HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: UPDATE ON HEALTH PLAN PARTICIPATION IN STATE INSURANCE EXCHANGES

HMA ROUNDUP: COVERED CALIFORNIA HEALTH PLANS TO BE ANNOUNCED TOMORROW; EXCHANGE PLANS REVEALED IN WASHINGTON DC, WASHINGTON STATE, AND RHODE ISLAND; VIRGINIA FINALIZES DUAL ELIGIBLE MOU WITH CMS; MASSACHUSETTS AND CMS INCREASE DUAL ELIGIBLE DEMONSTRATION RATES TO MCOS; NEW YORK CITY CONTEMPLATES BEHAVIORAL HEALTH DELIVERY SYSTEM REFORMS; IOWA GOVERNOR OPENS DOOR TO POSSIBLE MEDICAID EXPANSION; SOUTH CAROLINA AND LOUISIANA LEGISLATURES SHUT DOOR ON MEDICAID EXPANSION

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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: UPDATE HEALTH PLAN PARTICIPATION IN STATE INSURANCE EXCHANGES

This week, our *In Focus* section brings together the information currently available to the public on plan participation in state health insurance exchanges. We have reviewed the select states that have made exchange plan offering submissions public, as well as comments provided from both publicly traded health insurance companies and hospital management companies. As noted, plan offering submissions are not finalized in many states, and do not necessarily represent participation in a state's exchange. Below, we have summarized recent commentary from publicly-traded health insurance and hospital management companies related to exchange participation.[1] Later in the *In Focus* section, we summarize the individual and small group market offering submissions in seven states.

Based on the comments provided by the senior executives of the shareholder-owned health insurance and hospital management companies we highlight three key takeaways:

- Health insurance companies are taking a cautious approach to participation in health insurance exchanges for 2014. Most of the large national plans will only be offering exchange products in a subset of the markets in which they offer individual and small group coverage today. UnitedHealth appears to be among the more conservative companies with respect to participation, only targeting 12 states, while WellPoint sees a bigger opportunity in targeting all 14 of its Blues branded markets.
- Provider access will be constrained by narrow network products. As opposed to the open network products that dominate the commercial/employer market today, exchange based insurance products will have narrower network offerings in order to limit the cost of coverage.
- Hospital contracting appears to be coming in at a modest discount to commercial rates and above Medicare rates. The threat of Medicaid managed care companies being able to build exchange products using their Medicaid contracted rates is not materializing, at least not for 2014. Instead, hospitals that participate in exchange product networks will receive a more favorable reimbursement mix.

Commentary: Health Insurance Companies

Aetna

- Aetna has indicated its approach to exchange participation in 2014 will be cautious, currently planning to participate in individual exchanges in 14 states and in the small business health options program (SHOP) exchanges in a small handful of states.
- Aetna recently disclosed that it has been encouraged by the federal government to participate in state exchanges where interest from health plans may be limited.

[1] *Commentary excerpted from management presentations at investor events and from quarterly earnings conference calls which are available at www.SeekingAlpha.com.*

- On the contracting front, Aetna indicated on a recent conference call that it has contracted about 2/3 of its networks for exchange products. Aetna's exchange products will be based on narrow provider networks that are generally 25% to 50% of the size of its base networks in those marketplaces. The company has indicated that the rates it is negotiating for hospital services are between Medicare and Commercial levels.
- From an uptake standpoint, Aetna expects overall enrollment progress to be slow in 2014 and it will likely take a couple of years for the individual exchanges across the country to generate robust consumer participation.
- Similarly, Aetna CEO Mark Bertolini also doesn't expect significant migration to exchanges in the small group market in 2014, noting "In the Small Group market, we don't see a whole lot of traction in exchanges until we move into 2016, which, by then, we think there could be as many as 5 million lives that will leave the Small Group market through some sort of form of employers saying, "I'd rather work with exchanges."

Cigna

- Cigna has described its approach to exchange participation as a "controlled ramp."
- In a recent news article, CEO David Cordani specified five states where it plans to offer individual exchange products: Texas, Florida, Tennessee, Arizona and Colorado

Centene

- Centene has described the exchange market as representing its largest growth opportunity over the next several years, quantifying the market opportunity at $52 billion in states where it currently operates.
- Centene intends to focus on providing coverage at the low-income level and expects to be on the exchanges in a subset of the places where it operates Health Plans today.
- Centene is targeting members at the lower end of the income spectrum for its exchange products by using a network that has a similar composition to its Medicaid products and by offering plan designs that resemble Medicaid managed care benefit structures with limited out of pocket costs.
- The company has offered limited insight into its hospital contracting other than to say that it is comfortable where its negotiations are ending up.

Health Net

- Health Net has indicated that it has submitted a bid to participate in the Covered California exchange in 2014 (which will announce its participating plans in a press conference Thursday, May 23).
- The company has offered narrow network products in the small group market in California for a number of years and its exchange product will build off of that structure.

Humana

- Humana intends to offer exchange products in 14 states in 2014 where it believes it has significant network strength.

Molina

- Molina has stated that it intends to participate in exchanges in states where it has Medicaid contracts. Molina's strategy is to focus on the lower-income range of the exchange population where management sees synergies with its current Medicaid enrollment base.
- Molina expects premium rates on the exchanges to be approximately double what it is paid for a TANF Medicaid member due to higher unit costs and selection risk.

UnitedHealth Group

- UnitedHealth's management team has been cautious in its commentary on exchange participation for 2014. Specifically, CEO Stephen Hemsley stated on a recent conference call that "we will be very selective in where we participate and do not believe the exchanges will be a significant factor for us, either plus or minus, in our 2014 commercial market outlook."
- While originally providing a range of 10-25 states in which it might offer exchange-based products, the company subsequently revised that figure to 12.
- The company has said very little with regard to provider contracting other than to suggest that rates will be market specific and that they will "vary from commercial to something less."
- UnitedHealth has also suggested its products will reflect "value-based networks"

WellPoint

- WellPoint's management team believes that it is well positioned to compete effectively on individual and small group exchanges based on its local market brand name strength and its unit cost advantage over competitors.
- The company intends to offer exchange-based products in all 14 of its Blues-branded markets.
- WellPoint has indicated that it has signed provider contracts for its exchange products across all of its markets but did not disclose any pricing detail.
- WellPoint expects operating margins for exchange-based products to be in the low to mid single-digit range over time.

Commentary: Hospital Management Companies

Community Health Systems

- Community Health Systems indicated on its first quarter earnings conference call that it has signed contracts in 19 of the 29 states in which it operates hospitals including the five largest ones. At a subsequent event, management revised that figure to 22 states with contract terms being finalized in three other states and ongoing discussions in another three.
- On the pricing side, Community has indicates that it targets commercial rates in its negotiations and is in that range based on the contracts signed.

HCA Healthcare

- HCA recently disclosed that it has negotiated 36 contracts with major payers covering 27 of the 37 markets where it operates. The company noted that it expects to be in active negotiations for additional contracts over the next several months.
- 85% of its hospitals have access to at least one exchange product and in nine markets HCA will participate in multiple exchange products.
- Of the 36 contracts, 16 include "some form of network configuration".
- As for rates, HCA characterized its contracts as being "closer to commercial pricing than Medicare." The company quantified its revenue per equivalent admission averages as being approximately $18,500 to $19,000 for commercial and $10,000 to $10,500 for Medicare.

HMA, Inc.

- HMA disclosed that it has contractual language covering exchange participation covering 57% of its business.
- These contracts were described as at or near commercial rates.

Tenet Healthcare

- Earlier this month, Tenet disclosed that it has entered into exchange contracts covering 60% of its hospitals and that the pace of managed care contracting has picked up considerably in the last two months.
- Tenet noted that the pricing for these exchange products remains broadly in line with its commercial pricing.

Universal Health Services

- On its first quarter 2013 earnings conference call, Universal noted that it has negotiated a small number of exchange contracts at this time and it does not expect to see the pace of contracting pick up until later in the year.
- The contracts Universal has signed are at or slightly below its average commercial rates.

Vanguard Health Systems

- Vanguard indicated on its last call that its exchange contracts are coming in "at a very small discount off of commercial, so above Medicare, obviously, but a small discount below commercial."

Select State Plan Participation

Individual Market

Individual Market Submissions	Colorado	Connecticut	D.C.	Maryland	Oregon	Rhode Island	Vermont	Washington	Total
Kaiser	X		X	X	X			X	5
CareFirst BlueChoice, Inc.			X	X					2
United Healthcare Insurance Company		X	X						2
Aetna Health Inc.		X	X						2
BridgeSpan					X			X	2
LifeWise					X			X	2
Group Hospitalization and Medical Services			X						1
Optimum Choice, Inc.			X						1
Aetna Life Insurance Company			X						1
Coventry				X					1
Atrio					X				1
Community Care of Oregon (CO-OP)					X				1
FamilyCare Health Plans					X				1
Freelancers Co-Op of Oregon					X				1
Health Net					X				1
Moda Health (ODS)					X				1
PacificSource					X				1
Providence					X				1
Trillium Community Health Plan					X				1
Blue Cross Blue Shield of Rhode Island						X			1
Neighborhood Health Plan						X			1
MVP							X		1
Group Health								X	1
Blue Cross Blue Shield of Vermont							X		1
Premera Blue Cross								X	1
ConnectiCare		X							1
Anthem		X							1
HealthyCT		X							1
All Savers	X								1
Cigna	X								1
Colorado Choice	X								1
Colorado Health Insurance Cooperative	X								1
Denver Health Medical Plan	X								1
HMO Colorado	X								1
Humana	X								1
New Health Ventures	X								1
Rocky Mountain HMO	X								1
Total Plans Per State	10	5	7	3	12	2	2	5	

Small Group Market

Small Group Market Submissions	Colorado	Connecticut	D.C.	Maryland	Oregon	Rhode Island	Vermont	Washington	Total
Kaiser	X		X	X	X			X	5
United Healthcare	X	X		X		X			4
Aetna Health Inc.		X		X					2
Anthem		X							1
ConnectiCare		X							1
Healthy CT		X							1
CareFirst BlueChoice, Inc.			X						1
Group Hospitalization and Medical Services			X						1
Aetna Life Insurance Company			X						1
Blue Choice, Inc.				X					1
Coventry				X					1
Optimum Choice, Inc.				X					1
Atrio					X				1
Community Care of Oregon (CO-OP)					X				1
Freelancers Co-Op of Oregon					X				1
Moda Health (ODS)					X				1
PacificSource					X				1
Providence					X				1
Trillium Community Health Plan					X				1
Blue Cross Blue Shield of Rhode Island						X			1
Neighborhood Health Plan						X			1
Blue Cross Blue Shield of Vermont							X		1
MVP							X		1
Colorado Choice	X								1
Colorado Health Insurance Cooperative	X								1
HMO Colorado	X								1
Humana	X								1
Rocky Mountain Hospital & Medical Svcs. dba Anthem Blue Cross	X								1
Rocky Mountain HMO	X								1
Rocky Mountain HealthCare Options	X								1
SeeChange	X								1
Total Plans Per State	10	5	4	6	8	3	2	1	

Note: Connecticut submissions based on January 2013 press release. Does not indicate whether plan is participating in individual, small group, or both markets.

HMA Medicaid Roundup

Arizona

HMA Roundup

Arizona Senate Approves of Medicaid Expansion; House Vote Uncertain. Last Thursday, May 16, 2013, the Arizona Senate voted 18-12 to approve Medicaid expansion, the biggest legislative priority of Gov. Jan Brewer. Five Senate Republicans joined all 13 Senate Democrats to approve the measure, but the bill faces an uncertain future in the House. House Speaker Andy Tobin has not scheduled any hearings on the proposal and has been quoted as favoring taking the issue directly to the voters in a ballot measure. An aide to the governor notes that if all 24 House Democrats support expansion, just seven House Republicans would be needed to pass the measure. Meanwhile Gov. Brewer has vowed to maintain a moratorium on signing any further legislation into law until the legislature moves on the Medicaid expansion bill.

California

HMA Roundup—Jennifer Kent

Covered California Health Plans to Be Announced May 23. Covered California will announce the health insurance plans that will be offered through Covered California once the marketplace goes online in the fall. A press conference is scheduled for 9am PT with its regularly scheduled Board meeting open to the public starting at 12:30 pm PT (Link). The state has established 19 rating regions and has expressed an interest in offering 5-7 carriers in each region. Proposed premium rates by plan will also be disclosed as part of the announcement. These announcements are for the individual market – the SHOP procurement is not scheduled to be announced until June. We expect all of the current managed care organizations that participate in the individual and small group market, including Blue Cross of California, Blue Shield of California, Kaiser Permanente and Health Net, as well as some of the Medicaid managed care plans in the state, to be selected for participation. Covered California estimates that there are 5.3 million Californians who will be eligible to purchase insurance through the exchanges, with many of those qualifying for federal subsidies to help pay for their monthly insurance premiums.

Connecticut

HMA Roundup

Retiree Health Savings Help with FY 2014 Budget. On Wednesday, May 15, 2013, the state's Office of Fiscal Analysis lowered its projected state retiree health cost projections by nearly $307 million over the FY 2014 and FY 2015 periods. On the other hand, OFA increased its projected healthcare costs for current employees by nearly $83 million over the same period. State Comptroller Kevin Lembo attributes the savings to slower healthcare cost trend and improved pharmacy pricing. The net $224 million in savings fills about half of the budget gap caused by lower than expected revenues.

District of Columbia

HMA Roundup

DC Health Exchange Announce Four Insurers and Nearly 300 Plans. On Friday, May 17, 2013, the District of Columbia Health Benefit Exchange Authority announced four health insurers that will offer nearly 300 plans on the district's individual and small business health exchanges. Aetna, CareFirst Blue Cross Blue Shield, Kaiser Permanente, and United Health would together offer 34 individual plans and 259 small group plans. Exchange plan rates must be filed with the exchange by May 31 and actuaries will review the proposals to determine their appropriateness.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Medicaid Long Term Care Beneficiaries Begin Enrollment. As of Monday, May 20, 2013, long-term care Medicaid beneficiaries can now begin enrolling in managed care plans. The Agency for Health Care Administration announced the opening of phone lines

at the choice counseling call center to answer questions about providers, benefit coverage, and enrollment processes. On May 1, 2013, pre-welcome letters were sent to residents of Region 7, encompassing Brevard, Orange, Osceola, and Seminole Counties, informing beneficiaries of the changes in long-term care services and coverage. The next round of mail is being sent the week of May 20 including information about each of the long-term care plans contracted to service their region. Plan choices must be made by July 18 and covered services begin on August 1, 2013.

Gov. Scott Signs Record Budget, but Vetoes $368M in Spending. On Monday, May 20, 2013, Gov. Rick Scott signed into law the state's largest annual budget ($74.1 billion) for FY 2014, featuring a budget surplus for the first time in six years. At the same time, the governor used his line-item veto authority to nix nearly $368 million in spending. Scott did not, however, veto $65 million in hospital transition payments to a new Medicaid DRG payment system, which will adjust reimbursements based on services and patient complexity, rather than length of stay.

Georgia

HMA Roundup – Mark Trail

Integrated Eligibility System Strategy Presented to DCH. On May 14, 2013, Venkat Krishnan presented to the Department of Community Health Board a strategic overview of the rollout of an integrated eligibility system to accommodate MAGI rules under the Affordable Care Act. The Federal exchange will complete an initial assessment and the state will make a final determination on the integrated eligibility system. Phase I of the implementation will be completed in-house (i.e. no vendor) with state and contractor staff using existing systems to comply with ACA mandates, accounting for critical dates of October 1, 2013 (for a pre-enrollment FFE interface) and January 1, 2014 (implementation of MAGI rules). Phase II will be the full replacement of the current eligibility system, with the goal of adopting a working system from another state, using a rules-based engine, a master client index, and automated functions by December 31, 2015. Final rules from CMS have not yet been issued and questions remain about design, requirements, and process.

DCH Still Awaiting CMS Approval to Increase Medicaid Physician Rates. Georgia continues to await approval from CMS to retroactively increase Medicaid physician rates to 100 percent of Medicare rates. Only a handful of states have gotten the go-ahead to make the state plan amendments. Currently, it appears that physicians in Georgia will have to wait until July or August before receiving the adjusted rates, although increases will be retroactive to January 1, 2013. Currently, the department is in the process of collecting attestations from providers.

In the news

- **"State eyeing Medicaid expansion options"**

  The Atlanta Journal-Constitution reports that Georgia Governor Nathan Deal's administration is quietly exploring alternative Medicaid expansion options, despite publicly opposing a traditional Medicaid expansion. (Atlanta Journal-Constitution)

Illinois

HMA Roundup

House Committee Adds Accountable Care Entity RFP to Medicaid Expansion Bill. The Illinois House may vote later this week on a Medicaid expansion bill (SB 26), which was amended this week to require the state to issue a RFP this summer for Accountable Care Entities (ACEs). If approved, provider-led ACEs would bid on the children and families and Medicaid expansion populations. ACEs would initially receive a care coordination fee, but would be required to transition to risk-based capitation over time. In the Chicago area, ACEs would be required to serve between 20,000 and 40,000 Medicaid beneficiaries. The House will likely need to pass the bill by May 24 to gain Senate approval of the amendment before the end of the General Assembly session on May 31.

Iowa

HMA Roundup

Gov. Branstad Opens Door to Possible Medicaid Expansion. At a Monday May 20, 2013 press conference, Gov. Terry Branstad implied openness to some form of Medicaid expansion so long as the Federal Government could provide funding assurances. The governor continues to pursue a waiver to create a "Healthy Iowa Plan", which has drawn the ire of Democrats, even as he hopes to find a middle ground that can pass both the Republican House and Democratic Senate. Democrats have expressed concerns that the governor could gain a Federal waiver to enact his plan without legislative participation in the Medicaid expansion debate.

Louisiana

HMA Roundup

Medicaid Expansion Legislation Dies in Senate Committee, Fails in House. On Monday, May 20, 2013, Senate Bill 125—modeled on the Arkansas plan of Medicaid premium assistance for an expanded eligible population—failed when the Senate Finance Committee voted 7-3 to defer action on the measure. A companion bill (HB 233) was rejected 59-37 in a House floor vote on Tuesday, May 21, 2013. The state's fiscal office had previously estimated cumulative savings of $311-323 million over the next four years, at which point the proposed expansion could sunset (with the expiration of 100% Federal funding commitments). Gov. Bobby Jindal has opposed the Arkansas model, arguing that beneficiaries might drop private insurance in favor of fully-funded Medicaid benefits, ultimately limiting access to care.

Provider Tax Bills Pass Senate Committee. On Monday, May 20, 2013, two provider tax bills passed through Senate committees by 9-1 votes despite the opposition of Gov. Jindal. HB 532 would allow hospitals to contribute assessments into a hospital stabilization fund, which would qualify for additional Federal matching funds. HB 533 would protect provider taxes assessed on nursing homes, intermediate care facilities, and pharmacies under the state constitution. The Jindal Administration's Budget Project Director Jan Moller testified that such constitutional amendments would severely restrict budget flexibility, while the AARP and the Advocacy Center offered additional testimony

against the bills. Hospital and nursing home trade associations offered support for the legislation. If the bills get a two-thirds vote on the Senate floor vote, the constitutional amendments would be put before the voters in a 2014 ballot measure.

Maine

HMA Roundup

Maine HHS Commissioner Claims Department Will Run Out of Funds by June 10. Last Friday, May 17, 2013, HHS Commissioner Mary Mayhew claimed that her department will run out of funding by June 10 absent a budget agreement by May 28. Gov. Paul LePage wrote to Democratic leaders to pass a budget that will allow DHHS to continue paying for services, including $35 million in emergency funding. The Legislature's June 19 adjournment date looms more ominous as the tense budget discussions continue. The governor is opposed to the recent vote by Democrats to link repaying $484 million in debts to hospitals to an expansion of the Medicaid program.

Democrats Thwart GOP Efforts to "Study" Medicaid Expansion. On Tuesday, May 21, 2013, Republican legislators attempted to separate the issues of Medicaid expansion from hospital debt repayment by proposing a study committee for Medicaid expansion. However, in two party line votes, Democrats blocked the proposals by a 20-15 Senate vote and an 86-55 House vote. Meanwhile, Democrats passed L.D. 1546—a bill that links the two issues—by a 20-15 vote in the Senate on Tuesday and 87-56 in the House on Wednesday with the governor's veto threat intact.

In the news

- **"New health insurer prepares to sell policies in Maine, reaches agreement with physicians group"**

  Maine Community Health Options, a consumer-run health insurer announced it has contracted with the Kennebec Region Health Alliance. MCHO is working towards agreements with additional providers to form a statewide network, according to a press release. MCHO will offer policies to individuals, families and employers. MCHO has set a goal of attracting 50,000 members. (Bangor Daily News)

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Dual Eligibles Demo Improves Capitated Rates. On Wednesday, May 15, 2013, MassHealth issued an updated rate proposal for the Massachusetts Demonstration to Integrate Care for Dual Eligible Individuals. According to an analysis conducted by Deutsche Bank equity research analyst Scott Fidel, capitated rates increased about 6-7 percent compared to the previous proposal, based on adjustments to Medicare county baselines, the MassHealth component of the capitation rate, coding intensity, savings percentages, risk corridors, and sequestration. Coding intensity has been adjusted to account for all enrollees in the demonstration, resulting in a 341 basis point improvement to rates. The fee-for-service component of 2013 Medicare A/B baseline rates added 169 basis points to the rates. Another 125 basis point upward revision was made to account for

disproportionate share payments attributable to Medicare-Medicaid enrollees in Medicare FFS. However, a 2% cut from sequestration is also reflected in the new rates.

Study Shows Reform Did Not Cause a Meaningful Increase in Hospitals. Last week at an American Heart Association Quality of Care and Outcomes Research meeting in Baltimore, Dr. Amreseh Hanchate reported that Massachusetts health reform did not trigger a significant change in the use of hospitals. Compared to three control states (New York, New Jersey, and Pennsylvania), the post-reform period of 2008-2010 featured a negligible 0.3% change in quarterly admissions, 0.14% change in total days, and 1.1% increase in total charges per Massachusetts hospital over the pre-reform period of 2004-2006. Safety-net hospitals actually had a net decrease (-1.6%) in admissions. Only two minority subgroups—blacks and Hispanics—showed an increase in admissions of 2.8% and 4.5%, respectively. Researchers warned, however, that Massachusetts already featured a relatively low level of uninsurance pre-reform and may not be a representative sample for other states.

Michigan

HMA Roundup—Esther Reagan

Michigan Senate Passes Health Claims Tax. On Thursday, May 16, 2013, the Michigan Senate voted 25-13 to continue a 1% health care claims assessment through 2017. The payer tax is designed to increase Federal matching funds for Medicaid, but has generated about $130 million less than originally anticipated. The House has to vote on the measure to extend the program, which would otherwise expire at year-end.

Unexpected Revenue Windfall from Capital Gains Taxes Brightens Budget Outlook. Last Wednesday, May 15, 2013, Michigan's revenue estimating conference revealed that the state may enjoy $700 million in more tax revenues than previously assumed in January. Budget Director John Nixon noted that the bulk of the windfall is one-time in nature and could not fund ongoing commitments. Instead, infrastructure investments, debt paydown, and school consolidation incentives are being considered as worthy uses of the funds.

Minnesota

HMA Roundup

State House Narrowly Passed Home Care Unionization Bill. Following last week's Senate passage, the Minnesota House narrowly passed legislation (68-66) that enables unions to organize home care workers who care for patients that receive Federal and state health benefits. The Democratic-Farmer-Labor Party controls both legislative chambers and the governor's office. Gov. Mark Dayton promised to sign the legislation into law.

New Mexico

HMA Roundup

New Mexico Health Exchange Plans Adjusted Due to Deadlines. Although the state of New Mexico had planned to run its own health exchange, looming deadlines and logistical challenges have driven a shift in approach. On Monday, May 20, 2013, Dr. J.R. Damron, chairman of the governing board of the exchange, announced a hybrid approach similar to that of Utah because the state does not have adequate time to implement its own systems to handle the individual exchange by October 1, 2013. The state will operate the small business exchange while the Federal Health and Human Services Department will handle the exchange for individuals. The state will retain its regulatory authority over health plans and will manage outreach and education to enable its residents to enroll for coverage on the exchange. The Board will apply a $34 million grant to fund its five-year $40 million contract with Getinsured.com to build out the underlying infrastructure of the exchange.

New York

HMA Roundup—Denise Soffel

Revisions to NYS Patient Centered Medical Home Incentives. As of July 1, 2013, New York State Medicaid reimbursement policy and billing requirements for providers recognized as Patient Centered Medical Homes (PCMH) by the NCQA will change to conform with the Medicaid Redesign Team's (MRT) effort to improve care, improve health, and lower per capita costs. The new policy creates incentives to achieve NCQA PCMH recognition using 2011 (rather than 2008) standards by implementing healthcare IT systems, integrating physical and mental health, and ensuring patient-centered care. Incentive payments for Level 2 NCQA PCMH recognized providers using 2008 standards will be eliminated; providers that achieve 2011 PCMH standards would retain existing Level 2 incentive payments of $4 PMPM under managed care, $11.25 (institutional), and $14.25 (professional) per visit in fee-for-service. Level 3 PCMH providers under NCQA 2008 standards will see incentive payments shaved to $5 PMPM under managed care, $14.05 (institutional) and $17.85 (professional) per visit in fee-for-service. Those Level 3 PCMH providers that achieve NCQA 2011 standards will retain incentive payments of $6 PMPM under managed care, $16.75 (institutional) and $21.25 (professional) per visit in fee-for service.

Behavioral Health Reform Workgroup Highlights Care Management Steps. Earlier this month, the Behavioral Health Reform workgroup of the Medicaid Redesign Team discussed developments in planning for the next phase of moving Medicaid beneficiaries with serious and persistent mental illness into care management programs. Currently some behavioral health services are provided within the Medicaid managed care plans, and some remain carved out.

Which services are included depends on Medicaid eligibility. In the case of TANF populations, inpatient and outpatient mental health, as well as inpatient detox and rehab are carved in; continuing day treatment, partial hospitalization and outpatient chemical dependency services are provided on a fee-for-service basis. For individuals with serious

mental illness, covered through SSI, Medicaid managed care plans provide only detox services; all other behavioral health services are provided outside the plan on a fee-for-service basis.

The state contracted with behavioral health organizations in January 2012 to serve a number of functions that were intended to improve care coordination for the seriously mentally ill population, and to begin to move both managed care plans and behavioral health providers toward readiness for a risk-bearing relationship for these services and for this population.

Phase 2 of the BHO transition includes two separate components. The first component is that all plans must be prepared to take on care management for all individuals with a behavioral health diagnosis, and coordinate all the services that population will require. This includes services currently provided through the Office of Mental Health that fall outside the Medicaid benefit, such as Personalized Recovery Oriented Services (PROS), Intensive Psychiatric Rehabilitation Treatment (IPRT), partial hospitalization and outpatient rehab. Plans will be required to demonstrate their capacity to provide those services. To the extent that they cannot demonstrate that capacity, they will be required to contract with a BHO to provide care coordination for individuals requiring those services. They will be required to develop an interface with Local Government Units and social service systems related to housing, homelessness, criminal justice and employment. All plans will be required to qualify to manage currently carved out services.

The second component is specific to Medicaid beneficiaries who meet eligibility criteria for a new Medicaid benefit package designed specifically to meet the needs of individuals whose behavioral health diagnosis defines their need for health care services. The state has designed a new product called a HARP (Health and Recovery Plan). Eligibility for a HARP requires three things:

- SSI disability;
- Utilization of behavioral health services above a threshold over the last 12 months;
- A behavioral health diagnosis.

HARPs will be required to provide all the behavioral health services currently included in the state's Medicaid plan, as described above. In addition, they will be required to provide a number of services currently available through Section 1915 (i) home and community-based care waivers. HARPs will receive an enhanced premium for providing these services. Section 1915 (i) services include many recovery-oriented services such as crisis respite, family support, peer supports, and rehabilitation services, including transitional and supported employment, supported education, respite and habilitation. The exact benefit has not been established. Mercer is working with the state to identify the possible benefit package and determine its actuarial value. HARP plans will receive a premium based on these enhanced services.

NYS intends to release an RFQ in late-summer to determine plan interest in participating in this care management expansion. Plans will need to demonstrate capacity at two levels of care – to meet the behavioral health needs of all individuals enrolled in Medicaid

managed care, and to meet the needs of individuals who qualify for HARP services. New York City's Mayor Bloomberg has an interest in limiting the number of plans offering a HARP, creating a small number of plans with unique expertise in meeting the needs of individuals with serious mental illness. Those plans that do not establish a HARP will not be eligible for the enhanced reimbursement, even if they have members who are HARP-eligible. Their goal is to have beneficiaries migrate from their current plan to one of a small number of HARP plans. The state hopes that every Medicaid managed care plan will qualify as a HARP since the HARP-eligible population is already enrolled in every plan currently in operation. Limiting the number of HARPs would require a sizable number of HARP-eligible enrollees to either switch plansand enroll in a mainstream plan that does offer a HARP, or give up receiving HARP services through their plan. The state believes that every plan will have to meet the needs of the HARP-eligible, since CMS requires universal access to benefits across the state.

How care will be coordinated outside NYC remains an open question. The Department of Health has said that it needs to see the response to the RFQ from Medicaid managed care plans across the state before it finalizes its decisions. The DOH has emphasized that plans intending to become a HARP must offer a HARP product in every county in which they provide a mainstream plan.

The state has indicated that it will set a high bar for plans to qualify to take on care management for beneficiaries with behavioral health needs.

A link to the webcast of the Behavioral Health Reform work group, as well as meeting materials, can be found on the MRT web site **here.**

Pennsylvania

HMA Roundup –Matt Roan

DPW Refutes Independent Fiscal Office Medicaid Expansion Analysis. The Department of Public Welfare has sent a letter to the Independent Fiscal Office refuting assumptions contained in the April 2013 IFO Medicaid expansion analysis. The IFO estimated nearly $125 million in estimated savings to the state, but DPW believes the IFO made errors related to the general assistance program, the continuation of the gross receipts tax, the timing of funding under an expanded program, the enrollment rate, and administrative and staffing costs. As a result, DPW claims that the savings estimates are off by as much as $515 million, resulting in a net increase in costs to the commonwealth in FY 13-14 if Medicaid were to be expanded without appropriate reforms.

PA Health Care Cost Containment Council Notes a Drop in Hospital Margins. The Pennsylvania Health Care Cost Containment Council (PHC4) has released its annual report on hospital financial performance. According to the report, operating margin of general acute care hospitals in the Commonwealth dropped 122 basis points to 5.82 percent in FY 2012, attributable, in part, to an increase in uncompensated care costs.

PA Lottery Privatization Efforts Continue. The Corbett Administration continues to work on its plan to privatize the state lottery.. Attorney General Kathleen Kane had previously deemed the contract with Camelot Global Services unconstitutional for handing over too much administrative control. The Administration has not indicated a timeframe

for submitting a revised contract, and in the meantime continues to work with outside consultants and legal counsel to work out the issues. Opponents of Lottery privatization point out that the money being spent on these external resources could be going to support programs for Seniors including Home and Community Based Services.

Rhode Island

HMA Roundup

RI Approves Merger of Lifespan and Gateway. On Thursday, May 16, 2013, Rhode Island health officials approved the merger of Lifespan and Gateway Healthcare. This new entity brings together the largest hospital group in the state with the largest provider of community-based behavioral health services. The merger should be complete by July 1, 2013.

Rhode Island Exchange to Offer 28 Plans. On Wednesday, May 15, 2013, leaders of the R.I. Health Benefits Exchange announced that Blue Cross & Blue Shield of Rhode Island, UnitedHealthcare of New England, and Neighborhood Health Plan of Rhode Island will offer a total of 28 health plans as of October 1, 2013. There will be 16 plans for small businesses and 12 for individuals. Tufts Health Plan will not offer any health insurance products on Rhode Island's exchange until 2015. Rates will not be available until after July 1 when the Insurance Commissioner approves rate plans and the exchange certifies that plans comply with federal and state requirements.

Vermont

HMA Roundup

Vermont Health Connect Signs Contracts. Earlier this month, the Vermont Health Connect signed a $12.5 million contract extension with the state's current Medicaid call center provider, MAXIMUS, to provide call center services for the exchange. In addition, the exchange signed a 3.5 year $2.6 million contract with Benaissance to provide premium billing services.

New Mental Health Commissioner Announced. On Thursday, May 16, 2013, Gov. Peter Shumlin announced the appointment of Paul Dupre to become the next commissioner of the Vermont Department of Mental Health. Dupre heads Washington County Mental Health. Acting Mental Health Commissioner Mary Moulton will return to her previous position at Washington County Mental Health.

Virginia

HMA Roundup

CMS Executes MOU with Virginia on Duals Demo. On Tuesday, May 21, 2013, CMS executed a memorandum of understanding (MOU) with the commonwealth of Virginia on its dual eligible demonstration program. Virginia is now the sixth state to enter into an agreement with CMS to enroll duals into managed care plans that offer seamless and integrated benefits and services. The demonstration program should serve 78,600 Medicare-Medicaid enrollees in 104 localities covering five regions: Central Virginia, Northern

Virginia, Western Virginia, Southwest Virginia, and the Tidewater region. The managed care plans will offer a comprehensive assessment of medical, behavioral health, long-term services and supports, functional, and social needs under a capitated arrangement. Quality measures will cover beneficiary overall experience, care coordination, and fostering and supporting community living. An RFP issued in April (with responses due May 15, 2013) cover a two year period from January 1, 2014 through December 31, 2015, with provisions for two additional one-year extensions.

In the news

- **"Hospitals face anxious period on Medicaid"**

  Hospitals in Virginia are watching closely a state committee that will work to implement Medicaid reforms passed by the legislature, but must first wait on the state's decision whether or not to expand Medicaid. (Richmond Times-Dispatch)

Washington

HMA Roundup

State Health Exchange May Delay SHOP Start Date to October 2014. Because the state's Small Business Health Options Program (SHOP) exchange has attracted just one carrier, Kaiser Permanente Northwest, the board of the Washington Health Benefit Exchange is considering delaying the start date of the SHOP exchange to October 1, 2014. Kaiser's geographic network is limited to five counties and the lack of alternatives undermines the nature of a marketplace. It remains unclear how ACA tax credits would be administered if there is no operating SHOP exchange system in early 2014. The exchange board staff appears to support an October 1, 2013 opening of the SHOP exchange with Kaiser as the only carrier on the exchange.

In the news

- **"Premiums under new health-care law remain about the same"**

  Preliminary rates filed by insurers aiming to participate in Washington's health insurance exchange do not appear to show the increase in premium rates predicted by many to be as high as 70 percent under the Affordable Care Act. (Seattle Times)

National

HMA Roundup

House GOP Presses for HHS, Labor, and Education Department Spending Limits. On Thursday, May 16, 2013, House GOP Appropriations leaders offered proposals to limit spending for the departments of Labor, Education and Health and Human Services, a nearly 20% cut that would compound cuts associated with sequestration. Overall discretionary spending for these three departments would be down about $28 billion to $121.8 billion from previous estimates following sequestration and down nearly $42 billion (or 26 percent) from FY 2010 levels.

ACA Cited as the Cause of Increasing Individual Health Premiums…or Not. On Monday, May 20, 2013, the House Energy and Commerce Oversight Subcommittee held a hearing on the impact of the Affordable Care Act on individual health insurance premiums. Republicans pointed to various actuarial studies that indicate the law will lead to significant increases in individual premiums, while Democrats point to a different study that indicate the average consumer will save on premiums on plans available on exchanges in five states that have posted 2014 rates.

CMS Administrator Confirmed by the Senate. For the first time since Mark McClellan served from 2004-2006, CMS will have an Administrator that has been officially confirmed by the Senate. On Wednesday, May 15, 2013, the Senate voted 91-7 to confirm Marilyn Tavenner as CMS Administrator. Ms. Tavenner had already been serving as acting CMS Administrator since December 2011.

In the news

- **"Survey: Even In Southern States, Medicaid Expansion Is Popular"**

  A survey by the Joint Center for Political and Economic Studies found that despite only 33 percent approval for the Affordable Care Act in Alabama, Georgia, Louisiana, Mississippi, and South Carolina, 62 percent of the surveyed population supported the Medicaid expansion.

- **"Role of Health-Law 'Navigators' Under Fire"**

  Across the county, plans for health insurance 'Navigators,' indented to aid individuals in finding insurance through the exchanges, are coming under fire from Republicans opposing the fact that the federal government has directed funds to outside parties to fill the Navigator roles. (Wall Street Journal)

- **"Feds Make It Easier For States To Enroll Poor Under Health Law"**

  The Obama administration announced late last week the flexibility for states to use additional data sources – such as food stamps – to verify Medicaid eligibility. Additionally, the administration announced a rule permitting states to make annual redeterminations of Medicaid eligibility, allowing individuals to remain on Medicaid through a calendar year even if their income has increased. (Kaiser Health News)

- **"MACPAC Studies Interaction Between Medicaid and Exchanges"**

  At the Medicaid and CHIP Payment and Access Commission (MACPAC) meeting last week, CMS Consumer Information and Insurance Oversight (CCIIO) indicated that additional information is to come regarding the role of Navigators and the relationship between Medicaid and the Exchanges beginning next year. (CQ Healthbeat via The Commonwealth Fund)

OTHER HEADLINES

North Carolina

- **"McCrory announces plans to seek federal waiver to allow Medicaid reform"**

  Governor Pat McCrory announced last week that he has support of lawmakers to pursue a federal Medicaid waiver to implement the managed care transition planned for North Carolina. (The Business Journal)

Oklahoma

- **"Fallin urges health care fix in Oklahoma Legislature"**

  Governor Mary Fallin is urging legislators to redirect $50 million in tobacco tax funds to keep 9,000 individuals insured who will otherwise lose coverage a state-run low-income health insurance program that will lose federal Medicaid funding under new rules. (The Lawton Constitution)

South Carolina

- **"SC Senate kills last effort to expand Medicaid"**

  South Carolina's Senators this week voted down a bill that would have accepted the Medicaid expansion in the state. It is unknown whether Governor Nikki Haley, who publicly opposed expansion, would have signed a Medicaid expansion bill. (The State)

Texas

- **"Texas: House Votes to Ban Medicaid Expansion"**

  The Texas House of Representatives approved a measure this week that would prohibit the state from providing Medicaid to any individual not currently eligible for the program. The measure was added as an amendment to a Medicaid bill that has already passed the Senate without the ban. (New York Times)

- **"Texas' Struggling Rio Grande Valley Presses for Medicaid Expansion"**

  Texas' border counties in the Rio Grande Valley are upping their push for a Medicaid expansion in the state, citing strained local health budgets under nearly an uninsured rate of nearly 38 percent. (Kaiser Health News)

COMPANY NEWS

- **"St. John's picks Providence Health & Services in bidding war"**

  "[T]he owner of St. John's Health Center said it plans to sell the landmark Santa Monica hospital to Catholic chain Providence Health & Services. The hospital has been at the center of an intense competition that featured bids from UCLA Health System, other Catholic hospital chains and Los Angeles billionaire Patrick Soon-Shiong." (Los Angeles Times)

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
May-June, 2013	Rhode Island Duals	Contract Awards	22,700
May-June, 2013	South Carolina Duals	RFP Released	68,000
June 1, 2013	California Rural	Implementation	280,000
June 5, 2013	Washington Duals	Contract awards	48,500
June 17, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
June, 2013	Idaho Duals	RFP Released	17,700
June, 2013	Virginia Duals	Contract awards	79,000
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
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
Summer 2013	Michigan Duals	RFP Released	70,000
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Rhode Island Duals - Medicaid Only	Implementation	22,700
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
"Early 2014"	North Carolina	RFP released	TBD
January 1, 2014	California Duals	Implementation	456,000
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	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	79,000
January 1, 2014	Texas Duals	Implementation	214,400
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
April 1, 2014	Idaho Duals	Implementation	17,700
April 1, 2014	New York Duals	Implementation	133,880
April 1, 2014	Washington Duals	Implementation	48,500
July 1, 2014	Michigan Duals	Implementation	70,000
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		98,235	Not pursuing Financial Alignment Model				
California	Capitated	456,000	X	3/1/2012	4/4/2012	X	1/1/2014
Colorado	MFFS	62,982					10/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189	Not pursuing Financial Alignment Model				
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	X	10/1/2013
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	June 2013	TBD	TBD		4/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	7/1/2013
Michigan	Capitated	70,000	Summer 2013		TBD		7/1/2014
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					4/1/2014
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	22,700	X	3/27/2013			9/1/2013*
South Carolina	Capitated	68,000	Summer 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	78,596	X	5/15/2013	July 2013	X	1/1/2014
Vermont	Capitated	22,000	10/1/2013	TBD	TBD	7/15/2013	9/1/2014
Washington	Capitated/MFFS	115,000	X	5/15/2013 (Capitated	6/5/2013 (Capitated)	MFFS Only	1/1/2014
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		TBD**
Totals	**14 Capitated 7 MFFS**	**1.5M Capitated 485K FFS**	***8***			***6***	

** 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 Recent Publications

"Medicaid Health Plan Community Partnership Series"

The Commonwealth Fund

Sharon Silow-Carroll – Author
Diana Rodin – Author

As state Medicaid programs are increasingly shifting beneficiaries into managed care organizations (MCOs), some MCOs are expanding their traditional role to better meet the needs of their vulnerable members and communities.

In a new Commonwealth Fund report, Health Management Associates Managing Principal Sharon Silow-Carroll and Consultant Diana Rodin report on the efforts of four managed care organizations that are forging community partnerships to meet the needs of vulnerable Medicaid patients and others in their communities.

They developed four case studies:

- Gateway Health Plan
- HealthPartners
- L.A. Care
- Neighborhood Health Plan

These case studies describe the "how" and the "why" when it comes to MCOs addressing barriers and changing the way care is delivered, including internal and state policy drivers, leveraging partnerships, and key takeaways. (Link to report)

"Two-Thirds of States Integrating Medicare and Medicaid Services for Dual Eligibles"

AARP Public Policy Institute

Jenna Walls – Contributor

This report finds that two-thirds of the states either have or will launch new initiatives to better coordinate care for people who are dually eligible for Medicare and Medicaid services, the so-called "duals," over the next two years. To contain the growth of costs and improve care, many of them are moving to risk-based managed long-term services and supports models. (Link - PDF)