HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MASSACHUSETTS DUAL ELIGIBLE INTEGRATION RFR

HMA ROUNDUP: CALIFORNIA BILL LANGUAGE REVEALS DUALS INTEGRATION DETAILS; GEORGIA MEDICAID REQUESTS $300M BUDGET DEFICIT FIX; NINE PLANS SUBMIT ILLINOIS DUALS INTEGRATION BIDS; ILLINOIS TO PROCURE ELIGIBILITY VERIFICATION VENDOR; OHIO TO ANNOUNCE DUALS INTEGRATION RFP SCORING END OF JUNE

OTHER HEADLINES: IOWA, GEORGIA, MISSISSIPPI, MISSOURI AWARDED ENHANCED FEDERAL MEDICAID MATCHING FUNDS FOR HCBS; ADVOCATES CONTINUE PUSHBACK AGAINST KANSAS MEDICAID MCO STATEWIDE EXPANSION; AETNA FILES PROTEST IN OHIO REVISED MANAGED CARE CONTRACT AWARDS

HMA WELCOMES: BROOKE EHRENPREIS – SOUTHERN CALIFORNIA

JUNE 20, 2012

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: MASSACHUSETTS DUAL ELIGIBLE INTEGRATION RFR

This week, our *In Focus* reviews the dual eligible integration procurement released by Massachusetts Executive Office of Health and Human Services (EOHHS) this week. Massachusetts is the third state to issue a procurement for the dual eligible integration demonstrations, behind Ohio and Illinois. EOHHS is seeking to procure Integrated Care Organizations (ICOs) to serve the dual eligible population statewide between the ages of 21 and 64. The state's Request for Responses (RFR) indicates that ICOs will be for the full array of Medicare and Medicaid services, but also will have significant flexibility to provide a range of community-based services and supports as alternatives to or means to avoid higher-cost services. Although EOHHS had previously proposed an implementation date of January 1, 2013, this RFR now proposes a delayed implementation date of April 1, 2013.

Target Population

As indicated in the RFR, in calendar year (CY) 2010, there were more than 118,000 dual eligible individuals enrolled in both MassHealth (the fee-for-service portion of the Massachusetts Medicaid program) and Medicare. The individuals were dually eligible for an average of 11 months within CY 2010. The majority were over 45 years old and 96 percent lived in the community in CY 2010. Combined Medicaid and Medicare spending for the population exceeded $3 billion in CY 2010. Per member per month (PMPM) costs for the population were $2,100, with roughly $900 in Medicaid costs, $800 in Medicare Part A and B costs, and $400 in Medicare Part D costs.[1]

The population includes: adults with physical disabilities; adults with developmental disabilities; adults with serious mental illness; adults with substance use disorders; adults with disabilities who have multiple chronic illnesses or functional or cognitive limitations; and adults with disabilities who are homeless.

According to 2008 data, the dual eligible population has very high incidences of physical disabilities and behavioral health conditions. 79 percent of duals had a diagnosis of physical illness or disability. 65 percent of duals had a behavioral diagnosis. 14 percent of duals had a diagnosis of developmental disability.[2]

RFR Highlights

- Individuals in intermediate care facility (ICF), mental retardation (MR), or Home and Community Based (HCB) waiver programs are excluded.
- Enrollment will be voluntary initially. After some unspecified period of time, passive enrollment/opt out process will be initiated for non-choosers.

[1] "MassHealth Demonstration to Integrate Care for Dual Eligibles 2010 Profile of Dual Eligibles." MassHealth. Presented on April 9, 2012. Available at: http://www.mass.gov/

[2] "Dual Eligibles In Massachusetts: A Profile Of Health Care Services And Spending For Non-Elderly Adults Enrolled In Both Medicare And Medicaid." Massachusetts Medicaid Policy Institute. September 2011. Available at: http://www.massmedicaid.org/

- Auto-assignments will initially be made on a rotating basis among all bidders in each county.
- Respondents may submit a proposal for a service area comprised of full or partial counties, subject to approval by CMS and EOHHS.
- Respondents may bid to provide services in as few as one or as many as all 14 counties or in partial counties. In their RFR response, respondents must specify each county or partial county they wish to serve.
- EOHHS will award no more than five contracts per county.
- In addition, respondents must note any differences in the Service Area proposed in their response versus the service area described in the respondent's Demonstration Plan Application previously submitted to CMS. If there are any differences, the respondent must update its Application via email to CMS no later than June 22, 2012.
- Respondents may not add to their originally proposed service area, and may only remove counties or partial counties from their service area.
- Respondents may be awarded a contract for all, some, or none of their proposed counties or partial counties. Respondents shall accept Contract awards in all counties for which they are selected whether or not they are selected for each county for which they bid. ICOs covering a partial county will not receive Auto-assignments in that county.
- As a result of this RFR, CMS and EOHHS intend to enter into a single Contract with each selected ICO for an initial three-year Contract term effective April 1, 2013, through December 31, 2016.

Evaluation Criteria

- In reviewing bids, MassHealth will be determining whether the bidders:
  - Demonstrate core competencies across disability types,
  - Effectively contract with community-based organizations (CBOs) that focus on independence for people with disabilities
  - Have existing or developing relationships with organizations knowledgeable about recovery models and integration of behavioral health, and
  - Have expertise in serving homeless persons and other populations with unique needs.
- MassHealth will likely give preference to ICOs that describe:
  - Established relationships with, and perceived effective mechanisms for, contracting with CBOs for the provision of the LTSS counselors;
  - Effective plans/processes for integrating behavioral health and primary care;
  - How they will use the flexibility of the global payment to provide certain community support services as alternatives to more costly acute and long-term institutional services

RFR Timeline

Timeline	Date
RFR issued	June 18, 2012
Respondents' Conference	June 25, 2012
Written Inquiries Due	July 6, 2012
Respondents' Responses Due	**July 30, 2012**
Anticipated Date for Selection Announcement	August 31, 2012
Anticipated Contract Execution Date	December 15, 2012
Anticipated Service Start Date	April 1, 2013

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein/Jennifer Kent

At a budget hearing earlier this week, the state released the latest trailer bill language related to the California dual eligible integration proposal. Highlights include:

- **Number of Counties in Dual Demonstration.** Provides for up to eight Dual Demonstration Pilot counties in which dual eligibles (Medi-Cal and Medicare) would be enrolled into the demonstration. Does not authorize unbridled authority to expand this demonstration model statewide to all 58 counties within three-years.
- **Enrollment.** Generally, dual eligible individuals will be enrolled into the Dual Demonstration Pilot unless an affirmative choice is made to opt out of enrollment. After six months, a dual eligible may choose to change plans. Dual eligibles who choose to opt out of enrollment in the Dual Demonstration Pilot will still be mandatorily enrolled in Medi-Cal managed care but may choose to remain enrolled in Medicare fee-for-service or a Medicare Advantage plan for their Medicare benefits.
- **Sunset.** Establishes a sunset date of July 1, 2018 (five years) for the entire initiative. This provides for increased oversight by the Legislature since reauthorization is required.
- **Exempts Certain Populations.** Provides for exemptions or opt-outs for certain dual eligible populations from enrollment into the Dual Demonstration Pilot, and/or mandatory enrollment into Medi-Cal managed care. This includes the following: persons less than 21 years of age; persons diagnosed with HIV/AIDS; persons with end-stage renal disease; and other categories as deemed medically necessary by the department.
- **Requires Readiness Standards Prior to Enrollment.** Requires rigorous readiness standards before implementation of the Dual Demonstration Pilots. This includes provisions for:

  - comprehensive consumer notification, enrollment and informing materials with alternative formats (braille and languages);
  - comprehensive health assessments and risk assessments;
  - requirements for the assignment of primary care physicians; and
  - comprehensive requirements for other care management and care coordination across the medical and long-term care services and supports system.

- **Integration of Long-Term Care Services.** Limits integration of these services, including IHSS and nursing homes, to only the Dual Demonstration Pilot counties. No further expansion can occur without authorization from the Legislature.
- **In-Home Supportive Services.** Consistent with current law, counties continue to perform functions necessary for the administration of the IHSS Program, including assessments and determining hours for recipients. Managed care health plans may authorize additional home and community-based services, including in-home service hours. IHSS consumers also maintain the right to hire, fire and direct their care providers, and will be able to decide whether they want to participate in care coordination teams. The integration of IHSS into managed care will track with the timeline for the overall roll out of the Dual Demonstration Pilots.
- **Statewide Collective Bargaining.** Provides for the State to conduct collective bargaining for IHSS workers.
- **Behavioral Health.** Under the Dual Demonstration Pilot, health plans will collaborate with county-administered Medi-Cal specialty mental health services and substance use services to develop strategies for mental health care and substance use care coordination.
- **Provides Framework for Reimbursement Rates.** Expresses intent of the Legislature for Demonstration sites to reimburse providers at rates to ensure access to care for dual eligibles, for out-of-network emergency and post-stabilization services to receive prevailing Medicare and Medi-Cal fee-for-service rates, and for the use of voluntary intergovernmental transfers for enhanced rates. Also requires Administration to work with federal CMS in developing other reimbursement policies and to have transparency with these policies.
- **Payment Deferral.** Authorizes the Director of DHCS to defer payments to Medi-Cal managed care plans that are payable during the final month of the 2012-13 fiscal year.

In the news

- **Details of Exchange Begin to Emerge**

  California Health Benefit Exchange Board members yesterday heard presentations on a number of topics including stakeholder opinions on qualified health plans, potential exchange users' opinions on what they need from the exchange and possibilities for creating call centers. All of those discussions seemed to lead to the same two things: cost and service. (California Healthline)

- **California Bullish On Health Exchange—No Matter What**

  "California has been moving ahead 100 percent assuming it will upheld," says Peter Lee, who left his Washington job as a health policy official in the Obama administration to lead California's Health Benefit Exchange. "We [aren't] doing anything in the way of contingency planning because it makes no sense to plan for what seems like an outer bounds of possibility, and rather, we've got a big job to do to get ready to cover what will be millions of Californians in 18 months." On the legislative side, California lawmakers have been introducing legislation that would replicate key pieces of the federal law, including bills defining standard health benefits and guaranteeing coverage to people with preexisting conditions. (Kaiser Health News)

Georgia

HMA Roundup – Mark Trail

The Department of Community Health (DCH) presented an amended appropriations request on June 14. DCH's request identified a $308 million shortfall for SFY 2013 which is attributable to the following items:

- Funding for one additional months' MCO payment after the state delayed the payment cycle by a month last fiscal year ($82 million);
- Projections of higher caseload growth ($153 million)
- An unspecified "cash shortfall" ($50 million);
- Settlement payments to MCOs for the membership adjustment issue identified last year ($22 million)

The state will also request an additional $245 million to fund incurred but not reported (IBNR) claims. This represents a departure from the historical accounting treatment for medical expenses which has been on a cash basis. We believe this request suggests DCH is preparing for the expansion of managed care to the ABD population which would require IBNR be funded in plan payment rates.

In the news

- **As Medicaid Enrollment Rises, State Wants More Incentivized Managed Care**

  Georgia officials are confirming that a proposed revamp of the state Medicaid system will include shifting more patients from fee-for-service plans to managed care. To do it, they'll use performance-based contracts, in hopes of improving health outcomes and lowering long-term costs for the state. Whether or not the Supreme Court upholds President Obama's heath reform law this month, Medicaid spending will continue to grow as a percentage of overall state spending. After the ongoing Medicaid redesign is finalized at the end of the summer, DCH will invite private health management companies to bid on contracts. (WABE)

Illinois

HMA Roundup – Jane Longo and Matt Powers

With the Medicaid budget savings passed, we except to see a series of emergency rules posted in the coming weeks, as many of the changes are set to go into effect on July 1, 2012. As part of the budget package, the state will be issuing a procurement for an eligibility verification vendor. The RFP is expected to be released by July 13, 2012 with contract awards announced roughly one month later.

On Monday, June 18, responses were due for plans bidding on the dual integration RFP. HFS reported at the Medicaid Advisory Committee meeting on Wednesday, June 20, that nine plans submitted responses. A list of the bidders may be published on the HFS Care Coordination website in the coming days. Based on the RFP question and answer documents published in the past two weeks, the list of bidders is likely to include: HealthSpring, Family Health Network, Aetna, Meridian, WellCare, Molina, Centene, and Humana.

Additionally, responses to the state's RFP for provider-centered care coordination entities (CCEs) to serve the complex adult Medicaid population were due last Friday, June 15. The state received 20 responses and a list of applicants will be posted to the HFS Care Coordination website later this week.

In the news

- **Medicaid reform skips the norm for awarding contracts**

  A $120 million cost-cutting measure in the recently passed Medicaid savings package skirts the normal state bidding process, which was meant to find the best deal for taxpayers. Gov. Pat Quinn on Thursday signed a $1.6 billion Medicaid savings plan that would, among other things, kick ineligible Medicaid recipients out of the health-care program by ensuring everyone in the system meets eligibility, residency and other requirements. But to do so, the legislation allows the state to hire an outside vendor for the eligibility checks, and to expedite that hiring by avoiding timelines and procedures outlined in Illinois purchasing laws. Bypassing the standard procedure for accepting bids allows the state to award a contract without considering costs. Normally, sealed bids on contracts are submitted to the state and the contract is awarded to the lowest bidder that meets all requirements of the contract, a process that can take more than a year. (The News-Gazette)

Ohio

HMA Roundup – Alicia Smith

On Tuesday, The Ohio Department of Job and Family Services (ODJFS) announced that the results of the dual eligible integration program RFA scoring will not be released until the end of June. ODJFS cited ongoing discussions between the State and CMMI/CMS regarding ICDS enrollment and implementation for individuals who are dually eligible for Medicaid and Medicare as the reason for the delay.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Pennsylvania's seasonally adjusted unemployment rate held steady at 7.4 percent in May, unchanged from April, in spite of the national rate ticking up from 8.1 percent in April to 8.2 percent in May. Pennsylvania's unemployment rate was below the U.S. rate of 8.2 percent, and has been below the U.S. rate for 49 consecutive months, and at or below the U.S. rate for 67 consecutive months

Last week, providers in the New West Zone were notified about the elimination of Access Plus (the EPCCM Program) in all 13 of the New West Counties as well as the elimination of the United Health Care's voluntary managed care services in 7 of the New West counties on September 1, 2012. United did not win in New West so they will no longer be able to offer services after September 1, 2012 to the approximately 19,000 consumers they currently serve in the New West Zone.

Texas

HMA Roundup – Dianne Longley

Last week, Texas Health and Human Services Executive Commissioner Tom Suehs notified the Governor of his intention to retire on Aug. 31. In his three years in the position, Suehs oversaw dramatic improvements in the handling of applications for benefits and obtained federal approval to transform Medicaid payments to hospitals. Suehs' successor has not yet been announced.

In the news

- **For Some Druggists, Medicaid Changes Mean Pain**

  The transition to managed care this spring was bumpy, with numerous computer errors and miscommunications between the State Health and Human Services Commission, pharmacists and the pharmacy benefit managers. Although the state said that the program has become more stable and that the health plans quickly resolved the problems, many independent pharmacists — particularly those who serve a high volume of Medicaid patients — are still upset. They say the drastically reduced reimbursement rates set by the managed care plans to save the state money are forcing them out of business. (New York Times)

OTHER HEADLINES

Hawaii

- **Hawaii governor declares intent for state-based insurance exchange under US health care reform**

  Gov. Neil Abercrombie says Hawaii is the first state to declare its intent to develop a state-based insurance exchange — a key component of federal health care overhaul. Abercrombie says the 50th state's exchange will be called the Hawaii Health Connector. The private, non-profit corporation is a quasi-governmental agency. It was established by state law last year. The governor said Wednesday he formally declared Hawaii's intention earlier this month in a letter to the U.S. Health and Human Services Center for Consumer Information and Insurance Oversight. (Washington Post)

Iowa

- **New law for mental health care hit-or-miss**

  State leaders hope their mental health redesign will bring better services, but many front-line administrators doubt they'll see significant improvements soon. In fact, some worry that services could erode over the next year as money and some financial responsibilities are shifted from the counties to the state. Some long-term improvements are possible, they say, but cash likely will run short in the next few months. Several counties plan to limit or create waiting lists for some services for mentally ill or disabled adults starting July 1, when the new fiscal year begins. State leaders have vowed to help counties avoid radical cuts, but some counties see no alternative. The cuts would come at the very time that local officials are supposed to be planning ways to improve mental health services under new regional authorities. (Des Moines Register)

Kansas

- **Wichita crowd voices concerns about governor's plan to reform Medicaid**

  State health officials received a lot of feedback, nearly all of it negative, at a public meeting Monday in Wichita about Gov. Sam Brownback's plan to reform Medicaid. Several hundred people attended the meeting at Wichita State University's Hughes Metropolitan Complex, and 36 spoke out about the plan as Robert Moser, secretary of the Kansas Department of Health and Environment, and Shawn Sullivan, secretary of the Department on Aging, listened. Brownback's plan, called KanCare, would move nearly all of the state's 380,000 Medicaid beneficiaries into managed care plans run by private insurance companies beginning Jan. 1. State officials have said that will slow the growth of Medicaid costs and save the federal and state governments more than $850 million over five years while improving health outcomes. Five insurance companies have bid for three state contracts. (The Kansas City Star)

Maryland

- **Maryland braces for Supreme Court decision on health care reform law**

  In Maryland, where the law's implementation has been embraced, officials, advocates and providers already say they plan to push for reforms even without the law, though

leaders including Lt. Gov. Anthony G. Brown acknowledge that it would become much harder and more "piecemeal" to cover the state's 750,000 uninsured residents and tougher to maintain every benefit for those with coverage. (Baltimore Sun)

Massachusetts

- **Conference committee members selected to hash out health law**

  Six lawmakers were selected Thursday to negotiate the differences between House and Senate proposals for controlling health care spending in the state. The conference committee will include Senator Richard Moore and Representative Steven Walsh, both Democrats, who led efforts to craft the two bills. State House News Service reports that they are joined by Democrats Senator Anthony Petruccelli and House Majority Leader Ronald Mariano and by Republicans Senate Minority Leader Bruce Tarr and Representative Jay Barrows. (Boston Globe)

Minnesota

- **Medicaid numbers spike in Minnesota**

  The number of Minnesotans on Medicaid shot up at nearly twice the national rate over the past two years, while state costs soared by 40 percent to surpass $4 billion for the first time. There now are about 733,000 Minnesotans in the program, an increase of 125,000 in two years, according to a new federal study. While the weakened economy explains most of the rising Medicaid rolls in other states, much of Minnesota's increase came when Gov. Mark Dayton expanded the program by 80,000 people last year under an option in the federal Affordable Care Act. (Minneapolis Star Tribune)

Missouri

- **Five from Missouri sue over Medicaid cuts**

  Four ailing St. Louis residents, a Monroe City, Mo., man and Paraquad, a not-for-profit advocacy group for the disabled, sued state officials in federal court here Monday, claiming that they would be forced into nursing homes by cuts to the state Medicaid system. They say in their suit that the end of state money for transportation and personal care services will mean that they will be unable to get thrice weekly dialysis, unless they move into a Medicaid-funded nursing home. They have various ailments and have no way to get to dialysis for various reasons, the suit says. (STL Today)

- **Mo. to get additional Medicaid money for home care**

  Missouri could receive about $100 million of additional Medicaid funds over several years under a federal program intended to encourage more home- and community-based services for the elderly and disabled. The law offers a higher federal Medicaid matching rate for home- and community-based services to states that currently spend less than half their long-term care dollars on such services but commit to expanding access. Missouri's enhanced funding will begin July 1 and run through Sept. 30, 2015. The other states approved Wednesday for the program are Iowa, Georgia and Mississippi. (News Tribune)

New York

- **Deal in Albany on Policing Abuse of Disabled**

  Gov. Andrew M. Cuomo and legislative leaders reached a deal Sunday night to create a new state agency to police abuse and neglect of more than one million New Yorkers with developmental disabilities, mental illnesses and other conditions that put them at risk, state officials said Sunday. The governor also agreed to take some steps to bolster outside oversight of the state's care, yielding to concerns raised by Assembly Democrats and some advocates for people with disabilities that state regulators have long failed to adequately respond to cases of abuse on their own. Lawmakers also agreed to expand the state's public disclosure law, requiring thousands of nonprofit groups that provide services to disabled and mentally ill people to make records of abuse and neglect public. (New York Times)

North Carolina

- **Costs soar for updating NC's Medicaid computer system**

  In 2003, the state solicited bids to replace the outmoded Medicaid claims system, which had been operated for 35 years by EDS, a Texas company later purchased by Hewlett Packard. Millions of lines of computer code power the program, which accepts claims from some 70,000 providers – doctors, clinics, hospitals, nursing homes and others. After a cancelled contract with ACS from 2004, the state awarded a $265 million contract to CSC in 2008, with a go-live date of August 2011. Costs have kept rising, so much so that the expense of setting up the new system and running it for seven years, plus maintaining the old system, now adds up to an eye-popping figure: $851 million. (News Observer)

- **State Medicaid director fired**

  Dr. Craigan Gray was fired from his job as Medicaid director Monday. Gray, appointed to run the state Medicaid office in April 2009, oversaw the government's $12 billion insurance program for the poor, elderly and disabled. The Medicaid program has been buffeted by a wave of bad news in the past week. After working to plug a $205 million hole in this year's Medicaid budget, legislators learned last week the hole will be $75 million bigger than anticipated. (Charlotte Observer)

Washington

- **Health reform without a mandate: Lessons from Washington state**

  In 1993, Washington also passed a law both guaranteeing all residents access to private health insurance, regardless of their health status, and requiring Washingtonians to purchase coverage. The state legislature, however, repealed that last provision two years later. With the guaranteed access provisions still standing, the state saw premiums rise and enrollment drop, as residents only purchased coverage when they needed it. Health insurers fled the state and, by 1999, it was impossible to buy an individual plan in Washington — no company was selling. Washington state is among a handful of states that have pursued universal access to health insurance. The challenges they have faced could give some clues about the federal overhaul's fate should the mandate get struck down. (Washington Post)

National

- **If the ACA Mandate Fails, Who Covers the Uninsured?**

  Within days, the Supreme Court will rule on whether the new law is constitutional. If the law is upheld, millions of newly insured patients will have many of their hospital bills covered by insurance. But if the law, or just the insurance mandate, is struck down, those bills will be passed on to taxpayers, hospitals and privately insured patients, as they have been for the last quarter century. (Governing Magazine)

- **Pressure Growing on CMS to Rein In Duals Demo**

  Lawmakers joined a top outside adviser to the Medicare program Tuesday in suggesting that a demonstration program to move "dual eligibles" into managed care plans is moving too fast. The growing criticism of the pace of the test, set to be launched in January, could force Centers for Medicare and Medicaid Services officials to scale it back. Another potentially major Medicare change — redesigning the benefits for all beneficiaries — also drew a cautious if not cool response at a House Ways and Means Health Subcommittee hearing. (CQ Healthbeat)

- **In Health Care Ruling, Vast Implications for Medicaid**

  The expansion of Medicaid — if it is upheld by the Supreme Court — is among the most significant parts of the law, as it will provide coverage to people with the greatest financial needs. Many health care advocates support the expansion, saying it will allow poor people to receive needed care, while many state officials, especially Republicans, worry that it will bring budget-breaking new costs. The expansion may also strain the health care system, given the shortage in some places of primary care doctors, who will be vital to expanded coverage. The Supreme Court, which is expected to rule on the health care law this month, devoted more than an hour of argument to the Medicaid provision. (New York Times)

COMPANY NEWS

- **Aetna Better Health Files Protest of Ohio Medicaid Managed Care Awards**

  Aetna Better Health Inc., an Aetna Medicaid company, has filed a protest of the Ohio Medicaid Managed Care awards announced on June 7, 2012. The protest outlines significant legal issues in the Ohio Department of Job and Family Services' (ODJFS) decision to cancel its original contract award to Aetna and requests that the ODJFS immediately reinstate the award to Aetna. Aetna's protest notes that, after the submissions were all made, and after announcing the original contract award, ODJFS made the decision to retroactively change the definition of certain requirements outlined in its Request For Application (RFA). (Aetna News Release)

- **Molina Healthcare names new Presidents for Michigan and Texas**

  Molina Healthcare has named Craig Bass as the President of its subsidiary, Molina Healthcare of Texas, and that Stephen Harris will replace Bass as president of Molina Healthcare of Michigan. (Molina Press Release)

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 18, 2012	Illinois Duals	Proposals Due	136,000
June 19, 2012	Massachusetts Duals	RFP Released	108,000
End of June	Kansas	Contract awards	313,000
July 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
July 1, 2012	Washington	Implementation	800,000
July 1, 2012	Hawaii	Implementation	225,000
July 1, 2012	Florida LTC	RFP released	90,000
July 1, 2012	Nebraska	Implementation	75,000
July 1, 2012	Missouri	Implementation	425,000
July 1, 2012	Virginia Behavioral	Implementation	265,000
July 15, 2012	California (Central Valley)	Implementation	N/A
July 30, 2012	Ohio Duals	Contract awards	122,000
July 30, 2012	Massachusetts Duals	Proposals Due	115,000
July 31, 2012	Illinois Duals	Contract awards	136,000
July 1, 2012	Florida CHIP	Contract awards (delayed)	225,000
July/August, 2012	Georgia	RFP Released	1,500,000
August 31, 2012	Massachusetts Duals	Contract awards	115,000
September 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
September 20, 2012	Ohio Duals	Contracts finalized	115,000
October, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
Late 2012	New Hampshire	Implementation (delayed)	130,000
January, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
January 1, 2013	Georgia	Contract awards	1,500,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Florida TANF/CHIP	RFP released	2,800,000
January 1, 2013	Ohio	Implementation	1,650,000
January 1, 2013	Illinois Duals	Implementation	136,000
February 1, 2013	Ohio Duals, NW, NC, EC	Implementation	35,000
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	Ohio Duals, NE	Implementation	32,000
May 1, 2013	Ohio Duals, C, WC, SW	Implementation	48,000
Spring 2013	Arizona Duals	3-way contracts signed	120,000
July 1, 2013	Michigan Duals	Implementation	211,000
October 1, 2013	Florida LTC	Enrollment complete	90,000
January 1, 2014	New York Duals	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	Hawaii Duals	Implementation	24,000
February 1, 2014	Georgia	Implementation	1,500,000
October 1, 2014	Florida TANF/CHIP	Enrollment complete	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. As a note, this table will not reflect the implementation delay discussed in the Massachusetts roundup until it is finalized.

State	Model	Duals eligible for demo	Proposal Released by State	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Contract Award Date	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012	X	7/1/2012	N/A[+]	N/A[+]	N/A	1/1/2014
California	Capitated	685,000*	X	4/4/2012	X	6/30/2012				3/1/2013
Colorado	MFFS	62,982	X	4/13/2012	X	6/30/2012				1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	X	6/30/2012				12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012				1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	7/31/2012	1/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012				1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	X	6/30/2012				1/1/2014
Massachusett	Capitated	109,636	X	12/7/2011	X	3/19/2012	X	7/30/2012	8/31/2012	4/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012				7/1/2013
Missouri	Capitated[‡]	6,380	X		X	7/1/2012				10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012				1/1/2013
New Mexico	Capitated	40,000	X		X	7/1/2012				1/1/2014
New York	Capitated	133,880	X	3/22/2012	X	6/30/2012				1/1/2014
North Carolin	MFFS	222,151	X	3/15/2012	X	6/3/2012				1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	Late June	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	7/1/2012				7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012				1/1/2014
Rhode Island	Capitated	22,737	X		X	7/1/2012				1/1/2014
South Carolin	Capitated	68,000	X	4/16/2012	X	6/28/2012				1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012				1/1/2014
Texas	Capitated	214,402	X	4/12/2012	X	6/30/2012				1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	X	6/30/2012				1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012				1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012				1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012				1/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***3***			

**Duals eligible for demo based on 8 counties included in May 31, 2012 proposal to CMS. Will expand to further counties in 2014 and 2015 with approval.*

[+] Acure Care Managed Care RFP Responses due January 2013; Maricopa Co. Behavioral RFP Responses due October 2012. Duals will be integrated into these programs.

[‡] Capitated duals integration model for health homes population

HMA WELCOMES…

Brooke Ehrenpreis, Senior Consultant – Southern California

Brooke Ehrenpreis joined our Southern California office as a Senior Consultant on Monday, June 18th. Brooke comes to HMA from the National Health Foundation. Most recently, Brooke has served as Program Director, and has been responsible for designing, managing, and evaluating initiatives to improve healthcare access and quality for the underserved and to reduce health disparities. She also directed the foundation's role in national and state-wide health reform, represented the foundation among key health leaders, and created, maintained, and analyzed an extensive repository of health coverage and health reform policy information. Prior to her promotion to Program Director, Brooke served as Program Manager, and was responsible for directing a comprehensive education and training program on health coverage for assistors and health advocates, leading and evaluating a pregnant and parenting teen program, and writing numerous funding proposals to support new and ongoing initiatives. Earlier in her career, Brooke served as a Regional Workgroup Director for Insure the Uninsured Project in Santa Monica, California. Brooke earned her Bachelor of Arts degree at University of California Berkeley, and her Masters of Public Health degree at University of California Los Angeles.

HMA RECENTLY PUBLISHED RESEARCH

Health Care Use and Chronic Conditions Among Childless Adult Medicaid Enrollees in Arizona

Jack Meyer, Managing Principal
Esther Reagan, Senior Consultant
Dennis Roberts, Senior Consultant

Under the ACA and beginning in 2014, Medicaid eligibility will expand to 133% of the FPL for nearly all individuals. Arizona is one of the few states that already covers adults without dependent children in Medicaid through a longstanding Section 1115 waiver. This report, based on 2007 Medicaid claims data for adult Medicaid enrollees in Arizona, provides an analysis of health care utilization and health conditions for childless adults and compares them with parents and adults with disabilities. Understanding the health care use and needs of low-income childless adults can help inform other states' efforts to care for these adults under the Medicaid expansion in 2014. **(The Kaiser Commission on Medicaid and the Uninsured)**

UPCOMING HMA APPEARANCES

AHIP - Preparing for Exchanges: Medicaid and Exchange Linkages

Joan Henneberry, Panelist

June 20, 2012
Salt Lake City, Utah

AcademyHealth Annual Research Meeting: The Impact of the ACA on State Policy—Early Findings

Jennifer Edwards, Panel Facilitator

June 25, 2012
Orlando, Florida

AcademyHealth Annual Research Meeting: Health Insurance Exchanges: Progress to Date

Joan Henneberry, Panel Facilitator

June 25, 2012
Orlando, Florida

The National Council for Community Behavioral Healthcare - Medicaid Health Homes for Individuals with Behavioral Health Conditions

Alicia Smith, Panelist

June 25, 2012
Washington, D.C.

Healthcare Financial Management Association: HFMA National Institute 2012

Jennifer Kent, Panel Participant

June 27, 2012
Las Vegas, Nevada

Leadership Institute's Leadership and Learn Symposium: The Road I Have Traveled...

Izanne Leonard-Haak, Presenter

June 28, 2012
Harrisburg, Pennsylvania

The Council of State Governments - Medicaid Policy Academy: State Perspective Panel

Mark Trail, Panelist

June 28, 2012
Washington, D.C.