HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: FLORIDA MEDICAID MANAGED LONG-TERM CARE ITN

HMA ROUNDUP: COLORADO OUTLINES MEDICAID BUDGET INITIATIVES;
ILLINOIS LEGISLATORS LEANING TOWARD FED-STATE PARTNERSHIP EXCHANGE;
OHIO ANNOUNCES DUALS RFP SCORING, PROTESTS DUE JULY 13;
PENNSYLVANIA GOV. SIGNS FY12-13 BUDGET

OTHER HEADLINES: STATE REACTIONS TO SCOTUS RULING;
LOUISIANA MEDICAID BUDGET CUT BY NEARLY $900 MILLION;
CMS ANNOUNCES ADDITIONAL EXCHANGE FUNDING OPPORTUNITY

HMA WEBINAR: "WHAT THE COURT DID AND WHAT'S NEXT FOR HEALTH REFORM"
JULY 17, 2012 – NOON EDT

JULY 3, 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: Florida Medicaid Managed Long-Term Care ITN

This week, our In Focus section reviews the Florida Statewide Medicaid Managed Care (SMMC) Long-Term Care Invitation To Negotiate (ITN). As the first of two procurements expanding capitated managed care statewide, Florida is procuring managed care plans to serve roughly 87,000 Medicaid beneficiaries with long-term care needs across 11 regions. In state fiscal year (SFY) 2010-2011, this population accounted for Medicaid expenditures of more than $3.4 billion with per member per month (PMPM) costs of roughly $3,300. The ITN covers both dual and non-dual Medicaid beneficiaries ages 18 and above. Plans would begin enrolling beneficiaries in August 2013, and be fully implemented in all regions by March 2014.

Interested Bidders

AHCA requested non-binding letters of intent from plans interested in bidding on the LTC ITN contracts. These LOI respondents were publicized in April 2012 as well as the regions they intended to bid on. American Eldercare, Amerigroup, Freedom Health, Humana, Simply Healthcare, Centene, United, and WellCare all intend to bid statewide to serve the LTC population. Eleven of the interested bidders operate Nursing Home Diversion (NHD) plans in the state. The NHD plans will be phased out upon full implementation of statewide managed LTC. Twenty-one plans responded with an LOI.

Plan Name	Operates Nursing Home Diversion	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11
Aetna Better Health		X		X			X	X	X			
American Eldercare	Yes	X	X	X	X	X	X	X	X	X	X	X
Amerigroup	Yes	X	X	X	X	X	X	X	X	X	X	X
AvanteGroup				X	X			X		X		
Brevard Alzheimer's Foundation Inc.	Yes							X				
Catholic Health Services											X	X
Ganot Capital LLC				X	X			X	X	X	X	
Florida Healthcare Plus, Inc.							X	X				X
Freedom Health		X	X	X	X	X	X	X	X	X	X	X
Humana	Yes	X	X	X	X	X	X	X	X	X	X	X
Miami Jewish Health Systems											X	X
Molina	Yes	X			X	X	X	X		X	X	X
Neighborly Care Network	Yes					X	X	X		X	X	X
Prestige Health Choice							X		X			X
Simply Healthcare	Yes	X	X	X	X	X	X	X	X	X	X	X
Sunshine State Health Plan (Centene)	Yes	X	X	X	X	X	X	X	X	X	X	X
Tri-County Life Care								X		X	X	
Universal	Yes				X	X	X	X	X	X	X	X
United	Yes	X	X	X	X	X	X	X	X	X	X	X
WellCare	Yes	X	X	X	X	X	X	X	X	X	X	X
Worldnet Services Corp.	Yes	X			X			X				X
Total Number of Plans	**12**	**11**	**8**	**11**	**13**	**11**	**14**	**18**	**12**	**14**	**15**	**16**

Sources: AHCA LOI Responses, NHD Plan Enrollment

Target Population

In SFY 2010-2011 the LTC ITN population averaged nearly 87,000 Medicaid lives across 11 regions and accounted for more than $3.4 billion in total Medicaid spending. Per member per month (PMPM) costs averaged close to $3,300. A small portion of current spending (roughly $35 million) for the home and community based services (HCBS) waiver population will not be covered by the managed LTC plans. This would bring PMPM costs down by less than $100.

Region	MSA	Avg. Enrollees	Total Spending	PMPM
1	Pensacola	2,842	$128,140,456	$3,757
2	Tallahassee	4,028	$168,324,923	$3,482
3	Gainesville	6,911	$284,177,424	$3,427
4	Jacksonville	8,956	$377,355,846	$3,511
5	St. Petersburg	9,705	$407,042,661	$3,495
6	Tampa	9,309	$358,712,158	$3,211
7	Orlando	9,248	$375,803,701	$3,387
8	Sarasota	5,605	$260,417,101	$3,872
9	Palm Beach	7,869	$343,421,069	$3,637
10	Ft. Lauderdale	6,267	$212,706,935	$2,829
11	Miami	16,097	$502,808,896	$2,603
Total		**86,835**	**$3,418,911,170**	**$3,281**

Source: AHCA LTC ITN DataBook

The state intends to invite a minimum of four to seven plans for negotiation in each region, and will award between two and five contracts per region, as shown in the table below. If at least two Provider Service Networks (PSNs) are not included in the plans to be invited to negotiation, the next highest ranked PSN or PSNs submitting a response in the region will also be included to ensure that at least two PSNs are included in negotiation.

Region	Statutory Min./ Max. Plans	Min. Plans for Negotiation	Number of Contracts
1	2	4	2
2	2	4	2
3	3-5	5	3
4	3-5	5	3
5	2-4	5	3
6	4-7	6	4
7	3-6	5	3
8	2-4	5	3
9	2-4	5	3
10	2-4	5	3
11	5-10	7	5
Total		**56**	**34**

The ITN sets a maximum enrollment level per plan for each region. The maximum is set at the total eligible population in a region, divided by the minimum statutory plans required, multiplied by two. Plans may request higher maximum enrollment levels during the Plan Readiness review, if desired.

LTC ITN and Nursing Home Diversion

Florida operates a Medicaid Nursing Home Diversion (NHD) waiver program, providing home and community-based services to functionally impaired elderly people at risk of nursing home placement. The program serves dual eligibles over the age of 65. The following plans currently serve the more than 18,000 enrollees in the NHD waiver program. As noted, both Molina and WellCare have recently been approved to operate NHD plans.

Nursing Home Diversion (NHD) Plan	June 2012 Enrollment	Submitted LTC LOI	ITN Regions Currently Served by NHD Plan
American Eldercare	4,082	Yes	All
Amerigroup	2,527	Yes	3, 4, 5, 6, 7, 8, 9, 10, 11
Centene	2,019	Yes	3, 4, 5, 6, 7, 8, 9, 10, 11
Coventry	1,049		9, 10, 11
Hope Choices	177		8
Humana Florida	1,356	Yes	4, 5, 6, 7, 8, 9, 10, 11
Little Havana	1,020		9, 10, 11
Molina	N/A*	Yes	5, 6
Neighborly Care Network	788	Yes	3, 5, 6, 7, 8, 9, 10, 11
Project Independence at Home	722		10, 11
Simply Healthcare	57	Yes	5, 6, 7, 11
United Healthcare	1,998	Yes	3, 4, 5, 6, 7, 8, 9, 10, 11
United Home Care Services	1,065		11
Universal Health Care	1,077	Yes	3, 4, 5, 6, 7, 8, 9, 10, 11
Urban Jacksonville	168		4
WellCare	N/A*	Yes	1
Worldnet	31	Yes	1
Yourcare Brevard (Brevard Alzheimer's)	156	Yes	7
Total - All NHD Plans	**18,105**	**12**	

*Source: AHCA NHD Enrollment Data * Molina, WellCare approved as NHD plans within past month*

During the initial roll-out of the LTC component of the SMMC program, recipients currently enrolled in a Nursing Home Diversion plan who do not choose a managed care plan within the recipient choice timeframes indicated on the recipient notification letter will be automatically assigned to their existing plan, if that Medicaid Managed Care Plan has been awarded a LTC Managed Care Plan contract in the region and meets plan readiness deadlines.

Financial Requirements

The LTC ITN includes financial requirements of several mandatory bonds to be put up by the applicant throughout the application, negotiation and contract phases. These bonds requirements can amount to several million dollars per region and could provide a significant financial obstacle to smaller plans, instead favoring larger organizations with more available capital.

For example, in Region 11, serving the Miami-Dade area, the following bonds are required:

1. A proposal guarantee bond of **$1,078,652** to be returned after the state has received a plan's performance bond after contract execution;

2. A performance bond of **$1,000,000** per region served, which will be forfeited by the plan in the event of contract termination prior to the end of the contract period; and
3. A fidelity bond of **$250,000** per contract period.

Scoring Criteria

Below we list the scoring criteria for the technical proposal. There is a separate cost proposal wherein the plans are expected to bid within the actuarially determined range. If the plan is among the highest-scoring technical proposals and has bid a price within the range, it is selected to negotiate further with the state.

Scoring Criteria	Points	%
Mandatory Documentation	N/A	
Financial Information	180	10%
Past Performance	75	4%
Technical Response		
Qualifications & Experience	300	17%
Enrollee Services, Community Outreach, Marketing	130	7%
Covered Services	240	13%
Behavioral Health Care	40	2%
Provider Network	290	16%
Quality Management	215	12%
Grievance System	20	1%
Administration & Management	187.5	10%
Information Management & Systems	95	5%
Reporting Requirements	30	2%
Provider Comments	15	1%
Maximum Points Possible	**1817.5**	**100%**

Timeline

Timeline	Date
ITN Issued	June 29, 2012
Questions Due	July 6, 2013
Vendor Conference	July 19, 2013
Question Responses	July 26, 2012
Proposals Due	**August 28, 2012**
Respondents Publicized	August 31, 2012
Awards Announced	**January 15, 2013**
Enrollment Rollout:	
Region 7	*August 1, 2013*
Regions 8, 9	*September 1, 2013*
Regions 1, 2, 10	*November 1, 2013*
Region 11	*December 1, 2013*
Region 5, 6	*February 1, 2014*
Regions 3, 4	*March 1, 2014*

Link to AHCA LTC ITNs Regions 1 – 11:

http://www.myflorida.com/apps/vbs/vbs_www.search_r1.matching_ads_page

HMA Medicaid Roundup

Colorado

HMA Roundup – Joan Henneberry

State FY 2013 budget reduction initiatives from the Department of Health Care Policy & Financing include a combination of rate adjustments to realign incentives, service restrictions and financial efficiencies. Medicaid program expenditures will be reduced by $21.2 million total funds and $26.3 million General Fund in FY 2012-13.

Initiatives effective July 1, 2012 include:

- FY 2012-13 Class I nursing facility rates will be reduced by 1.5%. This includes hospice and PACE rates.
- Policies have been implemented to prevent the utilization of Seroquel for off label use. Seroquel is a drug used to treat schizophrenia. However, it is sometimes prescribed for treatment of insomnia and anxiety.
- The Department is in the process of clarifying rules regarding eligibility for orthodontics. These clarifications are expected to reduce utilization of orthodontics for all cases except those where the client has a condition where speech or the ability to eat is significantly impaired.
- The Department initiated a competitive procurement process to acquire a sole source diabetic testing supply provider whereby the Department can leverage purchasing power to obtain significant rebates.
- The Department has initiated a pilot project to shift some surgical procedures from the outpatient hospital setting to the less costly ambulatory surgical setting.
- Client copayments for certain procedures will be increased under the CHP+ and the Colorado Indigent Care Programs.

Upcoming events:

- The next Accountable Care Collaborative Advisory Committee meeting will be held on July 18, 2012, at Noon. For more information: (Colorado.gov)
- The next stakeholder meeting for the Duals Integration Demonstration is July 13, 2012, 1:30 p.m. – 3:30 p.m. at the National Multiple Sclerosis Society.

Georgia

HMA Roundup – Mark Trail

On Friday, June 29, Frank W. Berry III was named the next commissioner of the state Department of Behavioral Health and Developmental Disabilities. Berry, currently CEO of View Point Health in Lawrenceville, replaces Dr. Frank Shelp, the agency's first commissioner, who announced his resignation last week. Berry said he would target improving developmental disabilities services as the agency's top priority.

Regarding the SCOTUS decision, our sense is that Georgia is not likely to make a decision on Medicaid expansion before the legislature convenes next year.

Illinois

HMA Roundup – Matt Powers and Jane Longo

Illinois' Department of Health and Family Services (HFS) filed a significant number of rules which are mainly follow-up to the spring session that ended in May and begin to implement the budget that begins with the July 1, 2012 fiscal year. Rules included prior approval for pharmaceutical products including HIV drugs.

Illinois legislators announced that the state plans to implement a federal-state partnership exchange, as the state was not prepared to meet the upcoming deadlines this fall to run its own exchange. As a reminder, in May CMS offered states the option of establishing a federal-state partnership exchange. The partnership model will allow the federal government to set up and run an exchange in Illinois for one year until the state is ready to assume control with its version of an exchange.

Indiana

HMA Roundup – Catherine Rudd

The Indiana Family and Social Services Administration is hosting a dual eligible integration Advisory Council Meeting on July 13 at 1pm.

New York

HMA Roundup – Denise Soffel

Managed Long-Term Care

The state does not yet have formal CMS approval for the mandatory managed long term care program. They have nonetheless been given verbal permission to begin sending out mandatory enrollment packets to MLTC beneficiaries for the first wave of eligibles in Manhattan. Eligible beneficiaries will have 60 days to select a plan, after which they will be assigned to one. The first mailing, which is being coordinated by the enrollment broker Maximus, will go out next Friday, which means the first auto-assignments will happen on September 4. The mailings only go to people currently under service; if you are newly requesting services you will be referred directly to an MLTC for evaluation.

Medicare Advantage

The Medicare Rights Center has released a new report—*New York's Medicare Marketplace: Examining New York's Medicare Advantage Plan Landscape in Light of Payment Reform*—examining the impact of the Affordable Care Act and other policy changes on Medicare Advantage plans in New York State. The report explicates a range of complex payment and benefit issues that some analysts anticipated would weaken the attractiveness of the plans to beneficiaries while threatening company finances. The report looks at five Medicare Advantage plans in detail, examining changes in benefits and cost-sharing that might be attributed to the changing policy environment. They found the Medicare Advantage landscape in 2011 to be as robust as, and perhaps more beneficiary-friendly than, it was in 2010. They also find that insurers and consumer advocates anticipate larger payment changes in years to come and question insurer ability to weather the storm

without passing some of the costs onto beneficiaries or changing benefit packages. The report can be found at: http://www.uhfnyc.org/publications/880842

Medicaid Redesign Team Waiver: Reinvestment Strategy

In preparation for submitting an amendment to its 1115 waiver, NYS has hosted a series of informational webinars about the elements of its plan, which is being labeled a reinvestment strategy. The state is planning to ask that CMS allow NYS to keep $10 billion over the next 5 years, a portion of the savings they believe will accrue to CMS as a result of changes implemented by the Medicaid Redesign Team. The state wants to feed those savings back into the health care delivery system, helping providers prepare for the changes being driven by the Affordable Care Act and by the MRT process. Systemic changes in health care delivery are creating challenges for the provider community, and the state would like to target reinvestment in 13 different arenas. One area of interest is the need to expand primary care to accommodate up to 1 million newly insured in 2014, including both physical infrastructure and workforce development. Another arena is interest in new models of care that provide greater integration across physical and behavioral health. The state also hopes to strengthen its health home initiative, particularly in helping build out IT systems that would link physical health, behavioral health, social services and housing. The slide presentation materials and the archived webinars can be found here: (MRT Website)

Ohio

HMA Roundup – Alicia Smith

Managed care organizations that intend to submit protests to the scoring of the Ohio dual eligible RFA must submit their protests by July 13, 2012. Results for each region from the initial scoring are presented below.

	Northwest	Southwest	West Central	Central	East Central	Northeast Central	Northeast
1 (Rank)	Aetna	Molina	Molina	Molina	Aetna	Aetna	Aetna
2	United	Aetna	United	Aetna	United	United	United
3	CareSource	United	Aetna	United	CareSource	CareSource	CareSource
4	Buckeye	CareSource	CareSource	CareSource	Buckeye	Coventry Carelink	Buckeye
5	Paramount	Buckeye	Buckeye	Buckeye	Molina	Molina	WellCare
6	Molina	WellCare	Anthem	Anthem	Coventry Carelink	Buckeye	Molina
7	Anthem	Anthem	WellCare	WellCare	Anthem	WellCare	Coventry Carelink
8	WellCare				WellCare	Anthem	Anthem

Date	Next Steps
July 13, 2012	Opportunity for health plans to submit protests to ODJFS legal office. Protest will be carefully reviewed and scores may be adjusted.
August 6, 2012	Selection meeting for plans to choose markets.
August 7, 2012	Final tentative selection of ICDS health plans completed.
August 14, 2012	Estimated start of readiness review of selected ICDS health plans.
October 2, 2012	CMS, Medicaid, and ICDS health plans sign three-way contracts.
April 1, 2013	Enrollment begins.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

With 15 minutes to spare on the July 1 deadline , Governor Tom Corbett signed the FY 12-13 PA Budget totaling $27.7 billion, a 1.7 % increase over the FY 11-12 Budget. The increase was possible as a result of the revenue surge in March and April. The enacted budget provides $10.6 billion in state funds for the human service programs. The state passed county-based block grants for community-based programs such as behavioral health services, mental health services, child welfare and homeless assistance. The county block grants originally contemplated a 20% reduction in funding, but were reduced by 10% in the final budget, an $84 million adjustment.

On June 30, 2012, The Pennsylvania Department of Public Welfare issued 13 final notices of changes related to its nursing home, developmental disabilities and Medicaid waiver programs. Most of the changes relate to efforts to address service needs, rate setting reform or cost containment issues. Two of the notices related changes in the nursing facilities participation requirements. One notice addressed the changes to the Nursing Facility Assessment. There were five notices covering changes to payment methods and standards for nursing facilities. The other five notices addressed added services to the fee schedules, or changes in the rate setting methodologies, for the Medical Assistance Aging Waiver, the Consolidated and Person/Family Directed Support Waiver or the Adult Autism Waiver. More information can be found in the Pennsylvania Bulletin at this site: http://www.pabulletin.com/secure/data/vol42/42-26/index.html

In the news

- **Pennsylvania's budget restores funding for hospitals, nursing homes**

  Hospitals and nursing homes were happy to see millions in proposed cuts restored in the budget that Gov. Corbett signed Saturday. The $27.66 billion budget reversed Corbett's proposed 4 percent cut in Medical Assistance payments to the 600 nursing homes that accept the state and federal insurance for the poor, which is called Medicaid on the federal level. The restoration amounts to $46 million in state money, which translates into an additional $55 million in federal money, said Stuart Shapiro, president and chief executive of the Pennsylvania Health Care Association, a trade group for nursing homes. But even with the level funding compared with the previous year, nursing homes will continue losing $20 per day on each resident, Shapiro said. (Philadelphia Inquirer)

OTHER HEADLINES

Reactions to SCOTUS Decision on ACA

The table below was compiled from the collection of Governors' reactions to the SCOTUS ruling last Thursday by the website StateReForum.org.

Governors' comments: Moving forward	Governors' comments: In the middle/undecided	Governors' comments: Opposed, wait for Nov. Election
California	Alaska	Alabama
Colorado	Arkansas	Arizona
Connecticut	Michigan	Florida
Delaware	Missouri	Iowa
Kentucky	Nevada	Kansas
Massachusetts	Ohio	Louisiana
Maryland	South Dakota	Maine
Minnesota	Tennessee	New Jersey
Oregon	Virginia	Oklahoma
Rhode Island	West Virginia	Texas
Washington		Wisconsin

In addition, we have collected numerous articles below related to state decisions on implementing Medicaid expansions and Exchanges in the wake of the Supreme Court's decision.

Arkansas

- **Beebe inclined to expand Medicaid**

  Gov. Mike Beebe said today he is inclined to go ahead with the expansion of Medicaid proposed under the federal health care law. Beebe told reporters he would decide before the 2013 legislative session begins in January whether he favors the expansion, but at this point he leans toward pursuing it. (Arkansas News)

Colorado

- **Full speed ahead for Colorado health insurance expansion**

  The Supreme Court's decision on upholding key provisions of the Affordable Care Act should speed insurance expansions to nearly all Coloradans, while opponents regroup for future fights, state officials and health experts said. The state will redouble efforts to prepare for 2014's growth in Medicaid enrollment, and a consumer "exchange" where other individuals should find affordable, uniform benefits, proponents said. (Denver Post)

Florida

- **Florida says no to two healthcare law features**

  Florida will not implement two provisions of the U.S. healthcare law involving an expansion of Medicaid for the poor and creation of a private insurance exchange, Governor Rick Scott said on Sunday. Two other states with Republican governors, Wisconsin

and Louisiana, opted out of the two provisions last week in the wake of the Supreme Court decision upholding the Patient Protection and Affordable Care Act. (Reuters)

- **Scott to review health care ruling impact on Florida**

  Despite Supreme Court ruling, Gov. Rick Scott may wait until November elections to move ahead with new federal health care law. Florida Gov. Rick Scott, who dipped into his personal fortune to campaign against passage of the health care law and, after being elected, refused to implement it, told reporters Thursday he would need time to decide his next move. (Miami Herald)

Iowa

- **Branstad cool to Medicaid expansion**

  Gov. Terry Branstad said he doesn't trust the federal government to make good on its Medicaid promises and doesn't intend to expand the state's program if he's not forced to. Branstad called the proposed punishment "federal blackmail" when he spoke to reporters Monday morning. (Quad City Times)

Georgia

- **Georgia faces tough call on Medicaid**

  Gov. Nathan Deal said Thursday he had not yet reached a decision on Medicaid and noted that the November elections may change the landscape yet again. The governor and other elected officials have repeatedly expressed concerns about what the expansion could mean for the state budget. The state estimated last week that it would have to pay an additional $4.5 billion over 10 years if the Medicaid expansion goes through. (Atlanta Journal Constitution)

- **Weighing impact on Medicaid expansion, Exchange**

  Gov. Nathan Deal said Thursday that it's too early for the state to make a decision on whether to expand Medicaid or create its own health insurance exchange, if the Affordable Care Act (ACA) survives a renewed Republican effort to repeal it. Deal, expressing dismay over the Supreme Court ruling that largely upheld the health law, called for its repeal by Congress. He said at a press conference that he did welcome the part of the court ruling that left it up to the states whether they would expand their Medicaid programs to cover more low-income residents. (Georgia Health News)

Illinois

- **Gov. Quinn says Illinois going forward with expanding Medicaid**

  Gov. Pat Quinn said he plans to carry out the full Affordable Care Act, including expanding the Medicaid rolls. Quinn said that the federal assistance provided for the expansion would prevent the state's Medicaid system from becoming too costly. (Quincy Journal)

Kentucky

- **Beshear prepares to implement health reforms**

  Kentucky is ready to move ahead to create a statewide health insurance exchange after the U.S. Supreme Court upheld the federal health care federal health care overhaul,

Gov. Steve Beshear said Thursday. The second-term Democrat said he will issue an executive order "soon" to create the online exchange that's intended to help uninsured Kentuckians find affordable health coverage. (Bowling Green Daily News)

Maryland

- **Maryland forging ahead to expand coverage**

  Maryland's Lieutenant Governor, Anthony Brown, and Department of Health and Mental Hygene Secretary, Dr. Joshua Sharfstein, co-author an opinion piece asserting that the "Supreme Court decision allows our work to continue moving forward without interruption." (Baltimore Sun)

Michigan

- **Mich. Dems press House Republicans to create health insurance exchanges**

  Michigan Democrats are stepping up pressure on House Republicans to approve creation this summer of a state system for purchasing private health insurance plans. Michigan faces a January deadline to begin establishing the exchange or risk a federal takeover. At a press conference Friday morning on the steps of the Capitol, Democratic state Reps. Jim Townsend and David Nathan and advocates for the law called on House Speaker Jase Bolger to bring the 110-member House back into session immediately to pass the bill. (Detroit News)

- **Snyder: Michigan to move forward on health exchange**

  Michigan Gov. Rick Snyder is urging lawmakers to work with him to set up an exchange where the uninsured can comparison shop online for private health insurance now that the U.S. Supreme Court has largely upheld the Affordable Care Act. The Republican governor said in a Thursday statement that he didn't agree with everything in the law, which he says doesn't focus enough on promoting wellness and restraining health care costs. But he says he wants to work quickly to set up the MiHealth Marketplace. (Lansing State Journal)

- **Snyder, Michigan legislators to put off decision whether to expand Medicaid by 500,000 people**

  Gov. Rick Snyder said it's too early to make a decision whether to expand the state's 1.9 million-member Medicaid program by more than 500,000 low-income residents to follow one of the provisions of the newly upheld Patient Protection and Affordable Care Act. Mike Duggan, CEO of the Detroit Medical Center, said he does not expect the state Legislature to turn down millions of dollars of federal funds to expand Medicaid. David Spahlinger, M.D., CEO of the University of Michigan Faculty Practice Group, also said he thinks Michigan ultimately will expand its Medicaid program because it will help improve the health of the population. (Crain's Detroit Business)

Missouri

- **Missouri legislative leaders saying no to Medicaid expansion**

  If conservative Republicans who control the Missouri Legislature follow through on plans to reject an expansion of the Medicaid health care program for the poor, they will be turning down an estimated $8.4 billion windfall from the federal government. The

problem, Republican leaders say, is that to get that money, the state would have to pony up $431 million of its own — money they say Missouri doesn't have. (STL Today)

- **Missouri GOP pans Medicaid expansion, waits on exchange**

  Immediately after the court's ruling, Missouri Republicans said expanding Medicaid would be unlikely and too expensive. Republican Lt. Gov. Peter Kinder said the Medicaid expansion would have been "a break-the-bank provision for the state of Missouri." Kinder, who in 2010 filed his own, separate legal challenge to the federal health care law, pledged Thursday to continue fighting. House and Senate leaders said Thursday they preferred waiting until the outcome of this year's elections before launching into a state-based exchange. (Columbia Missourian)

Montana

- **State of Montana looks to insurance exchanges in wake of Supreme Court ruling**

  State officials said Thursday they will continue to implement the federal health care law after the U.S. Supreme Court decision to uphold it, a ruling the state attorney general pointed to as proof the lawsuit he declined to join was a waste of money. Montana insurance commissioner Monica Lindeen said the state will help the U.S. Department of Health and Human Services establish Montana's health insurance exchange, since the Republican-led state Legislature last year rejected a plan for Montana to design its own. (Missoulian)

Nevada

- **Governor, lawmakers to decide Medicaid expansion for low-income Nevadans**

  Gov. Brian Sandoval and Republicans have worried about the costs to the state, though the potential price tag for the expansion isn't immediately was unclear. Assembly Majority Leader Marcus Conklin, D-Las Vegas, said lawmakers are still reviewing the court opinion and the details of what an expansion would mean. Decisions on the Medicaid program, which is for the poor and disabled, rests with the executive branch - the governor. The Legislature does allocate money for any expansions. (Las Vegas Sun)

New Hampshire

- **Candidates split on Medicaid plan**

  New Hampshire's gubernatorial candidates have split along party lines over the Medicaid expansion, with Republicans pledging to defy it and Democrats saying the state should review all options to cover more of its citizens. (Concord Monitor)

New Jersey

- **Gov. Christie says he disagrees with health care law but will meet deadline**

  Governor Christie, who opposed the health care changes pushed by the Obama administration, vetoed legislation last month that would form an exchange in New Jersey, saying he wanted to wait until the Supreme Court determined whether the Affordable Care Act was constitutional. In the wake of the Thursday's ruling, the Republican governor said he would meet any deadlines imposed on the state. But on his monthly radio call-in program on 101.5 FM last night, he called the Supreme Court decision "a

screwy opinion," and promised to again veto the bill Democrats in the Legislature now want to re-introduce. (NJ.com)

Ohio

- **Ohio's plan for Medicaid is unclear**

Gov. John Kasich's administration yesterday stopped short of ruling out an expansion of the tax-funded health program, but officials said the long-term cost of providing care to as many as 800,000 more poor and uninsured Ohioans is a concern. The Republican administration also likely will punt on creating a state health exchange. Instead, state officials said, the federal government can set up an exchange for Ohio, the alternative given to states under the law. (The Columbus Dispatch)

Pennsylvania

- **Corbett promises to limit health care law's 'negative impact on Pennsylvanians'**

Republican Gov. Tom Corbett, who as attorney general challenged the law, read a statement and declined to answer questions, saying there had been little time to absorb the decision. He said he would comply with the ruling out of respect for "the law and the process of the law." It is unclear whether an opt-out could be done by the Legislature or by executive order of the governor. Kevin Harley, Corbett's spokesman, said the governor is still studying language on the Medicaid opt-out and how it could be done. (TribLIVE)

Utah

- **Utah governor to abide by health law mandates, for now**

Gov. Gary Herbert said Utah will abide by the mandates of federal health reform, for now, but vowed to do what he can "to replace bad policy on health care with good….I'm not going to do something that is going to bust our budget, I can tell you that," said Herbert, emphasizing as he has in the past that states, not Washington, should lead on health reform. (Salt Lake Tribune)

Virginia

- **Va. has tough Medicaid choice to make under health care law**

While elected officials in some states already have declared opposition to Medicaid expansion, Medicaid Director Cynthia B. Jones and other Virginia officials, including Gov. Bob McDonnell, are taking a more measured approach to the choice that the ruling allows. McDonnell and other state officials are concerned about the effect of Medicaid expansion on Virginia's budget, which already devotes more than 20 percent of state spending to the program. (Times Dispatch)

Washington

- **Unlike most in GOP, McKenna doesn't want to fight health-care law**

Attorney General Rob McKenna split with many prominent Republicans in the wake of Thursday's Supreme Court ruling, saying Congress should not move to scrap the federal health-care law or even its controversial individual insurance mandate. Although acknowledging disappointment in being on the losing side of the challenge to the Af-

fordable Care Act, McKenna, the Republican gubernatorial candidate, said he's ready to implement its new health insurance exchanges and Medicaid expansion if elected. (The News Tribune)

National

- **States Balk At Expanding Medicaid**

  A growing number of Republican lawmakers and state Medicaid officials, including those in Florida, Texas and at least seven other Republican-leaning states, have said they may indeed walk away from the nearly $1 trillion federal pot –putting at risk the administration's plans to cover up to 17 million people, or more than half the total expected to gain coverage under the law. (Kaiser Health News)

- **Hospitals Urge Medicaid Expansion**

  Hospitals are urging states to expand Medicaid under the new health-care law, bringing a potent political force to bear on governors who face pressure from Republican leaders to opt out of the beefed-up program. States won a reprieve from the requirement this week when the Supreme Court ruled they could decline to expand Medicaid to a broader swath of the poor in 2014 without losing their existing federal funding for the program. (Wall Street Journal)

- **Which States Have Most at Stake in Medicaid Expansion?**

  In Alabama, Kentucky, South Dakota and West Virginia, more than 60 percent of their uninsured would qualify for Medicaid under the ACA. California, Florida and Texas would add upwards of 2 million enrollees each. That could lead to substantial political and fiscal pressure (from, for example, hospitals that are otherwise treating those people without compensation) to adopt the new standards. On the other end of the spectrum, less than 40 percent of the uninsured in Maryland, New Jersey and Vermont would be eligible for Medicaid. Wyoming and North Dakota would enroll less than 35,000 additional people to comply. That could either make it easier for those states to adopt the new eligibility rules -- or lighten the political pressure to do so. (Governing Magazine)

- **Medicaid ruling could give red states more bargaining power**

- The Supreme Court ruling left the Democratic health care law intact — but it also left Republicans in a stronger bargaining position when it comes to Medicaid. The ruling gives them the right to opt out of the Medicaid expansion envisioned under the law. But they know one thing: President Barack Obama wants them to stay in, and so many might just go along and take the money — after they've squeezed out as many other concessions as they can get from the feds. One of the most health care-savvy governors, Louisiana's Bobby Jindal, is already wondering whether this creates a backdoor way to achieve the Holy Grail for Republican governors — turning his federal Medicaid dollars into a block grant. (Politico)

Other Headlines

California

- **California patients struggle to transition to managed care system**

  One year ago, California began moving certain Medi-Cal patients into a managed healthcare system with the goal of saving money while better coordinating treatment. But for some of these low-income seniors and disabled patients, the transition has been anything but smooth, forcing severely ill patients to give up their doctors, delay treatment and travel long distances for specialty care. As of this month, the state has transitioned 333,000 people. State health officials said managed care oversees all of the patients' treatment and guides them through the healthcare system, helping prevent unnecessary procedures and hospital visits. Patients could apply for temporary exemptions if they wanted to stay on a fee-for-service plan, where the state pays doctors based on the specific treatment provided instead of a managed care general rate that is usually less. But the patients had to meet a high bar: They had to be in ongoing care for a serious illness and any change could cause their condition to deteriorate. Nearly 18% of the 19,684 people who applied for exemptions between June of last year and April were approved, according to the state. Almost 32% were denied and the rest had their papers sent back as incomplete. (Los Angeles Times)

Kentucky

- **Lawrence Kissner is new Medicaid chief for Kentucky**

  The state Cabinet for Health and Family Services on Wednesday appointed Lawrence Kissner to serve as the state's new Medicaid commissioner despite his ties with a company that manages a portion of Kentucky's Medicaid program. (Courier Journal)

Louisiana

- **La. Medicaid funding unexpectedly slashed by $859M**

  Louisiana's health department was working Monday to strip $859 million from the state's Medicaid program for the poor and uninsured, cutting 11 percent of the funding for health services after Congress unexpectedly slashed the state's Medicaid payment. The cuts to the budget came as a surprise to Gov. Bobby Jindal's administration and lawmakers, cropping up last week when Congress reduced Medicaid funding to the state in the just-passed federal transportation bill as part of Republicans' efforts to offset some of the expense in highway funding. Congressional action blows a hole in the health care budget crafted by the administration and lawmakers for the fiscal year that began Sunday. On the chopping block are charity hospitals, hospice care and Medicaid providers who thought they had escaped deep reductions in the 2012-13 budget. (CBS News)

Texas

- **Managed Care Cuts Anger Disability, In-Home Care Groups**

  In a letter sent to care providers last week, Molina Healthcare officials said reimbursements for personal assistance services would be cut by 10 percent. That's the equivalent of about $1 per attendant hour — on top of the fact that care providers say Texas Medi-

caid already pays about $2 less per hour than any other state. The rate cuts weren't entirely unexpected: In June, three months after Molina expanded to serve managed care clients in Hidalgo and El Paso counties, as well as surrounding areas, the company disclosed in a regulatory filing that its Texas premium rates wouldn't be sufficient to cover the rising number of patients enrolled. (Texas Tribune)

National

- **CMS announces funding opportunity for state insurance exchanges**

  The Center for Medicare and Medicaid has announced that States can apply for additional grants on a quarterly basis up to October 15, 2014 for additional grants to set up health exchanges under the PPACA. Link to CMS announcement. (AHA News)

COMPANY NEWS

- **Amerigroup Now Serving Members in Washington State**

  Amerigroup Corporation began serving members in its 13th state, Washington, effective July 1, 2012. Amerigroup Washington is one of five health plans selected by the state to provide managed care to more than 800,000 Medicaid and 40,000 Basic Health program beneficiaries statewide. Amerigroup Washington is participating in the Healthy Options program, providing services for members enrolled in Temporary Assistance for Needy Families (TANF) and TANF-related Children's Health Insurance Program (CHIP), as well as seniors and people with disabilities who are not also eligible for Medicare. The Company will also coordinate care for members in the state's Basic Health program, which currently provides subsidized health coverage for additional low-income individuals and families. Amerigroup Washington will initially begin serving members in 16 counties. (Amerigroup Press Release)

- **Centene continues to provide, expand**

  Recruiting the medical claims processing company Centene to open a center in Great Falls in 2004 involved a partnership of the city, Great Falls Development Authority and the Montana Board of Investments. Great Falls was Centene's second claims processing center. The first is in Farmington, Mo. Centene Corp. recently opened a third center expected to employ about 300 people in Tyler, Texas. (Great Falls Tribune)

- **WellCare to Participate in Florida's LTC Community Diversion Pilot Project**

  WellCare Health Plans, Inc. announced that the Florida Department of Elder Affairs has approved WellCare of Florida to participate in the state's Long-Term Care Community Diversion Pilot Project. WellCare services under this program are expected to begin on July 1, 2012, and will focus on coordinating health and community-based services for program enrollees in Escambia and Santa Rosa Counties. (WellCare News 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
July 1, 2012	New York LTC	Implementation	200,000
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, 2012	Florida CHIP	Contract awards (delayed)	225,000
July 15, 2012	California (Central Valley)	Implementation	N/A
August 13, 2012	Ohio Duals	Contract awards finalized	122,000
July 30, 2012	Massachusetts Duals	Proposals Due	115,000
July 24, 2013	Kentucky - Region 3	Proposals Due	170,000
July 31, 2012	Illinois Duals	Contract awards	136,000
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	Kentucky - Region 3	Implementation	170,000
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. Preliminary scores were released on June 28, 2012 for the Ohio Duals RFP awards. Any protests are due on July 13, 2012. If revisions to scoring are required, the state will do so and finalize plan selection on August 13, 2012.

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	4/1/2013
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
Massachusetts	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 Carolina	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	Scoring: 6/28/12	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 Carolina	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.*

[+] Acute 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 Upcoming Webinar

What the Court Did and What's Next for Health Reform

July 17, 2012 – 12:00 Noon EDT

This post-Supreme Court decision webinar will be moderated by Jennifer Kent, a Principal in our Sacramento office, and will feature Joan Henneberry, a Principal in the Denver office, Jack Meyer, a Managing Principal in our Washington, DC office, and Kathy Gifford, a Principal in our Indianapolis office. The three panelists will briefly share thoughts on the outcome of the decision, the expected timing for changes to current reform planning, and the connections between the court ruling, elections, and 2013 legislation. Webinar participants will be invited to ask questions, share their perspectives and engage in a dialogue with the panelists.

Registration is limited so **register now** to reserve your seat.

HMA Recently Published Research

Comprehensive Hospital EHRs Improve Quality and Efficiency

Sharon Silow-Carroll, Managing Principal
Jennifer Edwards, Managing Principal
Diana Rodin, Consultant

HMA prepared a report for the Commonwealth Fund examining the experiences of nine hospitals with comprehensive electronic health record (EHR) systems. The report describes ways that the systems facilitate patient safety, quality improvement, and efficiency. The EHRs have contributed to faster, more accurate communication and streamlined processes, which improve patient flow, minimize duplicative tests, enable faster responses to patient inquiries, improve capture of charges, and generate federal incentive payments. The report presents challenges to EHR implementation and ways to alleviate them, and lessons for other hospitals and policymakers. **(Link to Report - The Commonwealth Fund)**

Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case

Mike Nardone, Principal

The Medicaid expansion under the Affordable Care Act will provide coverage to most of the estimated 1.2 million people who are homeless, including the roughly 110,000 individuals who are chronically homeless and more likely to suffer chronic, complex health conditions. This policy brief makes a case for states to explore the use of new Medicaid financing options available under ACA (e.g., health homes), as well as flexibilities afforded through Medicaid managed care, to support the funding of housing-based care management services in supportive housing for formerly homeless individuals. The research suggests that such an approach can improve care for these beneficiaries while lowering costs associated with avoidable hospitalizations and other crisis services. **(Center for Health Care Strategies – Policy Brief)**

Public and Private Insurance Coverage for Chronic Hepatitis B Patients: Health Reform Will Facilitate Early Investments Providing Long-Term Benefits

Jack Meyer, Managing Principal
Gaylee Morgan, Senior Consultant
Vern K. Smith, Managing Principal

The implementation of national health reform in the U.S. provides important opportunities to increase the awareness, routine screening, and treatment of viral hepatitis. An estimated 2.2 million Americans are infected with chronic hepatitis B (HBV), yet nearly two-thirds of these people are unaware of their disease until they have developed liver cancer, cirrhosis, or liver failure many years later. A growing body of evidence indicates that when HBV is detected early and properly treated, these highly adverse outcomes can be delayed or avoided altogether.

Enrollment in health coverage is absolutely vital to this early detection and treatment. In fact, our research shows that liver transplants can be reduced by 58 percent and the death rate can be reduced by 20 percent when lower-income people are enrolled in insurance coverage and treated early in the course of their disease. This study projects that over 70,000 people with HBV will newly enroll in Medicaid under the Patient Protection and Affordable Care Act and about 75,000 more people with HBV will newly enroll in Health Insurance Exchanges. We find that a 5 percent reduction in liver transplants for HBV patients could finance more than 420,00 screenings. **(Link to report)**