HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: FEDERALLY FACILITATED EXCHANGE GUIDANCE AND DESIGN

HMA ROUNDUP: ILLINOIS WRAPPING UP LEGISLATIVE ACTION ON MEDICAID BUDGET CUTS; PENNSYLVANIA TO MOVE AHEAD WITH MEDICAID MCO EXPANSION AS PROTESTOR WITHDRAWS; NEW YORK REVISES DUAL INTEGRATION HEALTH PLAN REQUIREMENT; CALIFORNIA ISSUES MEDICAID DENTAL RFP

OTHER HEADLINES: FLORIDA UNIONS OPPOSE PRISON HEALTH PRIVATIZATION; KENTUCKY TO AUDIT STATEWIDE MEDICAID MANAGED CARE PROGRAM; NEBRASKA EXPANDS MEDICAID MANAGED CARE STATEWIDE; STUDY SHOWS 36 PERCENT OF DOCTORS VIEW MEDICAID PATIENTS AS UNAFFORDABLE, HIGHER FOR SPECIALISTS

DUALS CALENDAR: HAWAII, IOWA, SOUTH CAROLINA SUBMIT PROPOSALS TO CMS; MASSACHUSETTS RFP RELEASE EXPECTED SOON

MAY 31, 2012

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

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

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

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IN FOCUS: FEDERALLY FACILITATED EXCHANGE GUIDANCE AND DESIGN

This week, our *In Focus* section highlights some key takeaways from the General Guidance on Federally Facilitated Exchanges, released on May 16, 2012, by the Center for Consumer Information and Insurance Oversight (CCIIO) and the Centers for Medicare & Medicaid Services (CMS). This round of guidance follows up the Exchange final rule, published at the Federal Register on March 27, 2012. The document outlines the federal approach to implementing an Exchange in a state where a state-based Exchange is not in operation. Under the provisions of the Affordable Care Act (ACA), states are responsible for establishing a Health Insurance Exchange. In the case of states that elect not to establish an Exchange or have been evaluated by the Department of Health and Human Services (HHS) to have not made significant progress by January 1, 2013, a Federally Facilitated Exchange (FFE) will be established. The document outlines opportunities for state partnership in the FFE development and implementation processes, the key policies guiding FFEs, and the scope of stakeholder engagement. Opportunities for state partnership are especially stressed in the guidance document. Additionally, the guidance addresses the interaction between FFEs and the roles of Navigators and Brokers in the Exchange.

Link to CCIIO Guidance: (PDF – 19 pp.)

HHS is accepting comments on FFEs and the state partnership opportunities through June 18, 2013.

States with Potential for Federally Facilitated Exchanges

In addition to the two states below that will not establish a state-based Exchange—Arkansas and Louisiana—Kansas' insurance commissioner said several weeks ago that a failure in action from the legislature this session essentially means the state will not establish an Exchange in time. However, until a state's status becomes more definite, it is best to be conservative in evaluation which states are definitely going to have an FFE. The list below, published by Kaiser Family Foundation on May 25, includes those states who have halted Exchange planning while waiting on decision from the Supreme Court.

Will Not Establish	No Significant Activity	Planning Halted, Waiting on Supreme Court	
Arkansas	Idaho	Alaska	Missouri
Louisiana	New Hampshire	Florida	Oklahoma
	North Dakota	Georgia	South Dakota
	Ohio	Indiana	Texas
	South Carolina	Kansas	Wisconsin
		Maine	Wyoming

Source: Kaiser Family Foundation, May 25, 2012

Role of States and State Partnerships

In the Exchange final rule, it was indicated that even if a state does not elect to establish its own exchange, that state will be able to enter into a partnership with the FFE. Under this partnership model, a state may administer plan management functions, in-person consumer assistance functions, or both. Whether a state elects to enter into a partnership with the FFE or not, HHS intends to work with states to preserve the traditional responsibilities of state insurance agencies. States can develop and implement standards for qualified health plan (QHP) certification, recertification, and decertification, as well as conduct QHP certification review and oversight and monitoring. Additionally, states may support, administer, and oversee the Navigator program. HHS is strongly encouraging states to consider partnership options and has noted that states may use grant funding available under section 1311 of the ACA for the development of functions under the partnership model. HHS additionally leaves the door open for states under a FFE to transition to a state-based Exchange in the future. This guidance seems to indicate HHS' commitment to the success of the Exchanges and the opportunity for states to be the predominant authority over the Exchanges if or when the political debate surrounding ACA dies down and the Supreme Court makes a decision on the constitutionality of the ACA .

<table>
<tr><th colspan="2">Partnership Model
Overview of State Functions</th></tr>
<tr><td>Plan Management</td><td>• Develop and implement processes and standards for QHP certification, recertification, and decertification within FFE parameters
• Conduct QHP certification review including:
- Licensure and good standing
- Service area
- Network adequacy
- Essential community providers
- Marketing oversight
- Accreditation, on the timeline to be established in future rulemaking
- Essential health benefits standards
- Actuarial value standards, including variations for cost-sharing reductions, as well as cost-sharing limits
- Discriminatory benefit design
- Benefits for meaningful difference
- Rates (new and increases), including compliance with market rating reforms
• Perform QHP issuer account management
• Perform QHP oversight and monitoring, including marketing
• Collect necessary data from issuers
• Verify accreditation status and data if any accreditation data will be displayed on the Internet portal
• Collect and display quality data (in future rulemaking)
• Coordinate with HHS on quality rating and enrollee satisfaction survey (in future rulemaking)</td></tr>
</table>

Consumer Assistance	• Support, administer, and oversee Navigator program • Provide other in-person assistance to help consumers, including: - Filing an application - Receiving an eligibility determination - Reporting changes during the coverage year - Renewing coverage - Comparing and selecting a coverage option - Enrolling in a QHP

Eligibility Determination in a Federally Facilitated Exchange

This round of guidance addresses the eligibility determination process and interaction with state Medicaid agencies in states where a FFE is in operation and there is no state partnership in place. HHS intends to issue future guidance on eligibility determination in states where a state is in partnership with a FFE. This guidance reiterates the importance of a coordinated eligibility determination process in cooperation with a state's Medicaid agency. This is to provide for a "single point-of-entry" for low-income uninsured individuals who may be eligible for Medicaid or the Exchange. A FFE will interact with a state's Medicaid administration in one of two ways:

1. The FFE will determine eligibility, and if an individual is deemed eligible for Medicaid or CHIP, transmit the eligibility determination electronically to the Medicaid administration. The Medicaid agency will accept the FFE's determination and enroll the individual in Medicaid or CHIP.
2. The FFE will determine eligibility, and if an individual is deemed eligible for Medicaid or CHIP, transmit the eligibility determination electronically to the Medicaid administration. The Medicaid agency will make final eligibility determinations and notify the Exchange if the applicant is deemed ineligible for Medicaid or CHIP

Qualified Health Plan Certification

In the initial year of the Exchanges, HHS intends to certify any health plan meeting all certification standards as a QHP. In future years, HHS indicates that this process may be changed or improved. This could indicate that there will be additional requirements, standards, or metrics added to the QHP certification process. HHS intends to release the QHP Issuer Application in early 2013. This application process will be handled through an electronic plan management system. These applications will be available to the stakeholder community and the general public. FFEs are likely to complete agreements with QHPs in late summer 2013, with open enrollment to begin October 1, 2013. Below is a high-level summary of the QHP certification standards under a FFE.

QHP Certification Process Issuer-level Review (Vehicle: QHP Issuer Application)	
QHP Certification Standard	High-level Summary of FFE Activity
Licensure and good standing	Confirm State licensure and compliance with State solvency and other related requirements.

Network adequacy	In States meeting minimum Federal standards, verify State review. Otherwise, review network adequacy data submitted in QHP Issuer Application.
Essential community providers (ECPs)	Collect information on inclusion of ECPs in provider networks and review for sufficiency.
Accreditation	Confirm accreditation status, depending on certification year (as described in future rulemaking).
Program attestations	Ensure submission of required attestations (for example, attestation of compliance with marketing standards).
Plan-level Review (Vehicle: Rate and Benefit Data Submission)	
QHP Certification Standard	High-level Summary of FFE Activity
Essential health benefits	Confirm coverage of essential health benefits.
Actuarial value standards, including variations for cost-sharing reductions	Confirm actuarial value levels of potential QHPs, including compliance with standards related to cost-sharing reductions, cost-sharing limits, and variations to cost-sharing structures.
Discriminatory benefit design	Conduct plan-level analysis (such as outlier analysis) targeting areas where discrimination would most likely occur.
Meaningful difference	Conduct review for meaningful difference across QHPs offered by the same issuer to ensure that a manageable number of distinct plan options are offered.
Service area	Confirm that service area is at least one county or that smaller service area is necessary, nondiscriminatory, and in the interest of consumers.
Rates (new and increases)	Review new rates and rate increase justifications for reasonableness, including confirmation of compliance with market rating reforms.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein / Jennifer Kent

The California Department of Health Care Services (DHCS), Medi-Cal Dental Services Division (MDSD), issued an RFP for dental plans to compete for a contract to serve Medi-Cal beneficiaries in Los Angeles County. The DHCS, Medi-Cal Dental Services Division intends to award contracts to the two highest scoring plans. Proposals are due June 20, 2012.

In the news

- **Medi-Cal works for most enrollees, survey finds**

  As California gears up for a major expansion of its publicly funded health program for the poor, a statewide survey released Thursday shows that Medi-Cal enrollees have more trouble finding doctors and use the emergency room more frequently than people with other health coverage. But overall, perceptions of the program were positive, with more than 70% of all recipients reporting that Medi-Cal provided high-quality care. The survey — called *Medi-Cal at a Crossroads* — comes at a critical time, as the state continues to cut costs and simultaneously prepare for new enrollees. (Los Angeles Times)

- **CA request to take over inmate health care denied**

  A federal judge rejected a request by California prison officials Wednesday to regain control of inmate health care, which has been under court-supervised receivership for six years, and said the state must first show it can provide adequate medical treatment. In a May 7 filing, Brown's Department of Corrections and Rehabilitation said it was ready to resume health care management within 30 days. The receivership drives up costs and "disrupts democratic principles by shifting control away from the state," the department said. (San Francisco Gate)

- **Kaiser Balks at Joining Healthy Families Conversion to Medi-Cal**

  The planned switch of Healthy Families children into Medi-Cal could leave as many as 43,000 children looking for new health care providers if the state can't convince Kaiser Foundation Health Plan to join the effort. That number would grow to 189,000 children if the state eventually converts all Healthy Families children to the Medi-Cal program. Kaiser has 189,000 of the overall 875,000 children in Healthy Families. Kaiser remains worried about an eventual conversion of all Healthy Families children to Medi-Cal. (California Healthline)

Illinois

HMA Roundup – Jane Longo / Matt Powers

The Illinois Legislature has passed several bills related to the $2.7 billion Medicaid budget deficit this week. Both chambers passed SB 2840, which includes $1.6 billion in Medicaid cuts, savings, and eligibility reviews, as well as HB 5007, authorizing the early Medi-

caid expansion for the Cook County Health and Hospital System. These two bills have been sent to Governor Quinn's desk; however, they are linked to SB 3397, which places limits on payment deferrals in FY 2013 and FY 2014. All three bills must be passed in order to take effect. SB 3397 is scheduled to be voted on today, May 31, the final day of session. Additionally, the cigarette and tobacco tax bill, SB 2194, passed both chambers and is also awaiting the Governor's signature. The revenue from the cigarette and tobacco tax increase, combined with Federal matching funds, would fill the remaining Medicaid budget deficit.

In the news

- **Medicaid cuts threaten nursing home reforms, advocates say**

  The $1.6 billion in Medicaid cuts passed by state lawmakers angered a key legislator and some advocates who contend the legislation will undercut nursing home reforms enacted two years ago and delay improved care in the facilities. But state officials said the 2010 reforms remain intact and added that they are pressing forward on measures to reduce violence and lift the quality of care for indigent patients. As part of a series of compromises last week, nursing home operators agreed to a reduction in their Medicaid reimbursement rate, and state officials set a level of care by registered nurses that was lower than what many advocates had hoped for. (Chicago Tribune)

Massachusetts

HMA Roundup – Jaimie Bern

We continue to expect the Massachusetts dual eligible RFP to be released in the near future. We expect an update on the Demonstration and a discussion of consumer issues to be the focus of a public meeting tomorrow, June 1, 2012.

Michigan

HMA Roundup – Esther Reagan

This week the conference committee appointed to finalize the Fiscal Year (FY) 2012-13 Department of Community Health (DCH) appropriation reported Senate Bill (SB) 950 to the Senate and House for final approval. SB 950 appropriates $15.0 billion Gross / $2.8 billion General Fund / General Purpose (GF/GP) for the operation of Michigan's Medicaid program and the provision of publicly supported mental health and public health services.

The FY 2012-13 appropriation recognizes assumed changes in Medicaid caseload, adjusts rates to Medicaid Managed Care Organizations to ensure actuarial soundness and funds several new initiatives including an expansion of Medicaid services to eligible children with autism, new programs to address public health and infant mortality and targeted increases in Medicaid reimbursement to some providers. Some highlights from SB 950:

- The budget funds a 20.0% increase in Medicaid reimbursement for OB/GYN services ($11.9 million), increases the mileage reimbursement rate for nonemergency transportation ($2.0 million), restores coverage for adult vision services ($4.5 million) and restores coverage for adult chiropractic services ($900,000).

- The budget increases funding available to hospitals for Graduate Medical Education (an increase of $8.6 million) and continues and increases "onetime" funding for targeted payments to Sole and Rural Community hospitals (an increase of $6.0 million).
- The budget provides an additional $11.8 million to reduce the number of individuals on the waiting list to receive services through Michigan's MIChoice home and community based services (HCBS) waiver program.
- The budget assumes savings through implementation of a new waiver that will allow those dually eligible for Medicare and Medicaid services to have their supports and care administered through a contracted Managed Care Organization.

New York

HMA Roundup – Denise Soffel

On May 25th, New York submitted its dual eligible proposal to CMS for review and comment. The only significant change relative to the most recent version released for state comment related to plan qualification criteria. Specifically, all MLTC partial capitation plans are eligible to participate as a Fully Integrated Duals Advantage (FIDA) program plan if they obtain CMS approval to be a Medicare Advantage Plan for 2014 and are able to meet the requirements of the FIDA program. The final New York dual eligible proposal is available here.

Also, state officials indicate that they are expecting CMS approval to implement mandatory managed long term care (MLTC) next week.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

On May 24, 2012, the Pennsylvania Office of Medical Assistance programs announced that the protestor on the HealthChoices mandatory managed care New West Expansion award has withdrawn its protest. The state is moving forward with implementation in that zone and plans to meet the September 1, 2012 target implementation date. As a reminder, contracts for the New West zone were awarded to AmeriHealth, Gateway, UPMC and Coventry. The state did not provide an update on the protests that have been filed for the New East zone.

Also at the May 25 Medical Assistance Advisory Committee (MAAC), Pennsylvania announced that it is not planning to target either January 1, 2013 or January 1, 2014 for implementation of a duals initiative. State officials reported that a July 1, 2014 implementation was more likely. No additional details on what model the state was pursuing were provided. In its original Letter of Intent, the state had expressed interest in further analyzing both capitated and FFS models. It would appear that the additional time would enable them to pursue a public discussion of the options.

OTHER HEADLINES

Florida

- **Unions sue to stop prison health care privatization plan**

  Gov. Rick Scott's administration was back in a familiar place Tuesday, the courtroom, where two unions are challenging a plan to save money by privatizing health care to the state's 100,000 inmates. The state has already hired two out-of-state firms to do the work at a minimum cost savings of 7 percent a year. But the Florida Nurses Association and American Federation of State, County and Municipal Employees (AFSCME) say the privatization plan is unconstitutional and want Circuit Judge Kevin Carroll to block its implementation. The 2011 Legislature mandated the privatization through the use of budget language known as proviso. The unions say that's a violation of the state Constitution, and that a policy change must be enacted through a separate piece of legislation. (Miami Herald)

Hawaii

- **Hawaii to shift $10M in federal funds to help care for poor at state's public hospitals**

  Private hospitals in Hawaii will lose federal funding that has helped offset costs of caring for Medicaid patients or those who are uninsured. Instead, the state will award most of the $10 million in federal money to help care for the poor at the state's public hospitals. The move is a major policy shift for the administration of Gov. Neil Abercrombie, which had continued awarding most of the federal money for charity care to private hospitals. (The Republic)

- **Hawaiian Lawmakers OK LTC Bills**

  The Hawaiian Legislature has sent the state's governor, Neil Abercrombie, two bills that could affect people who need long-term care. One bill, S.B. 2779, would appropriate $1.4 million to create aging and disability resource centers in each county, to help older adults with disabilities and their caregivers get easier, "one-stop shop" access to information and services. The other bill, S.B. 2466, would increase funding for Hawaii's QUEST Medicaid managed program by imposing a "provider fee" of up to 4% on health care items and services provided by private hospitals and large nursing homes, according to the bill text. The QUEST program would use the fee revenue to increase nursing home reimbursement rates for the low-income QUEST plan enrollees who need long-term care. The bill would exempt many facilities, such as nursing homes with 28 or fewer licensed beds and state-owned nursing homes, from the fee requirement. (LifeHealthPro)

Kentucky

- **Nursing home chain pulls out of Ky.**

  The Lexington Herald-Leader reports that Extendicare Health Services Inc. cited increased litigation against its facilities and the failure of state lawmakers to make it more difficult to sue nursing homes as reasons for its departure. The company says it will lease its 21 facilities to a long-term care operator in Texas, but declined to identify the company. (Bowling Green Daily News)

- **Coventry, ARH negotiations over Medicaid appear at an impasse**

  Negotiations between Medicaid managed-care company Coventry and Appalachian Regional Healthcare appear at an impasse as the two sides head to U.S. District Court on Thursday. Coventry is one of four companies hired by the state Cabinet for Health and Family Services to manage Medicaid in Kentucky. After Coventry said it would sever its contract with ARH, which operates eight hospitals and other health clinics in Eastern Kentucky, ARH filed a lawsuit. Earlier this month, Coventry agreed to continue its existing contract until June 30 while it negotiated with ARH for long-term coverage. On Wednesday, ARH filed a document in U.S. District Court in Lexington saying "further negotiations between Coventry and ARH appear futile." (Lexington Herald-Leader)

- **Medicaid Managed Care Audit**

  After months of mounting problems, State Auditor Adam Edelen says he will launch a full investigation into Kentucky's statewide Medicaid Managed Care system. Edelen created a Medicaid task force in February after taking a first look at the managed care system. He also gave recommendations to managed care companies, health care providers and the state on how to make the system run better in the future. But with clashes between private Medicaid companies and healthcare providers ongoing, Edelen wants to take a stronger look into the system. (WEKU News)

- **Audit shows improvement at Passport Health Plan, but concerns continue**

  A new audit released Tuesday of Passport Health Plan found significant improvements in the organization after a scathing 2010 audit found excessive spending on travel and food, high salaries and poor oversight. Passport, which manages care for Medicaid patients in Jefferson and 15 surrounding counties, came under fire after a state auditor's report found troubling practices at the managed care organization that was founded in 1997. (Kentucky.com)

- **Plan to Expand Companies Receiving Medicaid Contracts in Kentucky Could be Put on Hold**

  A Kentucky lawmaker says implementation of a federal mandate to allow private companies to compete for Medicaid contracts in Louisville could be delayed. Currently, Medicaid in Louisville and the surrounding area is managed by the private company Passport Health Plan. But the federal government has ordered Kentucky to open the area to competition. And the company United Healthcare is already attempting to gain a foothold in the region. It's also widely believed that the state's other three managed care operators--CoventryCares, Kentucky Spirit and WellCare--would also want to bid for the Louisville region contracts. But today, the Cabinet for Health and Family Services announced they would extend Passport's contract to the end of this year and start accepting other bids for services in 2013 and beyond. House Health and Welfare chairman Tom Burch says rushing competition could be dangerous, and Kentucky should ask the government to further delay the order. (WKYUFM.org)

Nebraska

- **Nebraska Medicaid physical health managed care to expand statewide**

  Nebraska Medicaid, through the Nebraska Department of Health and Human Services, is expanding the physical health managed care program statewide effective July 1. Currently, Nebraska Medicaid provides physical health managed care in 10 counties: Cass, Dodge, Douglas, Gage, Lancaster, Otoe, Sarpy, Saunders, Seward, and Washington counties through health plans with Coventry Healthcare of Nebraska, Inc. (CoventryCares) and United Healthcare (United Healthcare Community Plan). The additional 83 counties will be covered by AmeriHealth Nebraska, Inc. (Arbor Health) and Coventry Healthcare of Nebraska, Inc. Nearly 100,000 Medicaid clients are currently enrolled in Managed Care. The expansion will add about 65,000 people. (Grant Tribune Sentinel)

New Mexico

- **NM awards contract to simplify access for Medicaid clients**

  New Mexico's Human Services Department is renewing its partnership with Xerox with a 58-month, $105 million contract to manage and enhance the state's delivery of quality health care to Medicaid recipients. Through the system's Medicaid Web portal, recipients will now be able to view their own eligibility data, request replacement ID cards, and search for providers up to 100 miles away from a specific ZIP code or address. "Through the new system, health care providers will have the ability to submit a claim online and know instantly if it's approved for payment," said Julie Weinberg, director, Medical Assistance Division, New Mexico Human Services Department. (WSJ Market Watch)

North Carolina

- **NC House wants to go slow on prisoner health care**

  The full House agreed unanimously Wednesday to a Senate bill designed to set aside $205.5 million to eliminate a shortfall in the state Medicaid program this fiscal year by pooling money from several government pots and some unanticipated tax collections. House leaders, some of whom have heard state workers' objections to privatization, amended the measure earlier in the day in their budget-writing committee to include a provision that would restrict what actions the Department of Public Safety could take on the issue of prisoner health services through June 2013. Earlier this month, the state Department of Public Safety unveiled a request for proposals from companies interested in taking over the health care at all of its adult prisons. The state prison system spends about $250 million a year for inmate medical costs, department spokeswoman Pam Walker said. (CBS News)

Oregon

- **Oregon's Medicaid Experiment Represents A 'Defining Moment'**

  Gov. John Kitzhaber, a Democrat and a former emergency room doctor, has convinced the federal government that he has a way to make Medicaid treatment better, and cheaper, by completely changing the way the sickest people in Oregon get health care. Here's how it will work: Each city, like Portland, Salem and Eugene, will have its own

umbrella group for caring for the Medicaid population, known as a "coordinated care organization." Under these umbrellas will be most of the big hitters in the health sector: hospitals, doctors, mental health providers and dentists. Kitzhaber's vision is that all those health care businesses will stop competing so directly and will be linked electronically so that the systems can talk to each other — and patients can go wherever they need to get the best care. (NPR)

Rhode Island

- **RI releases RFP for building its Exchange**

Governing recently published the third in a series of articles about Rhode Island's implementation of its health insurance exchange. Now that Rhode Island has established a governance structure for its health benefits exchange and developed a conceptual model for the online insurance marketplace that streamlines the purchasing process for users, the state must build the necessary technological infrastructure. At the end of April, the state issued a Request for Proposals (RFP), asking software vendors to submit their plans for producing the health exchange that state officials envisioned. The exchange's informational and technological infrastructure "should be invisible to the consumer," said Elena Nicolella, Rhode Island's Medicaid director. (Governing Magazine)

Texas

- **Governor Perry: More than 300 Jobs coming to Tyler**

Gov. Rick Perry says the state is investing $1.3 million through the Texas Enterprise Fund (TEF) in Centene Corp. to open its third U.S. claims center in Tyler. Contingent upon completion of a local incentive package, Centene will create more than 300 jobs and $15 million in capital investment. (KETK News)

National

- **IT could end up being health reform's highest hurdle**

Even states that are solidly committed to pursuing an exchange are facing major logistical challenges in building the computer systems that will be able to handle enrollment when exchanges open for business in 2014. That's largely because the system that will actually connect people to the right coverage will have to "talk" to many other systems, and the systems don't use a common language. This includes a yet-to-be built federal "data hub" with tax and citizenship info, the enrollment systems of multiple private insurers selling exchange plans and — hardest of all — state Medicaid enrollment systems, many of which are not yet fully computerized. Even if all the states that have taken the biggest steps to launch exchanges — fewer than 20 at the moment — were charging full speed ahead, there's a lot of concern that they'll have to switch to a "partnership" exchange model, with the federal Department of Health and Human Services running key functions. That's because their IT systems could fail final tests in the months before the exchanges open in 2014. And that would mean losing some of the ability to customize the enrollment process for a state's needs. (Politico)

- **Conservatives campaign against insurance exchanges**

  Conservative organizations have canvassed the country in recent months to try to persuade state legislators not to pass bills to create health insurance exchanges. Many conservatives say that even if states create an exchange, the federal government will dictate how it is run, not the state. The federal government is paying for the start-up exchanges, and the law gives the states the flexibility to run their own programs. The Department of Health and Human Services announced this month that 34 states have accepted grants to pay for exchanges. If states don't create exchanges, their residents can participate in a federal program. (USA Today)

- **State-based insurance marketplaces hang in balance of Supreme Court health-care ruling**

  While partisan gridlock and logistical disputes have stalled preparations for the 2010 health-care law in about two dozen states, more than a dozen others have moved swiftly to set up the insurance marketplaces at the statute's core. So what will come of those efforts if the Supreme Court decides to overturn all or part of the law? Interviews with key officials in some of the states that are furthest along suggest the results could vary widely. If the court, which is expected to rule late next month, does not uphold the law, its options range from overturning the statute to striking one or both of the two provisions whose constitutionality have been directly contested: the law's expansion of Medicaid and its "individual mandate" requiring virtually all Americans to obtain health insurance. Even the most limited scenario — invalidation of only the individual mandate — could jeopardize the success of the state-based insurance marketplaces. (Washington Post)

- **Medical specialists push back on initiative from healthcare law**

  Medical specialists are urging regulators to slow implementation of an initiative funded by the 2010 healthcare law that aims to streamline care for some low-income elderly and disabled patients. In a letter, the Alliance of Speciality Medicine asked the Centers for Medicare and Medicaid Services (CMS) for a one-year delay on the grounds that the current "direction and speed" of the project's implementation would jeopardize payments to medical professionals as well as the care of so-called dual eligibles — people enrolled in both Medicare and Medicaid. (The Hill)

- **States Encounter Obstacles Moving Elderly And Disabled Into Community**

  A multi-billion dollar federal initiative to move low-income elderly and disabled people from long-term care facilities into the community has fallen far short of its goals, as many states have struggled to cobble together housing and other services. As of March 31 at least 22,500 had made the transition, about 36 percent below the states' target. Some states have found it especially difficult to move the elderly. While the vast majority of eligible people are seniors, only about one-third of the program's participants are age 65 or over, according to Mathematica Policy Research, a Princeton, N.J.-based firm hired by the government to evaluate the project. Most of the other participants are adults under 65 with physical disabilities living in nursing homes and developmentally disabled people living in institutions. (Kaiser Health News)

- **Insurers Must Improve Benefits For New Health Exchanges**

  Half the people who buy their own health insurance, rather than depend on an employer, are in plans that have fewer benefits than what the U.S. health-care law will require beginning in 2014, a study found. Companies that participate in the insurance exchanges mandated by the law will have to improve benefits in some plans to meet requirements that they cover at least 60 percent of the cost of a person's care, according to a study published today in Health Affairs. The research was paid for by the Commonwealth Fund, a New York- based nonprofit group that supports expanded insurance coverage. About 51 percent of people with individual coverage have average deductibles of $3,881, the study showed, five times the amount for employer group plans. In addition, coverage sold to single people today may exclude pre-existing conditions, and most individual policies don't include maternity care without costly riders. (Bloomberg)

- **Survey: 36% of Physicians Can't Afford to Take Medicaid Patients**

  Staffing company Jackson Healthcare's recent survey of several thousand physicians nationwide reveals that 36 percent of them are unable to accept new Medicaid patients due to declining reimbursements. Specialists surveyed were more likely than primary care physicians to stop accepting Medicaid patients. Sixty-six percent of dermatologists, 64 percent of endocrinologists, 58 percent of internists, 57 percent of physical medicine and rehabilitation physicians and 53 of adult psychiatrists said in the survey they cannot take on more Medicaid patients due to a lack of reimbursements. Currently, one out of every four practicing physicians does not accept Medicaid patients. A growing number of physicians surveyed said they also can no longer accept Medicare patients, again citing low reimbursement rates. Seventeen percent of physicians polled said they are unable to take on new Medicare patients. Currently, 10 percent of the physician population does not see Medicare patients at all. (Becker's Hospital Review)

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

DUAL INTEGRATION PROPOSAL STATUS

Below is a summary table of the progression of states toward implementing dual eligible integration demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	Proposal Released by State	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Deadline for Plans to submit applications	3-way contracts signed	Open enrollment ends	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012					N/A[+]	Spring 2013	N/A	1/1/2014
California*	Capitated	800,000	X	4/4/2012					5/24/2012	9/20/2012	12/7/2012	1/1/2013
Colorado	MFFS	59,982	X	4/13/2012					N/A	N/A	N/A	1/1/2013
Connecticut	MFFS	57,568	X	4/9/2012					N/A	N/A	N/A	12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012			TBD	7/1/2013	TBD	1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012			N/A	N/A	N/A	1/1/2013
Idaho	Capitated	17,219	X	4/13/2012					N/A	9/20/2012	12/7/2012	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012			TBD	TBD	TBD	7/1/2013
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012			N/A	N/A	N/A	1/1/2013
New York	Capitated	460,109	X	3/22/2012					TBD	TBD	TBD	1/1/2014
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	5/24/2012	9/20/2012	12/7/2012	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	5/20/2012			N/A	N/A	N/A	7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012			N/A	N/A	N/A	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	X	6/28/2012			TBD	9/20/2012	TBD	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012			TBD	TBD	TBD	1/1/2014
Texas	Capitated	214,500	X	4/12/2012					TBD	TBD	TBD	1/1/2014
Virginia	Capitated	56,884	X	4/13/2012					TBD	TBD	TBD	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012			TBD	TBD	TBD	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012			TBD	TBD	TBD	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012			5/24/2012	9/20/2012	12/7/2012	1/1/2013
Totals	**18 Capitated 5 MFFS**	**2.7M Capitated 482K FFS**	***23***		***15***		***2***					

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

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

HMA Recently Published Research

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

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

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

Upcoming HMA Appearances

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

Healthcare Financial Management Association: HFMA National Institute 2012

Jennifer Kent, Panel Participant

June 27, 2012

Las Vegas, Nevada