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# HMA

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HEALTH MANAGEMENT ASSOCIATES

## *HMA Investment Services Weekly Roundup Trends in State Health Policy*

**IN FOCUS:** HEALTH CARE REFORM IN PUERTO RICO

**HMA ROUNDUP:** MICHIGAN, OHIO GOVERNORS RECOMMEND MEDICAID EXPANSION; PENNSYLVANIA GOVERNOR DEFERS DECISION ON MEDICAID EXPANSION; FLORIDA RECEIVES LTC WAIVER APPROVAL; FLORIDA BUDGET INCLUDES FUNDING FOR MEDICAID MCO EXCISE TAX, PRIMARY CARE RATE INCREASE; NEW YORK CREATES PILOT PROGRAM FOR PRIVATE INVESTMENT IN TWO HOSPITALS; HAWAII WITHDRAWS FROM DUAL ELIGIBLE DEMONSTRATION

**OTHER HEADLINES:** STATES WRESTLE OVER MEDICAID EXPANSION DECISION; CBO PROJECTS SLOWER MEDICAID SPENDING GROWTH; PENNSYLVANIA DPW SECRETARY EXPECTED TO RESIGN; CORIZON WINS ARIZONA PRISON CONTRACT, RENEWS IDAHO; WELLCARE CLOSES ACQUISITION OF UNITEDHEALTH'S SOUTH CAROLINA MEDICAID SUBSIDIARY

**HMA WELCOMES:**  
MARCI EADS, DENVER

**FEBRUARY 6, 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: HEALTH CARE REFORM IN PUERTO RICO

This week, our *In Focus* section comes to us from HMA Principal, Juan Montanez. Below, Juan provides an update on the change in political landscape in Puerto Rico in the past few months, and the push for a health care design overhaul in the territory. As of November 2011, there were approximately 1.6 million Puerto Ricans enrolled in the government health insurance program (known in Puerto Rico as *MiSalud* or *Reforma*), which includes Medicaid, CHIP, Medicare-Medicaid dual eligibles, and a “commonwealth-only” population, similar to state-only eligibility categories in other Medicaid programs. There are 3.6 million residents of Puerto Rico as of 2012.

### Health Care Reform Background

As a result of last November’s general elections in Puerto Rico a pro-statehood, fairly conservative, Republican Governor and administration has been replaced by a fairly liberal, pro-commonwealth, Democratic Governor who ran on a universal health care platform. The pro-commonwealth party also won control of the local legislature.

Two weeks ago the new Governor’s administration announced it will pursue universal access to health care for all bona fide residents of the Commonwealth. While details on this model are still evolving, a key element of the Governor’s campaign platform on health care is the creation of “regional integrated delivery systems” – in essence the development of Accountable Care Organizations.

The details for this new regional integrated delivery system model have not been identified, nor has there been much discussion on how this new model will be operationalized. There has been some discussion about piloting this new model beginning later this year in one “region” of the island. Under the existing program, Puerto Rico is organized into eight distinct regions and purportedly one of these regions would serve as the pilot region for this new model. Additionally, it has been suggested that the target population for the pilot will be the uninsured population. According to a survey conducted last year under the supervision of HMA, there are approximately 300,000 uninsured individuals in Puerto Rico; thus the population in this pilot program could be on the order of 30,000 to 40,000 residents.

### Integral Health Plan Bill

The week before the new administration made its health care reform announcement, a bill that would implement an “Integral Health Plan” was filed by the new Vice President of the local Senate. This single-payer model would be funded by: employee and employer payroll taxes, an individual tax on self-employed individuals, all of the funding that the central and municipal governments currently pour into health care programs and “infrastructure”, the capped federal funds that Puerto Rico can access for Medicaid and the Children’s Health Insurance Program (as a U.S. territory, P.R. does not have “entitlement-level” access to federal Medicaid funds), and other sources. The central government would set up and administer an “essential health benefits plan” that all “bona fide residents” of the island would buy into. Premium contributions and cost-sharing obligations would be determined using a sliding-scale function based on income. Individuals

who would want to purchase insurance beyond what is covered by the “essential health benefits plan” would go into what would remain of the private health insurance market to purchase “supplemental insurance”.

Other elements of the bill include:

- Institutional providers would be under direct contract to the central government while physicians and other practitioners would be employed by or enter into direct contracting agreements with the central government;
- The central government would set up or utilize an existing government entity to administer the program and/or contract with a TPA/ASO-like entity;
- Some tort reform; and
- The creation of a centralized “health care infrastructure bank” that would be used to fund projects such as construction of new hospitals.

Finally, the bill is not explicit about a mandate to purchase health insurance, although it stands to reason that this model – or the Governor’s universal access model – might work best with some form of mandate.

### Looking Ahead...

The new Governor has not officially endorsed this bill, but some of the provisions of this bill are consistent with the elements of the model proposed by his administration. The models proposed by the new administration and the Senate Vice President are not expected to impact Tricare beneficiaries or non-dual Medicare beneficiaries. At this point in the process, it is not yet clear whether or how either model is intended to impact federal employees or employees of U.S. and foreign corporations with subsidiaries in Puerto Rico.

As deliberations about the proposed models proceed, within the next couple of weeks the new Governor is expected to sign an Executive Order to create a “Health Care System Regulation and Evaluation Board”. This Board will work with the Governor’s health care leadership team to flesh out the administration’s proposed model.

On a separate yet related topic, the executive director-designee of the Health Insurance Administration (the agency that manages the Commonwealth’s medical assistance program and the Government Employee and Retiree health plan) has indicated that a re-procurement of the managed care entities operating within the medical assistance program may begin as early as March/April of this year, however the proposed reforms to the health care system may impact this process.

The health care reform models being discussed in Puerto Rico could result in a sea change in how health care coverage is purchased and health care services are accessed in the Commonwealth. We will continue to monitor health care reform developments in Puerto Rico in order to advise clients and potential clients on the implications of these changes.

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## HMA MEDICAID ROUNDUP

### *California*

#### HMA Roundup – Jennifer Kent

**Duals Demonstration Moves Toward Memorandum of Understanding with CMS.** Over the past 18 months, CMS and the California Department of Health Care Services (DHCS) have worked in partnership to develop the Demonstration to Integrate Care for Dual Eligible Individuals (Demonstration). On February 1, 2013, DHCS received a letter from CMS noting significant progress in joint discussions toward creating an integrated system of care for dual eligibles. The Demonstration will lead to an increased focus on patient-centered, high quality care for the dual eligible beneficiaries. Assuming the remaining policy considerations can be resolved, CMS hopes to finalize the memorandum of understanding that will outline the principles under which CMS and the State will implement and operate the Demonstration in the near term for a targeted implementation beginning in September 2013.

**Medi-Cal Expansion Discussions Begin.** On February 1, 2013 the California Department of Health Care Services and Health & Human Services Agency officially opened the stakeholder process for the upcoming Medi-Cal expansion discussions that will be taking place between the counties, state and various advocacy organizations. Since the release of the Governor’s budget on January 10th calling for either a “state-based” or “county-based” Medicaid expansion, few details have been shared about the mechanics for implementing either option. Last week’s discussion represents the beginning of the public stakeholder process to explore the various statutory and federal processes that must be approved in order to expand Medi-Cal by January 2014.

#### In the news

- **“California passes up millions for prison healthcare, report says”**

“California's court-run prison healthcare program is missing out on tens of millions of dollars a year in federal funds because of disagreement with counties and software problems, a new legislative report states. The legislative analyst's office found increasing numbers of prison inmates who, because of their low income status, are eligible for the state's Medicaid program. That program, delivered through counties, draws matching federal reimbursements. The LAO notes that federal policy has allowed states to collect federal Medicaid reimbursement for eligible state prison inmates since 1997. The agency states that California has only recently developed a process to obtain this funding, and is not yet seeking the full amount possible.” ([Los Angeles Times](#))

- **“Finance, Health Care Linked in Expansion Effort”**

“State health care and finance officials met for the first time with stakeholders Friday to outline some of the differences between two possible approaches -- state-based or county-based -- to implementing the state's optional Medi-Cal expansion. Many details of the proposed expansion of Medi-Cal are unknown, state officials said Friday because they're waiting for more federal guidance in many areas. One important de-

tail is known: the federal government will fully pay for the expansion benefits for new enrollees for the first three years. Diana Dooley, the state's Secretary of Health and Human Services, said implementing the expansion will be influenced in equal parts by financial and health care considerations." ([California Healthline](#))

- **"As Healthy Families Deficit Rises, Tax Pressure Rises With It"**

"The Healthy Families program has run out of money, according to state health officials. The deficit currently stands at almost \$100 million and will keep rising every month, according to Janette Casillas, executive director of the Managed Risk Medical Insurance Board, which oversees Healthy Families. Gov. Jerry Brown's administration is pursuing two ideas for refilling the coffers: reinstatement of a recently expired tax on managed care organizations and an appropriation bill if the MCO tax isn't revived." ([California Healthline](#))

## Colorado

### HMA Roundup - Joan Henneberry

**Colorado Exchange Announced Navigator Guidelines.** The Colorado Health Benefit Exchange (now called Connect for Health Colorado) announced the guidelines it will use to select entities to serve as Navigators, to assist with finding and enrolling individuals into the exchange later this year. Connect for Health Colorado will award grants on a competitive basis, allowing organizations to have both paid and volunteer Navigators. Navigator entities will be responsible for the day to day management of Navigators and will provide the physical space and infrastructure necessary for Navigators to perform their duties. Navigator entities may serve the individual market or the SHOP (small business) market, or both. Regional Hubs will be Navigator entities that are awarded enhanced grant funds for agreeing to accept additional responsibilities including: convening Navigators in their region for information sharing, collaboration and training; serving as a hub for outreach and education; and providing technical assistance to Navigators and Navigator entities. Connect for Health Colorado envisions regional hubs will also support a system of referral among Navigators and Navigator entities that will help ensure that customers are able to access appropriate Navigator services.

**Colorado Moves Forward on Supplemental Physician Payments.** As of January 1, 2013, Medicaid physicians (family medicine, general internists, and pediatricians) are able to receive supplemental payments for primary care services paid for by Medicaid. Physician assistants and advance practice nurses are eligible for the supplemental payments if they are personally supervised by an eligible physician.

## Florida

### HMA Roundup - Elaine Peters

**Long-term Care Waiver Approval.** On February 4, 2013, Florida received approval from CMS for its long term care managed care 1915 (b)/(c) combo waiver. The waivers are effective for a three year period beginning July 1, 2013 through June 30, 2016. The waiver will provide home and community based services and nursing home services to nearly 90,000 recipients who are aged 65 and older and for individuals with physical disabilities

from ages 18 through 64 years old. The Agency has selected five managed care companies – American Eldercare, Amerigroup, Coventry, Sunshine State Health Plan (Centene), and United Healthcare – through a competitive solicitation worth an estimated \$3 billion. Enrollment will be phased in starting in Region 7 (Orlando) in August 2013 through March 2014. Governor Scott urged HHS to approve of the second waiver request which would drive most Medicaid recipients across the state into managed care plans.

**Select Committee on PPACA.** A joint Senate and House PPACA Committee met on February 4, 2013 to continue discussions on the establishment of exchanges. Florida has missed the deadline to run a state exchange in 2014 but lawmakers are considering whether they want to run their own exchange in the future or partner with the federal government. Lawmakers heard from two organizations already running similar programs and explored options of partnering with these organizations instead of building something new. Florida Health Choices (FHC) is essentially an online marketplace where small businesses can browse for health plans and is expected to go live at the end of February. Individuals will be added to the marketplace this summer. The Florida Healthy Kids Corporation (FHKC) has been operating for over 20 years and provides health insurance for school age children under the KidCare (CHIP) program. Both FHC and FHKC currently handle many of the main functions of the exchanges. The Senate Select Committee on PPACA is scheduled to meet on Monday, February 11, and will have a panel discussion on Medicaid expansion.

**Governor’s Budget FY 2013-14:** Governor Rick Scott unveiled his “Florida Families First” policy and budget recommendations for Fiscal Year 2013-14 on January 31, 2013. The Governor’s proposed budget is \$74.2 billion, which is 5.7 percent above the current \$70.2 billion budget. The proposed General Revenue budget is \$27.1 billion. Scott’s priority is education and includes a \$1.25 billion increase in school spending and \$2,500 pay raises for teachers. The recommended budget includes savings totaling \$1.2 billion, of which \$184 million represents a savings from General Revenue. As part of these savings, \$30 million is derived from enterprise efficiency initiatives and another \$56 million is due to operations and administrative efficiencies. The recommended budget reduces the state workforce by 3.1 percent from the current year, from 117,930 positions to 114,283 positions.

**Federal Health Care Law:** The Florida Families First Budget includes a number of issues related to the President’s health care law. The Recommended Budget only provides for the mandatory portions of the law. The budget does not include a Medicaid Expansion as Governor Scott has said there are many questions unanswered and the state continues to work with the federal government to get more information about how the optional Medicaid expansion would impact the cost, quality and access of health care services.

- Eligible but not Enrolled – Provides \$116.1 million for the currently eligible population in Medicaid who are not already enrolled. Similar to other states, the recommended Medicaid budget assumes 30 percent of this population will enroll in the first year. The 30 percent was derived by a meta-analysis of other states’ estimates and determining an average of those projections.

- Increased Rates for Primary Care Practitioners in Medicaid at the Medicare Rate - Provides \$703.5 million TF for increased rates for Primary Care Physicians funded 100% from federal funding, effective January 1, 2013.
- Health Insurance Tax on Managed Care Rates - Provides \$31.6 million (\$13.1 million state funds). This is an annual tax placed on health insurance providers under the new law. This increase is based on preliminary estimates for the 2013-14 year for Medicaid premiums. Estimates in the Kidcare Program and state group insurance are unknown at this time.
- Children's Health Insurance Program (CHIP) - Transfers \$60.7 million from the CHIP program to the Medicaid program as required by law. Children ages 6 through 18 from 100 percent to 138 percent of the federal poverty level who are currently enrolled in CHIP are now mandated to move to the Medicaid program.
- Providing Health Care to Other Personal Service (OPS) Employees - Provides \$29 million to offer health insurance to roughly 7,000 employees who don't currently receive coverage, but who work more than 30 hours per week.

### **Medicaid Program**

The budget includes the following other impacts to the Medicaid Program:

#### **Investment Measures**

- Medicaid Price Level/Workload - Provides \$1.1 billion related to price level and workload adjustments.
- Funding All-Payer Claims Database (APCD): Provides \$1 million to begin development of an APCD to promote a sound understanding of Florida's health care market. Data compiled by an APCD stand to inspire innovations and benefit health care payers, providers, patients, researchers, and policymakers.
- Developmentally Disabled Waiver - Provides \$36.3 million to serve an additional 750 individuals currently on the Medicaid waiver waitlist.
- Nursing Home Diversion/Aged & Disabled Waiver - Provides \$24.2 million to serve 2,000 individuals at risk of nursing home placement. This funding will reduce the Nursing Home Diversion and Aged and Disabled Adult Waiver waitlists for the frailest individuals by 65 percent and 49 percent, respectively.
- Medicaid LTC Budget - Transfers \$230.4 million from DOEA and DCF for the Aged and Disabled Waiver to consolidate funding in AHCA.
- Resource Utilization Group (RUG) - Provides \$2.0 million TF for a consultant to assist AHCA with transition to a prospective payment system using Resource Utilization Groups (RUGs) for Medicaid Nursing Home reimbursement.
- Statewide Medicaid Managed Care
  - Legal Representation - Provides \$4.4 million TF to hire additional legal staff and outside counsel to support anticipated increases in litigation due to implementation of Statewide Medical Managed Care (MMA) and increases in complex federal lawsuits and investigations.

- Managed Care Network Verification - Provides \$1.5 million TF to enhance the automated Provider Network Verification system with the tools to ensure submission of required reports submitted by managed care organizations as a result of Statewide Medicaid Managed Care implementation.
- Enrollment Broker Services – Provides \$6.9 million TF for Enrollment Broker Services as a part of the implementation of Managed Medical Assistance component of the Statewide Medicaid Managed Care program.
- Medicaid and Public Benefits to Counter Fraud - Recommends \$2.5 million TF and 7.0 FTE for the Public Benefits Integrity Data Analytics and Sharing Initiative which will detect and deter fraud, waste, and abuse in Medicaid and other public benefit programs within the state. This new approach is expected to enhance the current recovery of \$6.80 in Medicaid overpayments for every \$1 spent in fraud prevention and recovery.
- Medicaid Eligibility Determination (DCF) – Provides \$30.0 million for the second year funding of the Medicaid eligibility determination system (“FLORIDA”).
- Statewide Medicaid Residency Program – Transfers \$52.2 million of GME funding (excluding GME DSH) to the Department of Health to establish a program to improve access and quality of care for Medicaid beneficiaries, expand graduate medical education on an equitable basis, and increase the supply of highly-trained physicians statewide. This funding will help ensure that physicians that are educated in Florida will have a better opportunity of practicing their residency in Florida.

### **Savings Measures**

- Elimination of Chiropractic and Podiatrist Programs – reduces \$758,171 for Chiropractic and \$2.7 million for Podiatrist programs. This will impact approximately 34,360 individuals. With the upcoming implementation of Statewide Medicaid Managed Care, recipients enrolled in managed care will be able to choose among plans that offer expanded benefits. Chiropractic and podiatry services may be offered as expanded benefits if the plans choose to include these services.
- Hospital Inpatient Rate Reduction – reduces \$81.8 million (2% rate reduction) except for those hospitals with a children’s or rural specialty designation. Of this total, \$60.1million relates to hospital inpatient and \$21.7 million relates to managed care.
- Reduce Clinic Services Reimbursement Rates – reduces \$9.1 million (5% rate reduction). Of this total, \$3.0 million relates to managed care and \$6.1 million relates to Clinics. Medicaid reimbursement at a county health department is made based on an “all-inclusive encounter rate,” which includes diagnosis, therapy and consultation for primary or prevention services. The current average encounter rate of approximately \$150 is substantially higher than the fee-for-service rate paid to stand alone providers who deliver similar services in other clinic settings.

## Georgia

### HMA Roundup – Mark Trail

**DCH Audit Reveals Overspending of \$32M in FY12.** A recent audit conducted by the Georgia Department of Audits and Accounts indicated that the Georgia Department of Community Health (DCH) overspent its State General Funds allocation by nearly \$32 million in Fiscal Year 2012. The DCH attributed the overage to an accounting error from the previous year and a substantial increase in hospital billing from the State's largest hospital (Grady). Noted in the audit was the fact that the Aged Blind and Disabled (ABD) State General Fund budget line was actually over \$72 million overspent. It is also our observation that the ABD population has not been systemically managed since 2010 when the two State Primary Care Case Management (PCCM) programs serving this population were canceled. Documents are available at ([Link](#)).

**Provider Tax Senate Bill Passes House; to be Signed by Governor.** Senate Bill 24 passed the House without changes from the Senate version and has been sent to the Governor for signature. The Bill, entitled the 'Hospital Medicaid Financing Program Act.', authorizes the DCH Board to adopt rules which would then impose a Hospital Provider Fee, which then can only be used to match federal financial participation in the medical assistance programs. The actual use of the funds is still be subject to appropriation by the State General Assembly. The Bill includes language that will nullify the fee if at any time the funds become ineligible for federal financial participation or if the Department does anything that has the effect of reducing hospital reimbursement in effect on June 30, 2012. As noted in an earlier edition of the HMA Roundup, it is not known what impact this will have on the proposed change in outpatient hospital reimbursement to the APC Grouper reimbursement methodology in the FY 2014 proposed budget, accounting for a \$102 million total funds saving.

**Amended FY 2013 Budget:** On February 6<sup>th</sup>, the AFY13 budget passed out of the House Appropriations Committee. The most significant changes affecting health care include:

- Adding more state and total funds for private hospital DSH payments; increasing total fund payments from \$20 million to \$51 million
- Reducing state and total funds from pharmacy savings initiatives
- Updating Medicaid and PeachCare projections resulting from both enrollment and medical cost growth:
  - ABD Medicaid increased \$85 million state funds; \$249 million total funds
  - LIM Medicaid decreased (\$104 million state funds; \$305 million total funds)
  - PeachCare increased \$11 million state funds; \$45 million total funds

### In the news

- **“Small rural hospital closes doors; others may follow”**

“The Friday closing of Calhoun Memorial Hospital in the southwest Georgia town of Arlington reflects the financial squeeze that many rural facilities face. A handful of

other rural hospitals in the state also may be teetering on the brink, with rising levels of uninsured patients and with Medicaid continuing to pay low rates for services. HomeTown Health, an organization of rural hospitals in Georgia, says a half-dozen facilities could follow Calhoun Memorial's move and shut down in the coming months." ([Georgia Health News](#))

## *Hawaii*

### **HMA Roundup**

The State of Hawaii withdrew its proposal from the dual eligible demonstration program and announced that it is seeking a renewal of its Section 1115 demonstration. This includes continuing to support the Quest Expanded Access program (QExA), which enrolls 65+ and disabled Medicaid beneficiaries into managed care. ([Link](#))

## *Michigan*

### **HMA Roundup – Esther Reagan**

**Medicaid Expansion:** Governor Rick Snyder endorsed the Medicaid expansion in a public appearance today, Wednesday, February 06, 2013. The Governor's office posted a short fact sheet on the Medicaid expansion, available [here](#). The announcement comes a day before the release of Governor Snyder's budget recommendations on Thursday, February 7, 2013.

**State of the State.** Governor Snyder delivered his third State of the State address on January 16, 2013. He offered 23 proposals for consideration. He referenced the Blue Cross Blue Shield of Michigan restructuring, said the state needs to invest more money in and develop initiatives to improve mental health programs, urged creation of programs to assist veterans and urged appropriation of more funds to increase by 90,000 the number of children eligible for dental treatment. This last item relates to the Healthy Kids Dental program through which Medicaid children in 75 of the state's 83 counties now have access to dental care through a program administered by Delta Dental of Michigan.

**Duals in Medicaid HMOs.** As of January 1, 2013, there were 32,065 Medicaid beneficiaries dually eligible for Medicare (duals) enrolled in Medicaid HMOs to receive their Medicaid services, an increase of 923 since December. The number of duals enrolled through auto-assignment as of January 1, 2013 was 15,218, and the number of duals enrolled on a voluntary basis was 16,847. All Medicaid HMOs include duals although the enrollment numbers vary dramatically across plans.

As the table below reflects, Molina Healthcare of Michigan has the most duals receiving their Medicaid services from an HMO, more than 30 percent of the total; UnitedHealthcare Community Plan has almost 24 percent of the total; Meridian Health Plan of Michigan has 15 percent of the total (but the most voluntary enrollees); and the other 10 plans share the remaining 31 percent.

Eight of the 13 Medicaid HMOs in Michigan (or their parent organizations) are also federally contracted as Medicare Advantage Special Needs Plans (SNPs) to provide Medicare benefits for duals in Michigan: HealthPlus of Michigan, McLaren Health Plan, Me-

ridian Health Plan of Michigan, Midwest Health Plan, Molina Healthcare of Michigan, Total Health Care, UnitedHealthcare Community Plan and Upper Peninsula Health Plan. HealthPlus and Total are new Dual-SNPs beginning in 2013. As of January 1, 2013 these eight Dual-SNPs have a combined enrollment of 15,107 duals for whom they provide Medicare services; 57.9 percent of the duals are enrolled in the Molina plan, 29.5 percent are enrolled in the UnitedHealthcare plan and the remaining 12.6 percent are spread across the other six plans.

January 2013 Medicaid Dual Eligible Enrollment				
Medicaid Health Plan	Voluntary Enrollees	Auto-Assigned Enrollees	Total Enrollees	% of Total
Molina Healthcare of MI	2,585	7,111	9,696	30.2%
UnitedHealthcare Comm. Plan	3,590	3,971	7,561	23.6%
Meridian Health Plan of MI	3,888	928	4,816	15.0%
McLaren Health Plan	1,682	715	2,397	7.5%
Midwest Health Plan	1,067	709	1,776	5.5%
Priority Health Govt. Programs	883	667	1,550	4.8%
Total Health Care	764	229	993	3.1%
HealthPlus Partners	809	182	991	3.1%
Blue Cross Complete of MI	379	298	677	2.1%
Upper Peninsula Health Plan	455	222	677	2.1%
CoventryCares of MI	501	116	617	1.9%
PHP Mid-MI Family Care	223	42	265	0.8%
Pro Care Health Plan	21	28	49	0.2%
<b>Total</b>	<b>16,847</b>	<b>15,218</b>	<b>32,065</b>	

## New York

### HMA Roundup - Denise Soffel

**NY Health Benefit Exchange Invites Health & Dental Plan Participation.** The New York Health Benefit Exchange is designed to help New Yorkers to shop for and enroll in health insurance coverage. On January 31, the exchange issued an invitation to health insurers and dental plans to participate in the exchange. As a first step in the process, health insurers and dental plans that are interested in participating in the exchange must submit a non-binding letter of interest by February 15, 2013. Qualified health plans approved by the exchange will provide comprehensive health insurance coverage, with open enrollment projected to run from October 1, 2013 through March 31, 2014. Upon full enrollment, it is expected that more than one million New Yorkers will receive insurance via the exchange.

**HealthFirst Closes Purchase of Neighborhood Health Providers.** HealthFirst yesterday closed on its purchase of Neighborhood Health Providers (NHP), a 220,000-member Medicaid managed care plan. With the NHP transaction, HealthFirst covers 940,000 members and generates \$6 billion in annualized premium revenues. HealthFirst is the largest Medicaid managed care plan in downstate New York, and one of the largest Medicare Advantage and managed long term care plans in the area. ([Link](#))

**Additional Thoughts on Governor Cuomo’s Budget Proposals.** One of the Medicaid Redesign Team (MRT) work groups was charged with strengthening the health care safety net, with a specific focus on Brooklyn’s crumbling hospital infrastructure. The work group came up with a series of recommendations, some systemic, and some specific to the Brooklyn environment. This year’s budget picks up two of the “tools for change” recommended by the work group.

- **Expanding the Health Commissioner’s Powers over Hospital Operators.** The Governor’s budget proposes allowing the Health Commissioner to appoint a temporary operator for a hospital or other health care facility under two circumstances. The first is if the facility seeks financial support from the state due to serious financial instability. The second is if the Commissioner determines that conditions within the facility are jeopardizing the life, health or safety of patients. In either case, the Commissioner can appoint a temporary operator to assume sole control of the facility. A temporary operator would be appointed for an initial term of 180 days, with up to two 90-day extensions. Current facility leadership is provided the right to appeal the appointment of a temporary operator through an administrative hearing.
- **Pilot Demonstration Allowing a Business Corporation to Operate a Hospital.** Current New York State statute requires that any hospital operator in the state undergo a character and competency review prior to obtaining licensure. This rule effectively prohibits publicly traded businesses from operating hospitals in New York. The MRT work group on the health care safety net explored how this restriction limits access to capital, leaving hospitals in the state unable to make the necessary investments in physical plant, human resources or technology necessary to maintain an acceptable level of quality or access. The work group concluded that innovative options for capital formation, including private investment, are needed to support capital and operational improvements, specifically in 6 Brooklyn hospitals.

The Governor’s budget includes a proposed pilot demonstration to “assist in restructuring health care delivery systems by allowing for increased capital investment in health care facilities.” The pilot would allow two business corporations to be formed for the purpose of operating a hospital. One pilot is to be established in Brooklyn, the other is not geographically specified. The budget proposal requires an evaluation of the pilots after two years, to determine “the overall effectiveness of the program in allowing for access to capital investment in health care facilities and the impact such access may have on the quality of care provided...”

### In the news

- **“U.S. begins new audit as Cuomo tries to deal with \$15 billion in Medicaid overcharges”**

“Gov. Andrew Cuomo is confronting a multibillion-dollar problem that will result in a substantial loss of Medicaid funding for a variety of hospitals and providers. While the impact on the health care industry’s workforce could begin as soon as April, the

complications for state budgets might linger for years. The fiscal predicament rises from the federal government's finding that for 20 years New York overcharged Medicaid an estimated \$15 billion for the care of developmentally disabled people in what federal investigators described as a system of massive waste and illegal billing. A new audit by a team of federal health agency officials is about to begin, according to state and federal officials." ([Albany Times Union](#))

## Ohio

### HMA Roundup

**Ohio Opts to Expand Medicaid Eligibility.** On Monday, February 4, 2013, Governor John Kasich became the fifth Republican governor to support Medicaid expansion. In his 2014-15 budget proposal, Kasich emphasized that Medicaid expansion makes sense for the state of Ohio and would extend Medicaid coverage to about 275,000 uninsured Ohio residents. The state stands ready to undo the expansion should the Federal Government alter or renege on its funding commitments.

Kasich highlighted the need to alleviate financial burdens on hospitals that provide charitable care, secure Ohio residents' fair share of Federal dollars via the additional Medicaid funds, and enhance access to mental health and substance abuse services. The state will establish a cabinet-level Medicaid department. Finally, Kasich declined to create a state-run health exchange for Ohio, instead opting for a Federally-constructed one.

### In the news

- **"Sebelius Praises Kasich Backing of Medicaid Expansion"**

"Ohio Gov. John R. Kasich on Monday became the fifth Republican governor to announce support for expanding Medicaid, a decision that Health and Human Services Secretary Kathleen Sebelius called "a great step forward." Kasich's decision, which was announced in conjunction with the release of his two-year budget proposal, was widely anticipated. He had faced intense pressure from medical providers, business groups, religious organizations and patient advocates to expand the health care program for the poor. From CQ Hot Docs: [Ohio Medicaid documents \(PDF\)](#)"(CQ HealthBeat)

## Pennsylvania

### HMA Roundup – Izzanne Leonard-Haak and Matt Roan

**Governor Corbett Rejects Medicaid Expansion for Now.** On Tuesday, February 5, 2013, Governor Corbett issued his budget and indicated that he cannot recommend a "dramatic" Medicaid expansion. The Governor had written Health and Human Services Secretary Sebelius to indicate that absent flexibility to adapt the expansion to the commonwealth's particular needs, the costs of implementing the program would preclude expansion. Corbett's budget speech does not close the door on Medicaid expansion, arguing for greater clarity about the costs and options available to the state from the HHS.

Democrats decried the refusal of up to \$12 billion in federal dollars over the 2014-2016 timeframe—covering about 540,000 of the 1.3 million uninsured Pennsylvanians—while

Republicans argued that the expansion would likely require tax hikes that could cost more than \$4 billion through 2022. The Kaiser Family Foundation estimated that figure at closer to \$2.8 billion, compared to an additional \$37.8 billion of Federal funds over that span.

**Budget Secretary Charles Zogby Offers Additional Details on the Budget.** Budget Sec. Zogby offered additional comments about the 2013-2014 budget, following Governor Corbett's speech. From the first \$50 million installment of lottery payments, \$20 million would be allocated for home and community-based services on the OPTIONS waiting list, \$21 million would be earmarked for the home and community-based waiver program, \$5 million for Area Agencies on Aging, \$2 million toward attendant care services, and \$2 million for senior center modernization. Approximately \$8.5 million would be spent to expand the CHIP program to cover about 9,330 children.

In addition, Zogby noted supplemental appropriations requests for the 2012-13 budget, which includes \$62.3 million in additional funds for long-term living and a \$41.5 million increase for the Office of Medical Assistance.

**DPW Secretary Gary Alexander.** Secretary Alexander acknowledged speaking with the governor's office about stepping down to pursue private sector opportunities and spend more time with his family, but has not yet tendered a formal resignation.

### **In the news**

- **"Pennsylvania GOP Governor 'Cannot Recommend' Medicaid Expansion"**

"Republican Gov. Tom Corbett said in his budget message Tuesday that he is not ready to support expanding Medicaid in his state because he needs the federal government to give Pennsylvania more leeway in how it runs the health program for the poor. From CQ Hot Docs [Pennsylvania budget info.](#)" (CQ HealthBeat)

- **"Gov. Corbett's controversial public welfare secretary is leaving"**

"Gov. Corbett's controversial public welfare secretary is leaving the administration, according to two people with knowledge of the decision. Gary Alexander, who oversees a department charged with helping 2.1 million elderly, poor and disabled Pennsylvanians, will leave his \$149,804-a-year post by the end of the month." ([Philadelphia Inquirer](#))

## **Rhode Island**

### **HMA Roundup**

According to public comment responses dated January 17, 2013, the Rhode Island Office of Health and Human Services anticipated releasing an LOI on the dual eligible demonstration project within 3 to 4 weeks, with an MOU finalized in the first quarter of 2013 and implementation beginning September 1, 2013.

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## OTHER HEADLINES

### Arizona

- **“Arizona severs ties with prison health contractor”**

“The Arizona Department of Corrections says it has severed ties with a Pennsylvania company and has hired a new contractor to provide health services for all inmates in the state prison system. The agency announced Wednesday that "unforeseeable challenges" have resulted in the termination of its contract with Wexford Health Sources Inc. The agency says Corizon Inc. will take over March 4.” ([Bloomberg Business Week](#))

### Arkansas

- **“State lowers Medicaid shortfall projection to \$61M”**

“Democratic Gov. Mike Beebe told lawmakers at the start of this year's session that the lower spending so far this year meant the state could avoid the nursing home cuts, which would have affected as many as 15,000 seniors in the state. The department said it also no longer planned to eliminate Medicaid's adult dental program, an insurance program for low-income workers and community-based services for the elderly.” ([The Courier](#))

### Idaho

- **“Idaho Correction Board extends Corizon contract”**

“The Idaho Board of Correction will extend the state's contract with prison medical care company Corizon for at least one year. Board members made the decision Tuesday afternoon. Corizon's contract was set to expire this July, but the board has the option of up to two one-year extensions. Now the state will begin seeking proposals from other companies interested in providing medical and mental health care to Idaho's prisons starting in January of 2014.” ([Idaho State Journal](#))

### Illinois

- **“Increased Benefits Coming for Illinois Medicaid Recipients”**

“State officials say Illinois is moving toward the second phase of a new program for those in the Medicaid system. The Illinois Department of Healthcare and Family Services made the announcement. Officials say starting Friday there will be new services for more than 40,000 people in the Integrated Care Program. Those services include nursing home care and home and community-based care. State officials say they hope the program saves government money and offers better care. The first phase of the program focused on standard services like specialist care, lab work, mental health care and substance abuse. The second phase adds long-term care services. The third phase is expected to launch in 2014 and those suffering from developmental disabilities.” ([CBS St. Louis](#))

## Kansas

- **“Kansas' Great Hope: Managed Care Will Tame Medicaid Costs”**

“On Jan. 1, the state began enrolling nearly all of its Medicaid population -- including its most expensive patients -- into a managed care program called KanCare. This effort is unrelated to the federal health law's Medicaid coverage expansion, on which Republican Gov. Sam Brownback has yet to take a position. Meanwhile, as the transition proceeds, many policy analysts are watching to see if the state has done enough to meet the goal of controlling costs while ensuring that these vulnerable patients receive quality health care. Overhauling the program, which currently has about 380,000 enrollees, has been a longtime priority for Republican Gov. Sam Brownback.” [\(Kaiser Health News\)](#)

## Minnesota

- **“Essentia signs on to ‘shared-savings’ Medicaid reform”**

“A pilot program introduced in Minnesota on Friday will reward health-care providers for keeping patients out of their hospitals. Duluth-based Essentia Health is one of six providers that agreed to a “shared-savings” Medicaid reform, which Department of Human Services Commissioner Lucinda Jesson said is expected to save the state \$90 million over the next three years. It works like this: The state and the providers will agree on targets for cost and quality, such as meeting standards of quality care for heart failure. If the targets are met, the shared savings will be divided between the state and the providers.” [\(Duluth News Tribune\)](#)

- **“State working on adding 145,000 to Medicaid rolls”**

“Minnesota is preparing to expand Medicaid coverage to another 145,000 people, including thousands of children.... Gov. Mark Dayton's budget would expand the Medical Assistance program -- Minnesota's version of Medicaid -- to people who earn 138 percent over the current income limit. The expansion is expected to save the state \$143 million, as the federal government picks up the tab for health care that the state, or local emergency rooms, now provide.” [\(Minneapolis Star Tribune\)](#)

## Nevada

- **“Medicaid plan called one of Nevada government's biggest expansions”**

“The projected increase from 319,827 Medicaid recipients at the end of the current budget on June 30, 2013, to 490,103 on June 30, 2015, represents a 53 percent increase over two years. Total enrollment would represent nearly 18 percent of the state's entire population.... Gov. Brian Sandoval supports the expansion and has included it in his proposed 2013-15 budget. It is now up to lawmakers to debate the expansion and other aspects of the program. There has been strong bipartisan support for the recommendation.” [\(Las Vegas Review-Journal\)](#)

## New Hampshire

- **“NH panel hears from public on Medicaid expansion”**

“A bill to ban New Hampshire from expanding its Medicaid program as part of the federal health overhaul law attracted scant support at a public hearing Tuesday. In-

stead, opponents dominated the debate, arguing that expansion would help struggling families, hospitals and the state's economy.... Gov. Maggie Hassan, a Democrat, has expressed support for expanding Medicaid to help families and strengthen the state's economy. She is expected to address the issue when presenting her budget proposal to lawmakers next week." ([Boston Globe](#))

### North Carolina

- **"Audit: Mismanagement costs NC Medicaid system millions"**

"Inefficient management and lax oversight of contracts led to North Carolina spending much more to administer its Medicaid program than similar-size states, officials said Thursday. State Auditor Beth Wood said North Carolina's administrative costs are 38 percent higher than the average of nine states because of "structural flaws" in how the Department of Health and Human Services operates the Medicaid program. The higher costs translate into an extra \$180 million in North Carolina." ([WRAL News](#))

### Tennessee

- **"Tennessee's health insurance exchange guru leaving post"**

"The health reform expert in charge of setting up Tennessee's insurance exchange is leaving his post Friday, a spokesman for the state Department of Health Care Finance and Administration confirmed. Brian Haile, who has served as director of Gov. Bill Haslam's Insurance Exchange Planning Initiative for the past two and a half years, is taking his talents and knowledge of health care reform over to the private sector. Haile will head up health policy for tax prep company Jackson Hewitt." ([Nashville Business Journal](#))

### Texas

- **"Medicaid Expansion in Spotlight as Session Heats Up"**

"Will Texas expand Medicaid under the Affordable Care Act? That's the \$100 billion question at the Capitol this session. The state's Republican leadership says no, but supporters of federal health care reform may be gaining traction. A recent report by former Deputy Comptroller Billy Hamilton indicated that if the state spent \$15 billion on a Medicaid expansion over 10 years, it would get \$100 billion back, and about 231,000 new jobs by 2016.... Of course, there are arguments against expansion. One survey by the Texas Medical Association estimates that about 30 percent of doctors would take new Medicaid patients. Dr. John Holcomb, who has a private practice in San Antonio and works on Medicaid issues for the TMA, attributes the low buy-in to the state's Medicaid reimbursements." ([Texas Tribune](#))

- **"Texas Senate chairman seeks health budget changes"**

"Texas will use "all the money that there is available to spend" in the state budget just paying the health care costs of the growing number of poor, disabled and elderly unless dramatic changes are made to the Medicaid system, the chairman of the Senate Finance Committee said Wednesday. Tommy Williams, R-The Woodlands, called on fellow Texas lawmakers and state agency chiefs to prepare themselves to make tough choices but offered no details on how he would change Medicaid." ([Star-Telegram](#))

## Utah

- **“Gov. Herbert now wants feds to run individual health insurance exchange in Utah”**

“Gov. Gary Herbert said Tuesday he's asked the federal government to handle the newly mandated health insurance exchange for individual consumers while allowing the state to continue to run a similar program for small businesses.... Herbert said the decision to stop negotiations over the state providing the individual health insurance exchange was made in conjunction with lawmakers and representatives of the insurance industry.” ([Deseret News](#))

## Virginia

- **“Virginia Senate could be headed for budget stalemate”**

“Democrats in the evenly divided Senate signaled Sunday that they will try to force another budget stalemate unless the General Assembly agrees to expand Medicaid under the Affordable Care Act.” ([Washington Post](#))

- **“Republican Bolling makes case for expanding Medicaid in Va.”**

“Lt. Gov. Bill Bolling on Thursday came out in favor of expanding Virginia’s Medicaid program, carving out another position that sets him apart from Gov. Robert F. McDonnell and a Republican rival for governor. Bolling, a Republican who is considering an independent bid for governor, laid out in a letter to House and Senate leaders his “business case” for opening the state-federal health-care program to an additional 300,000 low-income Virginians.” ([Washington Post](#))

## Wyoming

- **“Senate rejects Medicaid expansion”**

“Legislation that would have expanded Medicaid to cover thousands more people in Wyoming failed in the state Senate on Thursday. The prospect of saving nearly \$50 million, while extending coverage to about a third of the uninsured population, did not entice lawmakers, who were wary of federal funding promises. Critics also complained that expanding Medicaid was an ineffective method of insuring the poor, although they offered no alternative.” ([Billings Gazette](#))

## National

- **“Health Insurance Companies Get in Shape for 2014”**

“Insurance companies across the country, whether national profit-making players like WellPoint and UnitedHealth Group or nonprofit Blue Cross plans in states like Arizona and Michigan, are undergoing radical change as a result. After years of focusing on selling plans to employers, rather than individual consumers, the insurers must alter course.” ([New York Times](#))

- **“CBO: Medicare Spending Growth Rate Slowest In More Than A Decade”**

“Medicare outlays grew by just 3 percent in fiscal 2012, the slowest rate of growth since 2000, according to a Congressional Budget Office report released Tuesday. And that slower pace of Medicare spending growth is projected to continue, with CBO

analysts estimating relatively modest growth of 4 percent, or \$21 billion, in fiscal 2013.” (CQ HealthBeat)

- **“Reid Appoints Three to Long-Term Care Commission”**

“Senate Majority Leader Harry Reid has appointed three members of a high-level commission that was created in the fiscal cliff law and is charged with making recommendations to Congress on long-term care for the elderly and people with disabilities. Reid, D-Nev., on Monday named Javaid Anwar, a Nevada physician; Laphonza Butler of California, president of the United Long-Term Care Workers Union; and Judy Feder of Virginia, a professor of public policy at the Georgetown Public Policy Institute.” (CQ HealthBeat)

- **“For insurance exchanges, states need ‘navigators’ – and hiring them is a huge task”**

“While some people will find registering for health insurance as easy as booking a flight online, vast numbers who are confused by the myriad choices will need to sit down with someone who can walk them through the process. Enter the “navigators,” an enormous new workforce of helpers required under the law. In large measure, the success of the law and its overriding aim of making sure that virtually all Americans have health insurance depends on these people. But the challenge of hiring and paying for a new class of workers is immense and is one of the most pressing issues as the Obama administration and state governments implement the law. Tens of thousands of workers will be needed – California alone plans to certify 21,000 helpers – with the tab likely to run in the hundreds of millions of dollars.” (Washington Post)

- **“Kathleen Sebelius: Medicaid expansion’s not ‘bait and switch’”**

“In a message targeted at states undecided about expanding Medicaid under the health care law, Department of Health and Human Services Secretary Kathleen Sebelius stressed Monday that the White House won’t back away from its promise to fund the expansions, even amid mounting battles over the federal budget. Sebelius said states hesitant to sign up for the Medicaid expansion under the Affordable Care Act shouldn’t fear that the federal funding commitment will disappear when states boost their Medicaid rolls.” (Politico)

- **“Will states actually enforce Obamacare?”**

“The health-care law will, in 2014, change the insurance industry in myriad ways. Some – like the end of preexisting conditions – are really big changes. Others are smaller, like disallowing waiting periods for employer-sponsored insurance and limits on how much insurers can charge their oldest (and likely sickest) patients. While states have traditionally regulated insurance markets, only 19 have updated their laws to allow them to enforce these new requirements, according to a report out Friday from the Commonwealth Foundation. If states don’t move soon, it could have the federal government playing a far larger regulatory role than initially expected.” (Washington Post)

- **“States Eligible for Medicaid Funding Increase for Preventive Care”**

“States can currently get a higher matching rate for covering preventive care and adult vaccines, Medicaid officials said in a letter to state officials on Friday. As of Jan. 1, the health care law allows states to get a federal matching rate increase of one percentage point if they offer patients free preventive care. It doesn’t matter whether the services are provided by a managed care plan or through a fee-for-service Medicaid system. Preventive Services Recommendations.” (CQ HealthBeat)

- **“CMS Official Pledges Health Exchanges Will Open On Time”**

“With the deadline for the Affordable Care Act's health insurance marketplaces officially eight months away, Gary Cohen, who is overseeing their implementation for the Centers for Medicare and Medicaid Services (CMS), assured health care advocates Thursday that they would open on schedule.... But several sources involved with state exchange planning have recently told *Governing* that they believe CMS is planning for contingencies if that deadline proves impossible.” (Governing Magazine)

- **“Tick, Tock: Administration Misses Some Health Law Deadlines”**

“The Obama administration is late in implementing several provisions of the federal health overhaul intended to improve access to care and lower costs. The programs, slated to take effect Jan. 1, were supposed to increase fees to primary care doctors who treat Medicaid patients, give states more federal funding if they eliminate Medicaid co-pays for preventive services and experiment with changes to how doctors and hospitals are paid by Medicare. The administration also has delayed giving states guidance on a new coverage option known as the "basic health program," designed to help low and moderate-income people who don't qualify for Medicaid. At least one state --Washington -- has already decided to not implement the program in 2014 because it won't have enough time. (Kaiser Health News)

- **“Sperling Says Obama Budget Proposal Won’t Cut Medicaid”**

“White House economics adviser Gene Sperling told a gathering of left-leaning activists Thursday that President Barack Obama’s fiscal 2014 budget proposal would not cut Medicaid even though the administration put as much as \$100 billion in such reductions on the table during the recent deficit reduction negotiations. But that decision means “we’re going to have to look harder for Medicare savings,” he warned.” (CQ HealthBeat)

- **“Federal Rule Limits Aid to Families Who Can’t Afford Employers’ Health Coverage”**

“The Obama administration adopted a strict definition of affordable health insurance on Wednesday that will deny federal financial assistance to millions of Americans with modest incomes who cannot afford family coverage offered by employers. In deciding whether an employer’s health plan is affordable, the Internal Revenue Service said it would look at the cost of coverage only for an individual employee, not for a family.” (New York Times)

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## COMPANY NEWS

- **“WellCare Approved To Expand Staywell Medicaid Services”**

“WellCare Health Plans, Inc. today announced that the Florida Agency for Health Care Administration (AHCA) has approved WellCare of Florida to expand its Staywell Medicaid managed care services. The expansion adds 25 new counties to the company's service area and positions WellCare as the only Medicaid managed care provider offering plans in all 67 Florida counties.” ([WellCare News Release](#))

- **“Kiran Patel to buy St. Petersburg's Universal Health Care Group”**

“Dr. Kiran Patel, one of the best-known players in Tampa Bay health care, emerged Friday as the new buyer of troubled St. Petersburg Medicare provider Universal Health Care Group.” ([Tampa Bay Times](#))

- **“WellCare Completes Acquisition Of South Carolina Medicaid Plan”**

“WellCare Health Plans, Inc. (NYSE: WCG) today announced that it has completed the acquisition of UnitedHealthcare's Medicaid business in South Carolina. On Oct. 31, 2012, WellCare stated that it had entered into an agreement to acquire the plan. The plan operates in 39 of the state's 46 counties, including the Columbia and Greenville metropolitan areas, through the South Carolina Healthy Connections Choices program.... WellCare has also announced the appointments of Dave Shafer to state president, South Carolina, and Kathy Warner to state chief operating officer, South Carolina.” ([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
TBD	District of Columbia	Contract Awards	165,000
TBD	Nevada	Contract Awards	188,000
TBD	Vermont Duals	RFP Released	22,000
TBD	New Mexico	Contract awards	510,000
February 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	Virginia Duals	RFP Released	65,400
March, 2013	South Carolina Duals	RFP Released	68,000
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, 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, 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	California Duals	Implementation	500,000
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		9/1/2013
Colorado	MFFS	62,982					4/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189	Not pursuing Financial Alignment Model				
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012		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	70,000	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			9/1/2013
South Carolina	Capitated	68,000	March 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402			Early 2013		1/1/2014
Virginia	Capitated	65,415	March 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	TBD	3/11/2013	4/1/2013		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
<b>Totals</b>	<b>15 Capitated 7 MFFS</b>	<b>1.7M Capitated 485K FFS</b>	<b>5</b>			<b>3</b>	

\*\* 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.

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## HMA WELCOMES...

### **Marci Eads, Principal - Denver, Colorado**

Marci Eads joined HMA's Denver office on February 1, 2013. Marci comes to us most recently from Climb Consulting where she served as the Owner for the past 9 years. In her role she conducted research, evaluation, and curriculum development/adaptation for national nonprofit organizations, government agencies, and foundations. Her work often involved the development of new initiatives, program and policy development, implementation and improvements as well as organizational expansion efforts. Projects included adaptation of the Women's Policy Institute and evaluation of the effectiveness of the Caring Economy Campaign.

She also comes to us most recently from the University of Colorado as well as the State of Colorado. In her 7 years with the University of Colorado she served as an Adjunct Faculty member for the Graduate School of Public Affairs and, most recently, as a Senior Fellow for the Buechner Institute for Governance. Marci served in several roles with the State of Colorado over the past 5 years to include Director of Dual Eligibles Integration, Manager of Medicaid Reform, Director of the Division of Behavioral Health Data and Evaluation, and Rates Analyst/Director for the Medicaid Infrastructure Grant.

Additionally, her previous experience includes working as the Research Director for OMNI Institute, Assistant Professor for Indiana University of Pennsylvania, Research Director for the Gill Foundation, and Senior Researcher for OMNI Research and Training, Inc.

Marci holds a Ph.D. in Sociology from the University of Colorado as well as a Bachelor of Arts degree from DePauw University.

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## HMA RECENT EVENTS

### **Greg Nersessian Interviewed on Bloomberg Industries**

HMA Principal Greg Nersessian recently sat down with Bloomberg Industries to discuss what's on the horizon in 2013 for state sponsored health care plans. Check out Greg's conversation with Mike Manns at: <https://vimeo.com/58371045>.

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## HMA RECENT PUBLICATIONS

### *"Empanelment in an Accountable Care Environment"*

#### **HMA Accountable Care Institute (ACI)**

**Greg Vachon, MD - Contributor**

**Lori Weiselberg, MPH - Contributor**

A foundation of both the Patient Centered Medical Home (PCMH) model of care and accountable care, "empanelment" is the process of creating and maintaining a relationship between each patient and a primary care provider. This document is a guide to implementing this foundational process in organizations that deliver primary care and are seeking to deliver on the triple aim of accountable care: improved health, better experience, and lower cost. ([Link - PDF](#))

### *"California Hospitals: Buildings, Beds, and Business"*

#### **California HealthCare Foundation**

**Lisa Simonson Maiuro, MSPH, PhD**

**Bret Corzine**

California's 393 general acute care (GAC) hospitals saw 46 million outpatients and discharged 3.5 million inpatients in 2010, while the number of beds available declined to the lowest level in a decade. This report examines the state's GAC hospital facilities including bed supply and capacity, use of services, financial health, and selected quality measures. ([Link - CHCF](#))

### *"The ACA's Impact on Corrections"*

#### **CorrectCare Magazine - National Commission on Correctional Health Care**

**Donna Strugar-Fritsch, BSN, MPA, CCHP - Author**

HMA Principal Donna Strugar-Fritsch maps out what implementation of the ACA means for corrections and those who interact with prisons, jails and ex-offenders, as well as actions corrections officials should consider in this article published in the Fall 2012 issue of CorrectCare, the quarterly magazine of the National Commission on Correctional Health Care. ([Link - PDF](#)) *The article is posted with permission from the Fall 2012 issue of CorrectCare. All rights reserved.*