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# HMA

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HEALTH MANAGEMENT ASSOCIATES

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

**IN FOCUS:** WE REVIEW HAWAII'S MEDICAID MANAGED CARE RFP

**HMA ROUNDUP:** HHS AWARDS \$185M IN EXCHANGE GRANTS TO STATES, PROPOSES RULES ON MEDICAID AND EXCHANGE ELIGIBILITY; THREE ILLINOIS HOSPITALS LOSE PROPERTY TAX EXEMPTIONS, MORE DETERMINATIONS COMING; CALIFORNIA LEGISLATURE RESUMES SESSION; FLORIDA IN DISCUSSION WITH PLANS ON DRAFT RATES; GEORGIA COMMITTEE VOTES TO MOVE FORWARD ON EXCHANGE

**OTHER HEADLINES:** U.S. CIRCUIT COURT RULES ACA INDIVIDUAL MANDATE UNCONSTITUTIONAL; MICHIGAN CLAIMS TAX BILL GETS ANNUAL CAP, 2014 SUNSET PROVISION; JUDGE OPENS DOOR FOR MICHIGAN BCBS "MOST FAVORED NATION" TRIAL

**HMA WELCOMES:** MAURICE LEMON (CHICAGO, IL)

**MEDICAID MANAGED CARE RFP CALENDAR UPDATED**

**AUGUST 17, 2011**

*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: HAWAII'S RFP TO REBID MEDICAID MANAGED CARE PROGRAM

This week, our *In Focus* section reviews the Hawaii RFP to rebid the QUEST Medicaid managed care program. The QUEST program provides Medicaid services to Temporary Assistance for Needy Families (TANF) and Children's Health Insurance Program (CHIP) lives under a capitated managed care structure on all of Hawaii's islands. QUEST currently services close to 225,000 lives, split between three incumbent plans. Annual revenue under QUEST could exceed \$600 million under the rebid program. Importantly, this RFP does not rebid the aged blind and disabled (ABD) or long-term care (LTC) Medicaid populations. ABD and LTC lives are covered under QExA, a separate capitated managed care program.

### *Current Market*

Of the three incumbent plans, HMSA (local Blue Cross Blue Shield non-profit) covers just under 120,000 lives, or roughly 54% of the current QUEST market. AlohaCare, founded in 1994 by Hawaii community health centers, has the next highest current enrollment, with over 75,000 covered lives, or 34% of the current QUEST market. Kaiser of Hawaii enrolls just over 27,000 lives, at 12% of the current QUEST market. Under the auto-enrollment methodology, individuals currently enrolled in a plan that wins a rebid contract will remain in their current plan unless they elect to enroll in a different plan. This provision should allow incumbent plans to retain a significant portion of their current market share, assuming they are awarded a rebid.

Incumbent Plans	Membership (6/11)	Market Share
HMSA (BCBS)	119,944	53.7%
AlohaCare	76,302	34.1%
Kaiser of Hawaii	27,229	12.2%
<b>Total</b>	<b>223,475</b>	

### *Timeline*

Plans must announce their notice of intent to propose by August 29, 2011, with proposals due a little over a month later, on October 7, 2011. The RFP states that delays in the rebid process would likely extend all future deadlines by the same amount of time. Currently, the state will announce contract awards on November 14, 2011, with enrollment and coverage beginning on April 1, 2012. Compared to other RFPs released this year, Hawaii has a drastically shorter turnaround time from RFP release to proposal due date and contract award date.

RFP Timeline	Date
RFP Issued	Aug. 8, 2011
Notice of Intent to Propose	Aug. 29, 2011
Proposal Due Date	Oct. 7, 2011
Issue Proposed Capitation Rates	Oct. 7, 2011

Issue Final Capitation Rates	Nov. 7, 2011
Contract Awards	Nov. 14, 2011
Commencement of Service to Members	Apr. 1, 2012

*Evaluation Criteria*

Bidders will be evaluated on the criteria in the table below. Notably, there is no price component of the evaluation criteria. Bidders must score a minimum of 75% of possible points in each of the evaluation categories. All bidders who meet this criteria will be awarded a contract. Beginning on July 1, 2013, 40% of the auto-assignment methodology will be based on health plan scores on CAHPS and HEDIS measures. This provision of the contract echoes a strong emphasis on quality measures in the procurement process.

Criteria	Possible Points	Minimum to Pass
Experience and References	160	120
Provider Network and Services	200	150
Covered Benefits and Services	180	135
Member Services	200	150
Quality Assessment / Performance Improvement / Utilization Management	160	120
Health Plan Admin. Requirements	100	75
<b>Total</b>	<b>1,000</b>	<b>750</b>

*Prospective Vendors*

HMSA, AlohaCare, and Kaiser all responded to the state’s RFI to rebid QUEST in January 2011, as did WellCare and UnitedHealth. WellCare and United both won contracts under the QExA ABD/LTC program in 2008. Additionally, we note that AlohaCare was not awarded a contract in the QExA 2008 procurement, due to low scores in two quality categories. While the RFP will likely draw interest from other national plans, the potential for relatively few enrolled lives due to the minimum score criteria could dissuade bidders not currently established in the Hawaii market.

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## HMA MEDICAID ROUNDUP

### *California*

#### **HMA Roundup – Stan Rosenstein**

The state legislature returned to Sacramento on Monday, August 15, with several health care-related items on the agenda. The appropriations committee is set to take up both the health insurance rate regulation bill and the basic health plan bill. Additionally, a legislative hearing was held yesterday on the costs and consequences of eliminating the adult day health care program. While there is certain to be a lot of news coverage and discussion of these topics this week and next, it should be noted that the legislature may not finalize any of the big health care related items for several weeks.

### *Florida*

#### **HMA Roundup – Gary Crayton**

The Agency for Health Care Administration (AHCA) is beginning discussions with health plans in the state on draft rates for Medicaid, which are nearing release. After the initial release of draft rates, there will be a period of review and comments, with a goal to finalize rates by September 1, 2011. However, with this date only two weeks away, it is likely that rate finalization will not occur until later in September or October. CMS awarded the state an extension of the current Section 1115 waiver through August 31<sup>st</sup> while approval of the new waiver is considered. All components of the waiver have been submitted to CMS.

### *Georgia*

#### **HMA Roundup – Mark Trail**

The committee appointed by Gov. Deal to address the establishment of the exchanges met on Tuesday and voted to develop recommendations for a legislatively-established health insurance exchange in Georgia. As noted in the article below, there has been a push from the small business committee to address the need for an insurance exchange. The committee has even discussed options for a state-based exchange in the case of repeal of the Affordable Care Act.

In other news, the state has finalized its contract with Navigant Consulting on the Medicaid redesign. Additionally, the non-emergency medical transportation (NEMT) RFP bids remain under evaluation.

#### **In the news**

- **Panel endorses action on health exchanges**

Governor Deal's health insurance exchange committee voted Tuesday to develop recommendations for legislation that would create a Georgia insurance exchange, which is required under the health reform law. The vote came just four days after a federal appeals court in Atlanta struck down a central provision of that law: the requirement that individuals buy health insurance. The 11th Circuit Court of Appeals upheld the rest of

the Affordable Care Act, including a vast expansion of Medicaid. Georgia is one of 26 states suing over the reform law, and it was their case that the 11th Circuit ruled on. All the various challenges to the law are likely to be resolved eventually by the U.S. Supreme Court. The state's advisory committee on exchanges has chosen to continue work on developing an exchange for small business and individuals, despite the uncertain prospects of federal health reform. ([Georgia Health News](#))

## *Illinois*

### **HMA Roundup – Jane Longo / Rick Hamilton**

The Illinois Department of Revenue, this week, denied three requests for property tax exemptions from not-for-profit hospitals. The three hospitals denied were Edward Hospital (Naperville, IL), Decatur Memorial Hospital (Decatur, IL), and Northwestern's Prentice Women's Hospital (Chicago, IL). While details from the state have been limited, the denial of property tax exemptions is tied to the amount of charity care provided by a hospital as a portion of total revenue. However, a spokesperson for the state has said that determinations are made in light of broader community benefits, and that there is not a specific requirement for percentages of total revenue devoted to charity care. More than two dozen additional determinations on hospital tax-exempt status are due over the coming weeks. For the hospital community, loss of tax-exempt status could mean millions in additional annual expenses. It is unclear what impact, if any, these determinations will have on the hospital payment reform initiative currently underway.

### **In the news**

- **Holy Cross Hospital, Vanguard combination canceled**

The planned purchase of Holy Cross Hospital by Vanguard Health Systems of Tennessee is off. Holy Cross, a financially struggling small community hospital on the city's Southwest Side, announced the sale in mid-December. Terms had not been disclosed. The definitive agreement expired on June 30 and was not renewed. The Vanguard deal was seen as a rescue for Holy Cross. About two years ago, Holy Cross had only enough money to keep the doors open for four days before receiving a cash infusion from the state. It has struggled to turn a profit because the bulk of its patients are either uninsured or on public aid. Nashville, Tenn.-based Vanguard's other Chicago-area hospitals include MacNeal in Berwyn, Weiss Memorial in Chicago and Westlake in Melrose Park. Vanguard also owns West Suburban Medical Center in Oak Park. Vanguard bought West Suburban and Westlake Hospital last August from Resurrection Health Care. ([Crain's Chicago](#))

## *United States*

### **HMA Roundup – Lillian Spuria**

Last Friday, HHS release three proposed rules on "Easy, Simple Access to Coverage for Consumers and Small Businesses," the Health Insurance Premium Tax Credit, and eligibility rules in the Exchanges and Medicaid. Of particular interest to many states, uncertain of the task of sorting out individuals newly eligible and previously eligible for Medicaid, was the proposal of three options for states to calculate federal matching rates for

enrollees. Under the Affordable Care Act, those newly eligible for Medicaid will initially receive 100% federal matching, while those eligible under current standards will, in most cases, receive the current matching rate. The aim of these rules is to avoid a burdensome eligibility determination process each time an individual enrolls in Medicaid. The regulation offers the following options for States to calculate the 100 % FMAP:

1. A state can apply eligibility thresholds in effect as of December 1, 2009.
2. A state can use a statistically valid sampling methodology to determine portion of expenditures to which 100% FMAP applies.
3. A state can use a CMS-determined FMAP calculation.

One point to note is that if the federal government wishes to score the savings attributable to the administrative efficiencies created by this proposed rule, the changes must be enacted through legislation, rather than regulation issued by HHS.

There will continue to be significant discussion on the proposed rules in the coming weeks. We will follow this as well as provide more detailed analysis of the proposed rules when it becomes available. For details on the \$185 million in federal exchange grant awards, also announced last week, please see the article below.

### **In the news**

- **Health-Plan Buyers Get a Look Under the Hood**

Consumers shopping for health insurance will soon get a peek at a new standard form that will lay out the details of each policy. Federal regulators are expected to unveil the proposed summary form, part of the health-care overhaul law, on Wednesday, and the requirement is supposed to take effect next March. Insurers said they were concerned about the potential cost and administrative burden of the new requirement, particularly if they have to create different iterations of the form for every possible plan design a consumer could explore and for every single employer. ([Wall Street Journal](#))

- **HHS may have to get 'creative' on exchange**

A quirk in the Affordable Care Act is that while it gives HHS the authority to create a federal exchange for states that don't set up their own, it doesn't actually provide any funding to do so. By contrast, the law appropriates essentially unlimited sums for helping states create their own exchanges. The lack of funding for a federal exchange complicates what is already a difficult task. HHS will likely be operating exchanges in states like Louisiana and Florida that oppose the ACA on principle and have said they will not comply with the exchange provisions. But HHS also will likely be responsible for several other states that may want to set up exchanges, but will be unable to enact laws and set up the infrastructure under the short time frame specified by the law. ([Politico](#))

- **Health Reform - What's Next**

Last week's ruling by a three judge panel of the 11th Circuit Court of Appeals almost insures that the Obama health reform law will reach the U.S. Supreme Court, but the timing of that remains unclear at best. The Obama Administration can choose to appeal last Friday's decision to the full 11th Circuit Court of Appeals, or go straight to the

Supreme Court. As of Monday, it still wasn't clear what the Justice Department decision would be; the feds have 90 days to decide. ([Atlanta Journal Constitution](#))

- **HHS awards \$185M in exchange grants**

Thirteen states will split \$185 million in grants to help establish the insurance exchanges created by the healthcare reform law, the Department of Health and Human Services (HHS) announced Friday. The grants are available to states that have taken some action to set up an exchange – not necessarily by passing a state law to create the new marketplace. The single largest establishment grant – more than \$38 million – went to California, the first state to pass an exchange law. ([The Hill](#))

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## OTHER HEADLINES

### Connecticut

- **State gets \$6.7 million for exchange plans; first meeting Aug. 29**

The state has secured a \$6.7 million federal grant to help create a health insurance exchange, the marketplace for purchasing coverage that must be operating by 2014 as part of federal health reform. In addition, officials announced that the first meeting of the quasi-public Connecticut Health Care Exchange will be held at 10 a.m., Monday, Aug. 29, in room 1A of the Legislative Office Building in Hartford. ([CT Mirror](#))

### Kansas

- **Insurance exchange meetings canceled by Chamber**

The remaining meetings scheduled for business leaders to learn about the proposed Kansas health insurance exchange have been canceled, the Kansas Chamber of Commerce announced today. The first meeting organized by the Chamber was Aug. 8 in Topeka. Three more were scheduled in Overland Park, Hays and Wichita. However an Aug. 9 announcement by Gov. Sam Brownback cast doubt on if and how exchange planning in Kansas might proceed. Brownback returned a \$31.5 million innovator grant awarded to Kansas for planning its exchange. ([Kansas Health Institute](#))

### Massachusetts

- **Health insurers post higher earnings**

The biggest commercial health insurers in Massachusetts yesterday posted sharply higher second-quarter earnings, citing their efforts to rein in administrative spending and a slower rise in medical costs reflected in the contracts they've negotiated with hospitals and doctors. Blue Cross Blue Shield of Massachusetts, the state's largest health insurance company, recorded net income of \$56.5 million for the three months ending June 30, a reversal from the \$14.3 million loss Blue Cross reported for the corresponding period last year. One major challenge for the health plans will be negotiating new contracts with hospitals and physicians that build on a continued moderation of price increases. The providers are also facing reimbursement cuts from their public payers for Medicare and Medicaid, the government health insurance programs for senior citizens and low-income residents. ([Boston Globe](#))

- **Did Employer Penalties Work In Massachusetts?**

The Massachusetts Taxpayer Foundation is downplaying the role of employer penalties in Massachusetts' higher than U.S.-average rate of employer insurance coverage. Instead, the foundation cites three reasons: (1) To hire qualified employees, employers must provide good benefits; (2) Employees demand health insurance in particular to avoid the individual mandate penalty; (3) Massachusetts has traditionally had high rates employer coverage. ([WBUR.org](http://WBUR.org))

## Michigan

- **Judge calls antitrust claims against Mich. Blues plausible**

In a written opinion on a motion to dismiss the lawsuit, U.S. District Judge Denise Page Hood concluded that the Justice Department and the state of Michigan had made plausible-enough allegations against Blue Cross and Blue Shield of Michigan that she decided not to throw out the case. The ruling means the case could go to trial, pending the outcome of an appeal. The Justice Department and the state of Michigan sued Blue Cross and Blue Shield of Michigan last year, alleging that the insurer's use of "most favored nation" clauses in contracts were illegally restraining free competition and driving up overall prices for healthcare in the state. Since then, federal investigators have sent requests for information on such contract provisions to five other Blue Cross insurers. Blue Cross argued that its conduct was protected because it is a "quasi-public" entity using contracts to get the best rates for its customers. ([Modern Healthcare](#))

- **House Appropriations Tightens Health Claims Tax**

The new 1 percent tax on all health insurance claims, critical to funding the 2011-12 Medicaid budget signed earlier this year, cleared the House Appropriations Committee on Wednesday with some significant changes. A House substitute would create a \$10,000 cap on assessments collected per insured individual or covered life annually, according to the House Fiscal Agency. It also includes a January 1, 2014, sunset and a base collection amount was set at \$400 million for the first year and any amount over that would be refunded. However, that amount would be adjusted annually according to the medical inflation rate as determined by the federal government. There had been and still was concern over how much the new tax would generate, which had been a major sticking point with the Michigan Manufacturers Association when the legislation emerged from the Senate. (Michigan Gongwer News)

## Minnesota

- **GOP leaders decry Dayton plan for health exchange**

Gov. Mark Dayton's plan to use a \$4.2 million federal grant to help plan a state health insurance exchange came under fire today from Republican legislators. They even hinted at a lawsuit to stop the action. Dayton, though, thinks the state health insurance exchange is a good thing. The new funding, from the U.S. Department of Health and Human Services, will be used by the state Commerce Department to "assist with exchange development, technical infrastructure, and stakeholder work groups to help design an insurance exchange marketplace." ([MinnPost](#))

## Wisconsin

- **Mental health reforms hit snags**

Milwaukee County's efforts to overhaul its troubled and outdated mental health operation have slowed, as hitches in federal funding, disagreement over building a new Mental Health Complex and overlapping planning efforts have cropped up. The months-long transition between the administration of Gov. Scott Walker, who left as county executive late last year, and that of Chris Abele, the new county executive elected in April, also contributed to wheel spinning on mental health reform, according to county officials and reform advocates. ([Milwaukee Journal Sentinel](#))

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## RFP CALENDAR

Below we provide our updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
August 22, 2011	Kentucky RBM	Bids due	N/A
September 1, 2011	Texas (Jeff. County)	Implementation	100,000
September 15, 2011	Washington	RFP Released	880,000
September 15, 2011	Nebraska	RFP Released	60,000
September 15, 2011	Kentucky RBM	Contract awards	N/A
October 1, 2011	Kentucky	Implementation	460,000
October 1, 2011	Arizona LTC	Implementation	25,000
October 1, 2011	Kentucky RBM	Implementation	N/A
October 3, 2011	Massachusetts Behavioral	Contract awards	386,000
October 7, 2011	Hawaii	Bids due	225,000
October 15, 2011	New Hampshire	RFI Released	N/A
December 1, 2011	Hawaii	Implementation	225,000
January 1, 2012	Virginia	Implementation	30,000
January 1, 2012	Louisiana	Implementation	892,000
January 15, 2012	New Hampshire	Contract awards	N/A
March 1, 2012	Texas	Implementation	3,200,000
March 1, 2012	Massachusetts Behavioral	Implementation	386,000
Early 2012	Nebraska	Contract awards	60,000
April 1, 2012	New York LTC	Implementation	200,000
July 1, 2012	Washington	Implementation	880,000
July 1, 2012	Florida	LTC RFP released	2,800,000
July 1, 2012	New Hampshire	Implementation	N/A
January 1, 2013	Florida	TANF/CHIP RFP released	2,800,000
October 1, 2013	Florida	LTC enrollment complete	2,800,000
October 1, 2013	Florida	TANF/CHIP enrollment complete	2,800,000

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## HMA WELCOMES...

### **Maurice Lemon - Principal**

On Monday, August 15th, Maurice Lemon will re-join HMA as a Principal in the Chicago office. Maurice has previously worked with HMA, both as a part-time colleague and subcontractor. After a brief time with HMA, Maurice was asked to assume the responsibilities of Chief Medical Officer at Stroger Hospital of Cook County, a role he has held since mid-2008.

Maurice has spent much of his career at Stroger Hospital, starting as an Attending Physician, serving as Residency Director for Primary Care Internal Medicine and as Section Chief for Primary Care, leading in the Department of Medicine as Program Director and then as the Associate Chairman of Education, and then Chairing the Department of Planning, Education and Research and serving as the Associate Medical Director before assuming his most recent role as the Chief Medical Officer. He is an Internist, with a certification of added qualifications in Geriatric Medicine.

Maurice earned his Bachelor degree at Brown University, his M.D. from Tufts University School of Medicine, and his Masters in Public Health at the University of Michigan.

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## HMA RECENTLY PUBLISHED RESEARCH

### *Children's Health Care: Making Great Strides*

#### **Jennifer Edwards, DrPH, HMA Managing Principal**

It is an often-repeated criticism that we have not seen monumental change in health care quality in the past decade despite the "call-to-arms" of the Institute of Medicine's seminal report, Crossing the Quality Chasm. Just quantifying the problem - 98,000 lives a year lost to medical errors and a finding that less than 50 percent of care meets standards of clinical evidence<sup>1</sup> - has not mobilized enough changes in health care delivery to register much improvement in health outcomes. There is some new work quietly percolating, though, that has the potential to make major improvements in health outcomes for children. ([Read more](#))

### *California 1115 Medicaid Waiver*

#### **Stan Rosenstein, HMA Principal Advisor**

The historic renewal of the California 1115 Medicaid waiver will bring billions of new federal dollars to the state's hospital safety net, enabling California to begin full-scale implementation of national health care reform and jump start reform of its public hospital delivery systems. The 1115 waiver provides California flexibility to use Medicaid funding in new ways to improve its program. ([Read more](#))

## ***Florida Reviews Taxpayer Funded Hospitals***

**Elaine Peters, HMA Principal**

The new Florida Commission on Review of Taxpayer Funded Hospital Districts is considering "whether it is in the public's best interest to have government entities operating hospitals, and what is the most effective model for enhancing health care access for the poor." Governor Rick Scott, a former for-profit hospital executive, has said he is "confident this new Commission will protect Florida taxpayers, and at the same time, the Commission's guidance will help provide Floridians a high-quality health care system." The Commission will evaluate how effectively privately owned and non-profit hospitals can care for the uninsured and low-income populations, a role generally filled by public hospitals. Expected outcomes include a more rational approach to compensating hospitals. ([Read more](#))

## ***Achieving Efficiency: Lessons from Four Top-Performing Hospitals***

**Sharon Silow-Carroll, HMA Managing Principal**

**Jennifer Edwards, DrPH, HMA Managing Principal**

**Aimee Lashbrook, HMA Senior Consultant**

Despite widespread acknowledgment of waste and inefficiency in the U.S. health care system, there have not been dramatic breakthroughs that point to more cost-effective alternatives. But changes under way at leading health care organizations suggest significant improvements in quality and value can be achieved.

A new report synthesizing findings from four hospital case studies showcases opportunities for all hospitals to achieve greater efficiency. The case studies focus on four of the 13 Leapfrog Group-designated "Highest Value Hospitals." ([Link to Report](#))

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## **UPCOMING HMA APPEARANCES**

### ***Aging Services of Michigan, Annual Leadership Institute***

*Vernon K. Smith, keynote speaker*

August 25, 2011

Traverse City, Michigan

### ***Osteopathic Physicians and Surgeons of California, 22<sup>nd</sup> Annual Fall Conference***

*Dennis Litos, featured speaker*

September 9, 2011

Monterey, California

**Keys to Success: Unlocking Critical Issues Involved in Creating an Arizona Health Insurance Exchange – Sponsored by St. Luke’s Health Initiatives**

*Donna Strugar-Fritsch, featured speaker*

September 16, 2011

Phoenix, Arizona

**Western Association of Medicaid Pharmacy Administrators,**

*Vernon K. Smith, keynote speaker*

September 19, 2011

Anchorage, Alaska