HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: THE FINANCIAL ARGUMENT FOR MEDICAID EXPANSION IN TEXAS

HMA ROUNDUP: FLORIDA HOUSE COMMITTEE REJECTS MEDICAID EXPANSION; NEW MEXICO RECEIVES CENTENNIAL CARE WAIVER APPROVAL; NEW YORK ACCELERATES MANDATORY MLTC TRANSITION; CALIFORNIA ANNOUNCES RURAL COUNTY MCO AWARDS; RHODE ISLAND RELEASES MLTC RFP; WASHINGTON NAMES NEW MEDICAID DIRECTOR

OTHER HEADLINES: ARKANSAS MEDICAID EXPANSION ARRANGEMENT ATTRACTS ATTENTION; VIRGINIA GOVERNOR REJECTS MEDICAID EXPANSION; IOWA GOVERNOR PROPOSES MEDICAID EXPANSION ALTERNATIVE; DC POISED TO ANNOUNCE MCO CONTRACT AWARDS

HMA ANNOUNCES THE CREATION OF THE ACCOUNTABLE CARE INSTITUTE

HMA WELCOMES: BARBARA SMITH – WASHINGTON, D.C.

MARCH 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: THE FINANCIAL ARGUMENT FOR MEDICAID EXPANSION IN TEXAS

This week, our *In Focus* section reviews an independent report out of Texas, which makes the case for Medicaid expansion in a state with significant political opposition to doing so. Texas has the highest uninsured rate of any state in the country, with more than 6 million uninsured, or nearly 24 percent of the population. The report, prepared by Billy Hamilton Consulting on behalf of Methodist Healthcare Ministries of South Texas, Inc., was released on January 28, 2013. Methodist Healthcare Ministries and HCA formed a joint venture in the mid-1990s and have operated since then as Methodist Healthcare System, the largest health system in South Texas. Billy Hamilton previously served as the Texas Deputy Comptroller of Public Accounts for 15 years prior to becoming an independent consultant. The report, titled *Smart, Affordable and Fair: Why Texas Should Extend Medicaid to Low-Income Adults*, is available here.

The report contends that the key to the Medicaid expansion decision is the existing state and local funding for health care services that will be covered under Medicaid if eligibility were extended to eligible individuals below 138 percent of the Federal Poverty Level (FPL). For the entire state and for each of the 20 regional health partnership (RHP) regions, the injection of federal funding from the Medicaid expansion is presented as a percentage of current state and local funding under three different enrollment scenarios. The report also outlines additional benefits of Medicaid expansion that include improved population health and benefits to the state's economy in terms of job creation and additional tax revenue.

Replacing State/Local Funding

If the Medicaid expansion is accepted, Texas will receive an estimated $7.7 billion in federal funds for adult coverage and an estimated $1.4 billion for child coverage in the 2014-2015 biennium, putting up just $297 million for adults and $889 million for children in state matching funds. As enrollment grows, the 2016-2017 biennium would amount to an estimated $18.3 billion in federal funds for $2.6 billion in state matching funds. These estimates represent the report's "moderate" enrollment scenario.

Enrollment Scenario	"Limited"	"Moderate"	"Enhanced"
Medicaid Expansion	**860,000**	**1,555,000**	**2,222,000**
Federal Funds	$5,377,000,000	$9,116,000,000	$12,649,000,000
State Funds	$512,000,000	$1,062,000,000	$1,605,000,000
Total Funding	**$5,889,000,000**	**$10,178,000,000**	**$14,254,000,000**
Federal Funds (adult) as % of Local Unreimbursed Costs	*108.1%*	*173.8%*	*234.9%*
Federal Funds per Enrollee (annual)	$6,252	$5,862	$5,693
State Funds per Enrollee (annual)	$595	$683	$722

Source: "Smart, Affordable and Fair: Why Texas Should Extend Medicaid to Low-Income Adults." Note: Enrollment and funding estimates rounded by HMA.

The key argument summarized in the table above is that, even under the limited enrollment scenario, the increase in federal funds for the adult expansion population alone will

exceed the current statewide burden of local unreimbursed costs. Under the enhanced enrollment scenario, federal funds would cover unreimbursed costs more than two times over. Unreimbursed health care costs in 2011 amounted to more than $2.5 billion, while hospital charity costs exceeded $1.8 billion for a total of nearly $4.4 billion in unreimbursed care and charity costs. The report cautions, however, that not all local unreimbursed care costs would be eliminated due to non-eligible individuals, such as undocumented immigrants. Finally, the report notes that Texas could use a portion of local savings under the Medicaid expansion to fund the state share of matching funds though an intergovernmental transfer arrangement, still realizing a net gain for local governments and hospitals.

Economic Impact of Medicaid Expansion

Expanding Medicaid in Texas would give the state an economic boost of nearly $68 billion over four years (2014 through 2017), according to the report. This includes more than 231,000 new jobs by 2016 and would increase gross state product by more than 1.0 percent. Moreover, the report highlights the increase in state tax revenue from the injection of federal funds only. By 2016, federal Medicaid expansion funding will generate more than half a billion dollars in new state tax revenues per year. This tax revenue amounts to nearly $1.8 billion over four years, and would offset nearly half of the estimated state matching funds required for expansion. Combined with the potential for intergovernmental transfer funds from local governments as mentioned above, this could fully fund the state share of expansion costs.

"Moderate" Scenario	2014	2015	2016	2017	Total (2014-2017)
Medicaid Expansion	**506,100**	**1,152,000**	**1,555,000**	**1,574,000**	***1,574,000***
State Match	$352 M	$834 M	$1,062 M	$1,492 M	*$3,740 M*
Federal Match	$2,711 M	$6,419 M	$9,116 M	$9,219 M	*$27,465 M*
Total Funding	**$3,063 M**	**$7,253 M**	**$10,178 M**	**$10,711 M**	***$31,205 M***
Jobs Created	71,500	166,000	231,100	229,200	
State Tax Revenue from Federal Funding	**$174 M**	**$413 M**	**$586 M**	**$593 M**	***$1,766 M***
As % of State Match	49.4%	49.5%	55.2%	39.7%	*47.2%*

Source: "Smart, Affordable and Fair: Why Texas Should Extend Medicaid to Low-Income Adults." Note: Enrollment estimates rounded by HMA.

Political Outlook

Despite the case made for expansion by the report including additional support from the Texas Medical Association and the Texas Hospital Association, as well as "nine chambers of commerce, seven local government entities and more than 40 other organizations," the Texas House of Representatives Republican caucus stated this week that they will not expand Medicaid unless granted significant flexibilities by the Obama Administration, according to Kaiser Health News. House Republicans may be looking to a block grant arrangement in exchange for their endorsement of the Medicaid expansion. In response, the report contends that the prospect for block grants makes the case for expansion even stronger, as block grant funding levels would likely be based upon historical spending levels.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

Last Wednesday, the California Department of Health Care Services (DHCS) posted its final Notice of Intent to Award for the continued expansion of Medi-Cal Managed Care to the eighteen counties that are currently fee-for-service. The counties covered by this contract are Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, and Yuba.

The two five-year awards were granted to Anthem Blue Cross (WellPoint) and California Health and Wellness Plan (Centene), with up to three one-year extension options. Seven counties were excluded from this expansion: Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity and be serviced by the county-operated system Partnership HealthPlan of California (PHC).

Lake and San Benito will be County Organized Health System (COHS) managed care counties using Partnership HealthPlan of California and Central California Alliance for Health. DHCS and Imperial County are working together on the latter's managed care plan selection process. Starting on June 1, 2013, more than 400,000 Medi-Cal beneficiaries in these 28 counties will begin transitioning to the aforementioned managed care plans.

In the news

- **"DHCS Agrees to Medi-Cal Managed Care Carve Out"**

  "Late Wednesday, the California Department of Health Care Services (DHCS) posted the final Notice of Intent to Award regarding the roll out of the implementation of Medi-Cal Managed Care. Originally, slated for posting on Monday, the Department delayed posting to continue working on the issue of seven counties that wished to be excluded from the Request For Application (RFA) and included instead under the county-operated system Partnership HealthPlan of California (PHC). Del Norte, Humboldt, Lassen, Modoc, Shasta, Siskiyou, and Trinity are excluded from the Request For Application bid and will be serviced exclusively by (PHC) Partnership HealthPlan of California, with Lake and San Benito counties creating County Organized Health Systems served by PHC in Lake County and Central California Alliance for Health in San Benito County. California Department of Health Care Services (DHCS) is continuing to work with Imperial County on its managed care plan selection process." (TSPN News)

Colorado

HMA Roundup – Joan Henneberry

SeeChange Plans to Bring Value-Based Insurance Plan to Colorado Exchange. A San Francisco-based insurer, SeeChange, plans to offer a "value-based health insurance" plan to Colorado's health benefit exchange. The company aims to provide individual and small group insurance plans that encourage consumers to take an active role in their own care via rewards for healthier behavior.

Slight Drop in Uninsured Children, Although 89K Were Eligible for Public Plans. On March 1, 2013, the Colorado Health Institute released its annual analysis of the number of eligible Colorado children who were still not enrolled in Medicaid or Child Health Plan Plus (CHP+) public insurance programs. Nearly 125,000 Colorado children, or 9.7 percent of all children in the state, were uninsured in 2011, down from the prior year's 132,000 uninsured children. About 89,000 of the uninsured children were eligible for a public health insurance program but were not enrolled. Of these eligible but not enrolled children, about 39,000 were eligible for Medicaid and about 50,000 were eligible for CHP+.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Legislative Select Committees on PPACA Hold Hearings. Both the Senate and House Select Patient Protection and Affordable Care Act (PPACA) Committees have been meeting since December 2012. A joint Select PPACA Committee met on March 4, 2013 to hear from the state's chief Economist on an economic analysis of PPACA and the Medicaid Expansion. The state's economist estimated that of the estimated 1 million individuals eligible for the Medicaid expansion, only about 463,000 individuals would sign up initially and that number would grow to 892,000 by 2020. The estimated state cost is $330 million in fiscal year 2020-21. The state will also spend an estimated $101 million in 2013-14 for currently eligible for Medicaid but not enrolled.

The House Select PPACA Committee met later that afternoon to discuss both the Exchanges and the Medicaid expansion. The members voted not to have staff draft a bill for a state exchange and not to have staff draft a bill for the Medicaid expansion.

The Senate Select PPACA Committee had recommended not pursuing a state exchange previously on February 19, 2013. The committee was scheduled to meet later in the afternoon on March 4, 2013 to make their decision on the Medicaid expansion but wanted to wait until after a March 7, 2013 Social Services Estimating Conference met to update the Medicaid expansion estimates.

2013 Legislative Session. Governor Rick Scott delivered an upbeat State of the State address to the Legislature Tuesday, March 5, 2013 declaring that his policies are working and Florida's economy is strong enough to give a generous pay raise to teachers. The Governor has two priorities to keep the economy growing: removal of the sales tax on manufacturing equipment, and investing in our teachers by providing them a $2,500 pay raise. He also stated that with the battle over the President's healthcare law and the presidential election lost, he supports the Medicaid expansion over the three year period that

the federal government is committed to paying 100 percent of the costs for the new Medicaid eligibles. House Speaker Will Weatherford, however, in opening session remarks stated that he was opposed to the Medicaid expansion because it crosses the line of the proper role of government.

In the news

- **"Florida Medicaid expansion suffers legislative setback"**

  "Florida Governor Rick Scott's plan to expand Medicaid coverage to cover about 1 million more poor people suffered a setback on Monday when the proposal failed to make it out of a key state legislative committee hearing." (Reuters)

Georgia

HMA Roundup – Mark Trail

DCH Working on Rules for Implementing Hospital Payment Program. Following the mid-February passage and signing into law of S.B. 24, the Hospital Medicaid Financing Program Act, the Department of Community has undertaken the task of developing rules and guidelines for review and adoption by the Board of Community Health. The DCH will administer the Hospital Provider Payment Program, much as it already does for nursing homes, effective July 1, 2013. In FY 2013, the DCH anticipates $235 million in hospital payments to be deposited into the Indigent Care Trust Fund, which will generate about $450 million in Federal matching funds. In turn, DCH projects $251 million to be paid back to Medicaid hospitals with the remaining funds applied to support Medicaid generally.

Senate Passes Bill to Study Medicaid Savings Opportunities. On March 5, 2013, the Georgia Senate passed S.B. 163 by a 39-10 vote. The legislation would require DCH to study how to lower costs in the Medicaid program and deliver recommendations to the House and Senate health care committees by year-end.

Medicaid Redesign to Transition Foster Kids into Managed Care. Georgia Medicaid is proceeding with its plans to transition foster children into managed care, while exploring the implementation of voluntary managed care programs for the Aged, Blind and Disabled Medicaid population. DCH aims to incorporate patient-centered medical homes and value-based purchasing in new or renewed procurements. The agency is working to develop a Preferred Drug List (PDL) for certain classes of drugs.

Georgia EHR Incentives Top $135M. Through February 25, Georgia's Medicaid Electronic Health Record (EHR) Incentive Program has dispensed more than $135 million in federal funds to eligible providers, since the September 2011 launch of the program.

Eligible Hospitals	156	$	93,904,356.90
Eligible Professionals	2097	$	41,654,269.00
Total Payments through February 25, 2013		$	135,558,625.90

Georgia Medicaid EHR Incentive Payment Program Outcomes

Life of the Program (Since September 2011)

	Adopt / Implement / Upgrade (AIU)		Meaning Use (MU)		Totals	
	Number Paid	Amount Paid	Number Paid	Amount Paid	Number Paid	Amount Paid
Eligible Hospitals	**121**	**$ 70,636,211.08**	**35**	**$ 23,268,145.82**	**156**	**$ 93,904,356.90**
Eligible Professionals	**1907**	**$ 40,047,768.00**	**190**	**$ 1,606,501.00**	**2097**	**$ 41,654,269.00**
Nurse Midwives	63	$ 1,338,750.00	16	$ 136,000.00	79	**$ 1,474,750.00**
Dentists	164	$ 3,485,000.00	0	$ -	164	**$ 3,485,000.00**
Nurse Practitioners	249	$ 5,291,250.00	29	$ 246,500.00	278	**$ 5,537,750.00**
Physicians	1419	$ 29,677,768.00	143	$ 1,207,001.00	1562	**$ 30,884,769.00**
Physician Assistant	12	$ 255,000.00	2	$ 17,000.00	14	**$ 272,000.00**
Grand Total	**2028**	**$ 110,683,979.08**	**225**	**$ 24,874,646.82**	**2253**	**$ 135,558,625.90**

Total Payments as of February 25, 2013

In the news

- **"Senate Passes Bill to Set Groundwork for Medicaid Reform"**

  "Under this legislation, the Board of Community Health will analyze the possible expansion of managed care, measures used by commercial insurers to encourage healthy consumer choices, and the use of accountable care organizations and patient centered medical homes. By December 31, 2013, the board is responsible for providing a report to the Governor, House Speaker, President of the Senate, and members of the House and Senate Health and Human Services Committees on its findings and recommendations. Senate Bill 163 will now transfer to the House of Representatives for consideration." (InsuranceNewsNet)

Illinois

HMA Roundup – Matt Powers and Jane Longo

Today, March 6, Illinois Governor Pat Quinn unveiled his FY 2014 budget proposal. The key focus of his budget address was the state's pension reform effort, but also included a call on the House of Representatives to pass the Medicaid expansion bill as approved by the Senate last week. Additionally, Gov. Quinn and Healthcare and Family Services Director, Julie Hamos, released a set of slides outlining the Medicaid budget for FY 2014.

- Medicaid liability is estimated to grow by 3.9 percent with initial ACA Medicaid expansion enrollment in FY 2014, from $9.8 billion in FY 2013 to $10.2 billion in FY 2014 (HFS estimates only 2.2 percent growth without ACA).
- In the second half of FY 2014, HFS projects 69,100 newly eligible Medicaid enrollees, with another 33,800 previously eligible but newly enrolled beneficiaries.
- The SMART Act cuts to Medicaid, implemented in FY 2013, have only achieved $1.1 billion of the estimated $1.6 billion in projected savings. However, lower than estimated FY 2012 medical liability mitigates the budgetary impact of the SMART Act savings variance.

- With the implementation of several care coordination and managed care initiatives in FY 2014, HFS has increased its requested care coordination appropriation to nearly $1.1 billion, up more than $800 million from the $242 million appropriated in FY 2013.

Additionally, the budget presentation includes revised estimates on Medicaid expansion enrollment and spending over the next several years. The HFS FY 2014 Budget Overview slides are available here.

In the news

- **"Illinois Senate approves Medicaid expansion"**

  "An expansion of Medicaid under President Barack Obama's health-care overhaul is one step closer in Illinois. The state Senate passed the expansion 40-19 on Thursday. The vote was strictly along partisan lines, with all Democrats voting in favor and all Republicans voting no. The bill now goes to the House." (State Journal-Register)

Indiana

HMA Roundup – Cathy Rudd

Senate Bill for Medicaid Expansion Using HIP Remains to Be Assigned in the House. Last week's overwhelming 44-6 Senate vote to expand Medicaid using the Healthy Indiana Plan as a vehicle has yet to be assigned to a House committee as yet. The Governor has requested approval from HHS Secretary Sebelius to proceed with this expansion option. Under the Senate bill, the office of Medicaid policy and planning would be required, by August 1, 2013, to present a report addressing the possibility of mandating managed care for the ABD population and how to handle dual eligibles and participants in Indiana check-up plan. Current law, however, prevents the use of mandatory managed care for ABD populations.

In the news

- **"Pence remains opposed to Medicaid expansion despite acceptance by other GOP governors"**

  "While cracks are starting to show in the Republican opposition to President Barack Obama's Medicaid expansion plan, Indiana Gov. Mike Pence remains staunchly opposed to the program. Pence sent his strongest message to date during a news conference last week, calling Medicaid a broken initiative rife with waste and fraud…. Pence, though, continues to dangle the possibility of a hybrid Medicaid expansion through the state's own program for the uninsured: the Healthy Indiana Plan." (Indianapolis Star)

New Mexico

HMA Roundup - Julie Johnston

Centennial Care gets CMS Agreement in Principle. On March 5, 2013, the New Mexico Human Services Department (HSD) announced an agreement in principle with CMS on the Centennial Care Medicaid Waiver. This agreement features (1) support for an inte-

grated Community Long Term Benefit that will offer a wide range of home- and community-based care options to individuals who qualify for nursing facility level of care and (2) support for the requirement that Native American Medicaid beneficiaries who are nursing facility level of care eligible or dual eligible enroll in Centennial Care, while allowing other Native American Medicaid beneficiaries voluntary enrollment in the program. The remaining issues for the state and CMS to work through include the movement of the Sole Community Provider program into the Centennial Care waiver and budget neutrality. The planning and transition process will continue through 2013 with an implementation date of January 1, 2014. The Agreement in Principle can be viewed here.

New York

HMA Roundup – Denise Soffel

Health Home Update. New York has designated health homes operating in every county across the state. According to the most recent February 2013 enrollment report, the largest health home in the state has 2,800 individuals either assigned to or enrolled and the smallest reports seven individuals enrolled. Seven health homes have more than 1,000 enrollments. Of the 13,677 individuals engaged by health homes statewide, 63% are in active care management, and 37% have been engaged in outreach through the health home.

Managed Long Term Care Contracting Policy Extended Through Year-End. New York State recently issued a policy that extends requirements around contracting with home attendant vendors. The current policy requires all Managed Long Term Care (MLTC) plans to contract with all home attendant vendors that have had a contract with the local district, and must pay the vendor the same rate for services. This policy, originally scheduled to expire March 31, 2013, has been extended through year-end. The contracting requirement originally only pertained to New York City's five boroughs, but now encompasses Nassau, Suffolk and Westchester counties, which similarly feature a mandatory Managed Long Term Care program for some Medicaid beneficiaries. Additionally, during the transition period, MLTC plans are also required to maintain the same plan of care and home care provider for at least 60 days for Medicaid beneficiaries who are currently receiving personal care services. The policy can be viewed here.

Managed Long-Term Care Enrollment to Accelerate. As part of the Governor's 30-day budget amendments, New York State plans to accelerate the mandatory enrollment of some Medicaid beneficiaries into Managed Long Term Care plans. The current target of 2,000 enrollments per month has been doubled to 4,000 per month. The state expects this will generate savings of $4.6 million in SFY 2013 and $3.1 million in SFY 2014. The state expects that all current Medicaid beneficiaries eligible for enrollment in the mandatory program will be transitioned by August 2013. Subsequent enrollment will be limited to newly eligible Medicaid beneficiaries, or new to the MLTC program requirement. The mandatory MLTC program also includes dual eligible individuals needing more than 120 days of community-based long-term care services.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

Pennsylvania General Fund Revenues in February Miss Target by 2.8 percent Revenue Secretary Daniel Meuser reported that Pennsylvania collected $1.6 billion in General Fund revenue in February 2013, 2.8 percent lower than anticipated. That said, year-to-date General Fund collections of $16.2 billion, are still running $105 million, or 0.7percent, above estimates.

Auditor General to Review FMS contract. On February 28, 2013, Auditor General Eugene DePasquale announced that his office will conduct an audit of the Department of Public Welfare's new financial management services (FMS) contract to administer payroll for direct care workers in waiver programs. PCG Public Partnerships LLC (PPL) failed to provide timely payments to direct care workers after its contract was implemented. The audit will focus on (1) the reasonableness of compensation paid to PPL, (2) DPW's direction of transition activities to the new vendor, and (3) DPW's oversight and monitoring of PPL.

Geisinger Dominates Medicaid Managed Care Plan Selection in New East Zone. The Office of Medical Assistance Programs reported on the status of plan selection of enrollees in the "New East" zone for the State's Medicaid Managed Care program to the Consumer Subcommittee of the Medical Assistance Advisory Committee. Fifty-six percent of beneficiaries were auto-assigned. Of the 44 percent of enrollees who voluntarily selected a plan, 69 percent chose Geisinger Health Plan, while 17percent chose Amerihealth NorthEast and 14 percent chose Coventry Cares. Effective February 28, 2013, United Healthcare voluntary managed care will no longer be operating in the 22 counties that comprise the New East Zone.

Legislators Pressure Corbett to Accept Medicaid Expansion. Activity in the Pennsylvania Legislature is heating up around Medicaid expansion with at least one key Republican expressing support for providing expanded eligibility. Representative. Gene DiGirolamo, chair of the House Human Services Committee, supports expansion and is hopeful that more colleagues in the Republican Caucus will eventually join him in his support. Separately, Representative Dan Frankel (D) has introduced a bill (HB 897) that would act as enabling legislation for Medicaid expansion. Meanwhile in the Senate, a group of Republican State Senators, including Senator Patricia Vance, Chair of the Health and Welfare Committee, have formed a group to study the issue in greater detail. The Governor's office claims that Medicaid expansion-related costs to the state are too high and that the Governor awaits more detail from Health and Human Services about potential state flexibility. The Governor's office announced that a meeting between the Governor and Secretary Sebelius is being scheduled at a date yet to be determined.

In the news

- **"Corbett administration looks to close some Pa. health centers, emphasizes community outreach'**

  "Gov. Tom Corbett's Department of Health wants to close nearly half of Pennsylvania's 60 health centers and lay off some nurses as part of an effort to save money and

improve the way the state handles its public health duties, officials said. The plan would keep 34 health centers and eliminate the positions of 26 nurses who perform services that are handled by other agencies. More emphasis would be placed on nurses traveling to public gatherings as a way to administer things like immunizations and, ultimately, serve more people, department spokeswoman Aimee Tysarczyk said Monday." (The Republic)

- **"Corbett facing pressure from GOP on Medicaid"**

  "The pressure on Gov. Corbett to expand the state's Medicaid rolls is no longer only geographic; it's now coming from within his own party. First there was Gov. Christie's announcement Tuesday that New Jersey would join other Pennsylvania neighbors - New York, Maryland, and Ohio - by opting in on the Medicaid expansion made available to all states under the Affordable Care Act. Now the heat is coming from some of Corbett's fellow Republicans in the state legislature. State Rep. Gene DiGirolamo (R., Bucks) said Wednesday that he supported Medicaid expansion because it would provide health insurance for an estimated 700,000 Pennsylvanians, many in low-wage jobs." (Philadelphia Inquirer)

Rhode Island

HMA Roundup

In pursuit of a more comprehensive and integrated healthcare delivery system, the Rhode Island Executive Office of Health and Human Services (EOHHS)/ Medicaid Program has posted two Integrated Care Initiative requests for proposal (RFP):

- Rhody Health Options, a capitated model for delivering the full spectrum of Medicaid services (including LTSS) for Medicaid-eligible individuals, including dual eligibles. Written questions must be submitted by March 12, 2013 and the bid submission deadline is March 27, 2013.
- Connect Care Choice *Community Partners*, an enhanced primary care case management (PCCM) program for medically complex individuals. Written questions must be submitted by March 14, 2013 and the bid submission deadline is April 2, 2013.

Washington

HMA Roundup – Doug Porter

MaryAnne Lindeblad Named Washington State Medicaid Director. In late February, MaryAnne Lindeblad agreed to accept the newly established position of State Medicaid Director within the Washington State Health Care Authority. Previously, MaryAnne Lindeblad was serving as Acting Director of the Health Care Authority, after having served as Assistant Secretary for the Aging and Disability Services Administration for the State Department of Social and Health Services. Dorothy Frost Teeter was named Director of the Health Care Authority in late January. The state intends to consider the experiences of such states as Oregon and Oklahoma, which have pursued similar models within a state Health Authority.

OTHER HEADLINES

Alaska

- **"Parnell opposed to Medicaid expansion now"**

  "Alaska Gov. Sean Parnell said Thursday he is opposed to expanding Medicaid in the state, given what he knows about the federal budget. Parnell told reporters he will not ask the Legislature this session for funding or authorization to expand the program. He said he will continue to study the issue, with his next decision point coming when he submits his next budget in December." (Anchorage Daily News)

Arkansas

- **"Lawmakers eye hiring Medicaid consultant"**

  "A former human services official for Rhode Island and Pennsylvania has been proposed as a consultant to aid the Arkansas Legislature in dealing with Medicaid issues. The Executive Committee of the state Legislative Council voted Monday to approve a contract for consulting services with Gary Alexander, former Rhode Island human services director and Pennsylvania secretary of public welfare. Alexander is known as the author of the 2009 Rhode Island Global Medicaid Waiver, which allowed that state to implement various Medicaid reforms. Gov. Mike Beebe has requested a similar waiver for Arkansas." (Arkansas News)

- **"Arkansas's unusual plan to expand Medicaid'**

  "Gov. Mike Beebe must get 75 percent of his legislature to sign off on any funds necessary for the Medicaid expansion — a tough sell when Republicans control both the state House and Senate. What the legislature could be sold on, they told the governor, was this: Using billions in federal Medicaid dollars to buy private health insurance coverage for the state's lowest income populations. To the surprise of many — Beebe included — Health and Human Services has given that plan the go-ahead." (Washington Post)

District of Columbia

- **"D.C. moves closer to awarding Medicaid contracts"**

  "The District appears poised to award some of its largest government contracts, tentatively choosing three firms to manage the health care of about 160,000 low-income city residents. According to a draft news release obtained by The Washington Post, the city has chosen Medstar Family Choice, Thrive Health Plan and the AmeriHealth Mercy Family of Companies for contracts that can be extended for up to five years. But Health Care Finance Director Wayne Turnage said Tuesday the awards are not final; they are currently under legal review and could still change." (Washington Post)

Iowa

- **"Branstad releases Medicaid expansion alternative"**

  "Gov. Terry Branstad's Medicaid expansion alternative received a cool reception from Senate Democrats, who would have to agree to the plan to make it a reality. Dubbed The Healthy Iowa Plan, Branstad's proposal covers roughly 89,000 uninsured Iowans, while Medicaid expansion is estimated to cover 150,000 uninsured Iowans. Branstad's plan also costs tens of millions more for the state than Medicaid expansion would. But the plan is a better deal for Iowans in the long run because there's no way the federal government is going to follow through the obligations it made under voluntary Medicaid expansion, the governor said." (Sioux City Journal)

Minnesota

- **"Minnesota Legislature Hammers Out Exchange Bill"**

  "The Democratic-majority Minnesota House has passed a key part of the Obama administration's health care law -- a state-based health insurance exchange. The bill's chief author called the measure the most significant health reform in 50 years. But abortion restrictions adopted Monday could run into trouble with Gov. Mark Dayton, a Democrat. The full Senate takes up its exchange bill on Thursday." (Kaiser Health News)

- **"Review raises questions about payment rates to HMOs"**

  "A review of how the Pawlenty administration set payment rates for HMOs managing care for public health programs raises questions about high profit margins for the private health plans. The audit is one of several underway and comes in response to questions from the federal government about whether the state's managed care contracts for public programs have been too generous. The report by Segal Company, an actuarial consulting firm, said the Pawlenty administration, the state's actuary and the federal government all missed opportunities to hold down payment rates." (Minnesota Public Radio)

Montana

- **"Bullock says Medicaid expansion bill will be introduced soon"**

  "Gov. Steve Bullock Wednesday unveiled more details about his plans to extend government health insurance to 70,000 low-income Montanans through expansion of Medicaid, and he said the bill to enact it will be introduced soon. Bullock said expanding Medicaid will improve health for thousands, reduce health care costs for all of Montana and create 5,000 jobs in its first year and many more in ensuing years." (Billings Gazette)

North Carolina

- **"Interview: A Southern Medicaid Director's Perspective on Health Care Reform"**

  Stateline presents an interview with North Carolina Medicaid Director, Carol Steckel. (Stateline)

North Dakota

- **"N. Dakota House approves Medicaid expansion bill"**

  "The Republican-led North Dakota House voted Wednesday to expand Medicaid to cover more uninsured residents of the state. The chamber approved the measure 57-36. The House bill now goes to the Senate for consideration, as the Legislature heads to its mid-session break." (Associated Press)

Ohio

- **"Ohio officials still seek Medicaid flexibility"**

  "Ohio continues to press the federal government for flexibility as state lawmakers review whether to expand the Medicaid program under President Barack Obama's health care law. Greg Moody, director of the governor's Office of Health Transformation, told reporters Tuesday he's encouraged by discussions with the Obama administration, but he said it's too soon to say the two sides have reached an agreement. Republican Gov. John Kasich has discussed whether Ohioans newly eligible for Medicaid under an expanded program could instead get private coverage subsidized by Washington. Those low-income individuals could then purchase insurance in the new health insurance market, known as the exchange." (Associated Press)

Texas

- **"Hospital poll: Texans favor Medicaid expansion"**

  "About half of Texans support expanding Medicaid, while roughly one-third say the state should turn down the federal government's inducements to enlarge the program for the poor, according to a new poll. In the poll, commissioned by the Texas Hospital Association, 54 percent of state voters said Texas should participate. Thirty-four percent said the state should reject the Medicaid expansion, a key provision of President Barack Obama's federal health care overhaul. It takes effect in January. The hospital group strongly supports the expansion." (Dallas News)

Vermont

- **"Vermont Awards HP $48 Million Medicaid Agreement"**

  "HP Enterprise Services today announced that the Department of Vermont Health Access has signed a $48 million contract to continue its 31-year relationship with HP as the state's Medicaid fiscal agent. The new four-year agreement includes services that assist the state in reaching its healthcare reform goals. The agreement covers the relocation of Vermont's current Medicaid Management Information System (MMIS) to a state-of-the-art HP data center." (MarketWatch)

Virginia

- **"McDonnell to feds: No Medicaid expansion"**

  "Gov. Robert F. McDonnell sent a letter Tuesday to President Obama's health secretary to stress that he and the General Assembly have not agreed to expand Medicaid." (Washington Post)

Wyoming

- **"Wyoming lawmakers move to block expansion commitments"**

  "A bill that would bar state officials from expanding Medicaid without lawmakers' approval passed its final legislative hurdle Wednesday. The prohibition, which is part of a larger bill to study health insurance exchanges, now awaits Gov. Matt Mead's signature. It would keep him and other officials from unilaterally extending health coverage to roughly 17,600 poor adults as called for in the federal health reform law." (Billings Gazette)

National

- **"Good News or False Hopes? State Tax Revenues Showed Strong Growth in the Fourth Quarter of 2012"**

  "Preliminary data for the October-December quarter of 2012 show continued growth in overall state tax collections, including income and sales tax revenues. The growth in total tax collections was the strongest in the last six quarters, mostly driven by the strong growth of 10.8 percent in personal income tax collections." (Rockefeller Institute)

- **"There's no precedent for feds dialing back Medicaid dollars"**

  Washington Post's Sara Kliff responds to concerns about decreased federal matching funds in the future for the Medicaid expansion. Kliff explains that it would be unprecedented for the federal government to increase the percentage share of Medicaid spending by states. The expiration of ARRA matching rates was the only time federal matching percentages were significantly decreased in the past 50 years. (Washington Post)

- **"Tavenner: 'All the Steps in Place' for 2014 Coverage Expansion"**

  "After working for nearly three years behind the scenes overseeing the implementation of the massive health law, Marilyn Tavenner is increasingly stepping out in public to talk about her handiwork. 'I think we are going to have all the steps in place to get it done,' Tavenner told a gathering of hospital executives Tuesday regarding the historic 2014 expansion of health coverage under the overhaul law." (CQ HealthBeat)

- **"Obama Clarifies Part of Health Law"**

  "The Obama administration on Friday released new rules aimed at smoothing the rollout of a piece of the 2010 federal health-care law designed to give Americans more insurance options. Federal officials said insurers that get a contract to offer a so-called multistate plan will have to adhere to most of the insurance laws in each state, but in some cases they would be allowed to use a federally approved package of benefits rather than replicating ones set for each state." (Wall Street Journal)

- **"Clients Turn to Medicaid Trusts as Costs Soar"**

  "More people who anticipate being in nursing homes someday are turning to Medicaid trusts to protect their homes and investments--as well as their children's assets--from being used to pay for the care. A growing number of middle-class Americans are waking up to the fact that paying for expensive long-term nursing care could be

financially devastating for their spouses or children. Facing this nightmare scenario, people in their 50s and 60s are turning to financial advisers for help in laying the groundwork to create a Medicaid trust." (Wall Street Journal)

- **"Medicaid Pay Boost Slow for Primary Care"**

  "Primary care providers haven't been receiving a boost in Medicaid reimbursements in 2013 as promised by the Affordable Care Act (ACA), doctor groups and Medicaid plans said. Instead, states are still submitting necessary amendments to Medicaid plans to the Centers for Medicare and Medicaid Services (CMS) to allow the agency to pay Medicaid primary care providers at the higher Medicare rates." (MedPage Today)

- **"Another Big Step in Reshaping Health Care"**

  "Hospitals and health insurers are locking horns over how much health-care providers will get paid under new insurance plans that will be sold as the federal health law is rolled out. The results will play a major role in determining how much insurers will ultimately charge consumers for these policies, which will be offered to individuals through so-called exchanges in each state. The upshot: Many plans sold on the exchanges will include smaller choices of health-care providers in an effort to bring down premiums. To keep costs low, the insurers are pressing for hospitals to grant discounts from the rates hospitals usually get in commercial plans. In return, participating hospitals would be part of smaller networks of providers. Hospitals will be paid less by the insurer, but will likely get more patients because those people will have fewer choices. The bet is that many consumers will be willing to accept these narrower networks because it will help keep premiums down." (Wall Street Journal)

- **"Federal Exchange to Handle States with Most Uninsured, Data Shows"**

  "New data from Enroll America, established to boost coverage levels under the health law, show that 13 states account for two-thirds of the uninsured population. And an analysis of that data reveals that 9 of those 13 states will rely on the federally facilitated exchange to direct the uninsured to the appropriate coverage, offer them a menu of plans, determine their eligibility for subsidies, and handle enrollment, which is scheduled to begin on Oct. 1. Of the 13 states, only California and New York are fully committed enough to carrying out the health care law by setting up their own exchanges. Of the remaining 11, two — Michigan and Illinois — say they'll partner with the federal government on a marketplace. The remaining nine will rely on the federal government. They are: Virginia, Arizona, New Jersey, Pennsylvania, Ohio, North Carolina, Georgia, Florida, and Texas." (CQ HealthBeat)

- **"IRS Issues Proposal On Insurer Fee to Industry Criticism"**

  "Insurers on Friday again called for a repeal of an annual health insurance fee that will be levied on them starting in 2014 as the Internal Revenue Service issued a proposed rule spelling out how that tax will be implemented. Insurers have been extremely unhappy ever since the fee was instituted as part of the health care law to help pay for the overhaul's extension of health coverage to uninsured Americans. Proposed Rule on Health Provider Plans (PDF)" (CQ HealthBeat)

COMPANY NEWS

- **"WellCare Joins With Georgia Partnership For TeleHealth To Expand Access To Health Care"**

  "WellCare Health Plans, Inc. announced an agreement with the Georgia Partnership for TeleHealth, Inc. (GPT) to expand access to specialty health care services for its Georgia Medicaid and PeachCare for Kids® members. Through GPT's telemedicine network and services, WellCare members can quickly connect with more than 200 specialists at over 300 patient locations in over 40 adult and pediatric specialties." (WellCare News Release)

- **"WellCare Approved To Expand Its New York Managed Long-Term Care Services"**

  "WellCare Health Plans, Inc. (NYSE: WCG) today announced that the New York State Department of Health (DOH) has approved WellCare of New York, Inc.'s expansion of its Advocate Medicaid Managed Long-Term Care (MLTC) health plan. The expansion adds four new counties to the company's MLTC service area: Nassau, Richmond, Suffolk and Westchester counties. WellCare opened member enrollment for its Advocate health plan in the four new counties on March 1. This expansion complements WellCare's existing MLTC nine-county coverage in the Bronx, Kings, Queens, New York, Buffalo, Orange, Rockland, Erie and Ulster counties." (WellCare News Release)

- **"Centene Corporation Received Notice Of Intent To Award California Medicaid Contract"**

  "Centene Corporation announced that its subsidiary, California Health and Wellness Plan, has been notified by the California Department of Health Care Services (DHCS) of its intent to award a contract to serve Medicaid beneficiaries in 18 counties, pending regulatory approval. Under the contract, California Health and Wellness Plan will serve members under the state's Medi-Cal Managed Care Rural Expansion program. The expansion program covers members eligible for Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP), as well as other populations." (Centene Press 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
Pending	District of Columbia	Contract Awards	165,000
TBD	Nevada	Contract Awards	188,000
March 15, 2013	Florida acute care	Proposals Due	2,800,000
March, 2013	Virginia Duals	RFP Released	65,400
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, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
April-May, 2013	Rhode Island Duals	Proposals due	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	South Carolina Duals	RFP Released	68,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
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	Rhode Island Duals	Implementation	22,700
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
October 1, 2013	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	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
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					6/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189	Not pursuing Financial Alignment Model				
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	X	10/1/2013
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	X	Apr-May 2013			9/1/2013
South Carolina	Capitated	68,000	May-June 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402			Early 2013		1/1/2014
Virginia	Capitated	78,596	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	5,500-6,000	X	8/23/2012	10/1/2012		4/1/2013
Totals	**15 Capitated 7 MFFS**	**1.7M Capitated 485K FFS**	***5***			***4***	

*** 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…

Barbara Smith, Principal – Washington, DC

Barbara comes to HMA most recently from the Centers for Medicare and Medicaid Service, Department of Human Services where she served as Director of the Consumer Operated and Oriented Plan (CO-OP) Program Division for the last few years. In this role she developed and established a new Federal loan program under the ACA to capitalize and implement the creation of consumer-governed private nonprofit health insurance companies to operate in every State and the District of Columbia.

Prior to that she was a Senior Advisor for the Office of Health Reform for the DHHS. Barbara worked as an Independent Consultant for nearly a decade. She consulted with policy and research organizations including the Institute of Medicine, the Economic and Social Research Institute, as well as HMA to provide health policy analysis, research, and policy development for financing of and access to health care services and coverage expansion; chronic disease management; Medicaid as an economic stabilizer; and mental health system delivery reform.

Barbara has also served as a Senior Program Officer for the Institute of Medicine, a Senior Research Staff Scientist for the Center for Health Services Research and Policy at George Washington University School of Public Health, and a Legislative Aide for Health Policy and Health Care Reform to Rep. Jim McDermott.

Barbara holds a J.D. from Boston University Law School and an A.B. from Harvard College with a concentration in history.

HMA RECENT PUBLICATIONS

"State Levers for Improving Managed Care for Vulnerable Populations: Strategies with Medicaid MCOs and ACOs"

The Commonwealth Fund

Sharon Silow-Carroll, MSW, MBA – Contributor
Jennifer N. Edwards, DrPH, MHS – Contributor
Diana Rodin, MPH – Contributor

HMA recently published a report detailing the 10 leading states' strategies for using managed care to promote quality, cost-effectiveness, and better health outcomes for vulnerable Medicaid populations. The authors also concluded there's plenty of room for MCOs and ACOs to not only co-exist in serving Medicaid populations, but interface as they're moving in similar directions toward greater accountability among health care providers for quality and cost. (Link - PDF)

HMA ANNOUNCES…

HMA Creates Accountable Care Institute

As the health care industry undergoes significant changes, HMA sees the growing need to transform health care delivery through models that will provide better quality and enhance overall health status, at less cost.

In order to meet this need, and assure that transformation extends to vulnerable populations and communities, HMA announces the formation of its Accountable Care Institute (ACI). The ACI is a venue where extensive expertise and on-the-ground experience converge to lead the transformation of health care delivery from siloed programs to integrated, accountable, and financially viable systems of care that serve patients and populations that have been traditionally underserved.

Over the past decade, HMA has assembled a highly experienced accountable care team that includes former health system administrators, senior health care clinicians, advance practice nurses, behavioral health and long-term care professionals, health information technology specialists, managed care leaders, and finance experts — all with decades of experience facilitating change in health care practice and working with providers who serve the uninsured and publicly-funded populations.

The ACI is built on the extensive experience of this multidisciplinary team which is using its knowledge and expertise to help clients and colleagues across the country address issues related to:

- development and implementation of multi-provider delivery systems in defined communities for targeted populations;
- building new financial models to incentivize value;
- developing training for elements of an integrated system including creative uses of information technology, medical home components, appropriate use of specialty care and transition management;
- engaging medical professionals, technical experts, and administrative leaders in transforming health care delivery systems;
- building innovative partnerships between providers and payers to assure effective care for the populations they are both trying to serve;
- training new leaders in health system change; and
- the development of tools and resources that leverage lessons learned in creating new approaches to delivering and financing accountable care.

For more information, see HMA's ACI homepage, here.