HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS RELEASES FINAL MEDICAID ELIGIBILITY RULE

HMA ROUNDUP: FLORIDA EXTENDS IMPLEMENTATION TIMELINE FOR ACUTE AND LONG-TERM CARE ITNS; INDIANA SELECTS MEDICAID PBM; MEDICAID SPENDING CUTS DEBATED IN ILLINOIS; CMS COMMENT PERIOD FOR MASSACHUSETTS DUAL ELIGIBLE PROPOSAL ENDS

OTHER HEADLINES: HOUSE REPUBLICAN BUDGET PROPOSAL RECOMMENDS MEDICAID BLOCK GRANTS; IDAHO CORRECTIONAL HEALTH CONDITIONS CRITICIZED; VIRGINIA BEHAVIORAL HEALTH RFP BIDDERS ANNOUNCED; MEDICAID MCOS CONTINUE NETWORK DEVELOPMENT IN KANSAS

RFP CALENDAR: CALIFORNIA DUAL ELIGIBLE SITE SELECTION EXPECTED SOON; NEW YORK DUAL ELIGIBLE PROPOSAL EXPECTED MARCH 22

MARCH 21, 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: CMS RELEASES FINAL MEDICAID ELIGIBILITY RULE

This week, our *In Focus* section highlights key provisions of the federal final rule on Medicaid eligibility and enrollment, released last Friday, March 16, by the Centers for Medicare & Medicaid Services (CMS). The final rule provides the standards for determining Medicaid eligibility after January 1, 2014, when the Affordable Care Act (ACA) expands Medicaid coverage to all individuals under 133 percent of the federal poverty level (FPL). Additionally, the rule provides new Medicaid enrollment standards and processes including measures to coordinate the Medicaid enrollment process with state-based Health Insurance Exchanges. The final rule reflects improvements and changes made to the proposed rule issued on August 17, 2011 as a result of public comments and feedback. A significant portion of the final rule document comprises a description of those public comments along with CMS' responses.

For a copy of the final rule and related documents and analysis, please see the CMS site: http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html

Potential Impact of Final Rule

A few key potential impacts of the final rule on Medicaid enrollment, states and providers are highlighted below.

- The Congressional Budget Office (CBO) now estimates that the ACA's Medicaid expansion will result in a net increase in Medicaid beneficiaries of 17 million by 2016. In its impact analysis, however, the CMS Office of the Actuary (OACT) estimates that the final rule could cause Medicaid enrollment to jump by 15 million in 2014 alone, with 24 million new Medicaid beneficiaries enrolled by 2016 including as many as 3 million individuals with employer-sponsored insurance who enroll in Medicaid for supplemental coverage. OACT assumes that the streamlined enrollment process will contribute to significantly higher Medicaid enrollment rates among eligible individuals than assumed by CBO.
- Providers, especially those currently serving the uninsured and Medicaid populations, are likely to significantly benefit from the streamlined enrollment process. The consolidation of eligibility categories and the simplification of the eligibility determination process should decrease the time required for Medicaid enrollment and payment to providers. While state budget pressures and other issues certainly should not be ignored, the eligibility process improvements could potentially reduce the Medicaid payment cycle for new enrollees making Medicaid a more attractive payer.
- States will see a significant influx of federal dollars as a result of the Medicaid expansion. OACT estimates more than $164 billion over three years, from 2014-2016, with CBO estimating $154 billion. Since the Medicaid expansion is almost wholly federally-funded, this represents a significant injection of funding to Medicaid providers and relatively little impact to state general revenue funds.

Key Elements of the Final Rule

1. Medicaid Expansion Population

The final rule codifies the new eligibility group, referred to as the "adult group." This group includes all individuals ages 19 through 64 with household incomes at or below 133 percent of the FPL that are not pregnant women, and are not otherwise eligible for or covered by Medicaid or Medicare. Because the ACA includes a 5 percent income disregard for the adult group, the effective income eligibility level for a newly-eligible adult Medicaid beneficiary is 138 percent of the FPL.

2. Simplified Medicaid Eligibility

Currently, states provide Medicaid services to individuals under numerous eligibility categories, with considerable variation from state to state. The final rule establishes a nationwide standard for eligibility categories for non-disabled non-elderly individuals and consolidates multiple groups into four categories: children, pregnant women, parents and caretaker relatives, and the newly-eligible adult group.

As required by the ACA, the final rule will require states to convert to the new modified adjusted gross income (MAGI) standard for Medicaid income eligibility determinations beginning in 2014. The MAGI standard must be used to determine eligibility for most Medicaid populations, including children, and non-disabled adults under age 65, and for the Children's Health Insurance Program (CHIP). To accomplish the goal of a seamless eligibility system across Medicaid and the Exchanges, MAGI will also be the standard used for determining eligibility for premium tax credits and cost-sharing reductions for individuals receiving health insurance through an Exchange. This allows a state to develop a single point of entry for eligibility determinations for Medicaid, CHIP and the Exchange.

3. Streamlined Enrollment Process

The ACA provides for a streamlined enrollment process for Medicaid, CHIP and the Exchanges, and the final rule codifies the procedures that will enable individuals to apply, enroll and renew coverage through the Internet. However, the rule provides flexibility to states in determining how these programs and eligibility systems will be integrated. Streamlined enrollment may be achieved through complete integration under one administrative body or through shared services and agreements across administrative entities.

The final rule also makes the following changes to Medicaid eligibility determination and renewal processes:

- A state may either make a final eligibility determination based on an Exchange's initial eligibility review, or the state may accept a final eligibility determination made by the Exchange, provided the Exchange utilizes state MAGI standards.
- A 12-month period of eligibility is established, except in instances where available information indicates a change in eligibility circumstances.

- A state will redetermine Medicaid eligibility based on information contained in a beneficiary's case account or other more current information available to the Medicaid agency.
- Additional verification documents will be permitted as necessary.

Still to come…

While last week's release of final rules on Exchanges and Medicaid Eligibility were two significant milestones in moving toward ACA implementation, a future federal rule will address the calculation of federal matching funds for the new Medicaid expansion population. The Federal Medical Assistance Percentage (FMAP) rule has yet to be released and will address the significant issue of "expansion" vs. "non-expansion" states, with "expansion" states being those that have already extended Medicaid benefits to individuals above the 133 percent FPL level established in the ACA Medicaid expansion provision.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

As a reminder, the state's timeline for dual eligible integration site selection is "mid to late March." Accordingly, we are expecting an announced from the state in the next ten days. As we have discussed in the past, we continue to believe that there is a high likelihood that Los Angeles will be included as one of the four selected counties based on the state's coverage and budget savings goals.

Florida

HMA Roundup – Gary Crayton

Florida's Agency for Health Care Administration (AHCA) has released an updated timeline for the statewide managed care implementation. The managed long term care procurement will be issued July 1, 2012, with awards announced in December 2012 as previously announced. The state is now indicating that all LTC beneficiaries will be enrolled by April 1, 2014 versus its previously stated goal of full implementation by October 1, 2013. Similarly, the Medical Assistance (acute care) RFP will be issued in January 2013, with awards announced in June 2013 as previously announced. However, the state is indicating that all Medical Assistance beneficiaries will be enrolled by April 1, 2015 versus its previous guidance of full implementation by October 1, 2014.

In advance of issuing a procurement for the managed long-term care program, AHCA released the long-term care (LTC) managed care data book earlier this week. The agency anticipates release of the procurement no later than July 1, 2012. The LTC data book provides the three most recent years of summarized regional and statewide historical fee-for-service data together with encounter data for populations expected to be eligible for the statewide Medicaid managed care (SMMC) LTC program and data for Medicaid ser-

vices that will be the responsibility of the LTC plans. Certain adjustments have been made to historical data in the data book, and additional adjustments to the data are expected to be made as the negotiation of actuarially sound rates with the plans occurs. The data book is available at: (ahca.myflorida.com)

In the news

- **Fla. dental managed-care rollout for kids stalled**

  The Florida Agency for Health Care Administration (AHCA) has delayed a statewide rollout of Medicaid dental services to children through a managed-care system. The agency announced the decision after lawmakers approved budget language saying that dentists in most of the state could still be paid for each service they provide instead of being required to participate in a type of managed care known as "prepaid dental plans,". The Florida Dental Association (FDA) reported that Medicaid dental providers had encountered numerous challenges with managed-care plans, including one area dentist, who represents the FDA on a statewide Medicaid advisory panel at AHCA, who raised concerns about the burden of obtaining the required authorizations from managed-care plans to perform procedures. (newspress.com)

- **Medicaid And A Tale Of Two Miami Hospitals**

  Florida is leading 25 other states in the Supreme Court challenge of the ACA, but that hasn't stopped two of Miami's most prominent hospitals, University of Miami Hospital and Jackson Memorial, from preparing for the Medicaid expansion. Dr. Lawrence Gardner, the policy dean for the University of Miami's medical school and hospital says Medicaid money spent preventing chronic illness and keeping patients out of the ER is efficient in the long run, which is why the University of Miami's preparation has included beefing up a network of satellite clinics and hiring community health workers. (NPR)

- **Medicaid Shift Could Face Unexpected Delay**

  Florida's overhaul of the Medicaid system likely will take longer than expected, with some beneficiaries not enrolled in HMOs or other types of managed-care plans until 2015, according to a revised state timeline. Enrollment, however, would be phased in, so some beneficiaries would still go into managed-care plans in 2013 and 2014. AHCA has been working for months to get approval from the federal government to make the changes. It also will have to contract with varying numbers of managed-care plans in 11 regions of the state and, ultimately, will have to help oversee hundreds of thousands of beneficiaries moving into the new system. (Florida Sunshine State News)

- **Disabled kids illegally warehoused in nursing homes, lawsuit claims**

  Florida needlessly and illegally warehouses about 250 severely sick and disabled children in nursing homes rather than pay to help them live at home or in the community, families said in a lawsuit filed this week. The denial of home nursing care and other services has left the children living for months or years in institutions even after doctors have cleared them to go home with their families, according to the suit, filed in federal court in Fort Lauderdale. A second group of families filed a separate suit saying

about 3,300 at-risk children still living at home fear the lack of services by Florida Medicaid will force them into nursing homes in the future. (Miami Herald)

Illinois

HMA Roundup – Jane Longo / Matt Powers

At a Department of Health and Family Services (HFS) Medicaid Advisory Committee meeting last Friday, March 16, 2012, HFS Director Julie Hamos provided an update on the state's Medicaid budget. Governor Quinn has called for $2.7 billion in cuts to Medicaid spending. At the same time, there is no discussion in the legislature regarding revenue increases. By the end of the current fiscal year, the state will have $1.8 billion in unpaid Medicaid bills, with many Medicaid providers going unpaid for one full year. This number could be as high as $4.7 billion by the end of next fiscal year. As a result, HFS is putting all possible eligibility cuts on the table, including higher income children, reducing income thresholds for parents, and all state-only funded programs. Additionally, cuts to the adult pharmacy benefit, roughly $800 million in annual spending, are on the table as well. The state is continuing to proceed with a plan for tightening the eligibility verification process, which may provide some fiscal relief.

The Care Coordination Innovations Project continues to move forward, with procurements under way for Phase I care coordination entities for high-cost, high-risk adult Medicaid beneficiaries. Additionally, the public comment period on the state's dual eligible integration proposal is drawing to a close in early April. A broader managed care RFP is still on track for later this Spring or Summer.

In the news

- **Advocate operating income falls as claims, charity care rise**

  Advocate Health Care Network's net operating income fell 10 percent, to about $301 million, in 2011, as the Chicago area's largest hospital system grappled with the rising costs of malpractice claims and charity care. Total revenue for the 12-hospital network rose 3.4 percent, to $4.4 billion for the year ended Dec. 31, 2011, up from $4.3 billion in 2010, according to Advocate's financial statement made available this month. Advocate also saw an 18 percent increase, to $76.4 million in 2011, of the value of free care it provided to the poor, compared with $64.6 million in 2010. (Crain's Chicago)

Indiana

HMA Roundup – Catherine Rudd

On March 8, 2012, the Indiana Family and Social Services Administration awarded the pharmacy benefits management (PBM) contract to SXC Health Solutions, Inc. Other bidders considered were ACS State Healthcare LLC, Goold Health Systems, and PerformRx. The contract is worth roughly $32 million. A link to the award recommendation letter is available here: (PDF, 7 pp.)

Massachusetts

HMA Roundup – Tom Dehner

The 30-day CMS comment period on the state's dual eligible proposal expired on Monday. At this point, the state and CMS will begin negotiations over the memorandum of understanding which the state hopes to have completed by the end of April, at which point it is expected the state will formally release the RFP for its proposed dual eligible integration program. For more information on Massachusetts' dual eligible integration program, please see our February 22, 2012 Weekly Roundup which is available on our website at: http://www.healthmanagement.com/newsletter.asp?newsletterid=3

OTHER HEADLINES

California

- **LAO Notes Possible Challenges for Gov. Brown's Proposed IHSS Cuts**

  Proposed cuts for California's In-Home Supportive Services program included in Gov. Jerry Brown's (D) fiscal year 2012-2013 budget proposal would be difficult to implement and likely would face legal challenges. Brown's $92.6 billion budget plan calls for cutting $163.8 million from IHSS by eliminating domestic assistance for beneficiaries in shared living environments. According to Brown, the IHSS cuts would reduce spending by 5% to $5.3 billion. Under the plan, the number of IHSS beneficiaries would decrease by 2.5% to an average of 422,993 individuals. The alternatives are extending a 3.6% across-the-board reduction in hours or reducing the amount the state pays in wages to IHSS caregivers. (California Healthline)

Idaho

- **Expert says Idaho prison care 'cruel'**

  Medical care is so poor at an Idaho state prison that it amounts to neglect and cruel and unusual punishment, according to a report that was unsealed Monday. Some of the medical problems described in the report are disturbing, including Stern's findings that inmates who were terminal or required long-term care and who were unable to move on their own were sometimes left in soiled linens, given inadequate pain medication and went periods without food and water. The Idaho Department of Correction and the prison health care provider, Brentwood, Tenn.-based Corizon, said they're disappointed and are preparing a response that will show the care delivered to inmates meets constitutional and health care standards. (AP)

Kansas

- **KanCare bidders heavily courting Medicaid providers**

  Gov. Sam Brownback's Medicaid reform plan, KanCare, has spawned one of the biggest, busiest and -some say- most confusing courtships in state history. Postai and other Medicaid providers – a group that includes doctors, hospitals, pharmacies, home health agencies, nursing homes, mental health centers and community-based programs for the developmentally disabled – are being wooed by the five companies that have

submitted bids to manage the state's $2.8 billion Medicaid program. State officials have said they plan to award contracts to three of the companies this summer. An exact date has not been announced. (Kansas Health Institute)

- **KanCare questions continue**

  Managed care companies bidding on state Medicaid contracts defended their financial stability this week after questions were raised about their credit ratings. But it remains a point of concern for legislators and advocates for the disabled already wary of the switch to managed care. A House committee mulling a bill to exclude long-term care of the developmentally disabled from the "KanCare" overhaul heard testimony this week about the spotty creditworthiness of three of the five KanCare bidders. (Topeka Capital Journal)

- **Q and A with HHS Regional Administrator Jay Angoff**

  As a senior adviser with the U.S. Department of Health and Human Services, Jay Angoff works with state and local governments on implementation of the federal Affordable Care Act. Angoff also is the acting director of the department's Kansas City regional office, which covers Missouri, Nebraska, Kansas and Iowa. He was interviewed a day after HHS released final health reform regulations governing the establishment of health insurance exchanges. (Kansas Health Institute)

- **Senate committee endorses KanCare oversight bill**

  The Senate Ways and Means Committee endorsed a bill that would create a joint legislative committee to oversee the implementation of KanCare, Gov. Sam Brownback's plan to move virtually all the state's Medicaid beneficiaries into managed care plans. The proposed committee would include six members from the House and five from the Senate. Its members would be appointed by July 1 and could meet prior to KanCare's proposed launch date, which is Jan. 1, 2013. No one testified against Senate Bill 459. Several advocacy groups submitted testimony supporting the measure. (Kansas Health Institute)

Kentucky

- **Dentists face Medicaid issues: Latest to complain about new system**

  Patients with severe dental problems are having increasing difficulty getting care under the state's new Medicaid managed care system. Patients with abscesses, rotted teeth and infections are forced to endure lengthy waits for treatment while dentists attempt to get "prior authorization" for routine procedures, dentist William Collins told the House-Senate Program Review Committee. Collins' testimony came as lawmakers continue to investigate complaints over the managed care system, which was launched by the administration of Gov. Steve Beshear Nov. 1 as a cost-saving measure. It moved about 560,000 Medicaid members outside the Louisville area to one of three companies that supervise care and control costs. Representatives of the three companies — CoventryCares of Kentucky, Kentucky Spirit Health Plan and WellCare of Kentucky — have testified that they are working to correct problems. (Courier-Journal.com)

Maine

- **Maine hits GOP roadblock in setting up health insurance exchange**

  A Democratic bill, LD 1498, that would have set up Maine's exchange failed Thursday in the Legislature's Insurance and Financial Services Committee in a party line vote. The committee voted 7-6 in favor of a bill sponsored by McKane that he described as a "defensive move" against the federal health reform law. The legislation, LD 1497, was amended to stipulate that in the event the ACA survives the court challenge, only licensed insurance brokers can enroll people in health plans through a state exchange. Thursday's votes culminate more than a year of disagreement in the committee about the state health insurance exchange. Both bills face final votes by the full Legislature. States that fail to set up their own exchanges will have to hand the reins over to the federal government. (Maine Bangor Daily News)

Mississippi

- **Lawmakers to tackle budget; look for hot Medicaid debate**

  The state Legislature will attack the budget this week, with the committee deadline for each chamber's own general bills behind them. The Medicaid budget is sure to draw heated debate, Frierson said. The House on Wednesday passed House Bill 421, which changes the method by which hospitals will be reimbursed. The Division of Medicaid has said the change could leave a $65 million deficit. As hospitals receive the most in Medicaid reimbursements, they would likely take the hit. An approved amendment to the bill would ensure hospitals not be cut. (Clarion Ledger)

- **Mississippi Builds Insurance Exchange, Even As It Fights Health Law**

  Unlike Louisiana, Alabama, Florida and other southern conservative states, Mississippi is well on its way to having an insurance exchange ready for operation by the 2014 deadline laid out by the health overhaul law. Efforts to set up an insurance exchange in Mississippi stretch back to before the Affordable Care Act passed, and an exchange had the outright support of former Mississippi Gov. Haley Barbour (who later attached the state to the case against the federal health law). A January study by the Center for Mississippi Health Policy showed that Mississippi has a lot to gain if an exchange functions in the state as the health law projects. The study found a working exchange could help lower the rate of people in the state without insurance from 20-percent to 7-percent. (Kaiser Health News and NPR)

New York

- **Under Pressure, New York Moves to Soften Tough Medicaid Audits**

  New York State was paying for the medical care of dead people when Gov. George E. Pataki and the State Legislature created the Office of the Medicaid Inspector General to curb billions of dollars in fraud and misspending by health care providers. Within four years the state had recouped $1.5 billion in Medicaid overpayments, the highest recovery rate in the nation. But a backlash from the politically powerful health care industry has erased broad support for the crackdown. Last year, Gov. Andrew M. Cuomo quietly dismissed the state's first Medicaid inspector general, James G. Sheehan, and di-

rected Mr. Sheehan's successor, James C. Cox, to collaborate with providers on changes to the agency's policies and auditing methods. (New York Times)

- **New York moves to set up health-insurance exchange**

  A health-benefit exchange for New York State is back on the table, and it could change the insurance market for small businesses. But at this point, experts say it's unclear exactly how. Gov. Andrew Cuomo included legislation in his 2012-13 proposed state budget that would set up a health-insurance exchange in New York. The exchange would meet requirements in the Patient Protection and Affordable Care Act, the 2010 federal health-care reform law. While it has yet to be approved by legislators, attorneys say small businesses may want to keep an eye on it - even if they don't currently provide insurance to their workers. (Central New York Business Journal)

Oregon

- **A Single Coordinated Care Organization Could Emerge in the Tri-County Area**

  As transformation moves ahead, an unlikely group of competitors have come together to create what many believed was impossible – a single coordinated care organization (CCO) for the Portland tri-county area. By April 2, the Tri-County Medicaid Collaborative intends to file a letter of intent with the Oregon Health Authority to coordinate healthcare for the 200,000 people on the Oregon Health Plan. The five managed care plans that currently provide such services are at the table – CareOregon, Family Care Health Plans, Kaiser Permanente, Providence Health & Services and Tuality Healthcare. (Oregon Lund Report)

Pennsylvania

- **Pa. changes worry home-care providers and clients**

  Gary Alexander, secretary of Pennsylvania's Department of Public Welfare, is determined to cut spending for programs run by the agency that has the biggest chunk of the state's budget. The reduction of Medicaid rolls by more than 80,000 children since August and plans to institute an asset test for food stamps in May have gotten widespread attention. But more subtle moves are roiling the mostly nonprofit world that serves disabled and elderly Pennsylvanians who live at home - instead of being institutionalized - with the help of attendants hired and supervised by the disabled person but paid by Medicaid under an inscrutable system of waivers. (Philadelphia Inquirer)

Utah

- **Utah is fifth state to adopt 'Health Care Compact'**

  Utah has become the fifth state to enter into a compact designed to get the federal government out of the health care business. The so-called "Health Care Compact" would transfer control of Medicare and Medicaid from Washington to the states and turn the two vast programs into block grants, giving states the freedom to manage health care as they see fit. Supporters of the idea say states are better suited than the federal government to manage programs that are relied on by their residents, but detractors say the proposal is dangerous and would harm the elderly, the poor and others in need of government assistance. While the compact is expanding — Utah joined Georgia, Mis-

souri, Oklahoma and Texas in adopting it — it would go into effect only if Congress lends its approval, and that appears to be an unlikely prospect. (Stateline)

Virginia

- **Virginia announces interested bidders for behavioral health RFP**

  Virginia announced this week the interested bidders in the state's Behavioral Health Services Administrator (BHSA) RFP. The following six bidders have submitted letters of intent: Community Health Partnership of Virginia, LLC (partnership between local Community Service Boards and Value Options); Magellan Health Services; Providence Service Corp.; KePro; eHealthObjects; and WVMI. Links to RFP (here) and interested bidders notice (here).

Wisconsin

- **State budget committee approves Medicaid changes**

  A plan to raise premiums for some of the poorest people enrolled in Wisconsin's Medicaid programs passed a Legislature budget committee Wednesday, but officials say it won't affect enrolled children, pregnant women, disabled people or the elderly. The Joint Committee on Finance voted along party lines to approve the plan proposed by the state Department of Health Services, who wants to lower the income level at which families must pay a premium. That would affect about 44,000 participants who previously didn't have to pay. (The Northwestern)

National

- **Some States Limit How Uninsured Pay For High-Risk Insurance**

  A handful of states have decided to prohibit third parties from picking up the tab for premiums in the government Pre-Existing Insurance Plan (PCIP). Concerns include: If an employer or insurer is permitted to pay someone's PCIP premium, for example, it may be tempted to dump people into those plans rather than insure them and absorb the cost of their care. Likewise, hospitals and other health-care providers might benefit financially by paying the premiums for people with serious medical needs, thereby encouraging them to receive care at those institutions, including possibly unnecessary care. (Kaiser Health News)

- **Insurers at Risk in Health Law's Medicaid Challenge**

  A Supreme Court decision striking down the U.S. health-care law's expansion of Medicaid might expose environmental and educational laws to legal challenges while hurting stocks that surged anticipating more than $600 billion in new spending over the next decade. Managed-care companies with large Medicaid businesses, such as Centene Corp. (CNC) of St. Louis, Missouri, have seen their stock prices more than double since March 2010 on the expectation that states with rising caseloads will turn to them to help control program spending. An adverse decision might affect those gains while also hurting hospitals, nursing homes and other health providers. The Congressional Budget Office projects that the expansion of Medicaid set to take effect in 2014 will lead to $627 billion in new federal spending over the next 10 years. Managed-care providers have the most to gain in the expansion -- and to lose if the Supreme Court stops it. In

the litigant states, those health insurers are expected to gain $46 billion in the first five years of the expansion (Bloomberg)

- **New Ryan Budget Would Transform Medicare And Medicaid**

  The Republican chairman of the House Budget Committee, Rep. Paul Ryan of Wisconsin, surprised no one Tuesday when he released a spending blueprint that would drastically reshape the Medicare and in an attempt to rein in their soaring costs. The GOP document projects an estimated $205 billion in Medicare savings over President Obama's proposed budget over ten years. The plan would gradually raise the eligibility age to 67 by 2034 and cap Medicare spending growth at gross domestic product growth plus 0.5 percent. Ryan's new budget would provide a set amount of money for future Medicare beneficiaries – those currently under the age of 55 - to purchase either a private health plan or the traditional government-administered program through a newly created Medicare exchange. That would begin in 2023. Private health plans would have to be at least actuarially equivalent to the coverage offered in the traditional, government-administered option. That means that the benefits could vary, but the value of the plan would have to remain the same. (Kaiser Health News)

- **States' revenue surge ebbs at end of 2011: report**

  Revenues in most U.S. states increased in the fourth quarter of 2011, but their recent surge is tapering off, as they grew just 2.7 percent from the final quarter of 2010, according to a report released on Monday. Altogether, revenue rose in 41 states and dropped in nine, according to the Rockefeller Institute's report. The largest decline was in California, where fourth-quarter revenue dropped 8.9 percent from the year-ago quarter, followed by Louisiana, where the revenue drop was 5.1 percent for the 2011 final quarter on a year-over-year basis, the Rockefeller report said. Illinois recorded the largest gain in fourth-quarter revenue of 24.1 percent year-over-year, followed by Connecticut, with a 21.9 percent increase, the report found. Altogether, eight states recorded double-digit percentage gains in revenue. (Reuters)

- **Aging Inmates Squeeze Health-Care Budgets: As prisoners get older and develop expensive health problems, states are looking for ways to cut costs.**

  According to the Bureau of Justice Statistics, the number of federal prisoners 55 and older nearly doubled over the last decade, from 8,221 in 2000 to 15,323 in 2009.Prisoners are in their 50s and 60s, and are developing age-related health conditions like heart disease, cancer and complications from diabetes. With years of hard living behind most of them, they have higher odds of carrying hepatitis C or HIV, of having AIDS, liver or kidney disease, substance abuse damage and mental illnesses. Correctional health-care costs reached $9.9 billion in 2009, according to Prison Health Services, a private company that provides health care to inmates. Given the current budget conditions, states are looking for ways to cut costs. The Kansas Department of Corrections (KDOC) has found one with a managed-care contractor called Correct Care Solutions. (Governing)

- **More states join Oklahoma in delaying action on health insurance exchange**

  At least 14 other states have joined Oklahoma in delaying legislative consideration of health insurance exchanges until after the U.S. Supreme Court rules on the constitutionality of the Affordable Care Act. The Oklahoma Legislature considered a proposal to partially comply with the law's mandate but not connect individuals to the federal subsidies. Under pressure from conservatives in their own party, Republican legislative leaders announced earlier this month that they were dropping the plan until the high court rules. Along with Oklahoma, Alabama, Alaska, Florida, Georgia, Indiana, Kansas, Maine, Michigan, Missouri, Nebraska, South Dakota, Texas, Virginia and Wisconsin reportedly have decided to put off any moves on the issue until after the Supreme Court rules, according to the Center on Budget and Policy Priorities latest report. Only 11 states have established authority for a state exchange, according to the center's tally. Seven other states have legislation pending on the issue. (Tulsa World)

- **Medicaid Expansion Rule Aims for Vastly Simpler Enrollment Process**

  A final rule released Friday spells out the terms for the expanded Medicaid eligibility in 2014 under the health care law and requires "real-time" enrollment that documents income, citizenship and other data without the applicant having to bring in paperwork. The rule also collapses the many eligibility categories now in Medicaid into just four: adults, children, parents and pregnant women. The health care law extends Medicaid coverage to all individuals between ages 19 and 64 with incomes up to 133 percent of the federal poverty level. Applicants will have to fill out just one application. They won't have to know ahead of time whether they should apply to Medicaid, CHIP or insurances exchanges to get tax credits. (CQ HealthBeat)

- **The New Jersey Experience: Do Insurance Reforms Unravel Without An Individual Mandate?**

  Although insurers have fought many parts of the health law, they have long favored the establishment of a mandate, which requires almost everyone who can afford it to buy health insurance or pay a fee, saying the reformed market cannot function without it. New Jersey created something called the "Individual Health Coverage Program." Insurers wishing to sell coverage to individual customers would have to do so through this program. And insurers could not deny coverage or charge higher premiums to the sick. In other words, they had to practice what policy wonks call "guaranteed issue" and "community rating." The result of forcing insurers to charge the same rates universally meant that older, sicker people would pay less -- but younger, healthier people would pay more. (Kaiser Health News)

- **Obama healthcare law not yet resonating with public**

  Just a tiny fraction of Americans has experienced a major benefit from the law. At the same time, tens of millions have continued to see insurance premiums and medical bills rise as they did before the legislation was signed. That reflects the design of the complex law, in which many of the key provisions were delayed in a bid to hold down costs and minimize disruptions while new systems are put in place to expand coverage. The law will not guarantee insurance to all Americans until 2014, and may take many more years to rein in healthcare costs. Two-thirds of Americans say they haven't

been personally affected by the law, according to the latest Kaiser tracking poll. By contrast, just 1 in 7 say they have experienced something positive from the law. (LA Times)

- **Medicaid Patients Struggle to Get Primary Care, Visit ERs More**

  Twice as many people insured by Medicaid as by private insurance report barriers to primary care and Medicaid patients are twice as likely to visit the emergency department as their privately insured counterparts, according to a study published online yesterday in Annals of Emergency Medicine. Even comparing patients with barriers to primary care side by side, Medicaid beneficiaries were still more likely to visit the emergency department than those with private insurance (61.2 percent v. 28.9 percent for patients with two or more barriers to primary care). Barriers included not being able to reach a doctor by phone, not being able to get a timely appointment and lack of transportation to the doctor's office. (Sacramento Bee)

- **Do Medical Homes Save Money?**

  The aim of the "medical home" concept is simple—improve primary care so fewer people need to go to the hospital. States experimenting with this nationwide movement say that when practiced by doctors serving Medicaid patients, it improves overall health conditions and saves billions of dollars in the long run. In the short run is where experts differ. A new study published in *The American Journal of Managed Care* reports that only one of hundreds of peer-reviewed studies of patient-centered medical homes definitively showed real cost savings — and it did not involve a Medicaid program.(Stateline)

- **Medicaid Commission Report Focuses on People with Disabilities and Fraud-Fighting Efforts**

  Medicaid officials should improve tools to measure the quality of care for patients with disabilities, coordinate care for those patients and make sure that anti-fraud practices for the program don't burden the states, according to a new report by the Medicaid and CHIP Payment and Access Commission. The MACPAC report notes that Medicaid, the federal-state partnership that provides care for low-income people and other groups, covers more than a fifth of the U.S. population and that patients with disabilities were the fastest-growing beneficiary group in the program. Half of the inflation-adjusted growth in Medicaid was linked to care for people with disabilities. The commission recommended that Medicaid officials in Washington and the states focus on developing ways to improve the quality of care for people with disabilities while lowering costs. (CQ HealthBeat)

COMPANY NEWS

- **Aetna Ready For 'Dual Eligibles' Despite Commercial Focus – CFO**

  Aetna Inc. (AET) believes it can ably serve health-challenged patients covered by both Medicare and Medicaid, even though the company doesn't have a major stake in those markets. Additionally, the commercially-focused health insurer doesn't need acquisitions to win business for dual eligible patients, according to Chief Financial Officer Joseph Zubretsky. Some of Aetna's big competitors have recently made deals with an eye on dual patients, and Aetna has faced questions about whether it has the right make-up for the market. (The Wall Street Journal)

- **CSC Wins Contract to Replace Maryland's Medicaid Management Information System**

  The Maryland Department of Health and Mental Hygiene (MD DHMH) awarded CSC a contract to replace the state's Medicaid Management Information System (MMIS) and provide fiscal agent services for selected DHMH programs. The contract has a five-year base period with three two-year options, bringing the estimated total value to $297 million. Under the terms of the agreement, CSC will develop and implement a new enterprise MMIS solution for healthcare administration supporting MD DHMH. CSC has partnered with CNSI, of Gaithersburg, Md., to develop this solution, which will be aligned with CMS' Medicaid Information Technology Architecture (MITA) framework. (The Wall Street Journal)

- **Temple to pay $83.8 million for Fox Chase Cancer Center**

  Temple University Health System revealed in a conference call that it has agreed to pay $83.8 million for the Fox Chase Cancer Center and immediately invest $30.9 million to expand Fox Chase into Temple's neighboring Jeanes Hospital. (The Philadelphia Inquirer)

- **Humana and CareSource Form Alliance to Serve Medicare and Medicaid Beneficiaries, Particularly 'Dual-Eligible' Population**

  Humana Inc., one of the nation's largest and most experienced Medicare companies, and CareSource, a community-based nonprofit, are joining forces in a strategic alliance designed to enable both companies to more effectively serve Medicare and Medicaid beneficiaries - particularly people who qualify for both programs, the 'dual-eligible' population. Humana and CareSource anticipate working together in multiple states. In states where Humana and CareSource work together, the relationship will be exclusive. The companies did not disclose financial terms of the alliance but acknowledged that there will be some level of risk-sharing. Humana has more than 5 million members enrolled in Medicare plans and CareSource has more than 900,000 Medicaid members (primarily in Ohio). (Humana News Release)

RFP CALENDAR

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

Date	State	Event	Beneficiaries
Mid to late March	California Dual Eligibles	Site Selection	500,000
March 19, 2012	Ohio	Proposals due	1,650,000
April, 2012	Arizona Duals	Demo Proposal released	120,000
April 1, 2012	New York LTC	Implementation	200,000
April 1, 2012	Louisiana	Implementation (GSA B)	315,000
April 2, 2012	Ohio Duals	RFP Released	122,000
April 9, 2012	Ohio	Contract awards	1,650,000
April 13, 2012	Massachusetts Duals	RFP Released	115,000
April 25, 2012	Florida CHIP	Proposals due	225,000
April 30, 2012	Illinois Duals	RFP Released	172,000
May 11, 2012	Ohio Duals	Proposals due	122,000
Mary 18, 2012	Kansas	Contract awards	313,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 15, 2012	Illinois Duals	Proposals due	172,000
June 20, 2012	Florida CHIP	Contract awards	225,000
July 1, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida	LTC RFP released	90,000
July 1, 2012	New Hampshire	Implementation	130,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Contract awards	115,000
July 31, 2012	Illinois Duals	Contract awards	172,000
July/August, 2012	Georgia	RFP Released	1,500,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
January, 2012	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	172,000
January 1, 2013	Massachusetts Duals	Implementation	115,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid to late March	California Dual Eligibles	Implementation	500,000
January 1, 2013	Ohio Duals	Implementation	122,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
July 1, 2013	Michigan Duals	Implementation	211,000
October 1, 2013	Florida	LTC enrollment complete	90,000
October 1, 2014	Florida	TANF/CHIP enrollment complete	2,800,000
January 1, 2014	New York Dual	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
February 1, 2014	Georgia	Implementation	1,500,000

HMA Recently Published Research

Webcast: Medicaid Budgets and California's Dual Eligible RFS

Vernon Smith, Managing Principal

Jennifer Kent, Principal

On Friday, March 2, 2012 HMA Principals Vernon Smith and Jennifer Kent hosted a conference call in conjunction with the Gerson Lehrman Group (GLG). On the call, Vernon provided an update on state Medicaid budgets and the expansion of Medicaid managed care while Jennifer led a discussion of California's request for solutions (RFS) for an integrated delivery model for Medicare-Medicaid eligibles. A webcast replay of the call is available at: **(GLG Research - Link to Webcast)**

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

Vernon Smith, Managing Principal

Kathleen Gifford, Principal

Michael Nardone, Principal

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

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