HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: HHS ISSUES FAQ FOR STATES ON EXCHANGE, MEDICAID ISSUES

HMA ROUNDUP: OHIO AND CMS FINALIZE DUAL ELIGIBLE MOU; PENNSYLVANIA PROVIDES GUIDANCE ON ENHANCED PRIMARY CARE RATES; IDAHO UPDATES STAKEHOLDERS ON DUAL ELIGIBLE DEMONSTRATION, HEALTH HOME MODEL

OTHER HEADLINES: NEVADA GOVERNOR SUPPORTS MEDICAID EXPANSION, ALABAMA, SOUTH CAROLINA GOVERNORS DO NOT; IDAHO ELECTS TO PURSUE STATE-BASED EXCHANGE, TENNESSEE DOES NOT; KANSAS MEDICAID WAIVER RECEIVES CMS APPROVAL; MAGELLAN, CAREOREGON ANNOUNCE SENIOR MANAGEMENT CHANGES

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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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Contents

In Focus: HHS Issues FAQ for States on Exchange, Medicaid Issues	**2**
HMA Medicaid Roundup	**4**
Other Headlines	**7**
Company News	**11**
RFP Calendar	**13**
Dual Integration Proposal Status	**14**
HMA Webinar Replay	**15**
HMA Recently Published Research	**15**

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IN FOCUS: HHS ISSUES FAQ FOR STATES ON EXCHANGE, MEDICAID ISSUES

This week, our *In Focus* section reviews the U.S. Department of Health & Human Services (HHS) FAQ document, published Monday, December 10, 2012, for states on Exchanges, market reforms, and Medicaid. The document provides updates and clarifications on State-Based, Partnership, and Federally Facilitated Exchange processes and upcoming deadlines. Additionally, HHS answers questions regarding the Medicaid expansion and how states' decisions to expand could impact matching rates for newly eligibles. Below, we highlight some of the key takeaways from the HHS FAQ as well as what to watch for in upcoming guidance and rulemaking from HHS in 2013.

Exchange Updates

- States pursuing State-Based or Partnership Exchanges will not be given additional time to submit declaration letters and blueprint applications. The deadline for State-Based Exchanges was previously extended from November 16, 2012 to December 14, 2012. As previously announced, Partnership Exchange documents must be submitted by February 15, 2013.
- For states that will have a Federally Facilitated Exchange, HHS responded to concerns regarding the role state insurance regulators and existing state insurance laws will play in the Exchange:
    - All qualified health plans (QHPs) in the Exchange must meet state licensure and solvency requirements, as well as all rules applying to individual and small group market products.
    - HHS is working to determine the extent to which traditional state insurance department activities, such as rate review, will be recognized as part of the QHP certification process in the Exchange. HHS believes most states currently have an effective rate review process in place.
    - HHS intends to build on existing state insurance regulation policies, capabilities, and infrastructure. Additionally, to improve federal and state alignment, HHS encourages states to apply to conduct plan management through a Partnership Exchange.
- HHS has proposed a monthly user fee rate on QHPs to fund the Federally Facilitated Exchanges. This proposed rate — 3.5 percent of premiums — is believed to be in line with rates charged by State-Based Exchanges. A final Payment Notice will be released in coming months and the 3.5 percent rate may be adjusted based on State-Based rates as they are finalized.
- States can be reimbursed for certain services provided to a Federally Facilitated Exchange if the state elects to provide them. These services include: developing data system interfaces, coordinating the transfer of plan information from the state insurance department to the Exchange, and other activities necessary to support the Exchange. These funds are currently available through Section

1311(a) Exchange Establishment funding, and HHS anticipates making additional financial resources available when this funding expires.

- States will be able to certify a Medicaid MCO to offer QHPs in the Exchange on a limited enrollment basis to certain populations. These plans, referred to as "bridge" plans, allow Medicaid beneficiaries to retain their current insurance plan and health care provider network as they transition from Medicaid eligibility to coverage through the Exchange.
- The U.S. Office of Personnel Management (OPM) released a proposed rule on Multi-State Plan Exchange participation on November 30, 2012. Public comments will be taken through January 4, 2013. HHS notes that the proposed rule seeks comments from states and other stakeholders regarding how OPM will ensure that Multi-State Plans will compete on a level playing field and comply with all state laws.

Medicaid Updates

- Several states have questioned whether a state can elect to only partially expand Medicaid, for example, only to 100 percent of federal poverty level (FPL), but still receive the enhanced federal matching funds rate for this partial-expansion population. HHS has determined that the ACA does not provide for a partial expansion, and as such, these expansions would not be eligible for the 100 percent federal matching rates in 2014 through 2016. States are free to undertake a partial expansion at the prevailing federal matching rate.
- In a state that does not expand Medicaid, individuals with incomes above 100 percent of the FPL will be eligible for premium tax credits and cost sharing reductions if they are otherwise eligible to purchase coverage in the Exchanges.

Upcoming Guidance and Rulemaking from HHS

- *Final Payment Notice for plans in Federally Facilitated Exchanges (2013)*
- *Final Rule on Essential Health Benefits (early 2013) – comments due December 26, 2012*
- *Final Rule on Multi-State Plans in the Exchanges (2013) – comments due January 4, 2012*
- *Guidance on Medicaid bridge plans in the Exchanges (2013)*
- *Guidance on Basic Health Plan (2013)*
- *Navigator grant funding opportunity announcement (early 2013)*
- *Final version of online/paper single application for Medicaid/Exchange (early 2013)*
- *Information regarding exemptions from shared savings responsibility (2013)*
- *Medicaid DSH allotment reductions methodology released for comment (early 2013)*

Link to HHS FAQ Document, date December 10, 2012:

http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf

HMA Medicaid Roundup

Georgia

HMA Roundup – Mark Trail

Georgia has yet to reach a resolution on the hospital provider tax renewal. At risk is over $200 million in revenues to the state, as well as funding to many Georgia hospitals. The Department of Community Health (DCH) board has provided budget reduction proposals for amended year 2013 and fiscal year 2014, only accommodating a portion of the Governor's 3-5 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.

Idaho

HMA Roundup

On Monday December 10, Idaho Medicaid hosted a webinar for stakeholders to provide updates on Idaho's initiative to integrate care for dual eligibles, and Idaho's Medical Home Collaborative and Medicaid's Health Home programs. According to the presentation, eleven organizations filed notices of intent to apply (NOIA) with CMS to participate in the Idaho dual eligible demonstration which is scheduled to begin on January 1, 2014.

Illinois

HMA Roundup – Jane Longo and Matt Powers

During the last week of November, HB 6253 was introduced to implement the Medicaid expansion under the ACA. The legislation has three parts:

- It revises the Public Aid Code to eliminate the coverage gap for adults ages 19 through 64 whose income is at or below 138 percent of FPL.
- It provides that the state will establish the specific benefit package for these newly eligible adults through rule, which at a minimum must cover the 10 "essential health benefits."
- It eliminates the state's moratorium on new eligibility expansions.

The bill was referred to the human services appropriations committee on December 6.

Michigan

HMA Roundup – Esther Reagan and David Fosdick

This past week, legislation that would change how Blue Cross Blue Shield of Michigan (BCBSM) is structured and regulated passed through the Michigan Legislature. Senate Bills 1293 and 1294 would establish BCBSM as a non-profit mutual insurance company and make a number of other changes including:

- Ending the company's tax-exempt status.

- Eliminating requirements that BCBSM serve as an "insurer of last resort" (a requirement that the carrier accept all individuals seeking coverage regardless of health status) as of January 2014.
- Eliminating the BCBSM "most-favored nation" clause in hospital contracts (language that prohibits a hospital from contracting with another insurer at a lower payment rate).
- Requiring BCBSM to establish and fund a separate non-profit entity charged with improving the health of Michigan citizens.
- Shifting authority to approve changes in BCBSM's rates from the Attorney General to the State Insurance Commissioner.

Ohio

HMA Roundup

This week, CMS granted approval to Ohio's dual eligible demonstration, known as the Integrated Care Delivery System (IDCS), and posted a signed memoranda of understanding (MOU) on their website. Ohio is the second state, behind Massachusetts, to finalize a MOU with CMS on the capitated duals demonstrations. According to the MOU, the program will launch on September 1, 2013 with the first year of the demonstration running through December 2014. Medicare Part A and B and Medicaid savings and quality withhold percentages are in line with what was included in the Massachusetts MOU. The MOU is available here.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

Enhanced Primary Care rates: At the most recent Medical Assistance Advisory Committee meeting, DPW provided additional information about its plans to implement the enhanced primary care fees that are a part of the Affordable Care Act. The Department clarified that rate increases would apply only to board-certified providers with specialties in family medicine, general internal medicine, and pediatric medicine. PA plans to implement the increase on April 1, 2013 with retroactive payment adjustments for claims with dates of service back to January 1, 2013. The Department reported that the fee increase will apply to Medicaid Managed Care programs as well, and the Department is working with the managed care plans to review implementation plans and how the MCO contracts may need to be amended as a result of the increased fees. The Department is asking providers to ensure that they have submitted current board certification documentation. Providers are being asked to submit their board certifications by March 2013 in order to be eligible for retroactive payments. For providers that submit documentation after March 2013, the increased fees will be effective as of the date the certification is added to the providers file in the Department' Information Management System.

Status update of state-wide expansion of Medicaid Managed Care: Also at the Medical Assistance Advisory Committee, The Department reported on the status of the implementation of the final phase of state-wide expansion of Medicaid Managed care to the

"New East" Zone. The "New East" zone includes 22 counties in northeastern PA, and will impact approximately 210,000 Medical Assistance consumers. Open enrollment for this zone will run from January 11 through February 7, 2013, with implementation scheduled for March 1. The Department has implemented increased outreach efforts to consumers and providers to encourage plan selection during open enrollment. Consumer advocacy groups have raised concerns about network adequacy among the plans, particularly related to pediatricians and OB-GYNs. The Health Plans selected to serve the New East zone are: AmeriHealth Mercy, Coventry, and Geisinger.

Non-General Acute Care Hospital Report: Last month, the Pennsylvania Health Care Cost Containment Council released a report on financial trends at non-general acute care hospitals. Rehabilitation hospitals showed the strongest overall gains. Their average statewide operating margin improved 3.76 percentage points, from 10.37 percent in FY 2010 to 14.13 percent in FY 2011. Their average total margin also climbed 3.21 percentage points, from 10.65 percent to 13.86 percent. Freestanding psychiatric hospitals' average operating margin dropped 0.67 of a percentage point, from 5.90 percent in FY 2010 to 5.23 percent in FY 2011, but their average total margin rose 0.19 of a percentage point, from 4.55 percent to 4.74 percent. Long-term acute care hospitals saw small declines of less than one percent in both – 0.26 of a percentage point in average operating margin, from 6.23 percent to 5.97 percent, and 0.14 of a point in average total margin, from 4.93 percent to 4.79 percent.

In the news

- **Connected Care Program from Community Care and UPMC for You Successfully Integrates Behavioral and Physical Health Care**

  Connected Care – a program developed by Community Care Behavioral Health Organization and UPMC for You – has resulted in significant reductions in the use of behavioral and physical health services by their members and is influencing other community-based programs that provide Medicaid services for individuals with serious mental illness. (Community Care Press Release)

- **More PA House Members Ask Corbett to Opt Out of Medicaid Expansion**

  Earlier this week, 48 members of the state House sent a letter to Gov. Corbett urging him to opt out of the Patient Protection and Affordable Care Act's Medicaid expansion, an optional portion of the PPACA which would expand government healthcare for those making more than is currently required for Medicaid, but still a percentage under the federal poverty rate. The letter, by Rep. Gordon R. Denlinger of Lancaster County, is an updated version of one he sent in July, though three new names have been added for further solidarity on the matter. All signers are Republicans. (Philadelphia Weekly)

OTHER HEADLINES

Alabama

- **Governor reaffirms stand against Medicaid expansion in face of study showing $1 billion benefit**

  Gov. Robert Bentley reiterated his stance against Medicaid expansion under the federal Affordable Care Act today following the release of a UAB study estimating $1 billion in new tax revenue under such an expansion. The statement came as a direct response to the research of University of Alabama at Birmingham School of Public Health economists David Becker and Michael Morrisey who say that the expansion in Alabama will provide Medicaid coverage to an additional 300,000 people and generate $20 billion in economic activity which will add $1.7 billion in tax revenue to Alabama coffers from 2014 to 2020. (AL.com)

Idaho

- **Idaho chooses state-based insurance exchange under "Obamacare"**

  Idaho Governor Butch Otter reluctantly opted on Tuesday for a state-based health insurance exchange under terms of President Barack Obama's healthcare overhaul, complaining it would do little to cut costs while inflating government. Idaho was one of several Republican-led states that delayed compliance with the Affordable Care Act until after the November 6 presidential election in hopes a victory by Republican candidate Mitt Romney would bring a repeal of the law. (Yahoo News)

Kansas

- **Federal Officials Allow Medicaid Overhaul in Kansas**

  Federal officials have granted Kansas permission to overhaul Medicaid, allowing the state to turn the $2.9 billion-a-year program for the needy over to three private insurance companies next year as planned, Gov. Sam Brownback announced Friday. (Kansas City Star)

Kentucky

- **Legal Issues with Kentucky Spirit Remain; Passport Withdraws Medicaid Complaint**

  Weeks after their announced departure from Kentucky's Medicaid managed care system, operator Kentucky Spirit and the state are still locked in a legal battle. Both sides have sued each other, blaming the other for the situation. Kentucky Spirit announced their departure, scheduled for the middle of 2013, due to massive losses in the system. In an interim committee meeting Tuesday, Kentucky lawmakers asked for an update on what the state hoped to recoup financially because of Kentucky Spirit's decision. But Medicaid Commissioner Lawrence Kissner declined to provide an update saying there are still a lot of legal issues to resolve. A different dispute with Passport Health Plan in Region 3 has been withdrawn by Passport, Kissner told lawmakers. (WKYU News)

Minnesota

- **Federal HHS probing Minn. Medicaid program**

The Office of Inspector General for the Department of Health and Human Services has sent a letter to state officials Minnesota Human Services Commissioner Lucinda Jesson seeking information about the state's Medicaid program under the former Gov. Tim Pawlenty's administration. The letter asks for documents and records to determine how Minnesota set its payment rates for HMOs that administered the Medicaid program from Jan 1, 2008 to Dec. 31, 2009. Pawlenty said in June that he had "no indication or reason to believe that anything was done incorrectly or overpaid." (MPR News)

Nebraska

- **Nebraska confronting rural doctor shortage**

Lawmakers will decide whether to extend Medicaid coverage to more residents, an idea that Gov. Dave Heineman staunchly opposes. But amid all the debate, Nebraska faces a more immediate problem with no easy answers: The state doesn't have enough doctors to treat all the new patients who will become insured when new pieces of the law take effect in 2014. Data released by the University of Nebraska Medical Center shows that the state lacks primary care physicians, and the shortage is worse in rural areas. Nebraska has 1,410 primary care doctors, but the study projects that the state will need at least 1,685 to meet the increased demand when new provisions of the federal health care law take effect in 2014. (Associated Press)

Nevada

- **Sandoval supports Medicaid expansion**

Gov. Brian Sandoval said Tuesday he'll support expanding Medicaid eligibility in Nevada as called for under the federal health care law to provide coverage for the state's neediest residents. In an exclusive interview with The Associated Press, Sandoval said expanding coverage will add 78,000 residents to the state's Medicaid rolls, but save the state $16 million in mental health programs that otherwise would be paid for out of the state general fund. The first-term Republican governor said while he opposed the health care law, his decision will help tens of thousands of people. About 22 percent, or 604,000 Nevadans, are uninsured. He added that his budget to be released to lawmakers in January will propose reducing taxes paid by small businesses to help them afford insurance coverage for their employees. He will also ask the Legislature to support a "cost-sharing" copayment for recipients who receive Medicaid services. (Associated Press)

South Carolina

- **Keck, Medicaid expansion advocates in SC argue cases at forum**

The debate over whether South Carolina should accept Medicaid expansion heated up Tuesday with a spirited give-and-take between advocates of expansion and the state’s most outspoken opponent. Tony Keck, director of the S.C. Department of Health and Human Services, which handles Medicaid in the state, took the stage at the USC Law School auditorium in a panel discussion with three advocates for expansion. Keck’s

most strident points were met with guffaws from the pro-expansion audience, while the other speakers occasionally drew applause. (The State)

Tennessee

- **Tennessee Governor Says No To Healthcare Exchange For Affordable Care Act**

  Tennessee Governor Bill Haslam has announced he does not plan to form a state-based healthcare exchange as part of the federal Affordable Care Act. (WREG News)

Texas

- **Drugs, fraud, mental health top legislative issues**

  Before lawmakers can even think about expanding the program, though, they must pass an emergency supplemental spending bill to cover the $4.7 billion hole they left in Medicaid in 2011. The expense is non-negotiable since the federal government requires states to put in $1 to get about $2 in matching funds. Failure to appropriate the money would shut down Texas Medicaid in March, leaving one in seven Texans without health care. In 2011, lawmakers used the Rainy Day Fund to make up for the Medicaid deficit they created, but higher than expected state revenues could mean there is a big enough surplus to avoid tapping the fund next year. Once that problem is solved, lawmakers will begin work on the Medicaid budget for the next two years, and will have to find another $5 billion to at least match what Medicaid cost over the last two years. (Beaumont Enterprise)

Utah

- **Utah Governor asks Obama to approve state's own health care exchange**

  Utah's Gov. Gary Herbert is asking President Barack Obama to approve a health insurance exchange the state already has in place and declare that it meets the requirements of the federal health overhaul. Significant changes would be needed for it to comply with the federal law and there are two main sticking points, said Jennifer Tolbert, director of state health reform at the nonpartisan Kaiser Family Foundation. First, Utah's plan is not designed to offer health insurance to individuals as required in the federal law. Secondly, Utah's is not structured to distribute federal tax credits aimed at low income people who are uninsured. Utah plans to open up the plan to individuals in the future. (Washington Post)

National

- **Insurers Face Jumbled Market With Health Exchange Rules**

  Rules for the six state insurance exchanges that won conditional approval from the Obama administration Dec. 10 are split evenly between those with strict criteria for companies that want to participate and states that have opened their exchanges to all comers, a scenario supported by the insurance industry. A high bar for inclusion could limit the number of insurers offering health plans in some states. (Bloomberg)

- **More time needed to launch state exchanges, Highmark CEO says**

  Despite the federal government's drive toward its 2014 health care overhaul goals, the chief executive of Pennsylvania's largest plan isn't sure there's enough time left on the

clock. There's "a lot of concern about the ability [of the government] to go live," Highmark CEO William Winkenwerder Jr. said. After meeting with national health industry leaders in Washington, D.C., last week, he said he came away with the sense that the state-based health care exchanges -- the online clearinghouses where people can shop for health policies -- may not be ready to go by October 2013, when the enrollment period is scheduled to begin. (Pittsburg Post-Gazette)

- **Democrats Warn Against Medicaid Cuts**

Some Democratic senators and congressmen said Tuesday that they would not support a budget-reducing deal that cut Medicaid, even as one leading House Democrat acknowledged that the party will probably have to accept Medicare cuts. House Republicans would like to cut $600 billion over a decade from Medicare, Medicaid and other health programs. Other Medicaid reductions that have been suggested include ratcheting down the amount of money that states can draw down in higher federal matching rates through taxes on providers, reduced funding for durable medical equipment like wheelchairs and savings in care for people who are dually eligible for Medicare and Medicaid. (CQ Healthbeat – Subscription Req.)

- **Medicare-Medicaid 'Dual Eligibles' Continue to Pose Cost Issue**

Lawmakers are continuing to look for ways to save money by improving care for "dual eligibles," a costly group of beneficiaries who qualify for both Medicare and Medicaid. The Senate Finance Committee will hold a hearing on the group Thursday, with testimony from three state medical officials and Melanie Bella, director of the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services. Senators Rockefeller, Baucus and four House Democrats requested a report from the Government Accountability Office on the consumer protections and different requirements in Medicare and Medicaid, especially when it comes to managed-care plans. The report found that dual eligibles face a variety of standards from Medicare and Medicaid. For example, while some states require Medicaid beneficiaries to enroll in managed-care plans, Medicare enrollment in managed care is voluntary. In addition, the two programs can have different consumer protection requirements and have different appeals processes that don't correspond with each other. (CQ Healthbeat – Subscription Req.)

- **OIG: Assisted Living Facilities Not Complying With All Medicaid Requirements**

Federal regulators promised to put heat on state Medicaid officials to better oversee those who provide home and community-based services, based on an Office of Inspector General's report released early Tuesday that found that more than three-quarters of beneficiaries receiving such care were in assisted living facilities that did not meet the program's requirements. In its official response included in the 27-page report, Centers for Medicare and Medicaid Services officials said they would issue guidance to state Medicaid officials urging them to make sure the facilities follow all of the rules of the waivers they received allowing states to treat beneficiaries in home and community-based settings. OIG Report (pdf). (CQ Healthbeat – Subscription Req.)

- **What Medicaid cuts might look like**

  In the ongoing battle over the fiscal cliff, Democrats and Republicans have exchanged plenty of words about what they would or wouldn't do to Medicare. The same can't be said about Medicaid. But behind the scenes, they're going to have to work that out to give Republicans enough entitlement savings — because Republicans have been demanding big changes in the low-income health program for years, and the Democrats are nowhere close to ready for the same level of savings. Here are some of the biggest cost-savings options that could get some attention: Blended rates ($14.9 billion); Limit provider taxes ($26.3 billion); Cut primary-care bonuses ($13 billion); Manage the "duals"($12 billion); and competitive bidding for medical equipment ($5 billion). (Politico)

- **GAO hits Medicaid on waste**

  The Medicaid program has government employees and contractors doing some of the exact same work, which is wasting government time and money, according to a new Government Accountability Office report released Monday. Medicare, meanwhile, could better use data programmed into claims processing systems to stop fraud, GAO said in a separate report. The reports come as lawmakers are likely to look to both programs for potential savings in the fiscal cliff negotiations and are part of the constant effort on Capitol Hill to reduce waste in both programs. Medicare is estimated to have made $28.8 billion in improper payments in 2011, according to GAO. Medicaid was estimated to have made $21.9 billion in bad payments — a higher percentage of its outlays than Medicare's bad payments because it is a smaller program. (Politico)

Company News

- **CareSource creates new business division, names leader over it**

  CareSource said it has created a new business division to better manage the nonprofit managed health care plan's growth. Stephen Ringel was named senior vice president to head the new Market and Product Group effective immediately. The Market and Product Group will be in charge of growing membership, membership satisfaction, developing CareSource's relationship with Humana, and new products coming such as the health benefit exchange, according to CareSource. (Dayton Daily News)

- **Grassley says UnitedHealth acquisition poses possible health exchange monopoly**

  Congressional Republicans are questioning whether a recent acquisition by UnitedHealth Group raises concerns about conflicts of interest in the development of health insurance exchanges. In a letter issued Monday, Dec. 10, Sen. Charles Grassley, R-Iowa, asks a series of questions related to a UnitedHealth acquisition of Quality Software Services Inc., or QSSI, a Maryland company that has a federal contract to build a database hub for health exchanges. (Twin Cities Pioneer Press)

- **Magellan Appoints CEO**

  Magellan Health Services Inc. announced that effective January 1, 2013, Barry M. Smith, a member of the company's board, will be appointed CEO, and that Chairman

and CEO René Lerer, M.D. will become the full-time Executive Chairman. He will serve in that role through 2013, becoming Non-Executive Chairman for 2014. Upon mutual agreement between Dr. Lerer and the board, he may remain as Non-Executive Chairman for a third year, with potential board tenure beyond that. These changes are part of a multi-year arrangement that will ensure continuity for all stakeholders. (Magellan News Release)

- **Dave Ford Retires as CEO of CareOregon**

  David E. Ford, CEO since 2003, has announced his retirement from CareOregon, and the board has named Patrick Curran as his interim successor. Ford will retire at the end of the year. (The Lund Report)

- **Vestar Capital Partners Completes Sale of Sunrise Medical**

  Vestar Capital Partners ("Vestar") announced the completion of the sale of Sunrise Medical Inc. ("Sunrise Medical") to funds advised by Equistone Partners Europe. Sunrise Medical is the leading global manufacturer, marketer and distributor of high-end custom manual and power wheelchairs and technologically advanced and proprietary seating systems. Terms of the transaction, which was previously announced on November 6, 2012, were not disclosed. (Vestar Capital Partners News)

- **Steward Healthcare System's Plan to acquire Mercy Health System in Maine falls through**

  Boston-based Steward Health Care System ended its discussions to acquire Maine-based Mercy Health System, formerly terminating a letter-of-intent it had initially signed this past August. The system did not provide any meaningful commentary on why the deal fell through, only indicating the two parties could not come to a definitive agreement. (Boston Globe)

- **Maine system, hospital exploring deal**

  Eastern Maine Healthcare Systems said it signed a nonbinding letter of intent to acquire Mercy Hospital, a 168-bed hospital in Portland, Maine, which was previously in talks to be purchased by Steward Health Care System. Eastern Maine Healthcare Systems, based in Brewer, is one of the largest systems in Maine and owns seven hospitals. Mercy Hospital is owned by Catholic Health East. (Modern Healthcare)

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
December 19, 2012	Nevada	Contract Awards	188,000
December, 2012	Texas Rural STAR+PLUS	RFP Released	110,000
December, 2012	Virginia Duals	RFP Released	65,400
TBD	Washington Duals	RFP Released	115,000
TBD	South Carolina Duals	RFP Released	68,000
TBD	Michigan Duals	RFP Released	198,600
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 1, 2013	Vermont Duals	Proposals due	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	District of Columbia	Contract Awards	165,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
February 28, 2013	Vermont Duals	Contract awards	22,000
TBD	Michigan Duals	Proposals due	198,600
TBD	Washington Duals	Proposals due	115,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March, 2013	Idaho Duals	RFP Released	17,700
TBD	Michigan Duals	Contract awards	198,600
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	New Hampshire	Implementation (delayed)	130,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April, 2013	Arizona - Maricopa Behavioral	Contract awards	N/A
April-May, 2013	Rhode Island Duals	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	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July 30, 2013	South Carolina Duals	Contract awards	68,000
July, 2013	Virginia Duals	Contract awards	65,400
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
TBD	Michigan Duals	Implementation	198,600
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					1/1/2013
Connecticut	MFFS	57,569					12/1/2012
Hawaii	Capitated	24,189					1/1/2014
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012		Fall 2013
Iowa	MFFS	62,714					1/1/2013
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	4/1/2013
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					1/1/2013
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 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.

HMA Recently Published Research

Medicaid Today; Preparing for Tomorrow - A Look at State Medicaid Program Spending, Enrollment and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013

Vernon K. Smith, PhD, Managing Principal
Kathleen Gifford, JD, Principal
Eileen Ellis, MS, Managing Principal

The findings in this report are drawn from the 12th consecutive year of the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) budget survey of Medicaid officials in all 50 states and the District of Columbia. This survey reports on trends in Medicaid spending, enrollment and policy initiatives for FY 2012 and FY 2013. The report describes policy changes in reimbursement, eligibility, benefits, delivery systems and long-term care, as well as detailed appendices with state-by-state information, and a more in-depth look through four state-specific case studies of the Medicaid budget and policy decisions in Massachusetts, Ohio, Oregon and Texas. **Link**