HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: MEDICAID MCOS AND COMMUNITY PARTNERSHIPS

HMA ROUNDUP: ARKANSAS GOVERNOR SIGNS MEDICAID EXPANSION INTO LAW; MEDICAID EXPANSION NEGOTIATIONS REMAIN UNRESOLVED IN FLORIDA, TEXAS, PENNSYLVANIA, OHIO, MONTANA, AND OTHERS; NEW JERSEY DELAYS MLTC CARVE-IN, BEHAVIORAL HEALTH RFP; NEW YORK DUALS DEMONSTRATION TIMELINE SLIPS; MASSHEALTH CAREPLUS RFR TO BE RELEASED MAY 2013; TEXAS RELEASES RFI FOR SSI CHILDREN

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"HMA PRINCIPALS OFFER INSIGHT ON MEDICAID EXPANSION, EXCHANGES"
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APRIL 24, 2013

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IN FOCUS: MEDICAID MCOS AND COMMUNITY PARTNERSHIPS

This week, our *In Focus* section reviews the key takeaways from a report HMA prepared with support from The Commonwealth Fund, examining the experiences of four MCOs in their community partnership efforts. The report, *Forging Community Partnerships to Improve Health Care: The Experience of Four Medicaid Managed Care Organizations*, was prepared by HMA Managing Principal Sharon Silow-Carroll and HMA Consultant Diana Rodin. The report looked at the experiences of the following four Medicaid MCOs in their efforts to engage community partners to meet the needs of vulnerable members and nonmembers:

- Gateway Health Plan – Pennsylvania
- HealthPartners – Minnesota
- L.A. Care – California
- Neighborhood Health Plan – Massachusetts

These four health plans were among a larger selection of plans identified by state Medicaid officials as being leaders in pursuing community-based strategies to improve access and care for vulnerable populations. HMA's report acknowledges that these four health plans are rooted in their communities, however, that does not mean that larger, multistate plans are less able to form local partnerships.

Goals, Challenges, and Strategies of Community Partnerships

HMA's report identified three overarching goals pursued by MCOs as they develop community partnerships: (1) improve health care coordination, access, and delivery; (2) strengthen the community and the local safety-net infrastructure; and (3) promote preventative care and reduce disparities.

The MCO-community partnership development process is not without challenges. Below are a few of the key challenges faced by the four MCOs:

- Establishing trusting partnerships takes time and commitment;
- Evaluating the impact of communitywide interventions can be difficult;
- Funding may be unpredictable;
- MCOs may fail to enlist affected groups in organizing new initiatives; and
- Targeting the highest-risk members of a health plan post particular challenges contacting members, managing logistics and home visits, and ensuring member compliance. .

All four MCOs use data to identify gaps in care, seek community input in designing interventions, and commit resources to engage community organizations. They target key populations and neighborhoods. Specific strategies differ across the MCOs; examples include bringing clinicians to homes, adult day centers, and low-income housing, as well as help supporting safety net providers in low-service areas.

Key Takeaways

The report identifies factors – both internal and external – that appear to contribute to MCO success in partnering with the community, as well as policy options for states wishing to foster MCO-community partnerships.

Internal drivers within a MCO centered around the plan's history, governance, visibility, and return on investment. On the other hand, external drivers of MCO-community partnership focused primarily on the historical MCO market and state policies and contract language.

The following are some of the key conclusions and policy implications from the report:

- As Medicaid managed care continues to expand, MCOs are challenged to ensure that vulnerable members have access to high-quality primary care, illness prevention, screenings, health education, chronic care, and care management and coordination.
- The four MCOs studied – as well as others across the country – are addressing the challenges presented by vulnerable populations through partnerships within the community, including health, social service, and faith-based organizations. Partnerships go further in some cases, including retail, housing, and transportation entities.
- Plans are reporting evidence of success in reducing disparities in screening rates, reducing inpatient readmissions, and improving dental, chronic, and other care access.
- However, it is difficult to measure evidence of overall impact of community partnerships on vulnerable MCO populations due to limited resources and methodological challenges.
- MCOs studied acknowledge that their community investments do not always bring financial returns in the short term. However, improved public image and relationships with providers as a result of community partnerships could make MCOs more attractive under Medicaid expansions in 2014, leading to higher enrollment.
- MCOs see state governments as natural partners in community partnership initiatives. States can further efforts through the following options:
    - Set voluntary guidelines on community benefits for Exchange;
    - Ask health plans to include community activities in Exchange proposals and Medicaid contracts;
    - Convene MCOs to share strategies for community engagement;
    - Establish priorities, goals, and baselines for community health;
    - Engage community stakeholders; and
    - Fund efforts to evaluate community activities by MCOs to identify best practices.

Link to Report and Individual MCO Case Studies

The report, *Forging Community Partnerships to Improve Health Care: The Experience of Four Medicaid Managed Care Organizations,* is available on The Commonwealth Fund website at: http://www.commonwealthfund.org/Publications/Issue-Briefs/2013/Apr/Forging-Community-Partnerships-to-Improve-Care.aspx

HMA developed four case studies for the report, describing in greater detail the drivers, strategies, challenges, and lessons from the experiences of each the four MCOs studied.. The case studies for each of the four MCOs are available at the links below:

Gateway Health Plan

HealthPartners

L.A. Care

Neighborhood Health Plan

HMA MEDICAID ROUNDUP

Alabama

HMA Roundup

Health Committees Approve Medicaid Managed Care. On April 17, 2013, Alabama's House and Senate health committees signed off on bills to transition the state's Medicaid program from fee-for-service to managed care. Neither chamber has yet taken a floor vote on the measures. The legislative session is slated to end by May 20.

Arizona

HMA Roundup

Medicaid Expansion Hangs in the Balance. Despite the support of Governor Brewer, Medicaid expansion still hangs in the balance and threatens to delay state budget approval. Republican leaders in the House and Senate oppose the Medicaid expansion. The governor's proposal would apply a hospital tax to cover any incremental state costs associated with the expansion. One legislative alternative floated by GOP legislators includes freezing spending on the current state-funded childless adult program, which the Legislature estimates to be $83 million in FY 2014, while the governor estimates around $200 million.

In the news

- **"Magellan protest rejected in hunt for Maricopa County contract"**

  Magellan has lost its protest bid in response to the Maricopa County Medicaid behavioral health RFP award, announced last month. Magellan had held the contract in Maricopa since 2009. The contract was awarded to a joint bid between Mercy Care Plan and Maricopa Integrated Health System. (Phoenix Business Journal)

Arkansas

HMA Roundup

Arkansas Governor Signs Medicaid Expansion into Law. On Tuesday, April 23, 2013, Governor Mike Beebe signed the state's own version of Medicaid expansion into law, which relies on premium assistance to purchase private plans on a health exchange. The state is pursuing final Federal approval of the plan.

Colorado

HMA Roundup—Joan Henneberry

Medicaid Dental Benefit Proposed. State Representative Dianne Primavera, Chair of the Colorado House Public Health Care and Human Services Committee, is co-sponsoring legislation that would require the Department of Health Care Policy and Financing to offer Medicaid dental benefits to adults. Last week, Senate Bill 242 passed out of the Senate and was introduced in the House on April 19, 2013. The legislation would establish a fund to cover the benefit from the unclaimed property trust fund. This bill is expected to pass, even without bipartisan support.

Mental Health crisis system: On April 23, the Senate gave preliminary approval to a bill that would allocate about $20 million next year — and about $25 million for every year after that — toward creating a "coordinated behavioral health crisis response system" specifically aimed at providing immediate care to mental health patients who pose a threat to themselves or others.

SB266 would create a five-part mental health crisis system:

- A 24-hour crisis hotline for people to talk through their difficulties;
- A walk-in crisis center to do the same thing in person;
- Crisis stabilization units in five population centers around the state to handle more troubled patients;
- Residential and respite crisis services in the five population centers in which those patients can stay for up to five days; and
- An advertising campaign to educate Coloradans about the new services specifically and the importance of not ignoring mental health treatment in general.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Medicaid Expansion Unresolved as Legislative Session Winds Down. With the May 3 end to the legislative session looming, the Florida legislature has still not resolved the question of Medicaid expansion. House Republican leadership has maintained its posture of refusing federal funding for an expansion of the Medicaid program. Gaining a majority in the House would require 60 votes, or a minimum of 16 Republicans to join the 44 Democrats supporting expansion. The House is expected to vote on its own proposed state-funded alternative to Medicaid expansion on Friday, April 26, 2013. Gover-

nor Rick Scott continues to support Senator Joe Negron's plan to accept additional federal funds that has proceeded in the Senate. A special session may be required to consider the issue if the two chambers cannot come to agreement by the session's end next week.

AHCA Releases Comparison of House and Senate Health Care Proposals. Last week, the Agency for Health Care Administration released a comparison of the House's health expansion legislation (Health Choices Plus) and the Senate's Medicaid expansion plan (Healthy Florida). The agency noted that the House plan aims to assist 115,000 Floridians, while the Senate plan would cover 1.1 million Floridians up to 138 percent of the Federal Poverty Line income threshold. The House plan would cost nearly $2.1 billion over the next decade and forego $46 billion in Federal funding. The Senate plan would save Florida taxpayers nearly $2.3 billion over the next decade (largely due to full Federal funding of the Medically Needy Program), while infusing $46 billion in Federal funds into the state.

Georgia

HMA Roundup—Mark Trail

Care Management RFP to Be Released in Summer 2013. The Coalition to Assure Redesign Effectiveness for Medicaid (Care-M) group was briefed by the Department of Community Health on efforts to address the needs of the aged, blind, and disabled (ABD) population. The Department of Community Health is moving forward with a request for proposal (RFP) to deliver medical care management to dual eligibles, children with special needs, and the ABD population. The target RFP release date is the summer of 2013, with a likely July 2014 implementation date. Discussions are ongoing with CMS about a 1932(a) or 1115 waiver. The intent is to have a single statewide vendor to deliver medical care management on a fee basis. Full-risk managed care is not being contemplated at this point.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

MassHealth CarePlus RFR to Be Released May 2013. The Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) will issue a Request for Responses (RFR) for bids from qualified managed care health plans under a newly established program, MassHealth CarePlus. Under the Affordable Care Act, this program will serve newly eligible adults between the ages of 21 to 64 with incomes under 133 percent of the Federal Poverty Level. The May 2013 RFR release date anticipates a contract start date of January 1, 2014.

MassHealth's contracted MCOs, Primary Care Clinician (PCC) Plan, and the current contracted behavioral health carve-out vendor, will continue to serve eligible MassHealth Members under age 65 who are ineligible for CarePlus.

MassHealth Primary Care Payment Reform Implementation to Be Delayed. On Monday, April 22, 2013, the Massachusetts Executive Office of Health and Human Services (EOHHS) announced that the Primary Care Payment Reform Initiative (PCPRI) implementation will begin on October 1, 2013, rather than the original August 1 target date.

The due date for responses to the Request for Applications has been pushed back from April 30, to May 31, 2013. The PCPRI will be a three-year program, with a risk-adjusted monthly capitated payment for a defined set of primary care services. Participating providers will have the option to include different levels of behavioral health services in the payment. Incentive payments for savings and quality measurements will be a key part of the program. More details on the program will be included in an upcoming HMA Roundup report.

Missouri

HMA Roundup

Missouri Senate Rejects Medicaid Expansion. On Monday, April 22, 2013, the Missouri Senate voted Democratic efforts to include Medicaid expansion federal funds in the state's budget. The vote ensures that neither the House nor Senate budgets include Medicaid expansion dollars, which precludes the final budget from effecting Medicaid expansion.

Montana

HMA Roundup

Montana Budget Talks Do Not Include Medicaid Expansion. As Montana's legislative leaders move toward final budget agreements this week, the package being sent for Governor Bullock's approval does not include provisions for Medicaid expansion. While the legislative session closes this week, the governor has indicated interest in calling a special session to address Medicaid.

New Jersey

HMA Roundup – Eliot Fishman

New Jersey is moving forward with three separate, major initiatives around managed care in the state, but all are facing significant delays.

Managed Long-Term Care: New Jersey first announced its commitment to managed long term care in early 2011, and at the time the state projected relatively rapid implementation by carving long-term care benefits into the incumbent acute care managed care contracts. The Personal Care and Adult Day benefits—both in the Medicaid State Plan—were carved into managed care contracts in the fall of 2011. Other Home and Community Based services provided through a 1915c waiver and nursing home remained fee-for-service. At that time the state also moved 45,000 ABD beneficiaries and 110,000 dual eligible beneficiaries to mandatory Medicaid managed care. From that point until late 2012, further expansion of managed long-term care was delayed by federal review of the state's broad Medicaid waiver, which was granted in October 2012.

However, over the course of 2012, some of New Jersey's incumbent plans had difficulty managing the partial HCBS carve-in. Recognizing these difficulties, the state pushed back further carve in of long-term care benefits repeatedly. At a Medical Assistance Advisory Council meeting in early April, Medicaid Director Valerie Harr announced that the state

was "taking a step back" from immediate completion of the MLTC rollout. Carve in of waiver HCBS is now projected for January 2014, and carve in of nursing home benefits for July 2014.

Managed Behavioral Health: A key component of the comprehensive Medicaid waiver approved in October was to shift adult community behavioral health treatment to Medicaid fee-based payment from non-Medicaid state contracting that has been tied to cost reporting. This shift will be coordinated with the rollout of a new behavioral health payor organization, to be selected via competitive procurement. The new organization will begin as an Administrative Services Only contractor, with an option for the state to move to a risk-based MBHO contract through an amendment filed with CMS. While acute MCOs will retain responsibility for limited behavioral services (such as that delivered in primary care sites or in medical detox units), and Medication Assisted Treatment will remain separately paid, the new ASO/MBHO will assume responsibility for the great majority of adult behavioral health payment.

This procurement process has also been pushed back multiple times from its original mid-2012 RFP release date. The state is now projecting RFP release this summer, with contract awards late this year, readiness review in early 2014, and a spring 2014 go-live date.

Shift to Procurement-Based Contracting: New Jersey currently has for managed care organizations operating in the state: Horizon NJ Health, Americhoice (UHC) Amerigroup (WLP) and HealthFirst. The state has historically been an open application state, in which MCOs could operate in part or all of the state based on licensure and certification through the Department of Banking and Insurance and the Department of Human Services (the Medicaid agency). Beginning with the accession of Valerie Harr to be Medicaid Director in 2010, the state has declared its intention to shift eventually to the competitive procurement model typical of most state Medicaid managed care programs. The state is still accepting applications through its current open non-competitive process, and Centene and WellCare are in the application process. Meanwhile, the RFP timeline has been pushed back from mid- to late-2013 to sometime in 2014. Notably, New Jersey is one of a number of states with Republican governors to move forward with the Affordable Care Act Medicaid expansion. Therefore, with exception of carveouts for behavioral health and developmental disabilities services, the 2014 RFP will be for acute and long-term care benefits for almost the entire New Jersey Medicaid population with the expansion population.

In the news

- **"Seeing healthy profits from ailing hospitals, 2 groups have big plans for N.J."**

  Hudson Hospital Holdco and Prime Healthcare Services have submitted bids to purchase St. Clare's Health System, which owns three hospitals in Morris County, according to anonymous sources close to the deals. Both groups have made other moves into the New Jersey hospital market. (NJ.com)

New York

HMA Roundup—Denise Soffel

New York City Health Plan RFP to Include Premiums for City Workers. According to Deputy Mayor Caswell Holloway, New York City plans to issue a request for proposal for a new provider for its $6 billion employee health plan, currently served by Emblem Health. The RFP, covering 300,000 city workers, will be issued by June 30, with the goal of—for the first time—charging employees a premium, with discounts for participating in wellness or preventative care programs.

Managed LTC Lowered Readmissions for NYC Dual Eligibles. The Commonwealth Fund published a study that reviews the results of managed long term care services offered by the Visiting Nurse Service (VNS) of NY's Choice Health Plans for dual eligibles in New York City. VNS offers a comprehensive bundle of long term care services, as well as a special needs Medicare Advantage plan. Among a cohort of 573 individuals continuously enrolled for 24 months, there was a 54 percent reduction in hospital admissions, a 24 percent drop in readmissions within 30 days, and a 27 percent decline in visits to the emergency department. VNS noted that 96 percent of its Medicare Advantage members had a primary care visit in the previous 12 months, likely helping with the results.

Health Benefit Exchange Regional Advisory Committee Meetings. The New York Health Benefit Exchange has scheduled its next round of Regional Advisory Committee meetings. The meetings will focus on the Exchange's plans for overall public communications, with an emphasis on effective outreach strategies to raise awareness among consumers and small businesses about the Exchange. The meetings will be held at 11AM in Rochester on May 21, Albany on May 23, and New York City on May 30.

Medicaid Enrollment Up 5 Percent; Expenditures Below Projections. Medicaid total enrollment reached 5,288,868 enrollees at the end of February 2013. This reflects an increase of almost five percent over the last year. Medicaid managed care enrollment, including Family Health Plus and managed long term care, reached 3,968,152 enrollees, an increase of over 10 percent in the last year. Of that increase, 84,000 enrollees can be attributed to a change in Medicaid eligibility for children, resulting in children who had been enrolled in Child Health Plus being moved over to Medicaid.

Despite program growth, total state Medicaid expenditures under the global spending cap are $192 million, or 1.3 percent below projections. The state is anticipating ending the fiscal year with $200 million in savings. In 2012-13, the state's Medicaid program is estimated to cost taxpayers $54 billion in federal, state, and local government funds. The global cap on Medicaid spending pertains to the State share ($15.9 billion) of the portion subject to the Department of Health's oversight. The balance of state spending is largely related to mental hygiene agencies (Office of Mental Health, Office for Persons with Developmental Disabilities, and the Office of Alcohol and Substance Abuse Services).

FIDA Demonstration Project Modifies Target Population and Timeline. The Department of Health is submitting an addendum to its May 25, 2012 Fully Integrated Duals Advantage (FIDA) Demonstration Proposal to CMS. The original start date of January 2014 has been pushed back to April 2014, while the end date of December 2016 will now be December 2017. The target population will now be full dual eligibles who require 120

or more days of Community-Based Long-Term Supports and Services (LTSS), and full dual eligibles who require Medicaid covered Facility-Based Long-Term Supports and Services (LTSS). FIDA plans will be required to either enter into contracts, or make other payment arrangements with all nursing facilities in the FIDA demonstration service area to ensure uninterrupted access to services.

For community-based LTSS participants, voluntary enrollment may begin in April 2014, while passive enrollment will begin in July 2014. For facility-based LTSS participants, voluntary enrollment may begin in October 2014, while passive enrollments will begin in January 2015.

New York State Health Innovation Plan to Transform Healthcare Delivery. New York State Health Commissioner Nirav R. Shah announced a State Health Care Innovation Plan to transform the state's health care delivery system, increase efficiency, and improve the quality of care for the state's residents. New York had been awarded a $1 million Pre-Testing Award from the Centers for Medicare and Medicaid Innovation (CMMI) State Innovations Model (SIM) initiative to promote strategies to reduce costs and enhance the quality of care for New Yorkers enrolled in Medicare, Medicaid, or the Children's Health Insurance Program (CHIP). The award will support development of a comprehensive plan to use health information technology to improve data access and care management tools. To kick off the development of the State Healthcare Innovation Plan, the State Department of Health (DOH) will host an informational webinar for health care providers, insurers, community groups, and other stakeholders from across the state on Thursday, April 25, 2013, from 10 to 11am. Online registration is available at https://www3.gotomeeting.com/register/462070878.

Ohio

HMA Roundup

Ohio Medicaid Expansion Proposal Still Alive with Budget Amendment. Governor John Kasich's negotiations with HHS to expand Medicaid have yielded some flexibility that form the foundation for "The Ohio Plan". While Arkansas has approved of its own model for premium assistance for private plans offered on the heath exchange, Ohio's program would offer a combination of additional enrollment in the traditional fee-for-service Medicaid program (for those under 100 percent of the Federal Poverty Level) and expanded premium assistance for private managed care plans (for those between 100 and 138 percent of FPL).

In a show of bipartisanship, House Republicans and Democrats approved of a budget amendment that directs the governor's Office of Health Transformation and his Medicaid director to provide the General Assembly, by October 1, 2013, the terms of any deal negotiated with HHS. Legislators would still have to vote to approve implementation of a plan by December 31, 2013.

In the news

- **"Exchange Enrollment Seen as 'Huge' Challenge in Ohio"**

  By declining to operate a state-based or partnership Exchange, Ohio passed up on access to millions of dollars in exchange establishment grants from the federal govern-

ment. As a result, there is just $2.2 million in federal funds available to pay enrollment assistance employees and an estimated 1.5 million Ohioans without health insurance who may seek to apply. (CQ HealthBeat)

Pennsylvania

HMA Roundup – Matt Roan

Independent Fiscal Office Notes Benefits of Medicaid Expansion. On April 23, 2013, the Independent Fiscal Office found that Medicaid expansion would increase federal expenditures by $3.2 billion per year from 2016-2021, while simultaneously reducing net state expenditures by $190 million annually, and increasing annual tax revenues by $215 million per year. The Department of Public Welfare responded with a letter from Acting Secretary Beverly Mackereth warning that the US Department of Health and Human Services may limit the ability of states to leverage Medicaid funding through a tax on managed care organizations. The welfare secretary says a change in the gross receipts tax policy could reduce Medicaid funding by an aggregate $1.5-billion over seven years.

DPW Secretary Mackareth Discusses HHS Medicaid Expansion Negotiations. Acting Secretary of the Department of Public Welfare Bev Mackereth confirms that HHS has addressed the Corbett Administration's concerns that PA might not be eligible for full funding of the initial expansion due to is prior health program for low-income adults, Adult-Basic. HHS further confirmed that a portion of the state's CHIP population must be moved to the Medicaid program under the law. Governor Corbett had hoped to retain these children in the CHIP program to tap more generous federal matching funds. Many recent impact studies have focused on increased revenue from the MCO tax associated with Medicaid expansion and additional federal matching funds drawn down by reinvesting the revenue in Medicaid services. However, Secretary Mackereth reported that HHS is reviewing the program and there is uncertainty as to whether it will be allowed to continue.

Texas

HMA Roundup – Dianne Longley and Linda Wertz

RFI for the Addition of SSI and SSI-Related Children to Medicaid Managed Care. On April 18, 2013, the Texas Health and Human Services Commission issued a Request for Information for the addition of SSI and SSI Related Children to Medicaid Managed Care. Currently, there are 163,000 children in Texas receiving health services through SSI and SSI-related Medicaid, with the vast majority receiving health care through the Medicaid fee-for-service system. HHSC aims to implement mandatory managed care for all SSI children. HHSC is interested in ideas, feedback, and comments about Medicaid managed care models for this population, which may help in the development of procurements for the delivery of Medicaid services to children on SSI. The HHSC will accept written comments and questions related to this RFI through June 17, 2013. Responses must be submitted to HHSC's sole point-of-contact, Richard Blincoe at (richard.blincoe@hhsc.state.tx.us).

Bill to Tap Medicaid Expansion Funds Passes Appropriations Committee. On Tuesday, April 23, 2013, by a 15-9 vote, the House Appropriations Committee approved House Bill 3791, authored by Rep. John Zerwas, which seeks to tap additional Federal funds for Medicaid expansion to pay for private insurance. The bill would direct state officials to seek HHS approval for Medicaid funds to be delivered to Texas in a block grant, seek a federal waiver to apply Medicaid expansion funds for private plan premium assistance with cost-sharing provision, and deploy health exchange premium taxes into private insurance plans. Governor Perry has expressed his unwillingness to consider Medicaid expansion and a House vote on this legislation would likely face significant GOP opposition.

National

HMA Roundup

Fourth Quarter 2012 State Revenue Growth Due to Income Shifting. According to the Nelson A. Rockefeller Institute of Government, the 5.2 percent increase in aggregate state tax revenues in the fourth quarter of 2012 is not a sign of recovery in state finances. Instead, it appears to be a one-time benefit associated with taxpayer actions to shift income into 2012 in order to lock in lower rates on income in advance of the 11th hour "fiscal cliff" agreement in January 2013. The institute notes that the median fourth tax payment grew a dramatic 25.2 percent year-over-year, compared to just 6.7 percent median growth for the first three payments. The institute projects slightly lower state tax revenues in the 2013-14 state fiscal years.

States Pursuing Policies to Shift State Workers into Health Exchange Plans. Recently, states have been pursuing policies that may have the effect of shifting traditionally state-funded healthcare benefits to the Federal Government. In Washington state, legislation has been proposed to save nearly $120 million over the next two years by offering state workers, who work between 20 and 30 hours a week, additional compensation in exchange for eliminating state health coverage. Those employees would be able to purchase health plans on the health exchange. Virginia has already limited part-time workers to no more than 29 hours in an effort to shift those employees off of state health plans onto health exchange plans.

In the news

- **"Rep. Paul Ryan warns governors on Obama health care plan"**

  Representative Paul Ryan is warning state governors not to expect the level of federal matching funds for the Medicaid expansion as is promised under the Affordable Care Act. (Chicago Tribune)

- **"Racing to Spread Word About New Health Plans"**

  Health care providers, insurers, and community organizers are working together to raise awareness of coverage options for more than 30 million people who will have new coverage available to them in 2014. Recent studies have shown that as many as three-fourths are unaware of the coverage options available to them under the Affordable Care Act. (New York Times)

- **"State Medicaid Officials Consider Multi-Tiered Benefits, Cost Sharing Under Overhaul"**

  The newly eligible Medicaid population, and the federal requirements for this population, create opportunities for states to impose greater levels of cost-sharing as well as different benefit packages than those for the existing Medicaid population. (CQ HealthBeat via The Commonwealth Fund)

- **"Health Insurance Actuaries In the Hot Seat On 'Rate Shock'"**

  Recent reports from actuaries on insurance rates under the Affordable Care Act have indicated premiums could rise 32 percent across the board due to sicker patients joining the coverage pool, while some states could see rates as much as 80 percent higher. Advocates and supporters of the ACA are hitting back at actuaries, accusing them of being too close to the insurers who have been talking up rate increases for the past several years. (Kaiser Health News)

- **"Study questions 'community benefits' paid by tax-exempt hospitals"**

  A New England Journal of Medicine article has called into question the value of community benefits provided by hospitals, gaining the hospital a tax-exemption. The report found that much of the community benefits provided went toward patient care, not to community health improvement. The article cited the annual value of community benefit tax exemptions at $13 billion. (Los Angeles Times)

OTHER HEADLINES

California

- **"Bill Aims To Reverse 10% Provider Rate Reduction"**

  A California Assembly member has mounted an effort to expand a bill that would reverse the 10 percent Medi-Cal provider rate cut passed in 2011 to all Medi-Cal providers. As it stands AB 900 would reverse the rate cut only for skilled nursing facilities. (California Healthline)

Connecticut

- **"Barnes, exchange board want to limit health insurers' profits, administrative costs"**

  Benjamin Barnes, Connecticut's budget director, announced last week a desire to limit administrative costs and profits on health insurers, arguing that higher costs could undermine the goals of implementing federal health care reforms in the state. A Connecticut health plan lobbyist countered that limiting administrative costs would mean a loss in jobs, while a consumer health advocate praised the plan for being aggressive and consumer-oriented. (The CT Mirror)

District of Columbia

- **"Chartered could owe D.C. health providers $85 million"**

  Chartered Health Plan could owe as much as $85 million in unpaid bills to providers, far more than the $16 million in assets Chartered reportedly has on hand. This includes $5 million from the sale of Chartered's membership and provider network to AmeriHealth Caritas. (Washington Post)

- **"Will D.C. Council steer funds to MedStar by digging into Thrive deal?"**

  Three D.C. Councilmembers have filed a measure to block the Department of Health Care Finance from finalizing a contract with Thrive Health Plans, the highest scoring bidder of the three plans awarded contracts for D.C.'s Medicaid program. The move could limit Thrive's market share if enrollment into the other two plans – AmeriHealth Caritas and MedStar Family Choice – is initiated before Thrive's contract is approved. (Washington Business Journal)

Kansas

- **"Brownback administration cites more savings from KanCare, wants to use funds for those with disabilities"**

  Kansas Governor Sam Brownback has revealed higher than estimated savings from the implementation of the KanCare Medicaid managed care program, indicating a desire to use the additional savings to carve-in the developmentally disabled population. This segment of the Medicaid population was initially excluded from KanCare at the urging of patient advocates and other stakeholders. (Lawrence Journal-World)

Louisiana

- **"Jindal says resolutions will not require administration to get legislative approval for hospital privatizations"**

  The Louisiana House and Senate have both approved resolutions to require legislative committees to formally approve the deals under which non-profit hospital companies would take over the public hospitals currently run by Louisiana State University. Governor Bobby Jindal said this week that these resolutions are not binding and that his administration must only continue to present these deals to the legislature, but need not be put to vote. (NOLA.com)

- **"Obamacare's Medicaid expansion is bad for Louisiana"**

  In a guest column, Governor Bobby Jindal's administration outlines the seven reasons Medicaid expansion is bad for Louisiana. (Greater Baton Rouge Business Report)

Oklahoma

- **"Okla. Medicaid option won't be ready this year"**

  Oklahoma officials indicated that an alternative to the traditional Medicaid expansion will not be finalized by the legislature this session. However, officials did indicate that a deal, when finalized, could resemble the Arkansas private option plan. (AP via San Francisco Chronicle)

Oregon

- **"Private Insurers May Be Forced to Keep Coverage for Inmates"**

  Oregon's Senate Health Committee has put forth a bill that would prohibit private insurers from dropping an individual for coverage who has been arrested or put in jail. Additionally, Senate Bill 457 would prohibit insurers from charging local correctional facilities above Medicare rates for health care services. A separate bill is in the works to move towards requiring Medicare and Medicaid to provide payment for hospital visits for eligible inmates. (The Lund Report)

COMPANY NEWS

- **West Virginia Judge Upholds $90 Million Judgment Against HCR Manor Care.**

  Last week, a West Virginia judge upheld a draconian $90 million penalty from 2011 on HCR ManorCare, involving the death of a resident. The West Virginia legislature recently passed legislation that specified that nursing homes are protected under the malpractice caps enacted in 2003, but plaintiff attorneys argued that a prior law applied, precluding any retroactivity on the verdict. The judge claimed that the facility was understaffed to "maximize profits" and the sizable financial penalty was necessary to deter such practices. The company plans to appeal the decision in the state's Supreme Court.

- **United Health Evaluating Cuts to Medicare Advantage Benefits in 2014.**

  Despite a surprise 3 percent increase in Medicare Advantage rates announced earlier this month, United Health has expressed concerns about future cuts to Medicare Advantage. The company may have to consider reducing benefits and withdrawing from certain markets.

- **"Insurer Centene: We Can Do Arkansas-Style Medicaid"**

  Centene indicated this week that it would operate well in a state where it offered plans in both Medicaid and on the Exchange, as in the example of Arkansas, which just approved its private option plan to expand Medicaid through premium assistance in the state's Exchange. By operating in both markets, a patient's provider continuity could be maintained as they transition back and forth from Medicaid eligibility to Exchange eligibility, a problem known as "churn" that has drawn concerns for continuity of care. (Kaiser Health News)

RFP CALENDAR

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

Date	State	Event	Beneficiaries
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 15, 2013	Washington Duals	Proposals due	41,000
May-June, 2013	South Carolina Duals	RFP Released	68,000
June 1, 2013	California Rural	Implementation	280,000
June 5, 2013	Washington Duals	Contract awards	41,000
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
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
"Early 2014"	North Carolina	RFP released	TBD
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
April 1, 2014	New York Duals	Implementation	133,880
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		98,235	Not pursuing Financial Alignment Model				
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	05/1/2013	Q2 2013	8/1/2013		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					4/1/2014
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	10/1/2013	TBD	TBD	7/15/2013	9/1/2014
Washington	Capitated/MFFS	115,000	X	5/15/2013 (Capitated	6/5/2013 (Capitated)	MFFS Only	1/1/2014
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		TBD**
Totals	**14 Capitated 7 MFFS**	**1.5M Capitated 485K FFS**	***8***			***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.*

‡ Capitated duals integration model for health homes population.

HMA Conference Call Replays

HMA Principals Offer Insight on Medicaid Expansion, Exchanges

HMA Principals Joan Henneberry and Greg Nersessian were recently featured in a conference call hosted by Darren Lehrich and Scott Fidel of the Deutsche Bank healthcare Equity Research team.

Joan and Greg were joined by Steve Schramm, CEO of Optumas, to discuss the current state of Medicaid expansion and Health Insurance Exchanges across the country. Specifically, the call focused on the financial and policy dynamics of the proposed "private option" model for Medicaid expansion in Arkansas and its implications for other states. You can hear their take on the outlook for state decisions related to coverage expansion under the Affordable Care Act by dialing in for a replay of the call through April 25.

Callers in the United States should dial (855) 859-2056. International callers should dial (404) 537-3406. The Access Code is 45315145.

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 released 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 served as co-editor for the March 2013 edition of the Nursing Clinics of North America's Clinics Review Articles on Asthma. Linda also contributed 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 State Innovation Models (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)