HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: ARKANSAS REVEALS "PRIVATE OPTION" DRAFT WAIVER

HMA ROUNDUP: IOWA GOVERNOR SIGNS LIMITED MEDICAID EXPANSION BILL, AWAITS HHS APPROVAL; NEW JERSEY, RHODE ISLAND PASS EXPANSION BILLS; SPECIAL SESSION ON MEDICAID TO KICK OFF IN MISSISSIPPI, NO SPECIAL SESSION FOR MICHIGAN; FLORIDA BEGINS MAILING MEDICAID MLTC ENROLLMENT PACKETS; INDIANA OFFICIAL BELIEVES CMS WILL APPROVE HEALTHY INDIANA PLAN EXTENSION; MASSACHUSETTS ANNOUNCES CONTRACT PROGRESS IN DUALS DEMONSTRATION; FEDERALLY FACILITATED EXCHANGE RATES DUE IN SEPTEMBER; HHS CALLS FOR 7 MILLION IN EXCHANGES BY MARCH 2014

INDUSTRY NEWS: TENET HEALTHCARE TO ACQUIRE VANGUARD; BAYLOR HEALTH CARE AND SCOTT & WHITE HEALTHCARE TO MERGE IN TEXAS

JUNE 26, 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

Health Management Associates (HMA) is an independent health care research and consulting firm. HMA operates a client service team, HMA Investment Services that is principally focused on providing generalized information, analysis, and business consultation services to investment professionals. Neither HMA nor HMA Investment Services is a registered broker-dealer or investment adviser firm. HMA and HMA Investment Services do not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients, including clients of HMA Investment Services.

IN FOCUS: ARKANSAS REVEALS "PRIVATE OPTION" DRAFT WAIVER

This week, our *In Focus* section reviews the Arkansas "private option" Section 1115 Waiver published for public comment before submittal to CMS for review and approval. The Arkansas private option plan, known as the Health Care Independence Act of 2013, eschews the traditional design of expanding Medicaid. Instead, parents and childless adults who are newly eligible for Medicaid have to option to enroll in a health insurance plan through the state Exchange, with Arkansas Medicaid paying all or most of the individual's premium. We previously reviewed the private option plan design in our March 20, 2013 Weekly Roundup, available here. The draft 1115 Waiver provides new details on the eligible population, timing, and the other operational details of the program. It is important to note that this draft waiver does not necessarily represent the final program design, as changes may be made in the public comment period and in negotiations with CMS. The state will receive comments through the first three weeks of July 2013 before submitting the waiver to CMS by August 2, 2013.

"Private Option" Eligible Population

The private option plan will cover two populations:

- Childless adults ages 19-65, with incomes at or below 138 percent of the federal poverty level (FPL); and
- Parents ages 19-65, with incomes between 17 percent FPL and 138 percent FPL. Parents with incomes 17 percent of FPL and below are currently eligible for Medicaid in Arkansas and not included at this time.

The state anticipates revising the 1115 Waiver within the year to include parents with incomes 0-17 percent FPL and children. The Waiver population excludes dual eligibles and individuals who are medically frail or have exceptional health needs. This will be preliminarily determined by a pre-enrollment screening process, as outlined in the waiver.

All told, Arkansas estimates 225,000 eligible individuals will be mandatorily enrolled by March 2014. The Arkansas Waiver cites a Health Affairs article from February 2011, which indicates that nationwide more than 35 percent of adults will experience a change from Medicaid to Exchange eligibility, or vice versa, within the first six months of enrollment.

Program Design, Enrollment, and Cost Sharing

The draft waiver document outlines several key elements of program design, as well as the structure for cost sharing in year one, and plans for amendments to cost sharing design as the program moves forward. The waiver is asking for a three-year program, from 2014 through 2016. A summary of the key program design elements and cost sharing structure follows.

Program Design and Enrollment

- The program will not be phased in, and will begin enrolling eligible individuals statewide on January 1, 2014.

- Eligible "Private Option" beneficiaries will select among the high-value silver plans offered in their geographic region. The state will assure a choice of at least two qualified health plans in each region.
- The open enrollment period will run from October 1, 2013 through March 31, 2014. Individuals deemed eligible for coverage through the Private Option who do not select a health plan will be auto-assigned with 30 days to transition.
- The Private Option waiver proposes to institute 12-month continuous eligibility to further reduce the impact of churning between eligibility categories.
- The qualified health plans will provide all benefits except for non-emergency medical transportation and early periodic screening diagnosis and treatment for individuals under 21 that are not covered under the health plan. These benefits will be provided under a fee-for-service structure.

Cost Sharing Design

- "Private Option" enrolled beneficiaries with incomes below 100 percent FPL will have no cost sharing obligations in the first year of the waiver. However, Arkansas Medicaid plans to submit waiver amendments to implement cost sharing for incomes between 50 and 100 percent FPL in the second and third years.
- Individuals with incomes of 100 to 138 percent FPL will be responsible for cost sharing consistent with the health insurance Exchange design, with a cap of 5 percent of 100 percent FPL, or roughly $604 in 2014.

Qualified Health Plan Applicants

Five insurance entities have submitted their intent to offer qualified health plans on the Arkansas Health Insurance Marketplace.

Qualified Health Plan Applicants – Arkansas Exchange
Arkansas Blue Cross Blue Shield
Celtic Insurance Company (Centene)
National Blue Cross Blue Shield Multi-state Plan
QualChoice of Arkansas
United Security Life and Health Insurance

Source: Arkansas Insurance Department

"Private Option" Timeline

Milestone	Timeframe
Waiver comment period	June 24, 2013 – July 24, 2013
Public hearings on waiver	July 2-9, 2013
Submit waiver to CMS	By August 2, 2013
Receive waiver approval from CMS	By October 1, 2013
Open enrollment period	October 1, 2013 – March 31, 2014
Coverage under Private Option goes live	January 1, 2014

HMA Medicaid Roundup

Alaska

HMA Roundup

Committee to Evaluate Managed Care for Public School Employees. Alaska's Senate Finance Committee is seeking a consultant to deliver an actuarial analysis of rolling public school employees into a state-managed care program to standardize coverage and lower costs. The project is expected to deliver a report to the panel by November 1, 2013.

Arkansas

HMA Roundup

Ballot Initiative Launched by Expansion Opponents. A group dubbed Arkansans Against Big Government is collecting signatures to force the state to place the Medicaid expansion proposal on the ballot for voters to decide directly whether to affirm or reject the "private option" signed into law by Governor Mike Beebe. To qualify for a ballot measure, the group must submit at least 46,880 signatures from registered voters by August 15, 2013.

California

HMA Roundup—Jennifer Kent

California Eliminates Pediatric Dental as Mandatory QHP Benefit. In a June 13, 2013 memo, the California Office of Administrative Law issued an emergency rulemaking action that approved the elimination of pediatric dental benefits as a mandatory benefit from qualified health plans (QHPs) offered on the state's exchange. Earlier in the month, Covered California appealed to the Department of Insurance to modify its essential health benefit package to remove the benefit to conform to federal requirements. So long as an exchange includes standalone dental plans that cover the essential pediatric dental benefit, QHPs are not required to offer the benefit themselves.

Exchange Dental Plans Unveiled. On June 25, 2013, seven companies were approved to offer dental plans on the state's exchange that cover children up to the age of 19: Access Dental, Anthem Dental, Blue Shield of California, Delta Dental of California, Health Net Dental, LIBERTY Dental Plan and Premier Access Dental. It is estimated that 140,000 children qualify for the low-cost plans that will be offered at CoveredCA.com.

Colorado

HMA Roundup—Joan Henneberry

Colorado Insurance Commissioner Resigns. Jim Riesberg, the head of the Division of Insurance, resigned effective July 8. With about 100 days to go before the exchange opens for business, stakeholders are concerned given the responsibilities of the DOI to qualify health plans and implement the so-called "3Rs" programs (risk corridors, reinsurance and risk adjustment). Jim Riesberg had been commissioner since July 2011 and a former

state legislator. Riesberg did not give a reason except to say he had been working for 60 years and this was a good time to leave. Doug Dean, director of the Public Utilities Commission, will serve as interim insurance commissioner until a permanent replacement is named by Governor Hickenlooper.

Colorado Fiscal Health Improves. State economists announced that Colorado has reached key benchmarks regarding jobs and revenues. The current employment levels are now back to where they were before the "Great Recession" of 2008 – 2.4 million jobs statewide. Governor Hickenlooper's budget director, Henry Sobanet, also announced that tax receipts are expected to be $307.5 million higher than predicted in March, leaving Colorado with a general fund surplus of $1.1 billion on June 30, the last day of the state fiscal year. By law, the surplus must go into the state education savings account. Economists attribute the additional revenue to higher-than-predicted individual income tax payments.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

South Florida Town Halls Focus on Medicaid Expansion. On June 25, Broward County legislators hosted a town hall meeting to urge the Governor to call a special session to expand Medicaid. The Palm Beach County Legislative Delegation has arranged its own town hall event on July 15 to promote the benefits of the Affordable Care Act and push for expansion of Medicaid in the state. Sen. Joe Negron was the author of the Senate bill to expand Medicaid, which was ultimately rejected by the House. Negron offered a sympathetic view of the meetings, but acknowledged that the House has not changed its position on his legislation.

AHCA Begins Rollout of Managed Long-Term Care Information Packets. Beginning on June 24, 2013, the Agency for Health Care Administration (AHCA) released welcome letters to Medicaid recipients in two regions for its Statewide Medicaid Managed Care (SMMC) Long-term Care (LTC) program. The welcome packets contain information about the SMMC Long-term Care program and the benefits offered by each of the plans in regions 8 and 9, consisting of 12 Florida counties. AHCA hosted stakeholder meetings with providers and partners in Ft. Myers on June 20 and in West Palm Beach on June 21. The full rollout schedule can be found on the Statewide Medicaid Managed Care website available here.

Florida Ranked Last in Pediatric Dental Care. According to a report published by the Pew Children's Dental Campaign, the state of Florida ranks last in the nation in delivering regular dental care to the state's children. Florida has consistently been at or near the bottom of national rankings for delivering dental care to its poorest residents, largely because only 15 percent of the state's dentists accept Medicaid patients, given low reimbursement rates and regulatory red tape. Pew recommends boosting Medicaid reimbursement rates, streamlining administration, and employing lower-cost dental alternatives (i.e. hygienists who received special training) to improve the rate of regular dental care for children.

Georgia

HMA Roundup – Mark Trail

DCH Holds Public Meetings on Foster Care/Adoption Care Management Program. On June 24 and 25, the Georgia Department of Community Health held public meetings to solicit comments related to the proposed move of children in Foster Care and Adoption Assistance to a risk-based care management program. Nearly 26,000 children, youth and young adults are in foster care and adoption assistance covered by fee-for-service Medicaid or PeachCare for Kids. If approved, the shift to a managed care approach aims to establish a more integrated delivery system that improves care coordination and outcomes.

New Deputy Director for Medicaid Aging and Special Populations. Recently, Marcey Alter was appointed the Deputy Director for Medicaid Aging and Special Populations at the Department of Community Health, replacing Catherine Ivy who became the Executive Director of the Georgia Chapter of the National Association of Social Workers. Ms. Alter most recently served DCH for three years as a program director managing Medicaid long-term care and home/community-based programs. Prior to joining DCH, Ms. Alter worked for six years in consulting, with an emphasis on developmental disabilities, aging, behavioral, and rehabilitation services. For nearly 11 years prior to her consulting roles, Ms. Alter worked on developmental disabilities policies and programs for the Georgia Department of Human Resources, Office of Developmental Disabilities and the Governor's Council on Developmental Disabilities for Georgia.

Hawaii

HMA Roundup

State May Bear $100 Million in Costs to Upgrade to EMR System. Last week, Hawaii Health Systems Corporation CEO Bruce Anderson indicated that the state may have to bear more than $100 million in funding to implement an electronic medical (EMR) system upgrade. The 14 public hospitals are 50 to 100 years old and initial estimates of cost did not adequately account for additional staffing or facilities upgrades necessary to maintain the system.

Indiana

HMA Roundup—Catherine Rudd

State Official Encouraged that CMS Will Approve HIP Extension by August. On Tuesday, June 25, 2013, Family and Social Services Administration Secretary Debra Minott told the Indiana General Assembly's Health Finance Commission that the state had met with CMS officials the prior week and was "encouraged" that the Healthy Indiana Plan (HIP) extension would be approved by August. However, until that issue is resolved, the administration will not begin negotiating to use HIP as the vehicle for a Medicaid expansion. Furthermore, the state is unwilling to remove the cost-sharing element of the program, which goes to "the essence of a consumer driven health plan". Governor Pence has opposed expanding traditional Medicaid but may consider an alternative that would give the state more control and place more responsibility on enrollees.

Iowa

HMA Roundup

Branstad Signs Limited Medicaid Expansion into law, awaits HHS approval. On Thursday, June 20, 2013, Governor Terry Branstad signed the Iowa Health and Wellness Plan into law. Under the plan, Iowans making between 100 and 138 percent of the federal poverty level (FPL) can obtain private insurance through the exchanges using Federal funds. Iowa will file a formal application for a waiver by the end of June and State Medicaid Director Jennifer Vermeer recently noted that talks with HHS were going well.

Branstad Vetoes Additional Funds for County Mental Health Spending Bill. On Thursday, June 20, 2013, Governor Branstad vetoed multiple spending bills, which included funding for counties to address mental health issues or disabilities services. Branstad noted that many of the services in question would already be covered under the aforementioned Iowa Health and Wellness Plan or transition funding for counties that had historically collected less than average amounts of property taxes. Democrats particularly criticized the veto of $8.7 million that would clear waiting lists of people with disabilities who qualify for various Medicaid benefits.

Maine

HMA Roundup

Democrats Evaluating Republican Bill as Means to Achieve Medicaid Expansion. Following two vetoes of Medicaid expansion by Governor Paul LePage, Democratic leaders are considering a bill proposed by House Republican leader Kenneth Fredette that would establish a Medicaid study commission. Democratic House Speaker Mark Eves intends to confer with Fredette to ensure that the study group is not symbolic, but action-oriented. GOP leaders have expressed interest in using additional federal funds for Medicaid to offer premium support to purchase private insurance.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Health Policy Commission to Review Partners' Proposed Acquisition. On Wednesday, June 19, 2013, Massachusetts' new Health Policy Commission unanimously decided to conduct a "cost and market impact review" of Partners HealthCare System's proposed acquisition of South Shore Hospital. This review marks the first by the commission and may slow down the spate of hospital consolidation in the commonwealth. The commission can recommend that the state attorney general take action to prevent the transaction, but has no formal authority, itself, to block a merger.

MassHealth Announces Three Plans Entering OneCare Contracting Phase. On June 21, 2013, MassHealth and CMS announced that Commonwealth Care Alliance, Fallon Total Care, and Network Health had entered the final phase of readiness review and contracting for the commonwealth's dual eligible program, One Care. Three other plans, Neighborhood Health Plan, Blue Cross Blue Shield of Massachusetts, and BMC HealthNet, have withdrawn from the demonstration. Additionally, Magellan has terminated its

planned joint venture with Fallon Total Care. MassHealth has finalized the 2013 capitated payment rates and will commence systems testing by the second week of July. MassHealth is planning on a mid-July outreach effort to eligible consumers, providers, and community-based organizations about the enrollment process that should begin October 1.

EOHHS Amends RFR for MassHealth CarePlus. On June 20, 2013, the Executive Office of Health and Human Services (EOHHS) amended its prior June 7 request for responses for MassHealth CarePlus, a new benefit plan that includes the ten categories of Essential Health Benefits defined in the ACA. 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. A bidder's conference on financial issues will be held in Boston on July 16, 2013. EOHHS intends to respond to questions on a rolling basis and encourages bidders to submit questions well in advance of the July 19 deadline. After the initial selection process, additional qualified bidders may submit responses whenever this RFR is re-opened for response submission in accordance with the open enrollment process. The letter of intent to bid is due on July 19 by 5PM, with initial responses due on August 7. EOHHS expects to announce its plan selections on September 20, with an effective contract date of October 15 and an operational start date of January 1, 2014.

Michigan

HMA Roundup—Esther Reagan

Snyder Will Not Force Senate Into Session for Medicaid Expansion. On Monday, June 24, 2013, Governor Rick Snyder told the press that he will not try to force the Michigan Senate to reconvene to take up his Medicaid expansion proposal. Although the House had approved the plan by a hefty 76-31 vote earlier this month, the Senate adjourned for the summer last Thursday, June 20. Snyder cut short a trip to Israel to return to Michigan with a plea to take a vote. The governor notes that the proposal still requires Federal approval and time is running short.

Mississippi

HMA Roundup

36 Counties Have No Exchange Health Plan Options. Mississippi residents in 36 of the state's 82 counties may not get to participate in health exchanges in 2014 because no health insurers have applied to offer plans. Only two insurers have announced plans covering 46 counties, to date. State Insurance Commissioner Mike Chaney noted that unless the two insurers expand their offerings or new companies apply, residents of the other 36 counties may be "just out of luck".

Medicaid Special Session to Start June 27. Governor Phil Bryant called for a special legislative session starting on Thursday, June 27, at 10AM to address the reauthorization of the state's Medicaid program, set to expire on July 1, 2013. Democrats have resisted reauthorizing the program without a vote to expand Medicaid first. Bryant urged the legislature to act immediately to authorize and fund Medicaid, without further waste of tax-

payer dollars. House Speaker Philip Gunn supports extending the authorization for the Medicaid agency for one year and study ways to improve the program. Previously, the Senate had voted to reauthorize and fund Medicaid without expansion. As a contingency, Governor Bryant believes he could administer Medicaid by executive order but Democratic Attorney General Jim Hood issued a non-binding legal opinion that the governor lacks the legal authority to do so.

Missouri

HMA Roundup

Missouri Committees to Evaluate Medicaid Reforms. On Thursday, June 20, 2013, House Speaker Tim Jones announced the formation of two committees to study Medicaid reforms. Citizens and Legislators Working Group on Medicaid Eligibility and Reform would consist of legislators, special interests, and Missouri citizens to identify ways to improve the program, reduce costs, and expand eligibility. An August report would be submitted to the House Interim Committee on Medicaid Transformation to translate recommendations into legislation.

Montana

HMA Roundup

Health Care Service Corp. Purchase of BCBS of Montana Gains Conditional Approval. On Tuesday, June 25, 2013, Montana Attorney General Tim Fox offered conditional approval for Health Care Service Corporation's proposed $40 million acquisition of Blue Cross and Blue Shield of Montana. State Auditor Monica Lindeen is charged with determining if the merger is in the public interest, but has yet to issue her final order on the deal.

Health Insurance Premiums Lower Under ACA. On Monday, June 24, 2013, State Auditor Monica Lindeen said that health insurance policies available on the state's health exchange for individuals and businesses will be lower than projected rates would have been without the law.

New Hampshire

HMA Roundup

Lawmakers Pass $10.7 Billion Budget with Medicaid Study Panel. On Wednesday, June 26, 2013, the Senate unanimously voted for the $10.7 billion budget. The House overwhelmingly voted for the budget bills 337-18 for HB 1 and 346-12 for HB 2. Among the provisions are additional funds to reduce waiting time for services to the disabled and mentally ill. Medicaid expansion will be addressed by a nine-member commission to study Medicaid expansion, with a report due by October 15, 2013. Governor Maggie Hassan may call a special legislative session in the fall to authorize Medicaid expansion. Five of the panel's voting members will be appointed by Democrats, while four will be appointed by Republicans.

New Jersey

HMA Roundup

Medicaid Expansion Legislation Passed by Legislature; Awaiting Christie's Signature. On Monday, June 24, 2013, Senate bill 2644, which would expand Medicaid coverage consistent with the ACA, passed the General Assembly with a vote of 46-32-0. Last week the Senate approved the measure by a 26-12 vote. Governor Chris Christie had already voiced his support for the legislation and is expected to sign the bill into law imminently. Various studies estimate that New Jersey should receive an additional $22 billion in federal funds over eight years, while expanding healthcare coverage to more than 234,000 New Jersey residents.

Hospital Provider Tax Vote Delayed. On Tuesday, June 25, 2013, New Jersey lawmakers delayed plans to vote on a hospital provider tax. The Christie Administration committed to conduct its own analysis of the proposal, but not before the legislature's summer recess. The bill would allow local and county governments to institute a tax of no more than 5.47 percent on hospital revenues, which would then qualify for federal matching Medicaid dollars that would be shared with safety net hospitals. Opponents of the bill were alarmed that municipalities could raid up to 20 percent of the taxes for whatever purposes they deem necessary.

New York

HMA Roundup—Denise Soffel

Update on NYS Waivers and Amendments. In a recent meeting, CMS staff indicated that they have not begun serious consideration of New York State's request to amend its Section 1115 waiver, the Partnership Plan. The amendment would allow the state to preserve $10 billion in federal savings that are expected to result from changes implemented as part of New York's Medicaid Redesign Team (MRT) efforts. Recent conversations between NYS and CMS have been dominated by efforts to resolve the overpayment issues around services to Medicaid beneficiaries with developmental disabilities who have been receiving services through the Office for People with Developmental Disabilities (OPWDD).

When the MRT concluded its work in 2012, the state submitted a number of state plan amendments (SPAs) necessary to implement proposed programmatic changes. Several SPAs provide the state with flexibility to temporarily increase Medicaid reimbursement to safety net providers. The SPAs are institution-specific, including one for nursing homes, one for hospitals, one for community health centers, and one for certified home health agencies. The SPAs would allow for a temporary rate adjustment to a facility that are subject to or impacted by the closure, merger, acquisition, consolidation or restructuring of a health care provider, if the facility can demonstrate that it needs additional funds to protect access, quality or cost-effectiveness. CMS recently approved the nursing home safety net SPA and expect to approve the hospital-related SPA soon. Safety net SPAs for community health centers and CHHAs are in the queue.

CMS and NYS have begun discussions about establishing a Delivery System Reform Incentive Payment (DSRIP) program. The original guidance that CMS had shared with the state has been changed, in part as a result of the experience of the DSRIP programs in California and Texas. CMS is now requiring much more specific detail about what are the programs, and where is the money going. They also want to be sure that the state has sufficient control over the program to assure that providers are held accountable for programmatic goals and overall spending. They expect that the state will have a much more central oversight role in future DSRIP programs.

After Hurricane Sandy, NYS applied for a waiver to offset the losses experienced by hospitals and other facilities as a result of the storm. The request, for $427 million, was denied by CMS because Medicaid rules do not allow for Medicaid payment when services were not delivered. New York was seeking funds to make up for lost Medicaid revenue for the period when facilities were closed, or were temporarily damaged or lost power, and had reduced capacity.

Update on Office for People with Developmental Disabilities (OPWDD). OPWDD submitted its People First waiver proposal to CMS on April 1 2013, hoping for an effective date of October 1. The People First waiver would establish Developmental Disabilities Individual Services and Care Coordination organizations (DISCOs) and would capitate the Medicaid payment for those services currently funded through OPWDD. Capitated payments will be determined through an actuarial formula that incorporates individual need for services. The payment is meant to cover the provisions of person-centered planning, coordination of services, and oversight of care. In essence, the DISCO will receive capitated payments to provide care coordination services. The DISCO will manage a network of providers and authorize services for beneficiaries. The DISCO must be a not-for-profit organization with experience in coordinating care for the DD population. The state is now engaged in weekly calls with CMS, and reports that an agreement is near. New York is also having discussions about rates, and is developing an additional amendment on changes to the rate-setting methodology. A waiver approval is anticipated by October 2013, with DISCO demos up and running by April 1, 2014. Readiness and enrollment should commence in January/February of 2014.

The RFA to become a DISCO has been redrafted and is being reviewed by counsel at OPWDD. It then goes to the Department of Health for review. They hope to begin the solicitation this summer. The revised draft does not contain any significant programmatic changes. They are also in the process of drafting the model contract, which will embody programmatic requirements.

The budget that was enacted in March 2013 allows for two other models of managing care for the DD population, through a mainstream Medicaid managed care plan, or through an MLTC. In both those cases the MCO will have to subcontract with an organization that has demonstrated experience coordinating care for people with developmental disabilities. Unlike a DISCO, the MCO does not have to be not-for-profit.

Pennsylvania

HMA Roundup – Matt Roan

PA Senate Considers Medicaid Expansion, with Reforms. The Pennsylvania Senate is working on legislation to expand Medicaid by enacting the reforms that Governor Corbett has been pushing for with the federal government. While the plan has not yet been introduced, negotiators in the Senate have been working to make amendments to the Public Welfare Code that would enact Medicaid reforms including increased co-pays, work requirements, and benefit package design changes. The measure would also provide for PA's participation in Medicaid expansion. Republican leaders in the Senate stressed that the will with be in line with what the Governor is trying to achieve, and said that the question of Medicaid expansion is too significant to not be considered alongside the state budget. Republicans in the House of Representatives continue to oppose any form of Medicaid expansion, and House leaders have indicated that they do not intend to bring Medicaid expansion up for a vote. Besides the potential costs, House leaders are worried that the proposed reforms cannot move forward without federal approval.

Despite Job Losses, PA Unemployment Rate Lowest Since 2009. The unemployment rate in PA has dipped by 1/10 of a percent to 7.5 percent in the month of May despite having larger over the month job losses than any other state. The unemployment rate decrease was driven by the addition of 16,000 Pennsylvanians to the workforce. While unemployment has slowed in PA, job growth in PA has been weak as compared to other states. A third of the jobs lost in May, approximately 3000, were government positions.

Rhode Island

HMA Roundup

Rhode Island House Committee passes budget with Medicaid expansion, to consider additional premium assistance for Exchange enrollees. Rhode Island's House Finance Committee unanimously approved a budget proposal on Tuesday, June 25, that boosts overall state spending by around 1 percent for the 2013-2014 fiscal year beginning July 1, 2013. The budget proposal includes the Medicaid expansion, while shifting those individuals in Rhode Island currently covered by Medicaid benefits above 138 percent of FPL to the Exchange. The House Finance Committee Chairman indicated the state will look seriously at subsidizing the cost sharing paid by lower income Exchange enrollees beyond the federal premium assistance amounts. Additionally, the approved budget proposal would freeze Medicaid payment rates to nursing homes, hospitals, and other providers.

Washington

HMA Roundup – Doug Porter

Washington Governor declares budget resolution, though details remain unclear. Washington Governor Jay Inslee announced on Monday, June 24, a breakthrough in the long-stalled budget reconciliation negotiations between the House and Senate, although the details of said agreement remain unclear. The delay to reach an agreement before the start of the new fiscal year was threatening government employee furloughs and other government shutdowns. Governor Inslee stated that health and social services would not be significantly cut under the budget. The Senate was looking to make significant cuts, while the House prescribed much smaller cuts to health and social services programs.

National

HMA Roundup

Federally Facilitated Exchange rates to be published in September. According to Gary Cohen of the Center for Consumer Information and Insurance Oversight (CCIIO), qualified health plan premium rates in the federally facilitated exchanges will be revealed in September of this year. Politico reported that Cohen presented the timeline at a meeting at the Brookings Institute on Tuesday, June 25.

HHS calls for 7 million enrolled in Exchanges by March 2014, unveils new website, hotline, enrollment drive efforts. HHS Secretary Kathleen Sebelius announced this week a goal of enrolling 7 million individuals in the new health insurance exchanges between October 2013 and the end of March 2014. HHS is targeting partnerships with the National Football League, among other organizations in an outreach campaign. A new HealthCare.gov website detailing health insurance options under the ACA and a 24 hotline also launched this week. Exchanges are supposed to begin enrollment on October 1, 2013, just over three months from now.

States failing to tap into Medicaid funding for prisoner health care. A Stateline article this week highlights the limited extent to which states have taken advantage of the longstanding ability to claim federal Medicaid matching funds when a Medicaid-eligible prisoner is hospitalized or institutionalized in a nursing home. Beginning next year, at least in those states expanding Medicaid, nearly the entire state prison and county jail would be eligible for Medicaid and open for reimbursement for hospital and nursing home stays. Combined, state prison and county jail populations excel 2.3 million nationwide. According to the article, "only Arkansas, California, Colorado, Delaware, Louisiana, Michigan, Mississippi, Nebraska, North Carolina, Oklahoma, Pennsylvania, Washington and some scattered local governments are tapping Medicaid to pay for inpatient medical and nursing home care. A few more states are looking into it, including Georgia, Massachusetts, Minnesota, New Mexico, New York and Virginia." HMA's Donna Strugar-Fritsch was quoted in the article, indicating that due to misinformation and complication, most states will likely not be poised to take advantage of this opportunity in 2014. However, she says, by 2015, the overwhelming financial incentives should drive state participation much higher.

INDUSTRY NEWS

Tenet Healthcare to acquire Vanguard Health Systems. Tenet and Vanguard revealed a deal this week in which Tenet will acquire Vanguard's 30 hospitals and 31 outpatient facilities for around $1.8 billion. This will bring Tenet's ownership to 79 hospitals and 157 outpatient facilities and increase their geographic presence. The deal is being hailed by many analysts as a sign of mergers, acquisitions, and market consolidation to come as providers adapt to and position themselves in the changing health care market.

Baylor Health Care System and Scott & White Healthcare to merge. Baylor Health Care System and Scott & White Healthcare, two large Texas health systems, announced a merger agreement last week. Combined, the two systems account for $6 billion in annual net revenue. The deal is subject to Federal Trade Commission and Texas Attorney General review.

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, 2013	Rhode Island Duals	Contract Awards	22,700
June, 2013	South Carolina Duals	RFP Released	68,000
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	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	Illinois Duals	Implementation	136,000
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	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	Idaho Duals	Implementation	17,700
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
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	1/1/2014
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	June 2013	TBD	TBD		3/1/2014
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 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)**