HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: ARKANSAS DETAILS PRIVATE OPTION PLAN FOR MEDICAID EXPANSION

HMA ROUNDUP: FLORIDA SENATE PROPOSES ALTERNATIVE TO MEDICAID EXPANSION; ILLINOIS LAUNCHES COOK COUNTY WAIVER PROGRAM; MICHIGAN GOVERNOR SIGNS BCBS CONVERSION LAW; PENNSYLVANIA GOVERNOR TO RESUBMIT LOTTERY CONTRACT FOR AG APPROVAL; DEVELOPMENTAL DISABILITIES LEGISLATION INTRODUCED IN TEXAS

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"TRANSLATING THE MEDICAID EXPANSION INTO INCREASED COVERAGE"

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"STATE LEVERS FOR IMPROVING MANAGED CARE FOR VULNERABLE POPULATIONS"
"MEDICAID BENCHMARK BENEFITS UNDER THE AFFORDABLE CARE ACT: OPTIONS FOR NEW YORK"

MARCH 20, 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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March 20, 2013

Contents

In Focus: Arkansas Details Private Option Plan for Medicaid Expansion **2**

HMA Medicaid Roundup **4**

Other Headlines **12**

Company News **15**

RFP Calendar **16**

Dual Integration Proposal Status **17**

HMA Webinars **18**

HMA Recent Publications **19**

HMA Upcoming Appearances **20**

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IN FOCUS: ARKANSAS DETAILS PRIVATE OPTION PLAN FOR MEDICAID EXPANSION

This week, our *In Focus* section reviews the Arkansas Medicaid expansion proposal. Arkansas has been generating a great deal of interest in the media and from other states, particularly those opposed to a traditional expansion of their Medicaid program under the Affordable Care Act (ACA). Last month, Arkansas Governor Mike Beebe announced a deal with Health and Human Services Secretary, Kathleen Sebelius, to expand the state's Medicaid program though the Exchange. However, it is important to note that while HHS officials have acknowledged the meeting and discussion on the issue, they have not formally commented on approval of the Arkansas plan.

Under the plan, federal funds would pay for premium assistance to those individuals otherwise newly eligible for Medicaid to purchase coverage through a qualified health plan offered on the Exchange. For the past several weeks, the Arkansas Medicaid expansion alternative had been drawing major interest, but few details were available. Within the past week, however, the state has released a proposed approach to the expansion as well as a report from a consultant hired by the state to evaluate the financial impact of what is being referred to as the Private Option Plan.

Arkansas' proposed plan is available here: (PDF – 3 pp.)

Arkansas' financial impact analysis is available here: (PDF – 2 pp.)

Private Option Plan Proposed Structure

Under the state's proposed Private Option Plan, newly Medicaid eligible individuals under 138 percent of the federal poverty level (FPL), as well as those currently eligible Medicaid adult caretakers and parents, will select coverage through the state's Exchange. Arkansas states that this structure will maintain continuity of care, eliminating the transition back and forth between Medicaid and the Exchange as income changes. Additional notes on the plan follow.

- The plan would enroll newly eligible childless adults and the parent/caretaker population not currently eligible for Medicaid. Arkansas currently covers parents and caretakers up to 17 percent of FPL.
- Plan selection would be limited to those qualified health plans in the "silver" category. The state contends that "silver" plans are the best suited for those individuals below 150 percent FPL based on the federal Exchange subsidy structure.
- The Medicaid program will pay the qualified health plans directly – paying both insurance premiums and supplemental cost sharing. These costs are estimated by the state to be no more than 15 percent higher than what would otherwise be federally funded for the Medicaid expansion.
- High-needs beneficiaries, such as the medically frail, would remain in the traditional Medicaid program, while other individuals who are enrolled through the

Private Option Plan may receive additional services through Arkansas Medicaid in the case of complex or exceptional health care needs.

Exchange and Medicaid Enrollment Impact

Arkansas estimates that the Private Option Plan would add approximately 250,000 low-income adults to the Exchange market. This estimate is in line with the 233,000 new Medicaid enrollees estimated by the Kaiser Center for Medicaid and the Uninsured and Urban Institute November 2012 report.[1] The plan would also reduce current Medicaid enrollment, as certain current Medicaid programs would be limited or eliminated altogether. Affected programs could include ARHealthNetworks, a limited employer benefit program funded with state and federal dollars, as well as the state's family planning waiver, breast and cervical cancer program, and tuberculosis program.

One of the key benefits of this proposal identified by the state is that it will reduce the amount of churning between Medicaid and exchange plans for beneficiaries whose incomes fluctuate around the 138% FPL threshold. On this point it is important to note that Arkansas does not currently administer a risk-based Medicaid managed care program so this arrangement would facilitate health plan continuity for beneficiaries that might otherwise be covered through fee for service Medicaid. In other states with well-established Medicaid managed care programs (and/or states that are resisting a state-based or partnership health insurance exchange), this alternative would not likely be as attractive in our opinion. Nevertheless, the key element of this arrangement is that it suggests that HHS is open to alternative solutions to coverage expansion developed by the states.

Financial Impact

Arkansas' Department of Human Services developed a financial impact of the Private Option plan with the assistance of consultants from Mannatt, Phelps and Phillips LLP and from Optumas, as well as the state's insurance department. The financial impact analysis counters Congressional Budget Office estimates of significantly higher costs, arguing that the plan can be funded with existing resources at the state level and no more than 15 percent in additional federal spending over what would have otherwise occurred under a more traditional Medicaid expansion.

This could be a potential sticking point on HHS approval. In guidance to states issued in December 2012, HHS discussed the premium assistance option and stated that states would have to adhere to federal standards of cost effectiveness. Arkansas' proposal may have to demonstrate cost effective of enrollment through the Exchange as opposed to regular Medicaid.

The report's takeaways on the lower cost estimates are summarized below.

- The differential between Medicaid costs and private insurance costs is significantly smaller in Arkansas as compared to the national average. Arkansas' average differential is less than 25 percent.

[1] "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Kaiser Family Foundation's Kaiser Commission on Medicaid and the Uninsured. Prepared by The Urban Institute. November 26, 2012. Available at: http://www.kff.org/medicaid/8384.cfm

- The estimated 250,000 additional enrollees in the Exchange will increase competition amongst carriers and price pressure on providers. The report estimates this will generate a 5 percent reduction in reimbursement rates.
- This increase in competition and price pressure would impact the entire Exchange, potentially reducing federal subsidies for non-Medicaid enrollees – those above 138 percent FPL in the Exchange – by approximately $700 million.
- Cost-sharing and its influence on consumer health care decision making could reduce the differential by another 5 percent.

However, the report acknowledges that the demand created by an additional 250,000 enrollees may stress the existing Medicaid provider network. The resulting pressure to increase reimbursement rates to providers may offset part of the lower cost estimates detailed above.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

Legislation introduced to Address Provider Shortages. Last week, legislation was introduced that would broaden the scope of practice for nurse practitioners, optometrists and pharmacists in an effort to deal with an expected shortage in primary care physicians. However, mental health providers were not included in the bills, alarming professionals that worry about a spike in demand for behavioral health services. One element contemplated by activists includes permitting the nearly 20,000 psychologists in the state to write prescriptions.

In the news

- **"Federal Approval of Duals Plan May Come Soon"**

  California Department of Health Care Services Director Toby Douglas indicated this week that the Department is still resolving a few issues with the MOU agreement with CMS, but hopes to reach an agreement within a few weeks. (California Healthline)

- **"Deal will avoid deep cuts in home care for elderly, disabled"**

  Governor Jerry Brown reached an agreement this week with unions and social services advocates regarding a proposed cut of 20 percent cut in hours for home health care service workers. After discussion, the unions and advocacy groups agreed to an 8 percent cut. As part of the agreement, payment rates will not be reduced, nor will eligibility qualifications for home care services be reduced. (Los Angeles Times)

Colorado

HMA Roundup – Joan Henneberry

Advocates Push to Make Children's Dental Benefits Mandatory on Health Exchange. Following a February 2013 decision by the Federal officials that dental care benefits are essential, but optional, health advocates in Colorado have initiated a push to mandate children's dental benefits. Oral Health Colorado points to the decline in dental health measures in the state and the 17 percent increase in the number of Coloradans without dental insurance. The Exchange board has supports dental and vision plans as separate optional Exchange offerings or bundled with health plans. The next Exchange meeting is scheduled for April 8, 2013.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

State Senator Negron Unveils "Healthy Florida" in Lieu of Medicaid Expansion. On Monday, March 18, 2013, the Senate posted details of S.P.B. 7038, Senator Joe Negron's proposal to create "Healthy Florida," an alternative to expanding the traditional Medicaid program. Instead, this bill would have Florida Healthy Kids Corp. administer an expansion of health coverage for some 1 million low-income working adults under 138 percent of the Federal Poverty Line. The proposal aims to allow the governor to appoint the chairman and board members of the Florida Healthy Kids Corp. board. The key provisions of the bill include benchmark benefits (other than preventive dental coverage), premiums and co-pays established each year in the state budget, a 90-day trial enrollment without lock-in, health savings accounts with incentives for healthy behavior, 85 percent medical loss ratios, and choice of health plans available either state-wide or regionally. The move to leverage the Healthy Kids infrastructure reflects the need to identify and enroll eligible beneficiaries and provide customer service to address questions about the program.

Healthy Florida would be evaluated for renewal after three years (similar to Governor Scott's recommendations) and would cease should federal funding fall below 90%. The Senate Appropriations Committee (chaired by Negron) is expected to take up this proposal that could lead to hundreds of thousands of uninsured adults getting coverage through private health plans. The bill would ambitiously seek federal approval by June 14, with enrollment beginning by October 1, and effective coverage starting January 1, 2014. The legislation would also provide Healthy Kids Corp. with the authority to make necessary changes to the program to secure federal approval with legislative notification.

Separately, the Senate Health Policy Committee will consider legislation from its chairman, Aaron Bean, that would leverage the Florida Health Choices program for people whose incomes fall below 100 percent of the Federal Poverty Line.

In the news

- **"Fla. Senators reveal Medicaid expansion plan"**
- Two proposals have emerged from Senate republicans on how to deal with the Medicaid expansion. The first, from Sen. Joe Negron, proposes a voucher program using

federal dollars for eligible recipients to purchase private health insurance. The other proposal, from Sen. Aaron Bean, passes up federal funding altogether and would use state funds to pay for a basic insurance plan for those eligible. (Miami Herald)

- **"Senate Health Committee Wants Feds to Set Rates for Insurers"**

  The Senate PPACA committee, led by Sen. Joe Negron, has called on the suspension of the state insurance department's authority over health insurance rates, instead passing the responsibility to the federal government. Negron argued the action is necessary due to the volume of new regulatory rulemaking coming out of the federal government. (The Ledger)

- **"Lawmakers, advocates lobby for Medicaid expansion"**

  Florida hospital executives and consumer advocates are continuing to push for acceptance of the Medicaid expansion, while some legislators are looking for any way to expand and draw the significant federal matching funds associated with the expansion. (Miami Herald)

- **"Florida House speaker Will Weatherford: No Medicaid expansion"**

  Florida House speaker Will Weatherford has said that the state will not expand Medicaid as proposed by Governor Rick Scott earlier this year. However, he does leave the possibility of alternative ways to expand coverage on the table, just not through the Medicaid program. (Politico)

Georgia

HMA Roundup – Mark Trail

Legislative Session Nears an End with the Budget Still Requiring Senate Approval. March 28, 2013, marks the end of the legislative session, with budget approval still on the docket for the Senate. The health appropriations subcommittee should pass its budget this week, including provisions authorizing the Department of Community Health to pursue an 1115 waiver for the ABD population.

Illinois

HMA Roundup – Matt Powers and Jane Longo

Cook County's Medicaid Expansion Program On Track to Enroll 115,000 by Year-End. The Illinois Department of Human Services has approved 2,200 applications for Cook County Health and Hospital System's 1115 waiver program. The county has accelerated its application submissions to about 300 daily, on track to hit the year-end target of 115,000 enrollees. The CountyCare program is expected to post nearly $100 million in annual net patient revenues.

In the news

- **"Cook County hospital tax funding drops by $100 million"**

  The taxpayer-funded subsidy directed to the Cook County Health and Hospitals System is down more 25 percent, from $386 million to just over $287 million. The reduc-

tion is due to savings from cost-cutting measures and decreased demand for care from the system. The tax dollars fill in the gap between Cook County's revenue and it's costs. Revenues were up roughly 5 percent while costs were down more than 9 percent in the last year. (Crain's Chicago)

Indiana

HMA Roundup – Cathy Rudd

HHS Response to Governor Pence Emphasizes Need for Public Hearings. Following a high profile letter from Governor Pence to HHS Secretary Sebelius regarding the use of Healthy Indiana as a vehicle for Medicaid expansion, there has been little news on the status of the request. However, HHS' response to the governor appears to have been swift and clear: the request could not be considered without two public hearings. Thus far, it is unclear what timeframe such hearings would be scheduled to trigger HHS consideration of the state's waiver request.

Michigan

HMA Roundup – Esther Reagan

Governor Signs Blue Cross Blue Shield Conversion Law. On Monday, March 18, 2013, Governor Rick Snyder signed into law legislation that converts Blue Cross Blue Shield of Michigan from a tax-exempt non-profit into a mutual insurer, which will likely generate $90 million in state and local tax revenues to with lower regulatory burdens related to rate hikes. The insurer would be obliged to give $1.5 billion over the next 18 years to a new Michigan Health Endowment Fund to benefit children and seniors. The Blues will enjoy less regulatory interference on rate hikes and the removal of public hearings and explicit support from the Insurance Commissioner for new rates. Finally, the legislation forbids "sweetheart deals" with hospitals that, effectively, shift costs to competing insurers.

Medicaid Expansion Still Uncertain as House Subcommittee Passes Budget without It. Although the Republican Governor has endorsed Medicaid expansion, some Republican legislators have expressed concerns about the Federal Government's ability to honor its full-funding promises. Indeed, on Wednesday, March 20, 2013, the House Appropriations subcommittee passed a budget plan (H.B. 4213) that did not include Medicaid expansion for the Department of Community Health. The Arkansas Medicaid proposal is getting more attention as a model for expanding health coverage through private plans, rather than through the traditional Medicaid system. Unlike many states, Michigan's fiscal year begins on October 1, not July 1, so final resolution of the Medicaid expansion issue may not come as soon as in other states.

In the news

- **"Delay in Lansing over 'Obamacare' health exchange results in HealthPlus postponing its entry into marketplace until 2015"**

  Due to uncertainty in the Michigan legislature, HealthPlus of Michigan has announced it will delay offering plans in the state's exchange marketplace until 2015. (MLive.com)

- **"AP Interview: Michigan governor says time running out to work with feds on health exchange"**

  Michigan Governor Rick Snyder is warning that if the republican-led Senate does not pass a bill to establish a state-federal partnership Exchange. Gov. Snyder has said if the Senate does not pass the bill before the session ends Friday, March 22, there will not be enough time to set up the Exchange before October 1. (The Republic)

Minnesota

HMA Roundup

Minnesota Health Exchange Bill Signed into Law. On Wednesday, March 20, 2013, Gov. Mark Dayton signed into law the health insurance exchange bill, which establishes an online marketplace for health plans for nearly 1 million Minnesotans. Insurers have until May 17 to submit plans for state approval to offer on the exchange. The exchange will have a seven person board, more than 80 employees, and will operate on about $50 million annually. The operating expenses of the exchange are expected to be funded by fees levied on premiums, with about 1.5 percent of premiums underwriting the exchange. By 2015, that figure could climb to 3.5 percent. The exchange—now named MNsure—will begin enrollment in October 2013.

In the news

- **"Health exchange bill passes Minn. Senate; heads to Dayton's desk"**

  Minnesota has joined the at least 17 states who will establish their own state-run Exchange. The Senate passed the Exchange bill on Monday, sending it to Governor Mark Dayton's desk for signature. (Minnesota Public Radio News)

Oregon

HMA Roundup

Oregon Passes Medical Malpractice Reform. On Monday, March 18, 2013, Governor Kitzhaber signed into law medical malpractice reform legislation that may resolve adverse healthcare incidents without litigation. The bill overwhelmingly passed both houses of the legislature with bipartisan support. The new law allows the patient and provider to enter into voluntary private discussions overseen by the Patient Safety Commission. Similar programs have been enacted in Illinois and Michigan.

Pennsylvania

HMA Roundup –Matt Roan

DPW Solicits for additions to its BH-MCO Vendor List. The Department of Public Welfare is soliciting applications from Behavioral Health Managed Care Organizations to be added to a vendor list that the Department maintains in order to quickly procure services in the event that a current vendor is terminated or voluntarily leaves the program. Potential contractors must have at least one-year experience with a State behavioral health Medicaid program, not be under suspension or debarment by the Commonwealth or any other state or governmental entity, licensed by the Departments of Health and Insur-

ance, and experienced in the use of management information systems to process HIPAA-compliant transactions. Applications must be submitted to DPW by 2pm on May 3, 2013 in order for a BH-MCO to be considered for addition to this list.

Report Finds Access to Care to be Adequate. The Pennsylvania Academy of Family Physicians (PAFP) released a study that found that access to care in the Commonwealth of Pennsylvania to be adequate. Despite ongoing fears about the rationing of care and provider shortages, PAFP found that 90 percent of Family Physicians report that they are accepting new patients, 62 percent accept and treat Medicaid recipients, while 98 percent provide treatment to the uninsured. Also, 40 percent of practices adhere to the principles of the Patient Centered Medical Home.

Governor Corbett to Revise and Re-Submit Lottery Contract. The Governor has announced plans to revise the proposed lottery privatization contract with Camelot Global Services and resubmit the agreement to the PA Attorney General for approval. Attorney General Kathleen Kane had previously rejected the contract, finding that it conflicted with the PA constitution and PA law. Corbett has allocated anticipated increased funding from the Lottery to expand services for Pennsylvania Seniors including home and community based services. Resolution of this contracting issue has become more important to the state's budget process as appropriators need to determine the availability of lottery funding to support the Governor's proposed budget will be available.

More PA Senate Republicans Support Medicaid Expansion. At least three Senate Republicans have announced conditional support for Medicaid Expansion in PA including Sens. Mike Brubaker and Lloyd Smucker from Lancaster County and Sen. Patricia Vance from Cumberland County. Sources report that there are as many as 12 other Republican Senators open to the idea of expansion. Nonetheless, Senate Republican Majority Leader Sen. Jake Corman has said that a bill on Medicaid Expansion is not likely to come to the floor of the Senate without the support of the Corbett Administration. Governor Corbett remains opposed to expansion citing costs to the state and lack of guidance from the Federal Government on the flexibility needed to make an expanded program work. The Governor sent a letter to Secretary Sebelius, last month, expressing the need for flexibility but has not provided a detailed description of what changes his seeks.

January Jobs Numbers Show Growth in Private Sector. The Department of Labor and Industry released its January employment figures which show that private sector jobs were up by 7,800 over the previous month. The Department also revised its previous figures and has reported higher overall private sector job increases since 2011. The Department is now reporting that 117,900 private sector jobs were added to the PA economy from January 2011 through January 2013. Pennsylvania's January 2013 unemployment rate stood at 8.2 percent.

Texas

HMA Roundup –Dianne Longley and Linda Wertz

Developmental Disabilities Legislation Placed on Intent Calendar. On March 20, 2013, Senate Bill 7 (authored by Sen. Nelson and Sen. Patrick) was placed on the intent calendar, having been reported favorably in a unanimous vote by the Senate Health and Human Services Committee over concerns expressed by a number of disability advocates. The bill's provisions are presented below:

- Implement an acute care and long term care support services systems for individuals with intellectual and developmental disabilities
- Requires the Department of Aging and Disability Services (DADS) to identify local intellectual and developmental disability authorities and private care providers to develop a managed care service delivery pilot program to be implemented by September 1, 2014.
- Acute care services for individuals with intellectual and developmental disabilities will be provided by the STAR program
- Requires Health and Human Services Commission to implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with intellectual and developmental disabilities under the STAR+PLUS program
- Transition TxHmL waiver and ICF-IID recipients to a managed care delivery system such as STAR+PLUS
- Mandatory participation all nursing home residents be transitioned to STAR+PLUS program
- Mandatory enrollment for the children eligible for the Medically Needy Dependent Children (MDCP) waiver, in a capitated managed care delivery system
- Expand housing options for individuals with intellectual and developmental disabilities
- Requires DADS to develop and implement specialized training for providers, family members, caregivers, and first responders providing direct services and supports to individuals with intellectual and developmental disabilities and behavioral health needs
- Requires HHSC, or its operating agencies, to create an incentive program that auto-enrolls a greater percentage of recipients, who did not actively choose their managed care plan, to a managed care plan, based on the quality of care provided through the MCO
- Require HHSC to develop quality-based payment systems and require MCOs to develop quality-based payment systems using certain quality-based outcome and process measures, for CHIP/Medicaid provider compensation.

- Authorizes HHSC to develop and implement quality-based payment systems for Medicaid long-term care services and supports providers designed to improve quality of care and reduce necessary services.
- Requires HHSC to adopt rules for identifying the incidence of potentially preventable admissions, potentially preventable readmissions, and potentially preventable emergency room visits by Medicaid long-term care services and supports recipients.
- Requires HHSC, if it determines that it is cost-effective, to include all or a portion of any retroactive fee-for-service payments payable under the Medicaid program in the premium paid to a MCO, including retroactive fee-for-service payment owed for services provided to a recipient before the recipient's enrollment in the Medicaid program or MCO.
- Requires HHSC, to the extent permitted under Title XIX or waiver, to adopt and implement in the most cost-effective manner a premium for long-term care services provided to a child under the Medicaid program to be paid by the child's parent or other legal guardian.

In the news

- **"Perry Pressured by Texas Businesses Over Medicaid Refusal"**

  The chambers of commerce in five Texas cities have sent letters to Governor Rick Perry urging him to accept the Medicaid expansion and arguing that the state should not pass up on the significant influx of federal funding associated with the expansion. The chambers of commerce typically support Gov. Perry. (Bloomberg)

- **"The case for a Texas solution"**

  Republican State Representative John Zerwas authors a Houston Chronicle op-ed urging support of House Bill 3791, which directs HHSC to negotiate a flexible solution with federal officials on a Medicaid expansion that meets the needs of Texas. (Houston Chronicle)

National

HMA Roundup

Federal EHR Subsidies Top $12 Billion. Since the passage of the American Recovery and Reinvestment Act (ARRA) of 2009, more than 200,000 healthcare providers have received $12.3 billion in electronic health record incentive payments. CMS reported that the incentive payments in the month of February 2013, alone, was $725 million. About three quarters of US hospitals eligible for these funds have received EHR payments, thus far. Approximately 41 percent of all physicians and eligible professionals have received EHR payments. In total, the government expects to issue $22.5 billion in incentive payments as part of these programs.

In the news

- **"Feds will need to enforce ACA reforms in 4 states"**

  Federal officials have indicated that at least four states – Missouri, Oklahoma, Texas, and Wyoming – have not implemented the proper oversight for insurance regulation reforms under the ACA. The federal government will enforce the reform implementation in these states. (Politico)

- **"Hash: HHS 'Anxious' to Talk to States About Using Medicaid Expansion Funds for Private Coverage"**

  HHS official Michael Hash, speaking to reporters Monday, indicated that the administration is "anxious" to discuss with states the option to use federal Medicaid expansion funds to purchase coverage through the Exchanges, as Arkansas has proposed. However, Hash indicates that no formal proposal has been submitted to HHS to do so. (CQ HealthBeat)

- **"Moody's warns of trouble for hospitals without Medicaid expansion"**

  Moody's Investor Services warned of financial trouble for hospitals in states that opt not to expand Medicaid. This is due to anticipated cuts to disproportionate share hospital (DSH) funding and other funds paid out to hospitals intended to cover uncompensated care to the uninsured. (The Hill)

- **"What's the Medicaid Expansion Worth to a State?"**

  Governing Magazine summarizes the fiscal argument on the Medicaid expansion presented by senior Urban Institute fellow Stan Dorn. Dorn walks through the Medicaid expansion and what it means on three fronts: costs, savings, and revenue. (Governing Magazine)

Other Headlines

Alabama

- **"Legislators hear comments on proposed Medicaid overhaul'**

  The Alabama legislature heard praise for a plan to transition the largely fee-for-service Medicaid program into a regional care management program. Community groups and managed care organizations spoke to House and Senate members on Tuesday regarding the plan, while some advocates urged consumer involvement in the legislative process. (AL.com)

Arkansas

- **"Care about Obamacare? Then you should really care about Arkansas."**

  Washington Post's Sarah Kliff argues that the Arkansas private Medicaid expansion option could have huge ramifications for the future of the Affordable Care Act. If the four other states now considering the option – Florida, Ohio, Louisiana, Maine – signed on, 2.4 million new Medicaid enrollees could be enrolled in the exchanges. (Washington Post)

District of Columbia

- **"Bill would raise feds' contribution to DC Medicaid"**

  D.C. Delegate Eleanor Holmes Norton introduced a federal measure that would increase the federal share of Medicaid funding in the District from 70 percent to 75 percent. Delegate Norton drew comparisons to New York City, which she contends pays only 25 percent of its Medicaid costs. (The Hill)

Idaho

- **"Bill To Create A State-Based Health Insurance Exchange Passes The Idaho House"**

  The Idaho House passed a bill to establish a state-based exchange for 2014, voting 41-29 in favor of the plan. The Senate passed a similar bill last month, but will have to sign off in the House bill before it goes to Governor C.L. "Butch" Otter for signature. The Governor has committed to the creation of the state-based exchange. (NPR's StateImpact)

Iowa

- **"Iowa Democrats' Medicaid compromise a 'first step,' Branstad says"**

  Iowa's governor is praising a Democratic proposal to end the Medicaid expansion if the federal matching percentage ever falls below 90 percent as a first step toward a compromise between legislative democrats and the republican Governor on the Medicaid expansion. (The Gazette)

Louisiana

- **"2 former health chiefs push La. Medicaid expansion"**

  Two former secretaries of the Louisiana Department of Health and Hospitals – one serving under a republican governor, the other a democratic governor – came out this week urging Governor Bobby Jindal to expand Medicaid. (The News Star)

- **"Jindal administration doesn't say yes or no to Arkansas-type Medicaid deal for Louisiana"**

  Governor Bobby Jindal and DHH Secretary Bruce Greenstein have indicated that they are interested in the Arkansas plan to expand Medicaid through the exchange, but would need to see more details and a final agreement before declaring their support for the plan in Louisiana. (NOLA.com)

Mississippi

- **"Medicaid at top of agenda"**

  Regardless of whether the state pursues the Medicaid expansion, Mississippi legislators must first reach an agreement to reauthorize the state's Medicaid program. The current authorization expires on June 30. Efforts in both the House and Senate to reauthorize Medicaid have stalled and Governor Phil Bryant may call a special session of the legislature to address reauthorization. (Hattiesburg American)

Missouri

- **"Missouri Senate, House panels defeat Medicaid expansion"**

  In the past week, the Senate Appropriations Committee and House Budget Committee both struck down legislation supported by Governor Jay Nixon to expand the state's Medicaid program. Republicans have opposed the expansion on long-term cost concerns. (Columbia Missourian)

Montana

- **"Montana legislators introduce new bills to expand Medicaid"**

  Senate democrats introduced a pair of bills to expand Medicaid this week as republican legislators prepare their own alternative legislation that passes up the full Medicaid expansion. Governor Steve Bullock supports the expansion and has put forth his own bill. One of the Senate bills, introduced by Sen. Dave Wanzenried, has the support of the state's hospitals. (The Missoulian)

- **"Gov. Bullock unveils bill to expand Medicaid in Montana"**

  Montana Governor Steve Bullock introduced a proposal to expand Medicaid to more than 70,000 Montana residents last week. The proposal includes funding of $5 million to implement the expansion and estimates more than $750 million in federal funding flowing to the state over the next two years. (The Missoulian)

New Hampshire

- **"Medicaid Overhaul Plan Hits A Road Block"**

  New Hampshire's plan to implement statewide Medicaid managed care has faced continued delays, and may be forced to again delay an April 1 launch. The delays have resulted from lack of contracts between hospitals and the three MCOs contracted with the state. Without contracts in place, none of the plans can meet network adequacy requirements. (New Hampshire Public Radio)

Rhode Island

- **"RI health exchange in middle of 'steady build'"**

  The director of the Rhode Island health insurance exchange said this week that the exchange is on track to begin enrollment later this year for the 2014 plan year. (Boston Globe)

Tennessee

- **"Gov. Bill Haslam against bill to block TennCare expansion"**

  Tennessee Governor Bill Haslam has formally opposed a bill that would prohibit the state from participating in the Medicaid expansion under any circumstances. Gov. Haslam indicated that he wanted to keep the state's options open with regards to the possibility of expanding TennCare. (Times Free Press)

Washington

- **"Medicaid forecast reveals swelling budget shortfall for state"**

Washington state legislators learned this week that Medicaid costs are expected to be $360 million more than budgeted through June 2015. The additional costs are tied to lower estimates of savings from shifting more of the state's Medicaid population into managed care organizations. (The Olympian)

COMPANY NEWS

- **"Centene Corporation Partners With MHM Services To Serve Massachusetts State Correctional System"**

  "Centene Corporation announced today that a subsidiary of its correctional healthcare joint venture, Centurion LLC ("Centurion"), has been notified by the Department of Correction in Massachusetts that it has been awarded a contract, contingent upon successful completion of contract negotiations. Centurion is a joint venture between Centene and MHM Services Inc. ("MHM"), a national leader in providing healthcare services to correctional systems…. The award is subject to final negotiations with the state and is contemplated to become effective in the summer of 2013." (Centene Press 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
Pending	District of Columbia	Contract Awards	165,000
TBD	Nevada	Contract Awards	188,000
March, 2013	Idaho Duals	RFP Released	17,700
March 27, 2013	Rhode Island Duals	Proposals due	22,700
March 29, 2013	Florida acute care	Proposals Due	2,800,000
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	5,500
April 1, 2013	Washington Duals	RFP Released	115,000
April, 2013	Virginia Duals	RFP Released	65,400
April, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
May 1, 2013	District of Columbia	Implementation	165,000
May 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
May-June, 2013	South Carolina Duals	RFP Released	68,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
July 1, 2013	Massachusetts Duals	Implementation	115,000
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
September 1, 2013	California Duals	Implementation	500,000
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Rhode Island Duals - Medicaid Only	Implementation	22,700
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
October 1, 2013	Illinois Duals	Implementation	136,000
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
December, 1 2013	Florida LTC (Region 11)	Implementation	16,400
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	526,902**	X	3/1/2012	4/4/2012		9/1/2013
Colorado	MFFS	62,982					6/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189			Not pursuing Financial Alignment Model		
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	X	10/1/2013
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	March 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013
Michigan	Capitated	70,000	TBD	TBD	TBD		1/1/2014
Missouri	MFFS‡	6,380					10/1/2012
Minnesota		93,165			Not pursuing Financial Alignment Model		
New Mexico		40,000			Not pursuing Financial Alignment Model		
New York	Capitated	133,880					1/1/2014
North Carolina	MFFS	222,151					TBD
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	X	9/1/2013
Oklahoma	MFFS	104,258					7/1/2013
Oregon		68,000			Not pursuing Financial Alignment Model		
Rhode Island	Capitated	22,700	X	3/27/2013			9/1/2013*
South Carolina	Capitated	68,000	May-June 2013	TBD	TBD		1/1/2014
Tennessee		136,000			Not pursuing Financial Alignment Model		
Texas	Capitated	214,402			Early 2013		1/1/2014
Virginia	Capitated	78,596	April 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	TBD	TBD	TBD		1/1/2014
Washington	Capitated/MFFS	115,000	April 1, 2013 (Capitated)	TBD	July 2013 (Capitated)	MFFS Only	1/1/2014
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		4/1/2013
Totals	**15 Capitated 7 MFFS**	**1.7M Capitated 485K FFS**	***6***			***4***	

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

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

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

‡ Capitated duals integration model for health homes population.

HMA WEBINARS

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

Jennifer N. Edwards, DrPH, MHS – Panelist

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

This week, the Kaiser Family Foundation's Commission on Medicaid and the Uninsured held a webinar to examine the role of application assistance in ensuring eligible individuals successfully enroll in health coverage. The webinar featured an overview of the importance of application assistance drawing on lessons learned from Medicaid and CHIP and insight into states' planning efforts to provide such assistance under the ACA. The Foundation also released a case study highlighting the experience of providing in-person application assistance for Medicaid through community health centers in Utah. Link to Recorded Webinar/Slides

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

Donna Strugar-Fritsch – Host

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

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

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

Registration is limited so register now to reserve your seat.

HMA Recent Publications

"State Studies Find Home and Community-Based Services to Be Cost-Effective"
AARP Public Policy Institute

Jenna Walls – Co-Author
Wendy Fox-Grage – Co-Author (AARP Public Policy Institute)

The vast majority of people who need long-term services and support want to live in their own homes and communities as long as possible. States have made progress in providing greater access to home and community-based services (HCBS) for people with low incomes. This research collected state studies about the cost effectiveness of HCBS. The 38 studies, published from 2005 to 2012, include state-specific analyses by public and other organizations. ***(Link - PDF)***

"Medicaid Benchmark Benefits Under the Affordable Care Act: Options for New York"
New York State Department of Health

Denise Soffel, PhD – Contributor
Robert Buchanan, MPP – Contributor
Tom Dehner, JD – Contributor
David Fosdick – Contributor
Lisa S. Maiuro, PhD, MSPH – Contributor

The New York State Department of Health enlisted Health Management Associates (HMA) to analyze available options for selecting a Medicaid benchmark benefit for people eligible for Medicaid's new mandated adult category established by the Affordable Care Act (ACA). ***(Link - PDF)***

"State Levers for Improving Managed Care for Vulnerable Populations: Strategies with Medicaid MCOs and ACOs"
The Commonwealth Fund

Sharon Silow-Carroll, MSW, MBA – Contributor
Jennifer N. Edwards, DrPH, MHS – Contributor
Diana Rodin, MPH – Contributor

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

HMA UPCOMING APPEARANCES

"Delivering on Accountable Care: The Handshake Between Cost and Quality" Medecision Client Forum 2013

Greg Buchert, MD – Panelist

April 11, 2013

Washington, D.C.