HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS PROVIDES DUAL ELIGIBLE DEMONSTRATION RATE SETTING GUIDANCE

HMA ROUNDUP: FLORIDA GOVERNOR SUPPORTS MEDICAID EXPANSION AFTER WAIVER APPROVED; CALIFORNIA LEGISLATURE DEBATES MEDICAID EXPANSION OPTIONS; INDIANA GOVERNOR PROPOSES HEALTHY INDIANA PLAN AS VEHICLE FOR MEDICAID EXPANSION; INDIANA HOUSE BILL PROPOSES TRANSITIONING ABD BENEFICIARIES TO MEDICAID MANAGED CARE; SOUTH CAROLINA PUSHES DUAL ELIGIBLE RFP TO MAY/JUNE

OTHER HEADLINES: HOSPITALS ENCOURAGE MEDICAID EXPANSION IN PENNSYLVANIA, KANSAS, MISSOURI AND COLORADO; ESSENTIAL HEALTH BENEFITS RULE FINALIZED; CCIIO CHIEF ADDRESSES CONGRESS' QUESTIONS REGARDING HEALTH INSURANCE EXCHANGE IMPLEMENTATION

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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: CMS PROVIDES DUAL ELIGIBLE DEMONSTRATION RATE SETTING GUIDANCE

This week, our *In Focus* section reviews guidance offered by CMS earlier this month on the joint rate-setting process for the Capitated Financial Alignment Model, or duals demonstrations. The joint rate-setting process is conducted by CMS and the states to set a combined Medicaid and Medicare capitation rate paid to the MCOs serving the duals under the demonstrations. CMS previously published details on the rate-setting process; however, the revised guidance answers several questions with regards to Medicare and Medicaid rate-setting, as well as payments to providers under the demonstration. The rate-setting guidance and FAQs are available here.

Joint Rate-Setting

Rate components for Medicare Parts A/B, Medicare Part D, and Medicaid will be established under the following process:

Determination of Baseline Spending

- Medicaid baseline spending will be established for the target population, taking into account historic Medicaid costs and any current capitated rates for dual eligibles served in Medicaid managed care plans. The State and its actuaries will be responsible for providing historical spending and underlying data for Medicaid services to CMS's contracted actuaries. The contractors, with guidance and input from CMS, will validate the data and projected baseline costs in Medicaid (absent the demonstration).
- Medicare baseline spending will be established under a weighted average of fee-for-service standardized county rates and Medicare Advantage rates that would have been paid in the absence of the demonstration. For beneficiaries coming from MA, the baseline will reflect the estimated amounts that would have been factored into payments made to MA plans including Part C rebates. We note that preliminary 2014 Medicare Advantage rates were released on February 15, 2012, with most analysts estimating rate reductions to Medicare Advantage plans of 7-9% after all of the adjustments are made.
- The Medicare Part D projected baseline for the Part D Direct Subsidy will be set at the Part D national average monthly bid amount for the payment year, which occurs in early August of each year.

Determination of Aggregate Savings Percentages

- CMS assumes that the demonstrations can achieve overall savings through improved care management and administrative efficiencies. The aggregate savings percentages would be applied to the Medicare A/B and Medicaid components of the rate. Savings percentages will not be applied to the Part D component of the rate.

- Savings percentages will vary by state based on factors that would impact their being realized (such as managed care penetration. historical utilization of LTC services etc.) but the example provided is for savings of:
    - 1% in year 1
    - 3% in year 2
    - 5% in year 3
- The guidance notes that the methodology utilized allows both Medicare and Medicaid to share proportionally in the savings regardless of how those savings are being realized.
- States have input into the aggregate savings percentage but they will be based on CMS modeling.

Risk Adjustment

- Medicare: The existing CMS-HCC and RxHCC risk adjustment models will be utilized for the demonstration for A/B and Part D, respectively.
- Medicaid: Risk adjustment for the Medicaid component of the rate will be based on a methodology proposed by the State and agreed to by CMS. This may include the identification of various rate cells/cohorts of the population (e.g., by age or sex, nursing home level of care, care setting, etc.). CMS will allow states to use different risk adjustment methodologies as long as the methodology selected incents home and community based services over institutional placement.

Quality Withholds

- CMS and the State will withhold a portion of the capitation payments that participating health plans can earn back if they meet certain quality thresholds.
- Quality withholds will be applied based on core quality measures and state-specific performance measures applicable to the target population.
- Withhold percentages will be:
    - 1% in year 1
    - 2% in year 2
    - 3% in year 3

Questions Answered

CMS answered several questions related to financing and payments under the duals demonstrations. We have highlighted a few key takeaways from the FAQs. For the full questions and answers, see the CMS document linked above.

Difference from Medicare Advantage rates: Plans will not submit rate bids. Instead, CMS and the state will set capitation rates under the process described above. However, as noted above, the Medicare rate component will be at least partially tied to Medicare Advantage rates.

Plan-specific rates: Medicare rates will not vary by plan, but risk adjustment for each enrollee may lead to actual payment differentials. With CMS approval, states may develop Medicaid rate-setting methodologies on a county, regional, or statewide basis, and may implement customized risk adjustment methods.

Medicare Part D payments: Baseline Part D will be set at national average monthly bid amount ($79.64 in 2013). Payments will be cost reconciled at the end of the year, as occurs with Part D plans today.

Medicare bad-debt/disproportionate share hospital (DSH) payments: Payments associated with Medicare bad debt and DSH are included in baseline spending under standardized FFS county rates and Medicare Advantage capitation rates.

Payments to in-network, out-of-network providers: As with Medicare Advantage plan-provider contracts, CMS will not prescribe payment rates to in-network providers. Out-of-network providers must be paid for emergent or urgent services. For services that are part of traditional Medicare benefits, plans must pay out-of-network providers the lesser of the provider's charges or the Medicare FFS rate, at a minimum.

Demonstration Year 2014 Timeline

CMS also recently updated the timeline of key actionable items for CMS, states, health plans, and beneficiaries for the 2014 duals demonstration calendar year.

Key Date	Entity	Required Action
Spring 2013	States	States develop specifications for representing Medicaid and demonstration-specific benefits and covered drugs
April 1, 2013	CMS	Release of the Plan Benefit Package module
April 22, 2013	CMS	Release of the CY 2014 Medication Therapy Management (MTM) program submission module
May 6, 2013	Plans	Deadline for submitting MTM programs
May 13, 2013	CMS	Release of Part D formulary submission module for 2014
May 31, 2013	Plans	2014 Part D Formulary Submissions due from all sponsors offering Part D including Medicare-Medicaid Plans
June 3, 2013	Plans	Deadline for submitting plan benefit packages
June 7, 2013	Plans	Deadline for Additional Demonstration Drug file and any applicable Part D supplemental formulary files
June/July 2013	CMS/ States	CMS and the states review plan benefit packages and drug file submissions
July 31, 2013	CMS	CMS completes MTM program reviews
Sept. 1, 2013	CMS	Roll-out of MA and Part D plan landscape documents, which include details about all available Medicare health and prescription drug plans for CY 2014
Sept. 16-30, 2013	CMS	CMS mails the CY 2014 Medicare & You handbook
Fall 2013	Plans	Plans submit annual network information
October 1, 2013	Plans	CY 2014 marketing activity begins
October 1, 2013	CMS	Medicare Plan Finder on www.medicare.gov goes live for CY 2014
October 15, 2013 – December 7, 2013	Beneficiaries	Annual coordinated election period

HMA MEDICAID ROUNDUP

California

HMA Roundup – Jennifer Kent

As part of the special session currently underway, the state Assembly began hearing legislative measures related to the implementation of the Affordable Care Act (ACA), including Medicaid expansion and individual market reforms, on February 19. The Assembly bill related to Medicaid expansion is available here.

As a reminder, Governor Brown proposed adopting the Medicaid expansion in California under one of two options – a county based approach or a state based approach. The Legislative Analyst's Office released a report earlier this week evaluating the viability and impact of each option and concluded that the state is in a better position than the counties to effectively organize and coordinate the expansion effort. The LAO recommended that the legislature adopt a state-based expansion, and also recommended that the legislature redirect a portion of funding currently allocated to counties under 1991 realignment for indigent health. The LAO report is available here.

In the news

- **"Jerry Brown asks for changes to state's Medi-Cal expansion plan"**

  "The administration submitted a laundry list of proposed changes to Speaker John A. Perez's bill to expand eligibility for Medi-Cal, the state's public insurance program for the poor. Among them is language that stipulates the state will only expand its coverage if the federal government makes good on its promise to pick up most of the costs." (Los Angeles Times)

- **"Health insurance rate-setting map would raise costs, official says"**

  "California's insurance commissioner says splitting the state into six zones would drive up premiums as much as 23% next year. He's pushing an 18-region plan. Under the proposal for six regions, the Insurance Department estimates that premiums for similar coverage would increase as much as 22% in Los Angeles and 23% in the Bay Area. Insurance Commissioner Dave Jones said he's pushing for an 18-region plan that would cap increases at 8%." (Los Angeles Times)

- **"California opens $24M prison mental health center"**

  "California opened a $24 million treatment center for mentally ill inmates on Thursday as state corrections officials used the occasion to push for ending federal oversight of that aspect of prison operations. The 44,000-square-foot building at the California Medical Facility in Vacaville includes rooms where inmates will undergo individual, group and recreational outpatient therapy. It will be used to treat inmates who are seriously mentally ill but are able to function without around-the-clock care." (Santa Cruz Sentinel)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida Receives Second Medicaid Waiver Approval from HHS, Governor Scott agrees to Medicaid Expansion. Governor Rick Scott announced that the Department of Health and Human Services (HHS) has approved the state's 1115 waiver application, enabling the state to implement Medicaid managed care statewide. The governor touted the potential to improve the coordination of care, expand preventative care, and reduce hospitalizations. This marks the second waiver granted by HHS to Florida in the last month, following the approval of a waiver that allows for managed long-term care. The waiver's approval addressed the pre-condition issued by the governor before agreeing to expand Medicaid coverage in the state, which he did late Wednesday, February 20.

The Statewide Medicaid Managed Care program aims to (1) emphasize patient-centered care, personal responsibility, and active patient participation; (2) integrate care through alternative delivery models via a uniform statewide program; and (3) implement innovative reimbursement, plan quality, and plan accountability initiatives.

Florida Opts for Federal Exchange. Florida defaulted to the Federal Exchange, at least for the first year. Legislative members stated that they consider the federal deadlines "flexible," and may look at the potential of a state-run exchange at a later date.

Molina and Humana Accept Bid Protest Awards. Following bid protests related to the Managed Long Term Care (MLTC) procurement, the Agency for Health Care Administration posted additional awards to Molina Healthcare of Florida, Inc. (Molina) and Humana Medical Plan, Inc. (Humana). Molina accepted awards in regions 5, 6, and 11, while Humana accepted awards in regions 4, 10, and 11. These negotiated settlements offer more choices to MLTC recipients and avoid litigation expenses.

Legislative Select Committees on PPACA Hold Hearings. The House Select Patient Protection and Affordable Care Act (PPACA) Committee met on February 18, 2013, to discuss the Medicaid expansion. The committee heard from a panel of hospital executives who all support Medicaid expansion. The Legislature's Chief Economist estimated that there are about 800,000 Floridians who would fall into the adult expansion category, and noted that these estimates will be updated at the ACA estimating conference scheduled for March 1, 2013. In addition, the committee heard from other states that had expanded Medicaid to nondisabled childless adults. Finally, the committee heard arguments against Medicaid expansion from a representative of the Foundation for Government Accountability about "lessons learned" from Arizona and Maine's coverage expansions to childless adult Medicaid recipients. The next meeting is scheduled for February 28, 2013.

On February 18, 2013, the PPACA Committee heard from the Director of the State Group Health Insurance (SGHI) program at the Department of Management Services regarding the impact of the federal health care law on the SGHI program. The committee also heard from the Deputy Commissioner at the Office of Insurance Regulation on the impact to insurance regulations.

A joint PPACA Committee meeting is scheduled for March 4, 2013 , the last day before the 2013 regular legislative session begins. A potential decision by the legislature on the Medicaid expansion could come after that meeting.

In the news

- **"Fla. hospitals push for Medicaid expansion"**

  "Florida hospital executives warned they will be hit hard if the state does not expand Medicaid coverage under the federal health overhaul because hospitals will lose federal funding they've been relying on to care for uninsured patients. Florida hospitals spent more than $2.8 billion caring for uninsured patients in 2011, hospital officials said Monday." (Miami Herald)

Georgia

HMA Roundup – Mark Trail

Board of Community Health February Minutes. The February 14, 2013 minutes from the Board of Community Health were released. The Policy Committee heard a presentation on the Affordable Care Act and its impact on Georgia and DCH, including discussions of the movement into Medicaid of Children's Health Insurance Program (CHIP) enrollees in the band of 100-138% of Federal Poverty Level income, premium taxes, eligibility, exchanges, and state health benefits. Georgia has already elected to defer to a Federal exchange and will not pursue Medicaid expansion.

CFO Vince Harris reviewed Governor Deal's budget proposal, including the hospital provider tax and the 0.74% provider reimbursement cut. Commissioner David Cook reminded the Board that, while DCH was unable to meet the Governor's original request for 3% cuts in state funds for FY 2013 and 5% cuts in FY 2014, the Board had approved several savings measures in the fall of 2012 that were reflected in the Governor's budget.

Harris also reviewed the $15 billion current liability for other post-employment benefits, which is threatened by the decline in the ratio of active employees to retirees and the lack of reserves.

Lastly, the audit committee discussed budgetary controls in light of DCH spending $32 million more than budgeted. Commissioner Cook noted that this figure equates to one day of Medicaid expenses and promised that there would be no overspending in the future.

In the news

- **"Georgia, South Carolina not expanding Medicaid"**

  "The governors of Georgia and South Carolina have decided not to expand Medicaid coverage to more uninsured despite high rates of working families with no coverage. In South Carolina, nearly half of the 766,304 uninsured, or 359,107, are working and 19.3 percent of people employed in the state lack insurance, according to the U.S. Census Bureau's American Community Survey 2011. In Georgia, 22.7 percent of the employed lack health insurance, and working families make up 48.3 percent of the uninsured." (Augusta Chronicle)

- **"Activists urge state legislators to approve autism insurance bill"**

  "In an attempt to have Georgia join 32 other states with mandatory insurance coverage of autism, local and statewide activists have succeeded in getting a bill, House Bill 309 — also called Ava's Law — into the Legislature." (Daily-Tribune)

- **"Health officials propose major cuts to Medicaid"**

  "The state's Department of Community Health busted its budget last fiscal year by $32 million, a mistake the agency's chief said won't be repeated. State officials laid out plans Thursday to cut tens of millions of dollars from the DCH budget. Proposed changes include a 0.74 percent Medicaid reimbursement reduction for some health care providers — a move consumer advocates fear could threaten access to care for poor Georgians." (Atlanta Journal Constitution)

Idaho

HMA Roundup

RFP Alternatives for Duals Demonstration RFP. Idaho is considering five alternative approaches in its dual eligible demonstration RFP process. The state's primary aims are to ensure the best coverage state-wide, provide choice for participants in all areas of the state, and to encourage bidders to deliver services in rural and urban areas of Idaho. The five primary options discussed were (1) requiring bidders to cover the entire state (rejected outright); (2) bidding by the Department of Health and Welfare's seven regions; (3) bidding by the IDHW's three established hubs; (4) bidding by hubs with the move of one county into a different hub; and (5) bidding by hubs with the move of four counties into a different hub.

Indiana

HMA Roundup – Cathy Rudd

Governor Pence Rejects Medicaid Expansion. Governor Mike Pence issued a flat rejection of expanding Medicaid in the state and, instead, requested Federal approval to serve an expanded Medicaid population through the Healthy Indiana Program (HIP). Pence wrote that "Medicaid is broken. It has a well-documented history of substantial waste, fraud, and abuse." Pence endorsed the health savings account program, HIP, as a bipartisan program that has increased preventive services and encouraged consumer-directed health choices. Pence asked HHS to grant the state a three-year extension for HIP through 2016.

Bills to Expand Medicaid Passed Out of Committee Using HIP as Vehicle. Senate Bill 551 gives the Family and Social Services Administration authority to negotiate state plan amendments or a waiver with HHS to establish Medicaid as a block grant system, including coverage to expansion population (up to 133% of FPL). This proposed bill would require FSSA to present a plan to the legislature by 8/1/13 concerning whether to enroll ABD in RBMC as well as how to address providing health care to HIP beneficiaries and duals. In addition, the bill would require the Department of Insurance to present a plan to the legislature by 8/1/13 concerning the establishment and implementation of an Indiana Exchange and a definition of essential benefits. Finally, this bill would dissolve the

state's high risk pool when an exchange begins operational in Indiana. The bill was passed out of the Health and Provider Services Committee on 2/13 and reassigned to the Appropriations Committee, which has a hearing on 2/21.

House Bill 1591 would authorize the expansion of Medicaid to 133% of FPL using HIP as the vehicle. This legislation would require the aged, blind, and disabled to enroll in risk-based managed care as of October 1, 2013. No request for proposal would be involved in plan awards.

Michigan

HMA Roundup – Esther Reagan

DCH Presents Budget Recommendations to House Appropriations Committee. The Department of Community Health recently presented its FY 2014 budget recommendations to the House Appropriations Subcommittee on Health. DCH offered a review the status of its 2013 initiatives, including Healthy Kids Dental Expansion, autism coverage, integrated care for dual eligibles, children's special health care services managed care transition, alignment of behavioral health provider systems, health and wellness initiatives, and the primary care transformation project. The dual eligible demonstration projection memorandum of understanding is being negotiated with CMS. The FY 2014 budget proposal of $16.6 billion is more than a 10% increase over FY 2013, but the entire increase comes from additional Federal matching funds. State general funds and private/local funds are essentially budgeted as flat year-over-year. Governor Snyder recommended depositing half of the revenues from expansion into a special healthcare savings "rainy day" account. These deposits are projected to finance Medicaid expansion for the next 21 years.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak and Matt Roan

Beverly Mackereth begins as Acting DPW Secretary. On February 16, 2013, Beverly Mackereth became acting director of the Department of Public Welfare, following the resignation of Gary Alexander. A former York County state representative, Mackereth had previously served as the welfare department's deputy secretary for the Office of Children, Youth and Families.

Legislative Budget Hearings Scheduled. The Department of Public Welfare will appear before the Senate Appropriations Committee on March 5, 2013, and the House Appropriations Committee on March 6th. It is expected that these legislative hearings will encompass Medicaid expansion, additional funding to address waiting lists for waiver programs, the Department's oversight of the new Financial Management Services contractor, and the expansion of a county human services block grant program.

DPW post Waiver Renewal Applications for Comment. The Office of Long Term Living within the Department of Public Welfare has posted changes to the Aging and Attendant Care Waivers for public comment. These Waivers expire on July 30th, and the Department must submit their renewal application to CMS by March 30th. While the OLTL has expressed that their primary goal is to renew the waivers with limited changes, modifica-

tions have been made to make the waivers consistent with current practice. A document comparing the current waivers to the new language being proposed is posted at the website below. Public comments are due by close of business on Tuesday February 26, 2013. Link

Governor Touts Effort to Reduce Waiting Lists for Services. At an event in Pittsburgh, Governor Corbett gathered with 15 advocacy organizations to tout his budget proposal to reduce the waiting list for Pennsylvanians living with intellectual disabilities. Corbett proposed an additional $20 million to provide home and community-based services for approximately 1,200 people. This proposal builds off the prior year's $17.8 million in funding to reduce waiting lists for services.

Corbett's Privatization Push for PA Lottery Thwarted by Attorney General. After pressure from Governor Corbett to complete a review of the proposed lottery contract with Camelot Global Services, PA Attorney General Kathleen Kane announced that she rejected the contract as non-compliant with the state constitution and lottery law. Corbett had already pegged $50 million in proposed funding for seniors, including home- and community-based services, to the execution of the lottery deal with Camelot. The administration has returned Camelot's $50 million bid security payment, which would be replaced with a $50 million promissory note if Corbett continues to pursue privatization.

In the news

- **"Democrats take on Corbett over Medicaid, pensions"**

  "Pennsylvania Senate Democrats on Tuesday challenged Gov. Tom Corbett's top budget adviser over the necessity of carrying out the administration's proposed pension fund changes and to explain how it developed an analysis that a Medicaid expansion would cost state taxpayers billions of dollars. Corbett's budget secretary, Charles Zogby, gamely answered questions for nearly 2 1/2 hours during the Senate's first Appropriations Committee hearing of 2013 as lawmakers begin to pick apart the Republican governor's spending plan." (Philadelphia Inquirer)

South Carolina

HMA Roundup

In an update released on February 15, the South Carolina Department of Health and Human Services noted that the proposed model of the South Carolina Dual Eligible (SCDuE) Demonstration continues to be reviewed by the Centers for Medicare and Medicaid Services (CMS). DHHS is still moving forward with planning activities for a 2014 implementation of the SCDuE Demonstration and is now planning to conduct the procurement process in May/June 2013 with contract awards in July.

Texas

HMA Roundup – Dianne Longley

Medicaid bills introduced in Texas legislature. Senate Bill 8, introduced by Senator Jane Nelson (chair of Senate Health and Human Services), has passed out of committee and will go the full Senate for a vote. This proposed legislation would create new divisions at

the Health and Human Services Commission to provide data analytics to detect fraud and abuse. In addition, this bill would carve-in non-emergency medical transportation into a managed care delivery model, effective March 1, 2014.

House Bill 1381 was introduced by Rep. Armando Martinez on February 19, 2013 aiming to prohibit Medicaid prescription drug programs under managed care. Given the political makeup of the House, observers do not expect action on this bill.

Washington

HMA Roundup – Doug Porter

Seattle Times Outlines a Legislative "To-Do" List. The Seattle Times Editorial Board highlighted a number of key healthcare issues that require Washington State legislative action. First off, the newspaper highlighted that legislators must provide budget authority to cover the state's participation in Medicaid expansion, which could add 350,000 newly eligible beneficiaries. Secondly, the paper highlights two senate bills that would expand psychiatric crisis commitment, establish outcome metrics, and introduce incentives for quality providers.

Revised Budget Figures in March. The legislature will recast its budget in the first week of March. It is expected that revenues will show a modest increase compared to last year. In addition, the Economic and Revenue Forecast Council must submit its own revenue forecasts to the governor and legislature on March 20, 2013.

OTHER HEADLINES

Colorado

- **"Health exchange will tap brokers but won't pay them"**

  "Health insurance brokers will get referrals and be able to sell plans to individual and business clients of Colorado's new health exchange. But they won't earn money directly from the exchange and won't have to abide by a strict conflict of interest policy that Colorado's exchange board passed Monday to govern new "health guides." Instead, insurance companies will continue to pay commissions to brokers as they currently do. And Colorado's Division of Insurance will continue to license and monitor brokers." (Health Policy Solutions)

- **"Study: Medicaid expansion would boost jobs, Colorado coffers"**

  "Federal spending funneled to Colorado as a result of the state joining the Medicaid expansion would boost jobs by 22,000 and produce $4.4 billion in new economic activity, according to a new economic analysis. The U.S. government would pick up 100 percent of the cost early in the health insurance expansion, rather than the usual 50/50 split with states, and the spending is projected to pump up average household earnings by $608 by 2026, said a study commissioned by the Colorado Health Foundation." (Denver Post)

Hawaii

- **"Hawaii Legislature considers bill allowing regional hospitals to become private"**

  "The Hawaii Legislature is considering a proposal to allow regional hospitals to be bought by private companies. The idea has been talked about in the past. Officials at Maui Memorial have talked about privatizing the hospital for years. But with Banner Health knocking, change could happen sooner rather than later. The Phoenix, Arizona,-based nonprofit health care organization with 23 hospitals in seven states is interested in running hospitals on Maui and the Big Island." (The Republic)

Kansas

- **"Kansas hospital group study predicts expanding Medicaid would generate 4,000 jobs"**

  "A study released today by the Kansas Hospital Association says that expanding Medicaid eligibility to levels called for in the federal health reform law would pump more than $3 billion into the state's economy and create 4,000 new jobs by 2020. The study, done for the association by the Center for Health Policy Research at George Washington University and Regional Economic Models, Inc., also shows that expansion would save the state more than it would cost." (Kansas Health Institute)

Missouri

- **"Missouri Democrats say rural hospitals need expanded Medicaid"**

  "The leader of a rural Missouri hospital warned lawmakers Monday that failure to expand eligibility for Medicaid could put institutions like his at risk of failure…. If Medicaid is not expanded — and Republican legislative leaders have opposed the idea — Noble said his hospital, in southeast Missouri, would lose around $1 million a year in federal reimbursements for treating uninsured patients." (The Kansas City Star)

New Hampshire

- **"N.H. to partner with feds in health exchange"**

  "The state will partner with the federal government to operate the new insurance markets required under President Barack Obama's health overhaul law, according to a declaration letter Gov. Maggie Hassan is sending out this week." (Seacoast Online)

New York

- **"Managed-care market consolidates as it grows"**

  "Five Medicaid managed-care plans now account for 65% of all enrollments in New York state, as the market for such plans grows and consolidates. At the top of the heap is Fidelis, which now has a 20.2% market share in the state with nearly 777,000 enrollees, a 19.6% increase over the plan's totals for 2012. The other leaders are Healthfirst, with about 562,000 members and a 14.6% market share; MetroPlus, with nearly 420,000 and a 10.9% market share; and Amerigroup, with more than 406,000 members and a 10.5% market share." (Crain's New York)

- **"Panel Endorses Report on New York's Medicaid System"**

  "The House Oversight and Government Reform Committee on Thursday approved an amended report on waste in New York's Medicaid program, alleging that billions of federal dollars have been wasted annually…. The report recommended six remedies, including an end to federal overpayments to state-operated developmental centers, state legislation that limits executive compensation at nonprofits that receive most of their funding from Medicaid and an independent audit of the program." (CQ Roll Call)

- **"For Brooklyn hospitals, it's all about the payer mix"**

  "Last week's joint legislative hearing on Brooklyn's hospital crisis triggered an analysis of the revenue streams of hospitals in the borough. Some politicians—Assemblyman Vito Lopez the most vocal among them—questioned the existence of a Brooklyn rate or a Manhattan rate. As pointed out by Stephen Berger, the former chairman of the Medicaid Redesign Team's Brooklyn Task Force, the key issue is not whether Manhattan hospitals command higher rates—it is the dismal payer mix of Brooklyn's community hospitals. Most have very little commercial business to offset cuts in Medicaid or Medicare. Insurers who cater to large employer groups can't do without New York-Presbyterian, or Mount Sinai, in their networks, said Mr. Berger. That gives the Manhattan hospitals more leverage than Brooklyn hospitals in negotiating rates." (Crain's New York)

North Carolina

- **"Mecklenburg will run managed-care organization"**

  "North Carolina's largest county has received permission from the state to run its own managed-care organization to treat the mentally ill. The move comes after Mecklenburg County's operations were reviewed by a consultant and state regulators. Health and Human Services Secretary Dr. Aldona Wos said Friday she's given approval for MeckLINK Behavioral Healthcare to begin operating March 1 under a state Medicaid waiver." (Henderson Dispatch)

Ohio

- **"Kasich implores GOP to expand Medicaid"**

  "Kasich used his third State of the State speech as governor to implore lawmakers in his own Republican Party to "examine your conscience" as they consider his proposed expansion of Medicaid." (The Columbus Dispatch)

Oklahoma

- **"Medicaid agency says bye to director"**

  "The agency that administers Oklahoma's Medicaid program said goodbye to its longtime director Thursday, while promising to still explore new ways to deliver health care services to the state's uninsured. Mike Fogarty, 64, is stepping down as CEO of the Oklahoma Health Care Authority effective March 1. He announced his retirement in September, two months before Gov. Mary Fallin rejected an opportunity to expand the state's Medicaid program." (Norman Transcript)

Tennessee

- **"TN rejects health insurance exchange partnership"**

  "Tennessee won't participate in a partnership with the federal government in establishing a health insurance exchange, Gov. Bill Haslam announced Friday. The Republican governor said in a letter to U.S. Health and Human Resources Secretary Kathleen Sebelius that the partnership model doesn't address his concerns over what he called 'aggressive federal timelines, a lack of true flexibility for states, and misguided federal policies.'" (Tennessean)

Virginia

- **"Plan to close Va. institutions stokes worry for families of the developmentally disabled"**

  "Virginia is among the last states to begin dismantling its large institutions for the developmentally disabled, a decision that was made as part of a year-old settlement agreement with the Justice Department, which argued in a lawsuit that Virginia was discriminating against training center residents by keeping them institutionalized. All but one of the commonwealth's five training centers, as the state calls them, are to be shuttered by 2020, with the one in Fairfax set to close by July 2015." (Washington Post)

Wisconsin

- **"LogistiCare to bid on new Medicaid transportation contract"**

  "LogistiCare, the company blamed for thousands of late and no-show medical rides for Wisconsin Medicaid patients, intends to bid on a new contract. That became official this week when the Department of Health Services revealed, in response to a Journal Sentinel request, that LogistiCare had submitted a notice of intent to bid, as have four others - Access2Care, American United Taxi Services, MTM Inc. and Wisconsin Coordinated Transportation Cooperative. Proposals are due Thursday. LogistiCare terminated its $38 million contract with the State of Wisconsin effective Feb. 17, saying it was losing money and it should have asked for twice as much. The company will continue to dispatch rides until a new contract is signed." (Milwaukee Journal-Sentinel)

- **"Analyst says Walker's health care plan won't work"**

  "Gov. Scott Walker's plan to move more people off state Medicaid plans and onto private insurance through a federal marketplace won't result in cutting the number of uninsured Wisconsin residents in half as promised, an independent analyst said Thursday. Walker's numbers are inflated because poor people near the poverty line won't be able to afford private health insurance that requires individuals to pay for annual deductibles and other cost-sharing expenses, Bob Laszewski, a Washington-based insurance industry consultant, told The Associated Press after reviewing the Republican governor's plan." (LaCrosse Tribune)

Wyoming

- **"Despite rejection, Wyoming studies Medicaid expansion"**

  "Despite the Wyoming Legislature's recent rejection of a plan to extend Medicaid coverage to 17,600 additional low-income adults, the state's Department of Health continues to study the possibility…. Gov. Matt Mead has directed the Wyoming Department of Health to continue studying the issue this year to be ready in case the Legislature reverses itself next year and decides to expand the program." (Billings Gazette)

National

- **"Essential Health Benefit Rule Made Final"**

  "The Obama administration on Wednesday released its final rule on essential health benefits, which sets out what benefits insurers must offer starting in 2014…. The final, 149-page rule says insurers must have procedures to allow patients to get "clinically appropriate" prescriptions which are not included on the plan's list of covered medications. It also retains requirements that insurers offer at least one drug per therapeutic category, or the same number as a state's benchmark plan, whichever is greater. Many state benchmark plans require at least two drugs per class. Advocates had wanted the government to require coverage of a broader range of drugs, but insurers and others said requiring many more would raise premium costs. The final rule says 'plans are permitted to go beyond the number of drugs offered by the benchmark.'" (Kaiser Health News)

- **"Big Firms Win Multimillion Dollar Contracts To Build Insurance Marketplaces"**

  "Deloitte Consulting, part of the Big Four accounting giant headquartered in New York, won four state contracts to set up the information technology systems at the heart of the marketplaces. Deloitte's contracts with Connecticut, Kentucky, Rhode Island and Washington are worth about $250 million over the next three years, according to company and state announcements. CGI., a U.S. subsidiary of the Montreal-based CGI Group Inc., also won contracts valued at more than $150 million in four states (Colorado, Massachusetts, Vermont and Hawaii,) and another, valued at $71 million over two years, to build the federal marketplaces that will operate in about half the states…. But the single largest contract to build a health insurance marketplace went to Accenture, which won a $359 million deal to set up California's exchange." (Kaiser Health News)

- **"Supreme Court Gives F.T.C. a Win on Hospital Mergers"**

  "The Supreme Court on Tuesday strengthened the power of the Federal Trade Commission to block hospital mergers, issuing an opinion that could limit the ability of public hospital authorities to claim immunity from federal antitrust laws. The unanimous decision restored the authority of the F.T.C. to challenge the merger of the only two hospitals in Albany, Ga. Some experts said the decision could mean that hospitals will have to be more cognizant of antitrust considerations when they join forces with other health care providers to form so-called accountable care organizations, as called for in the new health care law." (New York Times)

- **"Federal Government To Run Insurance Marketplaces In Half The States"**

  "The Obama administration will be running new health insurance marketplaces in at least 26 states— including the major population centers of Texas, Florida and Pennsylvania. The federal government had hoped more states this week would agree to form a partnership exchange—the deadline to apply was Friday—but the offer was largely rebuffed. New Jersey, Ohio and Florida, several of the biggest states that had not declared their intentions, officially said no late in the week." (Kaiser Health News)

- **"Some Employers Could Opt Out of Insurance Market, Raising Others' Costs"**

  "Federal and state officials and consumer advocates have grown worried that companies with relatively young, healthy employees may opt out of the regular health insurance market to avoid the minimum coverage standards in President Obama's sweeping law, a move that could drive up costs for workers at other companies." (New York Times)

- **"States worry about rate shock during shift to new health law"**

  "Less than a year before Americans will be required to have insurance under President Obama's healthcare law, many of its backers are growing increasingly anxious that premiums could jump, driven up by the legislation itself. Higher premiums could undermine a core promise of the Affordable Care Act: to make basic health protections available to all Americans for the first time." (Los Angeles Times)

- **"In Surprise Move, Federal Officials Cap High-Risk Pool Enrollment"**

  "Federal officials announced Friday that they are blocking new patients from enrolling in the high-risk pools for people with medical conditions, citing cost concerns. The suspension will take effect immediately in 23 states and District of Columbia, where the federal government runs the program, known as the Pre-Existing Condition Insurance Plan. "All applications must be received by February 15 to be eligible for enrollment," said a two-page memo from the Center for Consumer Information and Insurance Oversight." (CQ HealthBeat)

- **"Cohen Lays Out Path for Standing Up Federal Exchange"**

  "The top federal official in charge of establishing health insurance marketplaces under the health care law detailed plans Thursday for a poorly understood but major part of that effort: the federally facilitated exchange. It was long past time to do so, Sen. Orrin G. Hatch, R-Utah, indicated in his opening remarks at a Senate Finance Committee hearing on exchanges. "Many key details remain unanswered," Hatch complained in his opening statement at the hearing, which centered on testimony by Gary Cohen, head of the Centers for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services." (CQ HealthBeat)

- **"Luring Primary Care Docs into Medicaid"**

  "The Affordable Care Act will usher at least seven million more Americans into Medicaid next year, but the question of whether enough doctors will be there to welcome them is keeping some state health policymakers up at night. A report pub-

lished last year in Health Affairs signaled trouble ahead. According to that study by Sandra Decker, an economist at the National Center for Health Statistics, only two out of three primary care physicians surveyed in 2011 were willing to accept new Medicaid patients. Larger numbers said they would take on new Medicare patients or see new patients with private insurance. Medicare, health care for the elderly, is a purely federal program; Medicaid, which covers many poor people, is a joint state and federal enterprise." (Stateline)

COMPANY NEWS

- **Skilled Healthcare Reaches Settlement with California over Staffing Levels**

  California Attorney General Kamala Harris announced that the state had reached an agreement with a major California-based nursing home provider over staffing levels and quality of care. Skilled Healthcare Group has agreed to have its 20 facilities subject to surprise inspections for two years at a cost of $350,000 annually to monitor quality of care and adequate levels of staffing. This settlement puts an end to the misdemeanor case filed against the company by the state in October 2012.

- **"Ex-Amerigroup CEO Carlson leaving WellPoint after top job filled"**

  "Former Amerigroup Chief Executive James Carlson, who joined WellPoint Inc after his company was acquired by the No. 2 U.S. health insurer, will leave WellPoint at the end of the month, the company said on Friday. The announcement comes days after WellPoint selected Joseph Swedish, who had run a large nonprofit hospital system, to be its new chief executive." (Reuters)

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	District of Columbia	Contract Awards	165,000
TBD	Nevada	Contract Awards	188,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March 15, 2013	Florida acute care	Proposals Due	2,800,000
March, 2013	Virginia Duals	RFP Released	65,400
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, 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	South Carolina Duals	RFP Released	68,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June 1, 2013	California Rural	Implementation	280,000
June, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Massachusetts Duals	Implementation	115,000
July 1, 2013	Ohio	Implementation	1,650,000
July 1, 2013	Nevada	Implementation	188,000
July 1, 2013	Idaho Behavioral	Implementation	200,000
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
September 1, 2013	California Duals	Implementation	500,000
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
October 1, 2013	Illinois Duals	Implementation	136,000
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
December, 1 2013	Florida LTC (Region 11)	Implementation	16,400
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
January 1, 2014	Rhode Island Duals	Implementation	22,700
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	526,902**	X	3/1/2012	4/4/2012		9/1/2013
Colorado	MFFS	62,982					4/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189	Not pursuing Financial Alignment Model				
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	70,000	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				9/1/2013
South Carolina	Capitated	68,000	May-June 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402			Early 2013		1/1/2014
Virginia	Capitated	65,415	March 2013		July 2013		1/1/2014
Vermont	Capitated	22,000	TBD	TBD	TBD		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	**15 Capitated 7 MFFS**	**1.7M 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 Recent Events

Greg Nersessian Interviewed on Bloomberg Industries

HMA Principal Greg Nersessian recently sat down with Bloomberg Industries to discuss what's on the horizon in 2013 for state sponsored health care plans. Check out Greg's conversation with Mike Manns at: https://vimeo.com/58371045.

HMA Recent Publications

"Finance: A Guide to Safety Net Provider Reimbursement"
HMA Accountable Care Institute (ACI)

Doug Elwell, MSA – Contributor
Art Jones, MD – Contributor
Gaylee Morgan, MPP – Contributor
Steven M. Perlin, MBA – Contributor

The prevailing healthcare reimbursement system in the United States has failed to create effective incentives for providers to improve quality and contain costs. The current system has rewarded volume over value and has discouraged providers from working together toward improved health for the populations they serve. These issues are even more acute within the safety net, which faces stronger incentives to increase volumes to compensate for reimbursement rates that are often well below the cost of providing care. This paper describes key concepts that must be part of a value-based reimbursement system and describes how value-based reimbursement creates strong incentives for the development of effective, accountable delivery systems. (Link - PDF)

"Empanelment in an Accountable Care Environment"
HMA Accountable Care Institute (ACI)

Greg Vachon, MD – Contributor
Lori Weiselberg, MPH – Contributor

A foundation of both the Patient Centered Medical Home (PCMH) model of care and accountable care, "empanelment" is the process of creating and maintaining a relationship between each patient and a primary care provider. This document is a guide to implementing this foundational process in organizations that deliver primary care and are seeking to deliver on the triple aim of accountable care: improved health, better experience, and lower cost. (Link – PDF)