HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: A LOOK AT EXCHANGE ENROLLMENT ASSISTANCE PROGRAMS

HMA ROUNDUP: ARIZONA HOUSE SET TO VOTE ON MEDICAID EXPANSION; EXCHANGE APPLICANTS REVEALED IN ARKANSAS, FLORIDA, WASHINGTON DC, NORTH CAROLINA, AND MONTANA; GEORGIA NAMES DEPARTMENT OF COMMUNITY HEALTH COMMISSIONER; WISCONSIN REJECTS MEDICAID EXPANSION

OTHER HEADLINES: COURT RULES CENTENE CANNOT EXIT KENTUCKY CONTRACT EARLY; KANSAS TO SHIFT DISABLED MEDICAID BENEFICIARIES TO MANAGED CARE

HMA WELCOMES: SUSAN MORAN – LANSING, MICHIGAN

JUNE 5, 2013

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

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IN FOCUS: A LOOK AT EXCHANGE ENROLLMENT ASSISTANCE PROGRAMS

This week, our *In Focus* section comes to us from Matt Roan of HMA's Harrisburg, Pennsylvania, office. Matt's write up looks at upcoming Health Insurance Exchanges and explains the types of Enrollment Assistance the Marketplaces are seeking to implement, the roles and responsibilities of Navigators and other Enrollment Assisters, conflict of interest considerations, and variations across the states in the amount of funding being made available for enrollment assistance activities.

Health Insurance Exchange Implementation: Enrollment Assistance Programs

As the October 1, 2013, go-live date for open enrollment through Health Insurance Exchanges, or Marketplaces, quickly approaches, the Department of Health and Human Services (HHS) and the State Based Marketplaces are busy preparing their outreach strategies to ensure success in connecting the uninsured to coverage. As a result, there has emerged a patchwork of funding opportunities targeted primarily at Community-Based Organizations and Community Health Centers to provide information and assistance to individuals and small employers seeking coverage through the Marketplaces.

Enrollment Assistance by many names

Enrollment assistance will be provided through a variety of mechanisms, including state and federal programs that fund the assistance and specific certification programs for unfunded assistance. The primary differences between these mechanisms are how and whether they are funded, how and by whom they are selected or certified, and how they focus their work. The three main public mechanisms for enrollment assistance are:

1. **Navigators:** In Federally-Facilitated and Partnership Model Exchanges, Navigators are funded directly by HHS through the Navigator Grant Program. State allocations from this grant program are discussed in more detail below. In State-Based Marketplaces the Navigator designation is often given to assisters who are funded through the Marketplace's operational revenue derived from fees collected from Qualified Health Plans (QHP) listed on the Marketplace.

2. **In-Person Assisters (IPA) or In-Person Counselors(IPC):** For State-Based and Partnership Model Exchanges, HHS recognized that operating revenue from the Marketplace would not be available to fund enrollment assistance programs in the initial open enrollment period beginning in 2013. As a result states have been permitted to use Exchange establishment grant funding to establish IPA programs to perform the same function as Navigators. In some Partnership Model States there will be both federally funded Navigators and State-funded IPAs or IPCs. In these states the duties of Navigators and IPAs are generally being coordinated, often by defined geographic or target population responsibilities.

3. **Certified Application Counselors (CACs) and Certified Application Assisters (CAAs):** CACs are not funded by the Marketplace or the Federal grant program but are certified by Exchanges to provide enrollment assistance to individuals seeking coverage through the Marketplaces. State Medicaid or CHIP agencies may also elect to establish CAAs to emphasize support for certain Medicaid-

related renewal or documentation needs. CACs and CAAs will have access to the same training and certification as Navigators and IPAs but will not be obligated to perform the full set of duties of the funded enrollment assisters. These designations are targeted at current stakeholders who provide similar assistance today, particularly in health clinics, provider offices, and hospitals.

Duties of Enrollment Assisters

HHS has articulated six duties of Navigators, which are also being applied in most states to IPAs and IPCs. These duties are:

- Maintain expertise in eligibility, enrollment, and program specifications.
- Conduct public education activities to raise awareness about the Exchange.
- Provide information and services in a fair, accurate, and impartial manner. Such information must acknowledge other health programs (such as Medicaid and the Children's Health Insurance Program [CHIP]).
- Facilitate selection of a Qualified Health Plan (QHP).
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under Section 2793 of the Public Health Service Act, or any other appropriate state agency or agencies, for enrollees with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage.
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools, such as fact sheets, and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

While some of the state-based marketplaces are allowing these obligations to be fulfilled by a coalition of organizations, the Federal Navigator Program grant opportunity is requiring all funded organizations to meet all six duties.

Conflict of Interest Considerations

Given the role Navigators and other Enrollment Assisters will play in helping applicants select a Qualified Health Plan, several questions have been raised around potential conflict of interest. HHS has issued a regulation to address Navigator conflict of interest. These requirements also apply to other enrollment assisters who are funded directly by the states using Federal Exchange establishment funding. According to the Federal regulation:

- A Navigator may not be a health insurer; be a subsidiary of a health insurance issuer; be an association that includes members of, or lobbies on behalf of, the insurance industry; or receive any consideration, directly or in directly, from any health insurance issuer in connection with the enrollment of any individuals in a QHP or non-QHP.

- Navigators must also not be an issuer of stop loss insurance, or a subsidiary of an issuer of stop loss insurance, and must not receive any consideration, directly or indirectly, from any issuer of stop loss insurance in connection with the enrollment of individuals or employers in a WHP or non-QHP.
- Navigators must not have a conflict of interest during their term as a Navigator and must provide information and services in a fair, accurate, and impartial way.
- Having a conflict of interest means having a private or personal interest sufficient to influence, or appear to influence, the objective of a Navigators Official Duties.
- Navigators must disclose to the Exchange and Consumers certain conflicts of interest, i.e., pre-enrollment and post-enrollment services, that while they do not bar them from serving as Navigators can inhibit their ability to provide information and services in a fair, accurate and impartial manner.
- Navigators must disclose three pieces of information to the Exchange and any consumers who are receiving application assistance:

    1. Navigators and all staff members must disclose any lines of insurance business, other than health insurance or stop loss insurance, which the navigators intends to sell while serving as a Navigator.
    2. Navigators and their staff must disclose any existing and former employment relationships they had had within the last five years with any issuer of health insurance or stop loss insurance, or subsidies of such issuers.
    3. Navigators and their staff must disclose any existing or anticipated financial, business, or contractual relationships with one or more issuers of health insurance or stop loss insurance or subsidiaries of such issuers.

HHS has also clarified the role of Insurance Brokers in providing enrollment assistance. Brokers will be permitted to function in the context of Exchanges/marketplaces, but they are not eligible for Navigator grant funding. Additionally, brokers must disclose to applicants that they have a business relationship with some or all of the QHPs.

Enrollment Assistance Funding Opportunities

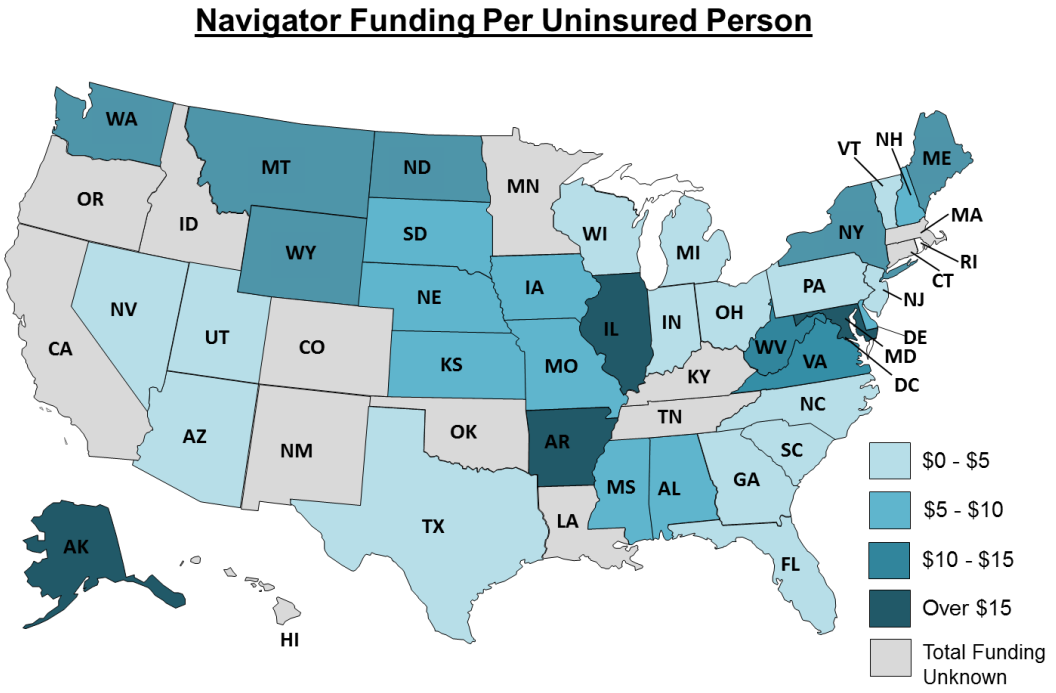
HHS issued a Funding Opportunity Announcement for the Federal Navigator Program on April 9, 2013. Applications for this grant funding are due on June 9, 2013. Organizations in 34 states with Federally-Facilitated Marketplaces or Partnership Exchanges are eligible to apply for funding. States with state-based Marketplaces are required to establish Navigator programs and have either completed a grant or procurement process, are in the process of awarding funds, or are expected to make funds available in the near future. Of the 14 states moving forward with State-Based Marketplaces, 7 have completed their funding application process, 4 have active funding opportunities, and 3 are expected to announce available funding soon. Partnership states are eligible for the Federal Navigator Program funding opportunity and are also able to establish their own funding programs. Three of the Partnership states have issued their own funding opportunities.

Chart: Status of Enrollment Assistance Funding Opportunities

State marketplace type and activity	States
State-based Marketplace with closed opportunities	CO, MD, NV, NY, OR, VT, WA
State-based Marketplace with open opportunities	CT, DC, HI, MN
State-based Marketplace with upcoming opportunities	CA, KY, RI
Partnership Marketplace with closed opportunities	AR, DE
Partnership Marketplace with open Opportunities	IL
Federally Facilitated or Partnership states included in the Federal Navigator program	AK, AL, AR, AZ, DE, FL, GA, IA, IL, IN, KS, LA, ME, MI, MO, MS, MT, NC, ND, NE, NH, NJ, OH, OK, PA, SC, SD, TN, TX, UT, VA, WI, WV, WY

Notes: As of June 3, 2013. ID and NM have submitted requests to CMS to convert from a State-Based Marketplace to a Partnership Marketplace; it is not clear whether they will be added to the Federal Grant Program. MA has already implemented an Exchange with an enrollment assistance program, it is not clear what changes they will make to their enrollment assistance program as a result of ACA implementation.

Graphic: Funding for Navigator Programs Varies Across States



Notes: DE, IA, NH and WV are all Partnership Exchanges that have not yet determined whether they will contribute State funds towards their Navigator programs. Currently they have received Federal Navigator Grant and CMS FQHC Grant Funds. The total spend for Navigator programs is the sum of the share of the Federal Grant program going to the state, if applicable, any state Navigator/Enrollment Assistance grant program, and the HRSA grant program which provides funding to Community Health Centers to perform enrollment assistance. The number of uninsured by state is available at: http://www.kff.org/medicaid/upload/8384.pdf

HMA Medicaid Roundup

Arizona

HMA Roundup

Mesa City Provider Tax Nears Passage. As of late last week, it appears that the Mesa City Council is on the verge of approving a provider tax for hospitals that should improve the finances of institutions in the city. Mesa's hospitals are expected to pay the city $461.91 for every patient discharge through the end of 2013. In turn, the city will transfer the funds to the Arizona Health Care Cost Containment System, qualifying for Federal matching funds to shore up hospital Medicaid rates.

House Speaker Succumbs to a Vote on Medicaid Expansion. On Tuesday, June 4, 2013, Arizona House Speaker Andy Tobin threw in the towel on his own Medicaid-expansion plan and announced that work would move forward on ten bills that include Governor Jan Brewer's proposed Medicaid expansion. Governor Brewer had expressed frustration with the pace of negotiations on Medicaid expansion and had held up all other legislation until a vote was taken on the proposal. Although Tobin maintained his opposition to the proposal as written, the limited time before the next fiscal year forced his hand to move on a budget vote that would include expansion. It appears that Governor Brewer has the support of anywhere from eight to ten House Republicans and the 24 Democrats in the chamber to pass the Medicaid expansion. Assuming House passage, the Senate would consider any amendments and schedule a final vote on the measure.

Arkansas

HMA Roundup

Exchange Funds Approved by Lawmakers. On Tuesday, June 4, 2013, the Arkansas Legislative Council approved by a vote of 23-9 the spending of nearly $16.5 million in Federal grant funding to establish a Partnership Health Exchange. The State lawmakers on Tuesday endorsed spending nearly $16.5 million in federal grant money to fund enrollment assistance and outreach for an open enrollment period that begins on October 1, 2013. The state aims to hire more than 600 "guides" to assist Arkansans navigate the enrollment process via the Exchange.

Four Insurers File to Sell Health Policies on the Exchange. On Tuesday, June 4, 2013, the state Insurance Department announced that four insurers—Arkansas Blue Cross Blue Shield, National Blue Cross Blue Shield Multi-State, Celtic Insurance Company/NovaSys Health, and QualChoice of Arkansas—had filed to sell health plans on the state's Health Exchange. Exchange Planning Director Cindy Crone announced that the department will review the service areas to ensure that each of the state's 75 counties have at least two carriers offering plans on the Exchange.

California

HMA Roundup—Jennifer Kent

House Democrats Questions Dual Eligible Demonstration. Several California House Democrats are raising concerns about the state's dual eligible demonstration program, set to launch in January 2014 and serve up to 456,000 dually eligible individuals in the state. In a letter to CMS, the 14 lawmakers raised concerns regarding access and beneficiary understanding of the demonstration program. In the letter, Representative Linda Sanchez singled out individual health plans for lacking experience serving the dual eligible population. Additionally, the letter raised concerns about trying to achieve savings through managing a vulnerable population.

Assembly to Debate Bill Penalizing Employers for Medi-Cal Shifting. The California Assembly is set to debate a bill this week that would fix what some lawmakers are calling a loophole that allows large employers in the state to shift employees from employer-sponsored coverage into Medi-Cal. AB 880 would penalize large employers that reduce hours or wages, thus making their employees eligible for Medi-Cal coverage.

Healthy Families Budget Shortfall Exceeds $360 million. State officials have identified more than $270 million in payments owed to Health Families insurers, exacerbating what is expected to be a more than $360 million budget shortfall for this fiscal year. Much of the deficit is due to an expiration of the state's MCO tax at the end of last year. A vote on renewing the MCO tax was delayed last week. State officials called on lawmakers to resolve the program's budget deficit.

Counties May Lose $2.5 Billion in Health Funding Through FY2016. Governor Jerry Brown addressed local officials last week, indicating that counties could lose $2.5 billion in state funds through fiscal year 2016. The funding, currently provided to counties for uncompensated health care services, will be reduced by $300 million this fiscal year, increasing to $900 million in fiscal year 2015. It is anticipated that county responsibility for health care will be drastically reduced as individuals enroll in the Medi-Cal expansion or in the state's Health Insurance Exchange.

In the news

- **"Low Costs and Narrow Networks: Inside Covered California"**

  California's Exchange, called Covered California, revealed the plans and providers that will serve the market last week. Absent from the list are major insurers – Aetna, Cigna, United – who are cautiously approaching Exchange participation. Additionally, California Healthline reports that many significant hospital providers are not included in the plans' networks, likely due to their high costs as compared to other in-network providers. (California Healthline)

Colorado

HMA Roundup—Joan Henneberry

Colorado Health Plans and Hospital Profits Remain Healthy. The latest Colorado Health Market Review from Allan Baumgarten noted that Colorado HMOs continue to keep their profit margins above 3 percent, especially in the Medicare Advantage market. HMOs also added tens of thousands of new members. Hospitals have also seen profits grow for the past ten years despite declining inpatient occupancy rates that have been a traditional source of profits. Denver-area hospitals had pre-tax net income of $774.6 million in 2011 — a profit of 12.3 percent of their overall net patient revenue of $6.27 billion, according to an analysis of Medicare cost reports, Baumgarten said. HealthOne/HCA, which operates seven hospitals in the area, topped the profit list with $428.5 million, equivalent to 20.9 percent of net patient revenue, Baumgarten said. The report does not discuss rural and critical access hospitals, whose margins tend to be far smaller than their urban counterparts.

Connecticut

HMA Roundup

Connecticut Legislature Approves Budget. On Monday, June 3, 2013, the Connecticut legislature gave final approval to its biennial $37.6 billion budget that moves $6 billion of Medicaid assistance (out of a total of $10.4 billion in program spending) off the books over the next two years to remain under the state spending cap. Legislators tapped new revenue sources, including the addition of 600 lottery terminals in retail establishments around the states.

New Proposal Would Require Health Exchange to Negotiate Rates. Last Wednesday, May 29, 2013, the Senate approved a proposal requiring the state's Health Exchange to negotiate premiums with participating health insurers. While consumer advocates believe this involvement will tamp down rates, the Connecticut Association of Health Plans fears greater complexities in the smooth transition to the Exchange. Having a parallel rate process to the Department of Insurance could create more uncertainty and confusion. The proposal aims to have the Exchange actively ensure that plans have used all available tools to keep costs down.

District of Columbia

HMA Roundup

Council Approves Small Business Exchange Mandate. On Tuesday, June 4, 2013, the D.C. Council approved a bill that mandates all health insurance for small businesses be purchased through the Exchange by 2015. Healthcare advocates and Exchange officials prevailed over the concerns of the health insurance industry. The legislation expires in October 2014 because its provisions are effective before congressional review. However, the council will draft a permanent bill in the spring of 2014.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Ten Insurers Apply to Serve in Florida Exchange. It was reported that ten insurers have applied to offer plans in Florida's federally facilitated Exchange, although the plans have not been officially revealed. However, a researcher from Florida CHAIN has identified the ten plans as:

- Aetna
- Blue Cross & Blue Shield of Florida Inc.
- Centene
- Cigna
- Coventry Health Care
- Florida Health Care Plan Inc.
- Health Options Inc.
- Humana
- Molina Healthcare
- Simply Healthcare Plans Inc.

Rate submissions, as with other federally facilitated Exchange states, have not been made available.

Georgia

HMA Roundup – Mark Trail

New DCH and Human Services Commissioners Named. On May 30, 2013, Governor Nathan Deal announced that Clyde Reese will become the new commissioner of the Department of Community Health, replacing David Cook, who will become secretary of the state Senate. This would mark the second time for Reese to run the department, having preceded Cook in the position. With Reese's move to DCH, Keith Horton, deputy director of the Georgia Vocational Rehabilitation Agency, would take Reese's position as commissioner of the Department of Human Services. Both moves would be effective July 1, 2013, subject to agency board approvals.

Idaho

HMA Roundup

Idaho Governor Otter Seeks Personal Responsibility in Medicaid. In an interview with the Idaho Statesman, Governor Butch Otter argued that Medicaid beneficiaries should be responsible for making healthy choices and getting better outcomes. Separately, the Department of Health and Welfare has outlined its "Healthy Idaho" plan to implement, should the legislature opt to expand Medicaid. The plan would reward providers with gain sharing as an alternative to the current fee-for-service system, while creating incentives for patients to pursue preventive care that reduce more expensive episodic care. The department has begun a dialogue with CMS about the parameters of this plan, should the state move forward with Medicaid expansion.

Illinois

HMA Roundup – Matt Powers and Jane Longo

Legislative Session Ends, State Sees Credit Downgrade. The Illinois legislative session ended Friday, May 31, without a resolution to the state's pension funding issue. This lead Fitch Ratings to downgrade Illinois' credit rating. Illinois already has the worst credit rating of any state in the nation from both Moody's and Standard & Poor's.

Lawmaker Introduces Bill to Place HFS under Purview of Board. On the second-to-last day of session, May 30, a bill was introduced in the Illinois Senate to form a board that would oversee the state's Department of Healthcare and Family Services (HFS). HFS is the agency overseeing the state's Medicaid program. If passed, the bill would remove the current HFS director, Julie Hamos, from her position effective March 1, 2014. Going forward, the HFS director and assistant director positions would be appointed by the HFS board members to serve no more than four year terms.

In the news

- **"Illinois governor signs bill that tackles $1 million budget backlog"**

  Illinois Governor Pat Quinn signed a bill on Wednesday, June 5, that pays of a portion of the state's backlogged bills. As part of the more than $1 billion package the Governor signed, roughly $500 million in unpaid Medicaid reimbursements will be made. (The Republic)

Iowa

HMA Roundup

Iowa Races to Gain Federal Approval for Medicaid Expansion Plan. Following a long and, occasionally, contentious process that yielded a compromise Medicaid expansion option last month, Iowa's Department of Human Services is racing to meet a June 28 deadline to submit a formal request for an 1115 waiver. Four public hearings were set on June 3 and 4 with a public comment period through June 17, 2013. The Iowa Health and Wellness Plan, passed by the legislature on May 23, will replace the previously drafted "Healthy Iowa Plan" as part of the 1115 waiver application. The Medicaid agency has been authorized to adjust the compromise proposal, as necessary, during discussions with CMS.

Maine

HMA Roundup

Maine Legislature Votes to Approve Medicaid Expansion, but Meets Certain Veto. On Monday, June 3, 2013, Maine's House voted 89-51 to approve Medicaid expansion, but Governor Paul LePage will almost certainly veto the legislation. Governor LePage vowed not to consider Medicaid expansion until the state can address an extensive wait list of 3,100 developmentally disabled people who are unable to access home- and community-based care. This legislation was separated from the hospital debt-repayment issue, which had previously been linked in a prior vote. Furthermore, the proposed expansion would

be repealed if the Federal Government reneged on its prescribed funding levels under the ACA.

CMS Confirms No Better "Deal" Could Be Negotiated with the State. In a May 24, 2013 letter from Cindy Mann to DHHS Commissioner Mary Mayhew, CMS confirmed that the Federal matching rate under ACA cannot be changed by regulation and waiver. Hence, CMS has no authority to adjust rates as requested by Governor LePage. Democratic leaders used the correspondence as evidence that there is no reason for further delay in enacting Medicaid expansion. LePage is disappointed that Maine's prior move to expand Medicaid coverage to non-disabled parents effectively prevents the state from receiving 100 percent subsidies for this population. Maine would continue to receive its existing 62 percent Federal matching rate. Mann, however, offered clarification that childless adults—previously covered under a prior Medicaid expansion—would be considered "newly eligible" because the benefits provided by the state did not meet ACA's essential benefits criteria. Hence, the absence of audiology services would allow the state to qualify for 100 percent Federal funding.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Health Reform Spurred M&A and Partnerships. On Thursday, May 30, 2013, PricewaterhouseCoopers issued a report that indicates that health reform has spurred seventeen health system mergers since the 2006 passage of health reform in the state. Since Federal health reform passed in 2010, one-third of Massachusetts hospitals have either merged or partnered with another system. Just 9 percent of all hospitals in the states remain completely independent. Health reform appears to have led most provider groups to recognize that partnering or scale is a critical success factor.

Michigan

HMA Roundup—Esther Reagan

Home Care Worker Survey Confirms Pay and Hours are Barriers to Recruitment. A survey of home care workers for Michigan's Medicaid home and community-based services programs highlights that low wages, unpredictable hours, and limited benefits create barriers to recruiting and retaining staff. The Office of Services to the Aging was given Federal funding to collect basic data on the "direct care" workforce in HCBS programs and the surveys.

Governor Snyder Invites Sebelius to Meet GOP Lawmakers to Discuss Recent 4-Year Cap Proposal. Last Friday, May 31, 2013, Governor Rick Snyder emphasized the preeminence of Medicaid expansion as an issue for the Michigan Legislature to address prior to its June 27 adjournment. Snyder has invited HHS Secretary Kathleen Sebelius to meet Republican legislators to discuss the GOP proposal to impose a four-year lifetime cap on Medicaid benefits for able-bodied adults. Many observers believe the proposal is highly unlikely to gain HHS approval.

Health Insurance Claims Assessment Tax. Last month, HMA's Michigan Update reported that one of the outstanding DCH budget issues related to the shortfall associated with the Health Insurance Claims Assessment (HICA) tax, estimated at more than $130 million. The claims tax was designed to fill the funding gap left when the state discontinued an assessment on Medicaid Health Plans, which generated about $400 million annually. Senate Bill 335 was introduced in mid-May to extend the current one percent tax but with no language addressing the shortfall. The bill was quickly passed by the Senate and sent to the House of Representatives. The House passed the bill without any changes. The bill will soon be on its way to the Governor for his signature. The conference budget for FY 2014 assumes the same level of HICA revenue at $398.1 million.

New Hampshire

HMA Roundup

Democrats Evaluating Administrative Decision to Expand Medicaid. While Republican legislators continue to slow-walk discussions about Medicaid expansion, two leading Democratic legislators have confirmed efforts to evaluate the possibility of Democratic Governor Maggie Hassan administratively implementing Medicaid expansion. Senate Minority Leader Sylvia Larsen and House Speaker Terie Norelli both expressed hope that the governor would explore this avenue. Governor Hassan's spokespeople have expressed a belief that legislative action is required. Republicans counter that the budget proposal, which includes Medicaid expansion-related funding, offers prima facie evidence that legislative approval is necessary.

In the news

- **"NH hospitals making move to Medicaid managed care"**

  On Tuesday, June 4, the President of the New Hampshire Hospital Association said that more of the state's hospitals are moving towards joining managed care networks, regardless of whether or not the state expands Medicaid. Hospitals' and other providers' resistance to managed care has long-delayed the rollout of the statewide program. (New Hampshire Union Leader)

North Carolina

HMA Roundup

New Medicaid Claims System Ready to Go Live July 1. On Tuesday, June 4, 2013, HHS Secretary Aldona Wos confirmed that the state was almost ready to launch a new Medicaid claims payment system. Computer Sciences Corporation will become the new fiscal agent for DHHS on July 1. Just two weeks ago, State Auditor Beth Wood found that NCTracks—the claims system—had technical issues that needed to be fixed before the July 1 "go-live." Wos confirmed that most of the issues have already since been addressed, or will be before launch.

In the news

- **"Few insurance carriers to participate in NC health insurance exchange"**

  According to the CEO of Coventry Health Care, there will likely be only two or three insurers offering qualified health plans in North Carolina's individual Exchange market, while the small business market will likely only be served by Blue Cross Blue Shield of North Carolina. (The Business Journal)

Pennsylvania

HMA Roundup – Matt Roan

Governor Corbett Protests Moving CHIP Beneficiaries to Medicaid. Governor Corbett sent a letter (attached) to Secretary Sebelius last week as part of the ongoing discussions between the state and HHS around healthcare reform. The Governor is pressing for concessions related to a requirement to move some children currently covered in the state's CHIP program to Medicaid. Corbett anticipates that approximately 70,000 children would be impacted, and that forcing these children to change health plans will be disruptive to their care. Advocates for low income Pennsylvanians contend that the move to Medicaid is a good thing, pointing out that many of the same insurers who run CHIP plans also offer a Medicaid option, and that most providers serving the CHIP population also accept Medicaid. More importantly, advocates argue, Medicaid offers a more comprehensive benefit package and is able to work in conjunction with other coverage as a secondary payer. CHIP is only available to children with no other coverage available. HHS has said in previous discussions with the state that the provisions of the ACA related to shifting CHIP lives to Medicaid are written in the law, and that HHS does not have flexibility to grant waivers of this provision to PA.

House Appropriations Approves Budget Bill, Democrats Introduce Their Own Plan. On Monday, June 3, 2013, the House Appropriations committee approved a Republican budget bill that calls for $28.3B in spending, and aligns closely with the Governor's proposed budget. The bill does not contain provisions to expand Medicaid. When asked about Medicaid Expansion, Appropriations Committee Chairman Rep. Bill Adolph (R-Delaware County) said that it was not included because the Governor had not made a decision, and negotiations with CMS are ongoing. Rep. Adolph then emphasized that the bill is expected to go through revisions before final passage, leading some to speculate that the House Republicans may be open to negotiating on Medicaid expansion. Meanwhile Senate Democrats introduced their own budget bill, which calls $28.4B in spending, and includes the elimination of proposed business tax cuts, increased education spending, and includes Medicaid Expansion as a net positive to the budget that allows for increased spending in other areas. The PA constitution requires the Legislature to pass the annual budget by June 30th.

Revenue Collections Higher Than Anticipated. According to the PA Dept. of Revenue, May revenue collections beat expectations by $35.1 million, and year to date collections are $102.3 million better than anticipated. The increased collections should make it easier for the Legislature to pass a budget for the next state fiscal year. While sales and corporate taxes beat expectations, personal income tax lagged behind expectations by about $10M in May.

DPW Launches Autism Initiative. The Department of Public Welfare has announced the creation of a new "one stop shop" for Pennsylvanians seeking information about services for people with autism. The Bureau of Autism Services has launched www.PAautism.org which provides information and resources coordinated by the Autism Services, Education, Resources, and Training (ASERT) Collaborative, a partnership of providers, community organizations, and researchers.

Vermont

HMA Roundup

Vermont's Largest Health Plan and Psychiatric Hospital Form New Company. Last week, Vermont's largest health plan—Blue Cross Blue Shield of Vermont—teamed up with the state's largest psychiatric hospital, the Brattleboro Retreat, to form a new company: Vermont Collaborative Care. The new firm will administer mental health and substance abuse benefits for 190,000 customers of BCBS of Vermont as of July 1, 2013. By shifting from an outsourced behavioral health approach to an in-house effort, BCBS of Vermont hopes to integrate physical and mental health services into a more cohesive approach to care.

Vermont Health CO-OP Appeal to State to Reconsider Licensure Rejection. Last Wednesday, May 29, 2013, Vermont Health CO-OP's CEO Christine Oliver and chairman Mitchell Fleischer appealed to the Governor and Financial Regulation Commissioner to reconsider the latter's rejection of the organization's licensure application. The regulator, Susan Donegan, had rejected the application based on noncompetitive rates, overly optimistic enrollment assumptions, solvency of the organization, and governance issues. The CO-OP leaders pointed to actuaries who are working to establish appropriate rates that will be competitive and the numerous prior interactions with Ms. Donegan to address various issues.

Wisconsin

HMA Roundup

Republican Legislators Vote to Reject Medicaid Expansion. On Tuesday, June 4, 2013, the Joint Finance Committee voted 12-4 to reject Medicaid expansion and approved Governor Scott Walker's plan to lower income eligibility for adults in the BadgerCare program to 100 percent of poverty level. Governor Walker assumes that 93 percent of individuals who would lose BadgerCare coverage would buy private insurance on the health Exchange with Federal subsidies. Democrats were outraged that the committee would bypass $120 million in Federal funds to cover the full cost of expanded eligibility.

National

HMA Roundup

Rand Corporation Study Claims States Rejecting Medicaid Expansion Will Lose $8.4 Billion. A Rand Corporation study released last week looked at the fourteen states that have rejected the Medicaid expansion. All told, the study found these states will face a combined $1 billion in additional spending, while losing out on $8.4 billion in new federal funds directed to the states. The Rand study is available through Health Affairs, here (subscription required).

Federally Facilitated Exchanges Light on Details So Far. While some states, such as Florida and Georgia, have begun to reveal the plans that will likely serve the federally facilitated Exchanges in their states, other details remain sparse. It is unknown how many of the 19 federally run Exchanges will feature only a small number of plans and it is not currently known when premium rates will be publicly revealed. It was revealed last week, however, that a total of 120 plans had applied across the 19 states.

In the news

- **"State Medicaid Leaders See Challenges in Covering the Dual Eligibles"**

  State Medicaid officials discussed the challenges in implementing dual eligible demonstration projects last week at the National Medicaid Congress in Washington, DC. Officials cited delays in the federal approval process, as well as concerns over managed care and Medicaid provider shortages as some of the challenges faced. (CQ HealthBeat via the Commonwealth Fund)

- **"Are Obamacare's Exchanges competitive? Here's what the experts say."**

  Washington Post's Sarah Kliff summarizes expert opinions on the degree to which Exchanges are providing a more competitive landscape. The opinion, although cautious, is generally that the Exchanges are providing at least some degree of additional competition, partly due to some lowered barriers to market entry. For example, California's Exchange attracted four new insurers to the market. (Washington Post)

OTHER HEADLINES

Oregon

- **"Oregon Mental Health Care System Could See Significant Expansion, Money Under Legislative Proposal"**

  Oregon lawmakers are considering a bill (SB 823) to significantly expand the state's mental health care system. The proposal, which has both democratic and republican support, lays out a six-year plan to increase funding for community mental health programs and a focus on early intervention. (Oregonian)

- **"Oregon Hospitals Use 'Grass Roots' Group To Promote Tax"**

  The Oregon Association for Hospitals and Health Systems is using a social media and emailing campaign through its grass roots advocacy campaign group to urge legislators to pass a bill renewing the state's hospital tax. The tax will generate an additional $1.3 billion for the state in federal Medicaid matching funds. (Oregonian)

Alabama

- **"Six hundred jobs to be eliminated as home health waiver jobs are outsourced to private companies"**

  The Department of Public Health will eliminate roughly 600 jobs associated with the state's Elderly and Disabled Medicaid Waiver on October 1, when the Department will cease to serve as a provider under the waiver. The legislature, however, increased waiver funds for the Department of Social Services by $2 million to contract with private entities to provide the same services. (AL.com)

Kansas

- **"Kan. Lawmakers Approve Disabilities Plan, Despite Pushback"**

  Kansas legislators approved a plan to transition non-medical services for disabled Medicaid beneficiaries into the state's KanCare managed care program, likely beginning on January 1, 2014. This move has been long-opposed, dating back to the initial approval for KanCare more than a year ago, when it was decided to initially carve-out these services. (KCUR News)

Montana

- **"Montana exchange could offer three carriers"**

  Montana's insurance commissioner revealed that Blue Cross Blue Shield of Montana, PacificSource Health Plans, and Montana Health CO-OP have filed to be qualified health plans in the state's Exchange. Montana's Exchange will be federally facilitated, at least for 2014. (Life Health Pro)

COMPANY NEWS

- **Kentucky Court Rules Centene's Subsidiary Cannot Terminate Contract.**

  On Friday, May 31, 2013, a Franklin Circuit judge ruled that Kentucky Spirit, a subsidiary of Centene, cannot terminate its three-year contract before the July 2014 end of the agreement. Kentucky Spirit served about 125,000 Medicaid managed care beneficiaries in 2012. Last October, Kentucky Spirit announced that it had received bad data from the state prior to bidding on the contract and the actual results have generated significant losses to the company. (Link to Centene Press Release)

- **"CareFirst scales back role in D.C. health insurance exchange, surprising city officials"**

  Washington, D.C.'s CareFirst BlueCross BlueShield drastically reduced the number of health plan offerings it intends to sell in the Exchange from 62 offerings to only eight. Officials raised concerns that this could limit participation and drive up costs in the Exchange. (Washington Business Journal)

- **"MTM adds Michigan contract"**

  Medical Transportation Management, Inc. (MTM) was awarded a $1.5 million contract with Detroit, Michigan-based Total Health Care. This comes on the heels of MTM's $51 million non-emergency medical transportation contract with the state of Wisconsin announced in April. (St. Louis Business Journal)

- **"Man accused of diverting nearly $17 million from D.C. tax-funded health plan"**

  In the latest development in the Chartered Health Plan case, the city-appointed receiver has filed a lawsuit asserting that former Chartered owner Jeffery Thompson diverted approximately $17 million dollars out of Chartered Health Plan's finances. (Washington Post)

- **"Molina Healthcare Selects Inovalon for Quality Measurement Analytics"**

  Inovalon, Inc., announced that it has been selected by Molina Healthcare to provide outcomes measurement and reporting under a multi-year contract. (Wall Street Journal)

RFP Calendar

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

Date	State	Event	Beneficiaries
June, 2013	Rhode Island Duals	Contract Awards	22,700
June, 2013	South Carolina Duals	RFP Released	68,000
June 17, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
June, 2013	Idaho Duals	RFP Released	17,700
June, 2013	Virginia Duals	Contract awards	79,000
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	48,500
Summer 2013	Michigan Duals	RFP Released	70,000
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
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	Massachusetts Duals	Implementation	115,000
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
"Early 2014"	North Carolina	RFP released	TBD
January 1, 2014	California Duals	Implementation	456,000
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	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	79,000
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
April 1, 2014	Idaho Duals	Implementation	17,700
April 1, 2014	New York Duals	Implementation	133,880
April 1, 2014	Washington Duals	Implementation	48,500
July 1, 2014	Michigan Duals	Implementation	70,000
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		98,235	Not pursuing Financial Alignment Model				
California	Capitated	456,000	X	3/1/2012	4/4/2012	X	1/1/2014
Colorado	MFFS	62,982					10/1/2013
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	June 2013	TBD	TBD		4/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	10/1/2013
Michigan	Capitated	70,000	Summer 2013		TBD		7/1/2014
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					4/1/2014
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	Summer 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	X	5/15/2013	July 2013	X	1/1/2014
Vermont	Capitated	22,000	10/1/2013	TBD	TBD	7/15/2013	9/1/2014
Washington	Capitated/MFFS	115,000	X	5/15/2013 (Capitated	July 2013 (Capitated)	MFFS Only	1/1/2014
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		TBD**
Totals	**14 Capitated 7 MFFS**	**1.5M Capitated 485K FFS**	***8***			***6***	

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

*** Wisconsin is completing a comment period on a draft MOU with CMS. Finalized MOU will determine implementation date.*

‡ Capitated duals integration model for health homes population.

HMA WELCOMES…

Susan Moran, Principal – Lansing, Michigan

Susan Moran joins HMA on Monday, June 10, 2013, as a Principal working out of the Lansing, Michigan, office. Sue comes to HMA most recently from the Michigan Department of Community Health, Medical Services Administration, where she has served as the Bureau Director for Medicaid Program Operations and Quality Assurance since 2004. In this role she has been responsible for the administration of managed care, customer service, pharmacy, program review, and the Office of Medical Affairs. She has provided leadership and direction of performance monitoring and quality improvement initiatives for the Medicaid and MI Child program. Some of her key accomplishments include serving as Co-Director of the Michigan Primary Care Transformation Project (MIPCT), directing three cycles of competitive Medicaid Health Plan rebidding and re-contracting processes for $3.5 billion managed care program, and serving as Director of the Reducing Disparities at the Practice Site (RDPS) project in collaboration with the Center for Healthcare Strategies (CHCS) and six Michigan-based Medicaid Health Plans.

The prior roles that Sue has worked in at the Michigan Department of Community Health include Division Director of the Comprehensive Health Care Plan Division; Division Director of Managed Care Quality Assessment and Improvement; and Manager of the Quality System Section. Sue also worked as a Compliance Administrator for Physicians Health Plan in Lansing and served in similar roles for Blue Care Network of Mid-Michigan over a span of 12 years.

Sue holds a Master's Degree in Public Health from the University Of Illinois School of Public Health and a BS in Nursing from the University Of Illinois School Of Nursing. She is a Licensed RN in the State of Michigan.

HMA News

Issue Brief Examines Medicaid Outreach and Enrollment Strategies

HMA Principal Jennifer Edwards and Consultant Diana Rodin worked with Samantha Artiga of the Kaiser Family Foundation to produce the recently released "Profiles of Medicaid Outreach and Enrollment Strategies: Helping Families Maintain Coverage in Michigan." It is the second installment in the "Gearing up for 2014" series, which highlights lessons learned from Medicaid and CHIP outreach and enrollment strategies. This brief profiles a new initiative of the Michigan Primary Care Association (MPCA) to facilitate coverage renewals through a systematic, technology-based reminder system coupled with one-on-one assistance. The inaugural issue brief profiled a successful initiative among health centers in Utah to provide one-on-one Medicaid enrollment assistance. **(Link to Issue Brief - PDF)**

HMA Advises on Safety Net ACO Readiness Assessment Tool

The Safety Net Accountable Care Organization (ACO) Readiness Assessment Tool is designed for organizations to assess how ready they are to take on the responsibilities of becoming an ACO serving a population of safety net patients. Pat Terrell, Managing Principal at HMA, served on author Stephen M. Shortell's Advisory Committee during its development. When released, Terry Conway and Art Jones, Managing Principal and Principal at HMA, spoke on the topic of accountable care during the kick-off conference. **(Link - PDF)**