HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: UNIVERSAL PDL TRENDS - POTENTIAL IMPACT ON MEDICAID DRUG REBATES

HMA ROUNDUP: CALIFORNIA DUALS DEMO IMPLEMENTATION DELAYED UNTIL JANUARY 2014; ALABAMA LEGISLATURE APPROVES MEDICAID MANAGED CARE TRANSITION; OREGON MEDICAID STUDY IGNITES DEBATE; COLORADO SEES MEDICAID ACO PROGRESS; WEST VIRGINIA GOVERNOR ANNOUNCES SUPPORT FOR MEDICAID EXPANSION; MEDICAID EXPANSION DEBATES CONTINUE ACROSS THE U.S.

OTHER HEADLINES: ILLINOIS, TENNESSEE REPORT EXCHANGE PLAN APPLICATIONS; NEW HAMPSHIRE ADJUSTS HOSPITAL RATES TO ENCOURAGE CONTRACT RESOLUTIONS IN LONG-DELAYED MCO ROLLOUT; AETNA COMPLETES ACQUISITION OF COVENTRY

MAY 8, 2013

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

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In Focus: Universal PDL Trends and Potential Impact on Medicaid Drug Rebates

This week, our *In Focus* section looks at the potential future of Medicaid prescription drug rebates given the landscape of the rebating changes under the Affordable Care Act (ACA), the Medicaid expansions beginning in 2014, and the ongoing growth of Medicaid managed care. We give particular focus to the states currently implementing Universal Preferred Drug Lists (PDLs) and states that may implement Universal PDLs in the future. In fiscal year 2012, Medicaid prescription drug rebates generated nearly $17 billion in combined revenue to states and the federal government.

About PDLs, Universal PDLs, and Rebating

Preferred Drug Lists (PDLs): States with fee-for-service (FFS) Medicaid programs maintain PDLs, as do Medicaid managed care plans, for pharmacy benefits. Prescription drugs on the PDL are selected for their clinical effectiveness and efficiency, and in many cases, there are significant considerations if supplemental rebate agreements are reached. Non-PDL drugs are subject to a prior authorization process before being approved for reimbursement under FFS or managed Medicaid.

Universal PDLs: Some states have instituted a Universal PDL, whereby all Medicaid MCOs in the state must adhere to a single state-determined PDL. A state's establishment of a Universal PDL can change the dynamics of rebating agreements between the MCOs and the pharmacy industry.

Prescription Drug Rebates: The Medicaid Drug Rebate Program requires a pharmaceutical manufacturer to enter into a national rebate agreement with the Department of Health and Human Services (HHS) in order to have its drugs covered under Medicaid. These rebates are shared between the federal government and states. States may also negotiate their own rebate agreements with manufacturers, known as sidebar or supplemental rebates. These supplemental rebates are often taken into consideration as a state creates or modifies its PDL.

Background – Rebate Collections and Spending in Context

All states and the District of Columbia receive prescription drug rebates under the national Medicaid drug rebate program, while 39 states have negotiated supplemental rebating agreements with drug manufacturers. The Drug Rebate Equalization Act of 2009 opened the door for states looking to add pharmacy benefits to their capitated Medicaid managed care programs without losing the national and supplemental drug rebate agreements in place. Previously, Medicaid drug rebates were unavailable if the pharmacy benefit was managed by a managed care organization (MCO).

- For states with no carve-out ("carve-in" states), drug rebate equalization provided a new revenue source as drugs covered under Medicaid MCOs became eligible for the drug rebate program.

- For states with a partial carve-out (many states have only carved-out certain drug classes or drugs for certain populations), drug rebate equalization provided a significant new revenue source.

FY 2012 Medicaid expenditures (from the most recent CMS 64 Medicaid expenditure report) show 23 states with MCO rebates in place totaling more than $2.5 billion. One state, Oregon, had a state supplemental agreement in place on the MCO rebates. The table below summarizes states rebate reporting.

United States Total	Rebates Collected	# States
Total Pharmacy Spending	$ 23.3 B	
Drug Rebate - National	$ 12.4 B	51
Drug Rebate - Supplemental	$ 1.0 B	39
MCO Rebate - National	$ 2.6 B	23
MCO Rebate - Supplemental	$ 0.7 M	1

Source: CMS 64 Medicaid Expenditure Report, FY 2012

Universal PDL Trends

With the rebates opened up to managed care lives, it may be useful going forward to look at possible actions and emerging trends with regard to state decisions on universal preferred drug lists (PDLs) and universal formularies.

- **Florida:** Managed care procurement (launching late-2014) requires plans to adhere to state PDL for first year, may request plan-specific PDL after year one.
- **Georgia:** Navigant Consulting group had recommended that the state require all MCOs adopt the same PDL for the purpose of administrative simplification. The state has not adopted that recommendation to date.
- **Indiana:** Indiana maintains a universal PDL, but carves out the pharmacy benefit from managed care. If the benefit is carved back in, it is uncertain whether the universal PDL would remain, as the MCOs would likely oppose a universal PDL.
- **Texas:** Currently operates a universal PDL; however, will sunset at the end of August 2013 unless legislature takes action to maintain current PDL requirements. In a March, 2013 annual report on the Texas Medicaid Drug Rebate Program, the Health and Human Services Commission (HHSC) indicated that the state would experience a significant decrease in rebate dollars if the MCOs were allowed to formulate their own PDLs.
- **West Virginia:** Carved in the pharmacy benefit to managed care on April 1, 2013 under a universal PDL.

Looking Ahead

Currently, 3.8 million out of 29 million (13.1 percent) Medicaid MCO enrollees are covered under a universal PDL, largely in Texas. Given the emerging market trends in Medicaid, and with many states indicating that the Medicaid expansion population will be largely or wholly enrolled into MCOs, the capitated Medicaid MCO population is likely to grow significantly over the next three to five years. Greater market share puts MCOs in a position to push back against universal PDL arrangements. However, states are like-

ly to continue to explore universal PDLs as they seek to maximize rebate revenue amidst increased MCO enrollment and pharmacy benefit carve-in. The rebate report in Texas highlights the significance of a universal PDL from a rebate revenue standpoint and Texas' decision later this year on whether to continue with a universal PDL may provide insight into the directions states will go on the universal PDL issues in the years to come.

HMA MEDICAID ROUNDUP

Alabama

HMA Roundup

Legislature Approves Medicaid Managed Care. On Tuesday, May 7, 2013, the Alabama House of Representatives gave final approval to the implementation of Medicaid managed care by a 99-0 vote and sent the legislation to Gov. Robert Bentley for his signature. The state will be divided into eight regions with a regional care organization to coordinate patient care. No current services will be cut and skilled nursing, dental, behavioral, and pharmacy programs will not be impacted until 2016.

Arizona

HMA Roundup

Governor Brewer Aims for Non-Traditional Alliance to Get Medicaid Expansion. Despite the vehement opposition of Arizona Senate President Andy Biggs, Gov. Jan Brewer insists that Medicaid expansion will happen. She has reached out to various individual lawmakers in a bid to get a floor vote on her plan. There is speculation that a discharge petition could be used to unblock the legislation, despite the Senate President's opposition. Eighteen senators would be required to effectuate this procedure, which means at least five Republicans would need to join all 13 Senate Democrats to force a vote. There remains the matter of the House Speaker, Andy Tobin, who continues to oppose Medicaid expansion, but has not written off the possibility of a floor vote.

In the news

- **"GW Institute: Medicaid expansion would line hospitals' pockets"**

  A Goldwater Institute editorial in the Tucson Sentinel this week argues that expanding Medicaid in Arizona would do little to eliminate hospital bad debt, leading hospitals to continue to report large amounts of uncompensated care. The editorial claims that only charity care amounts would be reduced from the expansion and that charity care amounts make up only a small portion of uncompensated care in the state. (Tucson Sentinel)

California

HMA Roundup—Jennifer Kent

Cal MediConnect Duals Launch Delayed to No Earlier than January 2014. On Monday, May 6, 2013, the Department of Health Care Services (DHCS) announced that the Cal MediConnect duals program would be launched no earlier than January 2014. In March, the state had received Federal approval to move forward with the program to cover as many as 465,000 dual eligible beneficiaries. DHCS noted that implementing this "kind of systematic change takes time" and the new timeline allows for each issue to receive "the full consideration it deserves." A final start date should be established in the next few months, as assessment efforts continue on systems, logistics, and outreach.

State Senate Leader Proposes Plan to Expand Mental Health Services. On Tuesday, May 7, 2013, State Senate leader Darrell Steinberg offered a proposal to meaningfully expand mental health services. The plan would involve increasing the number of prison parolees receiving mental health services from 1,500 to 5,000 to reduce the recidivism rate. Moreover, Steinberg's plan would boost crisis treatment beds in residential facilities by 2,000, as a cheaper alternative to emergency room utilization. Finally, 200 mental health triage workers would help the mentally ill with health, housing, and educational services, while 25 Mobile Crisis Support Teams would assist the homeless access short-term care. Law enforcement and advocacy groups offered initial signs of support for the proposal.

In the news

- **"Managed Care Tax Decision Left Until New Budget Proposal Arrives"**

  Gov. Jerry Brown has indicated he would like to reinstate the managed care organization (MCO) tax, which expired in December 2012. However, the governor wants to use the funds raised to support the state's rainy day fund. Previously, the MCO tax was matched with federal dollars and used to support the state's Healthy Families plan, which was transitioned into managed care in the last year. The governor's proposal was strongly opposed by the senate budget subcommittee. (Kitsap Sun)

Colorado

HMA Roundup—Joan Henneberry

Medicaid ACO Progress in Colorado. The Department of Health Care Policy and Financing (HCPF) is showing promising initial results of managing Medicaid services through their Accountable Care Program and Regional Care Collaborative Organizations (RCCOs). As of April 2013, the program has roughly 290,000 enrollees (out of 698,000 total Medicaid clients) and 379 Primary Care Medical Provider (PCMP) locations. The program is rapidly expanding and accepting new qualified Primary Care Medical Practices that receive PMPMs for care coordination, Administrative and Practice Support, and Data Analytics and Reporting Capabilities. The first Accountable Care Collaborative (ACC) program incentive payments were paid to Primary Care Medical Providers (PCMPs) and RCCOs in March 2013. This payment represents a first step in the program paying for value in the Medicaid program.

Colorado Budget Signed into Law. On Monday, May 6, 2013, Gov. John Hickenlooper signed into law the FY 2013-2014 $20 billion ($7.7 billion from the general fund) budget, which passed through both the House and the Senate. The budget included funding for Medicaid on a variety of issues including an expanded substance use disorder treatment benefit, funding for the purchase and enhancement of customer service technology, the reprocurement of the new Medicaid Information Management System, and funding for an administrative service organization for the Medicaid children's dental benefit.

Connect for Health Colorado Board Faces Protests Over Outreach Budget. On Monday, May 6, 2013, the Connect for Health Colorado (health exchange) board debated how much to spend on consumer education and outreach. Consumer groups were offended by a $14 million proposal by exchange staff for navigators, which falls short of the $20 million recommended by the advocacy groups. On the other hand, certain board members questioned the overall $125 million Federal grant proposal for being profligate and wasteful, given an existing operating budget of $61 million from prior grants. The application for the grant is due next week, but members of the board declined to vote on a target funding level until later this week. Members put off a decision on the target level of funding until consulting with a legislative oversight commission. Meanwhile, the Senate approved a measure to fund future operations beyond 2015 with a $1.80 per member per month (PMPM) fee for users who buy insurance via the exchange.

Senate Committee Rejects Governor's Proposal to Offer Transitional Housing for the Mentally Ill and Homeless. In the wake of last summer's mass shooting at an Aurora cinema, Gov. Hickenlooper had advocated for stricter gun legislation and investments in psychiatric care. However, his proposal to reopen a former psychiatric hospital (and prison) at Ft. Lyon to offer transitional housing for the mentally ill and homeless was rejected on Friday, May 3, 2013, by the Senate Appropriations Committee after having passed the House.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Democrats Push Governor to Call a Special Session on Medicaid Expansion. Various Florida Democratic leaders have called on Gov. Rick Scott to initiate a special legislative session to push for Medicaid expansion. On Monday, May 6, 2013, US Senator Bill Nelson joined State Senate Democrats urging the Governor to more assertively advocate for a policy he publicly supported earlier in the year. Unless the Governor is confident in peeling off at least 16 House Republicans from the 75 in the chamber, Scott appears unlikely to pursue a special session. House Speaker Weatherford remains opposed to accepting Federal funds for an expanded Medicaid benefit.

Florida Legislative Session Ends without Medicaid Expansion. Last Friday, May 3, 2013, the House and Senate adjourned the current legislative session without agreeing to accept 100 percent Federal funding for a Medicaid expansion. Despite the Governor's support and Senate approval of Sen. Negron's legislation to deploy the additional Federal funds toward premium supports, the House passed its own scaled down healthcare expansion bill that would rely entirely on state funds.

Florida House and Senate approve FY 2013-2014 Budget. Last Friday, May 3, 2013, the House approved the FY 2013-2014 budget by a 106-11 vote, while the Senate unanimously approved of the $74.5 billion spending plan.

Illinois

HMA Roundup – Matt Powers and Jane Longo

Illinois Soliciting Medicaid Dental Benefits Administrator. Late in April, the Illinois Department of Healthcare and Family Services (HFS) issued a RFP for a Medicaid dental benefits manager. Over the initial contract term of five years, the RFP notes that the population covered by the contract will diminish significant, from an estimated 2.7 million to an estimated 900,000 by the fifth contract year. This is due to the state's plans to shift at least 50 percent of the Medicaid population into managed care by January 1, 2015. RFP responses are due June 7, 2013.

Six Insurers to Offer 165 Plans on the State Health Exchange. On Wednesday, May 1, 2013, Gov. Pat Quinn announced that six insurers had applied to offer health plans on the Illinois health insurance exchange. In total, 165 Qualified Health Plans (QHPs) would be available on the Illinois Health Insurance Marketplace, well below the predictions of 260 plans from 16 insurers made by the state last fall. The Department of Insurance (DOI) will review the 165 plans to ensure compliance with the Affordable Care Act's requirements of essential health benefits, network sufficiency, and non-discrimination for preexisting conditions. DOI recommendations on certification will be made by July 31, 2013 and the Department of Health and Human Services will make final determinations by August 31, 2013.

In the news

- **"Illinois opens grant process for health guides"**

  Gov. Quinn's administration kicked off a competitive grant process for $28 million in available funding for organizations and community groups to serve as guides to the new health insurance exchange. (Crain's Chicago)

Indiana

HMA Roundup – Catherine Rudd

CMS Confirms Receipt of HIP 1115 Waiver. On April 30, 2013, CMS acknowledged receipt of Indiana's application for an extension of the Healthy Indiana Plan 1115 waiver. The agency completed a preliminary review and confirmed that the application met the requirements for a complete extension request. A 30-day Federal comment period commenced on April 30, 2013 (through May 30, 2013). CMS cannot render a decision on the application until at least 15 days after the close of the public comment period.

Louisiana

HMA Roundup

Louisiana House Approves Bill to Increase Medicaid Matching Funds. On Tuesday, May 7, 2013, the Louisiana House approved a hospital provider tax bill (HB 532) that could add $170 million in Medicaid federal matching funds. The overwhelming 99-6 vote would allow hospitals to "deposit" funds into a stabilization fund, which would qualify for matching Federal funds to be distributed to participating hospitals based on the services provided to Medicaid beneficiaries and the uninsured. The measure is a constitutional amendment that would require a 2/3 vote in the Senate before being placed on the ballot for voters to consider in 2014. The measure was compared to a similar "bed tax" that was applied to nursing homes.

Maine

HMA Roundup

MaineHealth and Anthem Partner to Create First Commercial ACO in the State. Maine's largest health plan—Anthem Blue Cross and Blue Shield of Maine—has partnered with one of the state's largest hospital systems, Maine Health, to form an accountable care organization designed to lower costs and improve outcomes. The collaboration intends to address 50,000 to 60,000 MaineHealth patients and would represent the first commercial ACO in the state. The model would allow MaineHealth to retain a portion of any savings realized under the arrangement, assuming the system hits quality benchmarks, such as patient satisfaction and preventive health screenings. MaineHealth would, conversely, be on the hook to return funds if it falls short of quality and savings targets. Anthem modeled this arrangement on another ACO partnership forged with New Hampshire's Dartmouth-Hitchcock Medical Center, which yielded lower patient costs and reduced use of emergency rooms.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Governor Files Legislation to Implement ACA in Massachusetts. Last Friday, May 3, 2013, Gov. Deval Patrick filed legislation (H. 3452) to implement the provisions of the Affordable Care Act in Massachusetts. Included in the proposal were a number of technical changes to state insurance laws to conform to the ACA. The legislation would define Medicaid state plan eligibility to include citizens and qualified aliens up to 133% FPL. (Most of these individuals already qualified for coverage under the state's existing Medicaid 1115 waiver.) The legislation also eliminates current provisions that prohibit individuals from buying individual coverage if they have access to employer-based insurance. Another section of the bill extends the ability of adult children up to age 26 to remain on their parent's coverage, because the federal law is more expansive than Massachusetts law. The legislation also eliminates obsolete references in current law to pre-existing conditions and waiting periods, and permits the phase-out of rating factors not allowed by the ACA.

State Releases Draft Medicaid Demonstration Waiver Amendment for Public Review. The Commonwealth of Massachusetts has recently released a draft Medicaid demonstration waiver amendment that would generally implement the provisions of the Affordable Care Act. Massachusetts seeks Federal approval to transition certain eligibility categories to those outlined by the ACA. The Commonwealth seeks to offer "State Wrap" subsidies that will supplement federal subsidies on the Health Connector. Because of the broader eligibility associated with ACA, Massachusetts will discontinue MassHealth Basic, MassHealth Essential, the Medical Security Plan, the Insurance Partnership (for small businesses) and Commonwealth Care. In addition, the amendment describes the Primary Care Payment Reform Initiative (PCPR) as the vehicle to transition MassHealth members to alternative payment methodologies, as required by Chapter 224, the Commonwealth's pioneering 2012 payment reform and cost containment legislation. MassHealth requests Federal approval for an extension in the deadline for developing a protocol to limit certain payments made under the Safety Net Care Pool to costs on a provider-specific basis from October 1, 2013 until June 30, 2014. The Executive Office of Health and Human Services (EOHHS) will accept comments on the proposed Amendment through 5pm on May 30, 2013.

Michigan

HMA Roundup—Esther Reagan

Senate Has Still Not Considered DCH Budget. While Michigan is on a different fiscal year than many other states (beginning October 1, rather than July 1), the Senate has still not considered the Department of Community Health budget. If the Senate establishes a DCH budget without Medicaid expansion funding, the initiative could be killed absent a supplemental bill. The legislature is aiming to deliver a budget to Gov. Rick Snyder by early June, but that leaves just a few weeks for the Senate and House to hash out any potential policy differences. The Governor has undertaken meetings with individual lawmakers to build support for his proposal.

Missouri

HMA Roundup

Missouri Legislature Rejects Medicaid Expansion. With the close of the legislative session, Republican lawmakers have chosen to ignore Gov. Jay Nixon's exhorations to support Medicaid expansion. A committee has been established to consider expansion options with an early 2014 date for a report. While some stakeholders hold out hope that a ballot measure could activate expansion, Missouri voters have symbolically voted against participating in the ACA (2010) and against empowering the governor's office from establishing state-run health exchanges unilaterally

New York

HMA Roundup—Denise Soffel

NY State Health Commissioner Cites Medicaid Redesign is Working. On May 8, 2013, the NY State Department of Health Commissioner Nirav Shah provided data that demonstrates the Medicaid Redesign Team (MRT) initiatives are slowing growth, even as enrollment continues to grow. In particular, long term care costs have slowed markedly with managed long-term care (MLTC) initiatives saving nearly $1 billion in New York City alone. MLTC enrollment has grown from approximately 10,000 in 2004 to nearly 70,000 as of November 2012. The number of MLTC plans has expanded from 16 to 38 over the same period.

In the news

- **"Obamacare could lower premiums in New York, new study finds"**

  A new study indicates that insurance reforms under the ACA may generate lower premiums for New Yorkers, although other states are unlikely to experience the same scenario. New York had previously passed insurance market reforms that did not include an individual mandate, which generated higher premiums, but greater protections for individuals with preexisting conditions. (Washington Post)

Ohio

HMA Roundup

Medicaid Officials Brief House Republicans on Program Improvements. This week, Medicaid Director John McCarthy told an Ohio House panel that the state is one of the leaders in implementing cost controls within the program. Medicaid managed care enrollment has grown significantly and care coordination, wellness efforts, and home and community-based initiatives have saved the program money. Certain Republicans are considering supplemental legislation that would expand the Medicaid program, as requested by Gov. John Kasich.

In the news

- **"Ballot is backup for Medicaid expansion plan"**

  The Ohio Hospital Association is leading an effort to gather the required signatures to put the Medicaid expansion on the ballot as a constitutional amendment, although given the short time frame, it may not be put to voters until November 2014. Ohio's governor, John Kasich supports the Medicaid expansion and included it in his two-year budget; however, it appears uncertain whether there is enough republican support in the legislature to pass a bill. (The Columbus Dispatch)

Oklahoma

HMA Roundup

CMS Confirms Waiver Request Requires Conformance to ACA Requirements. CMS responded to a request for an extension of an 1115 Medicaid waiver program (Insure Oklahoma) by confirming that the program must be changed to conform with requirements from the ACA. CMS Medicaid Director Cindy Mann noted that enrollment caps, for example, would have to be dropped but that the states retained flexibility in instituting some cost-sharing arrangements. Consistent with HHS comments to other states, CMS encouraged Oklahoma to work with the agency in building on its historical premium assistance approach to expand Medicaid coverage. Two Republican legislators are focusing on a proposal to reform Medicaid and, simultaneously, tap generous Federal funding commitments under ACA.

Oregon

HMA Roundup

Controversy Surrounds New England Journal of Medicine Study on Oregon Medicaid. Last week, the New England Journal of Medicine published a study that compared health outcomes of low-income Oregon residents who gained Medicaid coverage through a lottery in 2008 against those who had applied but failed to gain coverage. The findings were that certain elements of health improved, including a reduction in depression, greater use of physician services and prescription drugs, as well as an improved detection rate for diabetes. However, there was no statistically significant difference in such measures as blood pressure, cholesterol levels, and blood sugar levels. Supporters of Medicaid expansion and the ACA were quick to point out that Medicaid coverage increased use of the health care system, improved mental health measures, and expanded participation in preventative care, without a one-time spike in utilization. Opponents to the ACA noted the lack of statistically significant evidence of improved physical health measures, implying that Medicaid spending growth can hardly equate to improved health outcomes.

In the news

- **"Insurers skip Oregon's small employer insurance exchange — for now"**

  Cover Oregon, the managing entity for the state's health insurance exchange, has reported that twelve insurance companies have applied to offer plans in the individual and small group marketplace, but that only eight of the twelve have applied to serve the small employer market. There is an expectation that most small employers will retain the coverage they have, rather than enter the exchange market. (Portland Business Journal)

Pennsylvania

HMA Roundup –Matt Roan

Highmark Launches the Allegheny Health Network. With the long-delayed merger with West Penn Allegheny Health System now complete, Highmark has launched the Allegheny Health Network, an integrated healthcare delivery system consisting of West Penn's five hospitals and Highmark's healthcare providers in the Pittsburgh and Erie areas. Local experts see an opportunity for changes to the way healthcare is delivered in the Pittsburgh region with an effort to build a financially stable, patient-centered network that improves access to affordable care. The new entity will compete with UPMC, the powerhouse hospital leader in Western Pennsylvania.

Makereth Nominated to Be Official DPW Secretary. Gov. Tom Corbett has nominated Acting DPW Secretary Bev Makereth to officially fill the role of Secretary. Ms. Makereth previously served in human services leadership roles at the county level and has also served as a member of the PA General Assembly. Most recently, Makereth served as the Deputy Secretary for the Office of Children, Youth, and Families within DPW.

Legislature Passes Community-Based Health Care Act. The House offered unanimous final approval of Community-Based Health Care Act (SB-5), which is now on Gov. Corbett's desk for his signature. The legislation establishes Community-Based Health Care Program within the Department of Health to provide grants to community-based health care clinics ($4 million in FY 2013-14) to (1) expand and improve health care access and services; (2) reduce unnecessary utilization of hospital emergency services by providing an effective alternative health care delivery system; and (3) encourage collaborative relationships among community-based health care clinics, hospitals, and other health care providers. The bill requires clinics, with certain exceptions, to accept Medicaid or CHIP, capping at 25 percent the amount of grants that can be received by Federally Qualified Health Centers. The bill also outlines the grant award methodology and describes powers and duties of the Department of Health as well as providing for certain mobile health clinics. Limitations are placed on payments to community-based health clinics.

Texas

HMA Roundup – Dianne Longley and Linda Wertz

"Texas Solution" for Medicaid Expansion Declared Dead by Chief Author. Rep. John Zerwas declared on Tuesday, May 7, 2013, that his bill to offer up a "Texas Solution" for Medicaid expansion was hung up in the House Calendars Committee with virtually no prospect of making a House floor vote. Zerwas asserts that the bill might have had enough support to make it through a House vote given his efforts to align the bill's provisions with the block-grant idea embraced by the Governor. However, given strong opposition to any form of Medicaid expansion by Gov. Rick Perry, the legislation faced significant challenges and could not make it through the Calendars Committee.

West Virginia

HMA Roundup

West Virginia Governor Announces Support for Medicaid Expansion. On Thursday, May 2, 2013, Gov. Earl Ray Tomblin announced his support for Medicaid expansion in the state. Tomblin estimates that 91,500 people would seek coverage under the newly expanded eligibility standards, with the federal government picking up virtually all incremental costs for that expansion population over the next decade. According to a spokesperson, the Governor is authorized to move forward with the expansion without legislative approval, although the Democratic Governor would face little resistance given his party's majority status in both houses of the legislature.

National

HMA Roundup

Administration Prods States for Community-Based Mental Health Benefits. On Tuesday, May 7, 2013, CMS issued a Medicaid bulletin to states offering design options for community-based mental health benefits. The bulletin highlighted two initiatives — SAMHSA's Children's Mental Health Initiative and the CMS Psychiatric Residential Treatment Facility Demonstration Program — that have proven outcomes and lower costs. The document further outlined different avenues for the states to get Federal approval for such community-based Medicaid services, including various waivers.

CMS Releases Hospital Data that Demonstrates Wide Variances in Pricing. This week, CMS released hospital data from the more than 3,000 U.S. hospitals that receive Medicare Inpatient Prospective Payment System (IPPS) payments, highlighting the 100 most frequently billed discharges in FY 2011. As one example, the cost of implanting a pacemaker varied wildly from as little as $20,000 to more than $200,000.

Recent Slowdown in Healthcare Spending May Persist. While many observers believe that the recent slowdown in healthcare spending is a short-term phenomenon brought on by the deep recession and slow recovery, research has been released recently that attribute far less causality to the economy. One study conducted by economist David Cutler asserts that the economy was responsible for just one-third of the slowdown in healthcare spending, while 55 percent was due to structural changes such as greater cost sharing and improved provider efficiency.

In the news

- **"GOP Clashes Stymie Medicaid Expansion"**

  Arizona, Florida, Michigan, and Ohio all have republican governors who have supported expanding Medicaid, yet none of these four states has passed enabling legislation due to interparty conflicts between governors and republican lawmakers. There are 3.79 million uninsured who could be covered in states outright rejecting expansion, with another 3.93 million in states leaning against expansion. (Wall Street Journal)

- **"Private insurance exchange market heats up to rival state"**

  Companies like Mercer and Blue Cross Blue Shield are launching private health insurance exchanges alongside the state-based, partnership, or federally run exchanges. A senior partner at Mercer predicts that within three to five years, 30 percent of the employer-sponsored market will purchase benefits through an exchange, be it public or private. (Hartford Business)

- **"Multi-State Plans May Be a No-Show on Exchanges; Unions Want to Fill the Void"**

  Multi-state plans, plans offered in at least 60 percent of states, are taking a back seat to the greater push toward individual state offerings on the exchanges. Both Aetna and Cigna will not participate in 2014, while United is considering participation. Now several large union groups are exploring the multi-state plan option. (AIS Health)

OTHER HEADLINES

Kansas

- **"Eagle editorial: Don't delay Medicaid expansion"**

  The Wichita Eagle this week urged Gov. Sam Brownback and the legislature to not delay the Medicaid expansion. The Eagle argues that the expansion would get 150,000 Kansans insured, inject $3 billion into the state's economy, and add as many as 4,000 new jobs. (The Wichita Eagle)

Minnesota

- **"Medica asks for a rate hike. Are other Minnesota health insurers next?"**

  One of Minnesota's top-three insurers is seeking a 13 percent rate increase for a small portion of its small-business market. However, the move is drawing concern that Medica could raise rates on tens of thousands of other Minnesotans in small group plans, and that other insurers could follow suit. (Twin Cities Pioneer Press)

New Hampshire

- **"N.H. changes rates to boost managed care"**

  New Hampshire's Medicaid agency adjusted hospital and other provider rates this week in hopes of encouraging contracting between the state's three contracted Medicaid MCOs and the provider community. The state's transition to Medicaid managed care has been continually delayed due to provider contracting issues and now appears it will miss a targeted rollout date of July 1. (Concord Monitor)

North Carolina

- **"Blue Cross: Rates will rise under new federal health care law"**

  Blue Cross and Blue Shield has indicated that one third of their individual market will see premium increases for next year in excess of normal annual increases, while small group purchasers will see premium hikes of approximately 18 percent in North Carolina. (Charlotte Observer)

Tennessee

- **"BlueCross, Cigna submit plans for TN's federally run health exchange"**

  Friday, May 3, was the deadline for plans to submit applications to operate on Tennessee's federally facilitated exchange. BlueCross BlueShield and Cigna are two of the known applicants. Tennessee is one of five exchanges Cigna has chosen to operate in, with three others also being federally facilitated exchanges. (Memphis Business Journal)

Company News

Aetna Completes Acquisition of Coventry Health Care, Inc.

This week, Aetna completed its acquisition of Coventry Health Care. The acquisition increases Aetna's managed Medicaid business from 1.1 million to more than 2 million covered lives, while expanding its footprint from twelve to sixteen states. (Aetna Press Release)

Centene's Kentucky Subsidiary Announces Layoffs

On Monday, May 6, 2013, Centene's Kentucky Spirit Health Plan notified its workforce and local government officials of imminent layoffs in preparation for the sunsetting of its contract with the state. The first round of layoffs will begin on July 5, with further layoffs scheduled over the remainder of 2013.

Aetna and Cigna Indicate Conservative Approach to Exchange-Based Plans

On Tuesday, May 8, 2013, Aetna indicated that the company cut the number of states in which it might plan to sell individual plans on health exchanges. The company further noted that if exchanges appear unready or unprofitable, then Aetna might withdraw wholesale from participating in health exchange offerings. On Monday, May 7, 2013, Cigna's CEO David Cordani declared that the company would sell insurance in five federally-run health exchanges in Texas, Florida, Tennessee, Arizona, and Colorado in 2014.

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 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 17, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
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	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	California Duals	Implementation	500,000
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	1/1/2014
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					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					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 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)