
HMA

HEALTH MANAGEMENT ASSOCIATES

*HMA Weekly Roundup
Trends in State Health Policy*

IN FOCUS: RHODE ISLAND MEDICAID ABD/DUALS PROCUREMENT

HMA ROUNDUP: FLORIDA SENATE PPACA COMMITTEE VOTES AGAINST EXPANDING MEDICAID; CALIFORNIA SEEKS CMS APPROVAL FOR BRIDGE PROGRAM; PENNSYLVANIA COURT RESTORES ADULT BASIC PROGRAM FUNDING; MASSACHUSETTS POSTS PRIMARY CARE PAYMENT REFORM RFP; VIRGINIA DUAL ELIGIBLE MOU NEARS COMPLETION

OTHER HEADLINES: D.C. TO DELAY EXCHANGE MANDATE; D.C. MEDICAID MCO AWARDS NEAR RESOLUTION; MAINE FAVORING MEDICAID EXPANSION; NEW MEXICO MEDICAID MCO RFP AWARDS PROTESTED

HMA UPCOMING WEBINARS:

“NEW FACES IN THE EXPANSION POPULATION: PAROLEES AND EX-OFFENDERS”
KAISER: “TRANSLATING THE MEDICAID EXPANSION INTO INCREASED COVERAGE:
THE ROLE OF APPLICATION ASSISTANCE”

MARCH 13, 2013

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Contents

In Focus: Rhode Island Medicaid ABD/Duals Procurement	2
HMA Medicaid Roundup	5
Other Headlines	14
RFP Calendar	18
Dual Integration Proposal Status	19
HMA Webinar	20
HMA Recent Publications	21

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IN FOCUS: RHODE ISLAND MEDICAID ABD/DUALS PROCUREMENT

This week, our *In Focus* section reviews Rhode Island’s procurement for Medicaid health plans to serve the state’s aged, blind, and disabled (ABD), long-term care, and dual eligible populations. Since 2009, Rhode Island has mandated all ABD Medicaid adults into the state’s existing ABD managed care program, Rhody Health Partners, or into the ABD primary care case management (PCCM) program, Connect Care Choice (CCC). In addition to the health plan procurement, known as Rhody Health Options, Rhode Island is also procuring a PCCM vendor to continue to provide the option for enrollment in either a health plan or PCCM for the ABD, long-term care, and dual eligible population. Together the health plan and PCCM programs will be known as the Medicaid Integrated Care Initiative (ICI).

The Rhody Health Options health plan procurement is available [here](#).

The Connect Care Choice enhanced PCCM procurement is available [here](#).

Rhody Health Partners Background

Rhody Health Partners is served by two managed care plans, Neighborhood Health Partners of Rhode Island (NHPRI) and United Healthcare. These plans also serve the broader Medicaid managed care program, RlTe Care.

	NHPRI	United	Total	Spending	Avg. PMPM
RlTe Care	85,858	40,233	126,091	\$447,200,000	\$296
Rhody Health Partners	6,287	7,001	13,288	\$199,700,000	\$1,252
Total	92,145	47,234	139,379	\$646,900,000	

Source: Rhode Island Procurement, Data from FY2011

Currently, long-term supports and services (LTSS), provided under a waiver, are carved-out of the Rhody Health Partners benefit. Additionally, any Rhody Health Partners enrollee who has been a resident in a long-term care setting for more than 30 consecutive days is disenrolled from the program. Dual eligibles beneficiaries are also currently excluded from Rhody Health Partners enrollment.

Integrated Care Initiative - Phase I and II

Phase I

Phase I of the ICI will expand Medicaid care integration to the LTSS, long-term care residents, and dual eligible populations. These new enrollees will have the option of enrolling in an enhanced PCCM program or into one of the two or more health plans contracted to serve Rhody Health Options. The state estimates there are more than 28,500 eligibles, nearly all of them duals, who will enroll under Phase I of the ICI. Only 5,000 of these are expected to enroll in the enhanced PCCM option, while the remaining 23,500 will enroll in one of the contracted health plans.

Phase I of the ICI lays the groundwork for the state’s dual eligible financial alignment demonstration but is anticipated to begin prior to the demonstration’s start date. Under Phase I, dual eligible enrollees will have only their Medicaid benefits managed under either the PCCM or the health plan. Phase I is scheduled to begin September 1, 2013.

Phase II

During Phase II, tentatively scheduled to roll-out 12 months after Phase I on September 1, 2014, Rhode Island will transition all existing Rhody Health Partners enrollees into the ICI, giving them the choice of the enhanced PCCM or health plan model. However, the procurement advises that capacity in the enhanced PCCM may be limited, which should preserve the majority of enrollment in the health plan model.

Phase II will implement the financial alignment demonstration for the dual eligible population under an agreement with CMS. Plans contracted to serve the ICI must have provided evidence of their ability to qualify as a dual eligible financial alignment demonstration plan and must have a three-way contract in place with CMS and Rhode Island prior to the start of Phase II. It is important to note that the procurement indicates that the financial alignment demonstration may not launch at the same time as the rest of Phase II, meaning that if the state and CMS finalize a MOU on the demonstration, have contracts in place, and have conducted readiness reviews, the plans may begin serving the dual eligibles under the demonstration sooner.

Finally, Phase II leaves the door open for the state to carve in certain benefits for the developmentally disabled and severe mental illness populations. While these individuals will be enrolled in the ICI under Phase I, certain benefits will continue to be managed by the Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH).

Timeline and Evaluation Criteria

Responses on the health plan procurement are due to the state on March 27, 2013. PCCM responses are due April 2, 2013. The procurement does not lay out a timeline for evaluation and contract awards; however, it is likely that there will be a quick turnaround given the September 1, 2013 targeted start date.

Implementation Timeline	Date
Procurement Released	February 18, 2013
Questions Due	March 12, 2013
Responses Due	March 27, 2013
Implementation - Phase I	September 1, 2013
<i>Month One: previously enrolled, lost coverage when became dual eligible</i>	
<i>Month Two: Duals, Medicaid-only nursing home residents; one-third of duals not receiving LTSS</i>	
<i>Month Three: Duals, Medicaid-only receiving LTSS at home; one-third of duals not receiving LTSS</i>	
<i>Month Four: Remaining one-third of duals not receiving LTSS; DD and SMI</i>	
Implementation - Duals Financial Alignment Demo (possible sooner)	September 1, 2014
Implementation - Phase II	September 1, 2014

The evaluation criteria does not provide specific weights for each of the technical response sections, but greater description of each section is provided in the procurement document. Requirements pertaining to Phase II and the financial alignment demonstration are likely to be significant, given the goals of the ICI. As noted, only new plans to the Rhode Island market are required to submit the new bidder requirements.

Evaluation Criteria	Scoring
Required information, assurances/attestations	Pass/Fail
Prior experience, understanding	20%
Technical Responses	
<i>Enrollment</i>	
<i>Providing covered services, meeting accessibility standards</i>	
<i>Provider network, development of patient-centered medical homes</i>	
<i>Person-centered system</i>	
<i>Risk profiling</i>	
<i>Care management</i>	80%
<i>Nursing home transition members</i>	
<i>Member/provider services</i>	
<i>Medical management, quality assurance</i>	
<i>Reimbursement</i>	
<i>Evidence-based best practices</i>	
<i>Oral health benefits</i>	
<i>Phase II requirements</i>	
New bidder requirements (non-existing RI plans only)	Pass/Fail

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

Covered California Requests CMS Approval for Bridge Program. On March 11, 2013, Covered California requested approval by CMS of its proposal to establish a Bridge program. The correspondence referenced support from the Brown Administration and supporting legislation introduced by State Senator Ed Hernandez, chairman of the Senate Health Committee. The proposal aims to begin the administrative process in 2013 to allow plan options to be available in 2014. Covered California would negotiate contracts with qualified Medi-Cal managed care plans to serve as a bridge between Medicaid/CHIP coverage and private insurance. The proposal would allow individuals transitioning from Medi-Cal or Medi-Cal/CHIP coverage to Covered California to remain with the same issuer and provider network. An April 1, 2014 implementation date is assumed given delays associated with IT systems functionality. Covered California intends to continue discussions with CMS to develop a potential proposal that would broaden eligibility for Bridge plans up to 200 percent of Federal Poverty Level incomes.

In the news

- **“Geographic Rating Regions Amended”**

California legislators have amended the geographic rating regions for the individual and small group insurance markets, establishing the same 19 regions adopted last year for the large-group insurance market. According to the state’s exchange, Covered California, establishing the same rating regions could avoid consumer and industry confusion. ([California Healthline](#))

- **“Democrats, Brown at odds over healthcare act”**

Governor Jerry Brown’s administration is at odds with the legislature over the Medicaid expansion. While both parties support the expansion, Gov. Brown is proposing scaling back some of the benefits offered beyond what is required, including long-term care benefits. Additionally, the legislature is opposed to moving certain populations currently covered under Medicaid at higher income levels, such as AIDS and cancer patients, into the state’s exchange. ([Los Angeles Times](#))

Colorado

HMA Roundup – Joan Henneberry

All Payer Claims Database Legislation Passes Both Houses. Colorado’s All Payer Claims Database should soon be able to collect claims from the small group (i.e., insurance for businesses with fewer than 50 employees) market, with the passage of HB 13-1015. With strong bipartisan support, the legislation repeals a 40-year-old provision of state law that restricts how mental health claims data may be shared. Originally, those restrictions applied to all types of commercial insurance. Subsequent legislation to conform Colorado law with federal law eliminated this restriction for the large group and

individual markets—leaving small group as the only market segment still subject to these pre-HIPAA limitations. Colorado’s health plans, behavioral health providers, and the behavioral health consumer community supported the changes in the legislation to remove distinctions between “mental health” and “health.” Upon implementation, the APCD will present a more complete and integrated view of health care spending and utilization in Colorado.

Colorado Exchange Board Still to Make Key Decisions. The Connect for Health Colorado board took up the issues of finalizing their initial Level Two grant application from Center for Consumer Information and Insurance Oversight (CCIIO), which requires approval by a legislative oversight committee. Colorado has received two level-one grants but needs additional funds for technology, the customer service call center, and outreach. The board is considering various scenarios for the financial sustainability plan beyond federal support, including carrier fees that range from 1.4% of premium going up to 3.4% in 2015, and private foundation grants for outreach. The legislation that authorized the creation of an exchange for Colorado prohibits the appropriation of state general fund revenues at this time.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Legislative Select Committees on PPACA Hold Hearings. The Senate Select Patient Protection and Affordable Care Act (PPACA) Committee met on March 11, 2013 and voted not to expand “traditional” Medicaid, in favor of pursuing a Florida-based alternative private insurance solution. Senator Negron said he opposed “the Washington plan and wanted a Florida Plan”. Senator Negron outlined five guiding principles that he believes should be contained in the Senate’s alternative: cost sharing, administering the program through the Florida Healthy Kids program, creating health savings accounts, allowing the purchase of private insurance plans, and providing premium assistance. Last week, the House Select PPACA Committee voted against the Medicaid expansion and Speaker Weatherford stated that he believes “it crosses the line of the proper role of government.”. Both Houses are committed to jointly exploring private insurance options as a replacement for traditional Medicaid. The Senate Select PPACA Committee meets on Monday, March 18, 2013.

Medicaid ACA Estimates. The Social Services Estimating Conference met on March 7, 2013 to update projections related to the impact of the ACA on Medicaid. Under the Medicaid expansion, Florida is estimated to serve 1 million individuals and draw down \$51.5 billion in federal funds while costing the state of Florida \$3.5 billion over a 10-year period (2014 - 2023). The conference also estimated that the impact of the health insurance tax (HIT) on Medicaid managed care premiums would cost the state \$1.3 billion over the 10-year period.

Legislative Budget Allocations. Budget allocations from both chambers of the Legislature will be released to committees next week after the Revenue Estimating Conference meets on March 15, 2013 to update state revenue projections.

Medicaid Eligibility Vendor Selected. The Department of Children and Families announced on March 8, 2013 its intent to award a contract to Deloitte Consulting LLP to design, develop, and implement an integrated eligibility system to modify the current ACCESS Florida System. The vendor would support Medicaid eligibility MAGI requirements as well as other system enhancements related to Temporary Assistance for Needy Families (TANF) and Supplemental Nutrition Assistance Program (SNAP).

In the news

- **“Senate panel rejects Medicaid expansion in Florida”**

A Florida Senate committee chaired by Sen. Joe Negron, a staunch opponent of the Affordable Care Act, has rejected Governor Rick Scott’s proposal to expand Medicaid for at least three years. Negron outlined alternative options for expanding Medicaid and appears to be pursuing an arrangement similar to Arkansas, purchasing coverage through the Exchange using federal money. ([Miami Herald](#))

- **“Big Medicaid Gamble Based on Letter”**

The Florida Senate committee’s rejection of the Medicaid expansion as proposed by Governor Rick Scott relies on “significant flexibility” granted to states to expand Medicaid under Section 1937 of the Social Security Act. The flexibility, outlined in a letter from CMS to states on November 20, 2012, is the same basis for the Arkansas plan to expand Medicaid through the Exchanges, a plan which has reported approval from CMS. ([Health News Florida](#))

- **“House Republicans searching for alternatives to Medicaid”**

Florida House Republicans are working to develop alternatives to a Medicaid expansion, likely encouraged by Arkansas’ plan to expand coverage through the Exchange. Governor Rick Scott has endorsed a Medicaid expansion and Senate Republicans have indicated they would support his decision. ([Miami Herald](#))

- **“Medicaid Expansion Cost: \$3.5B Over Decade”**

Florida’s budget office has estimated the incremental state cost of accepting the Medicaid expansion at roughly \$3.5 billion over the next ten years. The analysis also indicates that the state would still be on the hook for \$1.7 billion without a Medicaid expansion, as the state would have to cover the Medicaid MCOs’ obligation under the ACA’s tax on health insurers. ([Health News Florida](#))

Georgia

HMA Roundup – Mark Trail

February Tax Receipts Up 4 Percent. Last week, Governor Deal announced February 2013 tax collections of \$796 million, up 4 percent over the prior year period. Fiscal year-to-date, Georgia’s tax collections were up 5.6 percent over the comparable year-ago figure. While individual income tax receipts were down almost 12 percent from the prior February, sales and use tax collections grew 8.3 percent and corporate tax collections advanced a whopping 92.3 percent due to reduced tax refunds.

House Passes FY 2014 Budget. On Tuesday, the House passed its \$19.8 billion FY 2014 budget and sent it to the Senate. Relative to the Governor's proposed budget, the House rejected the proposed consolidation of the currently separate ABD and LIM budgets, eliminated the proposed 0.74 percent provider rate cut, and proposed to make the move to an APC outpatient hospital reimbursement methodology cost-neutral. The budget assumes greater projected savings from the proposed "Case Care and Disease Management" effort.

Massachusetts

HMA Roundup – Tom Dehner and Rob Buchanan

Primary Care Payment Reform Request for Applications. Last week, the Executive Offices of Health and Human Services (EOHHS) posted a Request for Applications (RFA) for its Primary Care Payment Reform Initiative, a three-year program that EOHHS intends to begin on August 1, 2013. This initiative aims to improve access to care, patient experience, quality of care, and efficiency through a new care delivery model emphasizing Patient Centered Medical Homes, the integration of Primary Care Services with Behavioral Health Services and a new payment mechanism. Participants will offer care coordination for all beneficiaries, clinical care management for high risk beneficiaries, and integration of primary care and behavioral health services. EOHHS will collect reports on 23 quality measurements to evaluate quality of care and qualification for certain incentive payments. Payments will consist of a monthly risk-adjusted amount per beneficiary, a quality incentive payment, and shared savings payments. Applicant responses are due April 22, 2013.

Small Group Insurance Premium Issue Sparks a Debate. Last week, the Boston Globe published an editorial that highlights how provisions in the Affordable Care Act have undermined certain elements of Massachusetts' efforts to reduce healthcare costs for small business. The state allowed insurers, at their discretion, to provide discounts for larger small businesses, while tacking on surcharges for smaller small groups and individuals. ACA prohibits these adjustments as of 2014. Massachusetts has asked for a waiver, or at least the ability to phase out group adjustments, rather than a sudden elimination. However, the advocacy group Health Care for All is urging the Federal Government to hold its ground by maintaining as large a pool of small group and individuals as possible, without adjustments, in order to allow premiums to be consistent for everyone in the pool.

Pioneer ACOs Request Delay on Quality Penalties. Last month, 32 Pioneer Accountable Care Organizations (including five from Massachusetts) wrote CMS to express concerns about Medicare quality metrics and to urge the delay of penalties and bonuses. The ACOs requested a definitive response by April 2 in order to allow the organizations a chance to assess their ongoing participation in the program. Consumer groups pounced on the request, as did a number of employer groups. However, some experts have indicated that this push for pay-for-performance is a dynamic process that may require some time to implement and the Federal Government may need to be flexible with the pioneers to ensure the longer-term viability of the ACO effort.

Michigan

HMA Roundup – Esther Reagan

Medicaid Hospital Reimbursement Reform Initiative. The Department of Community Health (MDCH) has announced a process to evaluate the Medicaid hospital reimbursement reforms, given that Medicaid expansion (if adopted) would substantially increase Federal funding, while dramatically reducing uncompensated care. Michigan's DCH has established a Hospital Reimbursement Technical Workgroup with representatives from the state, hospitals, the Michigan Health & Hospital Association, and other stakeholders to review the current system and make recommendations for changes. The five guiding principles for this initiative are greater predictability, reduced volatility, efficiency, cost-effectiveness, and simplicity.

MDCH staff will host the workgroup from March to May 2013. It is expected that staff models of the impacts of workgroup reimbursement options will be conducted from April to June 2013. By June 2013, the workgroup is expected to make recommendations to the Hospital Reimbursement Steering Committee. The steering committee will review and act upon the recommendations, with MDCH staff responsible for developing the policies and seeking federal approval of the desired changes.

New York

HMA Roundup – Denise Soffel

Governor Cuomo's 30-Day Budget Amendments. New York State Medicaid Director Jason Helgeson conducted a webinar on March 6, 2013 to discuss the Governor's 30-day budget amendments. The budget amendments include substantial changes to the Medicaid budget, in response to ongoing issues between the state and CMS regarding alleged overpayments over many years to the state's Developmental Centers. While the dispute over the overpayments is outstanding, the Governor has suggested a number of budgetary actions that reduce state Medicaid spending by \$500 million. The Governor identified three additional sources of fiscal improvement: greater savings to state as a result of the ACA (\$100 million), greater claiming of federal funds through emergency Medicaid payments for services to undocumented immigrants (\$250 million), and comprehensive reform of the Developmental Disability delivery system (\$250 million).

The \$500 million cut in state spending is borne disproportionately by programs serving people with developmental disabilities. Providers face a 6 percent across the board reduction to Medicaid rates, yielding savings to the state of \$120 million. Other savings will come through accelerating some Medicaid redesign initiatives, such as mandatory enrollment into managed long-term care, dual-eligible demonstration savings, the move of behavioral health services into managed care, and modifications to Patient-Centered Medical Home (PCMH) provider incentive payments through eliminating payment for 2008 National Committee for Quality Assurance (NCQA) PCMH recognized Level 2 providers and reducing payments for 2008 NCQA PCMH recognized Level 3 providers from \$6 PMPM to \$5 PMPM. Providers recognized as NCQA PCMH Level 3 using 2011 standards will remain the same. Further savings are expected from the delayed implementation of such programs as supportive housing, nursing home quality pool, managed long-

term care incentives quality incentives, and seed capital for health home investment. The budget amendment presentation can be found on the MRT website [here](#).

Patient-Centered Medical Homes Grow Rapidly with Incentive Payments. New York State began an incentive payment for PCMHs, determined through NCQA recognition, in 2010. The program includes fee-for service providers as well as providers in Medicaid managed care and provides three levels of enhanced payment, commensurate with the level of NCQA recognition received by the provider. The program has grown rapidly since its inception. A recent report provides a snapshot of PCMH growth in New York. The quarterly report provides information for July-September 2012 and includes three sections: providers, enrollees, and payment. 4,626 providers have been recognized under New York's PCMH program. About 40 percent of the Medicaid population received care through a PCMH. Through the third quarter of 2012, New York made \$56.8 million in incentive payments to Medicaid managed care plans, and \$3.4 million to fee-for-service providers.

As noted above, one of the proposals in the Governor's budget amendment would change the NCQA recognition level and standard required to receive an incentive payment. Currently, payments are made to providers that have achieved recognition under the 2008 standards or the more stringent 2011 standards. The Governor is proposing that providers must be recognized as a Level 3 PCMH to be eligible for payment and meet the 2011 standards in order to receive the full incentive payment. Only 6 percent of current PCMH providers have met the 2011 standards. The report can be viewed [here](#).

In the news

- **"Opposition Emerges to Cuomo's Plan to Cut \$120 Million for the Disabled"**

Governor Cuomo's proposal to cut reimbursements to non-profit providers serving the developmentally disabled by 6 percent, or \$120 million, is drawing opposition. The proposed cut is part of \$500 million in savings needed due to federal changes in reimbursements to states for developmentally disabled services. ([New York Times](#))

Pennsylvania

HMA Roundup -Matt Roan

Court Orders Restoration of Funding for Low-Income Health Program. Last week, Commonwealth Court President Dan Pelligrini ordered the Corbett Administration to restore funding to the Adult Basic program, which offers affordable health coverage to low-income adults. The judge found that two laws that had stripped funding from Adult Basic and Medicaid programs violated terms of the 1998 Pennsylvania Tobacco Settlement Act, which requires the funds be used to make Pennsylvanians and future generations healthier. The ruling orders the set-aside of 30 percent of the tobacco settlement funding, as of July 1, 2013, to be distributed to AdultBasic premium subsidies and Medicaid for workers with disabilities. Proponents of Medicaid Expansion have suggested that the administration use these funds to cover state costs related to expanding Medicaid Eligibility. AdultBasic was created in 2002 to serve lower-income uninsured Pennsylvanians who did not qualify for Medicaid. The program was scrapped by Governor Corbett in 2011 following rising costs.

Conservative Advocacy Group Mobilizes Against Medicaid Expansion. In Pennsylvania, the local chapter of Americans for Prosperity has stepped up public advocacy against Medicaid expansion in the state. AFP’s emergence on this issue and a recent widely circulated open letter arguing against expansion from Montgomery County Commissioner Bruce Castor (a likely Republican primary challenger to Governor Corbett) highlight the mounting pressure from conservative corners on the governor not to support Medicaid expansion. While some Republican legislators appear to be angling for the additional federal dollars and the hospital association is clearly supportive of Medicaid expansion, the governor remains unconvinced.

Governor Corbett Maintains that Medicaid Expansion is Too Costly. Governor Corbett has indicated that he believes that Medicaid expansion is not sustainable and would cost Pennsylvanians too much to implement. He has said he is skeptical of the Federal government’s ability to make good on its 100 percent funding promises through 2016. Moreover, even with an upcoming meeting with Secretary Sebelius, there would need to be a “fundamental change in the facts” in order for him to change course and accept expansion.

Polls Show Medicaid Expansion Support. A recent poll conducted by Harper Polling has found that 49 percent of Pennsylvania voters support Medicaid expansion, while 39 percent are against expansion, and 13 percent are unsure. Sixty-seven percent of Republicans polled were against expansion.

Annual Cost of Nursing Home Care in PA almost \$100K. The Pennsylvania Health Care Association, a trade group representing skilled nursing facilities, released a study that Pennsylvania nursing home costs average nearly \$100,000, well above the national average of about \$81,000. In the proposed 2013-2014 budget Medicaid reimbursements to nursing facilities are being increased by 2 percent.

In the news

- **“Uncertainty for thousands, Corbett after judge's health ruling”**

A judge ruled last week that Governor Corbett’s decision two years ago to shift funding away from the state-only AdultBasic health program was unconstitutional. The shift resulted in more than 40,000 low-income adults losing coverage under the program. ([Philadelphia Inquirer](#))

Virginia

HMA Roundup

Virginia Duals Pilot MOU Approaching Final Stages with CMS. At a forum on Tuesday, Suzanne Gore, Virginia’s senior executive advisor from the Department of Medical Assistance Services, indicated that the agency is approaching the final stages for a CMS memorandum of understanding on a dual eligible managed care demonstration plan. The plan would involve voluntary enrollment in January 2014, with a phased-in enrollment of beneficiaries in five regions over the course of the year.

National

Sebelius Urges Cities to Push Governors on Medicaid Expansion. On Monday, at the National League of Cities' annual legislative forum, HHS Secretary Kathleen Sebelius encouraged mayors and local officials to pressure their governors to support Medicaid expansion. She characterized the refusal of 100 percent Federal funding for the Medicaid expansion population as “playing politics” due to opposition to the initial passage of healthcare reform in 2010. Regardless of their positions on Medicaid expansion, Sebelius pointed to the need for local officials to publicize the new healthcare coverage options that will become available in 2014.

House GOP Aims to Balance Budget in 10 Years with Repeal of ACA and Medicare Premium Supports. The House Republicans have passed another budget that indicates that it will reach balance in 10 years without raising taxes. The budget proposal assumes that Medicare cuts already enacted in the ACA law would remain in place, even as Exchange subsidies and other ACA provisions would be repealed. Furthermore, tax increases enacted in January to avoid breaching the debt-ceiling would remain in place. Americans under 55 years would be offered the choice of remaining in the traditional Medicare program or premium supports for private insurance. Federal funding for Medicaid would be distributed as block grants to states, which would project to trim \$756 billion of Federal Medicaid spending over the next decade from a \$4.1 trillion baseline under current law. Senate Democrats appear ready to vote on their own budget proposal that would include far fewer cuts and additional taxes.

CMS Announces New CCTP Participants. On March 7, 2013, CMS announced 20 new organizations participating in the \$500 million five-year Community-based Care Transitions Program (CCTP), which aims to reduce hospital readmissions. There are more than 100 community-based organizations (CBOs) now receiving funds over the next two years to facilitate better patient transitions between acute and post-acute providers to lower hospital readmissions. The CBOs will be paid an all-inclusive rate per eligible discharge based on patient-based cost of care transition services and the implementation of systemic changes at the hospital level.

In the news

- **“Innovations in Medicaid Managed Care: Highlights of Health Plans’ Programs to Improve the Health and Well-Being of Medicaid Beneficiaries”**

This week, America’s Health Insurance Plans (AHIP) released a report on Medicaid managed care initiatives in three areas: working with community partners, addressing obesity, and caring for people with complex health needs. (AHIP.org)

- **“State and Federal Officials Discuss Plans for Dually Eligible Beneficiaries”**

Virginia and California are both moving closer to signed memoranda of understanding (MOUs) with CMS on their respective dual eligible integration demonstration plans. Virginia hopes to select plans in June, with two or three plans in each of the state’s five regions, and begin serving up to 78,000 duals in January 2014. California officials are anticipating an end to their delay in reaching a MOU agreement, as state

officials and CMS have been working out financial aspects of the demonstration. (CQ HealthBeat – subscription required)

- **“Obama Names Three to Commission on Long-Term Care”**

This week, President Obama named three appointees to a new federal commission on long-term care. The President named Henry Claypool, executive vice president of the American Association of People with Disabilities; Julian Harris, director of the Office of Medicaid in Massachusetts; and Carol Raphael, vice chairwoman of the AARP Board of Directors. Twelve other members have been appointed by House and Senate Democrats and Republicans. The commission’s recommendations will be due to Congress in six months. (CQ HealthBeat – subscription required)

- **“Arkansas plan shows that health care law’s Medicaid expansion leaves flexibility for states”**

The apparent HHS approval of Arkansas’ plan to expand Medicaid through the Exchange opens the door for other states to proposal alternatives to a traditional Medicaid eligibility expansion, though questions on details of the plan remain. ([Washington Post](#))

- **“States wrestle with new Obamacare exchanges”**

While many states, particularly those with republican leadership, have firmly opposed running their own health insurance exchange, HHS is carving out, and states are embracing, a role for local oversight of commercial plans, even under the federal exchanges. ([Politico](#))

- **“HHS approves 4 more exchange under Obama's health law”**

HHS approved federal-state partnership exchanges in Iowa, Michigan, New Hampshire, and West Virginia late last week. The approvals bring the number of state-based and partnership exchanges up to 25 (including DC) nationwide. ([The Hill](#))

- **“Health Insurers See Big Opportunities In Health Law’s Medicaid Expansion”**

Kaiser Health News and USA Today highlight the efforts of Medicaid health plans, like Molina Health Care, preparing for the influx of Medicaid MCO enrollees under the Medicaid expansion next year. Molina is building standalone clinics in Florida, California, Michigan, New Mexico, Utah, and Washington. Other health plans are implementing telemedicine, increasing prominence of nurse practitioners, and incentivizing frequent health screenings and other healthy behaviors. ([Kaiser Health News](#))

OTHER HEADLINES

Alabama

- **“Gov. Robert Bentley backs changes for state's Medicaid program”**

Governor Robert Bentley announced this week that he will support the recommendations of a state Medicaid commission to transition the state’s Medicaid fee-for-service program to a regional managed care program. The state would be divided into eight regions, each served by local managed care networks. However, under the recommendation, regions retain the option to contract with traditional commercial MCOs instead. ([AL.com](#))

Arizona

- **“In Conservative Arizona, Government-Run Health Care That Works”**

In a Kaiser Health News/SCAN Foundation article, Arizona’s Health Care Cost Containment System’s success in implementing managed care for dual eligibles and other low-income, high-health needs Medicaid enrollees is highlighted. The article highlights higher-than-average payments rates to providers as one of the keys to the program’s success. ([Kaiser Health News](#))

Connecticut

- **“Conn. pushing ahead with new health care exchange”**

Connecticut is finding that being ahead of the pack on exchange implementation comes with challenges. The state’s exchange, Access Health CT, has announced it will have to stop making adjustments for federal regulations and begin testing on the system to be ready for the October 1 launch date. Further regulations will be implemented in the future. Additionally, the state has signed a contract with MAXIMUS to provide enrollment call center services. ([Boston Globe](#))

District of Columbia

- **“D.C. health insurance board moves to delay exchange mandate”**

The Mayor’s board appointed to implement the health insurance exchange in D.C. voted unanimously to transition to a single marketplace for small employers to purchase insurance, but have proposed postponing mandatory participation until the 2016 plan year. The mandate delay only applies to small employers currently providing insurance to employees. The proposal must be approved by the D.C. Council. ([Washington Business Journal](#))

- **“D.C. Medicaid contracts still in flux”**

At least one of the reported awardees in the District’s Medicaid managed care reprocurement was asked to resubmit a final bid, putting the tentative awards to Ameri-Health Mercy, MedStar Family Choice, and Thrive Health Plan into question. United Healthcare, Molina Healthcare, and Maryland-based Riverside Health are also believed to have submitted bids. It may be several weeks until awards are finalized. ([Washington Post](#))

- **“Sharon Baskerville joining D.C.'s likely new Medicaid contractor”**

Thrive Health Plan, one of the apparent winners in the Medicaid MCO reprocurement, appears to have brought on the former head of the D.C. Primary Care Association as CEO, in addition to rounding out additional management positions. ([Washington Business Journal](#))

Hawaii

- **“Health care law to create gap for 21K in Hawaii”**

The Hawaii Primary Care Association is cautioning that health insurance premiums through the state’s exchange could end up being too costly for those individuals between 138 percent and 200 percent of poverty, creating a gap in insurance coverage for as many as 21,000. ([Associated Press](#))

Idaho

- **“GOP lawmaker touts Medicaid expansion”**

An Idaho House republican has announced he will introduce a Medicaid expansion bill on Thursday, March 14, citing savings for taxpayers as a result of expansion. Both the House and Senate are controlled by republicans. The Senate recently passed an Exchange bill, which the House is set to take up this week. ([Idaho State Journal](#))

Maine

- **“Consensus to expand Medicaid in Maine seen as likely”**

Democratic legislators and Republican Governor, Paul LePage, appear to have reached a consensus on expanding Medicaid in exchange for the legislature’s approval of additional funding for hospitals. Governor LePage indicated that he is open to the Medicaid expansion, but would seek the best possible deal for Maine. ([Portland Press Herald](#))

Minnesota

- **“Minnesota Senate passes sweeping health insurance change”**

Last Thursday, the Minnesota Senate passed a bill to establish the state’s health insurance exchange. The bill had been approved by the Minnesota House earlier in the week. ([Minneapolis Star Tribune](#))

Mississippi

- **“Mississippi hospitals pressing for Medicaid expansion”**

Despite strong opposition from Governor Phil Bryant and the state’s legislators, several hospital CEOs calling for the state to accept the Medicaid expansion. The hospitals contend that without the increase in eligibility, there will be no offset to the reductions in funding for uncompensated care built into the ACA. ([Sun Herald](#))

New Mexico

- **“Three insurance companies appeal state Medicaid award decision”**

Three unsuccessful bidders – Lovelace Community Health Plan, Amerigroup, and Western Sky Community Care (Centene) – have filed protests of the Centennial Care

Medicaid MCO consolidation RFP awards announced last month. Lovelace and Amerigroup were incumbent plans in the state's Medicaid managed care and managed long term care programs, respectively. ([Albuquerque Business First](#))

North Carolina

- **“Medicaid Director Details Budget Shortfall for Legislators”**

North Carolina Medicaid Director Carol Steckel outlined a projected Medicaid budget shortfall in the coming year of between \$70 and \$132 million. Steckel attributed some of the shortfall to unexpectedly high utilization, likely due to the flu season. This comes on the heels of Governor Pat McCrory's call for state agency leaders to limit costs to help cover Medicaid obligations earlier this week. ([North Carolina Health News](#))

Oregon

- **“State insurance officials brace for tsunami of health-reform documents”**

Oregon insurance officials are preparing for the influx of proposals from each insurer wishing to offer individual and small group coverage in the state in 2014. Unlike traditional rate proposals, these filings require much more detail on exactly what plans will and will not cover. All plans must be approved by June 30, 2013. ([Portland Business Journal](#))

- **“Legislature tackles Salem Medicaid dispute”**

Oregon's Senate unanimously approved last week a measure to establish a mediation process for conflicts between the state's Coordinated Care Organizations (CCOs) and health care providers. The measure was introduced in response to a legal fight between Salem Hospital and the CCO in Marion and Polk counties, Willamette Valley Community Health, over reimbursement rates. ([KATU News](#))

Texas

- **“Impact of Medicaid Expansion on State Budget Examined”**

The Texas Tribune highlights general revenue fund savings by state health program that would be achieved if the state accepts the Medicaid expansion, as presented by Billy Hamilton Consulting in a report for Methodist Healthcare Ministries of South Texas. In response to potential savings, one Texas republican has proposed a constitutional amendment to reduce local tax rates if Texas expands Medicaid. ([Texas Tribune](#))

- **“House Sends Medicaid IOU Bill to Perry”**

Texas House members voted to send a supplemental budget bill to Governor Rick Perry for his signature. The bill pays off more than \$4.5 billion in Medicaid payment IOUs and ensures that MCOs would be paid ahead of a Thursday deadline. ([Texas Tribune](#))

- **“Lawmakers Seeking ‘Texas Solution’ to Medicaid Reform”**

Some Texas legislators are pushing for flexible options to expand Medicaid that could meet broader approval from the legislature and from Governor Rick Perry,

who remains firmly opposed to the expansion. Several legislators are proposing cost-sharing measures, such as co-payments, although it is not known how the Obama administration would respond to these proposals. ([Texas Tribune](#))

Utah

- **“Idaho, Utah, N.M. Running Out Of Time To Set Up State Exchanges”**

The three western states, each having received tentative approval for state-based exchanges, are running out of time to meet the October 1 launch date, according to Kaiser Health News. If HHS determines they are not ready, they would be added to the 33 states in which HHS will implement a federal exchange. Utah indicated last month that it does not wish to include individual health plans in its established state-based health insurance exchange. ([Kaiser Health News](#))

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
Pending	District of Columbia	Contract Awards	165,000
TBD	Nevada	Contract Awards	188,000
March, 2013	Virginia Duals	RFP Released	65,400
March, 2013	Idaho Duals	RFP Released	17,700
March 27, 2013	Rhode Island Duals	Proposals due	22,700
March 29, 2013	Florida acute care	Proposals Due	2,800,000
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	5,500
April, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
May 1, 2013	District of Columbia	Implementation	165,000
May 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
May-June, 2013	South Carolina Duals	RFP Released	68,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
July 1, 2013	Massachusetts Duals	Implementation	115,000
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
September 1, 2013	California Duals	Implementation	500,000
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Rhode Island Duals - Medicaid Only	Implementation	22,700
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
October 1, 2013	Illinois Duals	Implementation	136,000
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
December, 1 2013	Florida LTC (Region 11)	Implementation	16,400
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	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	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date	
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014	
California	Capitated	526,902**	X	3/1/2012	4/4/2012		9/1/2013	
Colorado	MFFS	62,982					6/1/2013	
Connecticut	MFFS	57,569					TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model					
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	X	10/1/2013	
Iowa	MFFS	62,714					TBD	
Idaho	Capitated	22,548	March 2013	Q2 2013	July 2013		1/1/2014	
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013	
Michigan	Capitated	70,000	TBD	TBD	TBD		1/1/2014	
Missouri	MFFS†	6,380					10/1/2012	
Minnesota		93,165	Not pursuing Financial Alignment Model					
New Mexico		40,000	Not pursuing Financial Alignment Model					
New York	Capitated	133,880					1/1/2014	
North Carolina	MFFS	222,151					TBD	
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	X	9/1/2013	
Oklahoma	MFFS	104,258					7/1/2013	
Oregon		68,000	Not pursuing Financial Alignment Model					
Rhode Island	Capitated	22,700	X	3/27/2013			9/1/2013*	
South Carolina	Capitated	68,000	May-June 2013	TBD	TBD		1/1/2014	
Tennessee		136,000	Not pursuing Financial Alignment Model					
Texas	Capitated	214,402			Early 2013		1/1/2014	
Virginia	Capitated	78,596	March 2013		July 2013		1/1/2014	
Vermont	Capitated	22,000	TBD	TBD	TBD		1/1/2014	
Washington	Capitated/MFFS	115,000	TBD	TBD	TBD	MFFS Only	1/1/2014	
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		4/1/2013	
Totals	15 Capitated 7 MFFS	1.7M Capitated 485K FFS	6			4		

* Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.

** 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.

† Acute Care Managed Care RFP Responses due January 2013; Maricopa Co. Behavioral RFP Responses due October 2012. Duals will be integrated into these programs.

‡ Capitated duals integration model for health homes population.

HMA WEBINARS

“New Faces in the Expansion Population: Parolees and Ex-Offenders”

Monday, March 25, 2013, 2:00 PM EDT

Millions of men and women released from prisons and jails will make up a large portion of those covered under Medicaid expansions and subsidized Exchange plans. This session will explore new opportunities to manage health care utilization and cost, reduce recidivism, and achieve better health outcomes for this newly covered population. It will address:

- Unique health characteristics of the offender population
- Requirements of Medicaid and Exchange plans to cover services delivered to enrollees while in jail and prison
- New roles and opportunities for states, health plans, providers, prisons, and jails in assuring continuity of care following release or parole.

Registration is limited so [register now](#) to reserve your seat.

Kaiser Family Foundation: “Translating The Medicaid Expansion Into Increased Coverage: The Role Of Application Assistance”

Jennifer N. Edwards, DrPH, MHS – Panelist

Tuesday, March 19, 2013, 2:00 PM EDT

The Kaiser Family Foundation’s Commission on Medicaid and the Uninsured will hold a webinar to examine the role of application assistance in ensuring eligible individuals successfully enroll in health coverage. The webinar will feature an overview of the importance of application assistance drawing on lessons learned from Medicaid and CHIP and insight into states’ planning efforts to provide such assistance under the ACA. The Foundation also will release a case study highlighting the experience of providing in-person application assistance for Medicaid through community health centers in Utah.

[Registration Link](#)

HMA RECENT PUBLICATIONS

“State Levers for Improving Managed Care for Vulnerable Populations: Strategies with Medicaid MCOs and ACOs”

The Commonwealth Fund

Sharon Silow-Carroll, MSW, MBA - Contributor

Jennifer N. Edwards, DrPH, MHS - Contributor

Diana Rodin, MPH - Contributor

HMA recently published a report detailing the 10 leading states’ strategies for using managed care to promote quality, cost-effectiveness, and better health outcomes for vulnerable Medicaid populations. The authors also concluded there is plenty of room for MCOs and ACOs to not only co-exist in serving Medicaid populations but also to interface as they are moving in similar directions toward greater accountability among health care providers for quality and cost. ([Link - PDF](#))