HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: CONGRESSIONAL BUDGET OFFICE REPORTS ON DUAL ELIGIBLES

HMA ROUNDUP: WASHINGTON ANNOUNCES DUALS DEMO AWARDS; ARIZONA, MICHIGAN MEDICAID EXPANSION BILLS GAIN TRACTION; CALIFORNIA BUDGET DEAL FINALIZED; INDIANA ISSUES CARESELECT RFP; MASSACHUSETTS ISSUES CAREPLUS RFR FOR MEDICAID EXPANSION; WISCONSIN ISSUES MEDICAID MLTC RFP; COLORADO, DC EXCHANGE RATES NOT SHOWING "RATE SHOCK"; MICHIGAN REVEALS FOURTEEN EXCHANGE PLANS; OKLAHOMA TO CONSIDER MEDICAID MANAGED CARE TRANSITION

COMPANY NEWS: INDEPENDENT LIVING SYSTEMS ACQUIRES ROYAL HEALTH CARE; CENTENE'S CENTURION SUBSIDIARY AWARDED TENNESSEE CORRECTIONAL HEALTH CONTRACT; MAGELLAN LAUNCHES INTEGRATED PHYSICAL AND BEHAVIORAL HEALTH MEDICAID PLAN IN FLORIDA

JUNE 12, 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

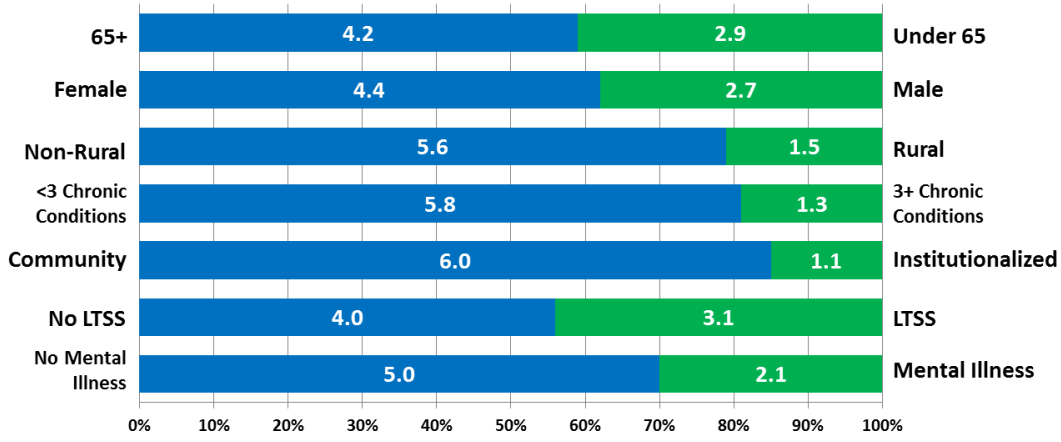
IN FOCUS: CONGRESSIONAL BUDGET OFFICE REPORTS ON DUAL ELIGIBLES

This week, our *In Focus* section reviews the findings of a Congressional Budget Office (CBO) report[1] on dual eligible beneficiaries, released June 6, 2013. In the report, the CBO looks at the demographic characteristics and quantifies the magnitude of spending associated with the dual eligible population. Additionally, the report lays out the existing policy landscape surrounding duals and looks ahead at the evolving dual eligible policy landscape. Below, we highlight some of the demographic and spending takeaways, as well as review the policies surrounding dual eligibles.

Dual Eligible Demographics and Service Needs

The CBO report analyzed demographic characteristics of the full dual eligible population as compared to the Medicaid and Medicare-only populations, utilizing data from 2009.

Chart 1 – Demographic Characteristics of Full Dual Eligibles (in millions)



Source: Congressional Budget Office.

Per the CBO data presented above, the full dual population is largely elderly, female, and living in urban or suburban areas. Eight-five percent of full duals reside in the community, while 30 percent of full duals have a mental illness. About 45 percent of duals are receiving long term supports and services (LTSS). This is significantly higher than both Medicare and Medicaid-only recipients. In fact, the CBO report found dual eligibles to be five times as likely to use LTSS as a non-dual Medicare beneficiaries, and about three times as likely to use LTSS as a non-dual Medicaid beneficiary.

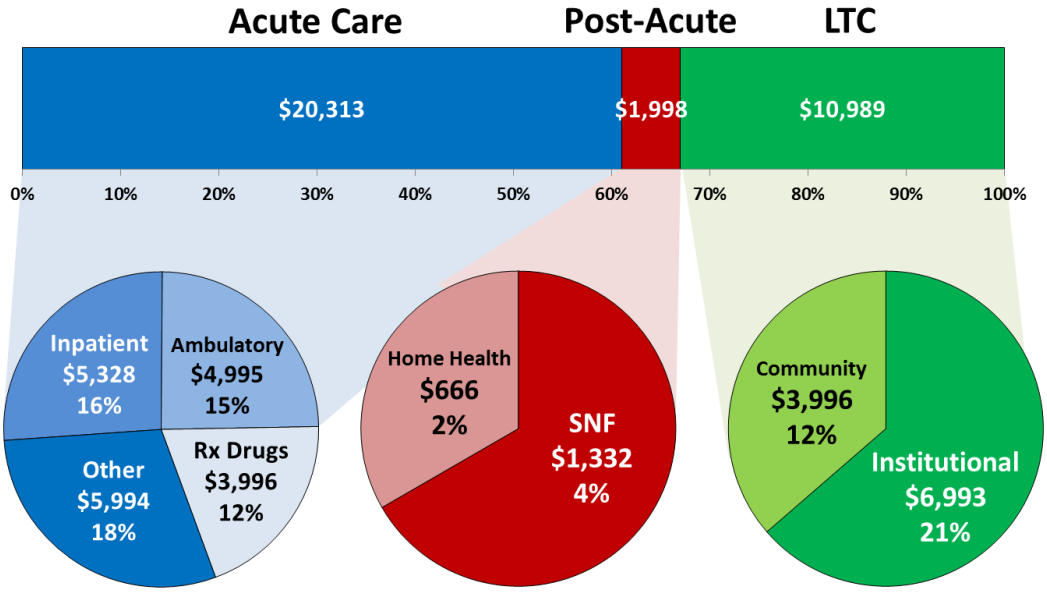
Diversity of services is key to successful dual eligible programs. CBO highlights the diversity of services needed, particularly among the large portion of the dual eligible population living outside of nursing homes. Variance in need for home and community based services (HCBS) and LTSS, varying degrees of coexisting chronic conditions, and subgroups with individualized needs, such as behavioral health services, mean that any single approach to delivery of care will likely not meet the needs of the entire dual eligible population in a given state or region.

[1] *"Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies."* The Congressional Budget Office. June 6, 2013. http://www.cbo.gov/publication/44308

Dual Eligible Expenditures and Spending Drivers

On average, dual eligibles spent $33,300 per beneficiary in combined Medicaid and Medicare expenditures in 2009. Of this, slightly over half ($18,200) was paid by Medicare. Of the average per beneficiary spending, 61 percent was spent on acute care, six percent on post-acute care, and 33 percent on long term care. Per Chart 2 below, institutional care contributes the largest single portion of duals expenditures, averaging nearly $7,000 per beneficiary, or 21 percent of all spending. However, only 15 percent of the dual population is institutionalized, meaning a small portion of the duals contribute significantly to overall spending.

Chart 2 – Dual Eligible Average Spending per Beneficiary (2009)



Source: Congressional Budget Office.

CBO finds dementia a significant driver of duals spending in Medicaid. In addition to the overall expenditure data presented above, the CBO identifies the top 10 percent of spenders in both Medicaid and Medicare. The top 10 percent of Medicaid spenders in the duals population accounts for an average annual spend of more than $103,000 per beneficiary, of which more than $80,000 comes from Medicaid. Dementia appears to be the major driver of this spending, as 41 percent of the top 10 percent Medicaid spenders are diagnosed with dementia.

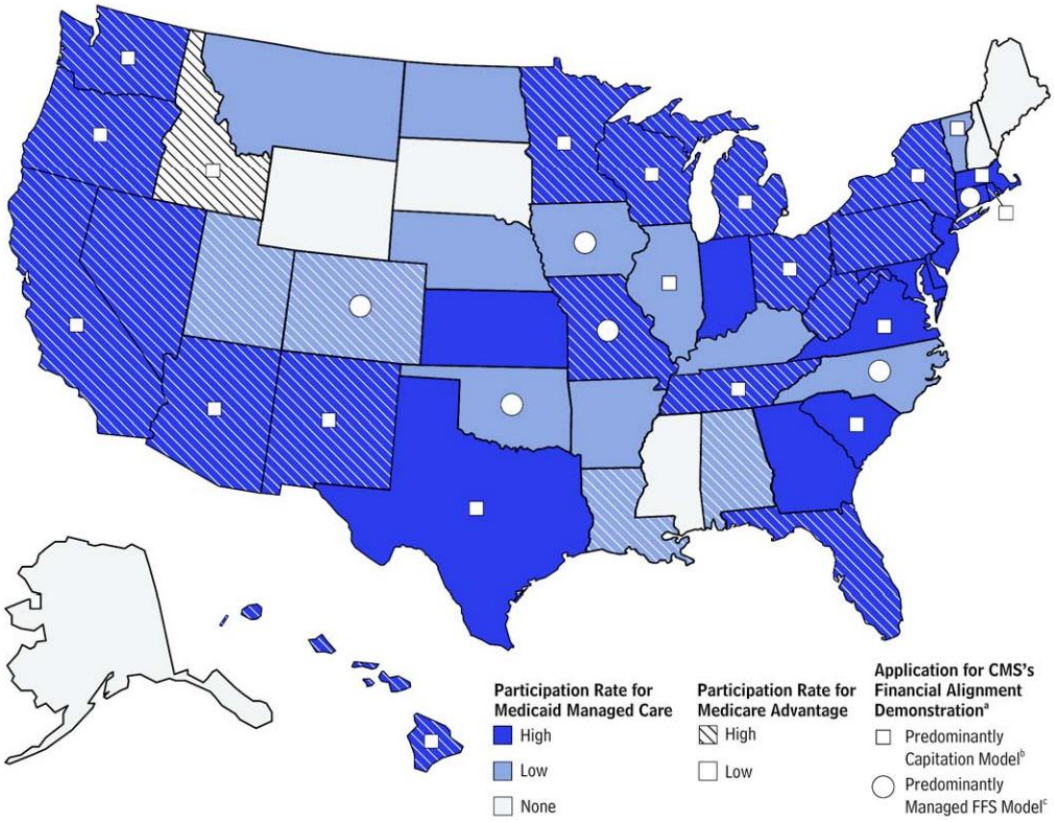
Policy Trends in Care Integration for Dual Eligibles

There have been several approaches pursued by states in integrating care for dual eligibles. These include initiatives aimed only at care coordination, such as states that have adopted the home health state plan option (11 states), or the multi-payer advance primary care practice demonstration launched by CMS (8 states). Other initiatives seek to implement care coordination along with financial alignment incentives, such as Medicare Advantage fully integrated dual eligible special needs plans (FIDE-SNPs) (7 states), or implementing a managed LTSS program that serves duals (16 states, plus additional planning).

However, the initiative drawing the most focus over the past two years is the Financial Alignment Demonstration offered by CMS to states. The demonstration allows states to implement a capitated managed care model for their dual eligible population or a subset of their duals. The CBO report catches up on the progress in states pursuing both the capitated and the managed fee-for-service demonstrations, highlighting the milestones achieved by states, as well as the obstacles and challenges states are facing, which have led some states to drop out of the demonstration completely (see HMA Duals Demonstration Status Calendar on pg. 17 for more detail).

Passive enrollment tests reveal potential for enrollee confusion. In particular, the CBO notes that CMS conducted passive enrollment field tests in Massachusetts, where duals will be passively enrolled in a managed care plan with the ability to opt out. The CBO reports that these field tests were largely unsuccessful due to enrollee confusion. This raises questions about the ability of dual eligibles to make informed decisions under the demonstrations and highlights the importance of beneficiary education as states continue to move toward enrolling duals in managed care.

Chart 3 – Participation Rates in Medicaid and Medicare Managed Care and CMS Financial Alignment Demonstrations



Source: Congressional Budget Office.

Notes: "High" participation means that more than 20 percent of a state's eligible beneficiaries were enrolled in Medicare Advantage plans or Medicaid managed care plans; "low" participation means that 20 percent or fewer eligible beneficiaries were enrolled. ***HMA note: map includes states that have withdrawn from demo (AZ, HI, MN, NM OR, and TN)***

HMA MEDICAID ROUNDUP

Alabama

HMA Roundup

Medicaid Pharmacy Commission Created. On Thursday, June 6, 2013, Governor Robert Bentley signed an executive order creating a commission to recommend cost-containment measures for the state's Medicaid pharmacy program by December 1, 2013. The order comes on the heels of signing into law the shift of Medicaid from fee-for-service to a managed care model.

Arizona

HMA Roundup

Governor Brewer Calls Special Session on Medicaid Expansion. Following an unexpected move by House Speaker Andy Tobin to adjourn until Thursday, June 13, Governor Jan Brewer called an immediate special session on Tuesday afternoon, June 11, to move on the 2014 budget and Medicaid expansion. A simple majority of the House would be required to bring bills to the floor for votes and could unseat leadership of the legislature, as necessary. There appear to be at least 32 House members (including eight Republicans) that support Medicaid expansion. Debates on legislation will occur on Wednesday, June 12, with final votes scheduled for Thursday, June 13. House Speaker Tobin and Senate President Andy Biggs issued a release that expressed stunned disappointment in the Governor's action.

California

HMA Roundup—Jennifer Kent

Guidance Issued on Home and Community Based Services under MediConnect. On June 6, 2013, the California Department of Health Care Services released revised policy guidance related to the administration of home and community based services under the MediConnect program. The policy aims to give Cal MediConnect health plans the incentive to provide beneficiaries with services that allow individuals to live independently in their homes. Depending on care plans, these "Care Plan Option" (CPO) services may include physical adaptations to the home (such as grab bars or ramps), nutritional counseling, respite care, and supplemental personal care. The guidance specifies which services are covered by traditional HCBS waivers as well as which Long Term Services and Supports (LTSS) are covered under Medi-Cal. (Link to Guidance)

California Budget Deal Reached. On Monday, June 10, 2013, Governor Jerry Brown and legislative leaders agreed to a $96.3 billion budget deal that incorporates the governor's more conservative economic assumptions for revenues. Legislators secured an additional $206 million to invest in mental health services ($143 million in one-time funds), as well as a partial restoration of adult dental Medi-Cal benefits amounting to $80 million. Senate negotiators gave up on their efforts to secure an additional $50 million in funding for Medi-Cal children's benefits and $32 million for nursing homes.

Duals Demo Financial "Poison Pill" Revised. Last week, the Department of Health Care Services established a revised "poison pill" provision that would allow the state to abandon the duals demonstration project if the Department of Finance determines the program is not saving the state money. This contingency provision would allow the state greater flexibility each year depending on changes in federal funding or state finances. In addition, DHCS de-linked mandatory enrollment of duals which maintains long-term services and supports as Medi-Cal benefits.

In the news

- **"Doctors brace for pain as 10 percent cut to Medi-Cal rates looms"**

  Providers are preparing for a 10 percent cut in Medi-Cal reimbursement rates that will go into effect on July 1, 2013. The cuts have been long-disputed, and will be made retroactively to 2011, with doctors cautioning that patients may see barriers to access for needed services. The reimbursement cuts are anticipated to save the state $459 million in FY 2014. (Los Angeles Times)

Colorado

HMA Roundup—Joan Henneberry

Colorado Exchange Plans Should Not Yield "Rate Shock". According to an analysis released by the Colorado Consumer Health Initiative (CCHI) on June 7, 2013, consumers should not experience "rate shock" for health plans on the state's exchange due to both competition and the effect of subsidies. Regulators from Colorado's Division of Insurance (DOI) continue to review all proposed plans and must approve or reject them by July 31. CCHI analyzed the silver level plans and characterized them as "good news for Colorado".

Colorado Health Exchange Preparing Contingency Plans. According to Health Policy Solutions, Colorado health exchange managers are preparing contingency plans to account for potential problems associated with the federal data hub, integration with the state's Medicaid systems, and the exchange's own system capacity to determine tax credit qualification. In that the state's exchange operates independent of state government, there are concerns about data handoffs between various entities. Federal officials approved an interim solution dividing eligibility system requirements between Medicaid and the exchange, but require a fully shared eligibility system by January 1, 2016.

Connect for Health Assistance Network Selections Announced. On June 10, 2013, Connect for Health Colorado announced that 58 groups have been selected to provide in-person help to health exchange participants starting in October 2013. The Connect for Health Assistance Network will serve individuals, families, and small employers in evaluating plan options as they apply for insurance affordability programs. At least 23 organizations will serve both individuals and small businesses, while two will serve small business customers exclusively.

Connecticut

HMA Roundup

FTC Criticizes Effort to Exempt Provider Collaborations from Anti-Trust Laws. In a June 4, 2013 comment letter, the FTC criticized a bill introduced in the General Assembly (H.B. 6431) that would permit health care providers to enter into cooperative arrangements exempt from antitrust laws. The FTC worries that the law would promote anti-competitive conduct that would ultimately hurt Connecticut health care consumers. The agency notes that if cooperatives are merely mechanisms for extracting higher reimbursement rates from health plans without establishing efficiencies from an integrated practice or lower costs for consumers, then the law would undermine central antitrust tenets.

District of Columbia

HMA Roundup

DC Health Exchange Rates Previewed. On Friday, June 7, 2013, the D.C. Department of Insurance, Securities, and Banking (DISB) offered a preliminary glimpse into rates that will be charged for plans available on the district's health exchange. According to Mila Kofman, director of the District of Columbia Health Benefits Exchange, there is "absolutely no rate shock." Michael Flagg, director of communications at the DC DISB, characterized the rates as "good news for everyone in this market".

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Governor Scott Signs Law Giving Florida Blue Expansion Options. On Friday, June 7, 2013, Governor Scott signed legislation that would allow Florida Blue to own other not-for-profit insurers and corporations in the state. This provision was an amendment to an underlying bill that allows for insurers without stockholders to insure municipal bonds. The legislation passed both houses of the legislature without opposition.

Georgia

HMA Roundup – Mark Trail

Georgia Health Information Network Launches Secure Messaging. Last week, the Department of Community Health announced that more than 2,100 health providers have registered for GeorgiaDirect, a secure messaging service provided by the state's Health Information Network Inc. (GaHIN). This offering aims to automate health care referrals between providers, enhance coordination of care, and lower administrative costs. GeorgiaDirect connects with other states, including Alabama, Florida, Hawaii, Mississippi, and Wisconsin, to foster the exchange of medical records for patients that move to other parts of the state or country.

Governor Deal Stands by Decision Not to Expand Medicaid. Last week, Governor Nathan Deal told a meeting of the Southern Group of State Foresters that the deepening of Savannah Harbor could commence before the end of the year if the federal government

raises the project's authorized spending limit and can spend money already allocated to the project. At the same meeting, Deal reiterated his opposition to the expansion of Medicaid given struggles to support the current program and the expected woodwork effect of 100,000 additional beneficiaries who are already eligible for the program but not enrolled.

Idaho

HMA Roundup

Evaluation of the Idaho Medical Home Collaborative Pilot. On June 6, 2013, the Division of Medicaid issued a request for information (RFI) that will help the Idaho Department of Health and Welfare prepare a Request for Proposal (RFP) for an evaluation of the Idaho Medical Home Collaborative (IMHC) Pilot. Specifically, the Division of Medicaid seeks recommendations for the most effective ways to assess utilization, patient care improvement, and the transformation of clinics to patient-centric coordinated care. The responses, due by June 26, 2013, will refine the requirements of an RFP, help project a budget, and identify potential vendors appropriate for a competitive proposal. The IMHC started a pilot for chronically ill patients on January 1, 2013 with four payers: Regence Blue Shield, Blue Cross of Idaho, Idaho Medicaid, and Pacificsource.

Indiana

HMA Roundup – Cathy Rudd

CareSelect RFP Posted. On June 7, 2013 Indiana issued a RFP for its CareSelect program, a voluntary disease management/care management program for the aged, blind, and disabled with current enrollment of about 32,000. The current contractors are MDWise and Advantage Health Solutions. The state is seeking a contract with one or more vendors for a four-year contract, with two additional one-year renewal options. Written questions must be submitted by June 14, 2013 and proposals must be submitted by July 5, 2013. The target contract award date is slated for August 9, 2013. The RFP is available here.

Indiana Medicaid Provider Rates to Increase. Last Tuesday, January 5, 2013, Governor Pence announced that the state's newly passed budget allows for an increase Medicaid rates paid to health care providers beginning in January 2014. The additional $37 million amounts to about a 2 percent increase to hospitals, nursing facilities, home health, and immediate care providers. In 2010, the Family and Social Services Administration cut rates paid to Indiana providers by 5 percent in the midst of a slow economic recovery. The governor's office says the reimbursement rate increase is made possible through a higher Medicaid appropriation in the recently passed state budget.

Kansas

HMA Roundup

KanCare Quarterly Report to CMS Made Public. Last week, Kansas made public a May 31 report filed with CMS on the progress of KanCare, the state's initiative to move virtually all Medicaid beneficiaries into managed care plans. The program, approved under a Section 1115 Medicaid waiver, aims to cut program costs and improve outcomes. As of March 31, 2013, 323,869 people enrolled in the three plans managed by Amerigroup, United HealthCare, and Sunflower State Health Plan, a subsidiary of Centene. The state noted that most transitional problems had been resolved, although it acknowledged inadequate timeliness and accuracy of information by personal care attendants. The report also notes that the state's electronic Medicaid enrollment and eligibility system is on target to connect with the federal health exchange by October 1, 2013.

Kentucky

HMA Roundup

Behavioral Health Department Commissioner Departs. On June 6, 2013, Dr. Stephen Hall, the commissioner of Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities, was replaced with Betsy Dunnigan. Ms. Dunnigan had been deputy commissioner of the department since 2006 and will serve as acting commissioner.

Maine

HMA Roundup

House Vote Fails to Hit Veto-Proof Threshold. On Wednesday, June 12, 2013, the Maine House voted 97-51 to approve of Medicaid expansion, but fell short of the two-thirds threshold necessary to override a veto from Governor Paul LePage. The compromise measure had passed the Senate 23-12 last Thursday, June 6, 2013 and would have the state withdraw from the expansion in three years should the Federal Government reduce coverage of expansion costs below 100 percent. The Legislature could, in the future, opt to continue Maine's participation in the expansion when the conclusion of the three year period. The proposal would have the state set aside savings from the program in an account that would cover future additional Medicaid costs, similar to a plan proposed by Michigan Governor Rick Snyder.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Massachusetts Health Homes Initiative RFI Issued. The Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) has issued a Request for Information (RFI) on the design and implementation of the Health Homes Initiative. Massachusetts intends to implement a Health Homes project for MassHealth members with Serious Emotional Disturbance (SED) and Serious and Persistent Mental Illness (SPMI). This initiative is part of a broader effort to shift from payer-based to provider-

based care management. In particular, EOHHS seeks commentary from behavioral health and primary care providers related to program design and features. Responses are due no later than July 12, 2013 at 3:00 PM.

EOHHS Releases CarePlus RFR. MassHealth has released a request for responses to solicit bids from managed care organizations to provide comprehensive health care coverage to MassHealth CarePlus members. MassHealth CarePlus is a new Benefit Plan that includes the ten categories of Essential Health Benefits as defined in the ACA, as well as non-emergency medical transportation services and diversionary behavioral health services. Adults ages 21-64 with incomes up to 133 percent of the Federal Poverty Level who are newly eligible for Medicaid coverage under the ACA will be eligible for MassHealth CarePlus. EOHHS hopes to choose at least two, and up to six, bidders per region. Contracts would be in effect from their execution (on or about October 15, 2013), with an operational start date of January 1, 2014 through September 30, 2015. There may be as many as five one-year extensions.

Boston Medical Center Considering Elimination of 85 of its 496 Beds. Boston Medical Center, the largest safety-net hospital in New England, is evaluating the closure of its East Newton Street campus, resulting in the loss of 85 of its 496 beds over the next five years. Any plan would require the approval of both the BMC board and the Boston Redevelopment Authority.

Michigan

HMA Roundup—Esther Reagan

Michigan Health Exchange Plans Announced. On June 6, 2013, the Michigan Department of Insurance and Financial Services (DIFS) announced that 14 health insurance companies had filed to offer plans on the Michigan health insurance exchange. Michigan's exchange will be federally-operated, but the state department of insurance will review all plans to ensure compliance with all relevant state and federal requirements. Rates will be made public on October 1, 2013. The 14 qualified plans that filed are:

- Alliance Health and Life Insurance Company
- Blue Care Network of Michigan
- BCBS of Michigan
- Consumers Mutual Insurance of Michigan (CO-OP)
- Health Alliance Plan
- Humana Medical Plan
- McLaren Health Plan
- Meridian Health Plan
- Molina Healthcare
- Physicians Health Plan
- Priority Health
- Priority Health Insurance
- Total Health Care USA
- United Healthcare

MDCH Hosts Forums on Duals Demo. On June 11, 2013, the Michigan Department of Community Health (MDCH) announced the hosting of public forums on the status of Michigan's dual demonstration program. The first forum is slated for June at the Henry Ford Community College in Dearborn. Michigan's Integrated Care Demonstration aims to align Medicare and Medicaid services and integrate physical and behavioral health services. Enrollees in the program will begin receiving services in July 2014. MDCH is currently in negotiations with the CMS to forge a Memorandum of Understanding (MOU).

Medicaid Expansion Bill Passes Committee to Gain House Floor Vote. On Wednesday, June 12, 2013, House Bill 4714—which would accept Medicaid expansion—passed the House's Michigan Competitiveness Committee by a 9-5 vote. The legislation eliminates the previously proposed 48-month lifetime limit on Medicaid benefits, which was highly unlikely to gain CMS approval. Non-disabled adults would incur greater cost-sharing after 48 months on the program. In addition, previous language that would have eliminated the expansion if the federal government reduced funding below 100 percent has been changed to indicate that the expansion would sunset should there be inadequate set-aside savings to cover the state's share of funding in the future. Health savings accounts remain in the legislation.

Governor Snyder Signs Bill to Continue Health Insurance Tax. On Tuesday, June 11, 2013, Governor Rick Snyder signed legislation that extends a 1 percent tax on health insurance claims beyond the 2013 sunset date through 2017. The law has generated $130 million less per year than expected. Michigan stands to lose $400 million in Federal matching funds due to the shortfalls.

Mississippi

HMA Roundup

Medicaid Program Still at Risk of Expiring on July 1. With an ongoing fight over Medicaid expansion, the state's Medicaid program is on the brink of not gaining necessary reauthorization before its July 1 expiration. Democrats have demanded a vote on Medicaid expansion first before reauthorizing the program. Republicans seek a deal on the budget for the Medicaid program as it stands. Governor Phil Bryant is expected to call a special legislative session to reauthorize Medicaid, but may need to issue an executive order to fund the program.

New Hampshire

HMA Roundup

New Hampshire Medicaid Expansion Still Subject to Negotiations. With budget deadlines looming, the Senate and House named negotiators to resolve budget differences by a June 20, 2013 deadline. On Wednesday, June 12, 2013, the Senate rejected a proposal that the state accept $5 million in federal funding to help consumers understand the ACA's provisions that go into effect in 2014. The state Insurance Department had won the federal grant, but legislative approval was required. Medicaid remains the biggest hurdle for a budget agreement.

New York

HMA Roundup—Denise Soffel

Managed Long Term Care and FIDA. Enrollment in New York's Medicaid managed long-term care plans surpassed 100,000 in June. The mandatory program operates in 8 counties, including New York City, where the bulk of enrollment has occurred. Mandatory enrollment will extend to other counties as capacity is developed. The state is involved in active discussion with CMS regarding the MOU that will define its duals inte-

gration demonstration, FIDA (Fully Integrated Duals Advantage). Once the MOU is finalized they will move immediately to readiness review, which the state expects will be sometime this summer. Twenty five plans will undergo the readiness review process.

City Council Bill Would Tighten Regulations on Adult Day Care Centers. Last week, a bill was introduced in the New York City Council that would impose minimum requirements for adult day care centers. The bill would limit the centers to serving impaired adults, would establish safety regulations, and require registration with the city's Department of Health and Mental Hygiene.

Ohio

HMA Roundup

Ohio Medicaid Receives $169M from HHS to Support Non-Institutional LTSS. On Wednesday, June 12, 2013, Ohio's Office of Health Transformation announced it had been awarded a $169 million State Balancing Incentive Payment Program grant through HHS. The program is designed to provide states the ability to financially incentivize the use of non-institutional long term supports and services (LTSS) for the Medicaid population. Ohio Medicaid will receive an additional 2 percent in federal match on non-institutional LTSS from July 1, 2013 through September 30, 2015, estimated at $169 million. A link to the state's press release is available here.

In the news

- **"Medicaid expansion unlikely to be in budget, but it's far from dead"**

  Although it is appearing increasingly unlikely that Ohio lawmakers will reach a deal to include the Medicaid expansion in the finalized budget, there is still talk from both parties of a resolution to expand Medicaid. Legislators are talking about the potential to reach a Medicaid expansion deal before summer, likely labeling it as a "Medicaid reform." (Cleveland Plain Dealer)

Oklahoma

In the news

- **"Oklahoma Considers Medicaid Managed Care Options"**

  After having a Medicaid waiver denied by CMS, Oklahoma is looking at the examples of Florida, Kansas, and Louisiana to design a Medicaid managed care program, one that would likely integrate long term care benefits as other states have done. Kansas and Louisiana have recently launched statewide managed care programs, while Florida is in the process of expanding its program statewide. Enabling legislation is expected to be given serious debate in the 2014 legislative session. (The Heartland Institute)

Pennsylvania

HMA Roundup – Matt Roan

Governor Corbett Calls for the Expansion of Human Services Block Grants. Governor Tom Corbett is urging the state legislature to pass a bill expanding a pilot program which provides counties with state funding for human services across seven categories including drug and alcohol treatment, mental health services, homeless assistance programs, and services for disabled children in the form of a block grant rather than separate funding streams. The program gives counties the flexibility to shift resources between programs to meet local needs. The PA County Commissioners Association has announced their support of the measure. Opponents of the plan point out that when the pilot was introduced, the added flexibility came at the expense of a 10 percent reduction in total funding; they fear that expansion of the block grant will come with additional cuts. Opponents also have asked for more time to evaluate the outcomes of the pilot, which provided block grant funding to 20 counties, before the program is expanded.

Democrat Legislators Fail to Add Medicaid Expansion to the Budget. As the Pennsylvania House and Senate begin debate on respective budget bills on the floor of the Legislature, attempts by Democrats to add Medicaid Expansion to the spending plan have been rebuffed. A proposed amendment in the House failed by a vote of 90-109, while in the Senate, a Welfare Code bill which Senate Democrats intended to amend to allow Medicaid Expansion was pulled from the Senate Appropriations Committee agenda by Republican leadership. Republican leadership fears that legislative action on Medicaid expansion will undermine ongoing discussions between the Corbett administration and HHS where the Governor has been pushing for added flexibility.

Washington

HMA Roundup – Doug Porter

Second Special Session Called. On June 11, 2013, Governor Jay Inslee called for a second special legislative session to flesh out a compromise between House and Senate budgets before the end of June. On Monday, the Democratic controlled House passed a temporary capital budget plan to infrastructure projects could continue even under a government shutdown. A nearly $1 billion budget deficit for the biennium still needs to be addressed.

Health Path Washington Successful Bidders Announced. On June 6, 2013, the Washington State Health Care Authority and Department of Social and Health Services announced that Regence BlueShield and United HealthCare have been declared apparently successful bidders on the state's dual eligible demonstration project for Snohomish and King counties. There is an opportunity for unsuccessful bidders to protest beginning Thursday, June 13 and ending on June 20. Payment levels under the contract will be set later this year through a joint rate-setting process by the federal Centers for Medicare and Medicare and the state. HCA Director Dorothy Teeter highlighted the efforts for improving outcomes, although savings should be an additional benefit.

Wisconsin

HMA Roundup

Managed Long-term Care RFP Issued. On June 7, 2013, the state of Wisconsin Department of Health Services announced an RFP for the delivery of managed long-term care in certain regions. DHS aims to contract with managed care organizations for Family Care and Family Care Partnership programs that assist frail elders and adults with developmental and physical disabilities with long term needs. Bids are due by July 19, 2013, with a tentative implementation date of January 1, 2014.

National

HMA Roundup

Minimum MLR Provisions Saved Consumers $2B in First Year. In a study released on June 6, 2013, the Affordable Care Act's minimum medical-loss ratio provision saved consumers more than $2 billion in just one year. Premiums would have otherwise been $1.9 billion higher in 2012 and plans returned $241 million in rebates last year. According to the authors of the study, individuals who purchased insurance on their own in 2012 spend 7.5 percent less on average than they otherwise would have.

In the news

- **"States Prepare to Launch New Health Law"**

  Beyond the headlines surrounded Medicaid expansion debates and decisions, states have been working to craft new IT systems to handle eligibility determinations and Exchange operations, as well as implementing new measures to fight fraud and abuse. Other actions are underway to ensure the successful expansion of coverage, such as expanding the scope of practice for nurse practitioners and licensing of retail clinics. (Stateline)

COMPANY NEWS

ILS Acquires Royal Health Care. In a June 6, 2013 press release, Independent Living Systems (ILS) announced the completion of its acquisition of Royal Health Care, a business and technology service provider delivering third party administrative services. ILS referenced Royal's diverse client base as an important contributor to an expanding footprint in Medicare, Medicaid, Dual Eligibles, Fully Integrated Dual Advantage (FIDA) and managed radiology benefits.

Centene Joint Venture Wins Correctional Health Contract with Tennessee. On June 11, 2013, Centene announced that its Joint Venture subsidiary, Centurion, had won a three-year $232 million contract from the Tennessee Department of Correction to deliver healthcare services to 20,000 inmates in 11 prisons starting this summer. This award follows a March announcement winning a contract with the Massachusetts Department of Corrections to serve 11,000 inmates.

Major Substance Abuse Clinic Alliance in the Works. In a June 4, 2013 joint statement, the Betty Ford Center and the Hazelden Foundation announced the pursuit of a "formal alliance," with agreements in principle from each of the respective boards. These two iconic leaders in drug and alcohol treatment referenced the impact of the Affordable Care Act, which makes addiction treatment an essential benefit offered by plans in health exchanges. Hazelden noted that "it appears that, institutionally, only the strong will survive and thrive."

Magellan Launches Florida HMO Plan That Integrates Physical and Mental Health. On June 12, 2013, Magellan Health Services announced the launch of Magellan Complete Care, a new Medicaid HMO plan serving Broward County. The plan will integrate behavioral and physical health services to coordinate care for "the whole person," focusing on prevention and wellness for both physical and mental health. The Care Coordination team will work with members, clinicians, counselors, family, and caregivers to establish individual goals, schedule appointments, ensure transportation to appointments, and promote adherence to treatment plans.

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
June 17, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
June, 2013	Rhode Island Duals	Contract Awards	22,700
June, 2013	South Carolina Duals	RFP Released	68,000
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
July 19, 2013	Wisconsin MLTC (Select Regions)	Proposals Due	10,000
Summer 2013	Michigan Duals	RFP Released	70,000
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
August, 2013	Wisconsin MLTC (Select Regions)	Contract awards	10,000
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
August, 2013	Wisconsin MLTC (Select Regions)	Implementation	10,000
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	6/6/2013	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 Upcoming Appearances

"Meeting the Needs of Vulnerable Populations through Community Partnerships"
Association for Community Affiliated Plans (ACAP) CEO Summit

Sharon Silow-Carroll – Presenter

June 25, 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 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 a 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)**