HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: MARYLAND PROPOSES MODERNIZED HOSPITAL RATE-SETTING

HMA ROUNDUP: FLORIDA PUBLISHES STATEWIDE MEDICAID MANAGED CARE BIDDERS; FLORIDA, INDIANA, PENNSYLVANIA CONTINUE TO PURSUE MEDICAID EXPANSION ALTERNATIVES; NEW YORK FINALIZES BUDGET; LOUISIANA DHH SECRETARY RESIGNS

IN THE NEWS: DC AWARDS THREE MEDICAID MCO CONTRACTS; NEW MEXICO GOVERNOR SIGNS EXCHANGE BILL; MISSISSIPPI MEDICAID EXPANSION FIGHT CONTINUES; WELLCARE COMPLETES ACQUISITION OF AETNA'S MISSOURI CARE PLAN

HMA RECENTLY PUBLISHED RESEARCH:
"GUIDE TO HEALTHCARE DELIVERY SYSTEM AND PAYMENT REFORM: PLANNING AND DESIGN"

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

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IN FOCUS: MARYLAND PROPOSES MODERNIZED HOSPITAL RATE-SETTING

This week, our *In Focus* section comes to us from HMA Managing Principal Theresa Sachs. Ms. Sachs summarizes the State of Maryland's proposal to tie hospital costs to overall economic growth. Maryland is in the unique position to implement such a proposal on top of its all payer hospital rate setting, which has allowed the state to set hospital payment rates for all payers for the past 40 years.

Background

Since the late 1970s, Maryland's independent Health Services Cost Review Commission (HSCRC) has set hospital inpatient and outpatient reimbursement rates for all public and private payers. According recent testimony (March 26, 2013) on the new proposal, this structure has provided major benefits to Maryland residents, including:

- eliminating cost-shifting between payers;
- allowing for creative uses of incentives to improve quality and outcomes;
- substantially limiting the growth of hospital per-case costs;
- providing for lower costs on an all-payer basis within the region;
- providing a stable and predictable payment system for hospitals;
- promoting financial stability for efficient and effective hospitals; and
- supporting equitable funding of uncompensated care and medical education.

The current rate-setting system, however, is not without limitations. When the system was developed, inpatient services were predominant, and cost per discharge and average length of stay were the only measures for efficiency. Recent testimony on the new proposal argues that focusing mainly on per-case costs does not incentivize the broader coordinated care across health care settings that is necessary for improved population health.

Modernizing All-Payer Rate Setting

Last week, the State of Maryland submitted for federal approval a novel plan for building upon its unique all payer hospital rate setting system. The new plan will limit cost growth for inpatient and outpatient hospital services to the rate of growth in the state economy on a per person basis. The state has proposed many tools to achieve those savings, including Accountable Care Organizations (ACOs), bundled payments, incentives to reduce unnecessary readmissions, and global payments. Some of these tools have been used under the current 40-year waiver, which allows the state to set rates across all payers irrespective of Medicare rate requirements, provided certain conditions are met, but on a more limited basis. The new model would shift from an evaluation methodology based on costs per Medicare case to one based on controlling the rate of cost growth on a per capita basis. The model also features incentives that would focus on quality of care and patient experience.

National policy experts and stakeholders in the state alike describe the new plan as bringing about dramatic and sweeping change. National health policymakers hail the Maryland system as the only remaining state that has rate setting and look forward to seeing how some of the new payment and delivery system reforms will play out in an all payer environment. Most of the details in the plan will be determined by a rate setting body known as the Maryland Health Services Cost Review Commission in a public process that includes those stakeholders.

Maryland's rate setting process has been in place since the 1970s, with a Medicare waiver dating from 1977. Under the waiver, State payments per admission for Medicare had to be below the national Medicare cumulative per case growth, a condition the State has met since the inception of the waiver.

The proposed model would modernize this system and align hospital incentives with the three-part aim of enhanced patient experience, improved outcomes, and lower overall costs. It would be in effect for five years, and state plans to submit a revised model that would be more inclusive of costs across the system by the beginning of year four.

The new plan will adopt many payment reforms that will require delivery system changes. In Maryland, ACOs can include all payers—permitting sharing of savings between payers and providers for more integrated, better quality care that is less costly. Bundled payments will allow for set payments for a particular procedure or service, combining costs for hospital, physician and other providers. The plan will also provide opportunities for global payments to hospitals that currently operate in rural settings. The plan will also expand on penalties for unnecessary admissions and readmissions.

Next Steps

Negotiations over the new plan still need to be concluded with the federal government. State officials estimate that the earliest the plan will take effect is January, 2014.

HMA has been assisting the State of Maryland with the preparation and submission of the new model. For recent legislative testimony about the state's proposal, see http://dhmh.maryland.gov/pdf/Colmers-Sharfstein-Senate-testimony.pdf

HMA MEDICAID ROUNDUP

Arizona

HMA Roundup

Arizona Grants Capped Contract to Phoenix Health Plan. Vanguard Health Systems' Phoenix Health Plan was granted a capped contract in Maricopa County to continue serving as a Medicaid MCO despite losing out in last month's reprocurement. Under the capped contract, Phoenix Health Plan may retain its current members, but accept no new enrollments. As such, it would be expected to see a gradual decline in Phoenix Health Plan's enrollment as members phase out of eligibility or opt for other plans. Phoenix was the only unsuccessful incumbent in Maricopa County, and currently enrolls roughly 95,000 members out of more than 630,000 members in the region. The region's only new plan, Health Net of Arizona, may see limited enrollment when contracts go live in October until a scheduled open enrollment period yet to be scheduled for 2014. Phoenix Health Plan also requested a capped contract in Pima County, which was denied.

Arkansas

HMA Roundup

GOP Legislative Leaders Commit to Passing Medicaid Expansion. On Monday, April 1, 2013, Republican legislative leaders voiced their support for Governor Beebe's Medicaid expansion proposal involving premium support for plans offered on Exchanges. Senate President Pro Tem Lamoureux dubbed the Arkansas plan a "win-win." House Speaker Carter and Lamoureux committed to passing the Medicaid expansion legislation and appropriation before the end of this legislative session.

California

HMA Roundup – Jennifer Kent

Legislation Challenges Tax Exemptions for Profitable Hospitals. On Tuesday, April 2, 2013, Assembly Bill 975 got its first hearing with the Health Committee. The legislation would establish tougher standards of oversight and scrutiny for private, non-profit hospitals whose operating margins exceed 10 percent, potentially removing tax exemptions from those institutions. Not-for-profit hospitals would be expected to spend a minimum of 8 percent of their annual operating margin on charity care by 2015. In 2012, a research arm of the California Nurses Association (CAN) released a study that claimed tax exemptions for not-for-profit hospitals exceeded charity care by more than $2 billion annually. The CNA supports the bill for promoting greater accountability to the communities they serve. California hospitals have vehemently opposed this bill, claiming that key services could be at risk of elimination, including cancer research, trauma centers, burn units, and training.

In the news

- **"State hires consumer group to help it review healthcare rates"**

  Insurance providers and policy experts responded this week to the announcement that California Insurance Commissioner Dave Jones had hired Consumer Watchdog, one of the state's most outspoken critics of the insurance industry, to supplement state review of insurance rate increases. (Los Angeles Times)

- **"New Survey Offers First Data on Managed Care Shift'**

  A survey released last week indicates that roughly two-thirds of aged and disabled Medi-Cal beneficiaries who were transitioned into managed care in 2011 are receiving the same or better quality care. However, the survey revealed issues regarding information provided to enrollees and issues with prescriptions, specialty care, and medical equipment. (California Healthline)

Colorado

HMA Roundup – Joan Henneberry

Joint Budget Committee Staff Recommendations for 2013-2014 DHS Budget. In March, the Joint Budget Committee (JBC) heard staff recommendations regarding the Colorado FY 2013-2014 Executive Budget Request for the Department of Human Services (DHS) and the Department of Health Care Policy and Financing (HCPF). JBC staff recommendations do not necessarily reflect the final decisions of the committee. Except where noted, JBC staff recommendations reflect the requests of the Departments.

JBC staff recommended several actions to strengthen Colorado's behavioral health system, including the establishment of a comprehensive statewide behavioral crisis care system, as well as a mobile crisis center statewide extension and short-term residential services, neither specifically requested by the Departments. JBC staff recommended expanding community services for individuals with behavioral health needs to help avoid institutional placement and increasing the number of available beds for individuals who have been determined by the court to be "Incompetent to Proceed." JBC staff recommended a 1.5 percent increase for community-based behavioral health services and for most other Medicaid provider types, as well as a 4.0 percent increase for the developmental disabilities program. JBC staff did not recommend HCPF's request for a Dental Services Organization for children's dental benefits. JBC declined to recommend legislation for an adult dental benefit. In addition, JBC staff recommended funding for the re-procurement of the Colorado MMIS system, implementation of technological changes to improve the operation of the HCPF customer contact center, a new data system to manage protection and advocacy for at-risk adults, and an Integrated Behavioral Health Services Data Collection System that consolidates mental health, substance use, and physical health. Finally, JBC recommended the Division of Developmental Disabilities transition from DHS to HCPF. Neither department had requested this change.

Connecticut

HMA Roundup

Connecticut Exchange Supports Role for Insurance Brokers. As one of the states running its own health exchange, Connecticut exchange officials have endorsed the payment of commissions by insurance carriers to insurance brokers that enroll clients in the exchange. Because brokerage fees are considered administrative expenses, which do not apply toward minimum medical loss ratios, fees have been coming down across the industry. Access Health CT sees brokers as an important part of the solution in educating and enrolling qualified individuals in the exchanges.

Delaware

HMA Roundup

Stephen Groff Named Medicaid Director. After having served as the acting Medicaid Director since January, Stephen Groff was appointed Director on March 25, 2013. Previously, Mr. Groff was Deputy Director of the Division of Medicaid and Medical Assistance. For 26 years, Mr. Groff has worked for the Department of Health and Social Services where he focused on policy and budget matters.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Statewide Medicaid Managed Care ITN Bidders Released. Responses to the statewide Medicaid managed care ITN were made public this week. MCOs bidding on the ITN were Amerigroup, Coventry, Florida True Health, Freedom Health, Humana, Molina, Preferred Medical Plan, Simply Healthcare Plans, Sunshine State Health Plan (Centene), UnitedHealthcare, and WellCare. Coventry, Humana, Centene, United, and WellCare each bid on all eleven regions statewide. Responses were also accepted from Provider Service Networks (PSNs) and Specialty Plans. A full table of respondents by region is included below.

	Region											
Plan Name	1	2	3	4	5	6	7	8	9	10	11	TOTAL
AHF MCO of Florida, Inc. D.B.A. Positive Healthcare Florida HIV/AIDS Specialty Plan										X	X	2
Amerigroup Florida, Inc.					X	X	X	X	X	X	X	7
Better Health, LLC - PSN	X	X				X				X		4
Care Access PSN, LLC - PSN											X	1
Coventry Health Care of Florida, Inc.	X	X	X	X	X	X	X	X	X	X	X	11
First Coast Advantage, LLC - PSN			X	X								2
Florida MHS, Inc. d/b/a Magellan Complete Care Serious Mental Illness Specialty Plan		X		X	X	X	X		X	X	X	8
Florida True Health, Inc.	X									X		2
Freedom Health, Inc.			X		X	X	X	X	X	X	X	8
Freedom Health, Inc. Cardiovascular Disease (CVD) Specialty Plan			X		X	X	X	X	X	X	X	8
Freedom Health, Inc. Chronic Obstructive Pulmonary Disease (COPD) Specialty Plan			X		X	X	X	X	X	X	X	8
Freedom Health, Inc. Congestive Heart Failure (CHF) Specialty Plan			X		X	X	X	X	X	X	X	8

Plan Name	Region 1	2	3	4	5	6	7	8	9	10	11	TOTAL
Freedom Health, Inc. Diabetes Specialty Plan			X		X	X	X	X	X	X	X	8
Humana Medical Plan, Inc.	X	X	X	X	X	X	X	X	X	X	X	11
Integral Health Plan, Inc. dba Integral Quality Care - PSN	X					X		X				3
Molina Healthcare of Florida, Inc.	X			X	X	X	X		X	X	X	8
Preferred Medical Plan, Inc.										X	X	2
Prestige Health Choice - PSN		X	X		X	X	X	X	X		X	8
Salubris, LLC - PSN									X	X	X	3
Simply Healthcare Plans, Inc.					X						X	2
Simply Healthcare Plans, Inc. d.b.a. Clear Health Alliance HIV/AIDS Specialty Plan	X	X	X	X	X	X	X	X	X	X	X	11
South Florida Community Care Network (SFCCN) - PSN										X	X	2
Sunshine State Health Plan, Inc.	X	X	X	X	X	X	X	X	X	X	X	11
Sunshine State Health Plan, Inc. Child Welfare Specialty Plan	X	X	X	X	X	X	X	X	X	X	X	11
UnitedHealthcare of Florida, Inc.	X	X	X	X	X	X	X	X	X	X	X	11
WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida	X	X	X	X	X	X	X	X	X	X	X	11
WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida Child Welfare Specialty Plan	X	X	X	X	X	X	X	X	X	X	X	11
HMOs	7	5	6	6	9	8	8	7	8	10	10	
PSNs	2	2	2	1	1	3	1	2	2	3	4	
Specialty Plans	3	4	7	4	8	8	8	7	8	9	9	

FY14 Initial Budgets Pass House and Senate. The Florida Senate Appropriations Committee on Wednesday, April 3, 2013 passed with unanimous bipartisan support a $74.3 billion budget that gives teacher's pay-raises, adds millions of dollars into university construction, and includes many hometown projects. The Senate budget does not include any money from the federal health-care reform's Medicaid expansion. The House Appropriations Committee also passed a $74.4 billion budget that included increases on education spending and merit pay raises. The House's budget passed by a 14-9, party line vote, over Democratic objections to the refusal of Republicans to include a federally funded Medicaid expansion. Both budgets, however, increase the $21 billion Medicaid program by about $1 billion.

Medicaid Alternative Bill Gets a Hearing from Senate Health Policy Committee. On Tuesday, April 2, 2013, the Senate Health Policy Committee approved (6-3) its chairman's legislation, SPB 7144, as an alternative to Medicaid expansion. Senator Aaron Bean's bill would create the "Health Choice Plus Program," designed to provide premium support to adults under 100 percent of FPL. The program would rely on Florida Health Choices for administration. In addition, Bean's proposal would create health benefit accounts to encourage greater financial responsibility among the beneficiaries. The legislation would add funds into the health accounts for beneficiaries who demonstrate healthy behavior. County and federally qualified health centers would play a larger role in the delivery of care to beneficiaries in this legislation. Bean estimates the state would have to spend $30 million to $40 million a year to help about half of the 600,000 eligible beneficiaries. Enrollees would have to pay at least $20 a month for their plans, while the state subsidy would be limited to about $10 a month. Unlike Senator Negron's Medicaid bill, which would qualify for Federal expansion funds, this bill has received little to no support from Democrats in the legislature to date.

Nursing Home Malpractice Reform Bill Approved by Senate Judiciary Committee. A bill changing the rules governing lawsuits against nursing homes (SB 1384) was approved by the Senate Judiciary Committee on April 1, 2013. The legislation would require that before a lawsuit could proceed, an evidentiary hearing would need to demonstrate that a breach of a legal duty resulted in an actual loss, injury, or damage to a resident. The bill's sponsor, Senator Bill Galvano said that the legislation is intended to raise the threshold for lawsuits to ensure that claims can be tested before going to trial. He claims that the burden of proof and the opportunity to seek punitive damages would remain unchanged. Advocates have opposed this bill on the grounds that it would make it harder for the elderly to receive compensatory awards and would undermine corporate accountability for poor quality of care. The bill would have to clear the Senate Rules committee before a floor vote.

Assisted Living Oversight Bill Clears Senate Judiciary Committee. On April 1, 2013, the Senate Judiciary Committee unanimously approved SB 646, a bill that would strengthen oversight of assisted living facilities, increase penalties for the abuse of residents, and mandate additional inspections by the Agency for Health Care Administration. Furthermore, AHCA would be given the discretion to revoke the license of a facility if the controlling interest had at least a 25 percent interest in a different facility that received sanctions. The bill will be sent to the Senate floor for a vote. There are at least three related House bills covering some of the same issues.

Georgia

HMA Roundup – Mark Trail

Georgia Health Legislation Update. With the close of the 2013 legislative session, the Georgia legislature passed a number of key health care bills under the wire. House Resolution 107 creates the Joint Study Committee on Medicaid Reform to determine appropriate changes to ensure sustainability. The committee will consist of members chosen by the House, the Senate, and the Governor and will be required to offer recommendations to the General Assembly by December 31, 2013. House Bill 240 ensures that speech-language pathologists who are clinical fellows licensed by the State Board of Examiners are reimbursed the same amount as are fully licensed speech language pathologists. Finally, Senate Bill 62 establishes the Federal and State Funded Health Care Financing Programs Overview Committee and amends the provider tax legislation (SB 24) to remove the prior limitation on any legislative or regulatory action that would have the effect of reducing Medicaid payments to hospitals.

Indiana

HMA Roundup – Cathy Rudd

Medicaid Expansion Bill Using HIP Passes House Committee. On April 1, 2013, the Indiana House Public Health Committee approved (8-5) a bill that would expand Medicaid using the Healthy Indiana Plan. However, the committee modified Senate Bill 551 by replacing the governor's requirement for federal block grants with standard Medicaid

matching funds. The Senate bill had required the use of HIP to expand Medicaid, while the House version gives the Pence Administration more latitude to determine appropriate changes. The bill would cancel any agreement should federal matching funds for the expansion population drop below 90 percent. The House amended the requirement for the office of Medicaid policy and planning to present a report addressing the possibility of mandating managed care for the ABD population from August 1, 2013, to December 15, 2013. The author of SB 551 bill, Senator Pat Miller, opposes the changes but recognizes the House move is but one move in what may be an extended period of negotiations before the end of the legislative session in late April.

Louisiana

HMA Roundup

DHH Secretary Resigns; Deputy Secretary Named as Interim Replacement. On March 29, 2013, Department of Health and Hospitals Secretary Bruce Greenstein resigned, effective May 1, 2013. The Jindal Administration had recently canceled an MMIS contract with CNSI, which had previously employed Greenstein, and a grand jury has requested more information about the process. Governor Jindal appointed Deputy Secretary Kathy Kliebert as interim secretary. Kliebert had previously served in leadership positions with the Citizens with Developmental Disabilities, Behavioral Health, Public Health, and Aging and Adult Services.

HHS Has Not Received Waiver Request from Louisiana. Following a DHH study that indicates potentially $368 million in savings from Medicaid expansion over the next decade, there has been renewed pressure to pursue Medicaid expansion dollars. The Jindal Administration insists on more flexibility before considering an expansion but has not submitted a waiver with the Department of Health and Human Services to formally request such flexibility. The Jindal Administration has ruled out the expansion of the traditional Medicaid program to expand coverage, although HHS has publicly noted flexibility in considering state proposals, including programs emphasizing private plans in Arkansas and Florida.

Massachusetts

HMA Roundup – Tom Dehner and Rob Buchanan

Committee on Public Health Holds Hearing on Regulation of Compounding Pharmacies. Massachusetts lawmakers are evaluating new regulations to oversee sterile compounding pharmacies, following a deadly nationwide fungal meningitis outbreak linked to a Massachusetts steroid distribution firm. On Tuesday, April 2, 2013, the Committee on Public Health scheduled a hearing on proposals that call for tougher standards, including one supported by Governor Patrick that would require the Pharmacy Board of Registration to include more non- pharmacists and mandate state licenses before distributing drugs.

Michigan

HMA Roundup – Esther Reagan

Michigan and Ohio Establish HIE Clinical Exchange. Michigan Health Connect and Ohio's CliniSync health information exchanges will enable physicians to exchange medical records across state borders through secure, encrypted emails. This agreement allows for more comprehensive, user-friendly, real-time access to clinical information, which may forestall the need to pursue redundant tests. The encrypted emails will leverage the Nationwide Health Information Network.

In the news

- **"Federal Court Strikes Down Blue Cross of Michigan's Denial of Applied Behavior Analysis Therapy to Children with Autism"**

  A federal district court has ruled that Blue Cross Blue Shield of Michigan's denial of ABA therapy to children with autism was illegal. As a result, the therapy will be covered for over 500 children with autism in Michigan. BCBS of Michigan denied coverage on the basis that the therapy was experimental. (PR Newswire)

New York

HMA Roundup – Denise Soffel

NYS $135B Budget Enacted On-Time for Third Consecutive Year. The legislature finalized their actions on the state budget, enacting the budget before the April 1 deadline, making the first time New York has had three consecutive on-time budgets since 1983. The total budget of $135.1 billion closes an estimated gap of $1.3 billion. Total Medicaid spending, including federal, state and local share, is projected at $57.6 billion. The global Medicaid spending cap, which was enacted two years ago, will increase by 3.9 percent, reflecting the 10-year rolling average increase in the Medical CPI. The budget includes statutory changes necessary to implement the New York State Health Benefit Exchange. The budget reflects a $90 million cut to the Office for People with Developmental Disabilities (OPWDD), necessitated by reductions in federal aid. The Governor had proposed cutting the OPWDD budget by $240 million, an amount that was reduced by the legislature.

Other changes from the Executive Budget proposal include the following:

- **Prescriber Prevails.** Governor Cuomo had proposed eliminating Medicaid prescriber-prevails regulations for atypical antipsychotics, the last class of drugs where the regulation applies. Instead, the new state budget expands prescriber-prevails rules, applying them to eight additional drug classes for Medicaid managed care recipients, starting July 1. The prescriber-prevail rules continue for all classes of drugs in the fee-for-service program.
- **No Scope of Practice Changes.** Governor Cuomo's budget proposal included a number of changes in scope of practice that would have increased access to primary care services. Those changes were eliminated from the final budget. One proposal would have removed a requirement for nurse practitioners to have a written practice agreement with a physician if the nurse practitioner is delivering only

primary care services. A proposal to create a pilot program allowing home health aides to administer medication in certain circumstances was also eliminated. These proposals were strongly opposed by the Medical Society of the State of New York and other organized physician groups.

- **Psychiatric Hospital Closures Delayed.** The Governor had proposed further consolidation and down-sizing of the state psychiatric facilities. New York has twice as many state-operated psychiatric hospitals as any other state and spends more money while serving fewer people than any other state. The Office of Mental Health proposed consolidating the system, establishing regional centers of excellence, reducing the number of hospitals and of hospital beds, and reinvesting in the community savings that result from downsizing the hospital sector. Public-sector unions successfully defeated those proposals, prohibiting any closure or reduction without a one-year notice of such act.
- **Delivery System Reform Incentive Payments (DSRIP) Established.** The budget creates a statutory framework for the state to establish a Delivery System Reform Incentive Payments (DSRIP) program. Mirroring programs in California and Texas, DSRIP creates a mechanism for public hospitals to fund delivery system reforms by using intergovernmental transfers to fund the non-federal share of Medicaid. The NYS 1115 waiver amendment request for $10 billion over five years to reinvest in Medicaid redesign includes $1.5 billion targeted specifically to public hospital innovation.

NYS Medicaid Managed Care Advisory Review Panel Update. On April 3, 2013, the New York State Medicaid Managed Care Advisory Review Panel held its bi-monthly update call. Below, we offer key takeaways:

- HealthFirst acquired Neighborhood Health Plan early in 2013; they will be merging operations effective June 1.
- HealthNow is withdrawing from the Medicaid managed care and Family Health Plus programs in Genesee and Niagara counties due to financial losses. This represents about 23 percent of HealthNow's total enrollment in public programs.
- The mandatory MLTC program for dual-eligibles requiring more than 120 days of community-based long-term services and supports will be expanded to Rockland and Orange counties effective June 2013.
- New York State has received federal approval for the next phase of the transition of benefits and populations into managed care, the Care Management for All initiative.
- Long Term Home Health Care Program: Individuals currently receiving services through the Long Term Home Health Care Program 1915(c) waiver program will now be enrolled into mainstream Medicaid managed care plans or MLTCs. For the 8 counties where the mandatory MLTC program is established (NYC, Nassau, Suffolk and Westchester), dual-eligible individuals currently enrolled in LTHHCP will be transitioned into MLTCs. The state estimates this includes 17,600 beneficiaries. Enrollment will continue statewide as MLTC capacity is established. For non-duals, an

estimated 3,100 individuals, the transition into mainstream Medicaid managed care will occur statewide.

- In preparation for enrolling the LTHHCP population the state has added two benefits to the Medicaid benefit package: medical social services and home-delivered meals.
- Individuals enrolled in the Medicaid Buy-In Program for Working People with Disabilities are moving into Medicaid managed care effective April 2013.
- As part of the MRT Basic Benefit Review work group, the state is committed to adding benefits to Medicaid that are evidence-based, particularly those recommended by the United States Preventive Services Task Force (USPSTF). One of the work group recommendations was to provide Medicaid reimbursement for International Board Certified Lactation Consultant (IBCLC) services for eligible pregnant women, with the goal of improving the health of infants, reducing short term health care costs, and potentially contributing to reductions in obesity. This is now a covered benefit.
- Finally, the state has requested approval from CMS for additional phases of expansion.
    - For July 2103: Adult Day Health, Adult AIDS Day Health, and Tuberculosis Directly Observed Therapy.
    - For October 2103: Individuals residing in nursing homes (non-duals).

Pennsylvania

HMA Roundup – Matt Roan

Corbett Notes Interest in Premium Support for Medicaid Expansion. The day after his April 2, 2013, meeting with HHS Secretary Sebelius, Governor Corbett expressed interest in deploying Medicaid expansion funds toward premium supports in private plans, although he has made no definitive decision about recommending an expansion to the state legislature. The governor is evaluating the option, which could mirror the Arkansas proposal broached last month by Governor Mike Beebe. Secretary Sebelius' office hopes to continue the dialogue with Pennsylvania to expand coverage to uninsured Pennsylvanians.

RAND Study Projects Economic Impact of Medicaid Expansion. The Hospital and Health System Association of Pennsylvania sponsored a report by the RAND Corporation to assess the economic impacts of Medicaid expansion in Pennsylvania. The study projects coverage expansion for 350,000 low-income, non-elderly Pennsylvanians who would otherwise lack insurance. Moreover, RAND forecasts that Medicaid expansion would bring in $2.2-$2.5 billion in additional Federal funds annually, while yielding an additional $3.2-$3.6 billion in annual economic activity. This growth would add more than 35,000 jobs. While the study also forecasts more than $1.6 billion in state costs over the next seven years, RAND believes that an additional $1.46 billion in tax collections from Medicaid managed care plan taxes would very nearly cover the incremental state costs.

DPW Details ACA-Related Physician Fee Increases. The Department of Public Welfare's Office of Medical Assistance Programs (OMAP) provided an update on the implementation of physician fee increases that are a part of the ACA.

- The State Plan Amendment is still CMS approval.
- MCOs have been asked by OMAP to provide their plans for implementing the fee increases by April 9th.
- The deadline for provider attestation is April 1 in order to receive the increased rates retroactive to January 1 2013.
- OMAP reported an agreement with CMS to create a crosswalk of the Vaccine codes that OMAP uses today with the higher level codes that were included in the CMS regulations for increased reimbursement. By completing the crosswalk, OMAP will have a mechanism to apply the increased rates to the more detailed vaccine codes that the Department uses.

Texas

HMA Roundup – Dianne Longley and Linda Wertz

Perry Continues Rejection of Medicaid Expansion. On April 1, 2013, Governor Rick Perry joined with the state's two U.S. Senators to emphatically reject Medicaid expansion. The governor dubbed the program a "broken system" that threatens to gobble up progressively more of the state budget. Democrats responded with their own press conference to push for active engagement with the Obama Administration to secure the nearly $100 billion in additional Federal funds that would flow into the state over the next decade. The Texas Senate's initial budget had included provisions that required the HHS Commission to develop a plan for more efficient healthcare coverage options and receive written approval from the Legislature before changing Medicaid eligibility.

In the news

- **"Texas Medicaid debate ignites in Austin"**

  Governor Rick Perry and fellow state republicans continued their strong stance in opposition to the Medicaid expansion this week, while reports emerged that local politicians and business leaders have upped their push for the Governor to expand Medicaid, citing the savings to state taxpayers. (San Antonio Express-News)

Vermont

HMA Roundup

Vermont the First State to Post 2014 Individual Health Insurance Rates. In contrast to recent headlines predicting dramatic increases in individual premiums, Vermont's first-in-the-nation posting of 2014 rates were consistent with current levels. While the state does not constitute a representative sample, given its existing prohibition on the use of health status in rate setting, it does represent a marked difference from the shocking rate increases some have predicted for other states. Vermont's bronze plans range from $4,200 to $4,440 in annual premiums.

National

HMA Roundup

Medicare Advantage Rates in FY14 Assume Physician Fix. On April 1, 2013, CMS issued Medicare Advantage rates for FY 2014 that assume Congress will override the Sustainable Growth Rate formulaic cut in physician rates under Medicare. Such an assumption has proven appropriate for the last decade, with an annual "physician fix" instituted before draconian cuts went into effect. As a result of this change in actuarial methodology, Medicare Advantage plans avoided a planned 2.2 percent rate cut that had initially been released in February.

CMS Releases Final FMAP Rule. On March 29, 2013, CMS released the final FMAP rule, which requires states to use the MAGI threshold methodology when calculating the FMAP for newly eligible Medicaid beneficiaries. States may receive the enhanced match for individuals above the "threshold" limit of eligibility based on December 1, 2009, standards. The final rule details the calculation of FMAP for "expansion states," which receive different enhanced matches for non-pregnant, childless adults because of more generous optional coverage offered prior to December 1, 2009. The regulation is posted at http://www.ofr.gov/OFRUpload/OFRData/2013-07599_PI.pdf

CMS Offers Clarification on Premium Assistance Proposals. On March 29, 2013, the Centers for Medicare and Medicaid Services (CMS) offered greater clarity about the various premium assistance options being pursued by states in implementing Medicaid expansion. CMS notes that premium assistance can be implemented by state plan amendment, rather than a waiver, although states must have "wrap-around" provisions to ensure that benefits are not inferior and cost-sharing provisions are not too great, relative to traditional Medicaid coverage. CMS emphasizes that beneficiaries must have an option other than private insurance coverage to receive Medicaid benefits.

In the news

- **"Confirmation hearing set for top healthcare nominee"**

  Marilyn Tavenner's nomination to lead the Centers for Medicare & Medicaid Services (CMS) will be heard by the Senate Finance Committee on April 9. Tavenner has received support from some prominent republicans, including House Majority Leader Eric Cantor. Tavenner has lead CMS in an acting role since last year. (The Hill)

- **"So you want to privatize Medicaid? Has HHS got a guide for you."**

  Washington Post blogger, Sarah Kliff breaks down the key highlights of a Q&A document released by CMS last week on the option for states to expand Medicaid through an Exchange, as is being pursued by Arkansas and drawing interest from other states. The CMS Q&A is available here. (Washington Post)

- **"Tight Medicaid Eligibility Leads To More Adults Delaying Care"**

  Research published in the New England Journal of Medicine found that states with tighter restrictions on Medicaid eligibility had higher rates of low-income adults delaying necessary medical care. (Kaiser Health News)

OTHER HEADLINES

District of Columbia

- **"Three firms picked for D.C. Medicaid contracts"**

  D.C.'s Medicaid agency announced final awards in the Medicaid managed care re-procurement last week, awarding contracts to incumbent MedStar Family Choice and newcomers AmeriHealth Mercy and Thrive Health Plan. AmeriHealth Mercy's award paves the way for completion of its acquisition of Chartered Health Plan, which was placed into receivership by the city. Incumbent UnitedHealthcare was not awarded a contract. Current contracts, set to expire at the end of April, will be extended for two months to allow for the transition. (Washington Post)

- **"Specialty Hospital centers sue D.C. for reimbursement of Medicaid costs"**

  Two hospitals operated by Specialty Hospitals of America are suing D.C. Medicaid for nearly $25 million in under-reimbursement over the past four years. Medicaid officials for the District claim they are paying reimbursements under federal guidelines. (Washington Post)

Maryland

- **"Maryland's Tough New Hospital Spending Proposal Seen As 'Nationally Significant'"**

  Maryland has proposed a plan to bring hospital spending in line with overall economic growth. The proposal, which requires federal approval, utilizes the state's unique rate-setting environment. For roughly 30 years, Maryland has set hospital payment rates for all payers. However, this new proposal to reduce the annual rate increases is being viewed skeptically by providers and insurers. (Kaiser Health News)

Minnesota

- **"Despite Federal Delay, Minn. Vows To Have Small Business Options On New Health Exchange"**

  The Obama administration announced this week that the Small Business Health Options Program (SHOP) Exchanges will not be available nationwide until 2015. However, Minnesota's Exchange, known as MNSURE, has vowed that small business will have access to exchange products on day one in Minnesota. (Kaiser Health News)

Mississippi

- **"Mississippi House Democrats block Medicaid budget"**

  House democrats voted down a Medicaid budget bill that would have funded the program beyond June 2013, though the legislature has yet to reauthorize the state's Medicaid program, set to expire at the end of June. In doing so, democrats are hoping to force a vote on the Medicaid expansion. Without the budget passage, even if Governor Phil Bryant were to reauthorize Medicaid through an executive order, there will not be Medicaid funding to continue the program. (Clarion Ledger)

Missouri

- **"What's next on Missouri's Medicaid expansion front?"**

  Governor Jay Nixon has indicated that he would support changes to the Medicaid program to drive efficiencies if the legislature agreed to the Medicaid expansion, something legislature opposes, but that the Governor has strongly supported. This signals there may still be potential for a deal on the expansion despite it being left out of the state's 2014 budget. (St. Louis Post-Dispatch)

New Mexico

- **"Governor signs bill for health insurance exchange"**

  Governor Susana Martinez signed a bill establishing a state-based Exchange in New Mexico late last week. Gov. Martinez is one of the few republican governors to endorse a fully state-run Exchange. The bill establishes an Exchange board, which will begin work immediately on issues such as selecting an IT vendor for the online Exchange portal. (AP via Boston Globe)

Oregon

- **"Oregon Shows Costs Of Putting Medicaid Enrollees In Private Coverage"**

  As Arkansas and other states pursue an alternative Medicaid expansion through the Exchanges, Kaiser Health News looks at the experience of Oregon, which has for years enrolled low-income adults in subsidized commercial coverage. The Oregon experience has been successful in reducing uninsured rates, but differs from the Arkansas plan in that it offers more limited benefits and institutes an enrollment cap to keep total program costs down. (Kaiser Health News)

COMPANY NEWS

- **"WellCare Completes Acquisition Of Missouri Care, Incorporated"**

  "WellCare Health Plans, Inc. today announced that it has completed the acquisition of Missouri Care, Incorporated, a subsidiary of Aetna Inc. Financial terms were not disclosed. On Jan. 22, 2013, WellCare stated that it had entered into an agreement to acquire the plan. As of December 2012, Missouri Care serves more than 100,000 MO HealthNet Medicaid program members in 54 counties across the state. Missouri Care's provider network includes more than 50 hospitals and 9,500 physicians." (WellCare News Release)

RFP CALENDAR

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

Date	State	Event	Beneficiaries
TBD	Nevada	Contract Awards	188,000
April 9, 2013	Rhode Island Duals	Proposals due	22,700
April, 2013	Virginia Duals	RFP Released	65,400
April, 2013	Washington Duals	RFP Released	115,000
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 2013 (Capitated)	TBD	July 2013 (Capitated)	MFFS Only	1/1/2014
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		TBD**
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.*

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

+ 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 WEBINAR REPLAYS

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

Donna Strugar-Fritsch – Host

Recorded: 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

Recorded: 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 insights 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

"Asthma" – March 2013
Nursing Clinics of North America – Clinics Review Articles

Linda M. Follenweider, MS, APN, C-FNP – Editor

HMA Principal Linda M. Follenweider serves as co-editor for the March 2013 edition of the Nursing Clinics of North America's Clinics Review Articles on Asthma. Linda also contributes an article to the journal, titled *"Epidemiology of Asthma in the United States."* (Link to Journal – *Subscription required for article access*)

"Guide to Healthcare Delivery System and Payment Reform: Planning and Design"
HMA Accountable Care Institute

Tony D. Rodgers – Contributor
Margaret Kirkegaard, MD, MPH – Contributor
Meghan Kirkpatrick – Contributor

The SIM Initiative gives states the opportunity to design innovative healthcare system models that are capable of addressing the underlying social/economic determinants of health. This guide provides an organized approach to the model design planning process, and provides a framework that helps states systematically think through the innovation process. (Link – PDF)

"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)

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.