HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: FLORIDA RELEASES STATEWIDE MEDICAID MANAGED CARE ITN

HMA ROUNDUP: ILLINOIS SELECTS MCOS FOR NON-DUAL ABD MANAGED CARE EXPANSION; CALIFORNIA GOV'S BUDGET PROPOSAL SET FOR RELEASE TOMORROW; FLORIDA UPDATES TIMELINE FOR LTC EXPANSION; GEORGIA HOSPITALS AGREE TO PROVIDER FEE STRUCTURE; TENNESSEE WITHDRAWS FROM DUALS DEMO PROGRAM; COLORADO TO EXPAND MEDICAID

OTHER HEADLINES: CALIFORNIA TRANSITIONS HEALTHY FAMILIES CHILDREN TO MEDI-CAL; FLORIDA SELECTS CORRECTIONAL HEALTH VENDOR; NEW MEXICO TO EXPAND MEDICAID; PROPOSED ELIGIBILITY RESTRICTIONS IN MAINE REJECTED; MACPAC RELEASES AGENDA FOR MEETING NEXT WEEK

HMA WELCOMES:
STEPHANIE CHROBAK - BOSTON
TOM MARKS, LANSING

JANUARY 9, 2013

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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IN FOCUS: FLORIDA RELEASES STATEWIDE MEDICAID MANAGED CARE ITN

This week, our *In Focus* section reviews the statewide Medicaid Managed Care invitation to negotiate (ITN) released by Florida's Agency for Health Care Administration (AHCA) on December 28, 2012, just ahead of the legislatively mandated deadline of January 1, 2013. The ITN will expand the managed care population statewide to include all TANF, SSI, dual eligibles, and nearly all other categories of Medicaid eligibility. The ITN also offers the opportunity for plans who are awarded managed Long Term Care (LTC) contracts (roughly 90,000 lives at stake) to combine their LTC contracts with a statewide Medicaid managed care contract. Those contracts are expected to be awarded in the next several weeks.

Currently, just over 1.2 million individuals are enrolled in Medicaid HMOs in Florida, with another 250,000 enrolled in capitated and fee-for-service (FFS) provider service networks, or PSNs. These roughly 1.5 million managed care lives could nearly double under the statewide ITN when it is scheduled to go live in January 1, 2014.

Medicaid Coverage	Enrollment
Fee For Service (FFS)	**1,109,409**
HMO (Includes Pilot)	1,226,484
Capitated PSN	97,806
FFS PSN	165,600
Medicaid Managed Care Total	**1,489,890**
PCCM (MediPass)	594,314
Nursing Home Diversion	20,089
PACE	714
Florida Medicaid Total	**3,214,416**

Source: State Enrollment Data, December 2012

ITN Highlights

- The ITN expands mandatory Medicaid managed care in all 11 statewide regions for the following categories of eligibility/covered populations: TANF, SSI, hospice, low-income families and children, institutional, dual eligibles, medically needy, as well as several other minor categories of enrollment. There are less than 400,000 out of 3.2 million total enrollees who will not be eligible.
- Plans may apply as a standard or a specialty plan. Specialty plans may focus on specific populations, such as HIV/AIDS, Child Welfare, or transplant patients. Plans may be awarded both a standard and a specialty plan within a select region. Plans may submit applications for multiple specialty plans in a single region, but will only be awarded one specialty plan contract per region.
- If a plan is awarded a standard contract in a region in which they have won a LTC contract (to be announced later in January), that plan will be considered a

Comprehensive LTC plan and may combine their standard and LTC plans under a single contract with the state.

- Current PSNs applying under the statewide ITN must apply as a capitated PSN. New PSNs not currently serving the Medicaid population may apply as a FFS PSN; however, the FFS option is only available for the first two years of the program, through the end of 2015.
- Within each of the 11 regions, AHCA will set a maximum enrollment cap per plan. Any enrollments above this cap will not receive a capitation payment. Plans may request an increase in their enrollment cap.
- Enrollees will have 90 days to change plans before a lock-in for the remainder of the 12 month enrollment period.
- In the first year of the contract, capitation rates will guarantee savings of at least 5 percent.
- There is a cap on reimbursement for nursing home and hospice services, so that plans will not be paid more than FFS.
- Plans will be subject to an Achieved Savings Rebate on all pretax income as a percentage of revenue:
    - Plans will retain 100 percent of income up to and including 5 percent;
    - Plans will share 50 percent if income above 5 percent, up to and including 10 percent;
    - The state will retain 100 percent of income above 10 percent of revenue.
- If a managed care plan terminates a contract in a region prior to the end of the five year contract term, they will be subject to penalties similar to those included in the LTC ITN. The plan must reimburse AHCA for the cost of enrollment changes for their members. Additionally, the plan is required to pay a per-enrollee penalty of up to three month's payment, as well as a penalty of 25 percent of the statutorily required minimum surplus, defined as "the greater of $1,500,000, or 10 percent of total liabilities, or 2 percent of total annualized premium." [1,2]

ITN Regional Overview

The table below details the eligible populations in each region, as well as the statutory range of number of plans as compared to the number of plans AHCA will invite to negotiate and eventually sign contracts with. It is worth noting that, similar to the LTC ITN, the number of contract awards is much closer to the statutory minimum number.

[1]2011 Florida Statutes. 409.967 Managed care plan accountability. Available at: http://www.flsenate.gov/laws/statutes/2011/409.967

[2]2011 Florida Statutes. 641.225 Surplus requirements. Available at: http://www.flsenate.gov/Laws/Statutes/2011/641.225

Region	Total Eligible Population	ITN Enrollment	Statutory Min./ Max. Plans	Min. Plans for Negotiation	Number of Contracts
1	88,468	88,468	2	4	2
2	100,009	100,009	2	4	2
3	224,885	149,923	3-5	5	3
4	258,829	172,553	3-5	5	3
5	158,816	158,816	2-4	5	3
6	357,637	178,819	4-7	6	4
7	330,475	220,317	3-6	5	3
8	178,460	178,460	2-4	5	3
9	220,487	220,487	2-4	5	3
10	478,987	478,987	2-4	5	3
11	484,817	193,927	5-10	8	6
Total	**2,881,870**	**2,140,766**		**57**	**35**

Source: ITN Library

On September 27, 2012, the state published a table of respondents to a non-binding letter of intent (LOI), in which plans indicated their interest in serving each of the 11 statewide regions.

SMMC MMA Program Non-Binding Letters of Intent	Regions of Interest										
Plan Name	1	2	3	4	5	6	7	8	9	10	11
Amerigroup	√	√	√	√	√	√	√	√	√	√	√
Care Access											
Community Health Solutions of America	√	√	√	√	√	√	√	√	√	√	√
Confident Care Health Plan	√	√	√	√	√	√	√	√	√	√	√
Shands Jacksonville Medical Center d/b/a First Coast Advantage				√							
First Coast Advantage Central, LLC			√								
Freedom Health	√	√	√	√	√	√	√	√	√	√	√
Florida True Health	√			√			√		√		
Healthy Palm Beaches, Inc.									√		
Humana Inc.	√	√	√	√	√	√	√	√	√	√	√
Integral Quality Care	√		√			√	√	√			
Jackson Health System											√
Magellan Complete Care		√		√	√				√	√	√
Max Care	√	√	√	√	√	√	√	√	√	√	√
Molina	√			√	√	√	√		√	√	√
PPSC USA LLC	√	√	√	√	√	√	√	√	√	√	√
Preferred Medical Plan, Inc.										√	√
Prestige Health Choice	√	√	√		√	√	√	√	√		√
Salubris									√	√	√
SunShine State Health Plan	√	√	√	√	√	√	√	√	√	√	√
United HealthCare Community Plan	√	√	√	√	√	√	√	√	√	√	√
Universal				√	√	√	√	√	√	√	√
WeCare Health Plans	√	√	√		√	√	√	√	√		
WellCare of Florida, Inc.	√	√	√	√	√	√	√	√	√	√	√
TOTAL RESPONSES PER REGION	15	13	14	15	15	15	16	14	18	15	17

Source: http://ahca.myflorida.com/medicaid/statewide_mc/pdf/mma/List_of_respondents_092712.pdf

Scoring Criteria

Below are the scoring and evaluation criteria for both standard and specialty plans. Both scoring criteria weigh qualifications and experience highest in addition to quality and utilization management.

Scoring Criteria	Standard MMA Plan Points	Standard MMA Plan %	Specialty Plan Points	Specialty Plan %
Mandatory Documentation	N/A		N/A	
Financial Information	140	11%	140	9%
Past Performance	47.5	4%	47.5	3%
Technical Response				
Qualifications & Experience	262.5	20%	292.5	20%
Eligibility and Enrollment	40	3%	80	5%
Enrollee Services and Grievance	95	7%	95	6%
Covered Services	138.75	10%	165	11%
Provider Network	175	13%	200	14%
Quality and Utilization Management	217.5	16%	247.5	17%
Administration & Management	210	16%	210	14%
Maximum Points Possible	**1326.25**	**100%**	**1477.5**	**100%**

Source: ITN Library

Current Managed Care Marketplace

Currently, 18 Medicaid HMOs serve the state's 11 regions, with a mix of national and local plans. Four plans – WellCare, Sunshine (Centene), and Amerigroup – make up roughly 63 percent of the current market.

Medicaid HMOs	Dec. 12 Enrollment	%
WellCare (StayWell, HealthEase)	371,987	30.4%
Sunshine (Centene)	210,072	17.1%
Amerigroup	189,543	15.5%
United Healthcare Plan	115,927	9.5%
Molina Healthcare	72,209	5.9%
Universal	64,660	5.3%
Humana	49,228	4.0%
Simply Healthcare Plan	31,438	2.6%
Freedom	30,168	2.5%
Buena Vista	25,412	2.1%
Vista HealthPlan of South Florida	23,708	1.9%
Preferred Medical Plan	16,339	1.3%
Healthy Palm Beaches	12,612	1.0%
Medica	7,038	0.6%
CareFlorida	5,376	0.4%
Clear Health Alliance	536	0.0%
Positive	231	0.0%
Total Medicaid HMO	**1,226,484**	

Source: State Enrollment Data, December 2012

Additionally, the Medicaid population is served by several Provider Service Networks (PSNs): two capitated PSNs and seven FFS PSNs.

Provider Service Networks (PSNs)	Dec. 12 Enrollment	%
Prestige Health Choice	74,308	28.2%
Integral Quality Care	23,498	8.9%
Total Capitated PSN	**97,806**	**37.1%**
First Coast Advantage	68,204	25.9%
South Florida Community Care Network	44,357	16.8%
Better Health, LLC	38,575	14.6%
Children's Medical Services	8,862	3.4%
First Coast Advantage Central	3,851	1.5%
WeCare Health Plans, Inc	1,385	0.5%
Care Access PSN, LLC	366	0.1%
Total FFS PSN	**165,600**	**62.9%**
Total PSN	**263,406**	

Source: State Enrollment Data, December 2012

Timeline

ITN responses are due on March 15, 2013 with contract awards tentatively announced on September 16. Contracts will begin on January 1, 2014 with a five-year contract term through the end of 2018. There are no contract extensions except in the case of a delayed implementation.

Correction: *Under the law, statewide Medicaid managed care was to be fully implemented by October 1, 2014. AHCA later defined this to mean implementation in at least one region and published a timeline that indicated enrollment would be completed by April 1, 2015. The ITN indicates that a roll-out schedule and plan readiness review will be published later. This is consistent with the LTC ITN where the law stated that full implementation in all regions would be completed by October 1, 2013. The AHCA timeline indicated that enrollment would be completed by April 1, 2014. Actual enrollment per the roll-out schedule will start August 2013 through March 2014.*

Timeline	Date
ITN Issued	December 28, 2012
Questions Due	January 22, 2013
Vendor Conference	February 12, 2013
Question Responses	February 26, 2013
Proposals Due	March 15, 2013
Responses Opened	March 18, 2013
Respondents Publicized	March 20, 2013
Negotiations	July 1 - August 20, 2013
Awards Announced	September 16, 2013
Contract Executed	December 31, 2013
Implementation	October 1, 2014

HMA Medicaid Roundup

Arizona

HMA Roundup

In a December 2012 letter to parties interested in serving the Arizona dual eligible population, the Arizona Health Care Cost Containment System (AHCCCS, the state's Medicaid agency) clarified the plan selection process. The letter was sent to all entities that submitted a notice of intent to apply (NOIA) to CMS to serve the Arizona duals population. Link to AHCCCS letter to interested parties: (AHCCCS Letter)

- The Arizona Acute Care Medicaid RFP, for which responses are due on January 28, 2013, will require awarded plans to be certified as a dual eligible plan and to serve the duals population.
- Current plans in the Arizona Long Term Care System (ALTCS) who have submitted a NOIA to CMS and meet the state and federal duals demonstration criteria will be included as duals demonstration plans. There will be no additional procurement for ALTCS.
- The Maricopa County Behavioral Health Authority is in the process of procuring health plans to serve the behavioral health population in Maricopa. Those plans awarded are required to participate in the duals demonstration. Proposals were due on January 8, 2013.

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

This Thursday, January 10, Gov. Jerry Brown is scheduled to release both his budget proposal and health care reform implementation plan.

In the news

- **State: Anthem Blue Cross rates for small business 'unreasonable'**

  California's insurance commissioner said an 11% rate increase for small businesses by Anthem Blue Cross is "unreasonable" because the company overstated its costs and improperly added fees related to the federal healthcare law. Insurance Commissioner Dave Jones also said Anthem, a unit of industry giant WellPoint Inc., was reaping excessive profits in California. But under state law the commissioner has no authority to block the rate increase from taking effect this month. (Los Angeles Times)

- **Low-income kids shuffled onto Medi-Cal**

  [Last week,] California started dismantling a popular health care program for low-income children by shifting nearly 200,000 young people into the massive Medi-Cal program, a move many health advocates fear will disrupt their care. By August, the nearly 900,000 people in the program will be shifted into Medi-Cal. The move is expected to save the state about $58 million in health care costs in 2013-14 and more than $70 million a year when Healthy Families is fully phased out. (San Francisco Chronicle)

Colorado

HMA Roundup – Joan Henneberry

Last week, Gov. John Hickenlooper announced the state will expand Medicaid under the ACA, with the state expecting to save more than $280 million in Medicaid spending over 10 years. Part of the savings will be achieved by continuing to expand the Accountable Care Collaborative and regional approach to care coordination.

In a December meeting of the Colorado Department of Health Care Policy and Financing's (DHCPF's) Medicare-Medicaid Enrollees Advisory Subcommittee, it was announced that the revised implementation target date for the Regional Care Collaborative Organizations (RCCOs) is April 1, 2013. The RCCOs are being implemented under the managed fee-for-service (MFFS) duals demonstration model offered by CMS. (Link)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

AHCA has recently posted information on the AHCA Statewide Medicaid Managed Care Program website relating to Long-term Care Managed Care Plan Readiness. The site includes an anticipated roll-out schedule by region with important deadlines for documentation submission and enrollment, effective dates, and links to various LTC readiness checklists. AHCA anticipates rolling-out the LTC component of the SMMC program on a regional basis in accordance with the following schedule:

Region	Documentation Submission Deadline	Deadline for Enrollment	Effective Date
7	January 23, 2013	May 1, 2013	August 1, 2013
8 & 9	February 6, 2013	June 1, 2013	September 1, 2013
1, 2 & 10	February 20, 2013	August 1, 2013	November 1, 2013
11	March 6, 2013	September 1, 2013	December 2013
5 & 6	March 20, 2013	November 1, 2103	February 1, 2014
3 & 4	April 3, 2013	December 1, 2013	March 1, 2014

The information can be accessed via the following link: http://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml#ltcpr

In the news

- **Rick Scott, Kathleen Sebelius have 'productive' Obamacare chat**

  A long-awaited sit-down Monday between Florida Gov. Rick Scott and Health and Human Services Secretary Kathleen Sebelius didn't provide any answers on whether one of Obamacare's biggest critics will suddenly embrace the law. But the fact that the meeting happened at all — and that Scott is keeping up the newly pragmatic tone he's had since the election — raises the intriguing possibility that one of the nation's most high-profile Republican governors might actually agree to implement some of the law. (Politico)

- **Scott to Look at Other Medicaid Cost Estimates**

  Gov. Rick Scott is willing to look at estimates on the cost of Medicaid expansion other than the ones he has been using, according to a release Tuesday evening. The statement from Scott's Communications Director Melissa Sellers came in apparent reaction to Health News Florida's report early Tuesday headlined "Legislative Analysts told Scott His Medicaid Estimates Are Wrong (But He's Using Them Anyway)." That report, based on a series of e-mails among state officials, was picked up by numerous other publications, including the Associated Press. (Health News Florida)

- **Florida outsources inmate medical care**

  Gov. Rick Scott's administration announced Thursday the state has signed a contract with a Pennsylvania company, Wexford Health Sources, to outsource medical care to more than 15,000 inmates in several South Florida prisons. The Department of Corrections said it signed a deal to pay Wexford about $48 million a year, with a promised savings to state taxpayers of $1 million a month. The contract includes a 90-day transition period, so it is expected Wexford will actually begin work in March. An estimated 400 state workers are affected, but Wexford officials said that most will be offered jobs with the company. Four of the major prisons where health care is being privatized are in Miami-Dade County. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

Georgia hospitals have agreed to an extension of the hospital provider fee that now must be approved by the state legislature, where it may face some opposition. The provider fee generates as much as $500 million in additional revenue to the hospitals through federal Medicaid matching funds and would avert cuts in payments that hospitals warned could be as high as 20 percent.

Gov. Nathan Deal is scheduled to make his State of the State address on January 17 and is expected to release his budget proposal the same day. The Department of Community Health (DCH) never proposed the full amount of cuts asked for by the Governor and his proposed budget could include further cuts to DCH.

Georgia's net tax collections for December totaled $1.69 billion for an increase of $150.75 million, or 9.8 percent, compared to December 2011. As of the midway point of the fiscal year, net revenue collections are up $400 million, or 4.9 percent, compared to last fiscal year.

In the news

- **Budget, health care will dominate Georgia session**

  Georgia lawmakers will convene Jan. 14 with a familiar theme: a budget shortfall explained mostly by an economy that's not keeping pace with rising health care costs. The single biggest variable is the Medicaid insurance program for the poor, most of them children. Medicaid already promises to be several hundred million dollars short of what it will need to continue existing services and payment rates in the fiscal year that begins July 1. Even more pressing is an expiring hospital tax. If that levy runs out

with no replacement, the shortfall jumps to the neighborhood of $1 billion. Hospitals have presented Gov. Nathan Deal with a plan to extend the tax scheme with some modifications, but they could face some heavy lifting to get an increasingly conservative House and Senate on board. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Andrew Fairgrieve

Updates from the Illinois HFS Medicaid Advisory Committee (MAC) Care Coordination Subcommittee meeting on Tuesday, January 8, 2013:

- There has been movement in the House on the Medicaid expansion bill; however, HFS is reporting that it has been a tough sell amongst some legislators. The bill was amended to eliminate the Medicaid expansion category of eligibility if Federal funding ever falls below 90 percent. With the current legislative session ending today, January 9, it is likely the bill will come to a vote after the new legislatures have been sworn in.
- HFS announced that the Integrated Care Program, currently serving Medicaid-only (non-dual) seniors and persons with disabilities (SPDs) through managed care organizations, will be expanding to the Central Illinois, Rockford, Quad Cities, and Metro East regions, tentatively beginning in April 2013. The Central Illinois region will be served by Molina Healthcare and Health Alliance (both awardees of duals demonstration contracts in Central Illinois), as well as Meridian Health Plan in Knox, Peoria, and Tazewell counties. The Rockford region will be served by Aetna, Centene (IlliniCare), and the Community Care Alliance of Illinois (CCAI), who was awarded a managed care community network (MCCN) contract in the Greater Chicago region under the complex adults RFP. Plans to serve the Quad Cities and Metro East regions are still to be finalized.
- HFS is in continued discussions with CMS regarding the dual eligible demonstration project, and anticipates a memoranda of understanding (MOU) to be finalized by the end of January.

New York

HMA Roundup – Denise Soffel

The Department of Health is continuing the roll-out of its mandatory Managed Long Term Care (MLTC) population into Nassau, Suffolk and Westchester counties this month for individuals receiving personal care, adult day and private duty nursing.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak, Matt Roan, and Ashley Derr

The PA Department of Public Welfare anticipates the systems changes necessary to make payments at the increased fees as required in Section 1202 of the ACA will be completed in April 2013. Qualifying physicians who submit their self-attestation to the Department by March 1, 2013, will be paid the increased fee retroactive to January 1, 2013. Qualifying

physicians who submit their self-attestation to the Department on or after March 2, 2013, will be paid the increased fee for dates of service beginning with the date the attestation is received by the Department. For more detail see: http://www.pabulletin.com/secure/data/vol43/43-1/23.html

Pennsylvania collected $2.4 billion in General Fund revenue in December, which was $112.4 million, or 4.8 percent, more than anticipated, Pennsylvania's Secretary of Revenue reported last week. Fiscal year-to-date General Fund collections total $12.2 billion, which is $171.5 million, or 1.4 percent, above estimate.

Our initial publication of last week's Roundup omitted the update for Pennsylvania on upcoming legislative issues. We have republished that update below:

- The Pennsylvania Legislature was sworn in for its 2013-2014 legislative session on January 1, 2013, and while the Republican Majority caucuses have announced their priorities for the session, healthcare issues are conspicuously absent from the agenda. Focus areas include transportation funding, natural gas drilling, economic development, and pension reform.
- Specific legislative actions related to healthcare will come into greater focus when the Governor presents his Fiscal Year 2013-2014 budget in an address to the General Assembly on February 5, 2013. Funding gaps in the state's public pension programs are expected to put increased pressure on the Medicaid program to find cost savings above and beyond savings targets in a normal budget year.
- The State's Medicaid Hospital Assessment is up for reauthorization in this legislative session. This assessment brings in approximately $500 million in annual savings. Reauthorization of the assessment will be vital in the 2013-2014 budget process.
- While the Governor has not announced his final plans for possible Medicaid Expansion, stakeholder groups and major newspapers in the state are pressuring the administration to implement expansion. Administration officials including Welfare
- Secretary Gary Alexander have been pushing for greater flexibility from the Federal government in how expansion could be implemented, including allowing states to pursue partial expansion with 100 percent federal funding, an option that HHS has said they will not allow.

In the news

- **'Gorillas' UPMC, Highmark bump chests in court**

  A hearing Friday on whether to dismiss UPMC's antitrust lawsuit against its health care rivals turned into a zoology debate. UPMC and Highmark are "two big gorillas. One is in the forest in country A, and one is in the forest in country B," said U.S. District Judge Joy Flowers Conti. The fact that one is the alpha ape in the health services forest and the other is the insurance silverback "makes it difficult" to decide who harmed whom, and how much, she said. At issue was the plausibility of UPMC's lawsuit claiming that Highmark conspired with West Penn Allegheny Health System to siphon off patients and depress payments for medical services. (Pittsburg Post-Gazette)

Tennessee

HMA Roundup

In a letter to TennCare stakeholders, dated January 4, 2013, the state announced its intention to withdraw its financial alignment demonstration proposal, also known as the dual eligible demonstration projects. The letter cites payment methodology concerns and delays among the chief reasons for the withdrawal.

Texas

HMA Roundup

On January 7, 2013, the Texas Health and Human Services Commission (HHSC) announced a tentative contract award for Enrollment Broker Operations and Texas Health Steps Outreach and Informing to MAXIMUS, Inc. Responses to the RFP were due in July 2012 and the new contract is set to implement on September 1, 2013.

OTHER HEADLINES

Arkansas

- **Ark. lawmakers eye surplus for Medicaid deficit**

The incoming leaders of the Arkansas House and Senate said Monday they're interested in using more of the state's surplus to avoid $138 million in proposed cuts to the state's Medicaid program. Gov. Mike Beebe said preventing the suggested nursing home cuts are his top priority, but said he's reluctant to use more one-time money than he's already proposed for ongoing needs in the Medicaid program. (AP News)

Connecticut

- **Nine Insurers Want To Join CT Health Exchange**

The Connecticut Health Insurance Exchange received notifications from nine insurance companies regarding their intention to offer health or dental coverage when it begins operations in October 2013. The Exchange is one of the first to solicit Qualified Health Plans (QHP) from insurance carriers as it works to fulfill its mission to offer a wide range of health insurance options to consumers and small businesses. Carriers were requested to notify the Exchange of their non-binding intent to participate by January 4, 2013. Five health insurers including Aetna, Anthem, ConnectiCare, Healthy CT and United Healthcare, said they plan to offer coverage within the Exchange. Four additional insurers, including Delta Dental, The Guardian Life Insurance Company, MetLife and Renaissance Dental, have told the Exchange they plan to offer dental insurance coverage. (Market Watch)

Maine

- **Maine: Medicaid Purge Is Rejected**

The Obama administration rejected Gov. Paul R. LePage's request to drop thousands of people from Medicaid rolls. Mr. LePage, a Republican, had sought to eliminate Medicaid coverage for nearly 15,000 parents with incomes between the federal poverty level ($23,050 for a family of four last year) and 133 percent of that level ($30,657 for a family of four). He also wanted to end coverage for more than 6,000 19- and 20-year-olds. (New York Times)

Massachusetts

- **Citing Shifting Landscape, Medicaid Insurer Jumps Into Commercial Market**

Citing the fast-shifting, post-Affordable Care Act health insurance landscape, Network Health, a nonprofit Medicaid health plan, is branching out into the commercial market. That means individuals, families and small businesses will be able to purchase Network's less expensive plans — which don't include hospitals in the state's most expensive hospital network, Partners Healthcare — through the state's Health Connector, and through Network Health directly. (WBUR.org)

Minnesota

- **Health insurance exchange, MinnesotaCare, Medicaid decisions due at Legislature**

  State lawmakers are under a tight deadline as they tackle a number of issues related to the federal health care overhaul, including passing legislation to set up a health insurance exchange, the fate of MinnesotaCare and an expansion of Medicaid. (Minnesota Public Radio)

Mississippi

- **Medicaid gets push from state groups**

  Expanding Medicaid was the goal of a statewide conference call on Monday sponsored by the Mississippi Health Advocacy Program. MHAP, along with other members of the Mississippi Health Care Access coalition, want to make health care accessible to thousands more Mississippians. Mississippi would have to pass legislation to expand the program, which MHAP plans to propose this legislative session and have in place by 2014. The American Cancer Society Cancer Action Network is fighting for the legislation as well. (Hattiesburg American)

Montana

- **Bullock includes Medicaid expansion, tax rebate in budget**

  Gov.-elect Steve Bullock on Friday proposed some changes to outgoing Gov. Brian Schweitzer's earlier budget recommendations, but retained the proposed expansion of Medicaid, the federal-state health insurance program for poor and disabled people. Until Friday, Bullock had been noncommittal whether he supported expanding Medicaid. Bullock said the Medicaid expansion is part of a broader package he proposed called "Access Health Montana" to increase health care coverage for more Montana families. (Billings Gazette)

- **Montana Health Cooperative gets official OK from state regulators**

  The Montana Health Cooperative, a new nonprofit health insurer established with help from the federal government, announced Thursday that it has obtained its operating license from state insurance regulators. The co-op, created under the auspices of the 2010 federal health reform law, should be up and running by next October, he said. The Montana co-op is one of several nonprofit health insurers being developed around the country, with initial financing from the federal government. It has a $58 million federal loan to help it get off the ground. (Billings Gazette)

New Jersey

- **Higher Payments May Prompt More NJ Doctors to Accept Medicaid Patients**

  A two-year project is under way to encourage primary care doctors to accept Medicaid-eligible patients by paying for many services at the same level as Medicare. Many poor or disabled patients have limited access to healthcare because so few doctors have been willing to accept the low Medicaid reimbursement rates. The federal government will cover the difference between Medicare and Medicaid reimbursements for 146 primary-care services from Jan. 1 through the end of 2014. The increased payments will be made to family physicians, pediatricians and internal medicine doctors who specialize in

primary care. The program is winning praise from New Jersey doctors and primary-care advocates, who said it is an important step in increasing access to healthcare for low-income residents. (NJ Spotlight)

New Mexico

- **N.M. To Accept Expanded Medicaid**

  Gov. Susana Martinez announced today that New Mexico will accept federal funding to expand Medicaid coverage. The expansion, which is part of the new Affordable Care Act, means New Mexico will get more than $6 billion from 2014 through 2020 to cover the lowest-income adult population. (ABQ Journal)

West Virginia

- **W.Va. Medicaid contract exemption facing repeal**

  West Virginia's Medicaid program could lose the authority to oversee the awarding of its contracts. The joint Legislative Oversight Commission on Health and Human Resources Accountability endorsed a bill Monday to repeal that power. A 2009 law has allowed the Bureau of Medical Services to bypass the state's normal contract bidding process. But a legislative review found in August that the agency had fumbled the handling of one of West Virginia's most lucrative contracts. (Charleston Daily Mail)

National

- **MACPAC Meeting Agenda – January 15-16, 2013**

  The next Medicaid and CHIP Payment and Access Commission (MACPAC) meeting is scheduled for January 15-16, in Washington, DC. Meeting agenda is available at: www.macpac.gov/

- **CMS announces funding to enroll children in Medicaid/CHIP**

  States and local governments and community-based and non-profit organizations can apply through Feb. 21 for a portion of $32 million in Patient Protection and Affordable Care Act grants to find and enroll eligible children in Medicaid and the Children's Health Insurance Program, the Centers for Medicare & Medicaid Services announced yesterday. CMS expects to award grants of up to $1 million each beginning in June for proposals to engage schools in outreach, enrollment and retention; outreach to subgroups with lower than average health coverage; strategies to streamline enrollment for people in public benefit programs; and application assistance and training programs. For more information, see the grant announcement. (AHA News)

- **House GOP Members Probe Medicaid Eligibility Problems in the States**

  As Congress sharpens its focus on deficit reduction and health care spending, some GOP members of Congress are taking a fresh look at how people shelter their assets in order to qualify for Medicaid long-term care. The move revives a long-running debate over whether Medicaid should be regarded as a middle-class entitlement or an assistance program for the truly needy. It also raises the question of whether 2005 changes in the law were effective in ensuring that people with enough money to afford nursing home care couldn't game the system. (CQ Healthbeat)

- **Surpluses Await Some States in 2013 Sessions**

  With a $500 million budget surplus and $2 billion in reserves, Indiana Governor-elect Mike Pence has pledged to give back some of that money when he takes office next week by cutting personal income taxes. Indiana is not alone going into the 2013 legislative session with extra money in the coffers and policy makers figuring out how to spend it. Through a combination of downsizing, changes in tax policy and sometime the luck of having energy and commodities, some states have weathered the recession better than others. Iowa is looking at an $800 million surplus. Florida's is more than $400 million. Michigan, which was in a recession years before the country entered one in 2007, has an extra $1 billion in its general funds. And of all places, even California, which every year for the past decade had to dig out of multi-billion-dollar deficits, is expected to fix its projected $1.9 billion budget shortfall by June of this year and possibly show a $1 billion surplus in 2014–15, growing to more than $9 billion in 2017–18. This dramatic turnaround is due in large part to voters approving Governor Jerry Brown's temporary tax increase last November. Despite the extra funds, don't expect a spending spree. States say that much of their surpluses will cover sweeping cuts anticipated in federal funding later and increases in Medicaid costs. (Stateline)

- **5 Pending Medicaid Waivers to Watch in 2013**

  As 2013 begins, here are five major Medicaid reforms waiting for the all-clear from CMS.

  1. Moving California children to Medi-Cal

     The waiver would transfer administrative responsibility for kids in the Healthy Families Program, which covers more than 860,000 children for medical, dental and vision needs, from the Managed Risk Medical Insurance Board to the larger state Medicaid program, Medi-Cal.

  2. Extending family planning benefits

     Since its inception, Medicaid has focused its attention on low-income families. As an extension of that, young women have often been covered for family planning services under a Medicaid waiver. But on Dec. 31, four states' waivers expired: Illinois, Mississippi, Pennsylvania and Texas.

  3. Overhauling Minnesota's long-term care delivery

     Minnesota has developed a program that would divide that population (made up of seniors and developmentally disabled) into different tiers based on their level of need. There would be those who require nursing home care, the most expensive kind, and then there would be those who could receive home and community-based services because their level of need isn't as great.

  4. Improving services for New York's developmentally disabled

     The program would place 100,000 developmentally disabled Medicaid enrollees into a managed-care program that would coordinate both their acute health care and long-term habilitative services into one delivery model. Covered services would be vast: from adult day care to psychotherapy to nutrition counseling. All

care would be overseen by a single entity, so that the entirety of a patient's experience is considered when delivering care.

5. Testing the Medicaid expansion locally in Ohio

   In Cuyahoga County, home to Cleveland and ravaged by the economic downturn, Ohio officials want to expand health-care services for the growing portion of uninsured childless adults. They'd do that by coordinating with MetroHealth, an academic health-care system in Cleveland that provides much of the health care for uninsured residents in the area, and expanding Medicaid benefits for people up to 133 percent of the federal poverty level. As many as 158,000 people could qualify, and about 20,000 will be initially enrolled to launch the project.

(Governing Magazine)

COMPANY NEWS

- **UPMC Center for High-Value Health Care Approved for Major Research Award**

  Filling the unmet medical needs of adults with serious mental illness is the goal of a pilot program from the UPMC Center for High-Value Health Care, which has been approved for a research award from the Patient-Centered Outcomes Research Institute (PCORI). The Center for High-Value Health Care, which is housed under the UPMC Insurance Services Division, was one of 25 health-related agencies approved for funding from PCORI. (InsuranceNewsNet)

- **Inova buying way into Medicaid field**

  More than a year before Inova Health System leaders had planned to even think about forming a Medicaid insurance contracting arm, the nonprofit hospital group bought one. In an unforeseen turn of events in late 2012, Inova successfully bid on Amerigroup Virginia Health Plan, which processes claims and manages care for 55,000 low-income beneficiaries of government-funded insurance plans. Inova, which recorded $2.4 billion in revenue last year, expects the new unit to generate $167 million in additional revenue annually while the health system relaunches another experiment in becoming an insurer. (Washington Business Journal)

- **Welsh, Carson, Anderson & Stowe Completes Acquisition Of GetWellNetwork**

  Welsh, Carson, Anderson & Stowe, a private equity firm exclusively focused on information/business services and healthcare, today announced the completion of the acquisition of GetWellNetwork, Inc., the leading provider of Interactive Patient Care solutions. The GetWellNetwork solution is deployed in over 30,000 hospital beds nationwide and facilitates over seven million patient interactions per year. (Market Watch)

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
TBD	Nevada	Contract Awards	188,000
January 15, 2013	Florida LTC	Contract Awards	90,000
January 21, 2013	California Rural	Applications due	280,000
January 28, 2013	Arizona - Acute Care	Proposals due	1,100,000
January, 2013	Vermont Duals	RFP Released	22,000
January, 2013	Virginia Duals	RFP Released	65,400
January, 2013	South Carolina Duals	RFP Released	68,000
January, 2013	District of Columbia	Contract Awards	165,000
February 1, 2013	New Mexico	Contract awards	510,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March 15, 2013	Florida acute care	Proposals Due	2,800,000
March, 2013	Idaho Duals	RFP Released	17,700
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April 1, 2013	Vermont Duals	Contract awards	22,000
April 1, 2013	Virginia Duals	Contract awards	65,400
April, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
April-May, 2013	Rhode Island Duals	RFP Released	22,700
May 1, 2013	District of Columbia	Implementation	165,000
May 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
June 1, 2013	California Duals	Implementation	500,000
June, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Massachusetts Duals	Implementation	115,000
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
September 1, 2013	Ohio Duals	Implementation	115,000
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	Illinois Duals	Implementation	136,000
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
December, 1 2013	Florida LTC (Region 11)	Implementation	16,400
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	Hawaii Duals	Implementation	24,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
January 1, 2014	Rhode Island Duals	Implementation	22,700
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
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	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	526,902**	X	3/1/2012	4/4/2012		6/1/2013
Colorado	MFFS	62,982					4/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii	Capitated	24,189					1/1/2014
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012		Fall 2013
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	March 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013
Michigan	Capitated	198,644	TBD	TBD	TBD		1/1/2014
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					1/1/2014
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	22,737		Apr-May 2013	6/1/2013		1/1/2014
South Carolina	Capitated	68,000	Jan. 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402		Late 2012	Early 2013		1/1/2014
Virginia	Capitated	65,415	Early 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	Jan. 2013	3/11/2013	4/1/2013	Dec. 2012	1/1/2014
Washington	Capitated/MFFS	115,000	TBD	TBD	TBD	MFFS Only	1/1/2014
Wisconsin	Capitated	17,600	X	8/23/2012	10/1/2012		4/1/2013
Totals	**17 Capitated 7 MFFS**	**2.4M Capitated 485K FFS**	***5***			***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 WELCOMES…

Stephanie Chrobak, Principal – Boston

Stephanie comes to us most recently from Massachusetts Health Connector Authority where she served as their Director of Operations and Implementation over the last several years. In this role she oversaw the Health Connector Programs and Commonwealth Care and Choice. She participated in health plan procurement and lead vendor oversight including contract negotiation and management, technology, and planning. She also oversaw member services, consumer education and outreach, premium billing, and web services.

Prior to her experience with MHCA, Stephanie worked for Tufts Health Plan for 14 years. Her most extensive role was that of Director of Member and Provider Services. Her responsibilities included account management, provider education, service assurance, and project management. She also led the development of provider reimbursement strategy for Tufts Health Plan. Her other roles within Tufts Health Plan included Director of Plan Benefits and Business Implementation, Manager of Program Development and Clinical Services, and Provider Unit Manager and Project Manager. Additional professional experience that Stephanie brings to HMA includes serving as the Director of Contracting and Managed Care Operations for Partners HealthCare Systems, Project Manager for USAID Health Insurance Organization (Cairo, Egypt), and Director of Health Behavior Program for the Department of Public Health (Boston).

Stephanie holds a Masters in Health Services Administration from the University of Michigan as well as a Bachelor of Arts degree from Western Michigan University.

Tom Marks, Principal – Lansing, Michigan

Tom comes to us most recently from the University of Michigan Health System. With over 20 years of experience at UMHS, Tom brings a wealth of knowledge to HMA. In his most recent role as Senior Director of Finance he was responsible for leading and directing the hospital reimbursement team. This included financial reporting, revenue optimization, cost reports, monitoring and advising on changes in legislation and regulation, as well as rate-setting and pricing. Tom managed and negotiated the hospital contract with Blue Cross and served as the finance liaison on teams engaged in ACO development, EHR, quality improvement, risk management, and clinical documentation.

Prior to his role as Senior Director of Finance, Tom served in the roles of Revenue Cycle Officer, Interim Chief Financial Officer, and Director of Accounting and Reimbursement at UMHS. Some of his notable accomplishments in these roles include improved accounts receivable to 35 days revenue (decrease of 16%), participated in the sale of a managed care company for a significant gain to include a negotiated new long-term contract with the purchaser (10% increase in hospital payment rates), negotiated contracts with largest insurer in Michigan resulting in increased revenues by 2-3%, and succeeded in third party payer appeals generating $40M.

Tom also worked for 12 years with Ernst and Young as a CPA where he provided audit and advisory services in the health care industry. He holds a Bachelors of Business Administration Degree from the University of Michigan.