HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: ARIZONA ANNOUNCES ACUTE CARE, BEHAVIORAL RFP AWARDS

HMA ROUNDUP: CALIFORNIA, CMS COMPLETE DUALS DEMO MOU; TEXAS DEVELOPMENTAL DISABILITIES LEGISLATION PASSES SENATE; FLORIDA CONSIDERS ALTERNATIVES TO MEDICAID EXPANSION; PENNSYLVANIA GOV. TO MEET WITH CMS ON MEDICAID EXPANSION NEXT WEEK

HEADLINES: TENNESSEE GOV. REJECTS MEDICAID EXPANSION, BUT OPEN TO ALTERNATIVES; NEW YORK DROPS PLAN TO ALLOW PRIVATE HOSPITAL INVESTMENT; LOUISIANA CANCELS MMIS CONTRACT TRANSITION

RECENTLY PUBLISHED RESEARCH:
"EARLY ADOPTERS OF THE ACCOUNTABLE CARE MODEL: A FIELD REPORT ON IMPROVEMENTS IN HEALTH CARE DELIVERY"

MARCH 27, 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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Contents

In Focus: Arizona Announces Acute Care, Behavioral RFP Awards 2

HMA Medicaid Roundup 6

Other Headlines 14

RFP Calendar 17

Dual Integration Proposal Status 18

HMA Webinars 19

HMA Recent Publications 20

HMA Upcoming Appearances 21

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IN FOCUS: ARIZONA ANNOUNCES ACUTE CARE, BEHAVIORAL RFP AWARDS

This week, our *In Focus* section reviews two Medicaid RFP awards announced by Arizona in the past week. Last Friday, March 22, the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid agency, announced awards in the Acute Care/Children's Rehabilitation Service (CRS) RFP. On the heels of the Acute Care/CRS RFP awards, the Arizona Department of Health Services (ADHS) announced an award Monday, March 25, in the Regional Behavioral Health Authority (RHBA) RFP for Maricopa County.

Acute Care/CRS RFP Award

The Acute Care/CRS RFP, released in early November 2012, rebid statewide contracts for acute care Medicaid benefits, as well as for the state's CRS program, which provides services to nearly 25,000 children with specified chronic or disabling conditions.

The following two tables rank the award recipients and non-recipients based on pre-established metrics, both by region and by their CRS program. Incumbent plans are highlighted. Additionally, AHCCCS has indicated the number of members transitioning from unsuccessful incumbent bidders into the new plans. Successful incumbent bidders will hold their current enrollees until each enrollee's annual open enrollment period begins. Under the RFP, unsuccessful bidders could request to retain their current enrollees under a new contract, but not accept any new enrollees. As of the date of publication, only Vanguard's Phoenix Health Plan has requested an enrollment cap. The tables additionally identify the transitioning enrollment if Phoenix's request is granted.

	GSA 2 Yuma, La Paz		GSA 4 Apache, Coconino, Mohave, Navajo		GSA 6 Yavapai		GSA 8 Gila, Pinal	
Awarded	**1**	U of AZ Health Plans, University Family Care	**1**	United Health Care	**1**	U of AZ Health Plans, University Family Care	**1**	Health Choice AZ
	2	United Health Care	**2**	Health Choice AZ	**2**	United Health Care	**2**	U of AZ Health Plans, University Family Care
Not Awarded	**3**	Mercy Care Plan (Aetna)	**3**	Mercy Care Plan (Aetna)	**3**	Health Choice AZ	**3**	United Health Care
	4	Health Choice AZ	**4**	Phoenix Health Plan	**4**	Mercy Care Plan (Aetna)	**4**	Care1st Health Plan
	5	Care1st Health Plan	**5**	Bridgeway Health Solutions of AZ (Centene)	**5**	Care1st Health Plan	**5**	Phoenix Health Plan
	6	Bridgeway Health Solutions of AZ (Centene)			**6**	Phoenix Health Plan	**6**	Bridgeway Health Solutions of AZ (Centene)
					7	Bridgeway Health Solutions of AZ (Centene)		
Total Enrollment		**48,300**		**75,412**		**31,162**		**46,862**
Transitioning		**11,668**		**22,700**		**31,162**		**30,026**
w/ Phoenix HP Cap		***11,668***		***0***		***16,078***		***0***

= *Incumbent Plan*

United held each of its three incumbent region contracts as well as its statewide CRS contract, while adding three additional regions that could add more than 50,000 new covered lives to United's Arizona business. United was unsuccessful in only one region. Notably, Phoenix Health Plan, an incumbent in five of the seven regions, rebid, but was shut out in each of the five. Additionally, Centene's Bridgeway Health Solutions of Arizona was unsuccessful in each of the seven regions on which it bid, scoring the lowest of all bidders in six of the seven regions.

		GSA 10 Pima, Santa Cruz		GSA 12 Maricopa		GSA 14 Cochise, Graham, Greenlee		CRS Statewide
Awarded	1	U of AZ Health Plans, University Family Care *(Pima, Santa Cruz)*	1	Maricopa Health Plan (U of AZ Health Plans)	1	U of AZ Health Plans, University Family Care	1	United Health Care
	2	United Health Care *(Pima, Santa Cruz)*	2	United Health Care	2	United Health Care		
	3	Health Choice AZ *(Pima only)*	3	Care1st Health Plan				
	4	Mercy Care Plan (Aetna) *(Pima only)*	4	Health Choice AZ				
	5	Care1st Health Plan *(Pima only)*	5	Mercy Care Plan (Aetna)				
			6	Health Net of AZ				
Not Awarded	6	Health Net of AZ	7	Bridgeway Health Solutions of AZ (Centene)	3	Health Choice AZ	2	Mercy Care Plan (Aetna)
	7	Phoenix Health Plan	8	Phoenix Health Plan	4	Care1st Health Plan		
	8	Bridgeway Health Solutions of AZ (Centene)	9	BCBS of AZ / Medisun Community Care Inc.	5	Mercy Care Plan (Aetna)		
					6	Bridgeway Health Solutions of AZ (Centene)		
Total Enrollment		**179,157**		**632,638**		**30,971**		**24,744**
Transitioning		**17,506**		**95,143**		**16,520**		**0**
w/ Phoenix HP Cap		***0***		***0***		***16,520***		***N/A***

= *Incumbent Plan*

Evaluation Criteria & Scoring Tables

Bidders were evaluated on four categories of which three – Program, Access/Network, and Organization – made up 67 percent of the scoring. These three criteria were scored on an aggregate basis for all of the regions on which a plan bid.

Program (33 percent)	Network (17 percent)	Organization (17 percent)
•Data sharing, care coordination; •Disease management; and •Medicare integration, alignment.	•Medicaid expansion; •Network development; and •Network management.	•Quality and cost containment; •Fraud and abuse; •Grievance processes; •IT demo and oral presentation.

Scores for the three criteria above are summarized in the table below for all regions on which a plan bid. Scores for each bidder are shaded based on their relative scoring as compared to the other plans in that category. Green scores are higher while red are lower. The number of regions bid upon and won are also included in the table below.

Evaluation Category	Access/ Network	Organization	Program	Total (Non-Cap.)	# GSAs Bid	# GSAs Won
Scoring Weight	*17%*	*17%*	*33%*	***67%***		
United Health Care Community Plan	1,130	1,277	2,890	**5,297**	**7 + CRS**	**6 + CRS**
University of Arizona Health Plans, University Family Care	1,220	1,463	2,265	**4,948**	**5**	**5**
Southwest Catholic Health Network dba Mercy Care Plan	1,140	1,393	2,400	**4,933**	**6 + CRS**	**2**
Maricopa Health Plan managed by University of Arizona Health Plans	1,220	1,439	2,265	**4,924**	**1**	**1**
Care1st Health Plan Arizona	1,300	1,361	2,125	**4,786**	**6**	**2**
Health Choice Arizona	1,080	1,025	1,660	**3,765**	**7**	**4**
Health Net of Arizona	760	719	1,665	**3,144**	**2**	**1**
Bridgeway Health Solutions of Arizona, LLC	510	818	1,550	**2,878**	**7**	**0**
Phoenix Health Plan	820	1,067	500	**2,387**	**5**	**0**
BCBS of AZ / Medisun Community Care Inc. dba Community Care	170	963	830	**1,963**	**1**	**0**

The remaining 33 percent was based on capitated proposals for each region individually. Plans submitted capitation proposals for each region bid upon, although these are not the final capitated rates that will be paid. Adjusted rates with reinsurance, premium tax, and risk contingency will be finalized prior to the October go-live date.

Maricopa Health Plan and University Family Care, both University of Arizona Health Plans, scored strong in the three categories above as well as their capitation rates. Meanwhile, plans with strong access/network, organization, and program scores – Care1st and Mercy Care Plan – were hurt by low capitation scores. Additionally, United's lone unsuccessful region (GSA 8) would appear to be due to their capitated score.

Capitated Scores by Region (33% Scoring Weight)	GSA 2	GSA 4	GSA 6	GSA 8	GSA 10	GSA 12	GSA 14	Average Capitated	Total (Non-Cap.)
Maricopa Health Plan managed by University of Arizona Health Plans						3,282		3,282	4,924
Health Choice Arizona	2,963	3,287	3,286	3,294	3,137	2,876	3,104	3,135	3,765
University of Arizona Health Plans, University Family Care	3,289		3,034	1,994	3,197		3,171	2,937	4,948
Phoenix Health Plan		2,828	2,665	2,882	2,681	1,235		2,458	2,387
Health Net of Arizona					2,247	2,474		2,360	3,144
United Health Care Community Plan	2,469	2,369	2,295	734	2,227	2,417	2,321	2,119	5,297
Bridgeway Health Solutions of Arizona, LLC	1,460	1,072	903	883	1,646	2,574	1,164	1,386	2,878
Care1st Health Plan Arizona	1,682		386	746	680	1,998	2,082	1,262	4,786
Southwest Catholic Health Network dba Mercy Care Plan	788	949	1,894		1,391	1,355	1,000	1,229	4,933
BCBS of AZ / Medisun Community Care Inc. dba Community Care						1,065		1,065	1,963

Timeline

Proposals were due to AHCCCS on January 28, 2013, and contract awards were announced, as anticipated, on March 22, 2013. Contracts will be finalized in the coming weeks with a go-live date of October 1, 2013.

Dual Eligible Integration

Arizona has yet to finalize a memoranda of understanding (MOU) with CMS on its dual eligible demonstration proposal. The state has proposed to cover dual eligibles under a demonstration model across the three managed care programs. If Arizona reaches an agreement with CMS on this plan, the awarded plans under the acute care RFP would serve the estimated 77,000 dual eligibles currently in the acute managed care program.

In case an MOU is not finalized with CMS, AHCCCS has opted to require a second option for integrating care for dual eligibles outside of the duals demonstration. AHCCCS will require plans to pursue parallel tracks and become both a dual demonstration plan and a Dual Eligibles Special Needs Plan (D-SNP). Beginning in January 2014, plans are required to offer a demonstration plan or a D-SNP. Going forward, AHCCCS will not contract with D-SNPs that are not awarded Acute contracts in the counties they offer their D-SNP, or that do not hold a contract in the Arizona Long Term Care System (ALTCS) or the Maricopa County Regional Behavioral Health Authority (RBHA).

Maricopa RBHA RFP Award

On the heels of the Acute Care/CRS RFP awards, the Arizona Department of Health Services (ADHS) announced an award Monday, March 25 in the Regional Behavioral Health Authority (RHBA) RFP for Maricopa County. The Maricopa RHBA contract was awarded to Aetna's Mercy Maricopa Integrated Care (MMIC) plan. Arizona's Medicaid managed care structure carves-out behavioral health services from all managed care contracts, and administers these benefits through the RBHAs. Scoring is not currently available for the RHBA RFP.

On average, Aetna's MMIC plan will manage the behavioral health services for more than 700,000 average monthly enrollees in Maricopa county, as well as the physical health benefits for roughly 15,000 average monthly enrollees with severe mental illness (SMI). If Arizona reaches an agreement with CMS on the dual eligible demonstration, the roughly 7,000 dual eligibles with SMI would be covered by MMIC under the duals demonstration.

MMIC beat out incumbent Magellan Health Services, as well as bids from United, Centene, and Partners in Integrated Health LLC.

The Maricopa RBHA contract is expected to go live October 1, 2013.

HMA Medicaid Roundup

California

HMA Roundup – Jennifer Kent

California Signs MOU with CMS on Duals Demonstration. California officials held a stakeholder call on Wednesday, March 27, to announce an agreement with CMS on the state's duals demonstration, now to be called Cal MediConnect. The MOU makes several changes to the demonstration plans.

- **Timeline:** Cal MediConnect will not begin implementation until October 1, 2013 at the earliest.
- **Enrollment Phase-In:** Eight counties will implement the Cal MediConnect program: Alameda, Los Angeles, San Bernardino, San Diego, San Mateo, Santa Clara, Orange and Riverside. The original proposal stated all counties would phased in enrollment process over 12 months. The MOU lays out enrollment strategies for each county. Specifically, assuming an October 2013 start, San Mateo County enrollment will complete enrollment in January 2014 and Los Angeles County enrollment will happen over a 15-month period
- **Opt Out Provisions:** The state had proposed a six-month stable enrollment period in which enrollees would remain with a single plan for the first six months of enrollment. This has been dropped and enrollees will be able to opt out at any time.
- **Target Population:** The Governor's budget had called for 800,000 duals to be enrolled. Under the MOU, enrollment is estimated at 456,000.
- **Los Angeles County:** Enrollment in Los Angeles County will be capped at 200,000 enrollees.

The state will be holding a stakeholder call Thursday, March 28, from 1:00 to 2:00 PM PST (Link to Registration). Details on the MOU are available at CalDuals.org.

California Providers Brace for Potentially Deep Retroactive Medi-Cal Cuts. Last week, during an Assembly budget subcommittee hearing, the Director of the Department of Health Care Services, Toby Douglas, testified that if the state wins its appeal to cut Medi-Cal provider rates by 10 percent, those cuts would be retroactive to June 2011. To make the impact slightly less severe, the State could phase in the retroactive cuts over a four-year period, equating to about 15 percent provider cuts through 2017. Douglas warned that CMS could disallow federal funding absent the implementation of its retroactive cuts. Such a move could prove damaging to patient access as the ongoing implementation of the Affordable Care Act brings additional enrollees into the system.

In-Home Support Services Budget Cut Settlement Reached. On March 19, 2013, California announced an agreement with In-Home Supportive Services (IHSS) advocates that ends multiple lawsuits challenging automatic budget cuts for IHSS services. The settlement provides for an 8 percent cut, effective on July 1, 2013, and a 7 percent reduction in 2014, achieving original budgeted savings for the Department of Social Services, while

changing the cuts from permanent to temporary. The IHSS program helps the blind, disabled, or low-income seniors remain in their homes with personal care services, grocery shopping, laundry, and house cleaning. Medical certification will no longer be required. The agreement plans to restore funds in 2015, as long as California can obtain Federal approval of provider taxes to increase Federal funding.

Colorado

HMA Roundup – Joan Henneberry

Colorado Exchange to Assess a Special PMPM Fee. Colorado General Assembly member Beth McCann introduced a bill in the House (HB 13-1245) that would authorize the Colorado Health Benefits Exchange (COHBE) to assess a special fee of up to $1.80 per member per month against small employer and individual carriers. The bill would also allow the creation of a state tax credit for any insurance company that becomes a "qualified taxpayer" by making a qualifying contribution to the exchange. The bill comes approximately one week after the March 11 decision by the Colorado Health Benefit Exchange board to approve an administrative fee of 1.4 percent of premiums on insurance carriers that participate in the COHBE market place starting in 2014. The fees are part of the strategy of the COBHE board to pay the estimated $22-24 million in annual operating costs for Colorado to operate its own health insurance exchange. Colorado law prevents the exchange being funded with state tax revenue. The bill has been assigned to the House Health, Insurance, and Environment Committee. No hearing date has yet been set.

Connecticut

HMA Roundup

New Accountable Care Plans Announced. In the last two weeks, two notable accountable care plans have been announced between health plans and providers. Aetna and ProHealth Physicians will use Aetna's Healthagen EMR systems to coordinate the care for ProHealth's 30,000 Medicare patients in Connecticut, eventually expanding to the 23,000 patients covered by Aetna and treated by ProHealth. In a separate announcement, ConnectiCare and Hartford HealthCare agreed to establish an accountable care model to coordinate the care of 12,000 Medicare Fee-for-Service patients, leveraging care management and EMR systems.

In the news

- **"Connecticut Races To Reach Uninsured, Open Health Insurance Marketplace"**

  Connecticut, one of 16 states established its own exchange, is rapidly deploying outreach efforts to meet its goal of enrolling 220,000 currently uninsured individuals by March 2014. That amounts to more than two-thirds of the state's uninsured population – and twice the percentage expected to enroll in exchanges nationwide. (Kaiser Health News)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Governor Scott "Open" to Negron's Plan. On Monday, Governor Scott expressed "openness" to Senator Negron's Healthy Florida proposal (SPB 7038), which has been cleared by a Senate committee. The plan would deploy Medicaid expansion federal funds toward premium assistance for nearly one million uninsured Floridians, establish health savings accounts to reward healthy behavior, and institute cost-sharing provisions for beneficiaries over 100 percent FPL. Business and consumer groups have rallied behind the proposal, joining hospital trade groups aiming to shore up reimbursements otherwise threatened by the loss of disproportionate share payments. There has been bipartisan support expressed in the Senate, although House leadership is still opposed to any Medicaid expansion, despite mounting pressure to consider the proposal.

Universal Health Care HMO Transition. Florida Agency for Health Care Administration announced this week that the Universal Health Care will be placed into receivership on April 1, 2013 and all enrollees will be transitioned out of the plan. A judge approved the move last week after insurance regulators uncovered financial mismanagement, including fraud. Universal Health Care had 40,000 Medicare enrollees, 60,000 Medicaid enrollees, and 1,400 Nursing Home Diversion Program enrollees as of February. Medicaid enrollees will receive notification of their change in coverage and assignment to a new health plan if applicable.

Legislation Capping Repackaged Drug Charges Moving Through Committees. Leading business groups, retail pharmacies, and Blue Cross Blue Shield have pushed legislators to move legislation that would limit the amount physicians charge for repackaged drugs, in an effort to slow the growth in workers compensation costs. Separate House (HB 605) and Senate bills (SB 662) have moved through their respective committees, but Automated Healthcare Solutions and the Florida Medical Association are fighting the measures. Similar legislation made it through the legislature in 2010 only to be vetoed by Governor Crist.

Optometrist Prescribing Legislation Moves Toward a Final Senate Vote. On Friday, March 22, 2013, the House unanimously approved HB 239, a bill that expands optometrists' ability to prescribe 14 oral medications. A 72-hour limit would be imposed on analgesic and anti-glaucoma prescriptions. Optometrists are permitted to prescribe oral medication in 47 other states. Ophthalmologists and the Florida Medical Association oppose the measure. A Senate floor vote remains to be scheduled.

In the news

- **"Senate Republicans, Democrats Back 'Healthy FL'"**

  Senator Joe Negron's Healthy Florida plan, which would funnel federal dollars through the state's Florida Healthy Kids Corp., a non-profit entity, to offer coverage to the Medicaid expansion, received support from both democrats and republicans on the senate appropriations committee this week. (Health News Florida)

- **"Insurers gear up for managed care plans under Medicaid"**

  The Miami Herald looks at the state's Medicaid managed care plans as they prepare for the statewide managed care expansion set to kick off next year. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

Senate Adjusts House Budget Bill. Over the weekend, the Senate made modest adjustments to the House budget bill (for FY 2014), transferring some $250 million in budget funding from low income Medicaid to ABD and CHIP, and reinstating provider cuts proposed by the governor but rejected by the House. The Senate adjustments reject the governor's proposal to combine the ABD and low-income Medicaid budgets, while allowing for up to 10 percent flexibility in budget authority. The legislative session comes to a close on Thursday, March 28, 2013.

House Resolution 107 Progresses Toward Senate Vote. A bill forming a joint study committee on Medicaid reform, already passed by the House three weeks ago, has received a second reading in the Senate with a floor vote to follow. This legislation would create an 18 member panel, with 6 appointments each by the House, Senate, and Governor. The committee would be asked to evaluate the efficiency and effectiveness of current Medicaid policies and programs, Medicaid expansion authorized under the ACA, and models used in other states to ensure the sustainability of the Medicaid program. A report of its findings and recommendations would be submitted to the General Assembly and the Governor by December 31, 2013. In contrast to Senate Bill 163, there are no explicit references to implementing Medicaid managed care reforms.

Georgia Ends Medicaid Payments for Elective Early Births. Effective July 1, 2013, Georgia will stop Medicaid payments for elective C-sections and induced deliveries before 39 weeks, in a move to reduce medical complications and extended stays in neonatal units. Georgia health officials argue that optional early deliveries creates short-term costs of extended intensive care stays, as well as long-term costs of developmentally delayed children. It is estimated that the state would save $7 million in the next fiscal year by implementing this measure.

Senate Passes Dentist/Rx Licensing Bill. On Tuesday, March 26, 2013, the Senate overwhelmingly approved a bill (HB 132) to move licensing authority away from the Secretary of State to two new agencies under the Department of Community Health. The bill is being sent to Governor Deal for his signature.

Indiana

HMA Roundup – Cathy Rudd

Public Hearings for HIP Waiver Held on March 20 and 22. In response to an HHS requirement that the state hold public hearings on its proposed expansion of the Healthy Indiana Plan, the Pence Administration hosted public hearings on March 20 and 22. Hospitals and providers lauded the medical savings accounts as helpful in reducing charitable care to the uninsured, and encouraging personal responsibility. In addition,

healthcare industry representatives point to the $10 billion in additional federal funds that could support an additional 30,000 healthcare jobs over the next decade. Various advocates derided HIP for being insufficient in addressing the healthcare needs of the poor and middle class, citing delays in enrollment and inaccessibility to families making more than 138 percent of FPL. Nearly 40,000 Indiana residents are enrolled in HIP, and CMS approval must be received by June to continue the current waiver which enables HIP. It is expected that Indiana's application to renew and expand HIP will be submitted by April 11.

Medicaid Block Grant Bill to Be Heard on March 27. The Republican-backed Medicaid block grant legislation (SB 551, which passed 44-6 in late February) is scheduled to be heard by the House Public Health Committee on Wednesday afternoon, March 27. This legislation would empower the Medicaid agency to negotiate with the federal government to establish a block grant for Medicaid and administer a state Medicaid expansion using the Healthy Indiana Plan.

Maine

HMA Roundup

Maine Seeks Medicaid "Global Waiver" and 100 Percent Funding for Ten Years. In a March 18, 2013 letter to HHS Secretary Sebelius, Maine HHS Commissioner requested full Federal funding of the state's Medicaid expansion for a decade (rather than the three years written into the ACA law), as well as a "global waiver" that offers the state flexibility to make "holistic changes" in the Medicaid program. Because of Maine's prior actions to expand Medicaid coverage, Maine would be one of ten states that would not receive 100 percent of expansion costs during the 2014-2016 time frame. That said, a Kaiser study recently projected that Maine would be one of a handful of states to see state spending on Medicaid drop over the next decade due to the rising share of federal funds flowing into the program for populations already covered under a more generous Medicaid program.

Massachusetts

HMA Roundup – Tom Dehner and Rob Buchanan

Edes Appointed Ass't Secretary for The Office of Disability Policy and Programs. On Friday, March 22, 2013, HHS Secretary Polanowicz announced the appointment of Rosalie Edes as assistant secretary for the Office of Disability Policy and Programs. Edes has served as deputy assistant secretary for the Office of Disability Policies and Programs at HHS since 2009, with responsibility over a $2 billion budget. She helped develop community based Medicaid waiver programs, promoted family support initiatives, and represented HHS on a statewide Autism Commission. Previously, Edes worked as executive director of Minute Man Arc for Human Services, following nearly a decade at the Department of Public Health's Division for Special Health Care Needs.

Michigan

HMA Roundup – Esther Reagan

Medicaid Expansion at Risk Due to Delayed Legislative Action. Governor Rick Snyder has endorsed a Medicaid expansion that would extend Medicaid coverage to most non-elderly adults with income below 138 percent of the federal poverty level beginning on January 1, 2014. Enrollment is projected to average as many as 330,000 in 2014 and about 450,000 within two years. However, language and funding related to the expansion was omitted from House Bill 4213 before the bill was approved by the subcommittee and sent to the full House Appropriations Committee. Representative Matt Lori, the subcommittee chair, said additional information and education is needed on the full implications of the proposal before action is taken on the bill after the spring recess. The Senate has similarly delayed action on Senate Bill 198, its DCH appropriation bill until after the recess.

Michigan to Have a Federal Health Exchange. A federal Health Insurance Exchange will likely be implemented for Michigan because the Senate adjourned for their two-week spring recess on March 21, 2013 without voting on a bill to allow development of a state-federal partnership Exchange. In January 2013, Michigan received a $30.7 million grant from the federal government to support planning and implementation of the state-federal partnership Exchange. The grant was to support the state's efforts to design Navigator and In-Person Assister programs, establish information technology interfaces and design the health plan management functions of the state's Exchange. Expenditure of these funds required approval of the Michigan legislature, which did not occur. While the House of Representatives, which refused to approve expenditure of an earlier $10 million grant, approved appropriation of the new grant funds, the Senate did not. Because legislative approval was not obtained, the state will also need to designate $8.3 million required for the information technology to host the Exchange. On a related note, new Department of Insurance and Financial Services (DIFS) Director R. Kevin Clinton issued a bulletin on March 18, 2013 providing guidance pertaining to the new Exchange. Staff at DIFS have indicated they are hopeful the federal government will allow Michigan to retain the plan management portion of the Federal Exchange.

Antitrust Lawsuit Against BCBS of Michigan Dropped. Following the passage of legislation banning "most favored nation" clauses in provider contracts with insurers and non-profit corporations, the US Department of Justice and Michigan's Attorney General dropped their antitrust lawsuit against Blue Cross Blue Shield of Michigan. Governor Snyder signed the legislation into law last week and the Insurance Commissioner voided all such provisions as of February 1. The lawsuit had aimed to quell a practice that was deemed to cause higher prices to other health insurers.

In the news

- **"Medicaid expansion in trouble in Mich. Legislature"**

  Despite Governor Rick Snyder's endorsement of the Medicaid expansion, and support from several republican legislators, the expansion still faces stiff opposition. Gov. Snyder imposed a June 1 deadline for passing expansion legislation and some advocates view the legislature's recent refusal to partner with the federal government on the exchange as a bad sign for the Medicaid expansion. (Detroit News)

New York

HMA Roundup –Denise Soffel

Proposal to Allow For-Profit Investment in Hospitals is Dropped. Despite inclusion in Governor Cuomo's proposed budget, a proposal to allow for-profit investments in two hospitals in New York State was dropped by the Assembly. The Assembly's Health Committee Chairman, Richard Gottfried, refused to include the measure in the budget, according to sources. Senate Republicans had been supportive of the proposal.

NY State Awarded a Balancing Incentive Program Grant. CMS has awarded New York a nearly $600 million State Balancing Incentive Program (BIP) grant under Section 10202 of the Affordable Care Act from April 1, 2013 through September 30, 2015. The grant will help the state increase access to non-institutional long-term services and supports. The structural changes will include a single entry point, conflict-free case management, and use of a core standardized assessment instrument. A webinar will be held on Thursday, March 28 at 1:30 PM. Participants can register here. There will be no dial-in number.

In the news

- **"Plan to Allow Investment in 2 Hospitals Is Dropped"**

  Plans to allow for-profit investment in two hospitals has been dropped from the state budget. The state currently does not allow for-profit ownership and investment in hospitals. The plan was strongly opposed by the nurses' union and patient advocacy groups. (New York Times)

- **"U.S. Wants State to Pay After Audit of Youth Care"**

  A Federal audit identified $27.5 million in improper payments made by New York's Medicaid program for services to mentally ill and emotionally disturbed children and teenagers. This represents more than 80 of the paid amount during the audit period that CMS is requesting New York to repay. (New York Times)

Pennsylvania

HMA Roundup –Matt Roan

Corbett Meeting with Sebelius Scheduled for April 2. After a long period of uncertainty, it appears that Governor Corbett will meet with HHS Secretary Sebelius on April 2, 2013 to discuss options available to the state with Medicaid expansion. As more Republican legislators and advocates express support for Medicaid expansion in the state, the Governor will be under pressure to change his long-standing opposition to Medicaid expansion. Given the support expressed for Medicaid expansion by governors in nearby states and various mechanisms approved by HHS for implementing expansion, Corbett may be able to receive enough flexibility from HHS to rationalize a change in policy.

Behavioral Health Consultants Licensure Deadline Extended Through Year-End. An initial May 26 deadline requiring behavioral specialists to obtain a state license has been extended until January 1, 2014. Behavioral specialists serve children with autism spectrum disorders and other behavioral/developmental conditions. Community advocates have voiced concerns that a large swath of this workforce could not hit the state's dead-

line for licensure. Less than 20 percent of the 3000 behavioral specialist workforce have applied for licenses. It remains unclear how many could meet the requirements to obtain a license and how the provider community can respond to a potentially dramatic falloff in the supply of eligible behavioral specialists.

House Approves DPW Name Change. Last week, the House Human Services Committee approved a bill that would rename the Department of Public Welfare. If signed into law, the DPW would be recast as the "Department of Human Services", in an effort to remove the stigma associated with "welfare". While the name change could cost the state $8 million, the changes might be phased in over time to lower the immediate fiscal impact.

Texas

HMA Roundup –Dianne Longley and Linda Wertz

Developmental Disabilities Legislation Passes Senate. On Monday, March 25, 2013, the Texas Senate unanimously approved a redesign of Medicaid long term care services to expand care to more Texans with disabilities while saving millions of state dollars. Senate Bill 7 is estimated to support an additional 12,000 Texans with disabilities, while generating $8.5 million in savings over the 2014-2015 biennium through the expansion of managed care, improved monitoring, and functional assessment tools. After initial misgivings, certain advocacy groups for those with disabilities lent support to the legislation following an amendment that allows enrollees in Medicaid waiver programs to stay in those programs or opt-in to Medicaid managed care plans, as well as ensuring access to home- and community-based services to keep enrollees out of institutions. The bill moves to the House of Representatives for further consideration.

In the news

- **"Texas congressional Democrats ask Perry to reconsider his opposition to Medicaid expansion"**

  Texas democrats are continuing to push Governor Rick Perry on the Medicaid expansion. A delegation of congressional democrats asked Gov. Perry to reconsider his opposition to the expansion, citing the state's disproportionate number of uninsured residents and the savings the state would realize in current uncompensated care to this population. (Houston Chronicle)

- **"New fight brews over prison health care"**

  Senators are at odds over legislation to reauthorize the state's Department of Criminal Justice. Senator John Whitmire is proposing to include in the legislation an increase in the number of medical schools participating in prison health care from two to eight. Some legislators and prison health officials are concerned this opens the door for privatization of the state's prison health care. (Austin Statesman)

Wisconsin

HMA Roundup

Dual Eligibles Demonstration MOU Drafted for CMS Review. On March 27, 2013, the Department of Health Services (DHS) issued a draft memorandum of understanding for a Wisconsin dual eligible capitation demonstration. The demonstration intends to test the effect of an integrated care and payment model on both community and institutional populations. The demonstration intends to minimize cost-shifting, align incentives between Medicare and Medicaid, and support improved outcomes. Participating plans would be responsible for managing the blended capitated payment to meet the needs of enrollees, with great flexibility to innovate in the form of care delivery and community-based services to avoid expensive institutional settings.

This MOU was modeled after the agreement forged by the Massachusetts commonwealth and CMS on their duals demonstration. As a part of the CMS approval and MOU negotiation process, DHS has offered additional details on program design elements. The draft has not yet been approved by CMS and is subject to further review. Comments will be received by Friday, April 5, 2013.

Other Headlines

Alabama

- **"Alabama Legislature: Medicaid overhaul on tap; state hopes to save money by delivering health care using for-profit companies"**

  The state's legislature is set to take up a bill that would transition the Medicaid program to managed care by 2017. The plan divides the state into regions, with each region permitted to contract with a managed care organization if they so choose. (Montgomery Advertiser)

Idaho

- **"Senate OKs state-based insurance exchange"**

  Idaho's senate passed a bill to establish a state-based exchange for 2014 last week. Republican Governor Butch Otter has supported the legislations and indicated he intends to sign the bill into law. (Idaho State Journal)

Louisiana

- **"Louisiana state analysis of Medicaid expansion shows state could financially benefit"**

  Louisiana's Department of Health and Hospitals estimates that accepting the Medicaid expansion would bring more than 577,000 new Medicaid enrollees into the program under a "low-impact" scenario and save the state $367 million over the next decade. A "high-impact" scenario would enroll more than 650,000 with only $1.71 billion in new spending over the next decade, while greatly increasing Medicaid reimbursement rates to providers. (NOLA.com)

- **“Jindal cancels contract”**

  Governor Bobby Jindal’s administration canceled a contract with CNSI that would have paid the firm at least $185 million for Medicaid claims processing amid investigations into the relationship between CNSI and former employee and current Department of Health and Hospitals secretary Bruce Greenstein. (The Advocate)

Maryland

- **“Advocates, insurers duel over cost of child dental coverage”**

  Health advocates in Maryland are concerned that federal regulations under the Affordable Care Act may drive up costs for dental coverage among lower income parents, adding as much as $2,000 in out-of-pocket costs per year and undoing the state’s efforts to expand dental coverage and access for low income parents and children. (Baltimore Sun)

Mississippi

- **“Mississippi Dems Weigh 'Nuclear Option' to Force Medicaid Debate”**

  Democratic lawmakers in Mississippi are angling for a debate and vote on Medicaid expansion before reauthorizing the state’s Medicaid program. The current program expires July 1. The tactic has been used before when various proposals to cut eligibility had been broached. With a potential inflow of $15 billion in additional expansion-related federal funds over the next decade, Democrats see an opportunity to have a more public discussion about expanding the program. Some Republican legislators are contemplating a temporary extension of the program or opting for a premium-assistance model similar to Arkansas’ proposal. However, the legislative session ends on April 7, so there may be few options remaining. (Governing Magazine)

New Hampshire

- **“State prepares to go live with new Medicaid computer system”**

  New Hampshire’s new MMIS system, developed under a contract with Xerox, is set to go live after nearly eight years of planning and numerous delays. (New Hampshire Union Leader)

Tennessee

- **“Gov. Haslam says no to Tennessee Medicaid expansion”**

  Tennessee Governor Bill Haslam said in a press release Wednesday, March 27, that Tennessee would not expand Medicaid for 2014. Gov. Haslam is instead proposing an alternative to expansion that would leverage federal dollars to enroll the uninsured in private insurance plans, while assessing co-pays on those individuals who could afford them. Gov. Haslam’s plan also calls for a sunset of the alternative program unless reauthorized by the general assembly, and a reforming of payment structure to reward health outcomes. (Governor's Press Release via Times Free Press)

Virginia

- **"Conditions for expanding Virginia's Medicaid program"**

  Virginia's general assembly has set three conditions under which the state will accept the Medicaid expansion. First, at no point must federal funding drop below its currently level for the expansion population. Second, savings realized in the initial years will be held in an "innovation and reform" fund to be used for higher state costs in the outyears. Last, the state will negotiate with CMS on a waiver for more flexibility with administering Medicaid through managed care for the long term care population. (Richmond Times-Dispatch)

National

- **"Study: Claims costs that drive premiums will rise 32 percent in under health law"**

  The Society of Actuaries released estimates this week that out of pocket costs in individual health plans could rise 32 percent when the Affordable Care Act is implemented. The study cites the inclusion of sicker individuals with higher utilization and costs as the driver of the higher premiums. (Washington Post)

- **"GOP's 'no' on Medicaid becomes "Let's make a deal'"**

  Republican governors, seeing the potential for flexibility from CMS on the Medicaid expansion, have begun to propose alternatives to a traditional expansion. Governors from Florida, Ohio, Missouri, Nebraska, and Indiana, among others, are looking at opportunities ranging from vouchers for private insurance to the renewal of calls for block grants. (Bloomberg Business Week)

- **"Who Are The Uninsured? The Feds Parse The Numbers"**

  CMS published a brief last week on the uninsured population, providing a demographic profile targeted at those with an interest in enrolling the uninsured in Medicaid and the exchanges beginning in 2014. (Kaiser Health News)

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 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 9, 2013	Rhode Island Duals	Proposals due	22,700
April, 2013	Virginia Duals	RFP Released	65,400
May 1, 2013	Idaho Duals	RFP Released	17,700
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
June 1, 2013	California Rural	Implementation	280,000
June, 2013	Idaho Duals	Proposals due	17,700
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
August 1, 2013	Idaho Duals	Contract awards	17,700
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Rhode Island Duals - Medicaid Only	Implementation	22,700
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
October 1, 2013	California Duals	Implementation	500,000
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	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	Idaho Duals	Implementation	17,700
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	456,000	X	3/1/2012	4/4/2012	X	10/1/2013
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	May 1, 2013	Q2 2013	August 1, 2013		3/1/2014
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**	**1.6M Capitated 485K FFS**	***6***			***5***	

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

+ Contracts were awarded in March 2013 to plans in the Acute Care and Maricopa RHBA programs. These plans will manage the dual benefit under the demonstration.

‡ Capitated duals integration model for health homes population.

HMA WEBINARS

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

Donna Strugar-Fritsch – Host

Monday, March 25, 2013

On March 25, 2013 HMA hosted a webinar by Principal Donna Strugar-Fritsch, "New Faces in the Expansion Population: Parolees and Ex-Offenders." Donna, who has a BSN with a master's in public administration and is a certified correctional health care professional, talked about the challenges and opportunities of covering this special (and large) population. Link to Recorded Webinar/Slides

Replay: *"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

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

HMA Recent Publications

"Early Adopters of the Accountable Care Model: A Field Report on Improvements in Health Care Delivery"
Commonwealth Fund

Sharon Silow-Carroll, M.B.A., M.S.W. – Author
Jennifer N. Edwards, Dr.P.H., M.H.S. – Author

Based on interviews with clinical and administrative leaders, this report describes the experiences of seven accountable care organizations (ACOs). Despite gaps in readiness and infrastructure, most of the ACOs are moving ahead with risk-based contracts, under which the ACO shares in achieved savings; a few are beginning to accept "downside risk" as well. Recruiting physicians and changing health care delivery are critical to the success of ACOs—and represent the most difficult challenges. ACO leaders are relying on physicians to design clinical standards, quality measures, and financial incentives, while also promoting team-based care and offering care management and quality improvement tools to help providers identify and manage high-risk patients. The most advanced ACOs are seeing reductions or slower growth in health care costs and have anecdotal evidence of care improvements. Some of the ACOs studied have begun, or are planning to, share savings with providers if quality benchmarks are met. (Link – PDF)

"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.