HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: ARIZONA'S DECISION TO EXPAND MEDICAID UNDER ACA

HMA ROUNDUP: ARIZONA DUALS DEMONSTRATION UPDATE; GEORGIA, NEW YORK GOVERNORS RELEASE BUDGET PROPOSALS; TEXAS ISSUES MMIS RFI; INDIANA GOV. DEFERS TO LEGISLATURE AS MEDICAID EXPANSION BILL INTRODUCED

OTHER HEADLINES: WELLCARE TO ACQUIRE AETNA'S MISSOURI CARE PLAN; PROPOSED FEDERAL POLICY COULD MEAN MORE MEDICAID CO-PAYS; FLORIDA SENATE COMMITTEE DEBATES MEDICAID EXPANSION ECONOMICS; MINNESOTA LEGISLATORS PUSHING BASIC HEALTH PLAN OPTION; ALABAMA PANEL ENDORSES COMMUNITY-BASED MANAGED CARE; NEW MEDICAID DIRECTOR TAKES OFFICE IN OKLAHOMA

HMA WELCOMES: MICHEALLE GADY – OLYMPIA, WA

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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: ARIZONA'S DECISION TO EXPAND MEDICAID UNDER ACA

This week, our *In Focus* section reviews Arizona's recent decision to expand Medicaid under the Affordable Care Act (ACA). While many states have been grappling with the decision of whether or not to expand Medicaid since the June 2012 Supreme Court ruling, Arizona is one of the only states to release a report documenting their financial justification for the expansion. Possibly motivated by the political climate in the state, the report and slides that accompany the report provide insight into Arizona's rationale for expansion, as well as potential insight into the decision-making occurring in other states as they consider the Medicaid expansion.

On Monday, January 14, 2013, Governor Jan Brewer announced her decision to expand Medicaid in accordance with the ACA. The Governor's office published a report, "Difficult Choice: Expanding Adult Medicaid Coverage" (link to PDF) and slides (link to PDF), detailing the rationale for the Governor's decision.

Key Highlights of Arizona Medicaid Expansion

- Over three fiscal years (2014-2016), Arizona can insure 247,300 new individuals through Medicaid, drawing more than $3.6 billion federal revenue at state costs of $286 million.
- Shifting the Phoenix hospital assessment to the state, combined with increased revenue under existing premium tax, could net Arizona more than $350 million in savings from FY 2014-2016.
- Expanding Medicaid can protect residents below the Exchange subsidy floor from unaffordable insurance costs, while providing necessary economic competitiveness as states attract jobs and new businesses going forward.

Medicaid Expansion Impact

The Governor's office report included the following estimates for state costs and savings, as well as the estimated magnitude in new federal funds received and the number of newly insured lives through the Medicaid expansion. We have included three-year cumulative totals based on the report estimates for fiscal years (FY) 2014 through 2016.

	FY 2014	FY 2015	FY 2016	Cumulative
State Match Increase	$27 M	$154 M	$105 M	$286 M
GF Savings per Provider Tax	($82 M)	($256 M)	($224 M)	($562 M)
Add'l Insurance Premium Tax	($7 M)	($34 M)	($36 M)	($77 M)
Net Cost (Savings)	**($62 M)**	**($136 M)**	**($155 M)**	**($353 M)**
Federal Funds Received	$337 M	$1.556 B	$1.712 B	$3.605 B
Newly Insured	**101,900**	**239,200**	**247,300**	**247,300**

Source: Arizona Governor's Office. "Difficult Choice: Expanding Adult Medicaid Coverage." January 14, 2013.

The report anticipates additional revenues will more than offset the costs of increased state matching funds through a proposal to shift the hospital provider assessment from cities to the state government, as well as increased revenue under the existing two percent premium tax. Even without the provider assessment and premium tax impacts, Arizona would receive an injection of federal funds of more than $3.6 billion over three years for only $286 million in state costs, a return of more than 12-to-1 on state funds. Furthermore, the state would spend less than $1,200 per additional insured individual over a three year period, an average of less than $400 per fiscal year per enrolled individual.

Unique to Arizona

There are several assumptions and scenarios buried within the estimates above that are unique specifically to Arizona or to only a handful of other states:

- **Childless Adult Expansion:** In 2000, Arizona expanded Medicaid coverage to all individuals with income below 100 percent of federal poverty level (FPL). The state received Medicaid Waiver approval for the expansion and received standard federal matching funds for this eligibility group. However, facing budget pressures, the state put a freeze on new enrollments, and since July 2011, enrollments in this population (Prop. 204) have fallen from 227,000 to an estimated 86,000. Going forward with the Medicaid expansion will allow Arizona to unfreeze enrollment and to receive increased funding on this eligibility group. Because Arizona has previously expanded coverage below 138 percent FPL, their federal matching structure beginning January 1, 2014, will be as follows:
  - 100 percent federal match (falling to 90 percent in out years) for parents and childless adults not covered under Prop. 204 from 100 to 138 percent FPL; and
  - 85 percent federal match (rising to 90 percent in out years) for restored eligibility to childless adults below 100 percent FPL.
- **Hospital Assessment:** The Phoenix City Council adopted a six percent hospital assessment on net patient revenue that, when matched roughly 2-to-1 with federal dollars, provides about $400 million in additional revenue to Phoenix hospitals to offset uncompensated care costs. Upon the assessment's expiration on December 31, 2013, the Governor has proposed that the hospital assessment be redirected to the state and expanded statewide. As noted in the table above, this would generate more than $560 million over three years (FY 2014-2016). The legislature would have to approve the change to the assessment.

Broader Arguments for Medicaid Expansion

Outside of the Arizona-specific justifications for expanding Medicaid above, the state's report outlines several broader arguments for expansion.

- **Taxpayer Dollars:** Arizona contends that, because the expansion is funded (at least in the initial years) by the federal government, the effect of not expanding is to send its state's federal tax dollars to other state who have chosen to expand.

- **Economic Impact:** Arizona likens the economic impact of the influx of federal dollars to an additional Air Force Base, another Intel facility, or three additional Cactus League baseball teams.
- **Economic Competitiveness:** As the state competes for jobs and business, the Governor's office believes employers will look closely at the cost of health care in deciding where to locate their business. States that adopt the Medicaid expansion will have a competitive advantage, since employers will not need to underwrite the cost of uncompensated care.
- **Overlap with Insurance Exchange:** The report gives the extreme example that, without a Medicaid expansion and Exchange subsidies only available above 100 percent FPL, individuals just under the subsidy floor could be left to face insurance costs of as much as 45 percent of their total income if purchased on their own.

HMA Medicaid Roundup

Arizona

HMA Roundup

The Arizona Health Care Cost Containment System (AHCCCS) released guidance on January 15, 2012 related to the state's dual eligible demonstration proposal. Specifically, AHCCCS notified MCOs that the state has not determined whether or not it will be pursuing the financial alignment initiative with CMS. Accordingly, plans should file applications to operate as Medicare/Medicaid Plan if the Demonstration moves forward and as Medicare Advantage Dual Eligible Special Needs Plan (D-SNP) if the State does not reach an agreement with CMS. Applications for both models are due to CMS by Feb. 21, 2013. If it does move forward with the Financial Alignment Initiative, AHCCCS is still aiming for Jan. 2014 implementation date. Link

Colorado

HMA Roundup – Joan Henneberry

Community-based Care Transitions Program: The Center for Medicare & Medicaid Innovation has announced Colorado as one of 35 new sites to participate in a Community-based Care Transitions Program (CCTP). As the designated Area Agency on Aging in the Denver metropolitan area, the Denver Regional Council of Governments (DRCOG) will be the grantee and serve Medicare beneficiaries living in eight counties. The model contemplates partnerships that link two hospital systems with community providers such as skilled nursing facilities, home health agencies, and various non-profit entities. The hospitals include Exempla Saint Joseph Hospital, Medical Center of Aurora, Sky Ridge Medical Center, Swedish Medical Center, Presbyterian/St Luke's Medical Center, North Suburban Medical Center and Rose Medical Center. This is an expansion of an existing project between these entities, the Denver Regional Care Connection program.

Insurance Exchange: The staff and board of the Colorado Health Benefit Exchange submitted their annual report to the Governor and legislature on January 15, 2013. The report highlights accomplishments in 2012, and challenges in 2013. In addition to the standard operational challenges they face to get ready for the October open enrollment period, COHBE needs to finalize plans for long-term financial sustainability beyond the federal grant periods, and they need to submit a Level Two grant application. Link

Georgia

HMA Roundup – Mark Trail

Governor Deal released his FY 2014 budget proposal on Friday, January 18th. The proposed changes for the Department of Community Health (DHC) budget include:

- **Medicaid – Consolidated** – The proposal is to bring the ABD and LIM Medicaid budgets back into one budget line. This will enable the DCH to manage cash flow and other fund movement without having to get legislative change in the actual

budget document. It doesn't change any other authority of the DCH; it simply affords some administrative simplification.

- **Other Transfer** – The ACA necessitated children between the ages of 6 thru 18, and between the FPL levels of 100% and 133% to be covered in Medicaid. Accordingly The proposal included a movement of $13M in state funds from PeachCare to Medicaid to accomplish that activity. Note this is not related to the optional Medicaid expansion opportunity in the ACA.

- **Medicaid (both ABD & LIM) and PeachCare** – the following items are included in the direct benefits budgets:

  - Increase funds for program growth ($88M state funds). These increases are not specifically described, however they are presumed to cover primarily enrollment growth;

  - Savings are expected from the following:

    - The federal match rates (FMAP) are increasing slightly for both Medicaid and CHIP ($4M state funds);

    - Eliminate funding for preventable hospital admissions ($1.1M state funds);

    - Anticipate savings from implementation of patient centered outcome incentives, related to case care and DM, presumed be the anticipated 'ABD ASO' program;

    - Enforce level of care determinations for LTC and HCB services. While not specified, much of this savings could result from providing a 'gatekeeping' function for programs like SOURCE;

    - Reduce narcotic prescriptions to no more than 6 per month;

    - Change outpatient hospital reimbursement methodology from a cost based to APC Grouper set pricing;

      - This proposal could be in jeopardy with the revised version of the hospital provider tax (SB 24) that passed the Senate on January 17th. That version prohibits any change in hospital reimbursement or methodology in effect on June 30, 2012. If not permissible, the Legislature will need over $34 million state funds through other savings or additional revenue (Total funds: $102 million). The Legislature cannot raise the overall revenue estimate, and would have to take revenue from another item in the budget to increase funds to cover a loss of the proposed reduction.

    - Increase number of drugs on the specialty reimbursement list;

    - Reduce all provider rates by 0.74%, excluding hospitals, primary care (presumed to be as defined in the ACA regulations), FQHC, RHC, and hospice.

In the news

- **"'Bed tax' fix passes Senate"**

  "Gov. Nathan Deal's proposed fix for the state's Medicaid funding plan cleared its first major hurdle Thursday. In just the first week of the legislative session, it passed the Senate and headed to the House. Deal had urged quick passage of Senate Bill 24. The bill would extend a 2-year-old funding mechanism known as the state's "bed tax" and avert a financial crisis in the state's budget." (Atlanta Journal Constitution)

Indiana

HMA Roundup – Cathy Rudd

Governor Mike Pence has appointed Debra Minott as Secretary of the Family and Social Services Administration, the umbrella agency that includes Medicaid. Minott served as the director of State Personnel during the Daniels administration.

Democrats have introduced a bill that would expand Medicaid under the Affordable Care Act. Although opposing the expansion in the past, Governor Pence has indicated that the issue should be decided by the legislature. The introduced bill also would establish a study committee to study and make recommendations to the legislative council concerning the establishment and implementation of a health benefit exchange in Indiana and define "essential health benefits." Governor Pence has previously indicated that Indiana would not establish a state-based exchange. Bill

Michigan

HMA Roundup – Esther Reagan and David Fosdick

Dual Eligible Demonstration: On January 17, 2013, the Michigan Department of Community Health announced that services through its dual eligible demonstration project will be provided through four identified regions. The four regions are Michigan's Upper Peninsula, Southwest Michigan (which will include the cities of Kalamazoo and Battle Creek), Macomb County (a suburban county near Detroit) and Wayne County (which includes Detroit). The demonstration would run for three years, beginning in January of 2014. Negotiations between the Federal government and the State of Michigan about the final structure of the program are still ongoing.

Medicaid Expansion: On January 16, 2013, Michigan Senator Bruce Caswell introduced Senate Bill 041, legislation that would forbid the State of Michigan from expanding Medicaid to adults under 133 percent of the Federal Poverty Level (FPL), as authorized under the Federal Affordable Care Act. The proposed bill was referred to the Senate Committee on Appropriations.

BCBS of Michigan Conversion: On January 16, 2013, Michigan Senators Joe Hune and Virgil Smith introduced Senate Bills 61 and 62 that would establish Blue Cross Blue Shield of Michigan as a not for profit mutual insurance company. This legislation is consistent with a proposal put forward by Michigan Governor Rick Snyder to dramatically change how BCBSM is regulated. Similar legislation was successfully passed during the previous legislative term but was vetoed by Governor Snyder because of language that

would forbid employer sponsored health insurance plans to provide coverage for elective abortion services. The bills have been referred to the Senate Committee on Insurance and will likely be a major focus of the Michigan Legislature early in this term.

New York

HMA Roundup – Denise Soffel

Governor Cuomo's Executive Budget Proposal: Governor Andrew Cuomo presented his $142.6 billion executive budget on January 22, 2013. The budget fills a projected a $1.3 billion budget gap, mostly by freezing state agency spending another year and streamlining government services. Total Medicaid spending, including federal, state and local share, is projected at $57.6 billion. The global Medicaid spending cap, which affects about 27 percent of total Medicaid spending, will increase by 3.9 percent, reflecting the 10 year rolling average increase in the Medical CPI. For the Medicaid expansion population under ACA they are proposing the full Medicaid benefit, excluding institutional LTC services. The programmatic direction for the Medicaid program was established by the Medicaid Redesign Team, which began its work in January 2011. The state is entering the third year of MRT implementation, with reform emphasizing the continued move to care management for all Medicaid beneficiaries, scheduled to be completed by 2016, as well as aggressive implementation of Health Homes for individuals with complex health care needs and chronic conditions. The Governor's budget projects additional savings from administrative streamlining, consolidating all Medicaid administrative functions within the Department of Health. The administrative functions are currently shared across the Department of Health, the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services, and the Office for People with Developmental Disabilities.

Health Insurance Exchange Funding: HHS announced a new round of funding for states to continue building their insurance exchanges under the Affordable Care Act on January 17, 2013. New York is receiving a Level Two Establishment Grant of $185.8 million. The funding will be used to support outreach and marketing, training for In-Person Assisters, and stakeholder engagement activities. New York will use funds to develop and operate the Call Center and back-end eligibility operations, make enhancements to the System for Electronic Rate and Form Filing (SERFF), and support costs for existing and new staff in 2013 and 2014. New York will purchase and maintain an accounting system for the Exchange, will use funds for financial and operational audits, simulation modeling, and program evaluation. Funds will also be used to pay for the balance of the marketplace IT system design and development costs (including IT consultants and privacy and security consultants). New York has received six grant awards to build its Affordable Insurance Exchange. In addition to the Level Two Establishment Grant, New York has received a Planning Grant of $1 million, an Early Innovator Grant of $27.4 million, and three Level One Establishment Grants ($10.7 million in August 2011, $48.5 million in February 2012, and $95.5 million in August 2012).

Empire Blue Cross Blue Shield: Empire BlueCross BlueShield named Brian Griffin president and general manager, effective Jan. 21. Mr. Griffin has 30 years of health-plan experience, most recently serving as chief executive of Medco Health Solutions. Mr. Griffin replaces Mark Wagar, who left his post as CEO and president.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

Pennsylvania Lottery: On January 17, Governor Corbett announced that Camelot Global Services, a U.K. based company has been selected to administer the state's lottery. Previously the state had administered the lottery through public agencies but conducted a competitive procurement for privatized management of the program beginning April 2012. Camelot agreed contribute an additional $50 million toward state programs benefiting Pennsylvania seniors including:

- **$21 million for the Aging Waiver:** The Aging Waiver Program provides in-homes service to 28,000 seniors over age 60 who are clinically and financially vulnerable.
- **$20 million for the OPTIONS Program:** OPTIONS provides care management, home-delivered meals, protective services and in-home services for individuals age 60 and older. Additional increases in revenue would help decrease the waiting list of 5,400 older adults who are waiting for home support and personal care services to keep them in their homes.
- **$5 million for Increased Investment in Area Agencies on Aging (AAAs):** Pennsylvania's 52 AAAs cover all 67 counties and serve as the front door for the Department of Aging services at the local level. The AAAs serve 600,000 people.
- **$2 million for Senior Center Modernization:** This investment will help senior centers prepare for the changing demographics and make them attractive to a younger, aging population.

The Pennsylvania Lottery was created in 1971 to generate funds for programs benefitting older adults. Since 1972, the Pennsylvania Lottery has contributed nearly $22.6 billion to programs that include property tax and rent rebates; free transit and reduced-fare shared rides; the low-cost prescription drug programs PACE and PACENET; long-term living services; and the 52 Area Agencies on Aging, including hundreds of full- and part-time senior centers throughout the state.

In the news

- **"Payroll trouble has aides in pinch"**

  "Starting Jan. 1, the state Department of Public Welfare consolidated payroll services for more than 20,000 recipients of Medicaid waivers for developmental disability and long-term living formerly processed by 37 service companies around the state. It had awarded Public Partnerships LLC, of Boston, a contract for waiver beneficiaries statewide. Under the Medicaid waiver program, patients eligible to receive in-home care submit their caregivers' timesheets to PPL, which directs Medicaid waiver reimbursements to caregivers as paychecks. But because some data from the former service companies was not received, was submitted late, was incomplete or did not conform to the new company's requirements, the company has struggled to identify all eligible caregivers, a company spokeswoman said." (Times Leader)

- **"Highmark to buy Pittsburgh health system, cash to bondholders"**

  "Insurer Highmark Inc said on Wednesday that it reached a deal to acquire a troubled Pittsburgh health care system while offering bondholders cash payouts of 87.5 cents on the dollar. The out-of-court restructuring agreement will cut West Penn Allegheny Health System's nearly $710 million of outstanding debt and inject cash into the system, likely averting a Chapter 11 bankruptcy filing, according to a statement by Highmark and a source familiar with the matter." (Reuters)

Texas

HMA Roundup – Linda Wertz

On January 17th, 2013, the Texas Health and Human Services Commission (HHSC) issued a Request for Information (RFI) for operations of the Texas Medicaid Management Information System (TMMIS) and performance of Fiscal Agent (FA) operations needed to support the Texas Medicaid Program. Among the functions, the new TMMIS vendor will be required to conduct are:

- Encounter processing and reporting for all Medicaid and State programs;
- Provider enrollment;
- Verification of client eligibility;
- Financial management and administrative reporting (i.e., Fee Schedule, Pricing)

RFI responses are due February 1, 2013 and an RFP is expected to follow later in the year. The RFI is available here.

In the news

- **"Leaders target fraud, rule out Medicaid expansion for now"**

  "Top statewide officials are opposing a recommendation allowing counties to use local revenue to pay for expanded Medicaid coverage, and instead say they are targeting fraud and improving the quality of care within the state's $30 billion program for the uninsured poor. Lt. Gov. David Dewhurst said Wednesday that expanding Medicaid under the federal health care law is off the table "at the present time." He said he didn't endorse the county option recommended by the Legislative Budget Board, which cited the proposal as a way to help relieve counties' cost of charity care. Instead, Dewhurst touted legislation by Senate Health and Human Services Committee Chair Jane Nelson, R-Flower Mound, whose anti-fraud effort targets areas including abuse within the Medicaid-paid state transportation program used by children and families to get to clinics and doctors' offices. Last year, the Houston Chronicle reported that the use of both Medicaid-paid van service and pediatric rehabilitation therapy clinics that used the vans was higher in the Rio Grande Valley than any other region in the state." (Houston Chronicle)

Other Headlines

Alabama

- **"State panel recommends community-based managed care for Medicaid reform"**

  "A state panel voted Wednesday to recommend converting the state's Medicaid system to a community-based managed-care network -- rejecting an effort to hand the program over to commercial managed-care companies. The commission's plan would divide the state into Medicaid regions, with a plan to develop a community care network in each. The state already operates similar patient care networks in four cities, but unlike private managed-care companies, those networks aren't funded with a simple per-patient fee. The commission's plan would expand those networks and move them toward the per-patient fee approach. The vote is just the beginning of potential reform for the Medicaid system, however. Williamson said it would be up to Bentley to accept or reject the recommendation. Full implementation of the change would likely require legislative action as well. The change would also require the state to get a waiver to deviate from current federal Medicaid rules." (InsuranceNewsNet)

California

- **"Report: California not ready to control inmate health care"**

  "It's too soon for California to retake control of its prison mental health system, a federal court overseer said Friday in dealing a blow to a proposal made by Gov. Jerry Brown last week. Too many inmates are still committing suicide and going untreated for their mental illness in California prisons, special master Matthew Lopes said in a 609-page report filed Friday in federal court in Sacramento. Lopes advises the federal judges who will rule on Brown's court motion last week to end the long-running class-action lawsuit over substandard treatment in prisons. The Democratic governor is also asking federal judges to lift a cap on the number of inmates, saying it would be too dangerous to release more prisoners." (San Jose Mercury News)

Florida

- **"Senators Tackle Medicaid Economics"**

  "The Select Senate Committee on PPACA heard dueling arguments from Massachusetts Institute of Technology professor Jonathan Gruber, who helped design a health plan in his state in 2006 that became the model for the 2010 federal law. One of the critics, Michael Cannon of the libertarian Cato Institute, appeared in person to debate with the virtual Gruber. Sen. Joe Negron asked the economists to focus on helping the senators with the two questions they must decide between now and the end of the legislative session: Should Florida expand its Medicaid program, as called for under the PPACA? Should the state build its own health insurance exchange or leave it to the federal government?" (Health News Florida)

- **"Florida Democrats Urge Skepticism of Florida Medicaid Waiver Request"**

  "Democratic members of Florida's congressional House delegation sent a letter Thursday to Health and Human Services Secretary Kathleen Sebelius expressing their concern over their governor's proposal for changes in the state's Medicaid program. The

Democrats urged Sebelius to be skeptical of an expedited waiver request from Florida Republican Gov. Rick Scott that they said could result in the loss of services for people needing long-term care, as well as seniors and people with disabilities. Scott has been moving to shift older and disabled Floridians into managed care already with "little oversight and few assurances that our neighbors will not lose access to the nutrition, therapy and care they need," the letter said." Florida Democrats' Letter (PDF) (CQ Healthbeat)

Kansas

- **"Ombudsman says most KanCare concerns are being resolved"**

"Kancare Ombudsman James Bart today assured members of the Senate Public Health and Welfare Committee that he's been able to resolve most of the 74 complaints that have reached his office since it opened on Jan. 2. Bart said he's heard from 46 consumers and 28 providers. Almost 95 percent of the concerns raised by providers and 89 percent of those raised by consumers were resolved within a few hours or days. The remaining issues, he said, were in the process of being addressed." (Kansas Health Institute)

Maryland

- **"2 Medicaid health care groups freeze local enrollment"**

"Two Medicaid health care organizations have stopped accepting new Frederick County members into programs serving low-income families with children and people with disabilities. The high cost of providing health care in rural areas coupled with diminished revenue prompted Priority Partners Managed Care Organization to halt expansion in Frederick County and 11 other Maryland jurisdictions. Another organization, Maryland Physicians Care, is also freezing enrollment in its comprehensive care program. Physicians Care is also shutting down a program that provided almost 300 county adults with primary care, according the local health department." (Frederick News Post)

Minnesota

- **"MinnesotaCare: Legislators ask feds to preserve health insurance program"**

"A bipartisan group of legislators is asking the federal government to help Minnesota tap funds that could preserve and improve the MinnesotaCare health insurance program. MinnesotaCare was created by the Legislature in 1992 as a way to provide coverage to lower-income people who don't get health insurance through their jobs. The future of the program has been in question because of the federal Affordable Care Act of 2010, which will offer premium subsidies for people to buy coverage through new insurance marketplaces known as health exchanges. But in a Thursday, Jan. 17, letter to federal officials, a bipartisan group of legislators signaled support for extending MinnesotaCare by tapping federal funds available to states that create what the federal health law calls a "Basic Health Plan." These new plans would cover a similar group of people to those currently enrolled in MinnesotaCare." (Twin Cities Pioneer Press)

Nevada

- **“Medicaid cost sharing will be hot debate in Nevada”**

“Gov. Brian Sandoval's recommendation that Medicaid recipients share in the cost of care has been met with criticism from advocates for the poor, but the agency chief who oversees Nevada's complex social safety net programs says such requirements are not a new concept. But critics say while that may be true for some programs, requiring co-payments from Nevada's poorest residents to receive care goes beyond acceptable boundaries.” (Associated Press)

New Hampshire

- **“Medicaid shortchanging N.H. nursing homes”**

“The Granite State leads the nation in Medicaid underpayment to nursing home providers, according to an annual study released by the American Health Care Association. The study released by Eljay LLC, titled "A Report on Shortfalls in Medicaid Funding for Nursing Center Care," projects that Medicaid underpayment to providers will exceed $7 billion nationally. On a per-resident, per-day basis, the average 2012 projected shortfall amount is $22.34. This is the largest shortfall reported since the inception of the study in 1999. New Hampshire leads the nation in terms of daily rate shortfall. The report projects that in 2012, Medicaid paid skilled nursing facilities (nursing homes) an average of $57.38 per day less than it costs to care for a resident enrolled in Medicaid. Over the course of the year, this shortfall will amount to a loss of $93,224,793 for New Hampshire care providers.” (Seacoast Online)

North Carolina

- **“NC health chief works on Medicaid billing systems”**

“North Carolina's new health secretary announced directives on Friday related to a beleaguered new Medicaid claims processing system she aims to ensure comes online smoothly and without unnecessary expenses. Health and Human Services Secretary Dr. Aldona Wos ordered no more program changes to the current 1970's-era billing computer system by the system vendor unless they're absolutely required to ensure providers are paid or patients are covered. Wos also said that outside consultants have been brought in to find any obstacles to the replacement system - one of the largest information projects in state government - to begin operating July 1.” (WTVD ABC News)

Oklahoma

- **“Incoming CEO for Oklahoma Medicaid agency faces challenges”**

“Nico Gomez, 41, has been tapped to be the next CEO of the $5 billion-a-year Oklahoma Health Care Authority - Oklahoma's Medicaid agency.” (Tulsa World)

Oregon

- **“Oregon bets it can slow rising Medicaid costs”**

“In 2011, Gov. John Kitzhaber faced a vexing problem: The state had a $2 billion hole in its Medicaid budget and no good way to fill it. The deal Kitzhaber struck was this: The Obama administration would give the state $1.9 billion over five years, enough to

patch the budget hole. The catch: To secure that, Oregon's Medicaid program must grow at a rate that is 2 percent slower than the rest of the country, ultimately generating $11 billion savings over the next decade. If it fails, those federal dollars disappear. Under the new deal, Oregon does not get a lump-sum payment. Instead, the federal government doles out the $1.9 billion over five years. If the state cannot deliver cost savings up front, while hitting certain quality metrics, it's cut off. The money it needs to keep doctor salaries stable and patients' benefits covered dries up." (Herald and News)

Utah

- **"Utah's most populous county endorses Medicaid expansion"**

"For the Salt Lake County Council, Republicans as well as Democrats, the financial ramifications to the county of not expanding Medicaid coverage in Utah are so great that they overshadowed philosophical reservations some had about embracing the federal health care reform law. [The council passed] an 8-0 vote Tuesday to encourage Gov. Gary Herbert and the Legislature to expand Medicaid to include more of Utah's poor." (Salt Lake Tribune)

Vermont

- **"Hospitals join to take big health overhaul step"**

"The two big academic medical centers serving Vermont, often seen as rivals in the past, announced Friday they are joining forces with 13 other Vermont hospitals and health clinics to form a new ''accountable care organization'' — OneCare Vermont — to focus on efficiency and quality in health care. The announcement by Burlington-based Fletcher Allen, a teaching hospital affiliated with the University of Vermont College of Medicine, and the Dartmouth-Hitchcock Medical Center, the hospital affiliated with Dartmouth's Geisel Medical School, was welcomed by Gov. Peter Shumlin, who said it squared with his push for a streamlined, universal health care system to serve all Vermonters, who are to have government-backed health insurance by 2017." (Boston Globe)

National

- **"HMO-like Plans May Be Poised To Make Comeback In Online Insurance Markets"**

"Limited network plans -- which have begun a comeback among employers looking to slow rising premiums -- are expected to play a prominent role in new online markets, called exchanges, where individuals and small businesses will shop for coverage starting Oct. 1. That trend worries consumer advocates, who fear skimpy networks could translate into inadequate care or big bills for those who develop complicated health problems. Because such policies can offer lower premiums, insurers are betting they will appeal to some consumers, especially younger and healthier people who might see little need for more expensive policies." (Kaiser Health News)

- **"Many Medicaid Patients Could Face Higher Fees Under a Proposed Federal Policy"**

"Millions of low-income people could be required to pay more for health care under a proposed federal policy that would give states more freedom to impose co-payments and other charges on Medicaid patients. Hoping to persuade states to expand Medi-

caid, the Obama administration said state Medicaid officials could charge higher co-payments and premiums for doctors' services, prescription drugs and certain types of hospital care, including the "nonemergency use" of emergency rooms. State officials have long asked for more leeway to impose such charges." (New York Times)

- **"Easiest Path to Mental Health Funding May Be Medicaid Expansion"**

  "Because Medicaid includes mental-health benefits, those states that opt into the Medicaid expansion included in President Obama's Affordable Care Act will be able to make mental health coverage available to thousands of their citizens who do not now have it." (Stateline)

- **"States to Share $1.5 Billion More in Exchange Grants"**

  "With fewer than nine months to go before Americans are supposed to be able to enroll in the new health care law insurance marketplaces, Health and Human Services officials announced Thursday that $1.5 billion more in grant money will be available to 11 states as they work to meet that deadline. Five states — California, Kentucky, Massachusetts, New York and Oregon — were awarded level two exchange grants, which are multi-year grants for states furthest along in developing their marketplaces. California will receive the largest share of the money, $973.7 million. The other six states — Delaware, Iowa, Michigan, Minnesota, North Carolina and Vermont — will get level one, one-year grants to begin building their marketplaces. Of those states, Delaware, North Carolina and Michigan are not planning to do their own exchanges. (CQ Healthbeat)

Company News

- **"WellCare To Acquire Aetna's Missouri Care"**

  "WellCare Health Plans, Inc. announced that it has entered into an agreement to acquire Missouri Care, Inc., a subsidiary of Aetna, Inc. As of December 2012, Missouri Care serves more than 100,000 MO HealthNet Medicaid program members in 54 counties across the state. Missouri Care has an extensive provider network that includes more than 50 hospitals and 9,500 physicians." (WellCare News Release)

- **"Insurers may prove choosy with overhaul exchanges"**

  "UnitedHealth Group Inc. CEO Stephen Hemsley told analysts the insurer's involvement in online exchanges that are expected to help millions buy coverage will depend on whether it's financially viable for the company. "We will only participate in exchanges that we assess to be fair, commercially sustainable and provide a reasonable return on the capital they will require," he said. These exchanges are expected to start accepting enrollment this fall for coverage that begins in 2014. Customers will use the websites, which will vary by state, to compare policies and apply income-based tax credits toward their bills. Many details on the exchanges have yet to be worked out, so Hemsley said the company hasn't made any specific decisions. But he estimated that UnitedHealth will participate initially in roughly 10 to 25 exchanges, when at least 100 might be set up." (Milwaukee Wisconsin Journal Sentinel)

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.

TBD	Nevada	Contract Awards	188,000
January 28, 2013	Arizona - Acute Care	Proposals due	1,100,000
January, 2013	Vermont Duals	RFP Released	22,000
January, 2013	Virginia Duals	RFP Released	65,400
January, 2013	South Carolina Duals	RFP Released	68,000
January, 2013	District of Columbia	Contract Awards	165,000
February 1, 2013	New Mexico	Contract awards	510,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March 15, 2013	Florida acute care	Proposals Due	2,800,000
March, 2013	Idaho Duals	RFP Released	17,700
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April 1, 2013	Vermont Duals	Contract awards	22,000
April 1, 2013	Virginia Duals	Contract awards	65,400
April, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
April-May, 2013	Rhode Island Duals	RFP Released	22,700
May 1, 2013	District of Columbia	Implementation	165,000
May 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
June, 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	Capitated	24,189					1/1/2014
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012		Fall 2013
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	March 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013
Michigan	Capitated	198,644	TBD	TBD	TBD		1/1/2014
Missouri	MFFS‡	6,380					10/1/2012
Minnesota		93,165	Not pursuing Financial Alignment Model				
New Mexico		40,000	Not pursuing Financial Alignment Model				
New York	Capitated	133,880					1/1/2014
North Carolina	MFFS	222,151					TBD
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	X	9/1/2013
Oklahoma	MFFS	104,258					7/1/2013
Oregon		68,000	Not pursuing Financial Alignment Model				
Rhode Island	Capitated	22,737		Apr-May 2013	6/1/2013		1/1/2014
South Carolina	Capitated	68,000	Jan. 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402		Late 2012	Early 2013		1/1/2014
Virginia	Capitated	65,415	Early 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	Jan. 2013	3/11/2013	4/1/2013		1/1/2014
Washington	Capitated/MFFS	115,000	TBD	TBD	TBD	MFFS Only	1/1/2014
Wisconsin	Capitated	17,600	X	8/23/2012	10/1/2012		4/1/2013
Totals	**17 Capitated 7 MFFS**	**2.4M Capitated 485K FFS**	***5***			***3***	

*** Duals eligible for demo based on 8 counties included in May 31, 2012 proposal to CMS. Will expand to further counties in 2014 and 2015 with approval.*

+ Acute Care Managed Care RFP Responses due January 2013; Maricopa Co. Behavioral RFP Responses due October 2012. Duals will be integrated into these programs.

‡ Capitated duals integration model for health homes population.

HMA Welcomes…

Michealle Gady, Senior Consultant – Olympia, Washington

Michealle comes to us most recently from Families USA in Washington, DC where she served as a Senior Health Policy Analyst for the last few years. In this role, Michealle led the organization's work in the area of health system reform and provided analysis of cost containment, health care delivery transformation, and quality improvement policies. She prepared written materials (to include reports, briefs, and fact sheets), technical analysis of policies and regulations, regulatory comments for submission to federal agencies, and Congressional testimony. Additionally she provided substantive technical assistance and strategic guidance to state and national health care advocates on a wide range of issues to include ACOs, Medicaid Health Homes, and quality measurement.

Prior to her work with Families USA Michealle served in several roles in Washington DC - Health Counsel for the Office of Congressman Lloyd Doggett, Deputy Policy Director and Counsel for the Medicare Rights Center, and Health Policy Analyst/Health Care Finance for the American Public Health Association. She has also worked as a Constituent Service Representative for Senator Lieberman. In these various roles Michealle was responsible for formulating legislative initiatives for Health and Social Security issue areas, writing speeches for Congressman Doggett, as well as representing Medicare clients in Medicare appeals.

Michealle holds a Juris Doctor from Quinnipiac University School of Law and a Bachelor of Science degree majoring in Rehabilitation Services from Springfield College.