HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: STATE INITIATIVES ON ALL-PAYER CLAIMS DATABASES

HMA ROUNDUP: VIRGINIA DUAL ELIGIBLE DEMONSTRATION RFP RELEASED; SOUTH CAROLINA DUALS DEMO TIMELINE UPDATED; FLORIDA HOUSE TO OFFER ALTERNATIVE MEDICAID EXPANSION PROPOSAL; NORTH CAROLINA GOVERNOR PROPOSES MEDICAID MANAGED CARE; TEXAS HHSC PROPOSES MID-CYCLE MANAGED CARE RATE INCREASE; MACPAC TO MEET APRIL 11-12 IN WASHINGTON, D.C.

IN THE NEWS: PENNSYLVANIA, INDIANA, LOUISIANA, OHIO, MISSOURI, OKLAHOMA DEBATE MEDICAID EXPANSION OPTIONS; NORTH DAKOTA LEGISLATURE PASSES MEDICAID EXPANSION; MAGELLAN PROTESTS MARICOPA BEHAVIORAL HEALTH CONTRACT AWARD

HMA RECENTLY PUBLISHED RESEARCH:

"A PLAN FOR EXPANDING SUSTAINABLE COMMUNITY HEALTH CENTERS IN NEW YORK"

"TWO-THIRDS OF STATES INTEGRATING MEDICARE AND MEDICAID SERVICES FOR DUAL ELIGIBLES"

APRIL 10, 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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IN FOCUS: STATE INITIATIVES ON ALL-PAYER CLAIMS DATABASES

This week, our *In Focus* section comes to us from HMA Senior Consultant Susan Mathieu in our Denver, Colorado office. Susan provides an update on All-Payer Claims Databases (APCDs) at the state level. As noted below, APCDs have been implemented in ten states, with implementation underway in another six states. The potential for transparent claims-level data across all payers – and the insight it can provide into overall health, care delivery systems, and spending – is drawing even more states to look into APCD implementation.

What is an APCD?

APCD as defined by the APCD Council is:

> *A database, created by state legislative mandate, that typically includes data derived from medical, pharmacy, and dental claims combined with eligibility and provider files from private and public payers, including insurance carriers (medical, dental, third-party administrators, pharmacy benefit managers and public payers (Medicaid, Medicare).*[1]

The claims data generally cover a range of services including primary and specialty care, inpatient stays and outpatient services, laboratory testing, dental services and pharmacy data. As part of the eligibility files, APCDs also typically include limited patient demographic information and encrypted social security information. APCDs do not contain clinical data from electronic medical records or test results. So, while the claims information, including diagnosis codes for example, is part of the database information stored, the diagnosis and clinical results are not included.

APCDs hold great promise in providing reliable information on a state's delivery system, costs, population health indicators, and in understanding high-level variation in health care utilization, and spending. This increased transparency gives states a more complete picture of what health care costs and provides important information to policy-makers as they design and implement payment and delivery system reforms as well as targeted population health initiatives. The information is also helpful to:

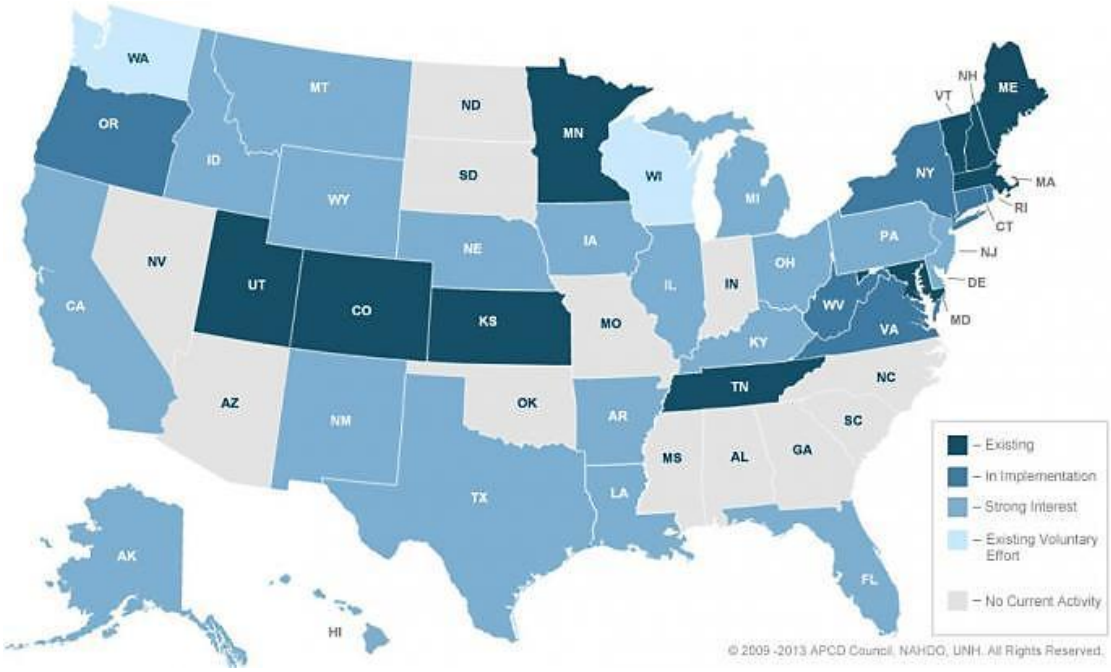
- businesses and employers by helping them know where they are with respect to coverage costs and benefit design, as well as giving them information to negotiate and choose products based on price and quality;
- consumers since they will have access to information that can support value-based purchasing and informed decision-making when selecting providers and treatments;
- providers who will be able to compare their performance to that of their peers and support their efforts in quality improvement initiatives.

[1] P Miller. "Why All-Payer Claims Databases Matter to Employers." *The Bureau of National Affairs, Inc* (2012). Reproduced with permission from *Pension & Benefits Daily*, 12 PBD 114, 06-14/2012.

History and Current Status

According to the APCD Council, in 2000, Maryland became the first state to go-live with an APCD. In 2003, Maine launched its APCD and concurrently became the first state to require all payers to report claims data. New Hampshire's APCD went live in 2005 and Massachusetts's in 2008. Today there are ten states with APCDs in operation, two more with voluntary APCDs, and a half-dozen more currently being implemented.

State APCD Initiative Status – As of April 2, 2013



Source: The APCD Council. http://www.apcdcouncil.org/state/map. Downloaded April 5, 2013.

Governance Structure and Funding

In most states, the APCDs are managed by a single state agency – Department of Insurance (in Vermont), Medicaid agency (in Massachusetts) or state health data organization (in Maine). In other states, APCDs are jointly managed across agencies (in New Hampshire). In Colorado, which launched its APCD in November of 2012, the nonprofit Center for Improving Value in Health Care (CIVHC) is the APCD administrator and is responsible for APCD operations. Two states, Washington and Wisconsin have voluntary APCDs.

APCDs have significant start-up and maintenance costs. The source of funding varies across states and can include general fund support, Medicaid federal matching funding, foundation support, mandatory fees paid by providers or insurers or, in voluntary programs, membership fees and or grants/contracts. Additional revenue can also be generated through the sale of data sets and custom reports once the system is operational.

Opportunities and Examples of Usage

As stated above, APCDs have the potential to benefit payers, consumers, providers, and policy makers by providing timely, actionable, quantitative data on variation in costs and utilization patterns stratified by geography and patient demographics. In striving to better understand the variation in utilization and spending and inform policies to improve

health, health care quality and bend the cost curve, states have used the data to assess their performance on different health policy initiatives and new programs. For example:

- Data from New Hampshire's APCD was used to calculate per member per month expenditures and utilization measures for the state's commercial medical home pilot.
- The State of Vermont has used its data to develop comparisons of cost and quality by region.
- New Hampshire, Massachusetts and Maine have all provided cost information of procedures in different medical facilities.
- Utah and New Hampshire have used APCD data to compare the prevalence and costs to treat chronic diseases across patient populations by geography.
- New Hampshire, Vermont and Maine have used their data to map variations in use of advanced imaging in health services across the three states.[2]
- Colorado, which just went live in November, 2012, is using its APCD to explore high-level variation in utilization and spending on inpatient, outpatient, emergency room, professional and imaging services as well prescription drug utilization (additional information is available at www.cohealthdata.org).

Issues and Challenges

While APCDs have the opportunity to support efforts to change the way health care is delivered and paid for, bend the cost curve, and promote cost and quality transparency, making APCDs operational is both challenging and resource-intensive. In many cases, the data included are not complete as states often start with some purchasers, for example, commercial claims, and then add other data later, like Medicaid. States are often challenged with obtaining and including Medicare, Department of Defense TRICARE, self-funded health plan (regulated under the Employee Retirement Income Security Act), and Federal Employees Health Benefits Program data. Data on the uninsured is rarely included although Maine does include some uninsured claims submitted by Maine Health, the largest health system in the state.[3] Some states have established thresholds on the commercial payers. For example, Massachusetts includes data from licensed carriers having at least $250,000 in annual premiums. In Colorado, the APCD currently includes claims data from the 14 largest commercial payers' individual and large-group fully-insured lines of business, plus Medicaid. Additional payer data, including Medicare and more companies that self-insure, will be added over the next few years.

In addition to challenges with incomplete data sets, the entities managing the APCDs also must engage stakeholders in developing data submission rules and public reporting standards. States currently define these rules differently which can be challenging for purchasers and providers operating in multiple APCD states. Recognizing this as a challenge, the APCD Council is encouraging the adoption of data submission standards

[2] P. Miller. "All-Payer Claims Databases: State Progress and Future of APCDs." August 2, 2012 Presentation. Available at: www.apcdcouncil.org. Downloaded April 5, 2013.

[3] D. Love, W. Custer, P. Miller. "All-Payer Claims Databases: State Initiatives to Improve Health Care Transparency." The Commonwealth Fund. September 2010.

across all states. Similarly, there are no national standards, regulations or policies for data release to support public health, research and other purposes. This is one of the most sensitive areas related to establishing and maintaining an APCD—detractors have raised concerns about government (or government-sponsored entities) having this level of access to protected health information. In some states, such as Maine and New Hampshire, aggregated payment data are provided on a public Web site and de-identified research files are made available to qualified users. Minnesota has very restrictive data release policies, and per the APCD Council, provides data and reporting to state government agencies only.

Finally, like all health information technology program and policy initiatives that involve multiple stakeholders, complex technology, and legal and regulatory constraints, developing an APCD s not a static activity. APCDs evolve and adjustments along the way are necessary. As an example, during this legislative session, three years after Colorado's APCD was authorized, and existing law was amended (with the support of Mental Health America Colorado and the Colorado Behavioral Health Council) to allow small group insurance plans to provide behavioral health claims data to the APCD.

Future Enhancements and Additional Resources

As more states develop APCDs, there is enhanced capacity for states to compare their own data with that of other states and to learn from experiences across the country. Also, additional linkages with clinical data from Health Information Exchanges will enable analysis of outcomes making the data and information provided more robust, complete and actionable.

Background and technical assistance resources are available through the APCD Council (www.apcdcouncil.org) and the National Association of Health Data Organizations (www.nahdo.org).

HMA MEDICAID ROUNDUP

Arkansas

HMA Roundup

Medicaid Expansion Proposal Moves Toward House Floor Vote. On Tuesday, April 9, 2013, the House Public Health Committee approved on a voice vote the Senate's proposal to expand Medicaid using federal funds to purchase private plans on healthcare exchanges. On Friday, April 5, 2013, the Republican-led Senate approved the Beebe Administration's proposal to use Medicaid expansion federal funds to purchase private insurance on health exchanges. The legislation requires the state to reauthorize the proposal in 2017, when federal Medicaid funding drops below 100% of the cost of expansion. A follow-on budget bill must gain approval by more than ¾ of the House and Senate, and the Senate's 24-9 vote falls short of that threshold.

California

HMA Roundup – Jennifer Kent

On Monday, the Assembly Budget Subcommittee on Health and Human Services heard testimony from Medi-Cal managed care plans, advocates, the Department of Health Care Services and the Governor's Department of Finance regarding two significant issues for Medi-Cal managed care in California: the Governor's proposal that the gross premiums tax on managed care be extended permanently (and retroactive to July 1, 2012) to generate $136 million in savings for 2012-13 and $233 million in 2013-14. The plans have opposed the reauthorization of this tax because it was originally used to support the Healthy Families program until last year when the program was eliminated and over 850,000 children were transferred into Medi-Cal. In an unusual display of agreement, advocates agreed with the health plans that the tax, as proposed by the Governor, was going to inappropriately direct the revenues to the state's General Fund and instead should be used exclusively to support the Medi-Cal program. Key to the passage of this item is a 2/3 vote in both houses of the Legislature – and if plans remain opposed, this vote threshold will be difficult to meet.

Second, the Committee also heard from health plans on the Administration's proposal to achieve $134 million through the implementation of "operational efficiencies" in the Medi-Cal managed care program. Since the Department was allowed to implement its 10 percent provider rate reduction, they have acknowledged that their managed care contracts will not allow them to retroactively collect money from the plans. Therefore, they have proposed taking these savings out prospectively – but have not offered any details for how to incorporate these adjustments into the rates. Plans, along with the same advocates as above, were strongly opposed to this proposal as well. Link to the agenda can be found here.

In the news

- **"Groups Calling for Pause in Transition"**

  Children's health advocates pushed legislators to halt enrollment transitions of 860,000 Medicaid children from the Healthy Families program into Medi-Cal managed care. Advocate groups argue the state has not provided for seamless care transitions and that the most difficult patient groups have yet to be transitioned. Roughly 600,000 children have been transitioned so far. (California Healthline)

Colorado

HMA Roundup – Joan Henneberry

Single Payer Senate Healthcare Proposal Approved by Committee. On Thursday, April 4, 2013, Senate Concurrent Resolution 2 was approved by the Senate Health and Human Services Committee. This proposal would amend the state constitution to create a single-payer, government-run healthcare system. The resolution would have the state impose a 9 percent tax on salaries (one third from individuals, two-thirds from employers) to fund a cooperative to offer insurance to Colorado residents, including undocumented aliens. The Democratic-controlled committee passed the measure, but a floor vote faces steep hurdles. Before a resolution to amend the constitution can make it to a ballot, more than two-thirds of the House and Senate would need to support the measure.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

House Republicans Appear Poised to Reject Federal Medicaid Expansion Funds. Following the passage of two Senate health bills out of committee, House Republicans appear poised to introduce their own proposal to address the poor uninsured on Thursday April 11, without expanding Medicaid coverage. Despite Governor Rick Scott's support for Medicaid expansion and a live proposal from Senator Joe Negron that would be financed by federal funds, published reports indicate the House plan would be funded exclusively with state dollars, consistent with comments made by Rep. Richard Corcoran, chairman of the Select Committee on the Affordable Care Act. On Monday, April 15, 2013, the committee is scheduled to hold a four hour meeting.

In the news

- **"Medicaid Funding Frenzy Grows at Capitol"**

  Florida House republicans are reportedly nearing release of their Medicaid expansion plan that would not accept federal funding for the expansion, instead using state-only dollars. Meanwhile, in the Senate, two plans have been put forward; Sen. Joe Negron's plan would accept federal funding, while Sen. Aaron Bean's plan would not. Both plans expand coverage through private insurance plans. (Health News Florida)

- **"Senate Medicaid plan would cut funding for Jackson, safety-net hospitals"**

  A Senate bill to transition Medicaid payments to hospitals to a DRG system would cut more than $104 million in annual reimbursements from safety-net hospitals, ac-

cording to analysis from the Safety Net Hospital Alliance of Florida. However, these cuts could be softened if the state accepts federal funding for the Medicaid expansion. (Miami Herald)

Illinois

HMA Roundup – Matt Powers and Jane Longo

HFS Reviewing Complex Children CCE RFP Responses. The Department of Healthcare and Family Services (HFS) announced it received seven proposals for care coordination entities (CCEs) for Medicaid children with complex medical needs: five in Chicago, one in Peoria, and one in Macon County. It is expected that they will announce RFP awards around the end of May. A full list of respondents is available here.

HFS Director Hamos Concerned About Medicaid Doc Shortage. A Crain's Chicago Business article, published April 10, quoted HFS Director Julie Hamos as concerned about adequate physicians willing to serve the expanded Medicaid population beginning in 2014. Crain's cites a study it conducted the previous year, which indicated 16 percent of the state's 47,000 doctors are not signed up as Medicaid providers, and even among the 39,000 plus who are, many only infrequently see Medicaid patients.

First Duals Demonstration Stakeholder Meeting Scheduled. On April 18, HFS will hold its first in a series of bimonthly stakeholder meetings on the state's dual eligible demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI). The meeting will be held via videoconference in both Chicago and Springfield locations. More information is available here.

Indiana

HMA Roundup – Cathy Rudd

House Ways and Means Committee Refuses Vote on Medicaid Expansion. Rep. Tim Brown, Chairman of Ways and Means Committee, announced that he would not hold a vote on SB 551, effectively killing the measure that was amended last week to allow the administration to negotiate some alternative to a Medicaid expansion with the federal government. The bill also contained a requirement for the agency to submit a report to the legislature concerning the feasibility of enrolling duals and the ABD population in risk-based managed care. The legislative session is scheduled to adjourn on April 29, 2013 so it is possible some of the provisions contained in SB 551 could be offered as amendments to other bills.

In the news

- **"Indiana Senate revives Medicaid bill in state budget"**

  The Indiana Senate's budget bill includes the expansion of Medicaid through the state's Healthy Indiana Plan, reviving the possibility of legislative approval of the expansion after Senate Bill 551 failed to move out of committee earlier this week. Governor Mike Pence has asserted that Medicaid could be expanded without legislative approval, but legislators have cited the desire to have input and approval over the expansion. (Indianapolis Star)

North Carolina

HMA Roundup

Governor Proposes Medicaid Reform Plan. On Wednesday, April 3, 2013, Governor Pat McCrory proposed an overhaul of the North Carolina's Medicaid program, leaning heavily on managed care plans that would focus on outcomes-based incentives and greater budget predictability. The proposal comes eight weeks after the state's Request for Information (RFI), which received more than 160 responses. The "Partnership for a Healthy North Carolina" would create "Comprehensive Care Entities" that would perform functional needs assessments, establish networks of providers, and compete with other CCEs to deliver care to Medicaid recipients. The Administration will file a formal application for a comprehensive Medicaid 1115 waiver. The Department of Health and Human Services tentatively plans to issue a Request for Proposals (RFP) for CCEs in early 2014.

Pennsylvania

HMA Roundup –Matt Roan

State Health Center Mergers challenged in Court. A plan by the Corbett administration to consolidate State Health Centers is being challenged in State Court by the SEIU and Democratic lawmakers who are claiming that the Governor's move circumvents the legislative process and is unconstitutional. The petitioners claim that the statutory authority for the funding and operation of state health centers requires legislative action before centers can be closed or consolidated. Democratic lawmakers are positioning Corbett's move to close some State Health Centers before the annual budget process has been completed as an attempt to bypass the legislature. This is the latest in a series of actions by the Governor that have been challenged in court.

DPW Acting Secretary Comments on HHS-Corbett Meeting on Medicaid Expansion. Acting Secretary Bev MacKereth commented on the Corbett Administration's meeting with Secretary Sebelius last week on the issue of Medicaid expansion. MacKereth reiterated that the administration is trying to find a way to restructure Pennsylvania's Medicaid program to mitigate the increasing pressure that the program puts on the state budget before they consider eligibility expansion.

South Carolina

HMA Roundup

On a webinar conducted earlier this week, SCDuE explained that is has been engaged in discussions with CMS about its Duals Demonstration proposal and the structure of the memorandum of understanding (MOU). Specifically, SCDuE has decided to revise its proposal to address some CMS requirements and concerns. Previously, home and community based services (HCBS) were carved out of the managed care benefit design, but now they will be included. SCDHHS now anticipates an MOU summer 2013 and RFI-2 mid-summer with their RFP approximately 30 days following that.

Texas

HMA Roundup –Dianne Longley and Linda Wertz

Texas House Rejects Medicaid Expansion Budget Amendment. On Thursday, April 4, 2013, after having approved a 2013-14 budget amendment that would have opened the door to Medicaid expansion negotiations, the Texas House voted 93-54 to reconsider. The amendment's author subsequently withdrew the amendment. The measure would have required any negotiation on Medicaid expansion to reduce uncompensated care, to promote private plans and health savings accounts, and establish pay-for-performance elements. A similar Senate amendment may still make it into conference committee.

Medicaid Premium Rate Proposal by HHSC Would Shave Budget Savings. The Health and Human Services Commission has requested legislative approval for a mid-year increase in Medicaid premiums to account for better data. The proposed 2.6 percent increases in Medicaid managed care premiums, 0.8 percent increases in long-term and acute care service premiums, and 1.8 percent increases in children's health premiums would require an additional $59 million for the remaining three months of FY 2013. HHSC estimates premium increases could shave the savings from using Medicaid managed care plans rather than fee-for-service from 13.2 percent to 9.7 percent.

In the news

- **"Proposal: Allow Private Mental Health Services in Jails"**

  Texas legislators are considering a bill that would allow the Department of Corrections to contract with a private company for the provision of mental health services to inmates deemed unfit to stand trial. After discussions with lawmakers, the advocacy community is not opposed to the bill, but has not yet endorsed its passing. (Texas Tribune)

Virginia

HMA Roundup

Virginia's Department of Medicaid Assistance Services (DMAS) has released an RFP for its dual eligible integration demonstration, anticipated to serve nearly 78,600 duals across five regions. The five regions are: Tidewater (18,098 eligible duals); Central Virginia (24,327 eligible duals); Northern Virginia (16,653 eligible duals); Roanoke (12,771 eligible duals); and Western/Charlottesville (6,747 eligible duals). Virginia DMAS will contract with a minimum of two plans per region, with an implementation date of January 1, 2014. RFA responses are due on May 15, 2013, with contracts expected to be signed by September and open enrollment on October 15. The RFA is available on the DMAS Integrated Care web page, here.

National

HMA Roundup

MACPAC Set To Meet Thursday and Friday, April 11-12. The Medicaid and CHIP Payment and Access Commission (MACPAC) is scheduled to meet Thursday and Friday of this week. Topics will include: adult dental services in Medicaid; Plan perspectives on state enrollment policies for Medicaid managed care; and Care coordination for people dually eligible for Medicare and Medicaid. (Link to Agenda)

House Republicans Propose Sustainable Growth Rate (SGR) Replacement. After more than a decade of temporary "physician fixes" to avoid increasingly draconian Medicare cuts as part of the SGR formula, House Republicans have offered a proposal designed to replace SGR with rates based on performance, quality, and patient satisfaction measures. Following a February 2013 estimate by the Congressional Budget Office that the repeal of SGR would cost $138 billion over the next decade, House Republicans have worked on a more permanent fix for physician rate setting.

MedPAC Suggests Medicare Cuts for Hospice Care in SNFs. On Thursday, April 4, 2013, MedPAC commissioners recommended considering 3-5 percent reductions in Medicare rates paid for hospice care in skilled nursing facilities. The Office of the Inspector General had previously noted that hospices seek out individuals in institutional settings, rather than home-based settings, because the agencies receive the same rate for care, despite SNF-based beneficiaries requiring less complex care.

In the news

- **"$54M In Grants Will Help Enroll Uninsured In 33 States"**

  On April 9, the Obama administration announced $54 million in grants to community groups in 33 states. The grants will support "navigator" hiring and training to help individuals enroll in the health insurance exchanges for 2014. (Kaiser Health News)

- **"In Obamacare, online insurance brokers see potential windfall"**

  Washington Post's Sarah Kliff explores the potential boon for online insurance brokers if states can be persuaded to partner with them on Exchange enrollment for 2014. Several states are considering this option, but none have approved a partnership as of yet. Consumer advocates caution it could lead insurers to pay larger premiums to brokers in exchange for enrollments. (Washington Post)

- **"Health-Care Costs: A State-by-State Comparison"**

  Recent data from the Centers for Medicare & Medicaid services point to significant differences in health care spending across the states, and that higher spending does not always equate to a healthier population. (Wall Street Journal)

- **"Ex-Felons Are About to Get Health Coverage"**

  Stateline examines the impact ACA will have on the roughly 5 million ex-offenders who are on parole or probation at any given time, as well as the 650,000 new prison inmates released each year. Most of this population will become eligible for Medicaid on the day of their release beginning in 2014. (Stateline)

OTHER HEADLINES

Louisiana

- **"Jindal administration rejects Arkansas Medicaid model"**

  Governor Bobby Jindal's interim DHH Secretary Kathy Kliebert told legislators this week that the administration is not considering a private option for Medicaid expansion as has been proposed in Arkansas and is drawing interest from other Republican administrations. (NOLA.com)

- **"Medicaid contractor objects to cancellation, says nothing improper done to get La. contract"**

  CSNI has objected to the cancellation of its contract to serve as the MMIS contractor for the Louisiana Medicaid program. CSNI's contract was cancelled when allegations surfaced that Department of Health and Hospitals Secretary Bruce Greenstein, a former CSNI executive, had influenced the contract award. Greenstein resigned his position last week. (Washington Post)

Massachusetts

- **"After Expanding Coverage, Health Care Pioneer Seeks to Tame Costs"**

  Having undertaken near-universal coverage in 2006, Massachusetts has focused on reducing health care spending in the years since. Beginning October 1, 2013, health care providers and payers will be effectively put on a state-imposed budget and be required to make public prices charges for services. The plan, known as Chapter 224, is projected savings of $200 billion over the next 15 years. (Stateline)

Minnesota

- **"DFL spending cuts target hospitals, HMOs"**

  Minnesota House democrats have proposed offsetting $150 million in Medicaid budget cuts with increases surcharges on hospitals through a provider assessment arrangement that would be repaid to many hospitals, and requiring Medicaid managed care organizations to pay a portion of cash reserves to the state. (Minnesota Public Radio)

Missouri

- **"Nixon and Republicans inching toward possible Missouri Medicaid expansion"**

  Governor Jay Nixon stated that his administration and republican legislators are getting closing to a compromise on the Medicaid expansion. Gov. Nixon has long-supported a full expansion of Medicaid under the ACA, while the current republican proposal would only expand to 100 percent of the federal poverty level, while eliminating many current eligibility categories with higher incomes. (The Kansas City Star)

North Dakota

- **"ND Legislature approves Medicaid expansion bill"**

  This week, the North Dakota Senate approved a Medicaid expansion bill passed by the House in February. The bill would fully expand Medicaid in North Dakota as prescribed in the Affordable Care Act. Governor Jack Dalrymple has given no indicated he would veto the bill. The state estimates an additional 20,000 Medicaid enrollees under the expansion. (The Jamestown Sun)

Ohio

- **"House Republicans strip Medicaid expansion out of state budget proposal"**

  Ohio's House Republicans unveiled a budget this week that eliminated funding for a Medicaid expansion. Advocates from the business and provider communities pledged increased pressure on lawmakers to expand Medicaid. (Cleveland Plain Dealer)

Oklahoma

- **"Consultant seeking Medicaid solution"**

  Oklahoma has hired Leavitt Partners to explore the Arkansas private option plan, as well as other alternatives to expanding Medicaid in Oklahoma, although it is not clear if Oklahoma will eventually pursue an alternative expansion plan before 2014. Governor Mary Fallin has publicly rejected the Medicaid expansion. (Norman Transcript)

South Carolina

- **"CVS clinics soon will accept all Medicaid plans in SC"**

  By the start of May, all CVS MinuteClinics in the state will accept Medicaid patients, regardless of their Medicaid plan. Previously, the clinics only accepted Medicaid patients enrolled in two of the state's Medicaid plans. (The State)

- **"Why South Carolina won't follow Arkansas's Medicaid lead"**

  Washington Posts's Sarah Kliff examines South Carolina Medicaid Director Tony Keck's continued opposition to the Medicaid expansion, even under a private option plan as is being pursued in Arkansas. Keck contends that the plan still would do nothing to improve the health of South Carolinians. (Washington Post)

COMPANY NEWS

- **Walgreens to Offer Primary Care Services.**

  Five years after establishing a national network of retail clinics through two acquisitions, Walgreens is now expanding its services to include multiple primary care functions, including diagnosis and treatment of chronic conditions. The drug chain plans to hire physicians to have oversight at the clinics, which traditionally had been staffed with nurse practitioners and physician assistants. These services will overlap with those offered by urgent care clinics and have been met with criticisms by certain physician groups.

- **Magellan Files Protest with Arizona Over Maricopa County Behavioral Health Contract Decision.**

  Last week, Magellan Health Services filed a formal protest over Arizona's decision to award the Maricopa County Regional Behavioral Health Authority to a rival vendor. Magellan's current contract, worth more than $700 million annually, is slated to conclude at the end of September 2013. The company's protest notes that one of the winning bidder's sponsors is a behavioral health provider, which should have precluded the bidder's consideration. Among other things, the company states that the RFP had been improperly amended to allow the winning bidder to participate in the RFP, despite not holding an Arizona State HMO license. Finally, in a civil lawsuit, Magellan claims that confidential and proprietary information disclosed by the company was inappropriately used by the winning bidder as part of the RFP process

- **"IBC to sell percentage of insurance subsidiary to Cooper"**

  Independence Blue Cross has agreed to sell 20 percent of its stake in AmeriHealth New Jersey to Cooper University Health Care. AmeriHealth New Jersey covers roughly 200,000 beneficiaries, largely in the small-group market. (Philadelphia Inquirer)

- **"Closure of three Southland hospitals may be part of a trend"**

  Pacific Health Corp. announced it will be closing its three remaining Southern California hospitals, totaling 461 beds. Pacific cited fallout from a fraud case settled last year for the closures. It did leave open the possibility that the hospitals could be reopened, potentially under new ownership. (Los Angeles Times)

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, 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 15, 2013	Virginia Duals	Proposals due	65,400
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	Summer 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	X	5/15/2013	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**	***7***			***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

"Two-Thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles"
AARP Public Policy Institute

Jenna Walls – Contributor

This report finds that two-thirds of the states either have or will launch new initiatives to better coordinate care for people who are dually eligible for Medicare and Medicaid services, the so-called "duals," over the next two years. To contain the growth of costs and improve care, many of them are moving to risk-based managed long-term services and supports models. (Link - PDF)

"A Plan for Expanding Sustainable Community Health Centers in New York"
Community Health Care Association of New York State (CHCANYS)

Deborah Zahn – Project Team Consultant
Melissa Corrado – Project Team Consultant

Community Health Care Association of New York State (CHCANYS), with support from the New York State Health Foundation, has developed a statewide plan for community health centers to increase their capacity to serve more patients. Based on extensive quantitative and qualitative analyses, the plan identifies geographic areas that have the greatest need and potential for sustainable growth, estimates potential increases in capacity within the existing system, and highlights strategies for creating more capacity. HMA worked with CHCANYS to design and implement the analyses and to develop recommendations and the final report. (Link - PDF)

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

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

HMA Senior Consultant 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)

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.