HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CALIFORNIA HEALTH BENEFITS EXCHANGE QUALIFIED HEALTH PLAN (QHP) SOLICITATION

HMA ROUNDUP: FLORIDA AWARDS MLTC AWARDS TO HUMANA, MOLINA; ILLINOIS POSTS SCHEDULE FOR SPD EXPANSION; PENNSYLVANIA RELEASES CHIP RFP; IMPACT OF MEDICAID EXPANSION STUDIED IN TEXAS, PENNSYLVANIA, INDIANA, MICHIGAN AND FLORIDA

OTHER HEADLINES: CMS DELAYS LAUNCH OF BASIC HEALTH PROGRAM; NEW MEXICO ANNOUNCES MEDICAID MCO CONTRACT AWARDS; COVENTRY, WELLCARE RECEIVE KENTUCKY RATE INCREASES; NORTH CAROLINA, WISCONSIN GOVERNORS REJECTS MEDICAID EXPANSION

HMA WELCOMES:
MARGARET KIRKEGAARD - CHICAGO

FEBRUARY 13, 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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Contents

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IN FOCUS: CALIFORNIA HEALTH BENEFITS EXCHANGE QUALIFIED HEALTH PLAN (QHP) SOLICITATION

This week, our *In Focus* section reviews the California Health Benefits Exchange Qualified Health Plan (QHP) solicitation. The solicitation was released by the Exchange on November 16, 2012, and amended on December 28, 2012. The solicitation will procure the health insurance issuers who will offer QHPs in the Exchange, open for enrollment in October 2013, with enrollment effective January 1, 2014. Issuers, as defined by the solicitation, may be either insurers regulated by the California Department of Insurance or health plans regulated by the California Department of Managed Care. Below we review the bidding process and evaluation process, as well as provide a timeline of key dates in the solicitation and contracting process. As noted in the timeline, the deadline for bidder responses has passed.

The QHP solicitation and appendices are available at:

http://www.healthexchange.ca.gov/Solicitations/Pages/QHPSolicitation.aspx

Bidding Process & Evaluation

Issuers must propose both a geography or geographies to serve, based on region, and a scope of plan offerings within each geography. Proposals must include all four metal tiers for each QHP (Platinum, Gold, Silver, Bronze) as well as a catastrophic plan. Under planned administrative rulemaking to come, proposals must include at least one standard design plan, either the co-pay or co-insurance model. The Exchange has proposed these two standardized plan designs, for which draft versions, dated December 12, 2012, are available on the solicitation website: (Draft Standardized Plan Design)

The solicitation does not provide explicit evaluation criteria, leaving room for consideration of the mix of plans in each rating region. However, there are several high level guidelines for evaluation proposals:

- Affordability is a key priority. Plans that demonstrate a large network will likely equate to maximized enrollment, which the Exchange states will drive lower costs through spreading of risk across a larger population.
- Quality and service will be a major point of the first phase evaluation, with focus on past performance and "value" based on quality.
- Availability of "standard" and "non-standard" plan designs. Selections may be limited with regard to the number of HMO or PPO design plans unless significant, meaningful differences exist between several HMOs or PPOs. This would indicated the Exchange intends to limit the number of plans per region; however, exact limits have not been set or made publicly available.
- Bidders are strongly encouraged to offer plans statewide or across a large geographic area that spans both densely populated regions and underserved rural regions.

- There is also a stated preference for plans with a focus on low-income populations. Demonstrated community partners, FQHC contracts, and investment in providers and networks serving the low-income population are a priority.
- Preference will be given to plans implementing delivery system improvements, such as patient-centered medical homes, quality improvement initiatives, and consumer engagement programs, particularly if bidders have demonstrated success.

Timeline

Per the timeline below, the window has already closed for issuers wishing to bid on offering QHPs in the Exchange for 2014. However, because of the process of evaluation and certification, many milestones still remain. This timeline may also provide insight into the QHP solicitation process to come in other states.

Milestone	Date
Final Solicitation Released	November 16, 2012
Bidder responses due	January 23, 2013
Submission of Essential Community Provider Network information	February 15, 2013
Submission of provider network documents to regulators	February 28, 2013
Submission of price proposals	March 31, 2013
Winning bidders selected	April 1, 2013
Execute contracts with certified QHPs	June 30, 2013
Open enrollment period begins	October 1, 2013
Enrollments effective	January 1, 2014

HMA Medicaid Roundup

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Additional Managed Long Term Care Awards Posted. Following the initial January announcement of LTC awards, the state has posted additional awards as of February 12, 2013. Humana Medical Plan was given LTC awards in regions 4, 10, and 11, while Molina Healthcare of Florida secured awards in regions 5, 6 and 11. The complete listing of awards by region appears below.

Statewide Medicaid Managed Care (SMMC)
Long Term Care Awards

Plan Name	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11	Total
American Eldercare	X	X	X	X	X	X	X	X	X	X	X	11
Amerigroup										X	X	2
Coventry Healthcare of Florida, Inc.						X	X		X		X	4
Humana Medical Plan, Inc				X						X	X	3
Molina Healthcare of Florida, Inc.					X	X					X	2
Sunshine State Health Plan	X		X	X	X	X	X	X	X	X	X	10
United Healthcare		X	X	X	X	X	X	X	X		X	9
Total Number of Plans	**2**	**2**	**3**	**4**	**4**	**5**	**4**	**3**	**4**	**4**	**7**	**41**

Select Committee on PPACA. The Senate Select Patient Protection and Affordable Care Act (PPACA) Committee met on February 11, 2013, to discuss Medicaid expansion. The committee heard from representatives of the Georgetown University Health Policy Institute, the Florida Center for Fiscal and Economic Policy, and the University of Florida, who discussed the economic benefits of expanding Medicaid. A panel of hospital executives likewise supported the Medicaid expansion and discussed the impacts of the federal health care law (i.e., the implications for treating the uninsured, providing charity care, and DSH) on their hospitals.

The committee also heard from representatives of the Foundation for Government Accountability and the Commissioner from the Maine Department of Health and Human Services, who opposed Medicaid expansion. They shared "lessons learned" from Arizona and Maine's experiences with expanding coverage to childless adult Medicaid recipients. Both states experienced higher enrollments and costs than originally estimated, and they did not see significant reductions in the uninsured. Finally, the committee heard public testimony from individuals, all of whom supported the Medicaid expansion.

The Senate Select PPACA Committee is scheduled to meet on Monday, February 19, when it will discuss the impacts on State Group Health Insurance as well as other insurance regulations. The House Select PPACA Committee meets on Monday, February 18, 2013, and will discuss the Medicaid expansion in other states, the impact on hospitals, and the impact on the provider workforce.

Managed Medical Assistance. The Agency for Health Care Administration held a well-attended vendor conference on February 12, 2013, related to the Managed Medicaid Assistance (MMA) program. Formal written responses to questions will be available February 26, 2013. The MMA program is the second managed care procurement that has been issued to transition the Medicaid program to statewide managed care.

The MMA program will provide primary and acute health care services to an estimated 2.9 million individuals including TANF, SSI, hospice, low-income families and children, institutional, dual eligibles, and the medically needy. Florida recently received approval of the LTC managed care program that provides long term care services to the elderly and disabled. The MMA Invitation to Negotiate (ITN) was issued December 28, 2012; responses are due March 15, 2013, with contract awards tentatively slated for September 16, 2013. Contracts will begin on January 1, 2014, with a five-year contract term through the end of 2018. Enrollment will be phased in beginning October 2014 through April 2015.

In the news

- **"Medicaid Expansion Can Backfire: Witnesses"**

  "Cautionary tales of how two states expanded their Medicaid programs in the past and lived to regret it made a big impression on members of the Florida Senate Select Committee on the Patient Protection and Affordable Care Act…. Tarren Bragdon, president and CEO of the conservative Foundation for Government Accountability, showed graphs displaying how fast the enrollment and expenses went up in Arizona and Maine after those states extended coverage to childless adults under the poverty

level. Covering those adults turned out to be 2 1/2 times more costly than the forecast, he said." (Health News Florida)

- **"Florida enhances program for disabled children"**

  "Florida health officials said Monday they will assign care coordinators to about 1,600 children with disabilities amid allegations from federal health officials that the state was cutting in-home services and essentially forcing kids into adult nursing homes. An individual care coordinator will work with no more than 40 disabled children at a time who are receiving in-home nursing services and ensure they have continued access to those services. The Agency for Health Care Administration said it will begin the transition within 90 days." (Associated Press)

- **"Medicaid Transformation Watched Closely In Florida"**

  "This week the federal government signed off on the first part of a plan that could eventually steer more than 3 million low-income Floridians on Medicaid into a managed care, or HMO system. The decision comes two years after Florida lawmakers approved the conversion in an attempt to control costs in the $21 billion program." (Kaiser Health News)

- **"Investigation finds pattern of financial mismanagement at Universal Health Care"**

  "Universal Health Care Inc., the troubled St. Petersburg Medicare insurer run by Dr. A.K. Desai, has been subjected to "a pattern of mismanagement" and illegal financial conduct that rendered it "insolvent or about to become insolvent," forcing regulators to seize control, a state investigation has found." (Tampa Bay Times)

Georgia

HMA Roundup – Mark Trail

January Revenues Up 10.4% Largely on Individual Tax Receipts. Governor Nathan Deal announced net January tax receipts of $1.73 billion, which represented growth of nearly $164 million year-over-year, or 10.4%. Over the last seven months, tax receipts are up about 5.7% year-over-year. The single biggest driver of overall tax receipts is the $143.25 million year-over-year growth in individual income tax receipts, representing 16.3% growth. Sales and use taxes were essentially flat compared to January 2012. However, corporate income tax collections ballooned $18.25 million, or 710%, over the year.

Deal Signs Provider Tax. At the Georgia Hospital Association's Annual Meeting, Governor Deal signed Senate Bill 24, which will authorize the Department of Community Health to implement a hospital provider fee and secure additional Federal matching dollars for the state's Medicaid program. Georgia's FY 2013 budget allocates $235 million in hospital provider fees and $454 million in Federal Medicaid matching funds associated with the fee.

In the news

- **"Medicaid changes may bring new jobs"**

  "A Medicaid expansion in Georgia would create 70,000 new jobs — more than half in health care — and produce an economic impact statewide of $8 billion a year, says a new report obtained by The Atlanta Journal-Constitution…. The $8 billion in annual economic impact would touch every corner of Georgia, from the largest cities and major hospitals to rural areas where tiny hospitals are struggling to survive. The new federal Medicaid dollars would result in about 38,000 new jobs for doctors, nurses and other health practitioners and support staff, the report forecasts. It found that other industries, including real estate and restaurants, would also benefit as the dollars from the new jobs ripple through the economy." (Atlanta Journal Constitution)

- **"Report: Talks break down on mega state Medicaid contract"**

  "Georgia officials have halted negotiations on a multimillion-dollar contract for a new electronic eligibility system for Medicaid and other health programs, reports Georgia Health News. The action follows months of negotiating with the highest-scored vendor, which industry officials identified as Deloitte, GHN said." (Atlanta Business Chronicle)

Illinois

HMA Roundup – Matt Powers and Jane Longo

This week, the Department of Healthcare and Family Services (HFS) posted a timeline and plan selection for the roll-out of additional regions in the Medicaid Integrated Care Program (ICP). The ICP serves non-dual Medicaid seniors and persons with disabilities (SPDs) under mandatory managed care enrollment. The program currently operates in the Chicago Suburbs and surrounding counties, with Aetna and IlliniCare (Centene) serving roughly 36,000 SPDs in the region. Beginning April 1, 2013, the ICP will roll-out in four additional regions, encompassing approximately 27,000 new SPD enrollees. The plans selected are all current ICP plans, contract winners in the MMAI (duals) RFP, or awarded contracts in the complex adults care coordination RFP for CCEs and MCCNs. Roll-out schedule:

- **Rockford Region** - Winnebago, Boone, and McHenry counties
  - April 1, 2013 – Service Package I; July 1, 2013 – Service Package II
  - 5,000 SPDs to be served by Aetna and IlliniCare, as well as Community Care Alliance of Illinois (MCCN)
- **Central Illinois Region** - McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, Knox, Peoria, Stark, and Tazewell counties
  - July 1, 2013 – Service Packages I, II
  - 13,000 SPDs to be served by Molina and Health Alliance in all counties, Meridian Health Plan in Knox, Peoria, Stark, and Tazewell counties, and Macon County Care Coordination (CCE) in Macon county only

- **Quad Cities Region** - Rock Island, Mercer, and Henry counties
    - July 1, 2013 – Service Packages I, II
    - 1,900 SPDs to be served by HealthSpring, IlliniCare, and Precedence (CCE)
- **Metro East Region** - Madison, Clinton, and St. Clair counties
    - July 1, 2013 – Service Packages I, II
    - 7,000 SPDs to be served by Molina and Meridian Health Plan

In the news

- **"HHS partners with Illinois on health insurance marketplace"**

  "During a visit with Illinois Governor Pat Quinn to the Erie Health Center in Chicago today, Health and Human Services (HHS) Secretary Kathleen Sebelius announced that Illinois has been conditionally approved to operate a State Partnership Marketplace (Exchange), which will be ready for open enrollment in October 2013. This partnership will allow Illinois to make key decisions and tailor the marketplace to local needs and market conditions." (HHS News Release)

Indiana

HMA Roundup – Cathy Rudd

Hospital Association Estimates $3.4 Billion in Additional Economic Growth from Medicaid Expansion. On Monday, February 11, 2013, the Indiana Hospital Association released a study on the impacts of Medicaid expansion that diverge meaningfully from a prior study commissioned by former Governor Daniels. The IHA study—conducted by the University of Nebraska Center for Health Policy—estimates more than $10 billion in funding from the Federal government under Medicaid expansion from 2014 to 2020, which could generate an additional $2.4 billion to $3.4 billion in economic activity and 30,000 additional jobs in the state. Moreover, this report projects that Indiana would bear about $500 million in additional costs over seven years to add more than 400,000 residents to the Medicaid rolls, far lower than the worst case scenario presented by the state's Milliman study, which projects as much as $2.6 billion in additional state spending. Finally, the study estimates that each Indiana family covered under private plans would save about $677 annually because of the reduction in cost-shifting associated with uncompensated care.

In the news

- **"Study: Expanding Medicaid adds $3.4B to Indiana economy"**

  "Expanding Indiana's Medicaid program under the Affordable Care Act would create up to $3.4 billion in economic activity, according to a report released today by the University of Nebraska Medical Center for Public Health…. The study, commissioned by the Indiana Hospital Association, estimates moving forward with expansion would result in about $108 million in state and local tax revenue annually, and support 30,000 jobs through 2020. The expansion would benefit from 300,000 to 400,000 uninsured Hoosiers, according to various studies. The report speculates that

by decreasing the number of uninsured Hoosiers, people who have their own private insurance would save $236 and families would save $677 in annual premiums beginning in 2014." (Indianapolis Star)

- **"Pence rules out Medicaid expansion in current form"**

  "Gov. Mike Pence is ruling out expanding Medicaid under the federal health care law unless Indiana gets approval to use state health savings accounts for the expansion. Pence told reporters Wednesday that the only way he would approve a Medicaid expansion would be if the state is given the choice of using its Healthy Indiana Plan to cover new enrollees." (Post-Tribune)

Michigan

HMA Roundup – Esther Reagan

Executive Budget Recommendation for 2013-2014.

This past week, Michigan Governor Rick Snyder revealed his Fiscal Year (FY) 2013-2014 Executive Budget Recommendation. The Governor's Recommendation, across all state departments, would appropriate $51.8 billion in total funding, of which $9.2 billion is State General Fund (GF). If appropriated, this budget would represent a small increase ($52.4 million or less than 1.0%) in State GF expenditure for the upcoming fiscal year. Included in the Governor's proposal is the expansion of Medicaid eligibility up to 138 percent FPL, as prescribed under the ACA.

Proposed Michigan Department of Community Health Appropriation

The proposed FY 2013-2014 appropriation for the Michigan Department of Community Health (DCH) was $16.6 billion Gross/$2.7 billion GF. The Governor's proposal would represent a dramatic increase (nearly 11.0%) in total funding available to DCH. This increase was almost fully driven by Governor Snyder's recommendation to implement the Medicaid coverage expansion authorized through the Federal Affordable Care Act (ACA). Detailed below is a summary of the major changes included in Governor Snyder's recommendation for DCH.

The FY 2013-2014 recommended appropriation would provide over $11.0 billion Gross/$1.2 billion GF to support Michigan's Medicaid program. Major changes to the program would include expansions of covered populations, as allowed through the Federal ACA, needed base adjustments to the current program, and efforts to expand children's access to Medicaid-funded dental services.

Proposed Changes to Current Medicaid Program

- **Integrated Care Organizations:** The Executive recommendation includes a placeholder line of $100 to fund Integrated Care Organizations that would be responsible for the care of individuals served by both Medicaid and Medicare under the proposed Integrated Care for Dual Eligibles (ICDE) demonstration project. The FY 2013-2014 budget reverses the assumed savings from the ICDE initiative that were reflected in the last two budgets. It would appear the Governor is waiting to see what happens with this initiative in the selected demonstration

sites of Wayne County, Macomb County, the Upper Peninsula, and Southwest Michigan.

- **Caseload, Utilization, and Inflation:** The Executive recommendation accounted for slower-than-anticipated growth in Medicaid program cost in the current fiscal year and projected modest growth in the current base Medicaid program through FY 2013-2014. **($644,100 Gross / $4.9 million GF)**
- **Medicaid Managed Care Rate Adjustments:** The recommendation would fund adjustments in capitation payments made to Medicaid Managed Care Organizations (2.5%) and Pre-Paid Inpatient Health Plans (mental health managed care providers) (1.25%). **($112.7 million Gross / $37.9 million GF)**
- **Healthy Kids Dental Expansion:** The recommendation would fund an expansion of the Medicaid Healthy Kids Dental program to Ingham, Washtenaw, and Ottawa counties (leaving only five counties where the program is not available – Kalamazoo, Kent, Macomb, Oakland, and Wayne). **($11.6 million Gross / $3.9 million GF)**
- **Graduate Medical Education (GME):** The current year appropriation made $4.3 million in "one-time" funding available for Medicaid GME payments to hospitals. This payment is not included in the Recommendation. **($4.3 million Gross)**
- **Special Indigent Care Payments:** Disproportionate Share Hospital payments related to Indigent Care Agreements (ICA-DSH) are reduced to $23.9 million for FY 2013-2014, reflecting an end of this program as of December 31, 2013. (The ACA reduces DSH funding for states beginning in 2014. The Secretary of the US Department of Health and Human Services has not yet released the rules that would enable Michigan to know exactly the dollar value by which Michigan's DSH capacity is being reduced.)

Proposed Expansion of Medicaid Eligibility

The Executive Budget Recommendation would fund the Governor's proposal to expand Medicaid coverage to all eligible adults under 138% of the Federal Poverty Level. This expansion on January 1, 2014, would be fully funded by the Federal government and is projected to increase the Medicaid program caseload by about 330,000 in FY 2013-2014 and by nearly 420,000 in FY 2014-2015. By 2017, Michigan would be required to provide limited match funding toward the Medicaid expansion (5.0% of eligible costs) with an anticipated 10% match requirement in 2020 and beyond. Detail behind the proposed expansion of Medicaid revealed the following Executive assumptions for the nine-month period from January to September 2014:

- Enrollment of 320,000 "newly eligible" Medicaid beneficiaries would increase Federal support for Michigan's Medicaid program by $1.3 billion.
- Additional Federal Medicaid funds would offset current State-funded mental health, substance abuse, public health, family planning and correctional health initiatives, reducing State GF expenditure in FY 2013-2014 by $181.0 million.
- Mental health funding for the expansion population is proposed at $288.6 million for the last nine months of FY 2013-2014. This level of spending would be more

than double the proposed $152.9 million reduction in GF spending for mental health services.

- A deposit of 50% of all identified GF savings achieved by the State as a result of the Medicaid expansion into a health savings fund. These savings would then be used to fund the State's Medicaid match requirements in 2017 and beyond.

The Michigan Legislature will now work with the proposal outlined above. In the weeks ahead, appropriations subcommittees in both the Michigan House of Representatives and Senate will generate their own proposed FY 2013-2014 spending plans. It is likely that a great deal of discussion will be centered around the DCH appropriation, in particular the proposal to expand Medicaid eligibility.

New Mexico

HMA Roundup

Last Friday, New Mexico's Human Services Department (HSD) announced contract awards in the Medicaid redesign RFP, known as Centennial Care. The RFP sought to consolidate the state's separate Medicaid managed care program, Medicaid managed long term care (MLTC) program, and managed behavioral health program under a single coordinated Medicaid managed care contract. Although no longer pursuing a dual eligibles financial alignment demonstration project with federal CMS, the Centennial Care program will cover dual eligibles in New Mexico and awardees will be required to be D-SNP or Medicare Advantage plans. The awarded plans were:

- UnitedHealthcare Community Plan of New Mexico
- Blue Cross Blue Shield New Mexico
- Molina Health Care of New Mexico, Inc.
- Presbyterian Health Plan, Inc.

Blue Cross Blue Shield, Molina, and Presbyterian were incumbents in the state's Medicaid managed care program, while United was an incumbent in the MLTC program. Lovelace Community Health Plan, a managed care incumbent, and Amerigroup, a MLTC incumbent, were unsuccessful in their bids. Link to press release: (PDF). We previously reviewed the Centennial Care RFP in our September 5, 2012 Weekly Roundup.

New York

HMA Roundup – Denise Soffel

New York Waiver Amendment Funding in Jeopardy. The Department of Health has been working aggressively to address the fallout caused by a congressional report prepared by Representative Issa, Chair of the Committee on Oversight and Government Reform. The report—leaked to the press last week—alleged mismanagement and waste of federal money over many years in New York's Medicaid program. New York has been engaged in negotiations with CMS regarding the state's request for financial support for its Medicaid Redesign efforts, seeking $10 billion over five years to invest in system redesign. Complicating matters, and creating a further fiscal predicament, is the federal gov-

ernment's finding that, for 20 years, New York overcharged Medicaid for the care of developmentally disabled people. It is estimated that the state overcharged Medicaid by $15 billion, although CMS reviewed and approved the state's reimbursement approach multiple times over that time period. The Issa report highlights the overpayments to the developmental disability centers as one of a number of problems in New York's Medicaid program. As a result of meetings between state officials and the NYS Congressional delegation, the report has not been publicly released, although its impact is being felt. The report complicates efforts to secure CMS approval for the $10 billion waiver amendment request and places the reform efforts both planned and underway in New York in jeopardy.

Joint Legislative Hearing on For-Profit Hospitals. On Friday, February 8, 2013, members of the Brooklyn delegation to the New York Assembly and Senate heard testimony on the potential entry of for-profit hospitals into the state—in light of the challenging environment for Brooklyn's hospitals—featuring testimony from a private equity executive. Stephen Berger, chairman of Odyssey Investment Partners, testified that he would not recommend private ownership of for-profit hospitals at this time. He suggested that there might be alternative sources of capital, such as healthcare REITs, in contrast to hedge funds or private equity firms, as "they don't take the long view." Separately, other speakers questioned why the state would allow the closing of Long Island College Hospital rather than actively pursuing alternatives such as a sale to larger hospital systems.

New York State Issues Request for Applications for In Person Assistor / Navigator Program. The New York State Department of Health (DOH) issued a request for application for participation in the New York Health Benefit Exchange (NYHBE) In Person Assistor (IPA)/Navigator Program. The IPA/Navigator Program will provide in-person, culturally competent, linguistically appropriate and disability-accessible health insurance application assistance. Approximately $27.2 million will be available annually for a period of five years for this program. The RFA is posted and available for download on DOH's public website at: http://www.health.ny.gov/funding/

In the news

- **"NY hopes to add 500,000 residents to Medicaid"**

  "With New York's Medicaid coverage already broader than federal law requires, the state expects to add about 75,000 more people to the program next year under the health care overhaul, plus another 425,000 who are already eligible but don't know it. Medicaid, the government health insurance program for the poor, currently covers 5.1 million New Yorkers, more than one-fourth of the state's residents. The income threshold to qualify for most programs is already above the federal poverty line." (Wall Street Journal)

North Carolina

HMA Roundup

The North Carolina Department of Health and Human Services (DHHS), Division of Medical Assistance (DMA), seeks to slow cost growth and improve quality for its $13 billion Medicaid program. DHHS has issued a request for information (RFI), due by Febru-

ary 14, 2013, regarding innovative system and payment reforms that are market-based, use North Carolina community-based providers, increase personal responsibility, deliver optimal levels of benefits, provide fiscal predictability, generate savings, and offer incentives to deliver care in the right setting. DHHS aims to learn about innovative reimbursement approaches and incentives that deliver meaningful results and improve the health of the state's citizens and lawful residents.

In the news

- **"North Carolina Governor Rejects Medicaid Expansion"**

  "North Carolina Gov. Pat McCrory on Tuesday became the 12th GOP governor to reject an expansion of Medicaid. The state will also rely on the federal government to run its exchange. McCrory joins a band of other Southern Republicans to say he will not broaden the health care program for the poor next year." (CQ HealthBeat)

- **"NC House debating holdback on health care overhaul"**

  "Gov. Pat McCrory and North Carolina House Republicans sound united on refusing to expand Medicaid coverage next year through the federal health care overhaul in part because they say state Medicaid problems should be fixed first. The full House was expected to debate and vote Wednesday on legislation blocking any Medicaid expansion to 500,000 people and leaving the federal government to operate an online marketplace for private health insurance." (Winston-Salem Journal)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

Department of Public Welfare Explains Opposition to Medicaid Expansion. Last week, the Department of Public Welfare released a "fact sheet" that laid out its opposition to Medicaid expansion. The Pennsylvania Medicaid program, often referred to as the Medical Assistance program, accounts for 75% of the DPW's annual $27.6 billion budget (including state, federal and other funds) and represents the budget's top cost driver at 30 percent of Pennsylvania's General Fund. The DPW estimates that Medicaid expansion would add over 800,000 new enrollees into the program – bringing Medicaid participation to nearly a quarter of all Pennsylvania residents. DPW argues that the premise of 100% Federal funding for the costs of expansion are misleading because that does not apply to current Medicaid recipients, the "woodwork" effect of new enrollees who are already eligible for the current Medicaid program, and incremental beneficiaries who dropped out of employer-sponsored coverage in favor of Medicaid coverage. DPW forecasts Medicaid expansion would require an additional $1 billion in Pennsylvania taxpayer dollars taxpayers through FY 2015-2016, rising to over $4.1 billion in total new state taxpayer dollars by the end of FY 2020-2021.

State Issues "Invitation for Bids" for CHIP Program. The State Department of General Services (DGS) has issued an "Invitation for Bids" for qualified health plans interested in serving children in the state's CHIP program. Awards will be made to all responsible and responsive bidders. Bid submissions are due on March 25, 2013. The Pennsylvania CHIP program provides coverage to approximately 190,000 children. Currently there are nine health plans serving this population throughout the state including Highmark, Aetna,

Geisinger, Capital Blue Cross, and Blue Cross and Blue Shield of NE PA among others. Here is a link to the solicitation from DGS. Link

Breast and Cervical Cancer Prevention and Treatment (BCCPT) Coverage Shifts to Managed Care. The Department of Public Welfare sent a notice last month to approximately 1,700 women receiving Medical Assistance benefits through the BCCPT program that, as of March 1 2013, they will receive their benefits through Medicaid managed care plans under the Health Choices program. Currently, BCCPT benefits are paid through Pennsylvania's Fee for Service program. This shift is consistent with an overall migration of Medical Assistance coverage to the Health Choices program.

Texas

HMA Roundup – Dianne Longley

Senator Ellis Authors Joint Resolution to Put Medicaid Expansion on the Ballot. Senate Joint Resolution 8 was introduced by Senator Rodney Ellis, a Democrat from Harris County. This resolution proposes amending the Texas constitution by adding Section 74, which would require the state to provide Medicaid coverage to anyone for whom the Federal Government provides matching funds to cover. The bill would require a two-thirds majority vote in each chamber of the Texas legislature before being put on the ballot in November 2013 for direct voter consideration. Since joint resolutions are not submitted to the governor, vetoes are not possible.

Study Projects Medicaid Expansion Would Create Economic Multiplier Effect in Texas. A study released by Texas Impact and Methodist Healthcare Ministries of South Texas—and prepared by Billy Hamilton Consulting—estimates that Medicaid expansion in the state would yield $16 billion to $38 billion in Federal Medicaid matching funds from fiscal 2014-2017, with incremental economic activity of $40 billion to $94 billion over the same time frame. That additional economic activity is projected to generate an additional $1 billion to $2.5 billion in state tax receipts, offsetting 44% to 56% of the incremental state spending on a Medicaid expansion. The study reiterates that the state ranks first in the nation for its share of uninsured residents at 23.8% in 2011, or 6 million people.

In the news

- **"Dallas County Urges Texas to Expand Medicaid"**

  "Dallas County officials adopted a resolution on Tuesday morning urging Texas legislators to extend Medicaid benefits to impoverished adults under the Affordable Care Act." (Texas Tribune)

- **"House to take up $4.5 billion Medicaid IOU next week"**

  "The House Appropriations Committee on Monday unanimously approved House Bill 10, an emergency appropriations bill whose primary purpose is to cover the $4.5 billion unpaid Medicaid tab. In 2011, lawmakers paid for only 18 months of Medicaid expenses as they tried to balance the budget without raising taxes or using the rainy day fund. Medicaid will have to stop paying doctors, hospitals and nursing homes if the bill is not signed into law by mid-March, said House Appropriations Chairman Jim Pitts, R-Waxahachie." (Austin Statesman)

OTHER HEADLINES

Arizona

- **"Judge rules against co-pays for Arizona Medicaid"**

  "A federal judge has again rebuffed efforts by the state to justify co-pays for medical care on some adults in Arizona's Medicaid program. Judge David Campbell said there was no evidence that U.S. Health and Human Secretary Kathleen Sebelius, who approved the charges, actually considered evidence that the payment requirements can cause harm to patients who might forego otherwise needed care." (Arizona Daily Sun)

California

- **"State lacks doctors to meet demand of national healthcare law"**

  "As the state moves to expand healthcare coverage to millions of Californians under President Obama's healthcare law, it faces a major obstacle: There aren't enough doctors to treat a crush of newly insured patients. Some lawmakers want to fill the gap by redefining who can provide healthcare. They are working on proposals that would allow physician assistants to treat more patients and nurse practitioners to set up independent practices. Pharmacists and optometrists could act as primary care providers, diagnosing and managing some chronic illnesses, such as diabetes and high-blood pressure." (Los Angeles Times)

Kansas

- **"KanCare pilot project launched but opposition to DD "carve-in" persists"**

  "After months of advisory committee haggling over what it should look like, state officials say they are ready to launch the pilot program that will pave the way for including long-term services for the developmentally disabled in the new KanCare program. Now, all they need to start the pilot are participants. A recruiting letter went out Friday, seeking organizations and individuals willing to volunteer, but representatives from the state's developmental disability organizations said doubts remain strong among their members about the pilot in particular and KanCare in general." (Kansas Health Institute)

Mississippi

- **"Feds reject Mississippi proposal to create state-run health insurance exchange"**

  "Mississippi Insurance Commissioner Mike Chaney says federal officials have rejected the state's proposed health insurance exchange…. Chaney submitted an exchange proposal to the U.S. Department of Health and Human Services in mid-November. Gov. Phil Bryant objects to the federal healthcare law and sent two letters to Health and Human Services Secretary Kathleen Sebelius trying to block Chaney's proposal. Bryant and Chaney are both Republicans. While HHS hasn't yet detailed why the blueprint was denied, federal rules state that a coordination strategy with other agencies must be developed and documented." (Washington Post)

Washington

- **"Inslee: It's time to embrace Medicaid expansion"**

  "Washington Gov. Jay Inslee says it's time to move ahead with expanding Medicaid coverage in the state. Inslee said Wednesday the expansion laid out under President Barack Obama's health care law is a good financial deal for the state. Republicans have expressed concern that the federal government may eventually lower its commitment to the program, leaving states paying the bill." (The News-Tribune)

Wisconsin

- **"Can Wisconsin expand coverage without Medicaid? Governor Walker thinks so"**

  This Washington Post blog post discusses Gov. Scott Walker's decision not to expand Medicaid, and instead cut Medicaid eligibility to 100% FPL, while shifting everyone above 100% FPL into the Exchanges. Gov. Walker cites the assumption that the enhanced federal matching rates for the Medicaid expansion will be cut in the future. (Washington Post)

- **"Scott Walker to back limited but not full expansion of BadgerCare"**

  "Gov. Scott Walker will not pursue a full expansion of the state's BadgerCare program as foreseen under the federal health care law, seeking instead a more limited expansion of coverage. A source familiar with the proposal confirmed some of the broad outlines of the proposal on Medicaid health programs that Walker is expected to make at an event Wednesday afternoon in Madison." (Milwaukee Journal-Sentinel)

National

- **"$2 Billion Medicaid Program Helps Mostly Illegal Immigrants"**

  "[A] little-known part of the state-federal health insurance program for the poor has long paid about $2 billion a year for emergency treatment for a group of patients who, according to hospitals, mostly comprise illegal immigrants. Most of it goes to reimburse hospitals for delivering babies for women who show up in their emergency rooms, according to interviews with hospital officials and studies. The funding -- which has been around since the late 1980s and is less than 1 percent of the cost of Medicaid -- underscores the political and practical challenges of refusing to cover an entire class of people." (Kaiser Health News)

- **"Boehner, McConnell Select Long-Term Care Commission Members"**

  "Congressional Republican leaders have selected six more members of the new commission on long-term care, leaving only President Barack Obama to make his picks to the panel charged with coming up with solutions to this problem. Speaker John A. Boehner has named Judy Brachman of Bexly, Ohio, national co-chairwoman of the Jewish Federations of North America's Aging and Family Caregiving Committee; Stephen Guillard of Chatham, Mass., a health care executive; and Grace-Marie Turner of Alexandria, Va., president of the Galen Institute, a right-leaning think tank. According to a GOP source, Senate Minority Leader Mitch McConnell has selected Bruce D. Greenstein, secretary of the Louisiana Department of Health and Hospitals;

Neill Pruitt Jr. of Atlanta, a former skilled nursing facility executive; and Mark Washofski, an official in the Treasury Department during the George W. Bush administration." (CQ HealthBeat)

- **"Seizing Medicaid Expansion as a Means to Reform"**

  "Just two states have governors who are physicians. Democrat John Kitzhaber of Oregon is an emergency room doctor. Republican Robert Bentley of Alabama is a dermatologist. Their states may have little in common, but the medically trained governors have embraced similar Medicaid reforms…. Launched last year, Oregon's current Medicaid plan relies on local health care organizations to coordinate all forms of health care, from acute medical services to mental health and dental care, all in an effort to lower costs and improve health. Basically, the local entities, which may be headed by a hospital, physician group, community service provider or a managed care organization, are given a budget and challenged to beat it. If costs exceed the budget, the organization takes the loss. Alabama lawmakers will soon consider a proposal from Bentley for a Medicaid overhaul based in part on Oregon's groundbreaking "community care organizations." Although Bentley has said he would not support an expansion of Medicaid "under its current structure," the expected reforms are seen as paving the way for a possible expansion as early as 2015." (Stateline)

- **"Forget the governors: Are doctors ready for the Medicaid expansion?"**

  "Republican governors have plenty to worry about with the health-care law's Medicaid expansion, ranging from the political fallout for supporting a key pillar of Obamacare to the risk of expanding an entitlement program only to face cuts down the line. There's one other factor that also weighs heavy on their minds: If they expand Medicaid, bringing 17 million new patients into the system, will there be enough doctors to see them? It's one thing to give out new insurance cards. It's quite another to ensure that the new card guarantees access to health-care providers." (Washington Post)

- **"CMS Officials Postpone Basic Health Program for One Year"**

  "Federal officials are delaying until 2015 the Basic Health Program, a health care overhaul option that would allow states to use federal tax subsidies to help cover low-income people whose income is too high to qualify for Medicaid. The program is an alternative to offering that population coverage in the exchanges that will begin operating in January 2014 under the overhaul. It is intended to help those with incomes between 139 percent and 200 percent of the federal poverty level. The delay in the start of the program was explained in a "frequently asked questions" document from the Centers for Medicare and Medicaid Services." (CQ HealthBeat)

COMPANY NEWS

- **"Health Management Associates, Inc. Executes Definitive Agreement to Joint Venture Bayfront Health System, St. Petersburg, Florida"**

  "Health Management Associates, Inc. announced that a subsidiary has executed a definitive agreement to partner with the 480-bed Bayfront Health System, located in St. Petersburg, Florida. The transaction is subject to the execution of a lease agreement between the partnership and the City of St. Petersburg, as well as customary regulatory approvals." (HMA, Inc. News Release)

- **"WellPoint Names Swedish Chief Executive Officer"**

  "WellPoint, Inc. announced that its board of directors has elected Joseph Swedish as the company's new chief executive officer, effective March 25, 2013. Swedish, 61, who most recently served as President and Chief Executive Officer for Trinity Health Corporation, succeeds interim chief executive officer John Cannon." (WellPoint Press Release)

- **"Coventry secures rate increase for Kentucky Medicaid"**

  "Coventry Health Care Inc. has secured a rate increase for its money-losing contract in Kentucky. MarketWatch reports that the company, one of three that began covering Kentucky Medicaid patients outside the Louisville area in late 2011, said in a Monday regulatory filing that it has agreed with the state to boost rates by 7 percent for each year left on the contract, which runs through late 2014. MarketWatch adds that analysts believe the rate increases could make the company's state Medicaid plan profitable by the end of the year." (Business First)

- **"HealthCare Partners seeks license to operate as managed-care plan"**

  "HealthCare Partners, the medical-group giant acquired last year by dialysis chain DaVita Inc. for $4.4 billion, is seeking a state license to operate as a managed-care plan after questions were raised about its compliance with California law." (Los Angeles Times)

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
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	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	TBD	TBD		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	**15 Capitated 7 MFFS**	**1.7M 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…

Margaret Kirkegaard, M.D. , Principal – Chicago, Illinois

Margaret comes to us most recently from Illinois Health Connect where she served as the Medical Director for the past seven years. In her role, Margaret was responsible for the design and implementation of Illinois Health Connect, a statewide, start-up medical home program that serves 1.9 million Illinois Medicaid enrollees and has achieved a 90+% client satisfaction rate over three years. She was responsible for network development, physician recruitment, and practice transformation to the medical home model for 5,700 primary care providers and 2,300 specialist providers. Additional responsibilities included developed quality management tools such as a pay-for-performance program, provider profiles, and monthly patient rosters with clinical data.

Prior to her role with Illinois Health Connect, Margaret served in several teaching capacities with Midwestern University/Chicago College of Osteopathic Medicine. She also served in several teaching capacities with Hinsdale Family Medicine Residency from 2002 to the present. Margaret worked in private practice as a Family Medicine Physician with Bolingbrook Family Medicine from 1992 – 1999.

She received her M.D. from the University of Minnesota and completed her Family Medicine residency at Hinsdale Family Practice Residency. Margaret holds a Masters of Public Health with a concentration in Health Policy/focus on Quality Improvement from Benedictine University as well as a Bachelor of Arts degree, majoring in Chemistry and Classics, from Saint Olaf College.

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.

HMA Recent Publications

"Finance: A Guide to Safety Net Provider Reimbursement"
HMA Accountable Care Institute (ACI)

Doug Elwell, MSA – Contributor
Art Jones, MD – Contributor
Gaylee Morgan, MPP – Contributor
Steven M. Perlin, MBA – Contributor

The prevailing healthcare reimbursement system in the United States has failed to create effective incentives for providers to improve quality and contain costs. The current system has rewarded volume over value and has discouraged providers from working together toward improved health for the populations they serve. These issues are even more acute within the safety net, which faces stronger incentives to increase volumes to compensate for reimbursement rates that are often well below the cost of providing care. This paper describes key concepts that must be part of a value-based reimbursement system and describes how value-based reimbursement creates strong incentives for the development of effective, accountable delivery systems. (Link - PDF)

"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)