemental payments, and transitioning CHIP to Medicaid;
- **North Carolina**: prior authorization for some services;
- **Pennsylvania**: premium rate increase for workers with disabilities;
- **Utah**: pursuing Medicaid Accountable Care Organizations (ACOs);
- **Washington**: prescription drug formulary changes, new or higher prescription drug copayments, expanded managed care, pursuing care coordination.

In proposed FY 2013 budgets, many states are also looking at new revenue sources to fund Medicaid:

- **Massachusetts**: proposed increase in tobacco tax;
- **Illinois**: passed $1 per pack cigarette and tobacco tax (passed after publication of NASBO report);
- **Missouri**: implementing long-term care upper payment limit;
- **Texas**: 1115 Waiver, approved December 2011, allows regional improvements and ability to leverage local funds in the Medicaid program.

The NASBO Report, *The Fiscal Survey of States, Spring 2012*, is available from NASBO's website, at: http://nasbo.org/sites/default/files/Spring%202012%20Fiscal%20Survey.pdf

Selected State-by-State Data From NASBO Report – FY 2012 to FY 2013

	General Fund Nominal % Expenditure Change		FY 2012 Mid-Year Medicaid Cuts	FY 2013 Medicaid Program Adjustment (Recommended)	FY 2013 Total Program Adjustments (Recommended)
	FY 2012	FY 2013	Value ($M)	Value ($M)	Value ($M)
Alabama	1.90%	-8.80%	($68.4)	($143.8)	($536.9)
Alaska	-7.70%	-0.08%		$45.1	$279.1
Arizona	5.20%	0.05%		$96.7	$638.1
Arkansas	3.50%	0.04%			
California	7.00%	0.07%	($18.6)	$195.4	$6,616.0
Colorado	4.60%	0.05%		$138.7	$266.8
Connecticut	3.30%	0.03%		$103.3	$558.7
Delaware	0.00%	0.00%		$24.1	$35.9
Florida	5.90%	0.06%		$490.0	$1,323.8
Georgia	4.80%	0.05%		$208.5	$1,052.9
Hawaii	4.70%	0.05%		$1.9	$152.5
Idaho	5.00%	0.05%		$44.8	$126.5
Illinois	3.30%	0.03%		$87.1	$678.5
Indiana	3.70%	0.04%			
Iowa	4.10%	0.04%		$49.0	$230.0
Kansas	-0.60%	-0.01%		$163.0	($39.0)
Kentucky	1.50%	0.02%			($188.5)
Louisiana	3.90%	0.04%	($53.8)	$279.1	$128.8
Maine	-5.80%	-0.06%		($47.5)	($45.6)
Maryland	1.90%	0.02%		$0.1	$576.1
Massachusetts	3.00%	0.03%		$604.7	$1,761.4
Michigan	2.10%	0.02%		($126.0)	$269.8
Minnesota	3.10%	0.03%		($23.0)	$512.8
Mississippi	-2.50%	-0.03%		$366.7	$66.0
Missouri	-0.20%	0.00%	($13.9)	$6.0	$159.9
Montana	4.30%	0.04%			
Nebraska	2.00%	0.02%		$36.6	$70.1
Nevada	2.00%	0.02%		($17.2)	($6.2)
New Hampshire	0.90%	0.01%			
New Jersey	7.20%	0.07%		($148.1)	$1,156.5
New Mexico	1.90%	0.02%		$41.0	$194.0
New York	2.90%	0.03%		$239.0	$1,660.0
North Carolina	1.30%	0.01%			
North Dakota	4.10%	0.04%			
Ohio	4.20%	0.04%		$1.8	($23.5)
Oklahoma	3.00%	0.03%			$124.8
Oregon	6.20%	0.06%			
Pennsylvania	-0.10%	0.00%	($2.1)	$214.1	($22.5)
Rhode Island	3.00%	0.03%		($25.9)	$126.6
South Carolina	3.30%	0.03%		$176.2	$246.7
South Dakota	2.90%	0.03%		$34.5	$156.0
Tennessee	1.70%	0.02%		$74.5	$587.0
Texas	-15.40%	-0.15%			
Utah	4.20%	0.04%		$156.5	$384.4
Vermont	5.50%	0.06%		($6.3)	($7.9)
Virginia	4.80%	0.05%		$150.4	$630.4
Washington	0.80%	0.01%		($20.0)	($1,101.0)
West Virginia	-0.70%	-0.01%		$52.8	$125.9
Wisconsin	5.50%	0.06%			
Wyoming	0.00%	0.00%			
TERRITORIES					
Puerto Rico	*1.20%*	*-1.90%*		*$21.2*	*($177.2)*
US Total	**3.30%**	**2.20%**	**($156.8)**	**$3,545.0**	**$18,747.7**

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein/Jennifer Kent

The Legislature is scheduled finalize the revised 2012-13 California budget by the end of the day Wednesday, June 27. The main budget passed nearly two weeks ago, but budget negotiations continued on trailer bills determining how cuts will be implemented. Two trailer bills AB1494 and AB1468, relate to the elimination of Healthy Families and the dual eligible integration demonstration, respectively. AB1494 would eliminate Healthy Families and transition all the child beneficiaries into Medi-Cal. As we have previously reported, this transition is highly contentious, particularly amongst medical providers and advocates. AB1468 will finalize the details of the dual eligible integration demonstration as the state shifts 1.4 million seniors and persons with disabilities into managed care.

Regarding tomorrow's SCOTUS decision, some state initiatives already underway may be impacted by the ruling. For example, on May 31, the state announced its intent to award a $359 million contract to Accenture to develop a simplified and streamlined web portal and eligibility and enrollment system. This contract is meant to implement part of the Affordable Care Act (ACA) in California by designing and building a new web-based California Healthcare Eligibility, Enrollment and Retention System ("CalHEERS"). Funding for developing this new system is dependent on the availability of grant funds from the ACA.

The state's Low Income Health Program (LIHP) may also be impacted by the outcome of the verdict. The LIHP Demonstration offers coverage to up to 500,000 low-income, uninsured individuals age 19-64 who are not eligible for Medi-Cal or CHIP. At this point, all but two counties in California intend to operate a LIHP. The creation of the LIHP was, in part, funded as an early implementation of the Medicaid Expansion as allowed under the ACA. It is unrelated to the individual mandate. If the Court rules that individual mandate is unconstitutional but leaves in place the Medicaid expansion, the LIHP is unaffected. If the Court decides that either the Medicaid Expansion is unconstitutional or that the entire ACA is unconstitutional because the individual mandate is unconstitutional, this may or may not affect funding for the LIHP.

The LIHP is a program under California's Section 1115 Medicaid Waiver. This waiver must be budget neutral to the federal government. A major component of budget neutrality in the current waiver for the LIHP is funding available from the early start-up of the Medicaid expansion as provided under the ACA. While this concept could end if the Medicaid expansion in the ACA is rejected by the Court, there may be other ways for the state and federal government to determine that the LIHP is still fundable under the waiver. Specifically, California's prior 1115 waiver supported 10 county Health Care Coverage Initiative (HCCI) programs, which were in existence pre-ACA. These programs were funded by other federal funding in the waiver, which may be a mechanism to continue all or a portion of the LIHPs if the Medicaid expansion is found unconstitutional.

If the Medicaid expansion is found to be unconstitutional and the state and federal governments decide to continue the LIHP under the waiver, the waiver could be amended to continue LIHP coverage beyond December 31, 2013.

In the news

- **California gets a jump on health coverage expansion**

  As the Supreme Court nears a decision on health reform, more than 360,000 Californians already are receiving medical coverage under a state-administered precursor to the landmark legislation. The effort, dubbed "The Bridge to Reform," is part of a sweeping Medicaid expansion unfolding in California. It exists to usher patients to health reform's planned implementation in 2014. Bridge to Reform patients are receiving care in 47 participating California counties, from tiny Del Norte near the Oregon border, to sprawling Los Angeles County. California Department of Health Care Services spokesman Norman Williams said even if the Supreme Court renders the Bridge to Reform a bridge to nowhere, just building it has been of value to the state's health care apparatus. But Williams offered no promises if the U.S. Supreme Court strikes down health reform in opinions expected next week. The justices could invalidate all or parts of the law, and the Medicaid expansion is among the pieces in jeopardy. (Santa Cruz Sentinel)

- **Heat Over Healthy Families Compromise Plan**

  Last week's state budget compromise between legislative leaders and the governor includes a provision that 880,000 children in the Healthy Families program will complete the shift to Medi-Cal managed care within a year, beginning Jan. 1. State officials, who had been using an enrollment figure of 875,000, now say the Healthy Families programs serves 880,000 California children. Suzie Shupe, executive director of California Coverage and Health Initiatives, and other advocates had pushed for the state to start the transition with roughly 200,000 "bright line" children -- beneficiaries who are at or below 133% of federal poverty level -- and then evaluate that process before expanding the program to the other Healthy Families children. (California Healthline)

- **California budget deal includes exception for Kaiser Permanente**

  Gov. Jerry Brown and Democratic leaders are crafting an exception for Kaiser Permanente as they prepare to move 880,000 Healthy Families patients to lower-cost Medi-Cal as part of their budget agreement. The provision would enable Oakland-based Kaiser to keep its 200,000 Healthy Families patients as Medi-Cal clients through a special contract with the state, according to Department of Health Care Services Director Toby Douglas. It would also allow Kaiser to avoid paying fees to county-based health plans that are typically required under Medi-Cal. (Sacramento Bee)

Georgia

HMA Roundup – Mark Trail

Frank Shelp, commissioner of the state Department of Behavioral Health and Developmental Disabilities, announced his resignation last week, effective August 10. Shelp has been the only commissioner of the agency since its creation by the General Assembly in 2009 and was well regarded for his initiatives to improve the state's mental health and developmental disabilities system. Press accounts suggest Shelp's resignation was related to allegations of inappropriate conduct such as accepting unauthorized meals from lobbyists. The state is conducting a search for Shelp's replacement, though we note that, to the extent the state decides to carve behavioral health services into managed care capitation rates under the redesign program, the agency's oversight responsibilities are likely to shrink.

Regarding tomorrow's SCOTUS decision, we note that the state is likely to move forward with the replacement of its eligibility system regardless of the verdict. In addition, the state and the small business community have generally been supportive of a small business exchange so plans to develop one may survive a partial or full repeal of the law. The fate of the individual insurance exchange is less clear.

In the news

- **Despite controversies, Shelp's exit worries many**

  For weeks, the rumors swirled about Dr. Frank Shelp – that he would soon be gone as head of the Department of Behavioral Health and Developmental Disabilities. The speculation irritated those in the mental health and developmental disabilities community who supported Shelp's work. Other people, though, wanted him gone. The rumors turned into reality Friday, when Shelp, the only commissioner in the agency's three-year history, announced his resignation. He will leave his post in August. Consumer advocates noted that Shelp's departure comes at a critical time for the state as it continues to carry out the Justice settlement and as it contemplates a restructuring of the state's Medicaid program, which covers many people with disabilities. (Georgia Health News)

Illinois

HMA Roundup – Matt Powers and Jane Longo

Illinois' Department of Health and Family Services (HFS) released the names of the health plans that have responded to its dual eligible RFP. The bidders are:

- Aetna Better Health
- Community Care Alliance of IL
- Health Alliance
- Healthcare Service Company (BCBS IL)
- HealthSpring of Tennessee (CIGNA)
- Humana

- IlliniCare (Centene)
- Meridian Health Plan of IL
- Molina Healthcare of IL

Additionally, we note that HFS released an RFP to select a vendor that will provide a Pharmacy Benefits Management System to replace the current HFS Electronic Claims Processing system and Drug Rebate system. This is envisioned as the first step in upgrading the HFS Medicaid Management Information System. Proposals are due August 30, 2012.

With regard to tomorrow's SCOTUS decision on the ACA, Illinois and Cook County will be forced to revisit the 1115 Waiver request for Cook County if the Court strikes down the Medicaid Expansion provisions of the law. Additionally, if the SCOTUS decision impacts the implementation of the entirety of the ACA, the state's eligibility system procurement may also be under reconsideration, depending if the ruling affects funding for eligibility system redesign.

In the news

- **Illinois not ready for 'Obamacare' target**

  An Illinois Democrat who has led work on implementing a key part of President Barack Obama's health care overhaul now says the state will need to partner with the federal government for its insurance exchange. Rep. Frank Mautino told The Associated Press this week that Illinois won't be able to meet a Nov. 16 deadline for the online insurance marketplace and must consider a new option — a federal-state partnership — to get ready for its first year if the U.S. Supreme Court upholds the law. (Crain's Chicago)

Ohio

HMA Roundup – Alicia Smith

On June 26, a Franklin County Judge granted Aetna's request for a temporary restraining order that will prevent the state from moving forward with its implementation of the redesigned Medicaid managed care program. As a reminder, Aetna is suing the Ohio Department of Job and Family Services (ODJFS) after the agency re-scored the proposals following a protest by the losing bidders and rescinded its contract award. Aetna is asking the state to reinstate the company in the program. This week, Amerigoup joined Aetna in filing suit against ODJFS. A hearing is scheduled for July 23.

With respect to the dual eligible integration, we continue to anticipate that the results of the RFA scoring will be announced by the end of June. Under the duals demonstration there will be two plans per region except in Cleveland where there will be three. Each plan will be awarded a maximum of three regions, unless there are not sufficient applications to limit plans. As such, it is likely that five contracts are to be awarded. However, our understanding is that the state will only release the scores, not contract awards, giving the plans an opportunity to identify any inconsistencies in the scoring prior to final awards.

In the news

- **State prohibited from entering into new Medicaid agreements**

  A Franklin County judge granted a temporary restraining order prohibiting the state from entering into agreements with managed-care companies for Ohio's $18 billion Medicaid program. Franklin County Common Pleas Judge Richard S. Sheward issued the ruling at the request of Aetna Better Health Inc., one of two companies recently stripped of preliminary contracts for the work. Sheward set a July 23 hearing to decide if the order will be permanent. Aetna – a newcomer to Ohio's tax-funded health-care program - filed suit against the state Department of Job and Family Services and agency director Michael B. Colbert, demanding its preliminary contract be reinstated. (The Columbus Dispatch)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The House Appropriations Committee is scheduled to vote on a final $27.65 billion state budget. This is less than the FY 2008-2009 budget, and contains no tax increases. The budget includes level funding for the state-related universities, adds $100 million for the Accountability Block Grant and monies for distressed school districts, restores $84 million to county human services, and level-funds supplemental hospital programs.

Awaiting tomorrow's SCOTUS decision on the ACA, the state's exchange planning RFQ and comments from the Department of Insurance have indicated that Pennsylvania will not pursue an Exchange unless required to do so by the federal government. If the Court's decision eliminates the requirement or funding for the Exchanges, it is not expected that Pennsylvania would continue down the course of developing an Exchange. The state has received responses on an Exchange planning and design RFP, but has not yet announced a contract award.

In the news

- **Report: Pa. did not adequately monitor Medicaid services to elderly, disabled**

  Pennsylvania was one of seven states that failed to monitor adequately the quality of services provided to the elderly and disabled at home or in community settings under a Medicaid program, according a report issued this week by the Office of the Inspector General of the U.S. Department of Health and Human Services. Federal regulations require states to review service plans for beneficiaries of the Medicaid program, ensure that service providers are qualified, and have a system to track abuse, neglect and exploitation by those who work in the beneficiaries' homes. Pennsylvania failed on all three counts, according to the report, which said that seven of 25 states analyzed did not have adequate systems in place to monitor the quality of care. Pennsylvania's deficiencies were for a program that had 7,000 beneficiaries in 2009, according to the Inspector General's Office. (Philadelphia Inquirer)

OTHER HEADLINES

Alabama

- **Alabama mental health commissioner resigns**

  Zelia Baugh, the current commissioner at the Alabama Department of Mental Health, announced she will step down Saturday. Gov. Robert Bentley named Jim Reddoch, a former official at the state mental health agency, to take Baugh's place. Baugh has been involved in controversial decisions to close some mental health facilities. Her abrupt resignation was attributed to "family priorities." (AL.com)

Arkansas

- **Arkansas Issues Medicaid RAC RFP**

  The Arkansas Division of Medical Services is soliciting responses from qualified vendors to provide post-payment identification and recovery of improper payments on behalf of the Arkansas Medicaid Program.

Colorado

- **JBC offers praise for progress in state benefits computer system**

  The Legislature's Joint Budget Committee on Wednesday heard glowing progress reports and heaped praise on improvements in the long-maligned state benefits management system. After repeated crashes and delays in processing Medicaid, food aid and other programs for hundreds of thousands of clients, the Colorado Benefits Management System now appears on track, state, county and legislative officials agreed. In February, officials sought $17 million in supplemental budgets to improve the computer network. That spending, and improved management, has increased timely processing and prevented new crashes. (Denver Post)

Florida

- **Privatized health care for inmates in peril**

  The Legislature ordered the Department of Corrections last year to hire private companies to provide health care to all 100,000 inmates at a savings of at least 7 percent in the first year of a five-year contract. But lawmakers didn't pass a law to require privatization. They mandated it in the fine print of the budget known as proviso, and two unions, for prison nurses and state workers, filed suit, challenging the action as unconstitutional. The judge has not issued a decision, but the unions and the state were back in a courtroom Tuesday. Both sides agreed the proviso expires with the budget. But Assistant Attorney General Jonathan Glogau, representing the prison system, argued that under a different law, the prison system can privatize inmate health care on its own. (Miami Herald)

- **Florida Gov. Scott says his state will carry out Obama's health law if Supreme Court upholds**

  Florida's Republican governor — one of the staunchest opponents of President Barack Obama's health care overhaul — says his state will carry out the law if the Supreme Court upholds it. Gov. Rick Scott told reporters Wednesday "if it is the law of the land, then we are going to comply." (Washington Post)

Kansas

- **Kansas Announces KanCare RFP Awards**

  The Kansas Department of Health and Environment has posted contract awards for three Medicaid managed care plans in the KanCare program. The RFP, issued in November 2011, procured managed care contracts for roughly 313,000 Medicaid beneficiaries. The plans awarded contracts are: Amerigroup Kansas, Sunflower State Health Plan (Centene), and United Healthcare. KanCare will cover medical, behavioral health, and long-term care services beginning January 1, 2013. Long-term services for people with developmental disabilities are carved out until January 1, 2014. (KanCare Contracts)

- **KanCare plan panned again at public hearing**

  Top health officials from the administration of Gov. Sam Brownback today tried to reassure nervous members of the Kansas public that the Medicaid makeover plan they hope to launch Jan. 1 is a good idea and that problems seen in other states that have expanded managed care would be avoided here. But few in the audience seemed satisfied by the various assurances described in turn by Sullivan, Moser and Kari Bruffett, director of the KDHE Division of Health Care Finance. Each of those three officials is expected to play a key role in implementing KanCare, should it garner the needed federal approvals to proceed. The hearing today was the second designed to meet some of the federal requirements for public input on so-called Section 1115 waiver applications submitted by states. Kansas turned in its initial application in April but then withdrew it pending necessary opportunity for input from the public and representatives of the state's American Indian health centers. (Kansas Health Institute)

Kentucky

- **Kentucky advertises for Medicaid insurance proposals in Passport area**

  Kentucky began the process this week of contracting with multiple companies to provide Medicaid services in the region that has been served exclusively by Passport Health Plan for the past 15 years. The state began advertising Tuesday for proposals from insurance companies to provide managed-care services for Medicaid in Jefferson and 15 surrounding counties. Bidders have until July 24 to respond. (Courier-Journal)

- **Judge orders Coventry Cares to continue contract with Appalachian Regional Healthcare**

  A federal judge ruled Wednesday that Coventry Cares must continue its contract with Appalachian Regional Healthcare through Nov. 1 to meet the medical needs of 25,000 Eastern Kentucky Medicaid patients. ARH operates eight hospitals and other health

clinics in the region. Coventry is one of three companies the state hired Nov. 1 to manage care for the 560,000 Kentuckians enrolled in the federal-state health care program for the poor and disabled. Michael Murphy, president and CEO of Coventry Cares of Kentucky, told state lawmakers Wednesday that the company has lost $50 million in the first quarter of 2012 in Kentucky. He said the company is trying to mitigate those losses by renegotiating contracts with health care providers. When Coventry said May 4 that it would sever its contract with ARH, the hospital chain filed a lawsuit in U.S. District Court in Lexington asking for a preliminary injunction to prevent the termination. (Lexington Herald-Leader)

Louisiana

- **Health care proposal gives Louisiana more Medicaid spending flexibility**

Rep. Bill Cassidy has introduced a bill that would change funding for Medicaid, the joint federal/state health program for the poor and disabled that would give states more flexibility in spending scarce health resources. Under the legislation, a state's share of funding would be limited to what is currently the lowest matching amount for the 50 states: the 24 percent share paid by Mississippi. Louisiana's matching share under the bill would drop from 27.2 percent to 24 percent. Savings to the states would be offset, though, because Cassidy's bill would bar the use of other federal funds, or interagency transfers to pay the state matching shares. Louisiana Health and Hospitals Secretary Bruce Greenstein praised the Cassidy proposal, saying it would enable the state to develop innovative programs that will both lower costs and improve health. (NOLA.com)

New Jersey

- **NJ Health Plans Selected in National Pilot to Improve Primary Care**

The federal government has chosen five health plans to join Medicare in a four-year pilot program that will channel new financial support to 75 primary care practices in New Jersey. The federal Centers for Medicare and Medicaid Services has chosen an application from New Jersey health plans as one of seven winners nationwide in the competitive CMS program created under the Affordable Care Act to improve primary care. The five health plans are Horizon Blue Cross Blue Shield of New Jersey, AmeriHealth New Jersey, UnitedHealthcare, the Teamsters multi-employer healthcare fund, and Amerigroup. (NJ Spotlight)

New Mexico

- **Administration, tribal officials clash over Medicaid changes**

Representatives of Gov. Susana Martinez's administration and Native American officials sparred Monday over how thoroughly the state consulted with New Mexico's 22 Indian tribes on a proposal to redesign Medicaid. Medicaid covers 1 in 4 New Mexicans, or 560,000 individuals, including many Native Americans. One criticism of the proposal tribal officials raised Monday is that the state would discontinue the payment of medical bills in the three months prior to an individual's enrollment in Medicaid, as is currently done. Tribal officials also said the plan doesn't recognize how difficult it is to deliver care on rural reservations, pueblos or tribal lands. The federal Centers for

Medicare & Medicaid Services criticized the state earlier this month for not properly notifying the health care providers serving the tribes. As a result of the federal agency's concern, the state sent copies of the state's waiver request and an introductory letter to several Indian health care providers in late May. The letter explains that the proposed Medicaid redesign would potentially allow the Navajo Nation, New Mexico's two Apache tribes and its 19 pueblos to take greater control of how Medicaid services are delivered to members. One suggestion under consideration in the state's plan is to make "mini block grants" available for pilot projects by tribal entities, according to a May 22 letter sent to providers. (Santa Fe New Mexican)

New York

- **State seeks Medicaid cash in waiver**

New York state is asking the federal government for a big favor — a $17.1 billion favor, to be exact. The state and federal government split the $54 billion cost of Medicaid, the public health program for low-income and disabled people, but statewide reforms have reduced the projected federal share by billions over the next decade. As a result, the state is asking for a waiver that would allow New York to keep a large chunk of the federal savings and reinvest it in the Medicaid program. It's one of the largest Medicaid waiver requests ever, and contains some controversial ideas — like providing supportive housing to the sickest Medicaid patients. (Times Union)

North Carolina

- **Medicaid Fixes Dominate Healthcare in General Assembly Budget**

House and Senate negotiators at the General Assembly announced an agreement Wednesday morning for a $20.2 billion overall state budget for the upcoming fiscal year. A discussion of the problems with Medicaid dominated a large portion of the press conference legislative leaders held to announce the budget deal. Medicaid was the topic of repeated committee hearings over the past year as the program developed a funding gap that grew steadily over the winter to at least $150 million. (North Carolina Health News)

Oregon

- **Oregon's Waiver to CMS Nears Completion**

The Oregon Health Authority is nearing the end of countless hours of negotiations with the Centers for Medicaid and Medicare Services (CMS) to finalize a waiver that will allow the state to legally move forward with reforming the Oregon Health Plan. The authority plans to submit the waiver on July 1, which will allow the state to be exempt from certain regulations and rules in federal Medicaid law. Particular components of the waiver represent "small, but significant" changes, so the state can implement coordinated care organizations (also known as "CCOs"), she said. Coordinated care organizations are expected to begin providing care to many of 650,000 Oregonians on the Oregon Health Plan in August, and integrate physical, mental and dental health, providing more efficient and effective care, and decreasing emergency room and specialty care use. CMS has expressed strong interest in these coordinated care organizations and considers them a demonstration project for how other states could develop a

more coordinated Medicaid system. The federal agency agreed last month to give Oregon $1.9 billion over the next five years to help fund coordinated care organizations. (The Lund Report)

Texas

- **'Rest Of The Country Should Take A Good Look At The Situation In Texas'**

  The Houston metropolitan area has one of the highest rates of uninsured people in America, and a health safety net imploding under the demands of too many people and too few resources. Almost one in three residents – more than a million people -- lack health insurance, and about 400 are turned away every day from the county hospital district's call center because they can't be accommodated at any of its 23 community or school-based centers. "If the Affordable Care Act is overturned, the rest of the country should take a good look at the situation in Texas, because this is what happens when you keep Medicaid enrollment as low as possible and don't undertake insurance reforms," said Elena M. Marks, a health policy scholar at Rice University's James Baker Institute for Public Policy and a former city health official. (Kaiser Health News)

National

- **Managed care organizations look for ways to rein in Medicaid medical costs**

  Until this spring, most health plans were upbeat about the managed Medicaid business when they spoke to investors, particularly the expansion populations they hoped to add to their rolls. The first quarter of medical claims from this year has put a damper on that cheer. Two MCOs that specialize in Medicaid managed care, Molina Healthcare and Centene Corp., reported unexpectedly high medical costs that forced them to downgrade profit forecasts for the year — in Centene's case by 43%. Joel Menges is executive director of Special Needs Consulting Services, a Washington-based firm that helps design coordinated care programs for Medicaid and Medicare beneficiaries. He said MCOs' focus for cost cutting isn't on payments to physicians, but on keeping patients out of the hospital, or making sure that enrollees aren't needlessly taking an expensive brand-name drug when they could be prescribed a generic. Rather than hitting physician payments directly, MCOs' push to control referrals and prescription costs could cost physicians time, he said. He said that time goes unpaid under a fee-for-service model, but that MCOs are in many cases moving to pay primary care physicians on a capitated basis so they are compensated for the time they spend coordinating care for Medicaid patients. (American Medical Association News)

- **States set to move on Medicaid**

  Even if the Supreme Court overturns the Affordable Care Act's Medicaid expansion, some state Medicaid officials plan to move forward with reform plans that already are being put into place. Without the Medicaid expansion, there'll be 16 million to 20 million people who won't be added to the Medicaid rolls starting in 2014 — and billions in federal funding for the coverage expansion won't be there. But some state Medicaid officials said they're already working toward changes that can move ahead, regardless of whatever the Supreme Court decides. (Politico)

- **Analysis: U.S. hospitals find a few defenders on Wall Street**

  Publicly traded hospital systems are drawing new interest from some investors, who are lured by the companies' historically low stock valuations and the expectation that their expanding clout and focus on efficiency will help solve a growing national healthcare crisis. They are betting against a wider market sentiment that hospitals will be pressured to rein in costs and see revenue suffer as Americans skimp on medical treatment in a weak economy. Many investors have also hesitated to buy into hospitals before the Supreme Court rules whether to strike down all or part of President Barack Obama's healthcare reform law. (Chicago Tribune)

COMPANY NEWS

- **Molina Healthcare Selected by the State of Florida, Department of Elder Affairs, to Participate in Nursing Home Diversion Program**

  Molina Healthcare, Inc. announced that its wholly owned subsidiary, Molina Healthcare of Florida, has executed a contract with the Florida Department of Elder Affairs (DOEA) to participate in the Nursing Home Diversion (NHD) program. Molina Healthcare will now provide home and community-based services in lieu of nursing home placement for beneficiaries who are eligible for both Medicare and Medicaid in Pinellas and Hillsborough, Florida. The NHD program is sponsored by Molina Healthcare of Florida and the State of Florida, Department of Elder Affairs. (Molina News Release)

- **Molina Healthcare to open primary care clinic in Albuquerque**

  Molina Healthcare New Mexico, which insures 89,000 New Mexicans, plans to open a primary care clinic in Albuquerque in late September. The health insurer, which serves 1.8 million people nationwide, recently opened a 5,100 square-foot primary care clinic in Santa Fe. (New Mexico Business Weekly)

RFP Calendar

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

Date	State	Event	Beneficiaries
June 27, 2012	Kansas	Contract awards	313,000
July 1, 2012	New York LTC	Implementation	200,000
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 1, 2012	Florida CHIP	Contract awards (delayed)	225,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Proposals Due	115,000
July 31, 2012	Illinois Duals	Contract awards	136,000
July/August, 2012	Georgia	RFP Released	1,500,000
August 31, 2012	Massachusetts Duals	Contract awards	115,000
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	136,000
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	Massachusetts Duals	Implementation	115,000
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 is a summary table of the progression of states toward implementing dual eligible integration demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	Proposal Released by State	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Contract Award Date	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012	X	7/1/2012	N/A[+]	N/A[+]	N/A	1/1/2014
California	Capitated	685,000*	X	4/4/2012	X	6/30/2012				3/1/2013
Colorado	MFFS	62,982	X	4/13/2012	X	6/30/2012				1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	X	6/30/2012				12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012				1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	7/31/2012	1/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012				1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	X	6/30/2012				1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012	X	7/30/2012	8/31/2012	4/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012				7/1/2013
Missouri	Capitated[‡]	6,380	X		X	7/1/2012				10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012				1/1/2013
New Mexico	Capitated	40,000	X		X	7/1/2012				1/1/2014
New York	Capitated	133,880	X	3/22/2012	X	6/30/2012				1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012				1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	Late June	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	7/1/2012				7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012				1/1/2014
Rhode Island	Capitated	22,737	X		X	7/1/2012				1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	X	6/28/2012				1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012				1/1/2014
Texas	Capitated	214,402	X	4/12/2012	X	6/30/2012				1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	X	6/30/2012				1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012				1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012				1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012				1/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***3***			

**Duals eligible for demo based on 8 counties included in May 31, 2012 proposal to CMS. Will expand to further counties in 2014 and 2015 with approval.*

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

[‡] Capitated duals integration model for health homes population

HMA Recently Published Research

Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case

Mike Nardone, Principal

The Medicaid expansion under the Affordable Care Act will provide coverage to most of the estimated 1.2 million people who are homeless, including the roughly 110,000 individuals who are chronically homeless and more likely to suffer chronic, complex health conditions. This policy brief makes a case for states to explore the use of new Medicaid financing options available under ACA (e.g., health homes), as well as flexibilities afforded through Medicaid managed care, to support the funding of housing-based care management services in supportive housing for formerly homeless individuals. The research suggests that such an approach can improve care for these beneficiaries while lowering costs associated with avoidable hospitalizations and other crisis services. **(Center for Health Care Strategies – Policy Brief)**

Public and Private Insurance Coverage for Chronic Hepatitis B Patients: Health Reform Will Facilitate Early Investments Providing Long-Term Benefits

Jack Meyer, Managing Principal
Gaylee Morgan, Senior Consultant
Vern K. Smith, Managing Principal

The implementation of national health reform in the U.S. provides important opportunities to increase the awareness, routine screening, and treatment of viral hepatitis. An estimated 2.2 million Americans are infected with chronic hepatitis B (HBV), yet nearly two-thirds of these people are unaware of their disease until they have developed liver cancer, cirrhosis, or liver failure many years later. A growing body of evidence indicates that when HBV is detected early and properly treated, these highly adverse outcomes can be delayed or avoided altogether.

Enrollment in health coverage is absolutely vital to this early detection and treatment. In fact, our research shows that liver transplants can be reduced by 58 percent and the death rate can be reduced by 20 percent when lower-income people are enrolled in insurance coverage and treated early in the course of their disease. This study projects that over 70,000 people with HBV will newly enroll in Medicaid under the Patient Protection and Affordable Care Act and about 75,000 more people with HBV will newly enroll in Health Insurance Exchanges. We find that a 5 percent reduction in liver transplants for HBV patients could finance more than 420,00 screenings. **(Link to report)**

UPCOMING HMA APPEARANCES

Healthcare Financial Management Association: HFMA National Institute 2012

Jennifer Kent, Panel Participant

June 27, 2012
Las Vegas, Nevada

Leadership Institute's Leadership and Learn Symposium: The Road I Have Traveled...

Izanne Leonard-Haak, Presenter

June 28, 2012
Harrisburg, Pennsylvania

The Council of State Governments - Medicaid Policy Academy: State Perspective Panel

Mark Trail, Panelist

June 28, 2012
Washington, D.C.