HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: WASHINGTON RELEASES DUAL ELIGIBLE DEMONSTRATION RFA

HMA ROUNDUP:

FLORIDA LEGISLATURE FINALIZES BUDGET, FAILS TO AGREE ON MEDICAID EXPANSION;
INDIANA CONTEMPLATES SHIFTING ABD MEDICAID BENEFICIARIES INTO MANAGED CARE;
NEW YORK FREEZES ENROLLMENT IN LARGEST MTLC PLAN;
PENNSYLVANIA DEPARTMENT OF INSURANCE APPROVES HIGHMARK/WPA MERGER;
WASHINGTON PROVIDER TAX REPLACEMENT LEGISLATION MOVES FORWARD;
ALABAMA MEDICAID REFORM BILL NEARS PASSAGE;
LOUISIANA TO REBID MEDICAID ELIGIBILITY CONTRACT;
CMS RELEASES SIMPLIFIED ELIGIBILITY APPLICATION

HMA WELCOMES: KATHY LEITCH – OLYMPIA

MAY 1, 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

---

ATLANTA, GEORGIA • AUSTIN, TEXAS • BAY AREA, CALIFORNIA • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
OLYMPIA, WASHINGTON • SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

Edited by:

Gregory Nersessian, CFA
212.575.5929
gnersessian@healthmanagement.com

James Kumpel, CFA
212.575.5929
jkumpel@healthmanagement.com

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

IN FOCUS: WASHINGTON RELEASES DUAL ELIGIBLE DEMONSTRATION RFA

This week, our *In Focus* section reviews Washington's dual eligible financial alignment demonstration request for applications (RFA). Washington's Health Care Authority (HCA) is pursuing both the managed fee-for-service (MFFS) and capitated dual eligible demonstration models offered by CMS. This RFA is for the capitated duals demonstration. The demonstration targets two counties in the state – King and Snohomish – which had combined dual eligible populations of roughly 48,500 in 2010. The RFA has a quick turnaround for interested applicants, with responses due May 15, just over a month after the RFA was released in April 2013. HCA intends to award no more than two plans in each county with contracts set to go live in November 2013 and enrollment to go live in April 2014.

RFA Target Population

The RFA targets full dual eligible adults and children in King and Snohomish Counties. As the table below indicates, King County had 36,367 duals as of 2010, while Snohomish County had 12,121 duals as of 2010. Total population under this procurement is nearly 48,500.

County	King	Snohomish	Total
Duals - Aged	23,088	7,119	**30,207**
Duals - Disabled	13,279	5,002	**18,281**
Total	**36,367**	**12,121**	**48,488**

Source: HCA RFA Appendix E

The RFA indicates that dual eligibles currently enrolled in Medicare Advantage and PACE plans will have the option to disenroll from their respective plan and participate in the financial alignment demonstration, but will not be part of the passive enrollment process. Under passive enrollment, as with other capitated duals demonstrations, duals are automatically enrolled into a plan, but may opt out of the demonstration after a 60-day retention period. The American Indian and Alaskan Native populations are also excluded from passive enrollment. As of 2010, there were 314 American Indian/Alaskan Native dual eligibles in the two counties – 229 in King, 85 in Snohomish. Finally, the developmentally disabled dual eligible population enrolled in the home and community based service waiver are excluded from the demonstration, although HCA is in discussions with CMS to include this population at a later date.

HCA has provided data for each of the counties on historical spending for the dual eligible population. In 2010, duals in King County accounted for more than $659 million in combined Medicare and Medicaid spending, with a per-member per-month (PMPM) cost of $1,510. Duals in Snohomish county accounted for more than $223 million in combined spending, with PMPM costs of $1,535. A full breakout of Medicare and Medicaid spending by category of service is provided in the Appendix (see page 4).

Contract Awards, Evaluation Criteria

HCA intends to award a contract to no more than two plans per county. The state also will not award a contract to a plan that is not eligible for passive enrollment.

Scoring of applicant responses will be based on the following high-level criteria:

- **50 percent:** applicant qualifications;
- **40 percent:** four case studies; and
- **10 percent:** alignment with State Purchasing Strategies.

HCA has provided a full scoring table, available here.

The RFA also makes explicitly clear the importance of applicants' understanding of the specific population in each county, indicating that the target populations and infrastructure of the two counties are unique and different from each other. This requirement could provide an advantage for incumbent plans who are already serving the Medicaid populations in King and Snohomish Counties.

Timeline

HCA has provided the following timeline for the RFA. Information from the bidders conference, held last Friday, April 19, will be made public, along with responses to written questions, on Monday, April 29. Responses are due on May 15, with awards projected to be announced on June 5, 2013.

Timeline	Date
Bidders conference	April 19, 2013 (1pm PST)
Responses to conference/bidder questions	Monday, April 29, 2013
Proposals due	May 15, 2013 (3pm PST)
Evaluation period	May 16-30, 2013 (approx.)
Projected award announcement	Wednesday, June 05, 2013
Protest period	June 13-20, 2013
Readiness review	September - October 2013
Contract execution	November, 2013

Current Medicaid Managed Care Market

In both King and Snohomish Counties, Molina and Community Health Plan of Washington account for roughly 80 percent of the current Medicaid managed care enrollments.

Health Plan	King	%	Snohomish	%
Molina Healthcare of Washington	83,215	49.4%	38,800	54.8%
Community Health Plan of Washington	50,242	29.9%	24,124	34.1%
United Healthcare	19,225	11.4%	2,560	3.6%
Coordinated Care Corp. (Centene)	7,810	4.6%	3,045	4.3%
Amerigroup (WellPoint)	7,382	4.4%	2,233	3.2%
Providence Eldercare (PACE)	418	0.2%		0.0%
Total	**168,292**		**70,762**	

Source: State Managed Care Enrollment Data

Appendix: Dual Eligible Spending by Category of Service, 2010

KING COUNTY (36,367 Duals as of 2010)				
Expenditures (2010)	**Medicare**	**Medicaid**	**Total**	**PMPM**
Total	**$ 339,248,028**	**$ 319,888,212**	**$ 659,136,240**	**$ 1,510.38**
Professional/Carrier	$ 56,092,419	$ 15,153,509	$ 71,245,928	$ 163.26
Home Health	$ 1,259,297	$ 101,396	$ 1,360,693	$ 3.12
Hospice	$ 13,956,604	$ -	$ 13,956,604	$ 31.98
Inpatient Hospital	$ 120,316,750	$ 2,122,413	$ 122,439,163	$ 280.56
Outpatient Hospital	$ 42,472,291	$ 6,073,472	$ 48,545,763	$ 111.24
Prescriptions	$ 69,969,909	$ 4,688,332	$ 74,658,241	$ 171.08
Skilled Nursing Facility	$ 35,180,758	$ 134,342,040	$ 169,522,798	$ 388.45
Home & Community Based LTSS	$ -	$ 153,358,714	$ 153,358,714	$ 351.41
Alcohol or Drug Treatment (AOD)	$ -	$ 2,024,168	$ 2,024,168	$ 4.64
AOD Inpatient	$ -	$ 311,878	$ 311,878	$ 0.71
AOD Outpatient/Other	$ -	$ 1,712,290	$ 1,712,290	$ 3.92

Source: HCA RFA Appendix E

SNOHOMISH COUNTY (12,121 Duals as of 2010)				
Expenditures (2010)	**Medicare**	**Medicaid**	**Total**	**PMPM**
Total	**$ 114,983,740**	**$ 108,389,437**	**$ 223,373,177**	**$ 1,535.72**
Professional/Carrier	$ 19,341,487	$ 6,176,984	$ 25,518,471	$ 175.44
Home Health	$ 585,871	$ -	$ 585,871	$ 4.03
Hospice	$ 5,647,777	$ -	$ 5,647,777	$ 38.83
Inpatient Hospital	$ 40,448,294	$ 813,508	$ 41,261,802	$ 283.68
Outpatient Hospital	$ 13,087,630	$ 1,854,721	$ 14,942,351	$ 102.73
Prescriptions	$ 23,733,939	$ 1,269,795	$ 25,003,734	$ 171.90
Skilled Nursing Facility	$ 12,138,742	$ 42,281,476	$ 54,420,218	$ 374.15
Home & Community Based LTSS	$ -	$ 55,210,995	$ 55,210,995	$ 379.58
Alcohol or Drug Treatment (AOD)	$ -	$ 390,979	$ 390,979	$ 2.69
AOD Inpatient	$ -	$ 40,547	$ 40,547	$ 0.28
AOD Outpatient/Other	$ -	$ 350,432	$ 350,432	$ 2.41

Source: HCA RFA Appendix E

HMA Medicaid Roundup

Arizona

HMA Roundup

Some Lawmakers Consider Taking Medicaid Expansion to the Voters. According to the Phoenix Business Journal, some Arizona Republican legislators are considering bringing Medicaid expansion directly to the voters as a means of avoiding a definitive vote that could anger different factions of the party. Governor Brewer, who supports expansion, indicated no interest in a ballot approach, preferring to get the job done during this legislative session. However, lawmakers face the prospect of primary challenges and fiscal conservative backlash if they follow the Governor.

CMS Confirms No Federal Funds for Enrollment-Capped Childless Adults. On Thursday, April 24, 2013, the Centers for Medicare and Medicaid Services clarified that federal matching dollars would not be continued for Arizona's enrollment-capped Medicaid program for childless adults as of January 1, 2014. Governor Jan Brewer indicated that the decision is further proof that the legislature needs to quickly move forward with a Medicaid expansion vote. While House Speaker Andy Tobin has not rejected a future vote on Medicaid expansion, Senate President Andy Biggs has refused to hold any Senate floor vote on a proposal that increases Federal funding for expansion. The Governor believes it has a majority of House members to approve expansion, but the Senate will be a tougher challenge.

Arkansas

HMA Roundup

Moody's Says Medicaid Expansion is Positive for AR Hospitals. On Monday, April 29, 2013, Moody's issued a report that cites the "private option" Medicaid expansion as a credit positive for Arkansas hospitals. Those hospitals with higher self-pay patients should benefit the most from a reduction in bad debt.

In the news

- **"Hundreds to be hired to help Arkansans enroll in insurance exchange"**

  The Arkansas News Bureau details the four categories of hirings that will need to take place to facilitate enrollment into the state's exchange. The exchange will employ hundreds, including navigators, guides, certified application counselors, and agents and brokers. (Arkansas News Bureau)

California

HMA Roundup—Jennifer Kent

Special Legislative Session Sends Two Bills to the Governor. The California Assembly and Senate approved bills (A.B. X1x2 and S.B. X1x2) that would enact the provisions of the Affordable Care Act, with additional elements. Beyond approving of the bans on discrimination for pre-existing conditions, guaranteed issue, and the establishment of an in-

surance marketplace, these bills include gay, bisexual, and transgender individuals in the definition of families, prevent excessive premiums for tobacco use, and prevent rate increases from occurring more than once a year. The legislature is expected to expand Medi-Cal and establish bridge plans for consumers who might otherwise switch between Medi-Cal and exchange plans due to changes in income or employment.

Senate Committee Approves Expanding Scope of Practice for Health Specialists. On Monday, April 29, 2013, the Senate Committee on Business, Professions, and Economic Development approved Senate Bills 491, 492 and 493. These bills would expand the scope of practice for nurse-practitioners, optometrists and pharmacists to include making some diagnoses, prescribing drugs, and performing certain medical procedures. Supporters point to a primary care shortage in various parts of the state, likely to be exacerbated by the implementation of the Affordable Care Act. Physicians argue that the legislation could put patients at risk.

In the news

- **"Federal judge renews order for California prison mental health plan"**

  A U.S. District Judge has given California until July 1, 2013 to produce a plan for how the state will improve mental health care for the more than 33,000 inmates needing mental health services. This new order comes amid Governor Jerry Brown's push for an end to the court oversight of prison health care services in the state. (Los Angeles Times)

Colorado

HMA Roundup—Joan Henneberry

Bill Aims to Standardize Pharmaceutical Prior Authorization Processes. Colorado Senate Democrats are trying for the second year in a row to force health insurance companies to speed up prior authorization decisions for pharmaceuticals. SB13-277 would require the Colorado Commissioner of Insurance to develop a uniform prior authorization process and forms to be used by all providers, carriers, and PBMs. The process must be developed by July 2014 and implemented by January 1, 2015. The goal is to create uniformity and reduce administrative burdens on providers, carriers, and PBMs and make the criteria used for deciding prior authorization requests transparent. The bill also calls for establishing a procedure for waiving the process under extenuating circumstances. The Commissioner is to appoint a work group of various stakeholders to make recommendations including national standards for electronic prior authorization.

Colorado HealthOP Certified as an Exchange Plan. The Colorado Co-op, created through a loan program as part of the ACA has a new name - Colorado HealthOP – and website COHealthOP.org. Colorado HealthOP is sponsored by the Rocky Mountain Farmers Union; they are preparing for open enrollment and plan to sell products on Connect for Health Colorado, the state developed health insurance exchange marketplace. The Colorado Division of Insurance just issued the Certificate of Authority certifying Colorado HealthOP as an official health insurance plan.

In the news

- **"Colorado Medicaid Expansion Moves Forward With One Republican Vote"**

  Colorado's House and Senate both approved a bill to expand Medicaid in the state. The bill's lone Republican supporter cited the strain of uncompensated care on hospitals in his district as his reason to vote for the bill. (Kaiser Health News)

District of Columbia

HMA Roundup

Thrive Health Plans Wins DC Medicaid Business. On Tuesday, April 30, 2013, the D.C. Council voted 7-4 (with two abstentions) to approve a Medicaid managed care contract, worth more than $500 million annually, with Thrive Health Plans. Despite a short track record following its 2011 founding, Thrive's proposal was deemed the best of the five submitted to the city's procurement panel and joined AmeriHealth Caritas and MedStar Family Choice with contract awards. Mayor Gray can now initiate the transition process for Medicaid beneficiaries from UnitedHealthcare Community Plan to Thrive, whose contract begins July 1, 2013.

In the news

- **"Plan coming for unpaid Chartered Health claims, Gray says"**

  D.C. Mayor Vincent Gray has indicated that the District's Health Care Authority will have a plan finalized soon to provide relief to providers owed as much as $60 million in reimbursements by Chartered Health Plan. Chartered is currently the largest Medicaid plan in D.C., although it has been held in receivership since last October. Chartered's contract will formally end next week. (Washington Post)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida Lawmakers Agree on $74 Billion Budget. On Sunday, April 28, 2013, Florida lawmakers reached agreement on a $74 billion budget deal that would implement $480 million in teacher pay raises and a new diagnostic related group Medicaid reimbursement approach to paying hospitals.

Florida House Unanimously Approves Senate Bill to Expand Florida Blue. On Monday, April 29, 2013, the Florida House passed S.B. 356 by a 112-0 vote. This bill includes an amendment that allows a not-for-profit insurance company to own other Florida not-for-profit insurers, clearing the way for Florida Blue to become a mutual insurance holding company. Governor Rick Scott is expected to sign the bill shortly.

Senate and House Agree to Disagree on Health Coverage Expansion. On Tuesday, April 30, 2013, the Florida Senate approved a bill to accept federal funds to expand Medicaid eligibility under the Affordable Care Act. The House had previously passed its own bill that would offer limited state funds to subsidize health insurance premiums for a smaller subset of the population. Each chamber has rejected the other's health coverage expansion bills. The Senate bill's author, Sen. Joe Negron, indicated that an agreement is

"unlikely at this point" and that a special session focusing on Medicaid expansion is "improbable."

Indiana

HMA Roundup – Catherine Rudd

General Assembly Ends Legislative Session with Tax Cut; No Medicaid Expansion. The General Assembly concluded its legislative session on Saturday, April 27, 2013, with a smaller tax cut than Governor Pence had requested. Rather than a 10 percent cut over two years, the legislature approved of a five percent cut phased in over four years. In addition, the legislature reduced corporate tax rates and eliminated the inheritance tax. Existing hospital and nursing facility provider taxes were extended through June 30, 2017.

The General Assembly did not pass legislation authorizing Medicaid expansion, or some derivation of it, but the Governor retains the authority to negotiate with the Federal Government to use the Healthy Indiana Plan to cover newly eligible Medicaid beneficiaries. The legislature set aside $250 million to prepare for a potential expansion in the HIP program. The Budget Committee will be required to review all Medicaid waivers and state plan amendments.

Finally, the Office of Medicaid Policy and Planning will have to prepare and present a report by December 15, 2013 to the Health Finance Commission regarding (1) an outline of provisions, (2) an estimate of savings to Indiana, and (3) an evaluation of the fiscal impacts to the state if ABD beneficiaries are enrolled in a managed care plan, a managed fee-for-service program, or a home and community-based services management program.

Maine

HMA Roundup

Democrats Links Hospital Repayment Plan to Medicaid Expansion. Democrats in the Maine Legislature have promised to pass Governor LePage's plan to repay overdue reimbursements to hospitals in return for supporting Medicaid expansion. The Governor LePage accused Democrats of reneging on a commitment to paying the state's 39 hospitals nearly $500 million in overdue reimbursements, which was partly attributable to a prior systems implementation more than a decade ago that resulted in significantly delayed reimbursements. The Governor wants to handle Medicaid expansion separately to secure greater Federal funding than is laid out in the ACA.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Attorney General Recommends Greater State Oversight on Hospital Consolidation. In a report released last week, Attorney General Martha Coakley urges greater state oversight for hospital and physician transactions that hold the potential to create too much market power. The report points to greater market share as a key factor in driving healthcare costs. While the Affordable Care Act encourages more coordination of care, the report notes that the state's biggest health systems may disproportionately benefit

from their resource advantages and could ultimately drive health cost inflation higher. Coakley recommends monitoring hospital-physician partnerships, including information on compensation arrangements and incentives.

House Approves Budget with MassHealth Appropriations Below Governor's Budget. The Massachusetts House passed its FY 2014 budget and sent it to the Senate for consideration. The House budget allocates $13.3 billion for MassHealth and other health reform activities, about $208 million lower than the levels proposed by Governor Patrick. Among the various differences, the governor had proposed $72 million for the full restoration of dental coverage for adults and provider rate increases, but the House budget includes just $17 million for partial restoration of dental benefits (primarily fillings). The House budget removes nearly $12 million in proposed funding for MassHealth's continued coverage of 3,400 legal immigrants not eligible for coverage under the affordable care act, as well as for 900 disabled adults. The House would not allocate the Governor's proposed $10 million for primary care rate increases. The Administration is concerned that it will be difficult to implement these lower MassHealth spending levels without impacting either rates or services to Medicaid beneficiaries.

Michigan

HMA Roundup—Esther Reagan

Medicaid Managed Care Enrollment Activity. As of April 1, 2013, there were 1,240,995 Medicaid beneficiaries enrolled in 13 Medicaid Health Plans (HMOs), an increase of 4,468 since March 1, 2013. The number of Medicaid beneficiaries eligible for managed care enrollment decreased in April - there were 1,300,819 eligible beneficiaries, down from 1,302,103 in March 2013.

The number of Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid benefits continues to grow - there were 35,533 duals enrolled in April, up from 35,089 in March, an increase of 444. The number of Medicaid children dually eligible for the Children's Special Health Care Services (CSHCS) program enrolled in Medicaid HMOs also continues to grow - there were 17,662 CSHCS/Medicaid children enrolled in April, up from 13,707 in March.

Every county in the state is served by at least one Medicaid Health Plan. Auto-assignment of beneficiaries into the HMOs is now in place in every county of the state and there are at least two HMOs serving every county in the Lower Peninsula. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned through federal "Rural Exception" authority to the one HMO serving the counties, Upper Peninsula Health Plan.

According to MAXIMUS, the DCH contractor for MIChild enrollment, there were 37,929 children enrolled in the MIChild program as of April 1, 2013. This is an increase of 383 since March 1, 2013.

Enrollment is dispersed between 10 plans, with 75 percent of the children enrolled with Blue Cross Blue Shield of Michigan (BCBSM). MIChild-enrolled children receive their dental care through contracted dental plans. Of the three available plans, more than 95 percent of the children are enrolled with either BCBSM (48.4 percent) or Delta Dental Plan (46.7 percent).

As of the middle of April 2013, DCH reports there were 38,844 adult benefit waiver (ABW) beneficiaries enrolled in the program, an increase of 12,829 since the middle of March. The increase is attributed to an open enrollment period during the month of April, the first since October - November 2010. The ABW enrollment figure will likely continue to climb for a month or two as Department of Human Services' staff process applications received during April. There are 28 County Health Plans (CHPs) serving ABW beneficiaries in 73 of Michigan's 83 counties. As of April 1, 2013, the combined ABW enrollment in the 28 CHPs was 22,692, a drop of 987 since March. The CHPs should begin to see enrollment growth by May 1, 2013.

Integrated Care for Dual Eligibles MOU Yet to Be Finalized. Michigan continues to plan to implement an integrated delivery system of health care for persons dually eligible for Medicare and Medicaid (duals) through contracts with Integrated Care Organizations (ICOs). In mid-January 2013, DCH announced that the agency was in the final stages of negotiation with the federal Centers for Medicare & Medicaid Services (CMS) on a Memorandum of Understanding (MOU) for a three-year demonstration to be implemented in four regions of the state - the entire Upper Peninsula, an eight-county region in southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren Counties), and the single county regions of Macomb and Wayne Counties. As of the end of April, the MOU has yet to be finalized; however DCH staff still express optimism that approval will occur. Implementation by January 2014 is very unlikely at this point; a mid-2014 date is more likely.

Medicaid Expansion Remains Uncertain. Governor Rick Snyder has endorsed a Medicaid expansion in Michigan, available through the Affordable Care Act (ACA) - the federal health care reform law. The legislature has yet to endorse the expansion and as a result the DCH appropriation for fiscal year 2013-2014 is in limbo. The House of Representatives passed its version of the budget bill for DCH without referencing the expansion and Senate Appropriations Committee Chair Roger Kahn has delayed action on the Senate's version of the budget bill to permit time for additional discussion. In addition to the Medicaid expansion issue, the two budget bills have other significant differences.

Issues of difference include funding for expansion of the Healthy Kids Dental program, the level of funding for hospitals for Graduate Medical Education, and funding for mental health and substance abuse services for veterans. Both chambers decreased funding for the Governor's recommended health and wellness initiatives but by different amounts. The Senate bill includes funding for autism research, which was not recommended by the Governor nor included in the House budget, but the Senate bill does not include language supporting fee increases recommended by the Governor regarding vital records, Certificate of Need and emergency services. Another issue that must be addressed is the shortfall associated with the Health Insurance Claims Assessment tax, estimated at more than $130 million. The claims tax was designed to fill the funding gap left when the state discontinued an assessment on Medicaid Health Plans, which generated about $400 million annually. If another source of funding is not identified there will be a need to reduce the DCH budget accordingly.

A joint revenue estimating conference involving both the executive and legislative branches is scheduled for mid-May. Any upward or downward revisions to estimates of Fiscal Year 2013-2014 revenues would also affect final appropriation decisions.

No-Fault Reform Legislation Introduced; Limits on Provider Rates Proposed. On April 18, 2013, Governor Rick Snyder unveiled his plan to overhaul how the state regulates medical coverage for individuals catastrophically injured in automobile accidents, and on April 23rd Representative Pete Lund introduced House Bill 4612 designed to do so. The bill would reduce auto insurance rates by $125 per vehicle and discontinue unlimited medical benefits through the Michigan Catastrophic Claims *Association*, instead establishing a new Michigan Catastrophic Claims *Corporation* that would cap medical coverage at $1 million. In addition, the bill would restrict what hospitals and other providers could charge to what they receive from the Medicare and Medicaid programs for the same services and would place restrictions on attendant care for individuals, both relative to the number of hours per day and the payment rate. The bill was referred to the House Insurance Committee for review, a committee chaired by Representative Lund.

Mental Health System Review Underway. Earlier this year, Governor Rick Snyder issued Executive Orders creating two new boards charged with recommending improvements to the state's mental health system. One of those boards, the Mental Health and Wellness Commission, a six-member advisory board to DCH chaired by Lieutenant Governor Brian Calley, held its first hearing on April 23, 2013. The Commission heard from witnesses who outlined problems with treatment and care for mentally ill individuals, who questioned whether the current decentralized mental health system is still appropriate or if additional state beds for individuals in need of longer care are necessary, and who emphasized the need for additional psychiatric and psychological practitioners to reduce the time it takes to initiate treatment. The Commission's charge includes identifying ways to address gaps in the delivery of mental health services and proposing new service models to strengthen the entire delivery spectrum of mental health services throughout the state. A report of findings and recommendations is due in December 2013.

Montana

HMA Roundup

Montana Governor Considering Special Session for Medicaid Expansion. According to published reports, Governor Bullock is evaluating calling a special legislative session to focus on Medicaid expansion, particularly given that the Montana legislature is not scheduled to reconvene until 2015. It remains to be seen if he has the votes to support an expansion, but his decision is expected to come within the next few days. Advocacy groups are also considering their options in pushing for a voter initiative to put Medicaid expansion on the 2014 ballot.

New York

HMA Roundup—Denise Soffel

NY State Cuts Off New Enrollment in State's Largest MLTC Plan. Last week, New York state officials decided to suspend new enrollment in managed long-term care plans operated by the Visiting Nurse Service of New York. Fraud investigators identified evidence that certain social adult day care centers may have persuaded seniors to enroll in these plans with inappropriate incentives. On Friday, April 26, 2013, Medicaid Director Jason Helgerson warned that MLTC plans should not enroll social day care users unless the individuals had functional or clinical needs requiring community-based long-term care services. Helgerson said that the Department of Health has mandated that all MLTC plans reassess any member currently receiving social day care as a plan benefit to ensure that they meet eligibility criteria.

The Office of the Medicaid Inspector General has begun conducting audits and the Department of Health would recoup any payments made for ineligible enrollees. The Inspector General has also begun an investigation into social adult day care centers to determine which providers have inappropriately offered materials, financial incentives, or other inducements to enroll in an MLTC plan.

VNS Choice is the state's largest plan with more than 20,000 enrollees and has more contracts with social day care centers than any other plan. In a New York Times letter to the editor, the Visiting Nurse Service of New York wrote that VNS enrolls only Medicaid eligible New Yorkers who qualify for the covered services and immediately remedy any improprieties in enrollment or marketing. Furthermore, the letter notes that "the socialization value of adult day care centers is indisputable."

In the news

- **"Advocates Say Managed-Care Plans Shun the Most Disabled Medicaid Users"**

  Advocates for New York's disabled Medicaid population reported to the state's Medicaid director that managed care plans are improperly avoiding enrolling the most disabled and high cost Medicaid patients in the state. These reports come as the state continues to shift more of the long-term care Medicaid population into managed care plans. (New York Times)

- **"Raske: Hospitals 'at high risk of failure'"**

  Greater New York Hospital Association President Ken Raske addressed members at the group's annual meeting last week, asserting that federal and state health care reforms will significantly impact New York hospitals' finances. Raske stated that the state's outstanding $10 billion Medicaid waiver request should be a major focus of the provider community. (Crain's Health pulse)

- **"Provider Rates Under Exchange?"**

  Donna Frescatore, executive director of the state's exchange, provided clarification to the hospital community that reimbursement rates under the exchange will not be tied to Medicaid in any way. Plans will negotiate reimbursement rates with providers the same as with existing commercial insurance products. (Crain's Health pulse)

Ohio

HMA Roundup

Ohio Director of Health Transformation Outlines Payment Innovation Strategies. On April 25, 2013, Greg Moody, the Director of the Office of Health Transformation, testified on the issue of payment innovation before the Senate Finance Medicaid Subcommittee. Mr. Moody broached the subject of leveraging Ohio's $17 billion in annual healthcare purchasing power (nearly $20 billion, if dual eligibles' Medicare spending is considered) and various delivery models that can lower costs and improve outcomes. Mr. Moody pointed to the Advisory Council on Health Care Payment Innovation, which reports to Governor Kasich, that aims to immediately find ways to reduce waste and catalyze innovative payment methods, while also eventually building out accessible medical homes and episode-based bundled payments to drive efficiency.

Pennsylvania

HMA Roundup –Matt Roan

DPW Secretary Expresses Need for Benefit Package Simplification. Acting DPW Secretary, Bev Makereth provided a report to the Medical Assistance Advisory Committee last week on the status of negotiations with CMS related to Medicaid Expansion. As has been previously reported, DPW has received answers to some of their concerns including confirming that PA is eligible for the full match for expansion and requirement to move children under 133 percent FPL out of CHIP and into Medicaid. The Secretary reported that as the administration considers Medicaid expansion they have identified the need to make several reforms to the Pennsylvania Medicaid program.

The major issue discussed was the need to simplify Pennsylvania's 14 benefit packages in order to achieve administrative efficiencies and tailor benefits to eligibility groups based on their need. The Secretary also talked about ways that DPW could encourage Medicaid recipients to find work that would provide better health insurance coverage. Finally, the Secretary reported that CMS is very focused on PA making progress in managing its long term care programs more effectively. The Secretary reported that it is considering options including Managed Long Term Care.

Deadline Extended for Providers to Receive Enhanced Primary Care Reimbursement. DPW announced at the Medical Assistance Advisory Committee last week that it is extending the deadline for providers to attest that they are eligible for enhanced reimbursement rates for primary care which were a part of the Affordable Care Act. The Department had previously set a deadline of April 30th for providers to submit attestations in order to receive retroactive payments back to January 1, 2013. With recent changes regarding how immunizations will be counted, additional providers may now meet the threshold in the law of 60 percent of a providers services being primary care. The Department is extending the deadline to July 1, 2013 to accommodate these providers who were previously thought to be not eligible. Any provider who submits attestation by July 1 and meets other program requirements will be eligible for the retroactive payments.

PA Insurance Dept. Approves Highmark/West Penn Allegheny Merger. On Monday, April 29, 2013, Pennsylvania Insurance Commissioner Michael Consedine announced the

Department's approval of the Highmark / West Penn Allegheny Health System transaction to create an integrated delivery network. The Department will continue to monitor the providers and has instituted safeguards to protect insurance consumers. This transaction's review was the largest in the department's history, including 64,000 pages of reports and analytical data, more than 10,000 pages of public comments and more than six hours of public testimony.

Washington

HMA Roundup

Provider Tax Bills to Be Aligned in Final Budget Negotiations. The House and the Senate have drafted hospital safety net assessment (provider tax) bills, H.B. 2016 and S.B. 5913, which include adequate funding to support care for Medicaid patients, contain contractual legal protections against a future raid of assessment funds, and include a four-year sunset date. The revised payment structures should provide more predictability to hospitals. The current provider tax is set to expire this year, potentially costing the state $260 million.

The Senate version ratchets down both the assessment program and payments by one-sixth each year. At the end of the program, hospitals would not be subject to the tax, but would face significantly lower Medicaid payment rates. Differences in the bills will be hashed out in final budget negotiations, which will likely occur during an additional session of the state legislature.

National

HMA Roundup

CMS Simplifies Health Coverage Application. Following controversy about a previous 21-page application, the Centers for Medicare and Medicaid Services has released a far simpler application, totaling just three pages for individuals and seven pages for families. The simpler application now compares favorably to applications required of most private health insurers. While officials hope and expect most applicants will use the online application, which can shorten the application process and dynamically adapt to individual responses, the paper application appears consumer-friendly enough to avoid discouraging eligible applicants from completing the enrollment process. The applications may be submitted starting on October 1 and can be found at Link

IPPS Proposed Rules Would Increase Hospital Payments 0.8 percent. CMS released its Inpatient Prospective Payment System proposed rule for FY2014 on Friday, April 26, 2013. Hospitals would have a 0.8 percent increase in payments, on average, although DRG weighting changes will obviously affect the actual Medicare rates experienced by individual facilities. Hospitals will be impacted by a (0.8 percent) recoupment adjustment, with further adjustments projected in FY 2015, 2016, and 2017. In an effort to deliver more pay for better performance, CMS has established penalties of up to 2 percent for hospitals with high readmission rates for heart attack, heart failure, and pneumonia. COPD and knee/hip implants will be added to the categories considered for readmissions penalties. The maximum penalty will be raised to 3 percent in 2015.

Brookings Bi-Partisan Report Pushes for Integrated Care and Payment Reform. A recent Brookings report indicates that the Federal Government could save more than $300 billion in healthcare costs over the next decade with a move to more integrated care and risk-based payments. Policy makers were urged to target holding healthcare spending growth in line with GDP growth, following nearly four decades of consistently higher healthcare growth.

The report recommends that Medicare pay providers a capitated amount adjusted for quality, patient outcomes, and per-capita GDP growth. Medicaid should aim for more coordinated care, slower cost growth, and improved care under a "patient-centric" approach to delivery. Brookings notes that a cap on the employer-sponsored insurance tax exclusion and an expansion in capitated dual-eligible alignment projects could drive further savings.

In the news

- **"Health-Care Owners Shun Nursing Homes"**

  Three large health care landlords – companies that lease health care real estate to providers – indicated this week that they intend to reduce their exposure in nursing home leases or will not pursue additional growth in the nursing home sector, citing uncertainty on the future of Medicare payments. (Wall Street Journal)

- **"'The outlook for Medicaid expansion looks bleak'"**

  Washington Post's Sarah Kliff looks at new reports from Avalere Health on state progress on the Medicaid expansion. Avalere's update indicates that 20 states and D.C. have agreed to expand Medicaid, with another four states – Tennessee, Kentucky, Florida, and New York – leaning towards expansion. (Washington Post)

- **"Uninsured Population Swells in Advance of U.S. Health Law"**

  A new report from The Commonwealth Fund found that 84 million Americans are currently uninsured or underinsured. This is an increase of 3 million since 2010 and an increase of 20 million since 2003. The report estimates that 85 percent of these will be eligible for Medicaid or subsidized coverage in 2014. (Bloomberg Businessweek)

- **"Obama Administration Mulls Rule To Give Home Health Aides Better Wages"**

  The Obama Administration is continuing to review a 2011 proposal to extend minimum wage and overtime wage protections to home care workers employed by third parties. Advocates for home care workers are trying to push the administration to finalize the rule, while some patient advocates have warned that it could increase home health costs. (Kaiser Health News)

OTHER HEADLINES

Alabama

- **"Medicaid bill moves closer to passage"**

  Last week, the Alabama senate approved a bill that would divide the state's Medicaid program into regional care organizations, which would have the option of contracting with traditional managed care plans. The bill now goes to the House. (Montgomery Advertiser)

Connecticut

- **"Conn. Seeks to blunt health plan premiums' costs"**

  Connecticut officials are seeking ways to limit the increase in health plan premiums that individuals may see in 2014, with one proposal floated that would limit the amount of spending on overhead and profits for small group health insurance plans. However, some have countered that legislation to limit premiums could have unintended consequences for the state's economy due to the high number of insurance industry employees in Connecticut. (Boston Globe)

Kansas

- **"Governor's plan would take 600 off waiting lists for social services"**

  Kansas Governor Sam Brownback detailed plans to use $18.5 million in additional funds to transition 400 physically disabled and 200 developmentally disabled Kansas Medicaid enrollees off of a waiting list for home and community based services. The funding was made available due to revised estimates, showing lower-than-anticipated Medicaid spending due to the implementation of KanCare, the comprehensive Medicaid managed care program implemented in the past year. (Kansas Health Institute)

Louisiana

- **"Medicaid expansion bill clears Louisiana Senate health committee"**

  The Senate Health Panel approved an amended bill this week that would require Governor Bobby Jindal's administration to accept the federal Medicaid expansion funding, so long as that funding be used to help eligible individuals purchase health insurance. The bill would require the Department of Health and Hospitals to apply for a waiver to use federal Medicaid funds for premiums and cost-sharing subsidies in the exchange. (The Times-Picayune)

- **"Louisiana to rebid Medicaid eligibility contract"**

  Louisiana's Department of Health and Hospitals will rebid a Medicaid eligible determination contract initially awarded to Deloitte LLP. The contract was cancelled due to contract clause requiring the winning bidder to utilize proprietary Microsoft Dynamics software. Former DHH Secretary Bruce Greenstein is a former Microsoft employee. Greenstein resigned last month in the wake of an investigation into the award to another former employer of Greenstein's, CSNI, for the state's Medicaid claims contract. (NECN.com)

- **"Fund to increase federal Medicaid dollars passes second Louisiana House committee"**

  A bill to allow a hospital assessment is set for a full vote before the Louisiana House after passing unanimously out of committee. The bill, HB 532, creates a "stabilization fund" that hospitals will contribute to. The fund will be matched at a 65-to-35 ratio with federal Medicaid funds and repaid to hospitals based on their levels of Medicaid and uncompensated care provided. The fund is expected to generate $170 million in reimbursements on $110 million in contributions. (NOLA.com)

- **"Jindal administration: Greenstein had improper contact with Medicaid contractor in bid process"**

  Governor Bobby Jindal's administration stated this week that former Department of Health and Hospitals secretary Bruce Greenstein had improper contact, including phone calls and text messages, with CNSI, a company awarded the Medicaid claims processing contract earlier this year. CNSI's contract was cancelled as of March 21 and Greenstein resigned in the wake of investigations. (Washington Post)

Maryland

- **"Maryland announces Connector Program to help enroll residents under federal health overhaul"**

  Maryland has announced the formation of the Connector Program, which will use $24 million in combined state and federal grants to fund organizations to aid individuals in enrolling in the state's health benefits exchange beginning in October. (Washington Post)

Oklahoma

- **"Oklahoma hospital group spearheads campaign to expand Medicaid"**

  A group organized by the Oklahoma Hospital Association is initiating a massive internet and radio advertising campaign to urge the legislature and the governor to accept the Medicaid expansion. The group estimates the value of federal funding to the state at nearly $9 billion and could create as many as 15,000 new jobs. (The Oklahoman)

West Virginia

- **"State's Medicaid expansion report revised, delayed"**

  A report commissioned by West Virginia to study the Medicaid expansion and the health benefits exchange has continued to undergo revisions and delays; a report was initially expected in January 2013. Governor Tomblin has indicated he will not make a decision on the Medicaid expansion until the report is finalized. West Virginia will operate a partnership exchange. (Charleston Daily Mail)

COMPANY NEWS

- **"naviHealth Receives Strategic Investments from BlueCross BlueShield Venture Partners and Ascension Health Ventures"**

  "naviHealth announced strategic investments from BlueCross BlueShield Venture Partners L.P. (BCBS Ventures), managed by Sandbox Industries, and Ascension Health Ventures (AHV). These new entities join Welsh, Carson, Anderson and Stowe, Universal American and Select Medical Corporation as principal investors in naviHealth. naviHealth is a leading post-acute care benefit manager, partnering with health plans, health systems, accountable care organizations and post-acute care providers, to drive better decision-making for patients who are emerging from acute care." (BusinessWire)

- **"Emergency Medical Services selects banks for IPO"**

  "Emergency Medical Services Corp, the largest U.S. provider of ambulance services, has selected underwriters for a $750 million initial public offering, two people familiar with the matter said on Wednesday. The Greenwood Village, Colorado-based company, backed by private equity firm Clayton, Dubilier & Rice LLC, has selected Goldman Sachs Group Inc (GS.N), Barclays Plc (BARC.L) and Bank of America Merrill Lynch (BAC.N) to lead the deal, which may come during the third quarter, the sources said." (Reuters)

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	Texas Rural STAR+PLUS	Proposals due	110,000
May 15, 2013	Virginia Duals	Proposals due	79,000
May 15, 2013	Washington Duals	Proposals due	48,500
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	48,500
June, 2013	Idaho Duals	RFP Released	17,700
June, 2013	Virginia Duals	Contract awards	79,000
July 1, 2013	Massachusetts Duals	Implementation	115,000
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
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	79,000
January 1, 2014	Texas Duals	Implementation	214,400
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
April 1, 2014	Idaho Duals	Implementation	17,700
April 1, 2014	New York Duals	Implementation	133,880
April 1, 2014	Washington Duals	Implementation	48,500
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					10/1/2013
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	June 2013	TBD	TBD		4/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013
Michigan	Capitated	70,000			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 WELCOMES…

Kathy Leitch, Principal – Olympia, Washington

Kathy comes to HMA most recently from C. E. Reed and Associates where she served as a Partner in the firm. She was also the sole proprietor of Kathy Leitch, HCBS Consultant.

A significant part of Kathy's career was spent as the Assistant Secretary of the Aging and Disability Services Administration for the Department of Social and Health Services, State of Washington. In this role she provided leadership by providing options to meet the long term care service and support needs of the elderly as well as persons with developmental, physical, or behavioral health disabilities. Some of her accomplishments include - developed an extensive in-home choices and community based residential options; achieved highest ranking of Medicaid long term care expenditures devoted to home community based services in the Medicaid 2009 expenditure report; provided quality assurance for nursing home and community residential residents as well as clients of supportive living agencies through licensing, certification, and complaint investigation protocols; and participation in the development of multiple automated information system projects including Provider One and Developmental Disabilities Comprehensive Assessment.

Kathy's 30+ years with the Department of Social and Health Services also included roles as the Division Director of the Home and Community Services Division, Director of the Planning and Program Development Division, and the Office Chief of Client and Community Relations.

Kathy holds a MSW from the University of Washington and a BA from Central Washington State College.

HMA Recent Publications

"Medicaid Health Plan Community Partnership Series"

The Commonwealth Fund

Sharon Silow-Carroll – Author
Diana Rodin – Author

As state Medicaid programs are increasingly shifting beneficiaries into managed care organizations (MCOs), some MCOs are expanding their traditional role to better meet the needs of their vulnerable members and communities.

In a new Commonwealth Fund report, Health Management Associates Managing Principal Sharon Silow-Carroll and Consultant Diana Rodin, report on the efforts of four managed care organizations (MCOs) that are forging community partnerships to meet the needs of vulnerable Medicaid patients and others in their communities.

They developed four case studies:

- Gateway Health Plan
- HealthPartners
- L.A. Care
- Neighborhood Health Plan

These case studies describe the "how" and the "why" when it comes to MCOs addressing barriers and changing the way care is delivered, including internal and state policy drivers, leveraging partnerships and key takeaways. (Link to report)

"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)