HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: HEALTH INSURANCE EXCHANGES – PROGRESS UPDATE

HMA ROUNDUP: ARIZONA DISCLOSES ACUTE CARE RFP BIDDERS; CALIFORNIA LEGISLATURE CONVENES SPECIAL SESSION ON HEALTHCARE; THREE BIDDERS PROTEST FLORIDA LTC CONTRACT AWARDS; ILLINOIS EXPANDS MEDICAID ABD MANAGED CARE; NEW YORK GOVERNOR RELEASES BUDGET PROPOSAL; TEXAS GOVERNOR REITERATES OPPOSITION TO MEDICAID EXPANSION; WASHINGTON NAMES HEALTH CARE AUTHORITY DIRECTOR

OTHER HEADLINES: ALABAMA CONSIDERS MEDICAID REFORMS; PROVIDER GROUPS URGE STATES TO ACCEPT MEDICAID EXPANSION

RECENT HMA RESEARCH: *"EMPANELMENT IN AN ACCOUNTABLE CARE ENVIRONMENT"*; *"CALIFORNIA HOSPITALS: BUILDINGS, BEDS, AND BUSINESS"*

RECENT EVENTS: GREG NERSESSIAN INTERVIEWED ON BLOOMBERG INDUSTRIES

JANUARY 30, 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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Edited by:
Gregory Nersessian, CFA
212.575.5929
gnersessian@healthmanagement.com

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

Health Insurance Exchanges – Progress Update

This week, our *In Focus* section reviews the current state of Exchange development across the states. In addition to an overview of federal regulatory and rulemaking developments, we highlight recent Exchange activity at the state level. Finally, we lay out key upcoming deadlines and milestones, as well as summarize the major programmatic decisions and activities states will grapple with over the next few months.

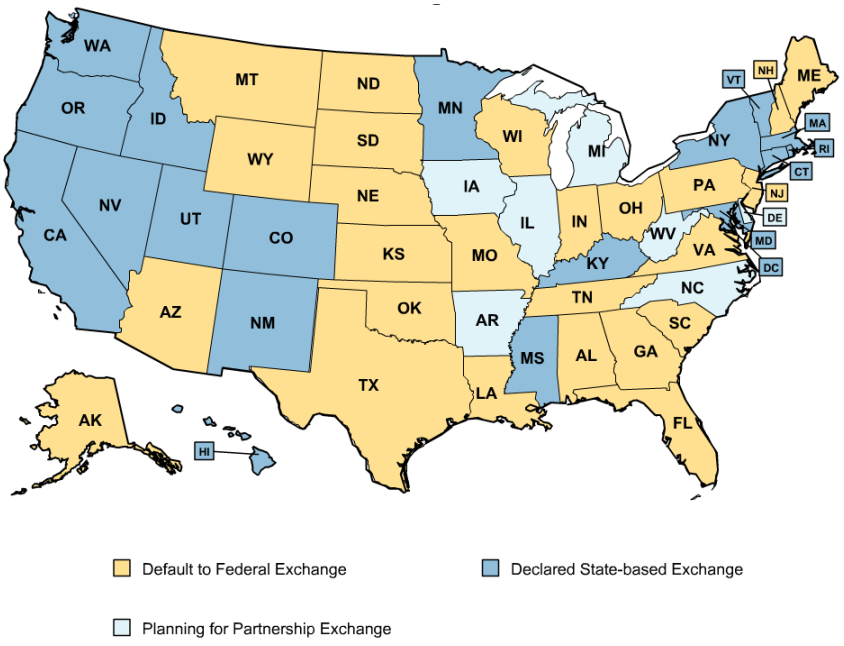
Recent Federal Developments

New rulemaking, published in the Federal Register on January 22, 2013, provides significant structure for the coordination of eligibility determination notices between Medicaid, CHIP, and the Exchanges, including the appeals process. In addition, the regulation addresses statutory provisions on eligibility and proposes modifying the existing benchmark benefits for low-income adults. Another piece of the rulemaking gives State-based Exchanges the option to rely on the Department of Health and Human Services (HHS) for verification of employer-sponsored insurance availability in making eligibility determinations.

Recent State Developments

As of January 4, 2013, the Kaiser Family Foundation's *Health Reform Source* reported on state status regarding decisions on Exchange authority. The map below indicates whether a state has declared it will establish a State-based Exchange (for which the deadline has passed), is planning for a Partnership Exchange, or will default to a federally-facilitated Exchange.

State Decisions For Creating Health Insurance Exchanges in 2014
(As of January 4, 2013)



Source: http://healthreform.kff.org/the-states.aspx

All 50 states and the District of Columbia have determined Essential Health Benefit (EHB) Benchmark plans. These Benchmark plans meet the ten federal EHB categories as well as define the standard benefits that must be offered by a plan on the state or federally-facilitated Exchanges, beginning in 2014. Each state's Benchmark plan is available on the Center for Consumer Information & Insurance Oversight (CCIIO) website, including benefit design, limits, and drug formulary information. Link to CCIIO: (Proposed EHB Benchmark Plans)

Upcoming Dates & Milestones

February 15, 2013: Deadline by which states must submit declaration letter to pursue a state partnership exchange and the Blueprint application. This is also the deadline for submitting an application for additional grant funding for Partnership Exchange development. In an effort to encourage more states to opt for the partnership model over a federally facilitated Exchange, CCIIO/HHS have continued to extend key deadlines to allow states more time for implementation planning. The dates provided below by HHS are suggested rather than absolute deadlines:

- **April 2013:** Begin the Qualified Health Plan (QHP) certification process. Many states operating state-run exchanges have already begun this process. This is one of the most time-consuming processes, so it is imperative that states move forward as quickly as possible.
- **July 2013:** Complete QHP certification process.
- **August 2013:** Begin QHP testing on web portal (after QHPs are certified)

October 1, 2013: This is the deadline for beginning early enrollment in the Exchange. However, there are doubts that every state will meet this target.

Current State Activities

- QHP certification requirements and processes are primary focal points of Exchange staff because they are critical components for meeting all future deadlines. The QHP certification structure needs to address the following:
    - Compliance with federal minimum requirements, although states can impose additional requirements that go beyond the federal standards;
    - Restrictions on the number of plans offered within Exchange; and
    - Bridge products for individuals transitioning between the Exchanges and Medicaid.
- Consumer outreach and education
- Navigator training and certification
- Quality Improvement activities and reporting
- IT development

Health Management Associates continues to monitor federal and state progress on the Exchanges and is working with states and other organizations in moving toward implementation of the Exchanges in the next year. Please contact us for more information.

HMA Medicaid Roundup

Arizona

HMA Roundup

On January 28, 2013, the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency, announced the list of bids received for the Acute Care/CRS RFP. Plans submitted bids for any of the seven regions across the state for acute care Medicaid benefits, as well as the state's CRS program, which provides services to nearly 25,000 children with specified chronic and/or disabling or potentially disabling health conditions. This procurement is noteworthy in that awarded contractors will also serve the dual eligible population, whether under a dual eligible demonstration or as a dual eligible special needs plan (D-SNP). Contract awards are expected to be announced around March 22, 2013.

Bidders	GSA 2 Yuma, LaPaz	GSA 4 Apache, Coconino, Mohave, Navajo	GSA 6 Yavapai	GSA 8 Gila, Pinal	GSA 10 Pima, Santa Cruz	GSA 12 Maricopa	GSA 14 Cochise, Graham, Greenlee	CRS
Bridgeway Health Solutions of AZ, LLC	Bid	Bid	Bid (Incumbent)	Bid	Bid	Bid	Bid	
Care 1st Health Plan Arizona	Bid		Bid	Bid	Bid	Bid (Incumbent)	Bid	
Health Choice Arizona	Bid (Incumbent)	Bid (Incumbent)	Bid	Bid	Bid (Incumbent)	Bid (Incumbent)	Bid	
Health Net of Arizona					Bid	Bid		
Maricopa Health Plan (U of AZ Health Plans)						Bid (Incumbent)		
BCBS of Arizona / Medisun Community Care Inc.						Bid		
SW Catholic Health Network (dba Mercy Care Plan)	Bid	Bid	Bid		Bid (Incumbent)	Bid (Incumbent)	Bid (Incumbent)	Bid
Phoenix Health Plan		Bid (Incumbent)	Bid (Incumbent)	Bid (Incumbent)	Bid (Incumbent)	Bid (Incumbent)		
United Health Care Community Plan	Bid (Incumbent)	Bid	Bid	Bid	Bid (Incumbent)	Bid (Incumbent)	Bid	Bid (Incumbent)
U of AZ Health Plans, University Family Care	Bid		Bid	Bid (Incumbent)	Bid (Incumbent)		Bid (Incumbent)	
Total Incumbent Bids	2	2	2	2	5	5	2	1
Total New Bids	4	3	5	4	3	4	4	1
Total Bids Received	**6**	**5**	**7**	**6**	**8**	**9**	**6**	**2**

Source: http://www.azahcccs.gov/commercial/Downloads/SummaryofProposalsbyGSA.pdf

California

HMA Roundup – Jennifer Kent

Special Session of Legislature Called to Implement ACA. Governor Brown, on January 24, 2013, called a special session of the Legislature beginning January 28th to continue work on implementing the ACA. The scope of the session will address the following:

- California's private health coverage market and rules and regulations governing the individual and small group markets related to guaranteed issue of coverage, pre-existing condition exclusions, rating restrictions, and any other requirements necessary to conform state law to federal rules.
- California's Medi-Cal program and changes that are necessary to implement federal law, including requirements for eligibility, enrollment, and retention.
- Options that allow low-cost health coverage to be provided to individuals who have income up to 200 percent of the federal poverty level within the California Health Benefit Exchange, to the extent allowed by federal law or regulations.

The special session will allow the Legislature to move bills through the legislative process and have the bills become effective more expeditiously than if passed during a regular session. Legislation will likely address a range of issues related to how the Exchange will operate, governance of the insurance market, the scope of coverage offered by the Exchange, Medi-Cal expansion, and major changes to Medi-Cal eligibility.

Given the abbreviated timeframe to implement ACA, it is anticipated that the Legislature will move quickly through this process. The Governor has indicated that the questions of how to implement the optional Medicaid expansion and the role of the counties may extend beyond the special session and may be addressed as part of the budget in June.

Provider Reimbursement Cuts Blocked by Court Filing. A 10% provider pay cut sought by Governor Brown was blocked by a filing of a petition for review with the 9th U.S. Court of Appeals. CMS had previously approved the cut in October 2011, and Brown had included the cuts in the Governor's FY 2013-14 proposed budget, with expected savings of greater than $400M. The California Medical Association argues that the state is in better fiscal shape than when the cuts had originally been approved by CMS.

In the news

- **"Managed Care Tax Key in Healthy Families Shortfall"**

  "The Healthy Families program is short by almost $100 million, according to California health officials. That number will rise, officials said, because the current deficit only covers the program's operation for January and half of December. The problem is restricted to this year, however, since the roughly 860,000 children in Healthy Families -- California's federally subsidized Children's Health Insurance Program -- are being moved into Medi-Cal managed care plans. This year's transition is planned in four phases. The first phase began Jan. 1. 'This (the funding shortfall) doesn't have anything to do with the transition," said Diana Dooley, Secretary of Health and Human Services.

"It has to do with a failure to extend the MCO (Managed Care Organization) tax.'" (California Healthline)

- **"Lawmakers introduce proposals to expand Medi-Cal"**

  "The state Legislature gaveled in a special session on healthcare Monday, with lawmakers introducing measures to help California implement President Obama's healthcare overhaul. Most Americans face the requirement in January 2014 to buy health insurance or pay a penalty under the federal Affordable Care Act. Underscoring the importance of the issue, legislative leaders in both houses sponsored bills that would dramatically expand Medi-Cal, the state's public insurance program for the poor. Under the proposals, individuals earning up to 138% of the federal poverty level -- or $15,415 a year -- would be covered, potentially adding more than 1 million Californians to the Medi-Cal rolls." (Los Angeles Times)

- **"So Far, Healthy Families Transition Going Smoothly"**

  "Given the immense amount of worry and concern over the planned shift of 860,000 kids out of the Healthy Families program and into Medi-Cal managed care plans, there has been surprisingly little turmoil throughout the start of the first phase of that transition. The transition started Jan. 1, moving 197,000 children to Medi-Cal managed care plans. So far, according to DHCS officials, the telephone complaint hotline has been pretty quiet." (California Healthline)

Colorado

HMA Roundup – Joan Henneberry

Colorado Health Benefits Exchange Receives Recommendations from Consumer Advocates. Consumer advocacy organizations surveyed potential exchange customers and presented recommendations to the Colorado Health Benefits Exchange (COHBE) board last week. Customers seek authoritative TurboTax-style guidance, assistance from trusted members of their communities, and side-by-side comparisons of complex health plans. There are concerns about the ability of exchange managers to meet the October 1 target date, and to avoid steering clients to plans that financially benefit the workers or health systems they represent.

Moreover, the development of a sufficient customer service organization remains a daunting task. The groups recommended a customer support effort that is culturally, linguistically, and technologically accessible to appropriately educate and enroll beneficiaries. Health exchange managers must have sufficient funding and comprehensive training and incorporate quality improvement measures to ensure a positive experience for consumers.

The board of the Colorado Health Benefits Exchange announced the new name for the exchange, which will be marketed to consumers later this year as "Connect for Health Colorado."

In the news

- **"New Colorado health exchange may sign up nearly 1,000 people a day"**

  "The state benefits exchange will open for business in October, and expects 150,000 residents to get their health plan through the computer system in the first year, its creators said Thursday. Before then, the exchange and affiliated groups must train thousands of "navigators" who can explain the system to a vast array of consumers. The exchange will also rely on existing private insurance brokers to help educate customers. In doing so, it will be navigating its own tricky shoals of conflict of interest. Federal rules prohibit navigators from making money off their recommendations, but the Colorado exchange says brokers will be a separate group from navigators and will have to fairly represent all insurance plans sold through the exchange." (Denver Post)

Florida

HMA Roundup – Gary Crayton

AHCA Moves Forward with Implementing Managed LTC; Three Vendor Protests Filed. The recent selection of vendors for Florida's $3B managed long term care program has set in motion a process that should result in the enrollment of nearly 90,000 seniors beginning in August 2013. As a reminder, the five designated vendors selected were American Eldercare, Sunshine State (Centene), United Healthcare of Florida, Coventry, and Amerigroup Florida (WellPoint).

Florida's Agency for Health Care Administration confirmed that three vendors have filed non-binding notices of intent to protest the awards: Molina Healthcare, Little Havana Activities and Nutrition Centers of Dade County, and Humana. The Agency will move forward with managed LTC implementation during the protest period in all but three areas (1, 2, and 9). The primary rationale for implementation is that when fewer plans are selected than the maximum permitted in a region, the agency may choose to contract with other plans in the region not challenging the decision before final resolution to the challenge.

Administrative Savings Due to TPA Re-procurement. On January 25, 2013, the AHCA announced that it would enjoy $15.8M in savings over five years due to a partnership with the Florida Healthy Kids Corporation (FHKC) because of efficiencies gained through contracting. FHKC re-procured its Third Party Administrator (TPA) administrative contract in FY 2013-2014 to require greater efficiencies to reduce the cost of processing Florida KidCare applications and renewals. The new TPA contract with Maximus is effective October 1, 2013.

Select Committee on PPACA – Both the House and Senate met last week and continued discussions on implementation of the federal health care law. The Senate committee heard from Massachusetts Institution of Technology economic professor Jonathan Gruber who resented the pro of expanding Medicaid while Cato Institute Director of Health Policy Studies Michael Cannon listed the cons, but both suggested a partnership exchange for Florida. The House committee heard from the Office of Insurance Regulation who requested an extension from the rate filing deadline of May 1 due to the state's uncertainty in implementing the ACA. Additionally, the House committee heard from the Association of Health Plans (FAHP) and America's Health Insurance Plans (AHIP) regarding

the increase in health insurance costs resulting from the federal health care law. A joint meeting of the Select Committee on PPACA will be held on Monday, February 4, 2013.

Key Medicaid conference dates for the legislative budget process:

February 25, 2013: Medicaid Expenditures, FMAP

March 1, 2013: Medicaid Long Term Expenditures, Affordable Care Act (ACA)

March 7, 2013: Medicaid Impact

In the news

- **"Officials Rethink Medicaid Expansion"**

  "When Florida sued to overturn the Affordable Care Act, lawmakers targeted a piece of the law that would have forced Florida to make Medicaid available to more than a million uninsured Floridians. Now some Florida lawmakers who originally opposed Medicaid expansion are seriously considering that option. A recent poll showed that nearly two thirds of Floridians are in favor of expanding Medicaid. Research from Georgetown University's Health Policy Institute and the Jesse Ball duPont Fund suggests Medicaid expansion could save Florida up to $100 million a year in health costs." (Health News Florida)

- **"Study: Medicaid expansion may save state money"**

  "Florida would save money over the next decade — not lose billions as Gov. Rick Scott has argued — by accepting Medicaid expansion under federal healthcare reforms, according to a detailed economic study. Miami-Dade legislators and healthcare industry leaders, getting together on Monday, heard about the report by Georgetown University — the most positive yet on a highly debated provision of what is often called Obamacare." (Miami Herald)

Georgia

HMA Roundup – Mark Trail

Provider Tax Extension Progresses Through House Committee. On January 29, Senate Bill 24 (S.B. 24), which would extend a provider tax on hospitals, cleared a state House committee. A floor vote may occur as early as this week. This bill would continue the "bed tax" on hospitals to secure additional Federal matching funds for the state's Medicaid program. Governor Deal and House Speaker Ralston support the bill to avoid significant Medicaid cuts to hospitals and the closure of rural and safety net hospitals across the state. The Department of Community Health would be given authority over the fee similar to its oversight on nursing home provider taxes.

Governor's Budget Includes State Health Plan Redesign Savings. On January 24, Governor Deal released a presentation to Georgia's Joint Appropriations Committee covering amended FY 2013 and FY 2014 budget proposals. For the last six years, Georgia's Medicaid spending growth has been slower than overall national Medicaid spending. In last week's *Roundup*, we discussed details to simplify Medicaid budgets through the consolidation of the ABD (aged, blind, and disabled) and LIM (low-income Medicaid) programs, generate greater funding through a hospital provider fee, and targeted reimbursement

cuts. We would add that the governor's budget projects significant savings from its state health benefits plan through plan redesign, higher deductibles, lower negotiated rates with its hospital network, and revisions to its prescription drug formulary.

Georgia Medicaid EHR Incentives Now Approach $130M to date. As part of the American Recovery and Reinvestment Act (ARRA) of 2009, the Centers for Medicare and Medicaid Services (CMS) has been administering an EHR Incentive Program for eligible providers that adopt, implement, upgrade or demonstrate meaningful use of certified EHR technology. The program has distributed more than $1.2 billion nationally since September 2011, with Georgia providers garnering an impressive 11% of the total.

Georgia Medicaid EHR Incentive Payment Program Outcomes

Life of the Program (Since September 2011)

	Adopt / Implement / Upgrade (AIU)		Meaning Use (MU)		Totals	
	Number Paid	Amount Paid	Number Paid	Amount Paid	Number Paid	Amount Paid
Eligible Hospitals	**120**	**$ 69,755,786.00**	**33**	**$ 22,191,208.33**	**153**	**$ 91,946,994.33**
Eligible Professionals	**1703**	**$ 35,884,181.00**	**146**	**$ 1,232,501.00**	**1849**	**$ 37,116,682.00**
Nurse Midwives	57	$ 1,211,250.00	15	$ 127,500.00	72	**$ 1,338,750.00**
Dentists	125	$ 2,656,250.00	0	$ -	125	**$ 2,656,250.00**
Nurse Practitioners	218	$ 4,632,500.00	23	$ 195,500.00	241	**$ 4,828,000.00**
Physicians	1292	$ 27,150,431.00	106	$ 892,501.00	1398	**$ 28,042,932.00**
Physician Assistant	11	$ 233,750.00	2	$ 17,000.00	13	**$ 250,750.00**
Grand Total	**1823**	**$ 105,639,967.00**	**179**	**$ 23,423,709.33**	**2002**	**$ 129,063,676.33**

Illinois

HMA Roundup – Andrew Fairgrieve

Last Thursday, January 24, 2013, the Illinois Department of Healthcare and Family Service (HFS), along with several other state agencies, held a town hall meeting in Chicago to discuss the expansion of Medicaid managed care in the state and the new service package included in the Suburban Chicago Integrated Care Program serving Medicaid-only seniors and persons with disabilities (SPDs). Beginning February 1, 2013, SPDs in suburban Cook County and the surrounding "collar" counties will begin receiving long term services and supports (LTSS) benefits through their managed care organization. Individuals in the Integrated Care Program must enroll in either Aetna Better Health or Centene's IlliniCare plan.

Additionally, it was announced that the Integrated Care Program would be expanding to the Rockford area in Spring 2013, enrolling an estimated 5,000 SPDs. In Summer 2013, ICP will expand to Central Illinois (13,000 SPDs), Quad Cities (1,900 SPDs), and Metro East (7,000 SPDs). As previously announced, the Rockford region will be served by Aetna, Centene (IlliniCare), and the Community Care Alliance of Illinois (CCAI), which was awarded a managed care community network (MCCN) contract in the Greater Chicago region under the complex adults RFP. The Central Illinois region will be served by Molina Healthcare and Health Alliance (both awardees of duals demonstration contracts in Central Illinois), as well as Meridian Health Plan in Knox, Peoria, and Tazewell counties. Plans to serve the Quad Cities and Metro East regions are still to be finalized.

Finally, HFS reported that it received 11 letters of intent from organizations interested in applying to serve the complex children Medicaid population under a RFP procuring provider and community-based organizations to serve as CCEs or risk-bearing MCCNs. Responses are due in April 2013. The RFP is available here.

In the news

- **"Execs named for Illinois health insurance nonprofit"**

  "A new nonprofit organization that will offer health insurance in Illinois has appointed an executive team. The board of directors of Land of Lincoln Health announced Tuesday it has chosen Daniel Yunker as CEO. Yunker is senior vice president of the Metropolitan Chicago Healthcare Council and will continue in that role. Other newly named members of the executive team are William Donahue as interim president, Dennis Rizzo as chief financial officer and Monica Katz as vice president. Land of Lincoln Health is the first co-op in Illinois to receive approval from the federal government." (Crain's Chicago)

- **"Catamaran hopes to snag Cook County health contract"**

  "Cook County hospital is set to ink a $3 million contract with Catamaran Corp. to manage pharmacy benefits for up to 115,000 patients that officials hope to enroll in a new Medicaid program this year. The 11-month contract would mean the Lisle-based company would manage drug services — including submitting reimbursement requests and obtaining prior authorization for high-cost pharmaceuticals — for patients in CountyCare." (Crain's Chicago)

- **"Cook County hospital CEO wants to sell health insurance"**

  "Dr. Ramanathan Raju wants Cook County hospital to get into the health insurance business, selling plans on a statewide health insurance exchange, a move he says could generate much-needed revenue. The ambitious proposal by the CEO of the Cook County Health and Hospitals System is an attempt to transform a network that is often perceived as the health care provider of last resort." (Crain's Chicago)

New York

HMA Roundup – Denise Soffel

Review of Governor Cuomo's Executive Budget Proposal. Governor Andrew Cuomo presented his $142.6 billion executive budget on January 22, 2013. The budget fills a projected $1.3 billion gap, mostly by freezing state agency spending another year and streamlining government services. Total Medicaid spending, including federal, state and local share, is projected at $57.6 billion. The global Medicaid spending cap, which affects about 27 percent of total Medicaid spending, will increase by 3.9 percent, reflecting the 10 year rolling average increase in the Medical CPI. The programmatic direction for the Medicaid program was established by the Medicaid Redesign Team (MRT), which began its work in January 2011.

The state is entering the third year of MRT implementation, with reform emphasizing the continued move to care management for all Medicaid beneficiaries scheduled to be completed by 2016. The budget removes all statutory barriers to moving remaining groups of

Medicaid beneficiaries into Medicaid managed care. The budget includes statutory authority to create Developmental Disability Individual Support and Care Coordination Organizations (DISCOs) with three pilot programs anticipated for the current fiscal year. The budget also continues New York's aggressive implementation of Health Homes for individuals with complex health care needs and chronic conditions. The Governor's budget projects additional savings from administrative streamlining, consolidating all Medicaid administrative functions including rate-setting and managed care oversight within the Department of Health. (They are currently shared across the Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities).

The budget extends MRT initiatives implemented over the last two budget years. This includes a number of discrete cost containment initiatives as well as the elimination of scheduled Medicaid inflationary rate increases. The budget extends the two percent across-the-board reduction in Medicaid payment through March 2015; the global cap was also extended. The budget includes statutory changes necessary to implement the terms of the Affordable Care Act. The state projects savings of $43 million for the current fiscal year as a result of the ACA's enhanced federal match and support for populations currently covered by state-only dollars. The budget also includes changes in the methodology for allocating payments from the indigent care pool in order to be compliant with federal DSH requirements.

Waivers. Budget initiatives contemplated as a result of a new Section 1115 waiver amendment do not appear in the budget. The state has requested $10 billion over five years to finance Medicaid Redesign initiatives, but the terms of that amendment are still being negotiated with CMS. Further, the state financial plan includes a contingency plan for the potential loss of $1.1 billion in federal funding due to lower rates for services provided by the Office for People with Developmental Disabilities both in the developmental center payment rates and for other services. Negotiations with CMS regarding a new payment structure for services provided by OPWDD are on-going. Negotiations are also continuing around programmatic aspects of the DISCO, which will provide integrated managed care for individuals with developmental disabilities.

New Initiatives. The budget proposal identifies nine initiatives that represent Phase III of Medicaid Redesign Team proposals. Amounts below are gross investments or savings in these initiatives.

- Supportive Housing - $12.5 million to continue and expand supportive housing initiatives including redirecting savings associated with the closure of hospital and nursing home beds. A total of $91 million is dedicated to expand access to supportive housing services.
- Payment reform – $62 million in increased funding to essential community providers; increase in the nursing home quality pool from $50 million to $60 million.
- Health home and investments - $25 million to support one-time grants for infrastructure development and Health Home Plus Design targeted at identifying individuals at risk of court-ordered Assisted Outpatient Treatment.

- Integration of behavioral and physical health - $715 million to fund two pilot programs to eliminate financial disincentives to integration and improve behavioral health screening in primary care settings.
- MLTC quality incentive - $20 million to incorporate P4P into the MLTC payment structure, building on New York's successful use of QAAR to reward health plans that have high levels of performance.
- Balancing Incentive Program Implementation - $20 million in enhanced federal match as part of the ACA Balancing Incentive Program designed to make structural reforms to increase nursing home diversions and access to non-institutional long-term services and supports.
- Pharmacy Initiatives - $26.5 million in pharmacy savings through the elimination of provider prevails for all drug classes in fee-for-service, atypical antipsychotics in Medicaid managed care, and opioids in excess of four prescriptions in one month; reduced fee-for-service reimbursement rates; tighter early fill rules; and supplemental rebates.
- Spousal refusal - $68 million in savings through the elimination of spousal refusal, which allows a person to refuse financial support in order to establish Medicaid eligibility for a spouse living in the community.
- Changes in covered benefits - $3.5 million in savings due to restricting coverage for 30 benefits that do not meet the state's effectiveness criteria.

ACA Implementation and Public Coverage Programs. New York currently provides Medicaid coverage for parents up to 85 percent of FPL and for childless adults up to 79 percent of FPL. In addition, through a Medicaid expansion, coverage is provided to parents up to 150 percent FPL and childless adults up to 100 percent FPL through the Family Health Plus (FHP) program. The budget proposes ending FHP by 2015. Most of the individuals in that program will be eligible for the Medicaid benchmark benefit established under the ACA.

New York proposes providing the Medicaid benchmark population with the state's current Medicaid benefit, with the exception of institutional long-term care services. Parents currently enrolled in FHP who are over 138 percent FPL are not eligible for the Medicaid benchmark under federal law. For that group of parents currently enrolled in FHP, New York proposes subsidizing their purchase of a silver-level plan through the Health Exchange. That subsidy will not be provided to parents not currently enrolled in the program. While New York has expressed interest in establishing a Basic Health Program which would provide coverage for individuals up to 200 percent FPL, that does not appear in the Governor's budget proposal.

State MLTC Report Released. The New York State Department of Health (DOH) reports that managed long-term care (MLTC) plans in New York are providing high-quality services to more than 70,000 New Yorkers. The state's MLTC plans arrange and pay for long-term care services—including adult day care and home care services—in home and community-based settings, as well as nursing homes (when home-based services are no

longer feasible). The MLTC Report and related consumer guides and reports are available on the DOH web site: http://www.health.ny.gov/health_care/managed_care/mltc.

In the news

- **"NY health exchange expects to insure 1.1 million"**

  "New York has an estimated 2.7 million uninsured among roughly 19 million residents. A state analysis indicates they will enroll about 1.1 million people through the New York Health Benefit Exchange." (Wall Street Journal)

- **"Budget Hole Seen After Loss of Aid"**

  "New York state is drawing up plans for a budget shortfall almost twice as large as the $1.35 billion gap described by Gov. Andrew Cuomo on Tuesday, as the federal government seeks to reduce how much it pays for health care to some of the state's most severely disabled people. Health-care officials in Washington and New York are negotiating a plan that would squeeze between $800 million and $1.1 billion out of federal Medicaid spending, potentially blowing a new hole in the annual budget Mr. Cuomo proposed on Tuesday. Much of that money is for the care of about 1,300 developmentally disabled people in nine state-run centers from Staten Island to Rochester, which get about $2 million a year from the federal government for each patient." (Wall Street Journal)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

DPW to suspend enrollment with Keystone Mercy Health Plan in the Southeast Zone. The Department of Public Welfare announced to the Medical Assistance Advisory Committee last week that it will suspend enrollment for Keystone Mercy Health Plan effective April 1, 2013 through December 31, 2013. Because of the processing time for member selection, any Medicaid consumer wishing to choose KMHP must select it by February 14th in order to get in before the suspension. DPW explained that the reason for the enrollment suspension is to protect the viability of the Health Choices program in the zone. Currently KMHP has a 55% market share serving over 300,000 Medicaid Members. By suspending enrollment in KMHP, DPW hopes to strengthen the other MCOs in the region and maintain plan choice going forward. Other MCOs serving the Southeast zone include CoventryCares, United Healthcare, Health Partners, and Aetna Better Health.

Consumers serving on the Advisory Committee expressed concern with the decision. They point to KMHP's high enrollment as an indicator that it provides better service to enrollees. By suspending enrollment, they argue, consumer choice is restricted. Provider stakeholders have also expressed concern that changing the rules for plan selection/enrollment could have an indirect impact on provider contracting, particularly for hospitals, because enrollment assumptions are often made during contract negotiations which may no longer be valid. DPW suspended enrollment with KMHP once before in 2010. At that time there were concerns about the network adequacy of the other plan options. DPW contends that this time it has evaluated the networks of the other plans and does not believe that access to providers will be an issue.

Aging and Attendant Care Waivers Up for Renewal. The Attendant Care and Aging Waivers expire on July 30th, and DPW must submit renewal applications to CMS by March 30th. DPW reports that it does not expect substantive changes as compared to the current waivers. Key dates:

- Draft waiver applications should be completed by Feb 7th and will be presented to the DPW Executive team.
- On Feb. 12th DPW will present a summary of the differences between the current waiver and the renewal application. Stakeholders will have two weeks to submit feedback.
- Application submitted by March 30th.

Rate increases announced for Waiver Programs. DPW has been examining HCBS waiver reimbursement rates. The Department has reported that previous efforts to review 12 rates for a variety of services have been suspended temporarily and instead the Department has focused on the enrollment rate for the Aging waiver and the Service Coordination rate for all waivers. A formal notice from DPW is forthcoming which will outline the following rate increases: the enrollment rate will increase to $95, and the Service Coordination rate (which varies by program and geography) will go up an average of $3.06 per 15 min unit. (current average rate is $14.89 new average rate is $18.15.)

In the news

- **"Democrats pressing Corbett to expand Medicaid"**

  "In a bid to build pressure on Gov. Corbett to expand Medicaid next year, Democratic members of the Pennsylvania Senate Appropriations Committee met Thursday in Philadelphia with city health officials, hospital experts, and advocates for the poor. The session in City Hall came less than two weeks before Corbett is to present his budget proposal for fiscal 2014. Were he to opt for Medicaid expansion under the Affordable Care Act, provisions for the rollout starting in October would have to be built into that budget, officials said." (Philadelphia Inquirer)

Texas

HMA Roundup – Linda Wertz

Perry Rules Out Medicaid Expansion and State-Run Exchanges. Gov. Rick Perry delivered his State of the State address to the 83rd Texas Legislature, emphasizing strong economic growth, tax relief, and school choice. The governor ruled out Medicaid expansion and state-run health exchanges. Medicaid was characterized as an unsustainable system and ACA was deemed a cost-burden on individuals and employers across the country.

Separately, State Senator Rodney Ellis filed a bill, SJR 8, that aims to allow voters the chance to decide whether or not Medicaid eligibility is expanded in Texas.

In the news

- **"Cook Children's, Aetna take disagreement to mediator"**

  "State regulators are scheduled to meet next week with representatives from Cook Children's Health Care System and Aetna insurance to help resolve a contract dispute

affecting thousands of Tarrant County Medicaid beneficiaries. Cook Children's, Tarrant County's specialty pediatric hospital, was dropped from Aetna's network of providers on Nov. 1 because of a disagreement over reimbursements. That means the 42,500 Medicaid members in the Aetna Better Health network who had been seeing doctors in the Cook Children's physician network have had to find another pediatrician or go to another facility for tests or procedures. Aetna is the smallest of three Medicaid managed care networks in Tarrant County. The others are Amerigroup and Cook Children's Health Plan." (Star-Telegram)

- **"Health Care Industry and Advocacy Groups Pressure Texas Officials to Expand Medicaid"**

  "If Texas expanded Medicaid, it would gain about $1.8 billion in new tax revenue from 2014 through 2017 — which could offset about half of the money the state would have to spend on the program during those years, according to a report released Monday by a Texas advocacy groups who favor expansion. The report is intended to pressure state legislators and Republican Gov. Rick Perry to expand the program as it has the option to do under the health care law. So far, Perry has resisted the idea of broadening the program." Texas Report (pdf) (CQ Healthbeat)

Washington

HMA Roundup – Doug Porter

Governor Names Director of Health Care Authority. On January 29, 2013, Governor Jay Inslee announced that Dorothy Frost Teeter will serve as director of the Health Care Authority, which is responsible for the health care services for state employees and low-income residents. Effective March 2013, Ms. Frost Teeter will oversee the state's implementation of the Affordable Care Act and the creation of state health exchanges.

Frost Teeter is a Senior Advisor for Policy and Programs at the Center for Medicare and Medicaid Innovation in Maryland, which evaluates innovative models of payments and service. Prior to that position, Ms. Frost Teeter was Chief of Health Operations and Interim Director of Seattle & King County Public Health. She has also served as Vice President of Quality and Systems Resources at Group Health Cooperative.

In the news

- **"Auditor's Office publishes Medicaid managed care program audit overview"**

  "The State Auditor's Office is pleased to provide an update on our performance audit of Washington's Medicaid managed care program. During our preliminary analysis, we identified areas with the highest potential risk for overpayments that are likely to increase the state's costs." (Washington State Auditor's Office)

OTHER HEADLINES

Alabama

- **"Commission recommends 'fundamental change' for Alabama Medicaid"**

  "A state commission recommended an overhaul of Alabama's Medicaid program that would divide the state into community-based managed care networks. The Alabama Medicaid Advisory Commission approved the report which recommends shifting Medicaid from a fee for service model. The report now goes to Gov. Robert Bentley, who created the commission. The regions could choose to contract with commercial care companies." (AL.com)

District of Columbia

- **"MedStar, Chartered fight hits Medicaid patients"**

  "Medical care for up to 2,100 District residents is in limbo as embattled D.C. Chartered Health Plan Inc. and MedStar Health fight over more than $28 million in claims. The dispute caused MedStar to end its contract with the Medicaid managed care organization and file suit in D.C. Superior Court. The developments leave Chartered, which processes claims for about 110,000 low-income recipients, without a business relationship with the city's dominant health care chain." (Washington Business Journal)

Louisiana

- **"Louisiana: Hospice Cuts Rescinded"**

  "Gov. Bobby Jindal's administration on Wednesday scrapped plans to shutter the state's Medicaid hospice program in February, meaning it will continue to provide end-of-life care to people who cannot afford private insurance. The announcement was made as hospice supporters gathered for a candlelight vigil on the State Capitol steps to protest the cut. Bruce D. Greenstein, the state heath secretary, said his department would use grant money to cover costs this year. Closing the program to new adult recipients was estimated to save $1.1 million this year." (New York Times)

Michigan

- **"Gov. Snyder eyes mental health makeover; GOP skeptical of expanding Medicaid"**

  "Gov. Rick Snyder may have to convince lawmakers across the political spectrum that expanding Medicaid eligibility under the Affordable Health Care Act will allow Michigan to also plug a gap in its increasingly underfunded mental health care system. Snyder has said one of the benefits of opting in is that it would allow the state to significantly expand assistance for those who need mental health care. The governor said Friday that he has not yet made his decision, but will announce it during his budget address Feb. 7. But he also said he has concerns about whether Michigan's health care system and providers would have the capacity to handle the increased number of people who would qualify for coverage." (MLive.com)

Mississippi

- **"Some Miss. hospitals backing Medicaid expansion"**

  "Some Mississippi hospital administrators say they worry about bad financial consequences if the state doesn't expand Medicaid under the federal health care overhaul. Specifically, they worry hospitals will have to continue providing care for uninsured people even if the federal government stops reimbursing part of the expense…. Republican Gov. Phil Bryant has said for months that Mississippi can't afford to put another 300,000 people on Medicaid, even with the federal government paying most of the tab from 2014 to 2017." (Associated Press via San Francisco Chronicle)

Missouri

- **"Missouri governor's budget likely to bank on Medicaid revenues"**

  "When Missouri Gov. Jay Nixon outlines a budget on Monday, he will be banking on federal Medicaid money to help bolster the state revenues available to spend on education and other government services. Nixon' proposed budget for the 2014 fiscal year also is likely to propose more spending than in years past, a reflection of the state's gradually improving tax collections after several lean years of cuts." (The Kansas City Star)

Nebraska

- **"Nebraska lawmakers propose Medicaid expansion"**

  "Nebraska lawmakers unveiled a proposal Wednesday to expand Medicaid coverage as part of the federal health care law, saying the state needs to seize millions of dollars in federal aid while giving more residents access to preventative care. Supporters argued that the measure would reduce long-term health care costs for county taxpayers and hospitals, and ease the financial pressure on the state by shifting many expenses to the federal government. The bill also sets up a likely showdown with Gov. Dave Heineman, a Republican who repeatedly has voiced opposition to expanding the program under a now-optional piece of the federal law." (Associated Press via San Francisco Chronicle)

New Hampshire

- **"Medicaid Managed Care Delay Could Leave $15M Hole In DHHS Budget"**

  "Implementation of the state's Medicaid managed care program continues to stall. Further delays could lead to a multimillion dollar budget shortfall in the state's largest department. Department of Health and Human Services Commissioner Nick Toumpas projects a $9 million shortfall in his budget for the rest of this fiscal year. As he explained to members of the House Finance Committee Thursday, that's because savings from the managed care program were assumed in the department's budget. The managed care program was supposed to roll out last July, but hospitals and community mental health centers are disputing reimbursement rates." (NHPR.org)

- **"Medicaid tax complicates N.H.'s budget process"**

  "Lawmakers expect there to be discussions about the Medicaid Enhancement Tax and its reliability as they start crafting a budget for 2014-2015. The Medicaid Enhancement Tax, or MET, is a 5.5 percent tax on net patient service revenue on all hospitals in the

state. The tax was expected to bring in $197 million in revenue to the state budget in 2012 and $213 million in 2013 but has fallen short in both years by $22 million and $34 million, respectively, according to Senate Finance Committee Chairman Chuck Morse, R-Salem. Morse said he expects multiple committees will have conversations about the MET in the weeks to come." (Seacoast Online)

New Jersey

- **"Questions Remain on Expanded Medicaid"**

"Advocates for the poor are making their case that New Jersey should expand the ranks of people eligible for Medicaid in what could be the next big decision on how the federal health insurance overhaul plays out in New Jersey. They say it will save state taxpayers money and give far more low-income people health coverage. But doctors are apprehensive, and hospitals aren't pushing hard for the change, which some anti-big-government groups oppose deeply. Gov. Chris Christie hasn't said whether he's willing to let more people be eligible for Medicaid. But many observers expect he'll announce his decision by late February, when he is scheduled to present his state budget proposal. A spokesman for Mr. Christie didn't comment for this article." (Wall Street Journal)

New Mexico

- **"A Q&A look at New Mexico's plan for a state-run health insurance exchange"**

"New Mexico plans to establish a state-run health insurance exchange and Republican Gov. Susana Martinez's administration is taking steps to implement it this year." Q&A provided by The Republic. (The Republic)

North Carolina

- **"CenterPoint on track to become managed-care group by Feb. 1"**

"State health regulators are giving Mecklenburg County another chance – and another month – to prove its local management entity can qualify as a managed-care organization. The N.C. Department of Health and Human Services confirmed Thursday that Dr. Aldona Wos, newly appointed department secretary, has told Mecklenburg officials that MeckLINK Behavioral Healthcare is being allowed more time to prove its readiness to start as an MCO by March 1." (Winston-Salem Journal)

Ohio

- **"Residents to find out next week if Ohio expands Medicaid"**

"When Gov. John Kasich introduces his two-year state budget on Feb. 4, he is expected to also announce whether Medicaid will be expanded; if so, then the bill passed in 2009 would provide coverage to many Ohio adults whose earnings are up to 138 percent of the federal poverty level." (Toledo Blade)

Oklahoma

- **"Surprise! Oklahoma is using Obamacare to improve Medicaid"**

"Oklahoma has made no secret of its opposition to Obamacare. The state will not build an exchange, nor will it expand Medicaid…. More quietly though, Oklahoma has ac-

cepted an influx of Obamacare dollars to digitize SoonerCare, the state's Medicaid program…. Using the federal dollars, Oklahoma has built technologies that allow patients to submit scanned documents online, rather than dropping a form in the mailbox. The state increased data sharing with its WIC program, so that local health offices might not need to ask for the same eligibility information twice. At a time when most Medicaid applications are still submitted as paper forms, 95 percent of Oklahoma's applications are submitted online." (Washington Post)

Virginia

- **"Warned on Medicaid, assembly acts on health exchange"**

"On the same day a Senate committee voted to give Virginia a role in the health benefits exchange the federal government will operate in the state, one of the Richmond area's biggest employers warned of dire consequences if Virginia does not expand its Medicaid program for the poor under the Affordable Care Act. Dr. Sheldon M. Retchin, CEO of the Virginia Commonwealth University Health System, told a House Appropriations subcommittee Monday that the state teaching hospital could not withstand cuts in payments for hospital care of uninsured Virginians unless the state extends Medicaid coverage to those patients." (Richmond Times-Dispatch)

Wisconsin

- **"Decision looms on state Medicaid expansion"**

"[Governor] Walker has not indicated what he will do, but his decision is expected to be part of his proposed budget next month. For the governor, neither option probably is attractive. As an opponent of the Affordable Care Act, Walker may be loath to give even tacit support to the law. But expanding the Medicaid program could bring hundreds of millions of federal dollars into the state each year and billions of dollars over the next decade. It also could reduce the cost of bad debts and charity care now borne by health systems and doctors, although to what degree isn't known. At least part of that cost is passed on to employers and health insurers. Robert Kraig, executive director of Citizen Action of Wisconsin, a liberal political action group, likens opposition to expanding the Medicaid program to the state's opposing a federal contract worth hundreds of millions of dollars a year to the Wisconsin economy." (Milwaukee Journal-Sentinel)

Wyoming

- **"Future of Wyoming Medicaid expansion appears more uncertain"**

"Bringing the Medicaid expansion bill to the Senate floor for a full debate will be difficult after it received negative recommendations from two legislative committees this week, the Senate's vice president said Friday. Normally, bills with a negative recommendation are treated as a low priority, said Sen. Eli Bebout, R-Riverton. But the bill's chances of being heard are better than if one of the committees had voted to kill it altogether, he added. Bebout's response differed from that of Senate President Tony Ross, R-Cheyenne, who said earlier this week that he intended to have an open debate on the matter." (Casper Star-Tribune)

National

- **"States' Fragile Recovery at Risk"**

  "Several crucial deadlines looming from Washington will have huge consequences for the budget year that begins July 1 in most states. The deal that Congress and President Obama reached in early January averted the most severe tax increases expected from the fiscal cliff, but put off the question of $85 billion in spending cuts for fiscal 2013 until March 1, a crucial question for states since the federal government provides about 30 percent of their revenue. For some states, that amount is even more…. The current set of fiscal deadlines could open broader deficit reduction talks, putting policies important to states on the table. A deficit reduction deal could include major changes in entitlement programs, such as Medicaid, and the tax-free treatment Washington gives to state and local government bonds to help market them." (Stateline)

- **"States that turn down Medicaid would leave citizens uninsured while immigrants get covered"**

  "Governors who reject health insurance for the poor under the federal health care overhaul could wind up in a politically awkward position on immigration: A quirk in the law means some U.S. citizens would be forced to go without coverage, while legal immigrants residing in the same state could still get it. It's an unintended consequence of how last year's Supreme Court decision changed the Medicaid provisions of President Barack Obama's health care law. The overhaul expanded the federal-state program for low-income and disabled people. The Supreme Court made the Medicaid expansion optional for states, which complicated things." (Washington Post)

COMPANY NEWS

- **"Oceans Healthcare Closes $17m Strategic Growth Equity Financing from General Catalyst Partners"**

  "Oceans Healthcare, Louisiana's largest provider of psychiatric facilities for geriatric patients, closed a $17m round of strategic growth equity financing from General Catalyst Partners. The financing will be used to capitalize the organization as a foundation for its geographic expansion. As part of the transformation, Charlie Baker, former CEO of Harvard Pilgrim Healthcare, one of the country's top-rated health benefits companies, will join Oceans as Chairman of the Board." (BusinessWire)

- **"Post Capital Partners Recapitalizes Invo HealthCare Associates"**

  "Post Capital Partners LLC today announced that it has recapitalized Invo HealthCare Associates, Inc., a leading provider of outsourced clinical services for special needs children operating in 23 states. In making the investment, Post Capital is partnering with Invo HealthCare's Co-Founder, CEO and President, Mary McClain, and Jason Ralph, COO." (Wall Street Journal)

- **"Medicaid managed-care program with Collier roots expands in Florida"**

  "A Medicaid managed-care provider with its roots in Collier County has added six more communities, including Lee County, to its roster of contracts with the state. Integral Quality Care, a nonprofit started by the Healthcare Network of Southwest Florida in 2010, now has contracts with 13 of the 67 Florida counties to be a managed-care entity for Medicaid recipients. Collier was one of the early counties. Besides Lee as one of the latest communities, the other five recent additions are Sarasota, Hendry, Hardee, DeSoto and Citrus counties." (Naples News)

- **"Health Net Awarded Medi-Cal Dental Contracts in Los Angeles and Sacramento Counties"**

  "The California Department of Health Care Services has awarded Health Net of California, Inc., a subsidiary of Health Net, Inc., five-year contracts to continue providing Medi-Cal managed care dental benefits in Los Angeles and Sacramento counties. In both Los Angeles and Sacramento counties, Health Net is the only Medi-Cal dental plan that covers non-emergency services for both children and adults. Health Net began providing services under the Sacramento contract on January 1, 2013, and is scheduled to begin providing services under the Los Angeles contract by July 1, 2013, subject to the parties agreeing to final terms and conditions." (Health Net News Release)

- **"WellPoint expects states to expand Medicaid"**

  "A top U.S. insurance industry executive on Wednesday predicted that most states will agree to expand their Medicaid programs under President Barack Obama's healthcare reform law, despite opposition from more than a dozen Republican governors. 'In the long run, the economic benefits to the states will be such that most states will eventually expand Medicaid,' said Richard Zoretic, the executive vice president who oversees Medicaid programs at WellPoint Inc., the-second largest U.S. health insurer…. His prediction comes at a time when about 15 state governors are weighing whether to participate in the dramatic expansion of the Medicaid program for the poor advocated by the Patient Protection and Affordable Care Act." (Baltimore Sun)

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
January 28, 2013	Arizona - Acute Care	Proposals due	1,100,000
January, 2013	District of Columbia	Contract Awards	165,000
TBD	Nevada	Contract Awards	188,000
TBD	Vermont Duals	RFP Released	22,000
February 1, 2013	New Mexico	Contract awards	510,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March 15, 2013	Florida acute care	Proposals Due	2,800,000
March, 2013	Virginia Duals	RFP Released	65,400
March, 2013	South Carolina Duals	RFP Released	68,000
March, 2013	Idaho Duals	RFP Released	17,700
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April 1, 2013	Vermont Duals	Contract awards	22,000
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, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Massachusetts Duals	Implementation	115,000
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
September 1, 2013	California Duals	Implementation	500,000
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
October 1, 2013	Illinois Duals	Implementation	136,000
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
December, 1 2013	Florida LTC (Region 11)	Implementation	16,400
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	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
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	526,902**	X	3/1/2012	4/4/2012		9/1/2013
Colorado	MFFS	62,982					4/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii	Capitated	24,189					1/1/2014
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012		Fall 2013
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	March 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013
Michigan	Capitated	70,000	TBD	TBD	TBD		1/1/2014
Missouri	MFFS‡	6,380					10/1/2012
Minnesota		93,165	Not pursuing Financial Alignment Model				
New Mexico		40,000	Not pursuing Financial Alignment Model				
New York	Capitated	133,880					1/1/2014
North Carolina	MFFS	222,151					TBD
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	X	9/1/2013
Oklahoma	MFFS	104,258					7/1/2013
Oregon		68,000	Not pursuing Financial Alignment Model				
Rhode Island	Capitated	22,737		Apr-May 2013	6/1/2013		1/1/2014
South Carolina	Capitated	68,000	March 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402		Late 2012	Early 2013		1/1/2014
Virginia	Capitated	65,415	March 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	Jan. 2013	3/11/2013	4/1/2013		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 Recent Events

Greg Nersessian Interviewed on Bloomberg Industries

HMA Principal Greg Nersessian recently sat down with Bloomberg Industries to discuss what's on the horizon in 2013 for state sponsored health care plans. Check out Greg's conversation with Mike Manns at: https://vimeo.com/58371045.

HMA Recent Publications

"Empanelment in an Accountable Care Environment"
HMA Accountable Care Institute (ACI)

Greg Vachon, MD – Contributor

Lori Weiselberg, MPH – Contributor

A foundation of both the Patient Centered Medical Home (PCMH) model of care and accountable care, "empanelment" is the process of creating and maintaining a relationship between each patient and a primary care provider. This document is a guide to implementing this foundational process in organizations that deliver primary care and are seeking to deliver on the triple aim of accountable care: improved health, better experience, and lower cost. (Link – PDF)

"California Hospitals: Buildings, Beds, and Business"
California HealthCare Foundation

Lisa Simonson Maiuro, MSPH, PhD

Bret Corzine

California's 393 general acute care (GAC) hospitals saw 46 million outpatients and discharged 3.5 million inpatients in 2010, while the number of beds available had declined to the lowest level in a decade. This report examines the state's GAC hospital facilities including bed supply and capacity, use of services, financial health, and selected quality measures. (Link – CHCF)

"The ACA's Impact on Corrections"
CorrectCare Magazine – National Commission on Correctional Health Care

Donna Strugar-Fritsch, BSN, MPA, CCHP - Author

HMA Principal Donna Strugar-Fritsch maps out what implementation of the ACA means for corrections and those who interact with prisons, jails and ex-offenders, as well as actions corrections officials should consider in this article published in the Fall 2012 issue of CorrectCare, the quarterly magazine of the National Commission on Correctional Health Care. (Link – PDF) *The article is posted with permission from the Fall 2012 issue of CorrectCare. All rights reserved.*