HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 20, 2013

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:

Greg Nersessian, CFA
Email

Jim Kumpel, CFA
Email

Andrew Fairgrieve
Email

THIS WEEK

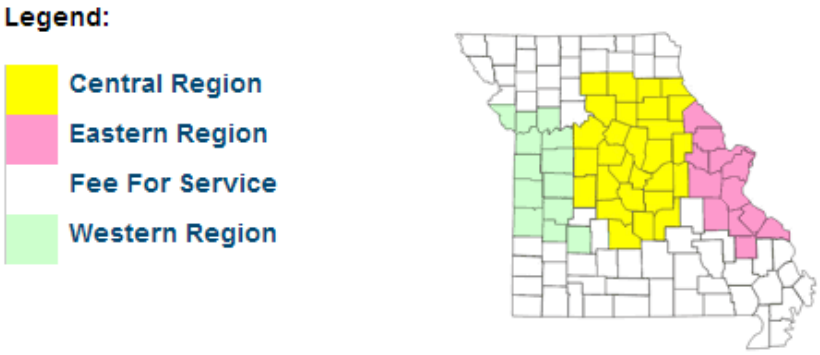
IN FOCUS

MISSOURI SENATE COMMITTEE DRAFT MEDICAID REFORM RECOMMENDATIONS REVIEWED

This week, our *In Focus* section reviews draft Medicaid reform recommendations from the Missouri Senate Interim Committee on Medicaid Transformation and Reform. The Committee is operating under a charge from the last legislative session to study the state's Medicaid program and make legislative action recommendations no later than December 15, 2013. The draft recommendations report was made public following the fifth and final public comment period on November 13, 2013. At this time, the draft recommendations do not include an expansion of the Medicaid program after the committee voted last week to exclude the Medicaid expansion from the report. Despite a push from state Democrats, the Republican majority of the committee stated that the Medicaid program needs to be reformed before considering expansion. The Committee's draft recommendations include significant Medicaid reforms including the statewide expansion of the state's current Medicaid managed care, creating regional accountable care organizations (ACOs) for non-traditional managed care populations, and dual eligible integration models. Summarized below are the Committee's major recommendations within the context of the current Missouri Medicaid program.

MO HealthNet Managed Care Statewide Expansion

The Senate Committee draft recommendations state that the current Medicaid managed care program, known as MO HealthNet, should be expanded statewide for the current populations served. MO HealthNet currently serves families, children, pregnant women, and newborns in the state's 1915b Waiver program, as well as children in the state's Children's Health Insurance Program (CHIP). MO HealthNet's three managed care organizations currently serve approximately 408,000 beneficiaries across these two programs in three regions (see map below).



Expansion of the MO HealthNet program to the remainder of the state would bring an estimated additional 180,000 new enrollees into managed care, based on June 2012 Medicaid enrollment numbers, as detailed in the table below.

MO HealthNet Enrollment	Sept. 2013	Medicaid Enrollment (June 2012)	*ABD Pct. (2010)*	Non-ABD Medicaid (Estimated)	MO HealthNet Expansion (#)	%
Total	**408,087**	**816,900**	***28%***	**588,200**	**180,100**	**44.1%**
HealthCare USA (Aetna/Coventry)	248,443					
Home State Health Plan (Centene)	58,439					
Missouri Care (WellCare)	101,205					

Sources: MO HealthNet Monthly Enrollment Data. Kaiser Family Foundation State Health Facts.

The draft recommendation includes recommended requirements when awarding contracts for the expansion, which suggests the potential for a procurement, rather than the expansion of existing MO HealthNet MCO contracts.

Regional ACOs for Non-MCO Populations

The Committee's draft recommendations include the creation of regional Accountable Care Organizations (ACOs) for the populations excluded from MO HealthNet, mainly the Medicaid-only Aged, Blind and Disabled (ABD) population, excluding those individuals residing in a skilled nursing facility (SNF). The recommendations envision ACOs as being either "corporate entities or contractually-linked provider networks formed through the collaboration of MCOs, hospital systems, community-based organizations, and other entities." The report's recommendations also indicate that the ACOs would expand the existing mental health DM 3700 program, which targets specific high utilizing Medicaid beneficiaries with chronic conditions, and the Health Home program. Based on the recommendations, regional ACOs would be expected to assume full risk under a global payment methodology developed by the state. Additionally, the ACOs would be expected to have a strong community focus, such as community health stakeholders and organizations represented within the ACO governance structure. Based on the Medicaid ABD population estimates and nursing facility penetration estimates from fiscal year 2010 Medicaid Statistical Information System (MSIS) data for Missouri, more than 220,000 estimated Medicaid-only ABD enrollees who do not reside in a SNF would be eligible for enrollment into Regional ACOs.

Integrated Care for Medicare-Medicaid Dual Eligibles

The Committee's draft recommendations also explore options for transitioning Medicare and Medicaid dual eligibles into integrated care coordination models that offer shared savings potential for the federal government, the state of Missouri, and the coordinating entity. The report suggests that the regional ACOs could serve as the coordinating entity in a duals integration program. Although Missouri did not apply for a capitated dual eligible financial alignment demonstration, using Minnesota as an example, it is possible to reach a dual eligible integration model agreement with CMS outside of the financial alignment demonstration program.

Additional Senate Committee Draft Recommendations

In addition to the major recommendations detailed above, the Senate Committee's draft report includes several other recommendations, listed below.

- Manage super-utilizers beyond current care management programs by building on the DMH 3700 and Health Homes.
- Continue to promote the use of technology to enhance both telehealth and transparency in Medicaid.
- Evaluate and analyze ways to decrease emergency room over utilization.
- Continue to enforce participant narcotics abuse and enact a Prescription Drug Monitoring Program.
- Strengthen Missouri's MO HealthNet False Claims Act and participant abuse investigations.
- Maximize and implement allowable cost-sharing, premiums and deductibles for non-preventive services.
- Adopt incentives for participants to seek preventive services, encourage health behavior, and to participate in his or her health care.
- Encourage health savings accounts that can be used for deductibles and co-pays.
- Increase the asset limit to allow for health care items or services.
- Add preventive dental services for adults and disabled to reduce emergency room visits.
- Reinvest future transformation savings into technology and provider payments.
- Ensure hospital health and sustain the Federal Reimbursement Allowance program.
- Consolidate departments responsible for providing Medicaid services into one agency responsible for the administration and transformation of the Medicaid program. Efficiencies gained should be reinvested into transformation efforts.

HMA Medicaid Roundup

Alabama

Medicaid Pharmacy Study Commission Reviewing Cost-Cutting Measures. In a November 14, 2013 meeting, the Alabama Medicaid Pharmacy Study Commission requested an actuary assess the economic impact of prescription drug cost-cutting measures. State Health Officer Don Williamson said that the economic impact on lost jobs or closed businesses need to be considered in addition to savings to the state's Medicaid program. A key consideration is the use of a pharmacy benefit manager to manage the Medicaid program's prescription drug benefits. Read more.

Alaska

Gov. Parnell Announces Alaska Will Not Expand Medicaid. In a November 15, 2013 press conference, Gov. Sean Parnell announced that Alaska would not expand Medicaid, calling the program a "failed experiment", much to the chagrin of advocates. Parnell cited a study by the Lewin Group that estimated the state would have to spend more than $200 million over seven years to expand Medicaid, compared to an additional $2.9 billion in matching federal funds over that time frame. The $200 million exceeded the $23 million estimated by the Alaska Native Tribal Health Consortium. Parnell added that he was creating a Medicaid reform group to study the program and report back findings in time to amend budgets in 2014. Critics of the decision point to the missed opportunity of bringing health insurance to as many as 40,000 Alaskans and noted that even the Chamber of Commerce had supported expansion. Read more.

California

Covered California Exchange Enrollment Called "Encouraging" by Executive Director. With the release of Covered California's October enrollment figures on November 13, 2013, observers note that the state leads the nation with nearly 31,000 Californians enrolled in the exchange, with an additional 86,000 deemed eligible for coverage on the exchange. Executive Director Peter Lee called the figures "better than encouraging" in eventually reaching the goal of having 500,000 to 700,000 subsidy-eligible residents enrolled by April 1, 2014. However, of the 30.830 Californians who enrolled in October, just 4,852 were subsidy eligible, meaning that the state would have to average nearly 100,000 subsidy-eligible enrollees per month through March 2014 to hit the low end of the target. Read more.

County Health Systems Face More Changes. In a November 18, 2013 article, California Healthline features the multitude of changes going into effect for the California county health systems. The realignment of funding between the state and county compounded by Medi-Cal managed care implementation and the rollout of the Affordable Care Act (ACA) has placed heavy burdens on the state's 58 county health systems. The state's "Bridge to Reform" 1115 Medicaid waiver created the Low In-

come Health Program, which enrolled 886,000 Californians in 53 counties, and has two months remaining for the program. Counties will remain responsible for delivering health coverage for the poor and uninsured, under the County Welfare and Institutions Code, but the ACA only relates to legal residents and citizens. Read more.

California Wrongly Warns 246,000 Residents That They May Need New Doctors Under Medicaid Expansion. Despite assurances by counties and community health centers that low income residents can retain their providers with the implementation of Medicaid expansion, California mistakenly released a letter to 246,000 residents in 11 counties communicating the contrary. Health advocates and providers, alike, were upset by the miscommunication, which triggered the release of a corrected letter shortly thereafter. While the California Department of Health Care Services believe that the transition into Medi-Cal will still proceed smoothly, others are concerned that confusion as a result of the initial letter would disrupt the continuation of necessary care to patients who may switch providers unnecessarily. Read more.

Attorney General Shuts Down Phony Exchange Websites. Last week, California Attorney General Kamala Harris shut down ten websites that were designed to mislead and divert consumers away from the state's Covered California site. Such websites as coveredcalifornia.com, californiabenefitexchange.com, and shopforhealthcare.org were found to be harmful to Californians seeking health insurance on CoveredCA.com. Read more.

Covered California Reluctant to Go Along with Extended Policies. Following President Obama's decision to allow plans and states to extend health policies that would otherwise be canceled, California's health exchange officials were reluctant to endorse the concept. Covered California Executive Director Peter Lee stated, on November 18, 2013, that extending policies into 2014 could result in adverse selection, leading to significant rate inflation in 2015. California Insurance Commissioner Dave Jones has been critical of Covered California for promoting the December 31, 2013 cancellation requirement. Read more.

Colorado

Joan Henneberry

Connect for Health Colorado has Enrolled 6,000 in QHPs. This week, Connect for Health Colorado reported that over 6,000 people have signed up for private health insurance through the exchange since the October 1 launch. The exchange also reports that 71,000 people have set up accounts but are still shopping or will wait until later to buy and pay their first premium. The first year goal of the exchange is 135,000. Medicaid has signed up over 47,000 people for enrollment that will begin January 2014. In addition, more than 47,300 people have enrolled in Medicaid since October 1. Read more.

Denver Health Cuts 170 Jobs. According to a November 18, 2013 article from Health Policy Solutions, Denver Health is cutting 170 jobs to deal with a year-to-date $7 million loss, a drop in hospital patient volumes, a reduction in tobacco tax revenue sharing, and a projected penalty from the Federal Government due to sub-par quality metrics. Of the 170 job cuts, 120 are either due to attrition without backfill or vacancies, although 34 were straight layoffs and other positions were converted to part-time. Read more.

District of Columbia

Federal Prosecutors in dispute with DC attorneys over Chartered settlement. A November 13, 2013 AP story explores a dispute between Federal prosecutors and attorneys representing the District of Columbia over a $7.5 million settlement between DC and a former Medicaid contractor, Chartered Health Plan. U.S. Attorney Ronald Machen claims that the city's Attorney General, Irvin Nathan, has refused document requests, thwarting an investigation into potentially criminal behavior. Jeffrey Thompson, who ran the now defunct Chartered Health Plan, is accused of directing $653,000 in illicit funds to Mayor Vincent Gray's 2010 campaign, just months in advance of a $7.5 million payment to the firm, to offset an estimated $10 million in underpayments for pediatric dental services. Read more.

DC Insurance Commissioner Fired After Criticizing President Obama's Health Plan Extension Proposal. On November 15, 2013, DC Insurance Commissioner William White was fired following a public statement he issued critical of President Obama's one-year health plan extension proposal. White expressed his view that the effect of the proposal would make exchanges more difficult to operate. White had not cleared the release with the Mayor's office and was replaced by Chester McPherson. Read more.

Florida

Gary Crayton and Elaine Peters

Weatherford and Gaetz Explain Opposition to Medicaid Expansion. Last week, House Speaker Will Weatherford and Senate President Don Gaetz spoke at a healthcare forum at Jacksonville University to explain their opposition to Medicaid expansion to an audience filled with health plan and hospital executives, who generally support expansion. Weatherford and Gaetz argued for reforming Medicaid before expanding a program that is already nearly a third of the state's $74 billion budget. Read more.

Florida Insurance Commissioner Supports One-Year Plan Extension Plan; Florida Blue Agrees. On November 14, 2013, shortly after the President proposed the one-year extension of health plans that might otherwise be canceled, Florida Insurance Commissioner Kevin McCarty offered his support for the proposal. Florida had already permitted Aetna, Humana, Coventry and Cigna to offer members the option of renewing their current policies into 2014. Following the President's proposal, Florida Blue agreed to extend its individual policies, including 40,000 policyholders that had originally been slated for cancellations by January 1, 2014. Those 40,000 would be insulated from rate increases given that it would be too late to meet a 45 day notice requirement. All 300,000 affected individuals with policies set to expire next year would eventually be extended the same option to renew coverage. Read more.

Florida Lawmakers to Evaluate Physician Pay Hikes Under Medicaid. Last week, the News Service of Florida published an article about a dilemma facing Florida lawmakers: whether or not to accept a temporary increase in Medicaid payments to physicians up to Medicare levels, which is fully funded by the Federal Government through 2014. While the Florida Medical Association has argued to include funding in the 2014-2015 fiscal year budget, the state's taxpayers would have to absorb an incremental $135 million in spending on the program starting in January 2015 when federal funding is no longer available. However, the Agency for Health Care Ad-

ministration does not include such funds in the budget and legislators hope to see if such enhanced provider reimbursement has led to more physician acceptance of Medicaid patients and improved access. Read more.

Jackson Health System Closes Fiscal Year with a $45 Million Surplus. On November 14, 2013, the Miami Herald reviewed the financial results of the Jackson Health System for the fiscal year ending September 30, 2013. The Miami-Dade public hospital network enjoyed a budget surplus of $45 million for the year, the second straight year in the black, and above expectations. The upcoming fiscal year is projected to generate a surplus of about $11 million, in part depending on the Miami-Dade County Commission's decision about whether or not to have employees contribute five percent of their base pay toward group healthcare costs. Eliminating the employee contributions would switch the projected surplus into a $6 to $7 million loss. Read more.

Georgia

Mark Trail

Commission Rejects Three Proposed Mandates on Autism, Children's Hearing Aides, and Prescribed Diets. On November 18, 2013, a Georgia commission tasked with reviewing mandated health benefits soundly rejected proposed new coverage of early autism treatments, children's hearing aids, and physician-prescribed diets. The votes on coverage requirements would only have related to individual and small-group plans available on the exchange, rather than self-insured plans available from employers. The commission noted that these benefits could be revisited through revisions to proposed legislation. Read more.

DCH Votes to Move Forward with an RFP for ABD Care Coordination. On November 14, 2013, the Department of Community Health Board voted to move ahead with issuing a request for proposal for care coordination of the aged, blind, and disabled (ABD) population. Medicaid Director, Dr. Jerry Dubberly, reiterated his previous comments about the initial adoption of the state plan amendment (SPA) and clarified that all members will be automatically enrolled upon implementation, but will have a 90-day opt-out period. The RFP is expected to be released imminently, with responses due back by February 10, 2014; contract execution by May 7, 2014; Go/No-go decision by September 1, 2014; and a go-live targeted for October 1, 2014.

Hawaii

Hawaii Connector Enrolls Just 257. As of November 15, 2013, the Hawaii Health Connector had enrolled 257 individuals in plans available on the state's health exchange. In addition, the state revealed that more than 1,750 people had completed applications, more than 2,370 were applying for coverage, and 1,156 were deemed eligible to enroll. Read more.

Indiana

Cathy Rudd

Gov. Pence Requests HHS Meeting to Use HIP as Medicaid Expansion Vehicle. Last week, Gov. Mike Pence released a copy of a letter sent to HHS last week requesting a meeting to move toward using the Healthy Indiana Plan as the state's vehicle for securing enhanced Medicaid federal funding. Gov. Pence hopes to expand

cost-sharing for Medicaid recipients, although Federal law prevents it for beneficiaries under the Federal Poverty income level. Pence points to HIP's high customer satisfaction rates, positive outcomes, and lower healthcare costs in his correspondence. Read more.

Maine

Maine Hires Former PA DPW Chief as Consultant to Assess Medicaid Expansion. On November 19, 2013, Maine's Department of Health and Human Services signed a $1 million contract with the Alexander Group, a consulting firm led by Pennsylvania's former head of the Department of Public Welfare (DPW) Gary Alexander, to evaluate whether or not the state should expand its Medicaid program. Alexander has publicly opposed the Affordable Care Act, but will be responsible for evaluating the impact of Medicaid expansion on the state. A feasibility study should be completed by December 1. The consulting firm is also tasked with building a plan to reduce waste and abuse in Maine's various social programs and improving the success of its welfare-to-work system. Read more.

Maryland

Maryland Posts Weak Enrollment in Light of Exchange Technology Problems. While some state-run exchanges are being held up as paragons against a pallid Federal exchange experience, Maryland's state exchange has failed to match the enrollment successes of California, New York, and Kentucky. With 1,278 enrollees in the month of October (and 465 in the first week of November), Maryland has enrolled about 1% of its target of 150,000 by the end of March. Maryland was among the most enthusiastic of ACA supporters, so the enrollment shortfalls due to technology glitches, downtimes, and inaccurate data are a surprise to many observers. Read more.

Massachusetts

Rob Buchanan

Health Connector Deadline for Enrollment in Exchange-based Plans Pushed Back to March 31, 2014. Last week, it was revealed that Massachusetts' Health Connector has pushed back the deadline for residents to enroll in an exchange-based plan to March 31, 2014 from the prior December 23, 2013 deadline. While there are 257,000 current enrollees on the state's plans, just 19,141 had been completed since the October 1, 2013 launch of the online program. To qualify for subsidies, individuals must re-apply online in order to calculate the federal tax subsidy that would apply to their coverage. Read more.

Massachusetts Health Insurers Suffer Declining Financial Results. Boston BizJournals posted an article covering the worsening financial performance of Massachusetts health insurers, which are squeezed by new state and federal regulations and the state's cost-containment law. BlueCross BlueShield of Massachusetts saw its third quarter 2013 net income fall 60 percent from the year ago period on flat revenues. Harvard Pilgrim Healthcare experienced a greater than 80 percent year-to-year drop in net income for the September quarter, despite membership and revenue gains. Tufts Health Plan similarly posted a nearly 80 percent year-to-year drop in net income in the third quarter. In contrast, Fallon Community Health Plan delivered almost 25 percent year-to-year growth in net income in the quarter, at $5.4 million vs. $4.4 million on nearly 10 percent revenue growth. Health insurers are

feeling the pinch as they struggle to comply with state and federal regulations, including ObamaCare and the state cost-containment law, known as Chapter 224. Pressures include keeping the lid on premium increases while taking on expensive new health IT investments to better manage the cost of care. Read more.

Massachusetts Insurance Commissioner Refuses Request to Extend Substandard Insurance Plans. On November 18, 2013, Massachusetts' Insurance Commissioner Joseph Murphy sent a letter to the Obama Administration refusing to permit consumers to retain substandard health insurance plans into 2014, as had been proposed by the President on November 14. Murphy said that the state had maintained minimum benefit levels for six years and virtually all health plans meet or exceed the national benchmarks. Read more.

Minnesota

Gov. Dayton Refuses to Extend Existing Substandard Health Plans. On November 18, 2013, Gov. Mark Dayton announced that Minnesota would not go along with President Obama's proposal to allow individuals to retain substandard health plans into 2014. Minnesota insurance companies blasted the President's proposal for causing market disruptions that would lead to higher premiums. Officials in Massachusetts, Washington, Rhode Island and Vermont have similarly rejected the President's proposal. Read more.

Michigan

Esther Reagan

Michigan Uninsured Can Pay for Dental Care with Volunteer Work. On November 17, 2013, Kaiser Health News profiled a unique dental care model in Calhoun County, Michigan that provides dental care in return for volunteer work. For every $100 of dental care, patients must volunteer at least four hours. Individuals under 200 percent of FPL can qualify for the program. Read more.

New Hampshire

NH Medicaid Expansion Relies on Private Coverage. With a November 21, 2013 vote on Medicaid expansion, New Hampshire lawmakers have to grapple with a point of contention: when to rely on private plans available on the exchange. Gov. Maggie Hassan and Democratic legislators want to allow more time for alternative plans to join Anthem Blue Cross Blue Shield on the exchange before leaning on the private option. Senate Republican leaders would shift people into the exchange plans by 2015, while the House Democratic plan requires a shift by 2017 only if three carriers offer plans on the exchange. The Senate plan would require reauthorization after three years, when federal funding for the expansion population falls below 100 percent. Read more.

New Hampshire Substance Abuse Treatment to be Available for the First Time. In early November, HHS Commissioner Nick Toumpas declared that the department would begin to offer substance abuse treatment benefits for existing enrollees beginning as soon as December 2014, when the state commences its second year of a Medicaid managed care phase-in. The federal Medicaid program requires Medicaid coverage of medically necessary inpatient detox treatments. Only New Hampshire, Arkansas, Louisiana, and Mississippi do not cover additional addiction treatments. Read more.

New York

Denise Soffel

Mental Health Commissioner Assumes Duties. Dr. Ann Sullivan began work in her new role as Commissioner in the NYS Office of Mental Health. Dr. Sullivan, named by Governor Cuomo in July, will serve in an acting capacity until her appointment is confirmed by the State Senate. Dr. Sullivan most recently served as Senior Vice President for the Queens Health Network of the New York City Health and Hospitals Corporation.

NY State Health Innovation Plan. In April 2013, the New York State Department of Health was awarded a State Innovation Models (SIM) Model Pre-Testing Assistance Award grant by the Centers for Medicare and Medicaid Innovation (CMMI) to develop a State Healthcare Innovation Plan (SHIP). The intent and goal of the SHIP is to identify and stimulate the spread of promising innovations in health care delivery and finance that result in optimal health outcomes for all New Yorkers. Multi-payer support of these initiatives is key to long-term success as is the input and recommendations of key stakeholders throughout the State. The state recently released its draft plan and is seeking feedback through November 27, 2013. New York has conducted outreach over the past several months, and is in the process of convening regional stakeholders to further refine its approach to transforming health care in the state. Read more.

The plan is a five-year blueprint for achieving the Triple Aim, with an emphasis on reducing avoidable hospital admissions and readmissions, two areas where the state's performance is poor. It is meant to align with work that has been done by the Medicaid Redesign Team, and with the NYS Prevention Agenda. The plan is organized around five pillars.

1. Improving access to care by increasing the number of New Yorkers with a usual source of care, and by reducing the number of uninsured.
2. Ensuring that individuals receive care through integrated-care delivery models.
3. Making health care cost and quality transparent to consumers.
4. Shifting payment methodologies to value-based payment models rather than volume-based strategies.
5. Connecting health care with the community by developing regional health resource centers and planning collaboratives that link community stakeholders and providers.

One of the plan's key objectives is to assure that by 2019, 80% of the State's population will receive health care in an integrated delivery system with **Advanced Primary Care** (APC) at its core. Building on the principles of the Patient-Centered Medical Home, APC envisions primary care providers taking responsibility for coordinating the complete health and social care needs of their patients in a comprehensive population health management model. This marks a fundamental shift in how health care is delivered and paid for in New York State. The report notes that New York's current delivery system has an undersupply of some critical health care services (notably community-based primary care) and an excessive supply of other resources (including physician specialists and inpatient beds).

FIDA Update: Fully Integrated Dual Advantage plans have entered Readiness Review. Desk Review is underway. Site Reviews will occur in January 2014, and Systems Testing will occur in February 2014. The Department of Health is meeting with

plans on an ongoing basis. They have begun development of a single provider credentialing/accreditation application. Drafting of the three-way contract is underway. Twenty five plans are undergoing Readiness Review. The Department of Health will announce which plans have met all requirements and will be participating in the FIDA demonstration when Readiness Review is completed, estimated to be April 2014.

Plans that Have Applied to Participate as a FIDA Plan

- Aetna
- Agewell
- AlphaCare
- Amerigroup
- Amida
- Catholic Managed Long Term Care, Inc. (Archcare)
- Centerlight
- Centers Plan for Healthy Living
- Elderplan (Homefirst)
- Elderserve
- Fidelis Care of NY (NYS Catholic Health Plan)
- GuildNet
- Healthfirst (Managed Health, Inc.)
- HHH Choices
- HIP
- Independence Care Systems
- Integra
- MetroPlus
- Montefiore
- North Shore LIJ Health Plan, Inc.
- Senior Whole Health
- United Healthcare
- VillageCare MAX
- VNYSNY Choice
- Wellcare

North Carolina

NC Tracks Continues to Experience Problems. In more than four months of use, North Carolina's Medicaid billing system NC Tracks continues to experience problems with delayed payments, call center snafus, and delays in pre-approvals. The system still does not approve claims from providers at the same rate as the prior system: 66 percent for the week ended November 1 vs. 78 percent for the previous system. Read more.

Oklahoma

Oklahoma's Medicaid Agency Needs $150 Million in Additional Funds. At a hearing on November 14, 2013, the Oklahoma Health Care Authority said that the Medicaid program would require an additional $150 million to continue offering current services due to a drop in Federal funding (associated with the state's increasing per capita income) and a projected increase in enrollment. About $50 million would cover the reduction in federal funding, $40 million would replace one-time funds from last year, and the remainder would apply to mandatory rate increases to health providers. Read more.

Oregon

Oregon Health Insurers Have Till November 22 to Extend Substandard Health Policies Otherwise Set to Be Canceled. On November 18, 2013, Oregon Insurance Commissioner Laura Cali announced that Oregeon health plans have until November 22 to determine if they will extend any of the substandard health policies that would otherwise have expired in 2014, in light of President Obama's recent proposal. Companies that choose to offer extensions will need to inform policy holders by November 29 of their decision. Regence BlueCross BlueShield has already announced its plans to extend such policies. Cali reminded Oregonians that members who remain in noncompliant plans cannot qualify for premium subsidies that are available through Cover Oregon. Read more.

Pennsylvania

Matt Roan

Estimated FMAP decrease for 2015 Causing Concern. Pennsylvania Hospitals are expressing concern about potential reimbursement cuts that may result from a projected decrease in Medicaid Federal Financial Participation in Pennsylvania for 2015. According to estimates released in October by Federal Funds Information for States (FFIS), increases in Pennsylvania's per-capita personal income will lead to a 1.7% reduction in FMAP. Secretary of Public Welfare, Bev Mackereth has sent a letter to CMS seeking validation of the FFIS estimates, and noting that the projected decrease is much larger than previous FMAP adjustments and will result in a $325M reduction in federal funds to support Pennsylvania's Medicaid program. The Secretary noted in her letter that due to the government shutdown FFIS was not able to verify its calculations with HHS, and that verification of the estimated FMAP for 2015 is needed as the Commonwealth prepares its budget for SFY 2014-2015. In FFIS's estimates, Pennsylvania is one of only seven states facing a FMAP reduction of greater than 1%. Also of note is that in the 2015 adjustments more states will receive higher FMAP rates than will face FMAP reductions. Read more.

Nurse Practitioners Seek Change in State Law Allowing Greater Autonomy. The Pennsylvania Coalition of Nurse Practitioners has come out in support of proposed legislation currently in the Pennsylvania Senate which would allow nurse practitioners to work without collaborative agreements with physicians who under current law must supervise their work. Seventeen states and the District of Columbia currently allow nurse practitioners to work without physician supervision, and the bill's proponents say that a similar law in Pennsylvania will help address projected physician shortages as more people gain access to health insurance through the ACA. The Pennsylvania Medical Society has opposed the legislation stressing the importance of "physician-led care teams" where the most well trained professionals are overseeing patient care. Pennsylvania currently has approximately 8,400 licensed nurse practitioners. Read more.

Pennsylvania Auditor General Finds DPW Mismanagement Cost Taxpayers Millions. State Auditor General Eugene DePasquale issued a report last week which found that the Department of Public Welfare (DPW) had mismanaged the transition of payroll vendors for publicly funded home care workers resulting in millions of dollars of additional costs to taxpayers. In December 2012, DPW began transitioning contracts from 36 state-based vendors to a single entity, Boston-based Public Partnerships Ltd. (PPL). The vendors handled payroll services to home care workers serving Pennsylvanians with disabilities who are enrolled in Self-directed Home and Community Based Waiver programs. DePasquale found that in the transition process, enrollee confusion and concerns about disruption of care led to at least 1,500 participants switching to higher cost services, resulting in $7M in increased program costs. Union representatives for the home care workers also complained that the transition led to delayed payment which caused undue hardship for the health aids who typically earn less than $10 per hour. DePasquale's report calls for additional DPW performance reviews of PPL, whose contract is set to expire at the end of next year. Read more.

Tennessee

Tennessee's Indecision on Medicaid Expansion Frustrates Many Constituencies. A New York Times article on November 16, 2013 discussed the plight of Gov. Bill Haslam, a Republican governor who is trying to "thread a needle from 80 yards" with regard to Medicaid expansion. While virtually every other state has made a determination (yes or no) on Medicaid expansion, Tennessee remains undecided, resulting in impatience and uncertainty for the state's residents and various constituencies. Haslam has promised not to make an executive decision—like Gov. Kasich of Ohio—but would enact a program only with the approval of the legislature, which remains unreceptive to the Affordable Care Act and Medicaid expansion. In addition to the business and advocacy interests favoring expansion vs. strong opposition by the Republican Party, Tennessee has to confront its own blemished history with TennCare, whose benefits had to be scaled back eight years ago following a star-crossed prior expansion. Read more.

Vermont

Vermont Lawmakers Raise Concerns over Exchange Difficulties. The problems with data accuracy and website responsiveness were discussed at a November 5 House Health Care Committee meeting, with lawmakers accusing the Shumlin Administration for "sugarcoated" updates on Vermont Health Connect. Lawmakers drilled Department of Vermont Health Access Commissioner Mark Larson with questions about the delay in mandating small business and individual enrollment by January 1. The new deadline of March 31, 2014 aligns with the end of the open enrollment period nationally. Northeast Delta Dental griped that the Shumlin Administration did not reach out to stakeholders with policy decisions, but announced them through the media. Read more.

Virginia

Virginia releases Medicare base rates for duals demonstration. The Virginia Department of Medical Assistance Services (DMAS) released a report disclosing 2014 final Medicare county base rates for the Commonwealth Coordinated Care dual eligible demonstration. The release only touches on the rate setting components related to Medicare benefits covered under the demonstration. DMAS indicates that a complete rate report including both the Medicare and Medicaid components is forthcoming. In terms of the Medicare rates, the key adjustments to the Medicare A/B components of the rate include:

- An update to fully incorporate the most current hospital wage index and physician geographic practice cost index.
- A 1.89% upward adjustment to account for the disproportionate share of bad debt attributable to Medicare-Medicaid enrollees in Medicare FFS
- Removal of the coding intensity adjustment (4.91%)
- The savings percentage (1%)
- The impact of sequestration

In general, the PMPM rates by county are approximately 3.5% to 4.5% above the FFS standardized county rates due primarily to the removal of the coding intensity adjustment. The guidance is available here.

Virginia Medicaid Access Comparable to Private Insurance for Many Services. Last week, a report from the Joint Legislative Audit and Review Commission demonstrated that Medicaid recipients access care from hospitals, pharmacies, and

nursing homes at comparable rates to those with private insurance, but face challenges accessing specialists given that nearly half refuse Medicaid patients. Medicaid recipients use primary care physicians less often and undertake preventative care less frequently than those with private insurance. Read more.

Washington

Insurance Commissioner Kreidler Opposes Extending Substandard Plans. Following President Obama's proposal to allow individuals with substandard health plans to continue on them for one more year, Washington State Insurance Commissioner Mike Kreidler was quick to reject the proposal. Kreidler pointed to the upheaval that would be caused in the health insurance market and the potential for higher premiums as a result of adverse selection. Read more.

Wisconsin

Gov. Walker Proposes Extending Deadline to Transition Medicaid Beneficiaries to Exchange. Given the difficulties of Healthcare.gov and federally facilitated health exchanges, Gov. Scott Walker called a special legislative session last week to push back the deadline for shifting 77,000 Medicaid beneficiaries to the exchanges from December 15, 2013 to April 1, 2014. Walker recognized that the problems caused by the technology glitches and shortfalls in Washington prevented a smooth transition from Medicaid to the exchange. GOP leaders were cool to the idea, potentially preferring a month-to-month extension, as necessary. Rather than tapping additional federal Medicaid matching funds to maintain the Medicaid recipients on BadgerCare, Walker would cover the additional expenses by delaying the addition of some 80,000 very low-income adults to the state program. Walker also proposed a three month extension to the state's high risk health plan through March 2014, paid for with a current $14 million surplus in that program. Read more.

National

Administration continues to work on Marketplace fixes, approves continuation of canceled plans. The Obama Administration continues to work on fixes to the Federal Marketplace enrollment portal, but acknowledged this week that a key piece of the system, which transfers payments from individuals to their qualified health plan, remains to be built. Press Secretary Jay Carney stated this week that the Administration is in talks with insurers to offer workarounds to get people enrolled outside of the Marketplace's online portal. Additionally, as has been reported, President Obama announced that insurance plans that would have been canceled for not meeting the ACA requirements could be continued for one additional year, although state insurance commissioners must approve the continued offering of the plans in their state.

Industry Research

Managed Medicaid 2013: New Growth, New Challenges. A new report from CRG provides statistical data on Medicaid plan financial performance, membership, and utilization data among both for-profit and not-for-profit entities. It also takes a close look at the pipeline for managed Medicaid conversions, the fate of the dual demonstration, and the outlook for expansion under the Affordable Care Act. For more information, please visit: http://www.corporateresearchgroup.com

Industry News

Tenet CEO comments on hospital market, acquisition environment. Tenet Healthcare's CEO Trevor Fetter stated in an interview with Bloomberg that the current hospital market in the U.S. is ripe for hospital acquisitions and that smaller health care systems will struggle, forcing closures or service reductions. Fetter also stated that lower-than-anticipated Marketplace enrollments raise concerns about higher uncompensated care levels than hospitals were previously projecting. Tenet, the third-largest hospital management company, owns 77 hospitals around the U.S. and recently acquired Vanguard Health Systems. Read more.

WellPoint CEO comments on ACA rollout. WellPoint's CEO Joseph Swedish indicated this week that the company has pulled back from marketing to new enrollees, citing unknowns on enrollment in the Marketplaces. Swedish, however, stated that he remains optimistic about the ACA and sees a potential for significant uptake if technical issues with the enrollment process are resolved. Read more.

Skilled Healthcare Group appoints new CEO. Skilled Healthcare Group, which operates long-term care facilities and provides a wide range of post-acute services, announced the appointment of Robert H. Fish to CEO on November 20, 2013. Fish is succeeding Boyd W. Hendrickson, who has retired after serving as CEO since 2002. From 2008 to 2012 Robert Fish served as Chairman of REACH Medical Holdings, a regional air medical transport company, from 2005 to 2006 he served as Executive Chairman of Coram, Inc., a large home infusion provider, from 2002 to 2004 he served as Chairman and Chief Executive Officer of Genesis Health Ventures, a long-term care and institutional pharmacy company.

RFP Calendar

Date	State	Event	Beneficiaries
November 21, 2013	Tennessee	Proposals Due	1,200,000
December 1, 2013	New Hampshire	Implementation	130,000
December 1, 2013	Florida LTC (Region 11)	Implementation	17,257
December 16, 2013	Tennessee	Contract Awards	1,200,000
December 30, 2013	Delaware	RFP Release	200,000
January 1, 2014	Massachusetts CarePlus (ACA)	Implementation	305,000
January 1, 2014	Massachusetts Duals	Implementation	115,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	Virginia Duals	Implementation	79,000
January 1, 2014	Texas Duals	Implementation	214,400
January 22, 2014	Texas NorthSTAR (Behavioral)	RFP Release	406,000
February 1, 2014	Illinois Duals	Implementation	136,000
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,538
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
April 1, 2014	California Duals	Implementation	456,000
April 1, 2014	Ohio Duals	Implementation	115,000
April 1, 2014	Idaho Duals	Implementation	17,700
April 17, 2014	Texas NorthSTAR (Behavioral)	Proposals due	406,000
May 1, 2014	Washington Duals	Implementation	48,500
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 30, 2014	Delaware	Contract awards	200,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Implementation	68,000
July 1, 2014	New York Duals	Implementation	178,000
July 1, 2014	Michigan Duals	Implementation	70,000
July 7, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	406,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
January 1, 2015	Vermont Duals	Implementation	22,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	406,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	456,000	X	3/1/2012	4/4/2012	3/27/2013		4/1/2014	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup
Colorado	MFFS	62,982						11/1/2013	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	2/1/2014	5/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714						TBD	
Idaho	Capitated	22,548	June 2013	TBD	August 2013			TBD	Blue Cross of Idaho
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	70,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
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	178,000				8/26/2013	7/1/2014	9/1/2014	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	60 days prior to passive	4/1/2014	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	3/27/2013	August 2013			11/1/2013*	Neighborhood Health Plan of RI
South Carolina	Capitated	68,000	X			10/25/2013		7/1/2014	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	6/27/2013	5/21/2013		10/1/2014	Health Keepers; Humana; VA Premier
Vermont	Capitated	22,000	10/1/2013	TBD	TBD			1/1/20115	
Washington	Capitated	48,500	X	5/15/2013	6/6/2013			5/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**13 Capitated 6 MFFS**	**1.5M Capitated 485K FFS**	***9***			***8***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

*** Wisconsin is completing a comment period on a draft MOU with CMS. Finalized MOU will determine implementation date.*

‡ Capitated duals integration model for health homes population.

HMA News

HMA Welcomes: Alana Ketchel – Senior Consultant – San Francisco, California

Alana comes to us most recently from Pacific Business Group On Health (PBGH) where she worked as a Senior Manager for the past 2 ½ years. In this role, Alana was the staff lead on a project to convene large purchasers to help identify their perspectives on health care cost containment policy. She also lead PBGH's Health Insurance Exchange Task Force by providing support for the development of business rules for consumer choice of health plans in the Exchange and drafting PBGH comment letters to help influence the design of the Exchange. Additionally, Alana managed the project for the National Quality Forum (NQF) to recommend criteria for selecting measure sets used in payment, public reporting, and programing monitoring initiatives.

Prior to joining PBGH, Alana served as a Senior Policy Analyst for Cal Econnect, Inc. where she played a key role in the organization charged with enabling statewide health information exchange services in California. Alana also worked for California Health and Human Services – eHealth Initiatives as a Consultant/CITRIS Fellow; Sutter health Institute for Research and Education as an Evaluation Consultant; and National Opinion Research Center as a Research Assistant.

Alana received dual Masters Degrees in Public Policy and Public Health from the University of California, Berkeley. She received a Bachelor of Arts degree in Human Biology with a concentration in Aspects of Health Care Delivery in Disadvantaged Communities from Stanford University.

"Health Insurance Exchanges"
American Institute of CPAs Healthcare Industry Conference
Barbara Markham Smith, Presenter
November 15, 2013
New Orleans, Louisiana

"Where Payor Meets Provider: Managing in a World of Managed Care"
HCap Conference sponsored by: Lincoln Healthcare Group
Greg Nersessian, Panelist
December 5, 2013
Washington, DC