HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: EXPLORING MEDICAL COST ISSUES IN TEXAS' HIDALGO REGION WITH GARY YOUNG

HMA ROUNDUP: CALIFORNIA BUDGET DEAL NEARS COMPLETION; MASSACHUSETTS HOUSE PASSES COST CONTAINMENT BILL; MASSACHUSETTS DUAL ELIGIBLE RFP EXPECTED FRIDAY; FLORIDA CLARIFIES GUIDANCE REGARDING LONG TERM CARE PSNS; GEORGIA ISSUES INTEGRATED ELIGIBILITY SYSTEM RFP; TEXAS RELEASES RAC RFP; WASHINGTON ANNOUNCES FINAL MEDICAID MCO COUNTY ASSIGNMENTS

OTHER HEADLINES: CENTENE, MOLINA AWARDED CONTRACTS IN OHIO PROTEST; IOWA DEVELOPING ALTERNATIVE TO ACA; HEALTH AFFAIRS STUDY PROJECTS STEEP RISE IN HEALTH CARE SPENDING

UPCOMING HMA WEBINAR: WHAT MIGHT THE COURT DO? CONSIDERATIONS FOR THE SUPREME COURT DECISION ON THE ACA – JUNE 19, 2012 – 12:00 PM EDT

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Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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IN FOCUS: EXPLORING MEDICAL COST ISSUES IN TEXAS' HIDALGO REGION WITH GARY YOUNG

This week, our *In Focus* looks at the unexpected utilization issues reported by health plans in the Texas Medicaid managed care expansion in the Hidalgo service area. In the past week, two managed care plans – Centene and Molina – have lower earnings expectations, partially as a result of unexpectedly high medical and long term care costs in the Hidalgo expansion region. Starting March 1, 2012, the STAR and STAR+PLUS programs began enrolling Medicaid beneficiaries in the Hidalgo Service Area which includes Cameron, Duval, Hidalgo, Jim Hogg, Maverick, McMullen, Starr, Webb, Willacy, and Zapata counties. The STAR managed care program provides Medicaid services to children, pregnant women, and TANF populations. The STAR+PLUS program serves those Medicaid individuals with long term care needs. With the majority of news on the Hidalgo expansion issues coming from plan-issued earnings guidance and financial analysts, we asked HMA-Austin's Gary Young to provide some insight as to what led to this higher-than-expected utilization and what cost trends may look like for this Medicaid population going forward.

About Gary Young

Gary Young joined HMA earlier this year from the Texas Health and Human Services Commission (HHSC) where he served as a Senior Policy Advisor in the Medicaid and CHIP division. Gary was responsible for the design, planning, and management of the $6 billion competitive procurement for the Medicaid managed care expansion, and participated on the team responsible for designing and negotiating the State's new 1115 waiver, approved in December 2011. Also, during his HHSC tenure, Gary was responsible for developing 1915(b) and 1915(c) waivers for federal approval, integrating value-based purchasing into Medicaid and CHIP managed care contracts, reviewing health plan financial performance, and assisting actuaries in rate development. Prior to his time at HHSC, Gary served as a Research Associate at the Texas Office of Public Insurance Counsel, where he initiated and directed implementation of the state's first HMO consumer report card, and analyzed underwriting practices and financial data of the managed care industry. Gary earned his Bachelor of International Studies at the School for International Training, and his Juris Doctor at the University of Denver College of Law.

Hidalgo STAR and STAR+PLUS Enrollment Overview

As of June 2012, the STAR and STAR+PLUS managed care expansion in the Hidalgo region has enrolled a combined 392,000 beneficiaries: 323,000 in STAR plans and 68,000 in STAR+PLUS plans.

Enrollment by Month	March 2012	April 2012	May 2012	June 2012
Hidalgo STAR Total	**262,025**	**318,226**	**321,275**	**323,855**
% month/month		*21.4%*	*1.0%*	*0.8%*
Hidalgo STAR+PLUS Total	**65,359**	**67,525**	**67,532**	**68,242**
% month/month		*3.3%*	*0.0%*	*1.1%*

Source: State enrollment data

Centene and Molina combined enroll 64 percent of the STAR beneficiaries and 78 percent of STAR+PLUS beneficiaries. Of the total lives in the Hidalgo service area expansion, Centene serves roughly 42 percent and Molina serves just under 25 percent.

Hidalgo STAR Plans	June 2012 Enrollment	%
Driscoll Children's Health Plan	53,091	16%
Molina Healthcare of Texas	65,455	20%
Superior HealthPlan	141,195	44%
UnitedHealthcare	64,114	20%
Total STAR Enrollment	**323,855**	**100%**

Source: State enrollment data

Hidalgo STAR+PLUS Plans	June 2012 Enrollment	%
HealthSpring	14,809	22%
Molina Healthcare of Texas	30,719	45%
Superior HealthPlan	22,714	33%
Total STAR+PLUS Enrollment	**68,242**	**100%**

Source: State enrollment data

Hidalgo Expansion Interview with HMA's Gary Young

Describe the issues Medicaid health plans are experiencing with respect to high medical and long term care costs in Hidalgo.

The Medicaid health plans report that utilization of acute care and long term services and supports (LTSS) in the Hidalgo service are much greater than anywhere else in the state. They also have concerns about a provision in their contract with Texas Medicaid which requires them to honor existing LTSS service authorizations for up to six months. The requirement does not apply if the health plan performs a new assessment of the member's needs and issues new authorizations at any time during the six-month period. For acute care services, prior authorizations must be honored for the first three months.

What was the process HHSC utilized for setting rates in this service area where Medicaid managed care plans had not operated previously?

Since there was no capitated managed care experience in the Hidalgo service area, HHSC used historical fee-for-service claims experience and applied trend to establish baseline estimates. HHSC also assumed that managed care efficiencies would reduce claims costs in the service area compared with fee-for-service. A somewhat analogous situation occurred in the Dallas and Tarrant service areas in 2011. HHSC has posted a detailed description of the rate-setting process used in that instance, which can be found here: http://www.hhsc.state.tx.us/rad/managed-care/star-plus.shtml.

What is the process HHSC will follow to ensure rate adequacy moving forward in this region?

STAR+PLUS rates in the Hidalgo service area have been certified as actuarially sound and there is insufficient credible claims experience at this point to determine that the rates are inadequate, the program having started operations on March 1, 2012. HHSC reviews relevant health plan encounter data and related financial information as well as

health plan business operations whenever health plans claim to be experiencing loses. The current rates expire August 31, 2012. New 12-month rates will be effective September 1, 2012.

Do you anticipate utilization in Hidalgo will eventually normalize to levels consistent with other regions? If so, how long would you expect that process to take?

Utilization of services is expected to decline. The state believes that there are significant savings to be achieved in the Hidalgo region as evidenced by the aggressive discount factor incorporated into the rate calculation.

Are you aware of any issues that have emerged with respect to the rate adequacy of the pharmacy carve-in?

The health plans have expressed some concern about the pharmacy rates. The pharmacy benefit became a capitated managed care service March 1, 2012. At this point, actual pharmacy claims experience is limited. In addition, pharmacy costs tend to follow a seasonal pattern. March and April —the early part of the current initial rating period — are typically higher cost months.

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

After conducting final budget hearings on Tuesday, the legislature is poised to pass the new state budget by June 15th. Key issues include the expansion of the duals demo to eight counties (from four) and expanding Medicaid eligibility for children between ages 6 and 18 to 133 percent of the federal poverty level, both of which we expect to pass. The eligibility expansion effectively transitions this cohort from the Healthy Families (CHIP) program to Medicaid a year before the change would occur under the Affordable Care Act. Another proposal under discussion is the imposition of copays on Medi-Cal beneficiaries. The proposed legislation would impose a copay of $3.10 for non-preferred drugs, with an exception for patients who receive those medications by mail, and a $15 copay for non-emergency use of the emergency room. This compares to legislation that passed last year but was rejected by CMS which called for copays of $5 per physician visit and $50 for an emergency department visit.

Colorado

HMA Roundup – Joan Henneberry

The Colorado Health Benefits Exchange will begin conducting outreach meetings statewide beginning on July 11.

Florida

HMA Roundup – Gary Crayton

On May 30, 2012, The Florida Agency for Healthcare Administration (AHCA) released guidance related to the long term care ITN. In that guidance, the agency clarified that in order to participate as a long term care provider service network (PSN), controlling interest in the sponsoring organization must be owned by one or more licensed nursing homes, assisted living facilities with 17 or more beds, home health agencies, community care for the elderly lead agencies, or hospices. Hospital or PSNs sponsored by other non-LTC provider groups will not be eligible to participate on a stand-alone basis.

In the news

- **Orlando Regional and Miami-Dade HMO ready for contract war**

  A Coral Gables-based HMO and a major Orlando hospital system are locked in a nasty contracting dispute that is about to land on the doorsteps of Central Florida residents. Simply Healthcare Plans, Inc., said Friday it will start an advertising campaign charging that Orlando Health — the parent of Orlando Regional Medical Center and other hospitals — is being unfair to the minority-owned HMO and is denying Orange County residents the ability to get care through the plan. Orlando Health rejected the allegations, saying Simply Healthcare's minority ownership has "nothing to do with our ability to reach agreement with them" and that it has had difficulty in getting timely and

accurate payment for services it has provided to Simply Healthcare patients. The dispute comes as Florida prepares to move to a statewide managed-care system in the Medicaid program. HMOs, such as Simply Healthcare Plans, need to have contracts with hospitals if they hope to successfully compete for business in the overhauled Medicaid program. (Orlando Sentinel)

- **Medicaid plan wins $36M contract**

  Medicaid patients and their doctors in 31 rural counties will soon get their first taste of real managed care -- the kind that requires permission to spend. The state has chosen the company that will be making the decisions: Better Health, a Coral Gables-based firm that sponsors a provider-service network in Broward County. It has signed a $36-million contract with the Agency for Health Care Administration. Better Health's task is to transform the Medicaid program known as MediPass into a standard managed-care program that requires "prior authorization" – permission -- for hospital stays and many other services. According to the contract, the company could handle up to 35,000 requests annually. It isn't clear when the requirement will begin. (Health News Florida)

Georgia

HMA Roundup – Mark Trail

The state issued an RFP for the integrated eligibility system (IES). However, applications are limited to the five prequalified vendors: Accenture, Northup, Deloitte, HP, and IBM. Proposals are due on July 20, 2012.

The Department of Community Health (DCH) released an updated timeline for its Medicaid redesign project last week. The state now intends to announce its decision on the redesign plans, including whether or not to transition the ABD population to managed care, by this summer. The RFP would then be released in late fall with contract awards scheduled for March/April 2013 and implementation on January 1, 2014.

Also last week, Governor Deal announced that state tax revenue increased 2.1 percent in May. Through 11 months of FY 2012, total net revenue collections increased $703 million or 5.1 percent compared to the last fiscal year.

Illinois

HMA Roundup – Jane Longo and Matt Powers

Last week, the Illinois Department of Healthcare and Family Services (HFS) posted several sets of question and answer responses regarding the dual eligible integration RFP. Those questions and answers, as well as other supporting documents for the procurement, are available on the HFS care coordination website: http://www2.illinois.gov/hfs/PublicInvolvement/cc/Pages/default.aspx

Dual integration RFP responses are due next Monday afternoon, June 18. Also, RFP responses to serve as a Care Coordination Entity (CCE) or Managed Care Community Network (MCCN) for the complex health adult Medicaid population are due this Friday, June 15.

Finally, the state announced that two plans submitted responses to the state's enrollment broker RFP by the June 7 deadline: Maximus and Automated Health Systems.

In the news

- **Brisk cut-off for parents on Medicaid**

  More than 25,000 working parents in Illinois stand to lose their state-provided health coverage on July 1 and most of them don't know it yet. State officials will eliminate their coverage in just three weeks as part of the $2.7 billion package of cuts and taxes the Legislature passed in May in an effort to save Illinois' Medicaid program from possible collapse. But with the clock ticking, the state has just sent out notices to the Medicaid families who will be affected once Gov. Pat Quinn signs the bill, as he has promised to do. (Quad City Times)

Indiana

HMA Roundup – Cathy Rudd

The Indiana Family and Social Services Administration has created a website to track developments related to its plans to integrate care for dual eligibles. We note that Indiana did not submit a proposal to participate in the CMS sponsored dual eligible demonstration and stakeholder documents posted to the site suggest it is pursuing a model outside of the demonstration authority. It is unclear at this early stage what the structure of this alternative model would be. Link

Massachusetts

HMA Roundup – Tom Dehner and Jaimie Bern

Last week, the House passed its version of a health care cost containment bill that legislators project will achieve $160 million in savings over 15 years. Key elements of the bill include greater transparency of health care costs, capping the rate of cost growth, encouraging the development of innovative payment models and redistributing funds to community hospitals through an assessment on insurers and large providers.

Additionally, late last week the state communicated that it tentatively expects to release the dual eligible demonstration request for responses (RFR) by Friday of this week. RFR responses would be due July 26 with plan awards announced on August 31. Initial enrollments through self-selection would be effective April 1, 2013, with the first wave of auto assignments into the plans beginning June or July 1, 2013.

In the news

- **House passes health care cost-control bill**

  The Massachusetts House last Tuesday night overwhelmingly approved its 278-page plan to curb the soaring cost of medical care. The final vote -- 148 to 7 -- sets up what could be difficult negotiations between the House and the Senate, which approved its own cost-control legislation last month. The House debated hundreds of amendments but did not make significant changes to its bill, although it did adopt a $20-million tax

on hospitals and insurers that would fund prevention and public health programs. (Boston Globe)

- **Bill seeking Alzheimer's, dementia care standards advances**

  A proposal to create minimum standards for Alzheimer's and dementia care in Massachusetts nursing homes is one step closer to becoming law. The state Senate Tuesday unanimously passed legislation that would require the Massachusetts Department of Public Health, which regulates nursing homes, to establish minimum standards for facilities with dementia care units. The House approved the proposal last month. A loophole in current Massachusetts law allows nursing homes to advertise specialized Alzheimer's and dementia care units, even though their workers may have such no training. (Boston Globe)

New York

HMA Roundup – Denise Soffel

SelectHealth

SelectHealth, an HIV special needs plan operated by the New York-Presbyterian Healthcare System, was acquired by VNSNY CHOICE as of June 1, 2012. VNSNY CHOICE is related to the Visiting Nurse Service of New York, a not-for-profit home health organization. SelectHealth, which has 6,000 enrollees, operates in New York City.

Medicaid Managed Care Update

New York's Medicaid program continues to shift the population from fee-for-service to care management. Enrollment in Medicaid managed care continues to climb, with a managed care penetration rate of 90 percent statewide. Two additional counties adopted a mandatory program as of May (Schuyler and Steuben), and an additional 2 counties will be operating a mandatory program by July (Cayuga and Wyoming). The remaining 6 counties currently operating as voluntary Medicaid managed care programs are scheduled to become mandatory in the fall of 2012. New York is also in the process of phasing out all partially capitated primary care programs, and shifting those enrollees into full Medicaid managed care plans.

Medicaid Transportation Carve-Out

Despite New York's decision to get out of the fee-for-service business, the state has decided to carve out transportation, both emergency transportation and non-emergency transportation, from the managed care benefit. Transportation management vendors are being procured to provide non-emergency transportation. Emergency transportation will be a fee-for-service benefit relying on local 911 and emergency services. The goal is to reduce redundancy across plans and to create efficiency incentives.

In the news

- **New York Hospitals Look to Combine, Forming a Giant**

Two of New York City's biggest hospital systems reached agreement on Wednesday to pursue a merger that would shake up the way medical care is delivered, especially in Manhattan, where hospitals compete to serve some of the wealthiest neighborhoods in the world. The proposed merger would bring together NYU Langone Medical Center, a highly specialized academic medical center, and Continuum Health Partners, a network of several community-oriented hospitals, including Beth Israel and the two St. Luke's-Roosevelt campuses. The deal was outlined in a memorandum of understanding approved on Tuesday and Wednesday by the boards of both nonprofit organizations, and it is still subject to final confirmation by the boards. It would also need regulatory approval, and at least one patient advocacy group promised to challenge it. (New York Times)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

The Department of Public Welfare announced that it has reached substantial agreement with the County Commissioners Association on a block grant proposal that would combine funding for mental health, child welfare and drug and alcohol programs to the counties. The county block grants would combine seven funding appropriations into one, allowing counties greater discretion in how the money is spent and streamlining reporting requirements into one, unified document. It is believed that the County Commissioners were more willing to reach agreement given the legislative budget proposal currently circulating which would reduce the overall grant by just 10 percent, down from the previously proposed reduction of 20 percent.

In the news

- **Pennsylvania budget: Main proposals pitched by Corbett, Senate are $500 million apart**

  It's not going to be as early a state budget as top Republican lawmakers had hoped, but Pennsylvania's second on-time spending plan in the past decade still looks like a solid bet. The GOP majorities in each chamber are working with the governor's office to bridge a $500 million gap between their plans for next year's spending, which mostly involves differences for education and welfare. Before they decide how much money to appropriate for the University of Pittsburgh or child-care assistance, negotiators say they must agree on the revenue the state can expect to gather in the year starting July 1. And they acknowledge that broader policy proposals, including education reform, also are on the table. (Pittsburgh Post-Gazette)

Texas

HMA Roundup – Dianne Longley

The Health and Human Services Commission (HHSC) re-released its recovery audit contractor (RAC) RFP. As a reminder, HHSC had released a RAC RFP and selected CGI earlier this year before cancelling that award and deciding to re-bid the program. According to the RFP announcement, the state is seeking a contractor to conduct improper payment recovery audit services for payments made by the state of Texas to its Medicaid-enrolled

providers for services provided under the Medicaid State Plan or a waiver of the Medicaid State Plan and other audit services related to fraud investigations as determined by the state.

Washington

HMA Roundup – Julie Johnston

The Washington Health Care Authority announced final county assignments for the managed care organizations participating in the Medicaid and Basic Health programs. Specifically, Molina is in 34 counties, UnitedHealth in 32, Centene in 30, Community Health Plan of Washington in 29 and Amerigroup in 16. In Clark County (Vancouver) the state added two plans (United and Community) to the existing two plans – Centene and Molina. More detail is available here.

OTHER HEADLINES

Arizona

- **New report: State Medicaid program pays $50M annually on care for ineligible patients**

  Arizona's Medicaid program is paying out up to an extra $50 million a year to provide care for those who are ineligible, a new report says. The study done by the state Auditor General's Office finds a 1.1 percent error rate in cases where people were determined to qualify for the free care. Auditor General Debbie Davenport acknowledged that appears to be half of what federal officials found for Arizona in 2008, the last time the Centers for Medicare and Medicaid Services did its own report on the Arizona Health Care Cost Containment System. That same year, Davenport said, the average error rate of the 17 states studied was 6.7 percent. But Davenport said Arizona's 1.1 percent rate still translates to real money. (East Valley Tribune)

District of Columbia

- **D.C. Medicaid reconsidering third contractor in short term**

  The D.C. Medicaid program may back off its plan to immediately add a third managed-care contractor due to lack of interest from the private sector, a senior aide to Mayor Vincent Gray said. However, the administration's tactic of seeking bids on a single-year contract for a new entrant while simultaneously opening bidding for new five-year contracts beginning in 2013 may have backfired. Most of the providers who showed interest in entering D.C. have reportedly decided to bid only on the new five-year program. (Washington Business Journal)

Iowa

- **Branstad working on 'Obamacare' alternative**

  Gov. Terry Branstad said Tuesday that he has been working with leaders from the insurance and hospital industries to form an Iowa alternative to President Obama's

health-reform plan. Branstad said his hope is that the federal government would grant Iowa flexibility to design its own program to help residents obtain affordable, high-quality care. He said details of the idea have not been fleshed out, but it would be less extensive than the plan the president pushed through Congress. (Des Moines Register)

Kansas

- **Medicaid makeover: Can Kansas learn from Kentucky?**

Kentucky Gov. Steve Beshear, a Democrat elected to his second term in 2010, said the for-profit companies' business-like approaches would save the state and federal governments hundreds of millions of dollars over a three-year period. At the same time, he said, the state's health outcomes would improve. Kansas Gov. Sam Brownback, a Republican, said much the same when he announced KanCare, his plan to remake the state Medicaid program. But Kentucky's transition to a fixed-rate managed care system, which began only a few days before Brownback announced his plan in November, has been plagued by problems during its first seven months of operations. The three insurance companies brought in to run Kentucky's Medicaid program – WellCare, Centene and Coventry – are among the five bidding on the Kansas Medicaid contracts, which were let in November and are scheduled to be signed by July. The Brownback administration's plan is to hire three of the companies to operate statewide, providing services to virtually all of the state's Medicaid clients, including long-term services for the elderly, physically disabled and ultimately the developmentally disabled. Those three Medicaid subgroups generally are considered the most expensive and problematic to include in managed care. They were left out of Kentucky's new managed care system. (Kansas Health Institute)

Minnesota

- **Minnesota's Medicaid program under investigation by yet another federal agency**

Add the Centers for Medicare and Medicaid Services to the list of federal agencies investigating the Medicaid program in Minnesota. In a May 16 letter, the agency that runs the federal government's two key health insurance programs asks Human Services Commissioner Lucinda Jesson to answer a series of questions about how Minnesota sets payment rates for managed care organizations in the state's Medicaid program. (Twin Cities Pioneer Press)

Ohio

- **Ohio officials seek Medicaid eligibility overhaul**

Ohio wants to take a complicated and lengthy process used to assess the Medicaid eligibility of more than 700,000 people and simplify it based on income, according to a draft of the plans released last Wednesday. About 2.2 million Ohioans are enrolled in the program that serves the poor and disabled. Eligibility wouldn't change for most beneficiaries, including children, pregnant women and adults getting long-term care. State officials are streamlining the process for a group of people they expect to see grow as a result of the new federal health care overhaul. The proposal targets non-pregnant adults who don't need long-term service or support. (Bloomberg Business Week)

Oklahoma

- **DHS commissioner resigns as chairman**

  Verbal fireworks erupted at an Oklahoma Department of Human Services meeting Tuesday as Brad Yarbrough announced his resignation as commission chairman at the same time another commissioner was demanding a commission vote to censure him. Gov. Mary Fallin appointed Yarbrough to head the commission that oversees the state's largest agency last September. She asked him to lead an agency in turmoil because of several high-profile deaths of children who previously had been reported to the child welfare agency as having been abused or neglected. (NewsOK)

National

- **Steep Rise in Health Costs Projected**

  Economists have been puzzling over whether a three-year slowdown in the growth of health-care spending, prompted by the economy, portends a permanent change. Federal projections indicate that isn't the case. A forecast released Tuesday said the growth rate for U.S. health spending of all types would stay historically low the next two years. But it would increase if most of the federal health-care overhaul takes effect in 2014. After that, the rate would drop, but spending still would grow at a higher rate than that of the past few years, according to the Centers for Medicare and Medicaid Services. The figures, published in the trade journal Health Affairs, suggest the current soft spending is a short-term trend. Consumers have been cutting back on doctors' visits and employers have trimmed insurance since the U.S. first fell into a recession. (Wall Street Journal)

- **Revenues recover but states still tight-fisted**

  States are remaining tight-fisted over spending even as their revenues are expected to top the levels seen before the height of the recession, unnerved by the clouds over the U.S. and global economies. For the upcoming 2013 fiscal year, total U.S. state revenues will increase by $27.4 billion, or 4.1 percent, to reach $690.3 billion. General fund spending, however, will rise by only $14.6 billion, or 2.2 percent, according to a survey of governors' budgets released on Tuesday. (Chicago Tribune)

- **Three Big Insurers To Keep Popular Health Law Provision Regardless of How Court Rules**

  Led by UnitedHealth Group Inc., three major U.S. insurers on Monday announced plans to preserve one of the most popular provisions of the health care law no matter how the Supreme Court rules this month. United, Humana and Aetna all said they would continue to allow young adults to remain on their parents' policies until they reach age 26, a provision that consistently has performed well in public opinion polls. They also promise to fully cover some preventive care provisions without requiring co-payments and to maintain easy-to-navigate appeals processes for policyholders dissatisfied with a claims determination. (CQ Healthbeat)

- **Hospitals Aren't Waiting for Verdict on Health Care Law**

  It was the first Monday in June, counting down to a United States Supreme Court decision that could transform the landscape of American health care. But like hospitals

across the country, Maimonides Medical Center in Brooklyn is not waiting around for the verdict. Win, lose or draw in court, administrators said, the policies driving the federal health care law are already embedded in big cuts and new payment formulas that hospitals ignore at their peril. And even if the law is repealed after the next election, the economic pressure to care differently for more people at lower cost is irreversible. (New York Times)

- **Medicaid Director Association Head: Uncertainty, Legislative Politics Have Slowed State Implementation**

  KHN's Mary Agnes Carey talks to Andy Allison, Arkansas Medicaid director and president of the National Association of Medicaid Directors, who is adamant that cash-strapped states won't be able to do much to expand coverage to the uninsured if the Supreme Court strikes down the law. States are expected to add 16 million people to Medicaid, but that's mostly because the federal government would pick up nearly all the cost. Allison said, "I'm not sure where those individuals will end up now, with money so tight" in the states. (Kaiser Health News)

COMPANY NEWS

- **State of Maryland Awards Cognosante $10.1 Million Contract to Support Medicaid Enterprise Restructuring Project**

  Cognosante, a leading provider of IT services for healthcare organizations, announced it was awarded a contract with the State of Maryland's Department of Health and Mental Hygiene to establish and support the state's Medicaid Project Management Office. The contract, which began on June 4, 2012 is valued at $10.1 million and will continue through May 31, 2016 with two one-year options. (WSJ MarketWatch)

- **Amerigroup to Partner with CMS on Comprehensive Primary Care Initiative**

  Amerigroup Corporation announced that it was selected by the Center for Medicare and Medicaid Services (CMS) to take part in the Comprehensive Primary Care Initiative (CPCi). CMS selected Amerigroup as one of the participating payers in the New Jersey demonstration. Selected payers demonstrated a commitment to support primary care to produce better health, better care and lower costs for patients through comprehensive primary care. CPCi is a four-year multi-payer demonstration project that includes Medicare Fee-For-Service (FFS) populations. The CPCi fosters collaboration between public and private health care payers to strengthen primary care. The objective of the CPCi is to work with payers and practices at the local level to achieve the three-part aim of better health, better care and lower costs by supporting new payment and delivery models that strengthen the capacity of primary care practices to coordinate the total cost and quality of care for its patients. Primary care practices that choose to participate in this initiative will be given resources to better coordinate primary care for its patients. Seven states were selected to participate in the demonstration. (Amerigroup Press Release)

- **Centene Corporation Revises 2012 Earnings Guidance Range**

Centene Corporation announced that it is revising its 2012 guidance to $1.45 to $1.65 per diluted share, from the previously announced range of $2.64 to $2.84 per diluted share. The revised guidance range reflects negative financial results in May for the Kentucky Health Plan and the Hidalgo service area in the Texas Health Plan, as well as in the Celtic individual health business. Higher than anticipated medical costs became evident at the end of the first week of June as part of the May closing process. For Kentucky, the increase in medical costs primarily resulted from the retroactive assignment of members and a significant volume of non-inpatient claims received in May for dates of service prior to May 2012. For Texas, Centene has experienced a significant increase in certain non-inpatient claims received for the Hidalgo service area. (Centene Press Release)

- **Molina Healthcare of Ohio to Continue as Medicaid Managed Care Provider in Ohio**

  Molina Healthcare, Inc. today announced that the Ohio Department of Job and Family Services (ODJFS) has upheld the protest filing of its Ohio health plan, Molina Healthcare of Ohio, and has recommended that Molina Healthcare of Ohio be awarded a Medicaid managed care provider agreement for coverage of the newly designated Central/Southeast, Northeast, and West regions. These three regions together represent the entire state of Ohio. As a result of the decision, Molina will now enter into a comprehensive pre-contracting assessment with ODJFS for a new Medicaid managed care contract commencing on January 1, 2013. (Molina News Release)=

- **Molina shares drop on margin squeeze in Texas**

  Shares in Molina Healthcare Inc fell more than 27 percent after the health insurer withdrew its 2012 earnings forecast, citing margin pressure in a Texas Medicaid plan where the company's costs were outstripping premium revenue. Analysts said other health insurers including Amerigroup Corp, Centene Corp and Cigna Corp could also be hurt by plans that service El Paso and Hidalgo counties. Centene was down about 10 percent, while Amerigroup fell about 5 percent. (Reuters)

- **Centene Corporation Selected for Ohio Medicaid Contract**

  Centene Corporation has been notified by the Ohio Department of Job and Family Services (ODJFS) that Buckeye Community Health Plan (Buckeye), Centene's Ohio subsidiary, has been selected as one of five health plans to be awarded a contract to serve Medicaid members in Ohio, effective January 2013. Under the new state contract, Buckeye will operate statewide through Ohio's three newly aligned regions (West, Central/Southeast, and Northeast). Coverage for both CFC and ABD recipients has been combined into a single contract for each region. The ODJFS on April 6, 2012, initially announced five health plans had been selected as part of the state's recent RFA process. Buckeye was not among the plans selected at that time and was one of five plans that filed a formal protest on April 16. After review of applications, the protests, and other correspondences from the applicants and, after a rescoring of the applications, the ODJFS has recommended Buckeye to be awarded a Medicaid contract. (Centene Press 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
June 1, 2012	Louisiana	Implementation (GSA C)	300,000
June 20, 2012	Florida CHIP	Contract awards	225,000
End of June	Kansas	Contract awards	313,000
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. As a note, this table will not reflect the implementation delay discussed in the Massachusetts roundup until it is finalized.

State	Model	Duals eligible for demo	Proposal Released by State	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	3-way contracts signed	Open enrollment ends	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012	X	7/1/2012	N/A[+]	N/A[+]	Spring 2013	N/A	1/1/2014
California	Capitated	685,000*	X	4/4/2012	X	6/30/2012			9/20/2012	12/7/2012	3/1/2013
Colorado	MFFS	62,982	X	4/13/2012	X	6/30/2012			N/A	N/A	1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	X	6/30/2012			N/A	N/A	12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012			7/1/2013	TBD	1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	9/20/2012	12/7/2012	1/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012			N/A	N/A	1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	X	6/30/2012			9/20/2012	12/7/2012	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012			9/20/2012	12/7/2012	1/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012			TBD	TBD	7/1/2013
Missouri	Capitated[‡]	6,380	X		X	7/1/2012			N/A	N/A	10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012			9/20/2012	12/7/2012	1/1/2013
New Mexico	Capitated	40,000	X		X	7/1/2012			TBD	TBD	1/1/2014
New York	Capitated	133,880	X	3/22/2012	X	6/30/2012			TBD	TBD	1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012			N/A	N/A	1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	9/20/2012	12/7/2012	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	7/1/2012			N/A	N/A	7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012			N/A	N/A	1/1/2014
Rhode Island	Capitated	22,737	X		X	7/1/2012			TBD	TBD	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	X	6/28/2012			9/20/2012	TBD	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012			TBD	TBD	1/1/2014
Texas	Capitated	214,402	X	4/12/2012	X	6/30/2012			TBD	TBD	1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	X	6/30/2012			TBD	TBD	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012			TBD	TBD	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012			TBD	TBD	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012			9/20/2012	12/7/2012	1/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***2***				

**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

UPCOMING HMA WEBINAR

HMA Webinar: What Might the Court Do? Considerations for the Supreme Court Decision on the ACA

Joan Henneberry, Panelist

Jennifer Kent, Moderator

June 19, 2012, Noon EDT

Registration Link

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 ACA 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 covers 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

AHIP - Preparing for Exchanges: Medicaid and Exchange Linkages

Joan Henneberry, Panelist

June 20, 2012
Salt Lake City, Utah

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

The National Council for Community Behavioral Healthcare - Medicaid Health Homes for Individuals with Behavioral Health Conditions

Alicia Smith, Panelist

June 25, 2012
Washington, D.C.

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