HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: TEXAS ISSUES RURAL STAR+PLUS RFP

HMA ROUNDUP: CALIFORNIA COURT UPHOLDS PROVIDER RATE CUT; WASHINGTON TO EXPAND MEDICAID; NEW YORK EXCHANGE APPROVED; COLORADO RECEIVES CHIPRA BONUS; FLORIDA MMA ITN EXPECTED SOON; GEORGIA PLANS FOR PHYSICIAN FEE INCREASE

OTHER HEADLINES: EIGHTEEN STATES OPT FOR STATE-BASED EXCHANGES; WASHINGTON MEDICAID MCOS SUE STATE OVER MEMBER ASSIGNMENT; WYOMING CONSIDERS MEDICAID MANAGED CARE; ORGANIZATIONAL ANNOUNCEMENTS AT MVP HEALTHCARE, BCBS MINNESOTA AND AETNA;

HMA WELCOMES: JIM KUMPEL – NEW YORK

DECEMBER 19, 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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IN FOCUS: TEXAS ISSUES RURAL STAR+PLUS RFP

This week, our *In Focus* section reviews the request for proposals (RFP) from the Texas Health and Human Services Commission last week, procuring managed care plans for an expansion of HHSC's STAR+PLUS program in the state's rural service areas. STAR+PLUS is a Medicaid managed care program integrating acute care services and community-based LTSS to aged, blind, and disabled (ABD) Medicaid recipients. The STAR+PLUS program enrolled 403,796 mandatory and voluntary beneficiaries as of December 1, 2012. The Medicaid Rural Service Area (MRSA) expansion is expected to add approximately 110,000 new STAR+PLUS lives.

The RFP and procurement library are available here.

RFP Overview

HHSC anticipates awarding at least two managed care contracts in each of the three MRSAs: Central, Northeast, and West. The MRSAs under this RFP cover a huge portion of the state, but have relatively small enrollment estimates.

MRSA	Medicaid Only	Dual-Eligible	Total
Central	13,160	15,285	28,445
Northeast	20,722	23,726	44,448
West	15,189	22,198	37,388
Total	**49,071**	**61,209**	**110,280**

Source: Procurement library

Plans will provide a full benefit package for Medicaid-only enrollees, including pharmacy benefits, while providing non-pharmacy Medicaid services, primarily LTSS, for the dual eligible enrollees. Based on estimated capitated payments provided by HHSC, we estimate a blended PMPM of $735 for the total STAR+PLUS rural expansion. Medicaid-only PMPMs are estimated at $1,033, with dual eligible PMPMs of $496.

MRSA	Medicaid Only	Dual-Eligible	Blended
Central	$1,025	$358	$667
Northeast	$1,008	$574	$777
West	$1,074	$507	$737
Total	**$1,033**	**$496**	**$735**

Source: Procurement library

Scoring Criteria

The RFP documents to not spell out specific scoring, but indicate that the highest priority will be given to plans meeting HHSC's priority objectives for the expansion:

- Continuity of care;
- Network adequacy and access to care;
- Service coordination;

- Increased utilization of member benefits with an emphasis on medical check-ups;
- Quality;
- Timeliness of claim payment;
- Behavioral health services;
- Delivery of health care to diverse populations; and
- Disease management requirements.

Additionally, the RFP indicates that proposals to serve all three MRSAs will be given preference.

RFP Timeline

Proposals are due on May 1, 2013 with award announcements yet to be determined.

Timeline	Date
RFP Released	December 12, 2012
Vendor Conference	February 15, 2013
Proposals Due	May 1, 2013
Tentative Award Announcement	TBA
Anticipated Contract Effective Date	September 1, 2013
Operational Start Date	September 1, 2014

Contracts will go live on September 1, 2014 and will expire on August 31, 2017, for a three year initial contract period. HHSC may extend contracts for additional periods, not to exceed a total of eight operational years, up to a five year extension.

Market Opportunity

With more than 110,000 potential enrollees, and a blended PMPM of $735, we estimate the annual revenue associated with this procurement at more than $970 million. With HHSC's preference for plans to serve more than one MRSA, there may be only a handful of awarded plans.

Current STAR+PLUS Market

The current STAR+PLUS market is served by five plans: Amerigroup, Superior, Molina, United, and HealthSpring. Amerigroup, Superior, and Molina make up roughly 80 percent of the current market as of December 2012 enrollment data.

Health Plan	Enrollment (Dec. 12)	%
Amerigroup	117,785	29%
Superior HealthPlan	108,181	27%
Molina Healthcare of Texas	95,983	24%
UnitedHealthcare	58,972	15%
HealthSpring	22,875	6%
Total STAR+PLUS	**403,796**	

Source: HHSC Enrollment Data

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

On Thursday December 13, the Ninth U.S. Circuit Court of Appeals upheld California's proposed 10 percent cut in Medi-Cal rates for doctors, pharmacies and certain hospitals. *CMA v. Douglas* is a consolidated set of cases brought by providers and beneficiaries to enjoin the state's rate reductions and was remanded back to the Ninth U.S. Circuit Court from the U.S. Supreme Court on February 22, 2012. One of the critical points noted in the U.S. Supreme Court decision was based on CMS' approval in October 2011 of the state's plan to reduce Medi-Cal payments by 10% for physicians, clinics, dentists, laboratories, pharmacists and nursing facilities. The physician rate decreases only apply to services for Medi-Cal adults, not children. All cuts will apply to both FFS and managed care. U.S. District Court Judge Christina Snyder tentatively blocked the cut, saying it could cause irreparable harm to patients. That decision was appealed and last week, the three-judge appeals court panel ruled that HHS Secretary Kathleen Sebelius has authority to decide whether California and other states can reduce Medicaid rates while still adhering to program regulations. Our expectation at this time is that the state will move to implement the rate reductions in 2013. The cuts would be retroactive to June 1, 2011 and are projected to save the state $623 million.

In the news

- **Healthcare crisis: not enough specialists for the poor**

  By the end of the decade, the nation will be short more than 46,000 surgeons and specialists, a nearly tenfold increase from 2010, according to the Assn. of American Medical Colleges. Healthcare reform is expected to worsen the problem as more patients — many with complex and deferred health needs — become insured and seek specialized treatment. Many of the newly insured will receive Medi-Cal, the government plan for the needy as administered through the state of California. Clinics already struggle to get private specialists to see Medicaid patients because of the low payments to doctors. Last week, an appellate court decision that authorized the state to move forward with 10% cuts in Medi-Cal reimbursement, which could make finding doctors for those patients even more difficult. (Los Angeles Times)

- **Critics Say California Medicaid Cuts Upheld By Appeals Panel Bode Ill for Health Care Law**

  States that get the backing of federal officials for cutting Medicaid payments to deal with budget pressures may be in a stronger position to make those reductions stick after a federal appeals court ruling this week. Providers and patients, on the other hand, may be weakened — possibly boding ill for expanded access to medical services in some states under the health care law. That may be the fallout from the ruling Thursday by Judge Stephen S. Trott, representing a three-member panel of the Ninth Circuit Court of Appeals. The ruling vacated a lower court's injunction blocking 10 percent Medicaid cuts to certain providers to save the beleaguered state budget $623 million.

The ruling dealt specifically with California but, coming at the appeals level, could influence the thinking of lower courts handling similar cases in other states. (CQ Healthbeat)

Colorado

HMA Roundup – Joan Henneberry

On December 19, 2012, the Department of Health Care Policy and Financing announced that Colorado Medicaid has received a $42.9 million Children's Health Insurance Program Reauthorization Act (CHIPRA) Performance Bonus from the Centers for Medicare and Medicaid Services (CMS). This bonus was the largest awarded in the country and marks the third consecutive year that Colorado Medicaid has earned CMS recognition for its ongoing efforts to identify and enroll eligible children in Medicaid and Child Health Plan Plus (CHP+). To qualify for the Performance Bonus, states must, 1) have in place at least five Medicaid and CHIP program features known to promote enrollment and retention in health coverage for children; and 2) demonstrate a significant increase in Medicaid enrollment among children during the course of the federal fiscal year.

Colorado met seven of the eight required program features:

- The removal of the asset test for Medicaid eligibility;
- The elimination of in-person interview requirements;
- The use of one application for applying and renewing Medicaid and CHP+;
- Presumptive Eligibility – the ability for applicants who appear to be eligible to receive health care services while waiting for final eligibility determination;
- Health Insurance Buy-In - A premium assistance program allowing families to receive subsidies for eligible Medicaid clients to enroll in and contribute to the cost of employer insurance;
- Administrative Renewal – the use of a pre-populated renewal form that is sent to families asking for household changes but is not required to be returned to renew eligibility; and
- Express Lane Eligibility, which allows families to opt to allow information on the school lunch program application to be used to start a joint Medicaid/CHP+ application.

In the news

- **Colorado Gov Pitches Plan To Mend Mental Health Safety Net**

  Colorado Gov. John Hickenlooper is proposing an $18.5 million plan to strengthen the state's mental health system. The proposal is the result of five months of work by a group of advisors convened by Hickenlooper in the wake of a mass shooting in July at an Aurora, Colo., movie theater that left 12 dead. The plan calls for 50 new treatment beds for those transitioning from institutional care, 20 more for those in jail or prison and 107 housing vouchers for people being released from in-patient treatment. It would also expand a 24 hour crisis telephone line from beyond Denver to the rest of

the state. The plan also calls for five "crisis stabilization centers" people could drop in to 24 hours a day for help. (Kaiser Health News)

- **New Colorado Medicaid program helps middle class with long-term issues**

  Colorado expanded Medicaid in July to allow middle-class families of children with severe, ongoing disabilities to "buy in" to the insurance traditionally for the low-income. The new benefit is being used by more than 160 children. It's being paid for with funds from the hospital provider fee created in 2009 to expand Medicaid eligibility in Colorado, and federal matching money. The state says no Colorado general funds are used for the Children's Buy-In. The benefits can go to families well into the middle and upper-middle class. A family of four can earn $5,700 a month and still qualify, and that's after a one-third income adjustment used in the calculations. So a family of four earning $8,500 a month before the downward adjustment, or $102,000 a year, would be eligible. Combined with an adult program for similar disabilities, the state expects more than 8,000 people to be enrolled in the buy-ins within three years. (Denver Post)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Managed Medical Assistance: We expect that the Managed Medical Assistance (MMA) invitation to negotiate (ITN) will be released late next week. The statutory deadline for the state to issue the ITN is January 1, 2013 and the earliest it can be released is December 21, 2012. We estimate that the MMA ITN will cover services representing approximately $8 billion in annualized Medicaid spending.

Diagnosis Related Group: Also expected by the end of the year is a legislative report providing additional detail on the state's plan to shift hospital payment rates to a DRG-based model. According to statutory language passed last year, the state is scheduled to convert to DRGs by July 1, 2013. The next scheduled public DRG meeting is January 8, 2013.

PPACA Legislative Committee: Finally, the Florida State Senate has created a website that allows residents to comment on the Affordable Care Act. The site can be accessed here.

In the news

- **FL Medicaid Doctors to get 105% Raise**

  Florida is one of five states that pay primary-care doctors so little for treating Medicaid patients that those doctors will get a raise of more than 100 percent when a federal subsidy kicks in on Jan. 1, according to a new study. The raise, which brings Medicaid pay up to the level of Medicare for two years, is part of the Patient Protection and Affordable Care Act. The idea is to lure more doctors into primary care and make it worth their while to care for those insured by Medicaid, the joint state and federal program for the very poor. (Health News Florida)

Georgia

HMA Roundup – Mark Trail

The Board of Community Health approved the initial release of a public notice to increase certain primary rates to 100 percent of Medicare rates, as required in the ACA. DCH Chief Dr. Jerry Dubberly noted that due to the late release of the CMS regulations related to the increase, DCH would probably not be ready to actually pay the increase until spring of 2013, though the payments would be retroactive to January 1, 2013. The delay results from edits that are needed to the MMIS system and to credential providers as qualified for the enhanced payment. He pointed out that the increase in payments would apply both in the FFS and CMO environments. He also noted that physician extenders would be eligible for the increased payment, but at their current 90 percent rate.

In the news

- **Temporary pay hike for Medicaid doctors is also boon for patients**

  Medicaid rates will be raised next year to the Medicare payment level, the result of a little-known provision in the Affordable Care Act. For a "sick" office visit, the pay for a physician is estimated to rise from about $40 to nearly $70. The pay bump will mean more Medicaid reimbursement for services by family physicians, internists and pediatricians, and for vaccinations, with the extra money supplied by the federal government. The pay hike is for two years. A survey of 1,400 physicians in Georgia found half of them do not accept new Medicaid or PeachCare patients. Pay is a major reason for those doctors' decision. In an economy that has been weak for years, some doctors have to make hard choices to stay in business. That, in turn, makes it harder for many low-income people to find doctors who will see them. In the overall effort to improve access to care in Georgia, low doctor pay from Medicaid has been a major obstacle. (Georgia Health News)

New York

HMA Roundup – Denise Soffel

On December 14, 2012, New York received conditional approval from the U.S. Department of Health and Human Services (HHS) to operate a state-based Exchange. The letter from HHS Secretary Kathleen Sebelius to Governor Andrew Cuomo is available on the NY health benefit exchange website. **Link**

In the news

- **Experts Warn of Budget Ills for the State, Lasting Years**

  New York State faces long-term budget problems that are compounded by the teetering finances of its local governments, an aging infrastructure and the possibility of severe cuts in federal funding, a panel of fiscal experts said Tuesday. The State Budget Crisis Task Force, a nonpartisan group, said that New York's problems had been "papered over with gimmicks" for decades, and that while Gov. Andrew M. Cuomo had taken some steps to rein in spending, the state was still saddled with burdens that would leave it unable to make ends meet in the long run. Over the past decade, the re-

port said, New York had postponed a reckoning by using one-time measures to produce $25 billion in revenue. (New York Times)

North Carolina

HMA Roundup

Governor-elect Pat McCrory named Aldona Wos as Secretary of the Department of Health and Human Services. Wos is a Greensboro physician and former U.S. Ambassador.

In the news

- **Governor Temporarily Fixes Group Home Funding Problem**

  People with mental health and developmental disabilities living in group homes have a short reprieve from the threat of losing their housing on Jan 1. Outgoing Governor Bev Perdue announced Tuesday morning she had found a way to provide $1 million to help group homes pay for housing for people with mental health and developmental disabilities through the month of January. The move is a temporary patch for the homes until General Assembly returns to Raleigh and can construct a longer-term fix to the problem. (North Carolina Health News)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

HealthChoices Enrollment: According to a recent analysis by the Delaware Valley Healthcare Council, the penetration rate for HealthChoices Medicaid managed care organizations in Southeastern Pennsylvania remains steady at about 80 percent, but the number of Medical Assistance enrollees in southeastern Pennsylvania dropped by about 10,000 from 734,404 in June 2012 to 723,776 in September 2012. Most of this decrease occurred in Philadelphia. Of the region's two newest plans, CoventryCares continues to grow steadily, but enrollment in Aetna Better Health dropped by nearly 3,000 between June and September 2012. With Aetna's recent acquisition of CoventryCares, the combined organization will have 9 percent market share, similar to UnitedHealthcare Community Plan's 10 percent share. Despite declining enrollment, Keystone Mercy Health Plan and Health Partners continue to dominate, with 55 and 27 percent market share, respectively.

Hospital Performance: According to the latest Hospital Performance Report, released by the Pennsylvania Health Care Cost Containment Council, In-hospital mortality rates decreased significantly statewide between 2007 and 2011 for four of the 12 conditions reviewed. The sharpest decline was for Pneumonia-Aspiration, where the mortality rate dropped from 10.0 percent to 7.7 percent. Colorectal Procedures (3.2 percent to 2.6 percent), Kidney and Urinary Tract Infections (1.0 percent to 0.6 percent), and Chronic Obstructive Pulmonary Disease (1.0 percent to 0.8 percent) also showed significant declines in mortality rate between 2007 and 2011. Readmission rates showed a statistically significant decrease statewide from 2007 to 2011 for Chronic Obstructive Pulmonary Disease (from 23.5 percent to 22.1 percent) and Congestive Heart Failure (from 26.9 percent to 25.6 percent), but a significant increase for Chest Pain (from 10.9 percent to 12.9 percent).

Washington

HMA Roundup – Doug Porter

On December 18, 2012 Governor Chris Gregoire released FY13 Supplemental and 13-15 biennial budget proposals. Included in the budget proposals were funding for:

- Medicaid expansion and a new eligibility system, fully integrated with the Healthplanfinder exchange;
- Expanding Washington's state-of-the-art billing system to include social services;
- The continuation of a hospital provider tax; and
- Implementation of HealthPathWashington – a state proposal to better coordinate services and improve care for the Medicare-Medicaid dual eligibles.

In the news

- **2 health plans sue state over allocation of Medicaid patients**

  Two health plans that have contracted with the state to administer managed-care health services to Medicaid enrollees have sued the state, saying its allocation formula will penalize them by assigning too many new patients to other plans. In a lawsuit filed in Thurston County Superior Court, Molina and Community Health Plan of Washington (CHPW) contend that the state has breached its contract with them, penalizing the plans that have served the state's Medicaid patients for many years. The two plans maintain that three new plans have been given an unfair advantage by a reworked formula the state wants to use to assign patients. The three plans newly contracted with the state, selected in January after a bidding process, include Amerigroup Washington, Coordinated Care Corp., and United Healthcare Community Plan. (Seattle Times)

OTHER HEADLINES

Louisiana

- **Louisiana cuts health care, Medicaid and hospice programs to rebalance budget**

  A $165.5 million hole in Louisiana's budget will be patched with a mix of cuts, savings from hiring freezes and taking funds from state coffers, Gov. Bobby Jindal's commissioner of administration announced Friday. The package enacted by the governor will strip funding from health programs, including hospice care and psychiatric services for Medicaid patients. The elimination of hospice programs for Medicaid patients who are not in nursing homes struck lawmakers on the state's Joint Legislative Committee on the Budget particularly hard. (The Times-Picayune)

Texas

- **Dual Eligible Payments to Be Partially Restored in 2013**

  Health care providers in Texas who treat dual eligible patients — those who qualify for both Medicare and Medicaid benefits — will get some relief in 2013. This week, state

Sen. Juan "Chuy" Hinojosa, D-McAllen, took physicians and hospital officials from the Rio Grande Valley to meet with state leaders in Austin, with the goal of getting state health leaders to restore full payment of dual eligible patients' $140 Medicare deductible. The delegation came away with an agreement to reinstate the deductible starting Jan. 1, 2013, state officials confirmed. (Texas Tribune)

Utah

- **Utah governor stands up for state-based insurance exchange**

Gov. Gary Herbert is moving forward with Utah's version of a health care exchange, with or without the blessing of the federal government. The federal government has not yet approved the state-based system for insurance reform, but says it will work with Utah to make the existing exchange comply with federal rules. In a letter addressed to U.S. Department of Health and Human Services Secretary Kathleen Sebelius, Herbert said he remains concerned about the level of flexibility that will be afforded to states under either a state or federal approach. Herbert again asked federal officials to certify Utah's version of an exchange as compliant with the Affordable Care Act. (Deseret News)

Wisconsin

- **Milwaukee County seeks to expand Family Care program to 5 more counties**

Milwaukee County is poised to expand its role operating state Family Care services for older residents and those with disabilities into five additional counties. The expansion plan, which has won initial state approval, would put Milwaukee County's program into competition with a private firm already serving clients in Waukesha, Washington, Walworth, Ozaukee and Sheboygan counties. The proposed 2013 growth follows the Milwaukee County Family Care program's entry into Kenosha and Racine counties this year. Growing to a regional provider of care services will help ensure the Milwaukee County program survives and thrives in a more competitive environment, said Maria Ledger, director of the Milwaukee County program. (Milwaukee Journal-Sentinel)

Wyoming

- **Medicaid reform moves forward in Wyoming**

Wyoming lawmakers will begin discussions next month on a reform package designed to address escalating costs in the state's Medicaid program. The bill would direct the Health Department to explore hiring private organizations to manage care for some or all of the state's Medicaid population. Generally, such organizations contract with health care providers to form networks for treating patients. Officials want to study whether managed care could save the state money while providing the same or better care than exists now. Wyoming is one of only three states in the country that doesn't use some form of managed care in its Medicaid program. (Billings Gazette)

National

- **States scramble to cover Medicaid costs, some face overruns**

Rising healthcare costs are pushing up the amounts states must spend on the Medicaid insurance program for the poor, sending some scrambling to find funds, according to a

report released on Tuesday by the National Conference of State Legislatures. The report found that spending on Medicaid and other public healthcare programs is currently over budget in 10 states, compared to six states at the same point last year. In contrast, only five states report that education, which has traditionally taken up most spending, is over budget. (Reuters)

- **Hospital Systems Branch Out as Insurers**

  A growing number of hospital systems are moving to start their own insurance plans, aiming to broaden their roles and prepare for the changes coming under the federal health-care overhaul. Piedmont Healthcare and WellStar Health System, both in the Atlanta area, are set to announce a jointly owned insurance arm, with the goal of marketing coverage to employers and Medicare recipients in 2014. They also will consider selling coverage on a health exchange, one of the online insurance marketplaces required in each state by the health-overhaul law. (Wall Street Journal)

- **Facing Deadline, Most States Say No To Running Their Own Insurance Exchanges**

  The Obama administration will have to build and operate online health insurance markets for more than 30 states, something few expected when the federal health law was approved in 2010. With today's deadline hours away, only 18 states and the District of Columbia had proposed running their own insurance markets, also known as exchanges, a key vehicle under the law to expand health coverage to an estimated 23 million people over next four years. (Kaiser Health News)

- **Senate Finance Committee Members Question Director of Duals Office**

  Sen. Jay Rockefeller on Thursday grilled the director of the office that the health care law created to oversee the care of those eligible for both Medicare and Medicaid about an initiative the administration is pursuing to shift recipients into managed or coordinated care plans. The West Virginia Democrat was a key backer of establishing such an office but has questioned the scope of its initiative, which would be undertaken in about half the country. Announced in July 2011, the effort would shift people who are dually eligible for the programs into either managed or coordinated care. The goal is to improve patient care and save federal and state funds. The governments spend more than $300 billion every year to care for the more than 9 million dually eligible patients. Rockefeller said at a Senate Finance Committee hearing Thursday that the Obama administration is moving too many people into the program. He raised concerns about whether patients will understand what is happening or realize that they can choose not to participate. Rockefeller questioned whether enough evaluation is taking place. He argued that if you enroll most of the population in a state into a demonstration program, it's no longer a demonstration: "It's the inevitable formulation of policy." Melanie Bella, the director of the duals coordination office, defended the administration's approach as "careful and deliberate." Senate Finance hearing (pdf). (CQ Healthbeat)

COMPANY NEWS

- **Gonick named to succeed Oliker as CEO of MVP Health Care**

  MVP Health Care of Schenectady, New York, has named Denise Gonick as president and CEO. Gonick, 46, who has been with MVP for 17 years, will succeed David Oliker, who will retire at the end of February. She has served as president of operations, leading the company's transition and day-to-day management since Oliker's retirement was announced this summer. (The Business Review)

- **Blue Cross and Blue Shield MN names new CEO**

  The state's largest commercial health insurer, Blue Cross and Blue Shield of Minnesota, has named a new CEO. Former Aetna executive Michael Guyette takes over the helm of Blue Cross and Blue Shield Jan. 7. The Eagan-based non-profit has had a quick succession of CEOs in the past year and a half. (MPR News)

- **MTS Health Investors Completes Investment in Vital Decisions, LLC**

  MTS Health Investors has acquired a majority stake in Vital Decisions LLC**,** an Edison, N.J.-based provider of counseling service to advanced illness patients, from the company's founders. No financial terms were disclosed. (MTS Health Investors)

- **Aetna Names New Illinois Medicaid Plan CEO**

  Aetna announced the selection of Sanjoy Musunuri as chief executive officer in Illinois for Aetna Better Health, Aetna's Medicaid health plan. The plan, which has administered benefits for Medicaid enrollees in the Illinois Integrated Care Program for more than a year, recently was selected by the Illinois Department of Healthcare and Family Services (HFS) to participate in the state's Medicare Medicaid Alignment Initiative as well. (Aetna News Release)

RFP Calendar

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

Date	State	Event	Beneficiaries
December 12, 2012	Texas Rural STAR+PLUS	RFP Released	110,000
December 19, 2012	Nevada	Contract Awards	188,000
January, 2013	Virginia Duals	RFP Released	65,400
January, 2013	South Carolina Duals	RFP Released	68,000
January 1, 2013	Wisconsin LTC	Implementation	38,800
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Kentucky - Region 3	Implementation	170,000
January 1, 2013	Florida acute care	RFP released	2,800,000
January 1, 2013	Vermont Duals	Proposals due	22,000
January 7, 2013	New Mexico	Contract awards	510,000
January 8, 2013	Arizona - Maricopa Behavioral	Proposals due	N/A
January 15, 2013	Florida LTC	Contract Awards	90,000
January 21, 2013	California Rural	Applications due	280,000
January 28, 2013	Arizona - Acute Care	Proposals due	1,100,000
January, 2013	District of Columbia	Contract Awards	165,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
February 28, 2013	Vermont Duals	Contract awards	22,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March, 2013	Idaho Duals	RFP Released	17,700
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
April-May, 2013	Rhode Island Duals	RFP Released	22,700
May 1, 2013	District of Columbia	Implementation	165,000
May 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
June 1, 2013	California Duals	Implementation	500,000
June, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July 30, 2013	South Carolina Duals	Contract awards	68,000
July, 2013	Virginia Duals	Contract awards	65,400
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
September 1, 2013	Ohio Duals	Implementation	115,000
October 1, 2013	Illinois Duals	Implementation	136,000
October 1, 2013	Florida LTC	Implementation	90,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	Hawaii Duals	Implementation	24,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
January 1, 2014	Rhode Island Duals	Implementation	22,700
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	526,902**	X	3/1/2012	4/4/2012		6/1/2013
Colorado	MFFS	62,982					1/1/2013
Connecticut	MFFS	57,569					12/1/2012
Hawaii	Capitated	24,189					1/1/2014
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012		Fall 2013
Iowa	MFFS	62,714					1/1/2013
Idaho	Capitated	22,548	March 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	4/1/2013
Michigan	Capitated	198,644	TBD	TBD	TBD		1/1/2014
Missouri	MFFS‡	6,380					10/1/2012
Minnesota		93,165	Not pursuing Financial Alignment Model				
New Mexico		40,000	Not pursuing Financial Alignment Model				
New York	Capitated	133,880					1/1/2014
North Carolina	MFFS	222,151					1/1/2013
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	22,737		Apr-May 2013	6/1/2013		1/1/2014
South Carolina	Capitated	68,000	Jan. 2013	TBD	TBD		1/1/2014
Tennessee	Capitated	136,000					1/1/2014
Texas	Capitated	214,402		Late 2012	Early 2013		1/1/2014
Virginia	Capitated	65,415	Early 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	1/7/2013	3/11/2013	4/1/2013	Dec. 2012	1/1/2014
Washington	Capitated/MFFS	115,000	TBD	TBD	TBD	MFFS Only	1/1/2014
Wisconsin	Capitated	17,600	X	8/23/2012	10/1/2012		4/1/2013
Totals	**17 Capitated 7 MFFS**	**2.4M Capitated 485K FFS**	***5***			***3***	

*** Duals eligible for demo based on 8 counties included in May 31, 2012 proposal to CMS. Will expand to further counties in 2014 and 2015 with approval.*

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

[‡] *Capitated duals integration model for health homes population.*

HMA WELCOMES…

Jim Kumpel, Principal - New York City

Jim comes to us most recently from BB&T Capital Markets where he served as the Managing Director and Group Head for Healthcare Equity Research. In this role he authored industry reports on contract research organizations and health/human services segments as well as managed healthcare research efforts covering post-acute care, PBMs, disease management, CRSOs, and HHS. He also identified contrarian investment ideas in pharmaceutical services and relatively undiscovered HHS companies.

Prior to his experience with BTT&T, Jim was the Managing Director of Equity Research for Madison Williams and Company, LLC. In his role he created a healthcare advisory network of more than 30 CIOs, wellness directors, think tank and policy leaders. He also developed "Transformational Healthcare" – an industry report focused on emerging growth and reform areas. Additional professional experience that Jim brings to HMA includes serving as Managing Director of Equity Research for Friedman Billings Ramsey as well as Senior Vice President of Equity Research for Raymond James & Associates.

Jim holds an MBA from Fuqua School of Business at Duke University as well as a Bachelor of Science degree in Industrial and Labor Relations with a focus on Economics from Cornell University.

HMA WEBINAR REPLAY

The Economics of the Medicaid Expansion

On November 30, 2012, HMA hosted a webinar by leading independent Medicaid policy and financing experts Jack Meyer, Vern Smith, and Kathy Gifford. They offered an objective perspective on the direct and indirect fiscal considerations of the Medicaid expansion under the Affordable Care Act (ACA).

A video recording of the presentation and the presentation slide deck for this webinar are available here.