HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS ISSUES GUIDANCE ON MLTSS WAIVERS

HMA ROUNDUP: CALIFORNIA, COLORADO, GEORGIA, MARYLAND EXCHANGE PLANS REVEALED; ARKANSAS TO SUBMIT MEDICAID EXPANSION WAIVER REQUEST BY AUGUST; CALIFORNIA MEDI-CAL PROVIDER RATE CUTS UPHELD; DELAWARE ISSUES MMIS RFP; MASSACHUSETTS REVISES TIMELINE IN DUAL ELIGIBLE DEMO; ILLINOIS, IOWA TO EXPAND MEDICAID, WHILE MAINE GOVERNOR VETOES; MICHIGAN, MISSISSIPPI GOVERNORS EXPLORING EXPANSION OPTIONS; OHIO BILL INTRODUCED TO EXPAND MEDICAID, TEXAS LAWMAKERS PASS BILL BLOCKING EXPANSION; OTHER MEDICAID EXPANSIONS DEVELOPMENTS IN ARIZONA, FLORIDA, TENNESSEE; MAGELLAN PROTEST CONTINUES IN ARIZONA BEHAVIORAL RFP AWARD

MAY 29, 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: CMS ISSUES GUIDANCE ON MLTSS WAIVERS

This week, our *In Focus* section reviews guidance from the Centers for Medicare & Medicaid Services (CMS) released on May 21, 2013, outlining the 10 essential elements for managed long-term supports and services (MLTSS) programs implemented through Section 1115 demonstrations or 1915(b) waivers. MLTSS programs utilize capitated Medicaid managed care structures for the delivery of home and community-based services and institutional-based long-term care services. CMS indicates that the guidance is a response to the increasing use of MLTSS programs by states and was formed based on the experiences of states that have already implemented MLTSS programs through demonstration or waiver authorities. Below, we review the 10 essential elements identified by CMS and look at current and upcoming states utilizing MLTSS programs.

CMS Guidance: (Link - PDF)

CMS MLTSS Homepage: (Link - HTML)

Ten Essential Elements Reviewed

1. **Adequate Planning.** States must allow adequate time for planning of implementing or redesigning their MLTSS program. This includes the planning and design phase, MLTSS readiness and MCO readiness evaluation, and oversight of the initial implementation and care transition phases.

2. **Stakeholder Engagement.** CMS found that successful MLTSS programs have developed robust stakeholder engagement structures throughout the design and implementation phases. Additionally, CMS expects states to require their contracted MCOs to have the same formal process for stakeholder engagement. MLTSS program transparency must also be considered an essential element of a state's program.

3. **Enhanced Provision of Home and Community-Based Services.** All MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's *Olmstead v. L.C.* decision. This requires MLTSS programs to ensure delivery of services in the most integrated setting and in a way that offers the greatest opportunities for active community and workforce participation.

4. **Alignment of Payment Structures and Goals.** MTLSS programs must be designed so that payments to providers are aligned with the goals of the program. CMS suggests that effective MLTSS programs hold providers accountable with performance-based payment incentives or penalties. As part of this, rate-setting must be conducted with MLTSS objectives in mind and rates must be sufficient to encourage adequate MCO and provider participation. States must actively oversee and evaluate the MLTSS payment structure and look for ongoing modification and improvements.

5. **Support for Beneficiaries.** MLTSS programs must provide conflict-free, independent, and no-cost plan choice counseling and advocacy or ombudsmen services. Additionally, states must, at a minimum, allow for transition to another MCO or to fee-for-service (FFS) Medicaid when the termination of a provider from their network could

cause a disruption. CMS suggests ideally that MLTSS enrollees would be able to disenroll at any time.

6. **Person-Centered Process.** MLTSS programs must require contracted MCOs to implement person-centered needs assessment, services planning, and service coordination policies and protocols. CMS stresses that the plan of service delivery must reflect the needs and preferences of the individual or the caregiver. Additionally, states that provide FFS LTSS programs currently and offer self-direction are expected to continue these practices in MLTSS. States not offering self-directed LTSS currently are strongly encouraged to do so.

7. **Comprehensive, Integrated Service Package.** CMS expects that states will pay MCO plans in a MLTSS program a single capitated payment for all physical, behavioral, and LTSS services. Additionally, MCOs should be permitted to make service authorization decisions only on the basis of the individual needs assessment. Finally, when an enrollee in a MLTSS program transitions between settings (e.g., from hospital to home), there should be care transition services provided as part of the MLTSS service package to ensure a smooth transition between care settings.

8. **Qualified Providers.** States must require MCOs in their MTLSS programs to maintain a network of qualified LTSS providers meeting all state licensing, credentialing, and quality requirements. Additionally, states with existing FFS LTSS programs should encourage MCOs to contract with existing LTSS providers serving the population. During the transition process, states should provide or require MCOs to provide support to LTSS providers in areas including information technology (IT), billing, and systems operations as they transition to MLTSS.

9. **Participant Protections.** States must establish, through MCO contracts and other provisions, participant rights and responsibilities protections as well as safeguards to prevent abuse, neglect, and exploitation. Additionally, CMS expects states to adopt policies that would ensure services continue to be provided during the appeal of a termination or denial of service action.

10. **Quality**. States must ensure the highest level of quality in its MLTSS program. A comprehensive quality strategy should include MLTSS and address all of the key elements in the CMS guidance on MLTSS. CMS provides a great deal of guidance and framework as a basis for designing a quality strategy.

Current and Upcoming MLTSS Programs by State

As part of a CMS report released last year, Truven Health Analytics analyzed the current and upcoming MLTSS marketplace. The tables below[1] show current and upcoming MLTSS programs by state and by populations enrolled. While these charts are not completely up to date, they remain fairly accurate. For example, New Mexico is in the process of combining its Coordination of Long Term Services (CoLTS) program into the all-inclusive Centennial Care program.

[1] *Source: The Growth of Managed Long Term Services and Supports: A 2012 Update. Prepared for CMS/DEHPG by Truven Health Analytics.*

Table 1 - Current MLTSS Programs – as of July 2012

State	Program Name	Children	Physical Disability	Intellect./ Develop. Disability	Age 65+
Arizona	Long Term Care System	X	X	X	X
California	SCAN Connections at Home				X
Delaware	Diamond State Health Plan-Plus	X	X	X	X
Florida	Long Term Care Community Diversion				X
Hawaii	QUEST Expanded Acess	X	X	X	X
Illinois	Integrated Care Program		X	X	X
Massachusetts	Senior Care Options				X
Michigan	Managed Specialty Support & Services	X		X	
Minnesota	Senior Health Options				X
Minnesota	Senior Care Plus				X
New Mexico	Coordination of Long Term Services	X	X		X
New York	Managed Long Term Care		X		
New York	Medicaid Advantage Plus		X		X
North Carolina	MH/DD/SAS Health Plan Waiver	X		X	
Pennsylvania	Adult Community Autism Program			X	
Tennessee	CHOICES	X	X		X
Texas	Star+Plus	X	X		X
Washington	Medicaid Integration Partnership		X	X	X
Wisconsin	Family Care Partnership		X	X	X
Wisconsin	Family Care		X	X	X

In the upcoming MLTSS programs chart below, many states are including LTSS populations in capitated dual eligible demonstrations. None of the states listed here have pulled out of the duals demonstration, but many are facing continued delays in timing of implementation. As such, these charts should be viewed as an indication of many states' plans but may not be all-inclusive as of May 2013.

Table 2 – Upcoming MLTSS Programs – as of July 2012

State	Program Name	Children	Physical Disability	Intellect./ Develop. Disability	Age 65+
California	Coordinated Care Initiative		X	X	X
Florida	Long-term Care Managed Care Program		X		X
Idaho	Demonstration to Integrate Care for Dual Eligibles		X	X	X
Illinois	Medicare-Medicaid Alignment Initiative		X	X	X
Kansas	KanCare	X	X	X	X
Massachusetts	Demonstration to Integrate Care for Dual Eligible Individuals		X	X	
Michigan	Integrated Care for People who are Medicare-Medicaid Eligible	X	X	X	X
Nevada	Comprehensive Care Waiver (NCCW)	X	X		X
New Hampshire	Medicaid Care Management Program	X	X	X	X
New Jersey	Managed Long Term Care		X		X
New York	Fully Integrated Duals Advantage (FIDA)		X	X	X
New York	Mandatory Managed Long Term Care		X		X
New York	People First Waiver	X		X	
Ohio	Integrated Care Delivery System		X	X	X
Rhode Island	Integrated Care for Medicare and Medicaid Beneficiaries		X		X
South Carolina	Dual Eligible Demonstration				X
Virginia	Demonstration to Integrate Care for Dual Eligible Individuals		X	X	X
Washington	HealthPath		X	X	X

HMA Medicaid Roundup

Arizona

HMA Roundup

Brewer Continues to Pressure GOP Legislators. Last Thursday, May 23, 2013, Governor Jan Brewer made good on her vow to block legislation until lawmakers acted to pass a budget and expand Medicaid with the veto of five separate bills. Meanwhile, reports emerged that GOP legislators have received emails urging them to "kill SB 1492, the Medicaid Expansion Act," along with threatening references to the Second Amendment.

Arkansas

HMA Roundup

State on Track to Submit Formal Waiver Request to HHS by August. On Thursday, May 23, 2013, Department of Human Services Director John Selig confirmed to state lawmakers that a waiver request to offer premium assistance for Medicaid recipients would be submitted to the federal Health and Human Services Department in August, subject to a comment period. Governor Mike Beebe's spokesman expects that, if all goes as planned, the state could move forward with its proposed Medicaid expansion approach by the October 1, 2013 deadline to begin enrolling beneficiaries. The Administration aims to have six to eight insurance providers offering plans on the exchange. Letters of Intent from insurers are due on June 3, 2013 and full applications must be submitted by June 30, 2013.

California

HMA Roundup—Jennifer Kent

California Health Plan Premiums Come in Lower than Many Expected. Last Thursday, May 23, 2013, Covered California announced the 13 plans that will offer health plans on the state's exchange: Kaiser Permanente, Anthem Blue Cross, Blue Shield of California, HealthNet, Alameda Alliance for Health, Chinese Community Health Plan, Contra Costa Health Services, L.A. Care Health Plan, Molina Healthcare, Sharp Health Plan, Valley Health Plan, Ventura County Health Care Plan and Western Health Advantage. Counter to widespread concerns about "rate shock," the proposed premiums were surprisingly low, according to many observers. Covered California said the individual plan rates range from 2% higher to 29% below the average small-employer plan premiums in major metropolitan areas. Exchange officials attributed the modest premiums to lower targeted profit margins for the participating plans and tough negotiations with providers, although many "high cost" providers have been excluded from the networks of the plans. In particular, critics note that the Blue Shield Exchange plan for Los Angeles excludes UCLA Medical Center and Cedars Sinai. Furthermore, for those ineligible for Federal subsidies, rates may still increase meaningfully compared to the cheapest individual and small group rates available today.

Federal Court Upholds Medi-Cal Provider Rate Cuts. Last Friday, May 24, 2013, the US Ninth Circuit Court of Appeals lifted injunctions on the state implementing 10 percent cuts in Medi-Cal provider rates, potentially saving California as much as $600 million annually. Providers are worried about the cut in rates as well as retroactive "clawback" provisions that would recover two years of inflated service fees. Although there are bills that have received bipartisan support in both houses, Governor Brown has promised a veto.

CA Senate Approves Bill to Expand Medical Roles of Certain Providers. On Tuesday, May 28, 2013, the California Senate passed SB491 that permits nurse practitioners to expand their role to deliver certain primary care functions, including certification of disability claims, writing prescriptions, and authorizing certain treatments. In addition, the Senate passed SB492 that allows optometrists to check for high blood pressure, measure cholesterol levels, and administer certain immunizations. A further vote on expanding the role of pharmacists is expected imminently.

Colorado

HMA Roundup—Joan Henneberry

Colorado Health Institute Legislative Review Released. On May 24, 2013, the Colorado Health Institute released its annual report, "2013 Legislation in Review: An Analysis of Key Health Policy Trends." The report highlights legislation that addressed implementation of the Affordable Care Act (ACA), regulatory changes and reporting requirements to reduce fraud and abuse in the healthcare system, elements of the budget bill that included increased investments in health care, and, several bills targeted at health care system efficiencies. The report also suggests policy and legislation that is likely to be taken up in the 2014 session that begins in January. The report can be found **here.**

Preliminary Health Exchange Plan Information Released. The Colorado Division of Insurance released information on May 22, 2013 about health plans proposed to be sold in the individual and small group markets in Colorado through Connect for Health, the state-based Exchange. Final details about health plans and premiums will be known in August, but 10 carriers requested approval to provide a total of about 150 health plans for individuals and families through the marketplace. Six carriers requested approval to provide nearly 100 health plans to small employers.

End-of-Life Treatment Process Now Eligible for Medicaid Reimbursement. HB 13-1202 is now state law in Colorado and makes counseling for Medical Orders for Scope of Treatment (MOST) eligible for reimbursement under the Medicaid program, provided federal cost sharing is available. The MOST process helps people to plan for and make end-of-life decisions. Currently, providers are not eligible to be reimbursed for the service. The added cost of MOST reimbursements is expected to be offset by the end-of-life cost savings, according to fiscal analysts.

Delaware

HMA Roundup

RFP for Delaware Medicaid Management Information System. On May 24, 2013, the State of Delaware Health and Social Services, Division of Management Services, released a Request for Proposal (RFP) for a new Medicaid Management Information System (MMIS), to be dubbed the Delaware Medicaid Enterprise System (DMES). Delaware seeks a single Contractor to develop a modular system that will promote interoperability. The five-year contract carries could be extended through June 30, 2024. Letters of Intent are due by June 14, 2013 and proposals are due by August 7, 2013. Bidder demonstrations will be held on August 23, with selected site visits from October 1-10, 2013. The selection and intent to award is expected to be announced on or around November 13, 2013 with a contract start date on February 3, 2014. The new system should be operational as of July 1, 2016.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Physician Attestation Reminder Issued. On May 29, 2013, the Agency for Health Care Administration (AHCA) reminded physicians of the May 31, 2013 deadline to complete attestations to qualify for a retroactive payment at enhanced rates for primary care services. To date, providers have been issued seven notices regarding the attestation requirement and approximately 9,000 eligible physicians have been certified for the enhanced rates.

US Senator Urges Gov. Scott to Veto Insurance Rate Suspension Legislation. Last Wednesday, May 22, 2013, US Senator Bill Nelson wrote to Governor Rick Scott recommending a veto of SB 1842, which would suspend the state's authority to set insurance rates for two years. Nelson is a former state insurance commissioner and calls the legislation "unconscionable." The GOP legislators who supported this bill argue that the legislation aims to help the state comply with evolving regulations associated with the ACA.

Georgia

HMA Roundup – Mark Trail

Georgia Health Exchange Features Seven Insurers. As of last week, the following seven health insurers have signed up to provide health plans on the state's Exchange: Aetna, Alliant, Blue Cross and Blue Shield of Georgia, Coventry, Humana, Kaiser Foundation Health Plan, and Peach State. The Atlanta area will feature the lowest rates, while the Albany area may face the highest premiums in the state. According to observers, premiums in the Silver tier compare favorably to similar plans offered to small employers today.

Idaho

HMA Roundup

Idaho Reiterates Exchange to Remain State-Run. Last week, Governor Butch Otter and Idaho Health Insurance Exchange Board Chairman Stephen Weeg issued a joint statement reiterating the state's commitment to running its own health Exchange. While the Exchange board has voted to run a "parallel" process to use the Federal IT infrastructure as the state develops its own, the governor and chairman note that this transitional IT strategy does not constitute a hybrid, partnership, or Federal Exchange.

Illinois

HMA Roundup – Matt Powers and Jane Longo

Illinois House, Senate Pass Medicaid Expansion Bill. The Illinois Senate, which had previously passed SB 26 in February 2013, approved a House-amended version of the bill on Tuesday, May 28, which expands Medicaid in Illinois next year. Illinois' Department of Healthcare and Family Services has estimated that 200,000 newly eligible individuals would enroll in Medicaid in 2014, with another 143,000 newly eligible and 170,000 previously eligible "woodwork" individuals enrolling by 2017.

Iowa

HMA Roundup

Iowa Adopts Medicaid Expansion. Despite initial opposition to the ACA, Governor Terry Branstad has decided to accept Medicaid expansion in a compromise deal reached last week with Democratic lawmakers. Last Wednesday, May 22, 2013, the Iowa Senate voted 26-24 to expand coverage to about 150,000 Iowans using enhanced Federal matching funds. On Thursday, May 23, 2013, the Iowa House voted 80-17 to pass Senate File 446. The newly created Health and Wellness Plan holds that individuals with incomes up to 100 percent of the federal poverty level would receive health coverage comparable to that of state employees, while individuals with incomes up to 138 percent of the poverty level will receive premium assistance for health plans offered on the state's Health Exchange. If the Federal government does not live up to the funding commitments made in the ACA, the state can opt out of this expansion of coverage to protect Iowa taxpayers.

Louisiana

HMA Roundup

Senate Passes Measures that Limit Rate Cutting Options to SNFs and Hospitals. On Tuesday, May 28, 2013, the Louisiana Senate offered overwhelming final legislative approval to bills that would shield nursing homes (34-4 vote) and hospitals (33-5 vote) from Medicaid rate cuts. The proposals are amendments to the state constitution requiring approval by voters in a ballot measure. The goals is to provide more financial stability to healthcare providers by enabling enhanced matching Federal funds, while eliminating the Department of Health and Hospitals' ability to cut rates without legislative assent.

In the news

- **"Grand jury to look into $200M Medicaid contract awarded by Jindal administration"**

  A grand jury was selected last week by the Louisiana attorney general's office to explore the possibility of criminal activity surrounding the Department of Health and Hospitals' (DHH) claims processing contract award to CNSI. Since the scandal emerged, Governor Bobby Jindal cancelled the contract with CNSI and the DHH Secretary at the time, Bruce Greenstein, resigned. (Washington Post)

Maine

HMA Roundup

Governor LePage Vetoes Medicaid Expansion Measure. Last Thursday, May 23, 2013, Governor Paul LePage vetoed legislation that would have expanded Medicaid coverage while repaying a $186 million debt to hospitals. The Governor had previously expressed great opposition to the tactic of explicitly connecting the hospital repayment to Medicaid expansion. To override the veto, four Republican senators and eight Republican representatives would need to join a united Democratic caucus in the legislature.

Maryland

HMA Roundup

Thirteen Insurers Submit Plans for Maryland Health Exchange. On Monday, May 27, 2013, the Maryland Health Benefit Exchange announced that thirteen insurers have submitted health plans to be offered on the state exchange: Aetna, BEST Life and Health, CareFirst, Coventry, Delta, DentaQuest MidAtlantic, Dominion Dental, Evergreen Health Cooperative, Guardian, Kaiser, Metropolitan Life, United Concordia, and UnitedHealthcare. The state must still certify the plans and announce rates.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

House Bill Aims to Trim Payments to Massachusetts Hospitals. Momentum is building in the US House of Representatives to unwind a Medicare payment provision that appears to benefit Massachusetts hospitals at the expense of rural areas. Rep. Kevin Brady—the Health Subcommittee Chairman on the Ways and Means Committee—has introduced legislation that would end the additional payments to hospitals in Massachusetts and nine other states. Massachusetts hospitals get $257 million more from the "rural floor" (while other states benefit to the tune of $111 million), paid for by lower payments in the other 40 states. HR 2053 would "amend title XVIII of the Social Security Act to apply budget neutrality on a state-specific basis in the calculation of the Medicare hospital wage index floor for non-rural areas". Brady cited supportive comments from CMS that labeled the provision a "manipulation" of the Medicare payment system. Other critics have derided the provision as the "Bay State Boondoggle". Similar legislation in the Sen-

ate has garnered bipartisan support, given that 40 states lose under the current budget-neutral scheme.

Duals Demonstration Timeline Revised. On May 29, 2013, Massachusetts' Executive Office of Health and Human Services issued a revised timeline for the implementation of OneCare, the state's dual eligible demonstration. Following discussions between MassHealth and CMS, the implementation date has been pushed back from July 1 to October 1, 2013. The first wave of auto assignments has been moved back from October 1, 2013 to January 1, 2014.

Key dates in the revised timeline include:

Action	Expected Date
One Care plans resubmit provider networks	Mid-June 2013
Public awareness campaign begins	July 2013
Three-way contracts signed	Mid-July 2013
MassHealth and plan implementation readiness activities	August 2013
Self-selection letters sent to individuals in target population	September 1, 2013
Plan marketing begins	September 1, 2013
One Care start date, self-selection enrollments only	October 1, 2013
60 day notice sent to first auto-assignment group	November 1, 2013
Effective date for first wave of auto-assignment	January 1, 2014
Second wave of auto-assignment effective (tentative)	April 1, 2014
Possible third wave of auto-assignment (tentative)	July 1, 2014

Michigan

HMA Roundup—Esther Reagan

Governor Snyder Meets with Obama Admin Officials. Last Wednesday, May 22, 2013, Gov. Rick Snyder met with Obama Administration officials to discuss options for Medicaid expansion. A current Michigan House bill (4714) would attempt to impose a 48 month lifetime cap on Medicaid benefits for non-disabled adults. Gov. Snyder recognizes this proposal as a significant impediment to gaining HHS approval for a waiver that could qualify for Federal Medicaid expansion funds. Snyder's prior Medicaid expansion proposal would aim to allocate the additional Federal funding into a "lock box" that could be used in future years when Federal funding for the expansion population declines.

Mississippi

HMA Roundup

Medicaid Alternatives Discussed with Sebelius and Tavenner. Governor Phil Bryant has discussed Medicaid alternatives with HHS Secretary Kathleen Sebelius' staff, CMS Administrator Marilyn Tavenner to identify alternatives that expand healthcare coverage without expanding Medicaid. The legislature adjourned their session without reauthorizing or funding Medicaid for the upcoming fiscal year. One GOP Senator, Billy Hudson, would support Medicaid expansion, if taken to a vote.

New York

HMA Roundup—Denise Soffel

Plan Unveiled to Stabilize Brooklyn Health Providers. On Tuesday, May 28, 2013, SUNY trustees unveiled a proposal that would create a new government entity that would oversee the establishment of a large Brooklyn-based provider network. The proposal would have SUNY Downstate release Long Island College Hospital to a new operator, close it, or begin layoffs at University Hospital of Brooklyn. A transfer of LICH could cost upwards of $130 million, according to the Wall Street Journal. The goal of the network would be to eliminate redundancies, reduce costs, and improve financial performance from more streamlined providers. SUNY officials believe there are at least three hospitals interested in joining the network. It is estimated that the state might have to spend $60 million to establish the public benefit corporation to oversee the network.

Ohio

HMA Roundup

Legislation Introduced to Expand Medicaid. Representative Barbara Sears—a GOP assembly person—has introduced legislation that would expand Medicaid coverage to Ohioans earning up to 138 percent of the federal poverty level, while requiring the state to identify reforms to lower costs and reduce uncompensated care. Furthermore, the legislation would dovetail with Gov. John Kasich's requirement that the state reverse the expansion if Washington does not live up to its funding commitments.

Oregon

HMA Roundup

Oregon Holds Public Hearings on Exchange Plans. From May 29 to June 7, 2013, the Oregon Insurance Division will hold public hearings to review individual and small business plans that will be offered on the state's health exchange.

Pennsylvania

HMA Roundup – Matt Roan

IFO Responds to DPW Criticism of Medicaid Expansion Analysis. On May 20th, 2013, the Independent Fiscal Office (IFO) responded to a letter sent by the Department of Public Welfare (DPW) questioning the findings of its analysis of the impact of Medicaid expansion in the state. The IFO conceded that its analysis is not meant to be used as a revenue estimate or fiscal note for the purposes of the legislative process but that it is accurate in providing legislators with critical information to make policy decisions. The IFO also pointed out that DPW has raised new issues around required staffing to support expansion that weren't included in the Departments own analysis of the impact of expansion from March 2013. The Legislature may take on the question of Medicaid expansion during the state budget process which is scheduled to conclude by June 30, 2013 or they may delay legislative action on the matter until the legislature reconvenes in the fall.

Pennsylvania Prisons to Outsource Mental Health Services at 27 State Prisons. The state Department of Corrections is considering outsourcing Mental Health services at 27 state prisons. The Department currently has a $91 million contract with Virginia-based MHM Correctional Services to provide mental health services at some of its facilities. The MHM contract expires in August of 2013, at which time the Department is planning to expand the scope of the outsourced agreement to include the additional facilities. Representative Mike Fleck has introduced legislation to stop outsourcing these services, claiming that Department staff would offer superior services to those of a contractor.

Medicaid Managed Care Plans Behind in Implementing Higher PCP Rates. DPW presented a status update on the implementation of enhanced primary care reimbursement rates as a result of the ACA. Pennsylvania's state plan amendment for the enhanced rates was approved by CMS on April 30, 2013 and, for the FFS programs, the higher rates will take effect on May 31, 2013, with retroactive payments going back to January 1, 2013 being made in July 2013. The vast majority of Medicaid recipients receive services through managed care organizations (MCOs); however, and the MCOs are still in the planning process to implement the higher payments. MCOs must submit their final implementation plans by May 31, 2013, including a timeline showing systems readiness, retroactive processing, and capitated provider adjustments. MCO capitation agreements with providers present a complication for implementing the enhanced fees that does not exist in FFS arrangements. MCOs have encouraged their capitated primary care providers to switch to a FFS arrangement but there are some that will remain on capitations. DPW also explained that in some cases current bundled payments for EPSDT services are less than the sum of the component services under the new enhanced rates. DPW is adjusting the EPSDT payments to ensure that providers receive, at a minimum, the new enhanced payment.

Rhode Island

HMA Roundup

Rhode Island Insurers Seek Dramatic Premium Increases. Health insurers in Rhode Island are seeking dramatic increases in premiums for individual and small group plans, pointing to escalating medical costs and additional expenses associated with the ACA. Blue Cross Blue Shield of Rhode Island has proposed an 18 percent increase for individuals and 15 percent for small groups, while UnitedHealthcare of New England has proposed an 18 percent increase for its small group HMO plan and a 13 percent increase for its preferred provider plan. The state health insurance commissioner is reviewing the proposals.

Tennessee

HMA Roundup

Governor Haslam Aims for Late Summer for a Medicaid Expansion Decision. Last Friday, May 24, 2013, Governor Bill Haslam said he expects a final decision on expansion of TennCare by the end of the summer. Haslam would like to use the Federal Medicaid expansion funds for premium assistance in the purchase of private health insurance, which could have more cost-sharing than traditional Medicaid. However, if the Federal Government places too many conditions on the state in implementing its version of expansion, the state may choose not to go forward with a TennCare expansion.

Texas

HMA Roundup – Dianne Longley

Texas Lawmakers Pass Bill Blocking Medicaid Expansion. In the final hours of the current legislative session, Texas lawmakers reached agreement on legislation that ensures the state will not expand Medicaid for uninsured adults of working age without legislative approval. During the session, several attempts were made to authorize the Texas Health and Human Services Commission (HHSC) to negotiate a Medicaid expansion waiver similar to the Arkansas agreement with CMS. Legislators opposed to the expansion wanted to be sure such a decision could not be made without their approval and negotiated a last-minute amendment. The language was added to Senate Bill 7, a Medicaid reform proposal introduced by Senate Health and Human Services Committee Chair Jane Nelson that will move certain individuals with development disabilities into managed care plans and expands the state's use of quality-based payment initiatives. Some last-minute technical changes were added in the House/Senate conference committee to allow the state to add other populations to Medicaid, including certain disabled individuals and children who must be moved from CHIP to Medicaid. The legislature also approved Senate Bill 8 by Senator Nelson, which includes an assortment of additional Medicaid reforms directed at reducing Medicaid fraud and improving the state's oversight of the program. Some of the key provisions of SB 8 include:

- Creation of a Medicaid data analysis unit to expand the collection and utilization of data for fraud detection and other activities related to contract management
- Authorization for the hiring of five commission law enforcement officers to investigate Medicaid fraud, waste, and abuse
- Additional restrictions related to marketing by providers who are soliciting Medicaid clients
- Improved oversight of prior authorization activities by managed care plans to reduce approval of unnecessary services

Both measures now await action by the Governor, who has until June 20, 2013 to sign or veto the legislation or allow it to become law without any action.

Vermont

HMA Roundup

Vermont Health CO-OP Denied a License. On May 22, 2013, the Vermont Department of Financial Regulation denied the Vermont Health CO-OP a license to health plans on the state's exchange due to concerns about the organization's financial solvency and corporate governance. Commissioner Susan Donegan highlighted that the CO-OP's proposed plan premiums would be 15 percent higher than established providers. Donegan pointed to a distinct lack of insurance industry experience among the CO-OP's board and management, which could create significant operational and financial risks.

National

HMA Roundup

Medical Spending Variances Due to Health Differences, Rather than Waste or Overtreatment. On Tuesday, May 28, 2013, a study published by James Reschovsky, Jack Hadley, and Patrick Romano asserted that geographic differences in Medicare spending are explained primarily by health differences, rather than by waste or overtreatment of conditions. The conclusion is in sharp contrast to the view put forth by the Dartmouth Institute for Health Policy & Clinical Practice, which has argued that aggressiveness in overtreating patients is a primary driver of geographic differences in spending.

Some House GOP Support for Individual Mandate for Illegal Immigrants. Despite fighting the Affordable Care Act for its reliance on the individual mandate for citizens, it appears that some House Republicans may support mandating that immigrants to buy their own health insurance while awaiting citizenship, to ensure those individuals are not a drain on the system. In other words, this requirement would reflect a tradeoff in return for gaining a path to citizenship.

Merger of Nursing Home Trade Groups. On Tuesday, May 28, 2013, the American Health Care Association (AHCA) and the Alliance for Quality Nursing Home Care (AQNHC) announced their merger under the AHCA moniker as of July 1, 2013. By unifying their lobbying efforts, the new organization hopes to be more effective and efficient in influencing policy. The AHCA largely represents for-profit entities, while another organization, LeadingAge, focuses on not-for-profit operators.

In the news

- **"States' Policies on Health Care Exclude Some of the Poorest"**

  The refusal by many states to expand Medicaid under the Affordable Care Act will leave many of the poorest Americans without viable options for health insurance next year. More than half of the nation's uninsured live in states that are not planning to expand Medicaid. While individuals with higher incomes will be eligible for subsidies through state or federally run exchanges, the lowest income individuals will likely remain uninsured. (New York Times)

OTHER HEADLINES

District of Columbia

- **"D.C.'s Medicaid upheaval puts health-care providers in a tight spot"**

  District of Columbia Medicaid providers are owed an estimated $60 million from former Medicaid contractor Chartered Health Plan. Some providers are raising concerns about their financial stability while they wait for payments the District says are being held up by pending litigation and negotiations with Federal CMS. Roughly 70 percent of the unpaid bills are owed to D.C. hospitals. (Washington Post)

Kentucky

- **"Kentucky Spirit must cover preventive care in schools, court rules"**

  A circuit judge has ruled that Centene's Kentucky Spirit plan must pay for nearly $8 million in health care services for students provided by local health departments. Kentucky's Cabinet for Health and Family Services has said Kentucky Spirit must make good on the unpaid bills or face substantial penalties for ending its contract with the state early. (The Courier-Journal)

- **"Kentucky short 3,800 doctors even before Medicaid expansion"**

  Kentucky's Cabinet for Health and Family Services commissioned a workforce study report by Deloitte Consulting, which found that the state needs nearly 3,800 additional doctors (including more than 180 primary care physicians) to meet the current needs of the Medicaid population. This number will only increase under the Medicaid expansion. The report included 11 potential ideas to mitigate the problem, including expanded nurse practitioner roles and changes to medical malpractice caps. (The Courier-Journal)

North Carolina

- **"Audit says new Medicaid claims system remains unready, unsteady"**

  The State Auditor last week issued a highly critical report of the state's new Medicaid claims processing system and questioning whether the system will be ready to go live in a little over a month, on July 1. The system, known as NC Tracks, must still receive federal approval before going live. (Charlotte Observer)

COMPANY NEWS

- **"Magellan still fighting loss of $1B contract with new appeal"**

  Magellan's third appeal of its lost behavioral health contract in Arizona, this time to the Department of Administration, has put a hold on the contract transition to Mercy Maricopa while the appeal is reviewed. Both Mercy Maricopa and the Department of Health Services have submitted letters to the DOA to reconsider. (Phoenix Business Journal)

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-June, 2013	Rhode Island Duals	Contract Awards	22,700
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	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
Summer 2013	Michigan Duals	RFP Released	70,000
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	Massachusetts Duals	Implementation	115,000
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	456,000
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
July 1, 2014	Michigan Duals	Implementation	70,000
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	10/1/2013
Michigan	Capitated	70,000	Summer 2013		TBD		7/1/2014
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	X	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***			***6***	

** 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

Shane Spotts, Senior Consultant – Indianapolis, IN

Shane comes to HMA most recently from Integrated Healthcare Management where he served as a Principal. In this role Shane consulted states, providers, and other stakeholders on Intellectual Disability and Developmental Disabilities (I/DD) systems, assisted a multi-state provider in financial modeling of moving a state I/DD system to managed care, and worked with a state on the development of Health Homes.

Prior to his work with Integrated Healthcare Management, Shane worked for Disability and Rehabilitative Services for over two years. He first served as the Director of Project Management, was promoted to Deputy Director, and assumed the role of Director before he left. During his tenure with them, Shane was responsible for the management of five bureaus, 800 employees and a $1.1 billion budget. He oversaw the shift in the Medicaid waiver program that included the consolidation of two waivers, reduction in the waiting list for services from 20,000 people to less than 9,000, and the development of a new outcome-based reimbursement methodology. He also oversaw the successful application for the Balancing Incentives Payment Program, which will lead to the deinstitutionalization of 3,000 beds and bring up to $100 million into the state Medicaid program, and oversaw the writing of a health home state plan amendment for individuals with developmental disabilities.

Shane also worked as the Program Director for the Office of Management and Budget for three years where he assisted in financial analysis of property tax caps on homeowners and businesses in Indiana as well as assisted with the implementation of performance based budgeting across the state of Indiana.

Shane holds a BS in Civic Leadership and Economics from Indiana University.

HMA Upcoming Appearances

"Medicaid Challenges and Opportunities in the States: Medicaid Directors Roundtable Discussion"
The Eighth Annual Medicaid Congress
Izanne Leonard-Haak – Moderator

Thursday, May 30, 2013

Washington, D.C.

HMA News

Issue Brief Examines Medicaid Outreach and Enrollment Strategies

HMA Principal Jennifer Edwards and Consultant Diana Rodin worked with Samantha Artiga, of the Kaiser Family Foundation, to produce the recently released "Profiles of Medicaid Outreach and Enrollment Strategies: Helping Families Maintain Coverage in Michigan." It is the second installment in the "Gearing up for 2014" series which highlights lessons learned from Medicaid and CHIP outreach and enrollment strategies. This brief profiles a new initiative of the Michigan Primary Care Association (MPCA) to facilitate coverage renewals through a systematic, technology-based reminder system coupled with one-on-one assistance. The inaugural issue brief profiled a successful initiative among health centers in Utah to provide one-on-one Medicaid enrollment assistance. **(Link to Issue Brief - PDF)**

HMA Advises on Safety Net ACO Readiness Assessment Tool

The Safety Net Accountable Care Organization (ACO) Readiness Assessment Tool is designed for organizations to assess how ready they are to take on the responsibilities of becoming an ACO serving your population of safety net patients. Pat Terrell, Managing Principal at HMA, served on author Stephen M. Shortell's Advisory Committee during its development. When released, Terry Conway and Art Jones, Managing Principal and Principal at HMA, spoke on the topic of accountable care during the kick-off conference. **(Link - PDF)**