HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: UPCOMING 2013 STATE LEGISLATIVE ISSUES

OTHER HEADLINES: ENROLLEES FILE SUIT AGAINST CALIFORNIA MEDICAID OVER MANDATORY MCO ENROLLMENT; COLORADO GOV. LIKELY TO EXPAND MEDICAID, ILLINOIS EXPANSION SUPPORTED BY HOSPITALS, HEALTH PLANS; NETWORK CONCERNS AS KANSAS MCOS GO LIVE; HHS GRANTS ADDITIONAL APPROVALS TO STATE EXCHANGES; DC CHARTERED AUDIT RESULT, SALE TO AMERIHEALTH MERCY DELAYED

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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: UPCOMING 2013 STATE LEGISLATIVE ISSUES

This week, our *Weekly Roundup* takes a look at upcoming legislative issues states will face in 2013. In lieu of our normal format, we have asked our Roundup contributors to highlight what is coming up for their state's legislature in the coming year.

California

HMA Roundup – Stan Rosenstein

- On January 10, 2013, it is anticipated that Governor Brown will issue his plan for implementing the Affordable Care Act in California, including various insurance reforms and the Governor's approach to addressing the Medicaid expansion in California. Related to the Medicaid (Medi-Cal) expansion, the LA Times reported that Health and Human Services Secretary Diana Dooley stated that "expanding Medi-Cal was not the only way forward…and that there are several paths to implementing the Affordable Care Act." While not stated in the article, one alternate path could be to continue the existing county operated Low Income Health Programs (LIHPs). If this path were chosen, the expansion might not be statewide nor up to the 138 percent poverty level provided in the Affordable Care Act, and the state could forgo obtaining the enhanced federal matching funds.
- Also on January 10, 2013, Governor Brown will propose his Budget for fiscal year 2013-14. While the state's fiscal situation has improved with the passage of Proposition 30, it is anticipated that the state will still have a structural deficit (though smaller) requiring cost savings proposals in Medi-Cal. The Brown Administration has stated that it plans to continue the 10 percent provider rate reduction recently approved by the 9th Circuit Court.

Colorado

HMA Roundup – Joan Henneberry and Emma Carpenter

According to the Colorado Health Institute, the three main themes in health care being considered in the upcoming legislative session will be Medicaid expansion, insurance regulations, and increased focus on behavioral and oral health. It is anticipated that bills related to all three will be introduced.

- Senator Irene Aguilar, Chair of the Senate Health and Human Services Committee, will likely introduce a bill that mandates expansion of Medicaid in Colorado to 133% of the federal poverty level per the ACA. Republicans are worried about long-term sustainability of the expansion, even with Federal help. Governor John Hickenlooper has signaled he will support an expansion, but final figures on the out-year costs are not due out for a few more weeks.
- The Division of Insurance will push for legislation that harmonizes current insurance structures with the Affordable Care Act, with focus on simplifying adminis-

trative processes as well as reconciling benefits and coverage of preventative services.

- Earlier this month (12/14), Governor Hickenlooper gave a speech recommending improved behavioral health care and a new focus on mental illness. His plan, costing $18.5 million, includes more beds for those transitioning out of institutions and prison, more housing vouchers for patients released from in-patient care, and expanding the 24-hour crisis hotline to be available outside of Denver. (http://capsules.kaiserhealthnews.org/index.php/2012/12/colorado-gov-pitches-plan-to-mend-mental-health-safety-net/)
- Additional measures being considered are real-time transfer of mental health records to the Colorado Bureau of Investigation, creation of a Mental Health Crisis Response Team, and an expanded substance abuse benefit for Medicaid patients.
- Potential oral health initiatives include Medicaid dental coverage for pregnant women and adding a dental benefit for adults on Medicaid.
- Senator Irene Aguilar has pre-released the "Health Care Cooperative Bill" she will introduce in the upcoming session. The bill will allow Colorado voters to decide to set up a statewide health care Cooperative to provide universal access to health care. (http://www.healthcareforallforless.com/BILL/)

Florida

HMA Roundup – Elaine Peters

- The 2013 Legislative Session convenes on March 5, 2013, and ends May 3, 2013 (60 days).
- Governor Rick Scott is scheduled to meet on January 7 with US HHS Secretary Kathleen Sebelius to discuss his concerns with federal officials concerning implementation of the federal health care overhaul. The Scott administration released new estimates on 12/20 contending that the federal health care overhaul would cost the state nearly $26 billion over 10 years if fully carried out.
- Both the House and Senate have formed the Select Committee on ACA that will review and make recommendations that will focus on protecting individual choice, limiting regulatory burdens, and promoting better value in health care purchasing. The Committee will study the following:
    - Health Insurance Exchange – review options, exchange functions, eligibility and enrollment.
    - Medicaid Expansion – review eligibility changes, simplification and enrollment, coordination with Florida Health Choices and Florida Healthy Kids Corporation, and fiscal impact of expansion.
    - Medicaid Eligibility System – review modified adjusted gross income (MAGI) changes, flexibility, replacement of current ACCESS/FLORIDA system.

    - Market Reforms – review market regulations, consumer protections and rate review.
    - State Group Health Insurance – review changes and fiscal impact to comply with the law.

- The 2011 Legislature approved statewide Medicaid managed care expansion. A decision is expected from CMS in February 2013 regarding federal approval of long term care managed care. The Agency recently released the invitation to negotiate (ITN) for Managed Medical Assistance and has been in discussions with CMS. Issues regarding managed care implementation may necessitate legislative changes.
- State Rep. Debbie Mayfield is filing a bill requiring more affordable insurance coverage for certain oral cancer treatments.

Georgia

HMA Roundup – Mark Trail

- The Georgia legislature will convene on January 14, 2013. A key item on the agenda will be renewal of the hospital provider tax. At risk is over $200 million in revenues to the state, as well as funding to many Georgia hospitals.
- With regard to the budget, the Department of Community Health (DCH) has provided budget reduction proposals for amended year 2013 and fiscal year 2014, accommodating only a portion of the Governor's 3 percent to 5 percent cut. We expect additional budget reductions to emerge in the Governor's budget proposals, which could become more severe if the hospital provider tax is not renewed. The current tax expires in June 2013, and the legislature is expected to address the expiration during its session in the first quarter of 2013.
- The state also plans to submit a 1915(b) waiver proposal to CMS that would enable DCH to implement a fee-based care coordination program for ABD beneficiaries in the state. DCH intends to contract with one ASO vendor statewide, selected through a competitive procurement, and has targeted October 2013 for implementing this program.
- DCH intends to select from one of the existing Medicaid managed care organizations to cover the state's foster care population

Illinois

HMA Roundup – Matt Powers and Jane Longo

- **Medicaid Expansion**. The most immediate issue is the authorization of the Medicaid expansion. This will be considered in the early part of January 2013; the primary vehicle is HB 5263.
- **Exchange**. Illinois is partnering with the federal government for its Exchange. The Department of Healthcare and Family Service (HFS) hopes to have a state-run Exchange in 2015 and needs authorizing legislation to pass to do so.

http://www.chicagotribune.com/business/ct-biz-1228-health-care-20121228,0,437972.story

- **Budget Issues**. The most discussed issue in Illinois is funding for state pensions. The Governor has called the Illinois pension plan the "worst funded in America".
- **Medicaid managed care expansion**. Related to the state's budget issues, the Illinois Medicaid agency has set forth an aggressive schedule in moving more than 2 million Medicaid recipients from FFS/PCCM program to risk-based managed care in the next 13 months. There will likely be challenges of the aggressive roll-out of the managed care expansion, but the managed care expansion is expected to move forward.

Indiana

HMA Roundup – Cathy Rudd

- Indiana has a $2 billion surplus, and December 2012 revenue projections say that the state will take in $27.9 billion over the next two years – about $1.28 billion more than the previous two years. The forecast also indicates significant increases in Medicaid expenditures -- $300 million over the next two years without an expansion. See: http://thestatehousefile.com/forecast-increased-tax-receipts-will-give-lawmakers-more-to-spend-in-2013-14/8602/
- Republican Governor-elect Mike Pence has already indicated his opposition to both a state-based exchange and a partnership exchange with the federal government. See letter issued November 2012:

  http://www.in.gov/gov/files/HealthcareLetter.pdf
- Governor-elect Pence, who will be working with a Republican super majority in both chambers of the legislature, has not indicated support for a Medicaid expansion unless Indiana's 1115 waiver program (Healthy Indiana Plan or HIP) can be used as the expansion vehicle. That waiver, which operates using a health savings account-like feature, is set to expire at the end of 2013. The Senate Appropriations Chairman, Luke Kenley, does not support moving forward with a Medicaid expansion unless the federal government gives states more flexibility in administration of the program. See: http://thestatehousefile.com/kenley-state-should-use-medicaid-health-exchange-as-bargaining-chips/8582/
- The newly appointed House Ways and Means Chairman, who is an emergency room physician, has indicated that education remains the top spending priority. http://www.wibc.com/news/story.aspx?ID=1817437

Massachusetts

HMA Roundup – Rob Buchanan

- **January 1:** All providers must give at least 60 days' notice to newly formed Health Policy Commission (HPC), the Center for Health Information Analysis (CHIA), as well as the Attorney General before making any material changes to their operations or governing structure (such as mergers or acquisitions).

- **January:** Expected release of MassHealth Comprehensive Primary Care Payment Reform RFP.
- **April 1:** Expected release of analysis and any draft legislation by the special commission on public payer rates including impact on providers and premiums.
- **June 30:** MassHealth 1115 Demonstration Waiver renewal request for FY 2015-2017 due to CMS.
- **July 1:** Expected implementation of MassHealth Comprehensive Primary Care Payment initiative; goal is to have 25% of eligible members in an alternative payment contract with providers in 2013.
- **July 1:** Expected implementation of Integrated Care Organizations (ICOs) for dual-eligibles demonstration.
- **July 1:** Expected release of Behavioral Health Integration Task Force Report.
- **October 1:** Provider organizations that accept downside risk must apply for a risk certificate through the Division of Insurance by this date.
- **October 1:** Health plans must disclose patient-level data to providers in their network for the purpose of care coordination and treatment plans.

Michigan

HMA Roundup – Eileen Ellis and Esther Reagan

Health Insurance Claims Assessment: There are two unresolved issues with Michigan's Health Insurance Claims Assessment, which was established to replace the Medicaid MCO tax that had to be discontinued due to changes in federal law. The first is that the tax is generating less revenue than had been projected and budgeted. There was an approximately $120 million shortfall for the fiscal year ending in September 2012 (which could be adjusted downward as the state goes through year-end book closing), and the shortfall estimate for the current fiscal year is even higher. There has been opposition from the business community to establishing a higher tax rate than the 1 percent, so it is unclear how the revenue shortfall will be handled. The second issue is that the Self-Insurance Institute of America filed a challenge to the Assessment, claiming that it violated ERISA preemption. While the State prevailed in federal district court, an appeal has been filed to the Sixth Circuit Court of Appeals.

BCBSM Restructuring: The bills to restructure Blue Cross Blue Shield of Michigan (BCBSM) from a non-profit health care corporation to a non-profit mutual insurer were enrolled and presented to the Governor for signature on December 27th. Contrary to expectations, at the last minute the Governor did not sign the bills to restructure BCBSM. The BCBSM restructuring goes back on the table for legislative review and action next year; however, the Governor's veto means the legislative process will have to start all over again.

Medicaid Expansion: Governor Snyder has not yet made a decision about Medicaid expansion. That will surely be an issue. His decision may become public in late January

when he gives his State of the State message. Otherwise the issuance of his budget in late February will require a decision on Medicaid.

Health Insurance Exchange: Michigan's legislature balked at establishing a state-operated health insurance exchange, so the Governor advised HHS that the state was opting for a state-federal partnership exchange. No details on how the partnership would work are yet known. Since the House of Representatives blocked the state from receiving federal Exchange establishment grant funds, the legislature could also prove to be an impediment to a partnership exchange.

Dual Eligibles: The Department of Community Health has been enrolling children dually eligible for Medicaid and the Children's Special Health Care Services program (these are children with very complex health conditions, and there are about 20,000 of them) into the Medicaid MCOs since October. The process is to be completed by February.

It appears that Michigan has reached a tentative agreement with HHS for the Integrated Care for Dual Eligibles (ICDE) initiative, including use of Integrated Care Organizations (ICOs) for acute and long term physical health care services and Prepaid Inpatient Health Plans (PIHPs) for behavioral health services. The goal is to have contracted plans in the fall of 2013, with member enrollment effective January 2014. To meet the Medicare schedule, ICOs will need to file applications with CMS by February 21. The State is expected to issue an RFP for ICO participation in late February.

Behavioral Health: Medicaid has created new regional service areas for the PIHPs for Medicaid behavioral health care services, reducing the number of regions from 18 to 10. More significantly, the state is requiring creation of new entities to be the PIHPs. Loose affiliations must be replaced by entities that are distinct from the Community Mental Health Service Providers (CMHSPs) and which have strong centralized management. Because of the timeframes for the ICDE initiative, the CMSHPs are being forced to move very quickly to form new entities that will be able to respond to RFPs in early 2013. Even if the PIHP region is not one selected for the ICDE initiative, the PIHPs will be required to conform to the new requirements to continue as Medicaid providers. The Michigan Department of Community Health has not indicated what will happen if a qualified PIHP is not created for one of the 10 regions.

New York

HMA Roundup – Denise Soffel

Waiver Amendments - New York State submitted an amendment to its 1115 waiver, the Partnership Plan, requesting $10 billion in federal funds for reinvestment in New York's delivery system. Funds are requested to enact proposals identified by the state's Medicaid Redesign Team, and to achieve CMS's "Triple Aim" of improving quality, improving health, and reducing per capita cost. In addition, New York submitted a request to amend its current Federal-State Health Reform Partnership (F-SHRP) Section 1115 waiver, seeking $427 million to finance a storm recovery grant program. Negotiations with CMS began in September, and while the state hoped to resolve the terms and conditions of the amendments by the beginning of the year, final resolution is still pending. The two requests have been consolidated. Much of the state's planning for 2013 is dependent on

federal financing, and plans are largely on hold until the negotiations with CMS are concluded.

Office for People With Developmental Disabilities (OPWDD) People First Waiver - OPWDD is in the process of developing a combined Section 1915 b/c waiver called People First, which will move OPWDD's service system to a care management structure in which fee-for-service delivery will eventually be replaced by some form of a capitated/global payment model of service provider reimbursement. OPWDD currently serves 126,000 New Yorkers with developmental disabilities. It has an annual budget of $7 billion, of which 95 percent comes from Medicaid. Almost half its clients are dually eligible. Consistent with the Medicaid Redesign Team goal of care management for all Medicaid populations, OPWDD will be moving its clients into organized systems of care management. An RFP for pilot demonstrations is expected in the spring of 2013.

Expansion of Managed Care – Populations and Benefits - In January 2011 Governor Cuomo's administration established the Medicaid Redesign Team, which was tasked with finding Medicaid savings while improving quality. A key reform element of the MRT is managed care for the entire Medicaid population. Over the next two years, New York Medicaid plans to get out of the fee-for-service business entirely. A number of populations will be moved into managed care in 2013, including individuals enrolled in the long-term home health care program, the Medicaid Buy-In for Working People with Disabilities, and individuals residing in nursing homes. In addition, the managed care benefit is being expanded to incorporate numerous benefits that had been carved out of the benefit package. Adult Day Health, hospice and nursing facility coverage will be shifted into the managed care benefit in 2013.

Behavioral Health Organizations - One of the MRT recommendations enacted into law in 2011 was the creation of Behavioral Health Organizations (BHOs). The goal is to move all currently unmanaged Medicaid behavioral health services into some form of care management. Phase I BHOs are monitoring inpatient behavioral health services within their regions for non-dual Medicaid enrollees whose inpatient behavioral health services are carved out of a Medicaid Managed Care plan. Phase II, scheduled to begin in 2013, will include some form of risk-bearing Medicaid managed care for adults and children with serious mental health issues or substance use disorders. Two models are proposed—a special needs plan model for New York City, and a mainstream Medicaid managed care/behavioral health organization partnership for the rest of the state. A limited number of SNPs will be selected in New York City to serve Medicaid patients with significant behavioral health needs. Mainstream plans, including those that partner with specialty behavioral health plans or health home networks with robust specialty behavioral health expertise and capacity, will be given preference. Free standing SNP applications will also be considered. In the rest of the state, mainstream plans will become responsible for managing all behavioral health services for their members. This will include both the existing behavioral health benefit, as well as those mental health and substance abuse services currently "carved-out" of mainstream managed care contracts. Plans will be required to work with a State-certified behavioral health organization (BHO) for management of behavioral health benefits. Mainstream plans that can demonstrate that they have the capacity to meet the same requirements could manage the behavioral health benefits with appropriate monitoring by OMH, OASAS, and DOH.

Mandatory Enrollment of Duals into MLTC - New York State has begun the mandatory assignment of certain dual-eligible beneficiaries into managed long-term care plans. Approval has only been granted for establishing the program in New York City. Prior to expanding into additional areas, the state must demonstrate adequate network capacity, ensuring choice of provider for all beneficiaries, within the time and distance standards established by the state. Phase II, which includes Nassau, Suffolk and Westchester counties, is anticipated for January 2013. Phase III, including Rockland and Orange is anticipated for June 2013. Phase IV, including Albany, Erie, Onondaga and Monroe, is anticipated for December 2013. Other counties may be included during 2014, based on demonstrated capacity.

Demonstration to Integrate Care for Dual Eligible Individuals - New York's demonstration proposal, designed under a contract with the CMS Medicare-Medicaid Coordination Office, includes three distinct components:

- Fully-Integrated Dual Advantage (FIDA) – a comprehensive managed care option. Building on mandatory managed long term care enrollment, duals who require more than 120 days of community-based long-term care would be passively enrolled into a FIDA plan. As with the mandatory MLTC program, this component of the proposal is limited to eight downstate counties (New York City, Nassau, Suffolk and Westchester). The state expects 124,000 enrollees. This phase of the demonstration will begin enrollment in the fall of 2013, with a January 2014 start date.
- Health Home Program with Managed Fee-For-Service – Building on New York's health home initiative, this component of the demonstration would identify the dual eligibles most in need of care for enrollment into already existing health homes. This component of the proposal is state-wide. The state expects 126,000 duals will meet the Health Home criteria. This phase of the demonstration was scheduled to commence in January 2013.
- FIDA OPWDD Demonstration – The state proposes a small demonstration program for individuals currently receiving services through the Office of People with Developmental Disabilities. This component of the demonstration, which is statewide, will be capped at 10,000 individuals. The state anticipates contracting with no more than two to three plans. As with FIDA, the state anticipates a January 2014 start-up.

Qualified Health Plan Certification - New York State has received conditional approval from HHS to operate a state-based Health Benefit Exchange. The Exchange will be distributing an invitation to participate in the Exchange to health plans in early January 2013. The invitations will outline the Qualified Health Plan Certification Requirements and the Certification Process, and will be non-binding. The purpose of the invitation is to assess health plan level of interest regarding participation, "metal" levels, types and numbers of products, and individual and/or SHOP coverage. The Exchange will begin accepting proposals for QHP Certification in March 2013; rate submissions are due April 1. Final certification of QHPs must be complete by June.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak, Matt Roan, and Ashley Derr

- The Pennsylvania Legislature was sworn in for its 2013-2014 legislative session on January 1, 2013, and while the Republican Majority caucuses have announced their priorities for the session, healthcare issues are conspicuously absent from the agenda. Focus areas include transportation funding, natural gas drilling, economic development, and pension reform.
- Specific legislative actions related to healthcare will come into greater focus when the Governor presents his Fiscal Year 2013-2014 budget in an address to the General Assembly on February 5, 2013. Funding gaps in the state's public pension programs are expected to put increased pressure on the Medicaid program to find cost savings above and beyond savings targets in a normal budget year.
- The State's Medicaid Hospital Assessment is up for reauthorization in this legislative session. This assessment brings in approximately $500 million in annual savings. Reauthorization of the assessment will be vital in the 2013-2014 budget process.
- While the Governor has not announced his final plans for possible Medicaid Expansion, stakeholder groups and major newspapers in the state are pressuring the administration to implement expansion. Administration officials including Welfare Secretary Gary Alexander have been pushing for greater flexibility from the Federal government in how expansion could be implemented, including allowing states to pursue partial expansion with 100 percent federal funding, an option that HHS has said they will not allow.

Washington

HMA Roundup – Doug Porter

Key 2013 legislative issues will be:

- The continued monitoring of WA's health insurance exchange
- Authorization of proposed elimination of state only programs in anticipation of Medicaid expansion
- New cost reductions in Medicaid
- Authorization for new funding for MMIS to meet demands of Health Insurance Exchange interface
- Continued Program Integrity efforts.

OTHER HEADLINES

California

- **Medi-Cal patients sue state over being forced into managed care**

  Advocates for low-income seniors and disabled people who rely on government-funded healthcare sued California officials Friday in Los Angeles Superior Court. They want to stop the state from forcing Medi-Cal patients with severe, complex conditions into managed care, where they allegedly lack access to specialists they need. The Legal Aid Foundation and the Western Center on Law and Poverty jointly filed a complaint in L.A. Superior Court Friday that accuses health officials of using "secret" standards to deny requests for opting out of managed care — regardless of the consequences. (Southern California Public Radio)

- **Brown: Medi-Cal expansion could hit Calif. budget**

  Expanding the state's Medi-Cal program to meet new federal guidelines could increase costs by up to $4 billion a year at the same time California is implementing federal health reform, potentially putting its budget "right out of whack" if negotiations over the so-called fiscal cliff aren't favorable, Gov. Jerry Brown said Thursday. In a telephone interview with The Associated Press, Brown said his administration is seeking federal waivers for some of the proposed expansions to California's health care program for the poor. The changes could add more than a million people to the 7.7 million already served under the state's version of Medicaid. (The Record Searchlight)

Colorado

- **Colorado likely to opt for Medicaid expansion**

  Gov. John Hickenlooper has tipped his hand that he's likely to push for Medicaid expansion. In documents presented Wednesday to the Legislature's Joint Budget Committee, the governor's staff wrote: "we are likely to opt in to the expansion." The governor insisted that the decision to expand rests solely with his office, a contention that lawmakers challenged. (Health Policy Solutions)

Illinois

- **Hospitals, insurers back Illinois Medicaid expansion**

  With attention turning in 2013 to how states will implement the health law, Gov. Pat Quinn is pushing legislation to establish a state-run health insurance exchange to help middle-class citizens and small businesses, along with a multi-billion-dollar expansion of Medicaid to cover the poor. While the state's Democratic leaders generally have supported the new health care law, neither proposal will be a slam dunk for passage. Consumer groups and the insurance industry are warring over whether the state should be able to negotiate with insurers to get lower premiums for people participating in the health insurance exchange. It's not clear where the governor stands, but it would be difficult to pass a bill over the industry's objections. Quinn is expected to get support from the hospital industry and major insurance companies for the Medicaid expansion, since it involves bringing billions of federal dollars to the state, but some legislators object in principle to such an expansion of government programs. States do

not have to expand their Medicaid programs under a U.S. Supreme Court decision issued earlier this year. The Medicaid issue could be addressed when the legislative session begins Jan. 2, before several dozen lame-duck lawmakers leave office. (St. Louis Post-Dispatch)

Kansas

- **KanCare companies lack specialists in Topeka area**

The three managed care companies that will take over Kansas Medicaid services have strong primary care physician networks but some gaps in their specialty provider networks in the Topeka area, according to recent data. Sunflower State Health Plan had no providers within 25 miles of Shawnee County in nine of 22 medical specialties, including allergy, dermatology and orthopedics, the Topeka Capital-Journal reported Thursday based on data collected earlier this month. Shawnee County, which includes Topeka and the surrounding area, is the third most populous county in the state. A second company, Amerigroup, didn't have any providers in nephrology, physical medicine/rehabilitation and plastics and reconstructive surgery within 25 miles of Shawnee County, and United Healthcare had no neonatologists within 25 miles of Shawnee County. The three companies have been building provider networks since this summer, when they were announced as the recipients of contracts for KanCare, Gov. Sam Brownback's managed care plan for Medicaid. Most of the state's 380,000-some Medicaid recipients have been assigned to one of the companies, but starting Jan. 1, they will have 90 days to switch between them. (NECN News)

Kentucky

- **Central Kentucky doctors cut ties to Medicaid provider Coventry**

The Physicians' Network, a group of 550 independent physicians in Central Kentucky, has announced plans to cut its ties with Medicaid provider Coventry Cares of Kentucky. Dr. Ralph Alvarado, president of the network, which includes family care providers and specialists, said Thursday that Coventry had told the group that it would begin to pay less than the established Medicaid rate in reimbursements — as much as 10 percent less for care from specialists. (Lexington Herald-Leader)

Louisiana

- **Analysis: LSU getting out of the hospital business**

LSU leaders are finally saying what political watchers knew back in July when Gov. Bobby Jindal made deep budget cuts to the public hospital system. They're acknowledging the reductions are forcing the university system out of the hospital business. They're describing it with a positive spin, but they're confirming that Jindal's budget-cutting decisions imposed a sweeping change in the way Louisiana cares for its poor and uninsured patients. Jindal stripped more than $300 million in state and federal funding for the LSU health system after Louisiana's Medicaid financing was reduced by Congress earlier this year. Since then, Jindal's health secretary, Bruce Greenstein, has pushed for agreements with private hospitals to take over health services. (Shreveport Times)

Missouri

- **Nixon administration releases new Medicaid figures**

  Expanding Medicaid to give health care coverage to as many as 300,000 Missourians will reduce state spending on the program and release almost $250 million in the next three years for other uses, according to new figures from the state Office of Budget and Planning. Gov. Jay Nixon is pushing lawmakers to accept a federal offer to pay the full cost of expanding the program for three years, followed by a small but growing state contribution. By the state's 2021 fiscal year, Missouri would pay 10 percent of the projected $2.6 billion total annual cost of expansion. Even in the most expensive year, the new figures show, the savings from other parts of the program plus the expected new state revenue would exceed the costs to the state's general revenue fund. (Columbia Tribune)

New Jersey

- **St. Joseph's Keeps Amerigroup in Network**

  St. Joseph's Healthcare System announced on Monday that it will continue to include Amerigroup of New Jersey in its network for managed care participation in 2013. St. Joseph's facilities, which include St. Joseph's Regional Medical Center and St. Joseph's Children's Hospital in Paterson, St. Joseph's Wayne Hospital in Wayne, and ambulatory sites throughout northern New Jersey, will continue to be in network with Amerigroup and may render services to Amerigroup members. (The Alternative Press)

Ohio

- **Ohio spends fewer Medicaid dollars than budgeted**

  State officials have been working to rein in the cost of the $19.8 billion program. In the budget year that ended in June, state figures show Ohio spent $590 million less than it had anticipated. Medicaid spending for the current fiscal year is also tracking below projections. The state has spent about $6.2 billion on Medicaid since July. That's about $219 million less than it expected to spend through November. Officials credit the slowdown to changes in how providers are reimbursed and claims are processed, among other reforms. (WIVB News)

Wisconsin

- **U.S. grants extension to state's SeniorCare benefits**

  The prescription drug program SeniorCare will continue through at least 2015 after Wisconsin received an extension from federal authorities. SeniorCare has been in place since 2002 under a Medicaid waiver for Wisconsin approved by the Center for Medicare and Medicaid Services. The waiver was to expire on Monday, the last day of the year, but Gov. Scott Walker announced Thursday that the federal agency had extended the waiver until Dec. 31, 2015. The state can later apply for a further extension. (Journal Sentinel Online)

National

- **Companies Prepare for Health Law**

  One of the biggest decisions for many companies this year will be what to do about their health benefits. They have just 12 months before the major provisions of the federal overhaul law take effect on Jan. 1, 2014, reshaping health coverage in the U.S. Employers with at least 50 workers will owe penalties if they don't cover full-time employees. Most Americans will face a parallel "individual mandate" to obtain insurance. And new online marketplaces called exchanges will sell insurance plans in each state, paired with federal subsidies for lower-income people. (Wall Street Journal)

- **For-Profit Nursing Homes Lead in Overcharging While Care Suffers**

  A report by federal health care inspectors in November said the U.S. nursing home industry overbills Medicare $1.5 billion a year for treatments patients don’t need or never receive. Not disclosed was how much worse it is when providers have a profit motive. Thirty per cent of claims sampled from for- profit homes were deemed improper, compared to just 12 percent from non-profits, according to data Bloomberg News obtained from the inspector general’s office of the U.S. Department of Health and Human Services via a Freedom of Information Act request. (Bloomberg)

- **Health Law Seen Boosting Xerox, HP**

  When Tennessee Medicaid Director Darin Gordon walks around his department in an office park north of downtown Nashville, he sees dozens of workers from technology giant Hewlett-Packard. HP's employees help to operate the massive computer systems that run Tennessee Medicaid. When Gordon wants a report on how much the government health insurance program is spending, or the quality of the care for 1.3 million enrollees, he relies on HP-generated data -- "the backbone of everything we do," he says. Growth in the program for the poor has created boom times for data management companies like HP and Xerox. Even before passage of the federal health care law, states were farming out the operations of the safety net program. Now, with Medicaid poised for broad expansion under the law and with online insurance markets being built in most states, those companies are well-positioned to profit. (Kaiser Health News)

- **HHS Gives Conditional Approval to Three States for Exchanges**

  The Department of Health and Human Services officials said Thursday that they believe three more states have demonstrated that they will be ready to open exchanges in 2014, including one that will operate through a partnership with the federal government. HHS issued conditional approvals to Delaware, Minnesota and Rhode Island. Delaware is the first partnership exchange to win a conditional approval. Last week, HHS officials said they have deemed that Colorado, Connecticut, the District of Columbia, Kentucky, Massachusetts, Maryland, New York, Oregon and Washington will be ready to operate state-based exchanges in time for open enrollment in October. (CQ Healthbeat)

Company News

- **GTCR Acquires Correctional Healthcare Companies**

  GTCR has acquired Correctional Healthcare Cos., a Greenwood Village, Colo.–based provider of inmate healthcare services to jails and prisons. Sellers include Enhanced Equity Fund and Gemini Investors. No financial terms were disclosed.

- **Jury rules against Acadia Healthcare in $6.9M verdict**

  Universal Health Services has won a $6.89 million jury verdict against Franklin-based Acadia Healthcare Co. and five former Universal employees, according to Modern-Healthcare.com. Universal Health Services, based in King of Prussia, Penn., accused Acadia of violating non-compete clauses and misappropriating confidential information, according to court documents. (Nashville Business Journal)

- **WellPoint Completes Acquisition of Amerigroup**

  WellPoint, Inc. announced the completion of its acquisition of Amerigroup Corporation, one of the nation's leading managed care companies that is focused on meeting the health care needs of financially vulnerable Americans. With Amerigroup, WellPoint's affiliated Medicaid health plans now serve approximately 4.5 million beneficiaries of state sponsored health care programs in 20 states, bringing the company's total medical enrollment to approximately 36 million members in all affiliated plans. WellPoint also now has a presence in several states with significant dual eligible managed care opportunities. Amerigroup will operate as a wholly owned subsidiary within WellPoint and will remain dedicated to effectively managing state sponsored programs and further expanding this business. Amerigroup's management team will lead the combined Medicaid businesses. (WellPoint Press Release)

- **Aetna Names New Pennsylvania Medicaid Plan CEO**

  Aetna announced that Denise Croce has been named the chief executive officer of Aetna Better Health of Pennsylvania. Aetna Better Health manages Medicaid benefits for the Commonwealth of Pennsylvania. Croce most recently served as chief operating officer of MajestaCare, an Aetna-administered managed health care plan in Virginia. (Aetna News Release)

- **D.C. Chartered Health Plan audit results, sale pushed to January**

  It'll probably be January before D.C. officials lift the curtain on Chartered's troubles, after promising Dec. 3 to have the audit complete by today. In fact, they indicated back in October, when D.C. Insurance Commissioner William White put the company under control of a receiver, that it might have been just a matter of weeks then. That obviously didn't happen; auditors asked for more time. Michael Flagg, a spokesman for the D.C. Department of Insurance, Securities and Banking, won't elaborate, citing the sensitive process of auditing a company under control of a government-appointed receiver who is negotiating to sell the company. It's not clear whether the company-hired auditors' pace is affecting negotiations with Philadelphia-based AmeriHealth Mercy, which wants to buy Chartered's assets and its roughly 110,000 Medicaid beneficiaries. On Dec. 3, White said a deal was close at hand, but stopped short of calling it imminent.

AmeriHealth Mercy bid on a new five-year-contract to replace Chartered's, which expires April 30. Aside from the public interest in knowing what happened to Chartered's money, there is a sense of urgency to this. Under federal rules, D.C. Council must approve the new up-to-five-year Medicaid contracts by Feb. 1 to start transitioning to the new contracts. According to the timeline now laid out by Flagg, only a few weeks may pass in between a final Chartered acquisition and decision day on the long-term Medicaid contract. (Washington Business Journal)

RFP Calendar

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

Date	State	Event	Beneficiaries
TBD	Nevada	Contract Awards	188,000
January 1, 2013	Wisconsin LTC	Implementation	38,800
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Kentucky - Region 3	Implementation	170,000
January 1, 2013	Florida acute care	RFP released	2,800,000
January 7, 2013	Vermont Duals	RFP Released	22,000
January 7, 2013	New Mexico	Contract awards	510,000
January 8, 2013	Arizona - Maricopa Behavioral	Proposals due	N/A
January 15, 2013	Florida LTC	Contract Awards	90,000
January 21, 2013	California Rural	Applications due	280,000
January 28, 2013	Arizona - Acute Care	Proposals due	1,100,000
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
Feburary 25, 2013	California Rural	Application Approvals	280,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
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 1, 2013	California Duals	Implementation	500,000
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
September 1, 2013	Ohio Duals	Implementation	115,000
October 1, 2013	Illinois Duals	Implementation	136,000
October 1, 2013	Florida LTC	Implementation	90,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
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
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation	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		6/1/2013
Colorado	MFFS	62,982					TBD
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	Capitated	136,000					1/1/2014
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	1/7/2013	3/11/2013	4/1/2013	Dec. 2012	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 Announcement

HMA's Joan Henneberry appointed to University of Virginia's State Health Care Cost Containment Commission

HMA Principal, Joan Henneberry (Denver) has been appointed to the State Health Care Cost Containment Commission, a project of the University of Virginia Miller Center for Public Affairs. The goal of the 12-member bipartisan Commission is to develop a process and practical policies that states can adopt and implement to hold the growth rate of all health care spending in a state to a level similar to the growth rate of the overall state economy, i.e., the Gross State Product. The Commission includes representatives of all the key sectors of the health care industry including insurance plans, hospitals and physician provider groups. It also has representatives from all the key groups that purchase health care including Medicaid, Medicare and the private sector as well as a consumer advocate. The commission held its first conference call last October and is scheduled to have its first meeting in February. The initiative is being funded by Kaiser Permanente and the Robert Wood Johnson Foundation

HMA Welcomes…

Lori Cavanaugh, Principal - Boston

Lori comes to HMA most recently from the Massachusetts Office of Medicaid (MassHealth)/Executive Office of Health and Human Services (EOHHS) where she served as the Director of Purchasing Strategy for the last four years. In this role she provided strategic cost control and quality improvement direction to executive leadership to include payment reform, integrated care for dual eligible, and the EOHHS Multi-Payer Primary Care Medical Home Initiative (PCMHI). Lori was also responsible for managed care rate development and also provided analyses and guidance on methodologies to promote evidence-based decision making. Prior to her experience with MassHealth/EOHHS, Lori was a Program Development Consultant with Prescription Advantage/Massachusetts Executive Office of Elder Affairs, a Senior Program Development Associate with Public Sector Partners, Inc., and the Regional Director of Client Services for the Government Operations Division of the MEDSTAT Group. Lori holds an ABD from Heller School of Advanced Social Welfare, Brandeis University as well as an MPH from the University of Massachusetts and a BA from Wesleyan University.

Debra Mathias, Principal – Costa Mesa, California

Debra comes to HMA most recently from Children's Hospital of Orange County as the Executive Vice President and Chief Operating Officer for the past six years. In this role she was responsible for in-patient and ambulatory clinical operations, financial outcomes, program evaluation including the development of tertiary/quaternary services, and development of team-based annual strategic and business plans in collaboration with the senior executive management team. Some her accomplishments in his role include increased net revenues by 5% while experiencing a 5% increase in Medicaid days, decreased per patient day operating expenses by 5%, and lead an organization-wide reengineering project that resulted in identification of $5.4M in savings. Prior to her expe-

rience with Children's Hospital, Debra was the President and CEO of Mathias Consulting and Research Services, Inc. In this role she performed a countywide assessment and evaluation of Orange County's uninsured children and health care funding opportunities for the Children's Health Initiative of Orange County. She also conducted numerous consulting projects for area hospitals to include a comprehensive fiscal and operational assessment of primary care ambulatory programs. Debra has worked for the Center for Health Administration at the University of Colorado as an Associate Director and Adjunct Professor, the Chief Operating Officer for Children's Hospital in Denver, and Executive Director as well as Associate Executive Director for Human Hospital in Westminster, CA. Debra has her MS in Health Administration from the University of Colorado and a BS in Nursing from the University of Arizona. She is currently a Candidate for Doctorate in Public Administration (ABD status) from the University of Colorado.

Mona Shah, Senior Consultant – Costa Mesa, California

Mona comes to us most recently from the U.S. Senate, Committee on Health, Education, Labor and Pensions/Office of Senator Barbara A. Mikulski. She has served in several roles with the U.S. Senate – Staff Director Subcommittee on Children and Families, Professional Staff Member, and Health Policy Fellow. Mona served as a Senior Advisor and Chief Health Counsel to Senator Mikulski. She also developed, drafted, and negotiated major sections of the health reform bill including sections on quality and delivery systems containing care coordination, patient safety, comparative effectiveness pieces, and women's health. Prior to her work with the U.S. Senate, Mona was a Student Attorney for the Health Care/Child Welfare/AIDS Clinic at the University of Maryland School of Law, an Albert Schweitzer Fellow with Baltimore Health Care Access, and a Law Clerk for the Office of the General Counsel/U.S. Department of Health and Human Services. Mona has her JD with a Certificate of Concentration in Health Law from the University of Maryland School of Law. She received her MPH in Health Policy and Management as well as her BS in Human Biology and Anthropology from Emory University.

HMA Webinar Replay

The Economics of the Medicaid Expansion

On November 30, 2012, HMA hosted a webinar by leading independent Medicaid policy and financing experts Jack Meyer, Vern Smith, and Kathy Gifford. They offered an objective perspective on the direct and indirect fiscal considerations of the Medicaid expansion under the Affordable Care Act (ACA).

A video recording of the presentation and the presentation slide deck for this webinar are available here.