HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: ILLINOIS DUALS INTEGRATION RFP

HMA ROUNDUP: ILLINOIS PROPOSES MEDICAID CUTS; CALIFORNIA BUDGET NEGOTIATIONS CONTINUE; COLORADO ANNOUNCES EXCHANGE IT AWARD; INDIANA ISSUES EXCHANGE RFP

OTHER HEADLINES: MASSACHUSETTS SENATE PASSES MEDICAID COST-CONTROL BILL; ARIZONA ISSUES MEDICAID PHARMACY BENEFIT MANAGEMENT RFP; NEW MEXICO MEDICAID REDESIGN RAISES CONCERNS AT FIRST PUBLIC HEARING; MICHIGAN, NEVADA RECEIVE FEDERAL HEALTH CARE CO-OP FUNDING

HMA WELCOMES:
RAY JANKOWSKI – LOS ANGELES
STEPHANIE DENNING – DENVER

MAY 23, 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

In Focus: Illinois Duals Integration RFP **2**

HMA Medicaid Roundup **5**

Other Headlines **9**

Company news **13**

RFP Calendar **14**

Dual Integration Proposal Status **15**

HMA Welcomes… **16**

HMA Recently Published Research **17**

Upcoming HMA Appearances **17**

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

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

IN FOCUS: ILLINOIS DUALS INTEGRATION RFP

This week, our *In Focus* section highlights the key points of the Illinois RFP, released May 14, 2012, to integrate care for dual eligibles under the capitated model. Illinois is the second state, after Ohio, to release an RFP for dual eligible integration. 23 states have released proposals to CMS for dual eligible integration demonstrations, with 18 states pursuing a capitated financial model. The Illinois RFP is part of a broader care integration initiative undertaken by the State's Healthcare and Family Services (HFS) agency. The Care Coordination Innovations Project (CCIP) is likely to issue a total of four procurements. In February 2012 HFS issued the Phase I care coordination RFP. The May 14, 2012 dual integration RFP is the second of the four procurements. A 2011 state law mandated that 50 percent of the Medicaid population be enrolled in care coordination by January 2015.

RFP - Greater Chicago Region: Link to PDF

RFP – Central Illinois Region: Link to PDF

Target Population

Illinois issued two RFPs for the dual eligible target population, one for the Greater Chicago region and one for the Central Illinois region. In total, the target population includes 136,000 dual eligible lives. The vast majority of the target population, 118,000, resides in the Greater Chicago region. The Greater Chicago region in the RFP covers an estimated 118,000 dual eligible lives in Cook, DuPage, Kane, Kankakee, Lake, and Will counties. The Central Illinois region in the RFP covers just under 18,000 dual eligible lives in Champaign, Christian, De Witt, Ford, Knox, Logan, Macon, McLean, Menard, Peoria, Piatt, Sangamon, Stark, Tazewell, and Vermillion counties.

Key RFP Elements

- The RFPs indicate that the State will award a minimum of two, and no more than five contracts, in each region. At the HFS Medicaid Advisory Committee (MAC) meeting on May 18, HFS staff indicated that they would likely award five contracts in the Greater Chicago region and two contracts in the Central Illinois region. However, if a Managed Care Community Network (MCCN) is established in the Greater Chicago region, serving any of the counties, it may be one of the five awarded dual integration contracts. MCCNs are provider led Medicaid networks which operate under HFS authority. They are not licensed HMOs. MCCNs are one of the coordinated care plan model options available under the Phase I care coordination RFP issued by HFS in February 2012 to serve the adult Medicaid population with complex health needs or seniors and persons with disabilities (SPDs) who do not have Medicare coverage.
- As with other dual integration models, target population lives would be passively enrolled into managed care plans with the ability to opt-out prior to enrollment or any time after enrollment. At the MAC meeting, HFS staff acknowledged that this could produce enrollments lower than the target population of 136,000.
- The first month of coverage is expected to be January 2013.

- If two or more plans are performing well, the State may expand the initial geographic scope of the dual integration demonstration. The RFP also indicates that plans performing well may also have the opportunity to serve non-dual Medicaid SPD population in the Integrated Care Program in expanded areas as well. It is unclear where duals and ICP expansion might occur. The state has previously indicated an interest in expanding managed care for duals to areas including Rockford, Quad-Cities, and East St. Louis.
- The RFP asks bidders to identify additional benefits they will provide beyond the required benefit package. Within seven days of State release of capitation rates, bidders will have an opportunity to revise their supplemental benefits plans. This would appear to indicate that capitation rates will be released to plans after the proposal due date of June 18, 2012.
- Enrollment in the awarded plans will be phased in, enrolling first those who affirmatively choose to enroll in a MCO and those in the Medicare Part D low-income subsidy for January 1, 2013 coverage. According to the RFP, HFS expects to add 5,000 enrollees per month over subsequent months.

Current Managed Care Market

Illinois currently operates the Integrated Care Program, a mandatory managed care program for non-dual aged, blind, and disabled (ABD) Medicaid enrollees in the Greater Chicago area excluding the city of Chicago itself. In a little over a year, the program has enrolled nearly 36,000 of an expected 42,000 non-dual ABD lives. These beneficiaries are served by Aetna and Centene.

Integrated Care Program (Non-Dual ABDs)	May 2012 Enrollment	%
Aetna Better Health	18,179	50.6%
IlliniCare (Centene)	17,745	49.4%
Total ICP Enrollment	**35,924**	

Source: State Enrollment Data, May 2012

Additionally, the State operates a voluntary managed care option for the TANF related Medicaid and CHIP population (All Kids, Moms & Babies, and FamilyCare for children, parents and pregnant women). Combined, the three plans have enrolled more than 213,000 Medicaid lives as of May 2012. Meridian Health Plan is available in Cook County, McHenry County and 2 regions in western Illinois. Family Health Network, an MCCN, operates exclusively in Cook County. Harmony Health Plan, by far the largest of the three plans, is available in Cook and Kane counties as well as southern Illinois. Aside from Cook, McHenry and Kane counties, none of these plans overlap with the target population geographies under either of the dual integration RFPs.

Voluntary MCO Program	May 2012 Enrollment	%
Meridian Health Plan	7,245	3.4%
Family Health Network	73,100	34.3%
Harmony Health Plan (WellCare)	132,908	62.3%
Total Voluntary MCO Enrollment	**213,253**	

Source: State Enrollment Data, May 2012

Scoring Criteria / Response Timeline

Both the Care Coordination and Care Management and Past Performance sections of the scoring criteria would likely disadvantage plans who have not previously served the dual eligible population. At the MAC meeting on May 18, HFS affirmed that it is looking for the best possible plans to serve the dual eligible population and that past performance serving the duals is a key factor in this determination. However, the past performance item is only 100 points, while care coordination and network account for 60 percent of the total scoring.

Scoring Criteria	Points
Organization/ Operation	140
Provider Network and Services	200
Care Coordination and Care Management	400
Outcomes/ Evaluation	60
Health Information Technology	100
References/ Other Contracts/ Past Performance	100
Total	**1,000**

RFP responses are currently due on June 18, roughly five weeks after the RFPs were released. The timeline below builds in little room for delays if the State is going to meet the January 1, 2013 target date. This timeline does not include the important Medicare timeline milestones that interested plans have been required to meet over the past few months.

Timeline	Date
RFPs Released	May 14, 2012
Proposals Due	June 18, 2012
Capitation Rates Released	June-July, 2012
Contract Awards	Late July, 2012
Implementation Phase-In Begins	January 1, 2013

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein / Jennifer Kent

The California Budget Subcommittees are meeting to discuss the changes proposed in Governor Brown's revised budget proposal. Key issues under discussion include:

- Shifting all children in the Healthy Families program (875,000) to Medi-Cal vs. an alternative approach to shift just those children in families with income under 133% federal poverty level (FPL) to Medi-Cal, a change that would take place in 2014 under the ACA. This shift would affect approximately 200,000 children currently enrolled in Healthy Families.
- Revising the Medi-Cal $15 co-payment proposal for non-emergency room ER visits and $3.10 co-pay for certain drugs. The drug co-pay would be applied to managed care with plan rates being reduced based on the actuarial amount of these co-pays.
- Increasing caseload for community-based adult services program from 50% of the original adult day health care Medi-Cal benefit recipient population to 80% of that population
- Expanding Medi-Cal managed care to 28 counties beginning June 2013
- Expanding the dual eligible demonstration program from four to eight counties. We note that earlier this week, the Department of Health Care Services communicated to Medi-Cal health plans that it is in discussions with CMS about a potential July 1, 2013 implementation date for its dual eligible demonstration pilot. As a reminder, the revised budget recommended a March 1, 2013 implementation date.
- Reducing reimbursement rates for hospitals and nursing facilities.
- Extending the gross premium tax assessed on Medi-Cal managed care plans (which requires a 2/3 vote).

Once the Budget Subcommittees complete their actions, the budget will go for a vote in each Budget Committee and then to each house. The budget will then proceed to a Budget Conference Committee consisting of members of each house and this Committee and negotiations with the Governor will lead to a final budget. Passage of the budget is expected by June 15, 2012 and with the exception of any tax increase or tax extension can be done with a majority vote. Signature of the budget by the Governor, after any potential vetoes, is expected to occur before July 1, 2012

In the news

- **Healthy Families Conversion Slowing Down**

  California health officials need to go a little slower in their plan to move 875,000 children out of the Healthy Families program and into Medi-Cal managed care, according to a Senate budget subcommittee that voted Tuesday to reject the state's full plan. It did endorse the transition of about 200,000 Healthy Families "bright line" children to Medi-Cal -- those beneficiaries at or below 133% of federal poverty level. The Afforda-

ble Care Act requires that those children be moved to Medi-Cal by 2014. (California Healthline)

- **Democrats Likely To Spurn Four Key Proposals in Brown's Budget**

  Democratic legislators in California are likely to disagree with Gov. Jerry Brown (D) on four main proposals in his revised fiscal year 2012-2013 budget plan, the San Francisco Chronicle reports. Democrats and the governor mostly will disagree on four proposals involving cuts to: CalWORKS; Cal Grants, which provides financial aid for low-income college students; Funding that the state provides families to subsidize child care expenses; and IHSS. (California Healthline)

Colorado

HMA Roundup – Joan Henneberry

The Colorado Health Benefit Exchange released an RFP in January seeking an array of services and technology that will support the state's health insurance exchange. On May 17, the COHBE Board announced it has tentatively awarded the contract to CGI Inc. and is finalizing contract terms.

In the news

- **Colorado Medicaid expansion goes slower than expected**

  When Colorado became one of the few states offering public Medicaid health insurance to adults without children, need was predicted to be much higher than supply. Colorado can afford only 10,000 adults in the joint federal-state funded program, while health officials calculated 50,000 would be eligible. The state set up a lottery system to handle the expected flood of demand. Instead, as the first group of clients gets enrolled for care, about 6,000 have finished the application process. That leaves thousands more spots available, at least for now, and health advocates are casting the net wider for those in need who may not have heard. (Denver Post)

- **Colo. governor expected to sign Medicaid payment reform**

  A bipartisan bill (link to bill) in Colorado creating a Medicaid payment reform and innovation pilot program is expected to be signed soon by Gov. John Hickenlooper. Co-sponsored by state Reps. Cheri Gerou and Dave Young, the measure creates a process by which the state's healthcare policy and financing department would pilot-test fee-for-service alternatives and regional care collaborative organizations. Pilots could incorporate elements such as global payments, risk-sharing and aligned payment incentives. The bill calls for the healthcare policy and financing department to select projects to be included in the program by April 1, 2013 and specifies that pilots proposing global payment methodologies should be given preference. (Modern Healthcare)

Illinois

HMA Roundup – Jane Longo / Matt Powers

Tuesday, the Illinois Department of Healthcare and Family Services released an updated list of proposed budget cuts totaling $1.36 billion in savings. The list includes:

- $350 million in savings from employing a private vendor to conduct enhanced eligibility verification
- $180 million from limiting adult and children's prescriptions to four per month without prior approval
- $77 million from high cost branded prescription drugs going generic
- $72 million from eliminating Cares Rx, state-only program that provides support for prescription drug costs to seniors
- $40 million from establishing a performance-based payment system related to potentially preventable readmissions
- $44 million from increasing co-pays to the maximum allowable limit
- $30 million from eliminating payment for an entire hospital stay if a provider preventable condition occurs during that period
- $16 million from enhanced care coordination including the duals demo

A Medicaid budget proposal being debated in the House and Senate includes a 3.5 percent rate reduction to hospitals, excluding critical access hospitals. Nursing home rates would be reduced by 2.7 percent.

Illinois Care Coordination and Budget Timeline – Key Dates and Milestones

Date	Care Coordination	Budget/Medicaid Cuts
January 2012	***Phase I RFP Released*** Complex Adults, no MCOs	
February 2012	75 LOIs received	***Gov. Address, Feb. 22.*** Call for $2.7B in Medicaid cuts.
March 2012		HFS released menu of possible cuts and associated savings.
April 2012	***Phase I Proposal Due Date Delayed***	***Gov. Budget Proposal*** April 19, 2012
May 2012	***Dual Integration RFP Released*** May 14, 2012	***HFS posts revised menu of budget cuts and savings*** – May 22, 2012 Legislative Scheduled Session ends May 31, 2012
June 2012 through August 2012	***Phase I Proposals Due*** June 15, 2012 ***Dual Integration Proposals Due*** June 18, 2012 ***Dual Integration RFP Winners*** To be announced July 1, 2012	If nothing passes, Legislature moves to extended session with two-thirds majority required to pass a law.

June 2012 through August 2012	***Phase II RFP Release*** Complex Children ***Medicaid MCO RFP*** Summer 2012, may be delayed	
January 2013	***Phase I, Phase II, Duals*** Go live January 1, 2013 ***Medicaid MCOs*** Depends on possible delay	

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

In the news

- **Medicaid cuts advance in Illinois Legislature**

  Democrats unveiled their plan Monday to slash spending on health care programs for low-income Illinoisans by nearly $2 billion. The 400-plus page amendment contains cuts to dozens of Medicaid programs, as well as provisions aimed at fighting fraud and shoring up eligibility rules. If enacted, the changes are designed to be combined with a proposed $1 increase in the state cigarette tax to help bring the total reduction in Medicaid spending to $2.7 billion. (Quad City Times)

Indiana

HMA Roundup – Cathy Rudd

On May 15, Indiana released an RFP to procure Eligibility Determination Services through an automated system that includes solution development, configuration, implementation, and maintenance services to support the Indiana programs providing TANF, SNAP (Food Stamps), health care coverage (Medicaid), and other related eligibility services. Indiana's current system (ICES – Indiana Client Eligibility System) was implemented in 1993. A pre-proposal conference is scheduled for May 23. Bids are due on July 2. The RFP requires that the new system begin operation by December 31, 2015. In addition to award of a contract for the design, development, and implementation of the new system, the procurement will also include award of a four-year operation and maintenance contract with two one-year options to renew. The incumbent is Deloitte.

Link to RFP: http://www.in.gov/idoa/proc/bids/rfp-12-113/

Michigan

HMA Roundup – Esther Reagan

On May 18, CMS announced that Michigan will receive a $72 million award to finance the new Michigan Consumers Healthcare CO-OP (MCHCO), a member-governed non-profit health insurance company. Funding to develop CO-OPs is authorized through the Affordable Care Act through low-interest and no-interest loans from the U.S. Department of Health and Human Services (HHS). Co-Ops have member-based boards and are meant to offer member-friendly, affordable health insurance options to individuals and small businesses. MCHCO projects an initial enrollment of about 37,000 members and is expected to be available to consumers by January 1, 2014. HMA Colleagues Larry

Zbanek, Linda Hamacher, and Janet Olszewski worked with the MCHCO to develop the loan application and to go through the CMS review process.

In the news

- **Michigan CO-OP Awarded $72 Million to Provide Health Insurance Options in 2014**

  The Centers for Medicare and Medicaid Services (CMS) today announced its award of $72 million in financing for the new Michigan Consumers Healthcare CO-OP (MCHCO), a member-governed nonprofit health insurance company that will help to control costs while providing accessible healthcare for all residents. By Jan. 1, 2014, Michigan residents will have the opportunity to buy health insurance coverage as individuals or families from the Michigan Consumer Healthcare CO-OP. The MCHCO will differ from other insurance companies because it will be governed by its members - the individuals and businesses that purchase the coverage. (WSJ Market Watch)

OTHER HEADLINES

Alabama

- **Medicaid CFO, actuary proposed**

  While the state's public health officer said he does not support privatizing Alabama Medicaid agencies, he said Tuesday that he does support it hiring a chief financial officer and an actuary to keep track of spending costs as part of a managed care model to "bend the cost curve" for the $5.3 billion program. (Montgomery Advertiser)

- **If voters reject oil-gas fund bailout that is linchpin of state budget, crisis forecast for Medicaid**

  Alabama voters will get the chance this September to decide the fate of the linchpin of the Legislature's budget, something state officials say is necessary to prevent even greater cuts to Medicaid and prisons. The Legislature on May 16 passed a $1.67 billion budget to fund most non-education state services in the fiscal year starting Oct. 1. The General Fund budget is about $67 million less than the current fiscal year. Lawmakers debated further cutting Medicaid and prisons, but ended up giving citizens the chance to vote Sept. 18 on a constitutional amendment authorizing the transfer of $145.8 million from an oil and gas trust fund to the General Fund. The same amount would also be transferred in 2013 and 2014. (AL.com)

Arizona

- **Pharmacy Benefits Management RFP**

  Arizona released an RFP to select a vendor that meets both the District's strategic and operational needs and objectives going forward as it shapes the future direction of its health and welfare pharmacy benefit program. The District will partner with the selected vendor(s) who can accommodate the District's desire to place a greater focus on keeping people healthy, well and productive, and who can identify areas for aggressive disease (care) management for the District's employee and retiree population, and thereby maintain or reduce costs. The partnership will support the objectives of the

customized benefit package for which proposals are being sought. Proposals are due June 5, 2012.

Kansas

- **Kansas Submits Medicaid Waiver Revisions for State-Based Health System**

  Kansas legislators are seeking approval for key Medicaid system reforms the state will need to survive federal cuts over the next five years and streamline their program. Through the application submitted to the Centers for Medicare and Medicaid Services (CMS), the state seeks support for the new Kansas-based health care system, KanCare, to be implemented in 2013. The revisions to the state's Section 1115 demonstration waiver application include the second facet of a two-track process which requests further federal funding to address needs for Kansas' large aging population, according to Republican Lt. Gov. Jeff Colyer, M.D. (Heartlander)

Maine

- **GOP achieves promised cuts to MaineCare**

  When Republican lawmakers took office with majorities in both chambers nearly two years ago, they pledged to cut state spending and, in particular, the state's Medicaid program. At the time, there were 361,000 Mainers on MaineCare, the state's version of Medicaid. Today, there are 343,000, according to the Department of Health and Human Services. And while some of that drop is because of attrition and other factors, much of it is because of new limits imposed on the program. After all the cuts take effect -- some require federal permission -- 38,000 people in Maine will be dropped from Medicaid health care coverage and an additional 12,000 will lose some of their coverage, according to the Legislature's nonpartisan fiscal office, as well as estimates from social service advocates. (Morning Sentinel)

Massachusetts

- **Funding for state 'safety net' hospitals approved**

  Seven Massachusetts hospitals that primarily serve low-income patients will receive up to $628 million over three years to change how they care for patients, with the goal of improving quality and cutting costs, state officials announced Tuesday. The Patrick administration is pushing hospitals to change so that they can focus on keeping patients healthy, rather than on the tests and treatments for which they are paid. But doing that requires investing in improved communication between providers and better monitoring the needs of large groups of patients. The infusion of money to hospitals that serve the most vulnerable patients will help them take those steps, said Dr. JudyAnn Bigby, state secretary of Health and Human Services. (Boston Globe)

- **Mass. Senate Passes Historic Health Care Cost-Cutting Bill**

  Crunching through 265 amendments during two full days of public debate, the Senate on Thursday capped a framework of nation-leading health care reforms with landmark cost-control legislation that will save the Commonwealth $150 billion in the next 15 years while improving the quality of care and increasing the transparency and accountability of the state's entire health care system. The bill passed 35-2. The approved bill, for the first time in the nation, establishes a statewide health care cost growth goal

for the health care industry equal to the projected growth of the state's gross state product (GSP) plus .5 percent from 2012 to 2015 and equal to the state's GSP beginning in 2016. This change will result in an estimated $150 billion in savings over the next 15 years which will be passed on to businesses, municipalities and residents of the Commonwealth who are struggling with increasing premiums and other health care costs. (WBUR.org)

Minnesota

- **Feds probe Minnesota's Medicaid bills**

  Congressional investigators are raising new questions about how Minnesota bills federal taxpayers for Medicaid costs, seeking evidence that the state has been overpaying state Medicaid contractors to cover losses from state-run public health programs. The letter to Minnesota Human Services Commissioner Lucinda Jesson, obtained Friday by the Star Tribune, revives allegations of inflated payments and represents an escalation in one of three continuing federal probes into the state's use of Medicaid funds over the past decade under Republican and Democratic governors. It comes three weeks after a U.S. House panel made the state the focus of a grueling public hearing. (The Star Tribune)

Nevada

- **Co-op health plan gets U.S. loans**

  The Centers for Medicare & Medicaid Services awarded a loan Friday to a Las Vegas coalition to start a statewide, consumer-governed health insurance company called a consumer operated and oriented plan. Hospitality Health CO-OP received two loans totaling $65.9 million to begin offering health plans through insurance exchanges established under the Patient Protection and Affordable Care Act. Hospitality Health CO-OP is sponsored by the Culinary Health Fund, its national parent UNITE HERE Health and the Health Services Coalition, a local consumer advocacy group that negotiates health care costs and tracks quality of care for more than 300,000 members employed by cities, unions and major corporations. (Las Vegas Review-Journal)

New Mexico

- **Beneficiaries raise concerns about proposed NM Medicaid overhaul at first public meeting**

  Dozens of health care providers said Thursday that New Mexico's proposal to overhaul its $3.9 billion Medicaid program could make them lose money. Medicaid beneficiaries and representatives of state and tribal governments raised concerns at a public meeting about proposed changes to the health care system, which serves 560,000 people. Providers, however, said they don't have the tools to execute some of the state's quality improvement ideas. Critics also oppose proposed new requirements such as not allowing people to enroll retroactively. Hospital administrators argue not allowing people to enroll after they start receiving care would leave unpaid medical bills. The state's Department of Children, Youth and Families said this could mean children could lose care while waiting to be enrolled. A proposal to require Native Americans to obtain Medi-

caid benefits through managed care organizations has drawn opposition from Navajo Nation officials. (The Republic)

New York

- **Medicaid Overpaid New York on Disabled Care, U.S. Says**

The federal government paid New York State $700 million more in 2009 than the state needed to care for residents with developmental disabilities who lived in its institutions, according to the inspector general of the Department of Health and Human Services in Washington. The finding suggested that billions of dollars earmarked for institutional care in New York had been used for other purposes over the last several years. No penalty is recommended, however, because the payments were approved by federal regulators. (New York Times)

Pennsylvania

- **Pennsylvania's Employment Situation for April 2012**

Pennsylvania's seasonally adjusted unemployment rate was 7.4 percent in April, down one-tenth of a percentage point from the 7.5 percent March rate. Pennsylvania's unemployment rate was below the U.S. rate of 8.1 percent, and has been below the U.S. rate for 48 consecutive months, and at or below the U.S. rate for 66 consecutive months. The state's unemployment rate was down 0.5 percentage points from April 2011. (Pennsylvania Dept. of Labor & Industry)

Rhode Island

- **Chafee drops proposal to cut Medicaid dental care**

Better-than-expected state revenue forecasts have led Rhode Island's governor to back away from a proposal to eliminate dental care for adults on Medicaid. The good fiscal news also led Gov. Lincoln Chafee to reduce the magnitude of his proposed meals tax increase. He had sought to raise the tax from 8 percent to 10 percent but is now proposing to raise it to 9 percent. When he offered the proposals in January, the independent governor said he hoped to revise them this spring if projections indicated that state revenues would increase. Earlier this month, state budget experts said Rhode Island can expect to take in tens of millions more this fiscal year and next. (Boston Globe)

Texas

- **State's Medicaid Chief Retiring**

Billy Millwee, who oversees the state's giant Medicaid and Children's Health Insurance programs, will retire in August. He has directed the Medicaid and CHIP programs, which account for nearly a quarter of the state's total budget, since early 2010. (Texas Tribune)

National

- **Medicare and Medicaid: When Two Is Not Better Than One**

Experts all agree that controlling Medicare and Medicaid spending is crucial to slowing rising health care costs. However, under the current system, the most expensive subset of Medicare and Medicaid beneficiaries are lost in a complicated web of multiple pay-

ers and programs that lack both the incentive and the ability to curb risings costs. These beneficiaries are "dual eligibles"--people who are eligible for both Medicare and Medicaid at the same time--and they are among the poorest and sickest individuals in our society. The Atlantic poses that Congress should do away with the dual eligible model and instead place responsibility for this population in one federal program that can ensure quality of care and cost control. (The Atlantic)

- **Red States Unswayed By Federal Health Exchange Plan**

  Following another apparent offer of state flexibility for health exchanges from the U.S. Department of Health and Human Services (HHS), officials from some Republican-controlled states remained stalwart in their opposition to the concept, even as the Obama administration described this week what an online insurance marketplace run by the federal government would look like. (Governing Magazine)

COMPANY NEWS

- **DaVita and HealthCare Partners Announce Merger Agreement**

  DaVita Inc., a provider of kidney care services, has agreed to acquire HealthCare Partners, a Torrance, Calif.-based operator of medical groups and physician networks. The deal is valued at approximately $4.42 billion, including $3.66 billion in cash and approximately 9.38 million shares of DaVita common stock. Sellers include Summit Partners, which first invested in Healthcare Partners seven years ago. (DaVita News Release)

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
May 25, 2012	Ohio Duals	Proposals due	115,000
Late May	Kansas	Contract awards	313,000
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 20, 2012	Florida CHIP	Contract awards	225,000
July 1, 2012	New York LTC	Implementation	200,000
June 4, 2012	Massachusetts Duals	Proposals due	115,000
June 18, 2012	Illinois Duals	Proposals Due	136,000
July 1, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida LTC	RFP released	90,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Contract awards	115,000
July 31, 2012	Illinois Duals	Contract awards	136,000
July/August, 2012	Georgia	RFP Released	1,500,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
September 20, 2012	Ohio Duals	Contracts finalized	115,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
Late 2012	New Hampshire	Implementation (delayed)	130,000
January, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida TANF/CHIP	RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	136,000
January 1, 2013	Massachusetts Duals	Implementation	115,000
February 1, 2013	Ohio Duals, NW, NC, EC	Implementation	35,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
April 1, 2013	Ohio Duals, NE	Implementation	32,000
May 1, 2013	Ohio Duals, C, WC, SW	Implementation	48,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
July 1, 2013	Michigan Duals	Implementation	211,000
October 1, 2013	Florida LTC	Enrollment complete	90,000
January 1, 2014	New York Duals	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	Hawaii Duals	Implementation	24,000
February 1, 2014	Georgia	Implementation	1,500,000
October 1, 2014	Florida TANF/CHIP	Enrollment complete	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

Below 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	Deadline for Plans to submit applications	3-way contracts signed	Open enrollment ends	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012					N/A[+]	Spring 2013	N/A	1/1/2014
California*	Capitated	800,000	X	4/4/2012					5/24/2012	9/20/2012	12/7/2012	1/1/2013
Colorado	MFFS	59,982	X	4/13/2012					N/A	N/A	N/A	1/1/2013
Connecticut	MFFS	57,568	X	4/9/2012					N/A	N/A	N/A	12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012					TBD	7/1/2013	TBD	1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	5/16/2012			N/A	N/A	N/A	1/1/2013
Idaho	Capitated	17,219	X	4/13/2012					N/A	9/20/2012	12/7/2012	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012			TBD	TBD	TBD	7/1/2013
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012			N/A	N/A	N/A	1/1/2013
New York	Capitated	460,109	X	3/22/2012					TBD	TBD	TBD	1/1/2014
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	5/20/2012			N/A	N/A	N/A	7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012			N/A	N/A	N/A	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012					TBD	9/20/2012	TBD	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012			TBD	TBD	TBD	1/1/2014
Texas	Capitated	214,500	X	4/12/2012					TBD	TBD	TBD	1/1/2014
Virginia	Capitated	56,884	X	4/13/2012					TBD	TBD	TBD	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012			TBD	TBD	TBD	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012			TBD	TBD	TBD	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Totals	**18 Capitated 5 MFFS**	**2.7M Capitated 482K FFS**	***23***		***13***		***2***					

**Duals eligible for demo based on approval of 10 county expansion, Gov. Brown's May Revise Budget limits to 8 counties, delays implementation date to March 1, 2013.*

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

HMA WELCOMES…

Stephanie Denning – Denver, Colorado

Stephanie Denning joined the Denver office as a Senior Consultant on May 21. Stephanie has over a decade of experience in health care and comes to HMA from Kaiser Permanente where she has served as the Senior Manager of Public Programs Operations. In this role , Stephanie oversaw the management of Kaiser Permanente Colorado's Medicaid, CHIP and Charitable Health Coverage lines of business; interfaced with the Colorado Department of Health Care Policy and Financing on contract issues and member and program needs; and represented Kaiser Permanente Colorado with external organizations for Medicaid reform, outreach and enrollment efforts, and public policy discussions. Prior to joining Kaiser Permanente, Stephanie served as a member of an four-person SWAT Team working for the Executive Vice President for Service Delivery at Policy Studies, Inc. (PSI), and was responsible for assessing business processes across multiple PSI operational sites, identifying process improvements, and implementing process changes. Prior to this assignment, Stephanie served as the Director of Business Development and Client Management in the Government Health Division of PSI and as the Program Manager of the CHP+ Program Contract. Earlier in her career, she was the Chief Communications Officer at Child Health Advocates in Denver and the Director of Marketing and Public Relations at the Denver Health and Hospital Authority. Stephanie earned her Bachelor of Science degree and her Master of Public Administration degree at the University of Denver.

Ray Jankowski – Los Angeles, California

Ray Jankowski joined the LA office as a Principal on May 23. Ray has over 30 years of experience in hospitals and health plans and comes to HMA from CalOptima where he served at the Executive Director of the Medi-Cal Program. In this role, Ray was responsible for the daily oversight of the $1.2 billion Medi-Cal managed care program in Orange County, California, including the delegated Health Network delivery system, behavioral health integration, and the Healthy Families Program. He also played a leadership role at CalOptima in the areas of auto assignments, intergovernmental transfer arrangements, and other key projects. Previously, Ray served as the Chief Operating Officer of CalOptima and the Chief Financial Officer of CalOptima. From 2003 to 2010, Ray served as the Chief Executive Officer of Community Hospital of Long Beach. During this time, he was responsible for leadership and management of the hospital, including clinical functions and financial performance. Earlier in his career, Ray served as the Chief Financial Officer at Western Medical Center in Santa Ana, at Long Beach Community Hospital, and at St. Francis Medical Center in Lynwood, California. Ray earned his Bachelor of Science degree and his Master of Business Administration degree at UCLA.

HMA Recently Published Research

Health Care Use and Chronic Conditions Among Childless Adult Medicaid Enrollees in Arizona

Jack Meyer, Managing Principal
Esther Reagan, Senior Consultant
Dennis Roberts, Senior Consultant

Under the Affordable Care Act and beginning in 2014, Medicaid eligibility will expand to 133% of the FPL for nearly all individuals. Arizona is one of the few states that already cover adults without dependent children in Medicaid through a longstanding Section 1115 waiver. This report, based on 2007 Medicaid claims data for adult Medicaid enrollees in Arizona, provides an analysis of health care utilization and health conditions for childless adults and compares them with parents and adults with disabilities. Understanding the health care use and needs of low-income childless adults can help inform other states' efforts to care for these adults under the Medicaid expansion in 2014. **(The Kaiser Commission on Medicaid and the Uninsured)**

Upcoming HMA Appearances

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

Jennifer Kent, Presenter

May 24, 2012

Princeton, New Jersey

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

Jennifer Edwards, Panel Facilitator

June 25, 2012

Orlando, Florida

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

Joan Henneberry, Panel Facilitator

June 25, 2012

Orlando, Florida