HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: MASSACHUSETTS PAYMENT REFORM LEGISLATION

HMA ROUNDUP: GEORGIA SEEKS ADDITIONAL SPENDING REDUCTIONS; COLORADO RECEIVES CO-OP GRANT; PENNSYLVANIA HEALTHCARE BUDGET DETAILS REVEALED; SOUTH CAROLINA DUALS RFI RELEASED

OTHER HEADLINES: COORDINATED CARE PLANS LAUNCH IN OREGON; TENNESSEE REDESIGNS LONG-TERM CARE ELIGIBILITY; MINNESOTA EXTENDS COVERAGE TO 16,000 CHILDREN; WISCONSIN TO CREATE COORDINATED CARE PROGRAM FOR FOSTER CHILDREN

RFP CALENDAR: ILLINOIS DUALS RFP AWARDS DELAYED

AUGUST 1, 2012

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: MASSACHUSETTS PAYMENT REFORM LEGISLATION

This week, our *In Focus* section provides a summary of Massachusetts Payment Reform legislation, passed on Tuesday, July 31, 2012. HMA's Tom Dehner (Boston, Massachusetts) provides a summary of *Senate Bill 2400: An Act improving the quality of health care and reducing costs through increased transparency, efficiency and innovation*.

Background

On July 31, 2012, the Massachusetts legislature passed a wide-ranging bill intended to reduce the rate of growth in health care costs. S.2400 is the outcome, on the last day of the legislative session, of more than a year of discussion and debate on approaches to health care cost containment in Massachusetts. Governor Deval Patrick filed a bill in early 2011, and each legislative branch passed competing proposals in 2012, culminating in this Conference Committee report. The Senate passed the Conference report unanimously, and the House approved on a 132-20 vote. The bill is referred to in legislative summary materials as the "Next Phase of Massachusetts Health Care Reform," a characterization used regularly by supporters throughout the debate. Gov. Patrick is expected to sign the bill into law in early August.

The bill sets statewide health care cost growth targets and establishes a wide range of regulatory activities and reporting requirements, including the preparation of analytical reports and the holding of annual hearings by the state intended to monitor those targets and support the analysis of the operation of the state's health care market. The creation of Accountable Care Organizations (ACOs) and the institution of alternative payment methodologies (such as episodic payments, shared savings models, and capitated provider-based contracting arrangements) are seen as essential elements of the effort to contain health care costs and improve quality. As a result, the bill encourages the development of ACOs and sets in place regulatory mechanisms that will establish standards for ACOs and for provider organizations that take on risk under alternative payment arrangements. The bill explicitly encourages the adoption of alternative payment methodologies and the utilization of ACOs by state purchasers, including the state Medicaid program, known as MassHealth, and the state employee health insurance program, known as the Group Insurance Commission (GIC).

Cost Growth Targets

The bill sets a statewide health care cost growth benchmark, which is related to (and until 2022 can be no greater than) growth in gross state product (GSP). GSP, a measure of projected economic growth in the state's overall economy, is set at 3.6% in 2013 and set by agreement of the administration and legislature thereafter.

Years	Health Care Cost Growth Benchmark	Notes
2013-17	Set at GSP	
2018-22	Set at GSP minus 0.5%	May be modified but cannot exceed GSP
2023-beyond	Set at GSP	May be modified in any amount

Based on historical rates of health care spending growth in Massachusetts, which have outpaced inflation and state economic growth, the cost growth target provisions of the bill are presented as creating $200 billion in savings over the next 15 years. The bill requires the monitoring of cost growth targets and the identification health care entities (providers or payers) that contribute to excessive cost growth. The bill does not provide especially strong direct enforcement authority over such providers or payers, but requires such payers to submit and implement performance improvement plans intended to reduce cost growth.

State Agency Restructuring and New Regulatory Authority

The bill substantially restructures state agencies that monitor health care cost and quality, in part for the purpose of defining regulatory authority over ACOs and the implementation of alternative payment methodologies. The bill eliminates one state agency (the Division of Health Care Finance and Policy or DHCFP) and the existing Health Care Quality and Cost Council. It transfers some of the existing authority of those entities to other existing state agencies and also creates two new state entities, the **Health Policy Commission** and the **Center for Health Information and Analysis**.

The Health Policy Commission is governed by an 11-member board including certain cabinet officials and appointees of the Governor, Attorney General, and State Auditor, with an Executive Director appointed by the board. The Commission is responsible for implementation and policy development, including setting or modifying health care benchmarks, certifying ACOs and medical homes, and monitoring changes in the health care market. The Commission can conduct cost and market impact reviews of market acquisitions or of high-cost providers, and can refer providers to the Attorney General for review of anti-competitive behavior.

The Center for Health Information and Analysis is an independent state agency led by an Executive Director appointed by majority vote of the Governor, Attorney General, and State Auditor. The Center is responsible for collecting and analyzing data from health care payers and providers, submitting annual reports in preparation for hearings to examine the reasons for health care cost growth, and identifying significant price variations by provider and payer.

ACOs and Alternative Payment Methodologies

Regulation of Provider Organizations and ACOs

The bill requires the Commission to develop a process to register providers and provider organizations. The Commission will also implement standards for the certification of ACOs and Patient-Centered Medical Homes. The legislation contains a fairly detailed set of expectations for ACOs, including general goals and specific services that must be provided by or through ACOs.

Provider organizations that enter into alternative payment arrangements that include the assumption of risk must also apply for and receive a risk certificate from the Division of Insurance – a process that mimics financial solvency reviews for insurers and is intended to determine whether the provider's financial condition is appropriate for the assumption of risk.

Medicaid and State Agency Participation with Alternative Payment Arrangements

Under the bill, state purchasers are expected to transition to alternative payment methodologies. The bill provides explicit benchmarks for MassHealth to meet in this transition: 25 percent of enrollees by July 1, 2013; 50 percent of enrollees by July 1, 2014; and 80 percent of enrollees by July 1, 2015. The bill authorizes MassHealth to "take actions necessary to amend its managed care organization and primary care clinician contracts as necessary to include such contracts in the innovation project."

The bill also uses MassHealth to encourage a transition to alternative payment methodologies by other providers. It provides a 2 percent Medicaid rate increase "bonus" (above any other ordinary base rate calculations) to hospitals and primary care providers that demonstrate a "significant transition" to the use of alternative payment methodologies.

ACO Consumer Protections

A variety of provisions in the bill are intended to extend existing consumer protections and regulatory oversight, currently applied in the context of managed care, to ACOs.

Other Significant Provisions

Investments in Community Hospitals, HIT Adoption and Health Care Workforce

The bill creates a new surcharge on providers and insurers that raises $225 million over five years. Hospitals with less than $1 billion in net assets and hospitals with over 50 percent of their revenue derived from public payers are exempt from the surcharge, and other small hospitals or high public payer hospitals may receive an assessment mitigation of up to 66% of the surcharge. The funding is distributed as follows:

- $135 million for distressed community hospitals
- $60 million for the Prevention and Wellness Fund, to support grants for implementation of community-based preventative health activities
- $30 million for the e-Health Institute Fund, to support the adoption of health information technology and EHRs (particularly by providers that do not qualify for federal HITECH Act funding) and the establishment of a statewide health information exchange.

Medical Malpractice Changes

The bill includes provisions that allow a provider to admit to or apologize for a medical error without fear that the apology will be admissible in court. The bill also establishes a six-month cooling off period before the continuation of a medical malpractice lawsuit to encourage early settlements.

Workplace Wellness Programs

The bill encourages the adoption of workplace wellness programs in a variety of ways, including by: establishing a wellness tax credit for employers to cover the cost of a wellness program, up to $10,000 per employer; requiring the development of a model guide for such programs and providing funding to support businesses that implement them;

and requiring a premium adjustment for small businesses that adopt approved work-place wellness programs.

Administrative Simplification

Among other provisions intended to promote administrative simplification, the bill requires the development of certain standardized forms for prior authorization that will be available to and used by all payers.

HMA MEDICAID ROUNDUP

Colorado

HMA Roundup – Joan Henneberry

On July 27, the Colorado Health Insurance Cooperative, Inc. announced that its loan application for $69 million to start and operate a statewide nonprofit health insurance cooperative was approved by the U.S. Department of Health and Human Services (HHS). Details:

- The Consumer Operated and Oriented Plan (CO-OP), is a nonprofit health insurance company designed to offer affordable, high quality health coverage to individuals and small businesses.
- The CO-OP is sponsored by the nonprofit Rocky Mountain Farmers Union Foundation, which received grants from the Colorado Health Foundation and the U.S. Department of Agriculture.
- The CO-OP will begin marketing its health insurance products in 2013, with coverage beginning January 1, 2014.
- The CO-OP plans will be available through the Colorado Health Benefit Exchange as well as through local insurance brokers and agents.
- Purchasers of the insurance plans will become members of the CO-OP, and operating profits will be used to benefit members by improving plan coverage and programs and keeping rates lower.
- Lindy Wallace is serving as President of the volunteer Formation Board that will be in place until the Member Board is elected in 2014.
- The federal Affordable Care Act provides for at least one CO-OP in each state to receive loan funding for start-up expenses and to meet state insurance solvency requirements.

Additionally, the Department of Health Care Policy and Financing (DHCPF) announced its intention to issue a Request for Proposals (RFP) to rebid behavioral health services; current contracts expire 6/30/14. DHCPF currently contracts with 5 regional Behavioral Health Organizations (BHOs) to provide or arrange for these services. BHOs are required to work closely with the Regional Care Collaborative Organizations responsible for primary care for Medicaid clients.

Lastly, DHCPF is preparing to begin implementation of payment reform legislation passed last session, HB1281, allowing the Department to accept proposals for innovative payment reforms that will demonstrate new ways of paying for improved client outcomes while reducing costs. As part of the process for selecting proposals DHCPF will be releasing a call for abstracts and posting fact sheets and evaluation criteria; all providers must work through the Regional Care Collaborative Organization in their region to propose a new payment mechanisms.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

On July 19, the Agency for Health Care Administration (AHCA) hosted a vendors' conference bidders' meeting for the LTC Managed Care Invitation to Negotiate(ITN) that is underway. Earlier this week, AHCA posted responses to the 580 questions submitted by interested vendors. Questions were submitted by the following organizations: Simply Healthcare, Amerigroup, WellCare, Coventry, Centene, APS Healthcare, Universal Health Care Group, Worldnet/Universal American, Aetna, Prestige Health Choice, Freedom Health Plan, Physicians United Plan, American Eldercare, Molina, Humana, United Healthcare and Little Havana Activities and Nutrition Centers of Dade County. As a reminder, responses to the ITN are due August 28, 2012 with contract awards in January 2013.

With respect to the upcoming Managed Medical Assistance (acute care) ITN, AHCA issued a Request for Information (RFI) seeking information from entities with direct experience in the managed health and long term care industries about best practices and innovations in Medicaid managed care business and service delivery models. The AHCA will consider information gathered from responses to this RFI in preparing the ITN for the statewide Medicaid Managed Medical Assistance program, which is scheduled for release no later than January 1, 2013. RFI responses are due August 15, 2012.

In the news

- **Florida pharmacists accuse state of shutting them out of Medicaid**

  The Florida Pharmacy Association announced that it has filed a lawsuit in Leon County's Circuit Court in an attempt to nullify state procedures they say is beginning to leave Florida pharmacists out of the business of fulfilling prescriptions for Medicaid patients. The state's Agency for Health Care Administration has been entering into contract with HMOs and managed care companies to provide services to Medicaid patients, and those companies have been requiring clients to use mail-order pharmacies, the lawsuit alleges. That is leaving Florida-based pharmacies out of the equation and causing them to lose thousands of customers, the association said. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

On July 26, The Governor's Office of Planning and Budget released its instructions to state agencies. Citing modest projected revenue growth and needs in core state services, the State has asked all agencies' budget submissions to identify 3% of their FY 2013 (cur-

rent fiscal year) appropriation of State General Funds for reduction. For FY 2014, the Department of Community Health has been asked to submit an additional 2% reduction plan for State General Funds in the Medicaid (Aged, Blind, and Disabled, and Low-Income Medicaid) and PeachCare programs.

In the news

- **Report: Insurer hires 'heavily' from Dept. of Community Health**

  Since 2010, six former employees of the Georgia Department of Community Health have gone to work for health insurance giant UnitedHealthcare after leaving the state agency, reports Georgia Health News. Among the latest is the former inspector general of the agency, Robert Finlayson, who recently left for United, a major contractor of the state, GHN said. UnitedHealthcare covers almost 90 percent of the members in the State Health Benefit Plan. The state plan covers more than 660,000 schoolteachers, school personnel, state employees, retirees and dependents, GHN reported. GHN added that while state law does not forbid contractors from hiring state employees, the number involved with United over a two-year period - along with the high level of the positions they formerly held with the state - appears unusual. (Atlanta Business Chronicle)

Illinois

HMA Roundup – Jane Longo and Matt Powers

Illinois had anticipated announcing contract awards for its dual eligible demonstration program by July 31, 2012. However, at a Medicaid Advisory Committee (MAC) meeting on July 20, the State announced that, due to the depth of the proposals, awards announcements would be delayed until the first half of August.

Additionally, at the MAC meeting, the Department of Healthcare and Family Services (HFS) presented a policy that would mandatorily enroll duals in managed care plans for their Medicaid benefits, even if an individual opts out of managed care coverage for their Medicare benefits. Medicaid-only aged, blind, and disabled beneficiaries (ABDs) would be mandatorily enrolled in the Greater Chicago and Central Illinois regions, although HFS has not finalized a timeline for this. According to HFS, these policies are not finalized, but have the support of Governor Quinn.

Policy position slides are available at HFS' Care Coordination website: here.

In the news

- **States Cut Medicaid Drug Benefits To Save Money**

  Illinois Medicaid recipients have been limited to four prescription drugs as the state becomes the latest to cap how many medicines it will cover in the state-federal health insurance program for the poor. Doctors fear the state's cost-cutting move could backfire on patients, who have to get state permission to go beyond the limit. Sixteen states impose a monthly limit on the number of drugs Medicaid recipients can receive and seven states have either enacted such caps or tightened them in the past two years, according to the Kaiser Family Foundation. (Kaiser Health News)

Michigan

HMA Roundup – Esther Reagan

The Republican caucus in the Michigan House of Representatives remains divided over legislation to create a health insurance exchange, and hearings are being conducted to gather more information about the proposed structure. Specific questions under consideration include:

- "The language in Obamacare says federal penalties only apply if a state sets up an exchange. However, the IRF has ruled that mandates and penalties will apply whether the state or the federal government establishes the exchange. Therefore, will Michiganders face an individual mandate, and will Michigan citizens and job providers face the tax penalty, if the state does not establish an exchange?"
- "What specific flexibility does the state of Michigan have with regard to the details of an exchange and, based upon that flexibility, what parameters should the state be sure to include?"
- "What are the advantages and disadvantages to a health exchange established by the state versus one being established by the federal government, specifically for individuals, job providers and state government."
- "Are there private companies similar to Travelocity or Orbitz that would be able to establish a marketplace exchange for Michigan citizens to compare and shop for insurance and, if so, would such private run systems meet the mandates of the federal government?"

Governor Snyder, who supports the creation of a health insurance exchange in Michigan, has been urged by advocacy groups to create one through executive order, though at this time he favors a legislative approach. The legislature returns for a one-day session on August 15.

As a reminder, Michigan began enrolling dual eligibles into Medicaid managed care plans on a voluntary basis in October 2011. As of July 2012, the number of Medicaid beneficiaries dually eligible for Medicare (duals) who were enrolled in Medicaid HMOs totaled 24,604. All Medicaid HMOs have duals enrolled, although the numbers vary dramatically across plans. A Medicaid HMO member who gains Medicare coverage and remains in the HMO is categorized as auto-assigned or voluntarily enrolled based on the means through which the member was initially enrolled in the HMO. Duals enrolled in a Medicare Special Needs Plan (SNP) for their Medicare benefits but receiving Medicaid on a fee-for-service basis are auto-assigned to the related Medicaid HMO if applicable. Any dual is able to "opt out" of the HMO and receive Medicaid benefits on a fee-for-service basis. Molina Healthcare of Michigan has the most dual enrollees receiving their Medicaid services from an HMO, 8,374 or 34 percent of the total. UnitedHealthcare Community Plan has 5,826 or almost 24 percent of the total followed by Meridian Health Plan of Michigan with 3,344 or 14 percent of the total. Enrollment figures by plan are available here.

New York

HMA Roundup – Denise Soffel

Donna Frescatore is the new executive director of the New York Health Benefit Exchange. She currently works as deputy director of health care redesign. Gov. Andrew Cuomo created the exchange, part of the federal reform act, by executive order in April.

In the news

- **Dual Eligibles Cost $35B**

  The state's 700,000 dual eligibles, enrollees in both Medicaid and Medicare, cost New York $34.8 billion annually, said John Ulberg, the state Department of Health's director of the Division of Health Care Financing during a presentation yesterday. That represents 45%, or $23.4 billion, of Medicaid spending and 41%, another $11.4 billion, of Medicare spending in the state, much of it on long-term care. The state has been trying to get a solid tally of the cost of dual eligibles since last autumn. Mr. Ulberg settled on $34.8 billion annually for the elusive figure. "We are getting much more comfortable that this is the number," he said. It's a figure "that requires a lot of thought from a financial perspective." DOH also announced yesterday that it had submitted Friday to the Centers for Medicare & Medicaid Services a draft of its $10 billion Medicaid waiver application. The formal waiver will be sent the first week of August. (Crain's New York)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

On July 24, the Department of Public Welfare (DPW) released the details of its FY 2012-2013 enacted budget. Highlights include:

- The DPW budget is $27.6 billion, which consists of $10.6 billion in general revenue funds, $14.5 billion in federal funds and $2.5 billion in other funds.
- The Medical Assistance (Medicaid) budget is $19.1 billion, which consists of $6.3 billion in general revenue funds, $10.3 billion in federal funds and $2.5 billion in other funds.
- Medical Assistance and Long Term Living represent 22.8% of Pennsylvania's general fund budget.
- Medical Assistance caseload growth is projected to be minimal for the period, consistent with FY 2011-2012.
- No reduction is scheduled for inpatient fee-for-service rates.
- For managed care rates, the State's presentation indicated rates will be set in an actuarially sound manner. In response to a question at the July Medical Assistance Advisory Committee meeting, DPW representatives acknowledged that there is no increase contemplated in the budget for managed care rates. Later in the presentation, DPW acknowledges the ACA requirement that primary care

provider rates be raised to Medicare levels, though the methodology for implementing this change is not described.

- The Transportation appropriation received a 5.2 percent increase.
- Implementation dates for the New West (10/1/12) and New East (3/1/12) regions for mandatory Medicaid managed care remain unchanged.
- Co-payments will be imposed on families with household incomes above 200 percent of the federal poverty level (this is for children with a severe disability whose families' income does not count when determining MA eligibility).
- With respect to the ACA Medicaid expansion, DPW simply states no decision has been made and that it is currently studying the impact on the State.

South Carolina

On July 30, South Carolina issued a request for information (RFI) related to the South Carolina Department of Health and Human Services (SCDHHS) State Demonstration to Integrate Care for Dually Eligible Individuals (SCDuE). The RFI is in reference to future Requests for Proposals (RFPs) to develop a service delivery model that integrates care for individuals who receive services from both Medicare and Medicaid. Responses to the RFI will be used in the development of a more detailed system design and subsequent RFP document(s). Additionally, responses will be used in the formulation of agreements between SCDHHS and CMS. RFI responses are due August 17, 2012.

Texas

HMA Roundup – Dianne Longley

Gov. Rick Perry has appointed Dr. Kyle Janek of Austin as executive commissioner of the Texas Health and Human Services Commission (HHSC) effective Sept. 1, 2012, and announced that Chris Traylor of Austin will serve as chief deputy commissioner. Janek is a board-certified anesthesiologist and director of anesthesia services at Lakeway Regional Medical Center. He is a past member of the Texas Legislature, serving in the House of Representatives and Senate from 1995 to 2008. He replaces Tom Suehs, who is retiring. Traylor has served as commissioner of the Texas Department of Aging and Disability Services since 2010. He helped oversee the consolidation of the 15 health and human services agencies into the current five in 2004 and is past associate commissioner for Medicaid and the Children's Health Insurance Program.

In the news

- **Adult day care providers protest rate cut**

  A statewide rate cut for personal care providers has led Rio Grande Valley adult day cares and home health agencies to encourage their clients to leave the health maintenance organization that enacted it. Molina Healthcare, a Calif.-based health maintenance organization, implemented the 10 percent provider rate cut last month for providers that offer personal assistance and similar services to clients through Medicaid. Company officials say the statewide cut was forced by high costs and high utilization

of those services since the March rollout of managed care to South Texas. But caregivers and advocates at a town hall meeting Thursday in Donna said they were encouraging patients to consider switching to other health maintenance organizations, or HMOs. (Equities.com)

OTHER HEADLINES

Alaska

- **Health department staff wanted state insurance exchange**

While Alaska won't create a health insurance exchange on its own, a consultant's report suggests that some in the state's Department of Health and Social Services would have liked to see the state take the lead on its own exchange. Public Consulting Group, presented a draft report looking at the state's options in April and a final report in June that was made public the day the decision was announced. The report warned that relying on the federal government to create an insurance exchange for Alaska was the option that carried the most uncertainty, and warned that it, too, could also be costly. And the PCG report also indicated that the staff at the Department of Health and Social Services may prefer Alaska develop its own exchange. (Alaska Journal)

California

- **Calif. Lawmakers Seek Changes to Spending on Mental Health Programs**

Two members of the state Assembly Health Committee are seeking changes to how California spends funding on mental health programs, AP/U-T San Diego reports. The Mental Health Services Act -- known as Proposition 63 -- has raised $7.4 billion through a 1% tax on residents with incomes greater than $1 million annually. A recent AP report found that tens of millions of dollars generated by Prop. 63 have been allocated to aid residents who have not been diagnosed with a mental illness. The report found that the money has been used to bolster programs such as yoga, art and drama classes, horseback riding and gardening. On Monday, Assembly member Dan Logue (R-Linda) told the AP that he will call for an independent audit by the state Treasurer's Office on the use of Prop. 63 revenue. Logue also said he expects to send a letter Tuesday to Assembly Health Committee Chair Bill Monning (D-Carmel), asking him to hold an oversight hearing on the matter as soon as possible. Meanwhile, Assembly member Brian Nestande (R-Palm Desert) said he would support legislation to clarify how the funds can be used. In addition, some mental health advocates and public health workers want state lawmakers to approve a "clarifying amendment" saying that money raised by Prop. 63 can only be used to help people with mental and emotional problems. (California Healthline)

- **California builds the nation's largest prison medical facility**

California is building the largest prison medical facility in the nation — and it's doing it at a record clip. That's because the state has to comply with a federal court order to improve health care for inmates. The medical hub is designed to provide long-term care to 1,700 inmates too sick to live in regular housing. (SCPR.org)

Kansas

- **KanCare information forums begin**

  Representatives of hospitals, doctor practices and other Medicaid providers turned out in relatively large numbers for the beginning of a series of meetings aimed at answering questions about KanCare, Gov. Sam Brownback's plan to remake the state Medicaid program. State officials said they still hadn't resubmitted their application for the federal waivers needed to launch the administration's Medicaid makeover plan but intend to refile that paperwork "very soon" and meanwhile are moving forward with their desired Jan. 1 start date for the new program. Federal approval is necessary for the administration to advance its plan of moving virtually all of the state's 383,000 Medicaid beneficiaries into fixed-cost managed care plans run by insurance companies. (Kansas Health Institute)

Minnesota

- **Minn.'s health care safety net expands for thousands of kids**

  The state of Minnesota is expanding health care coverage to thousands of uninsured children. The new initiative, first approved by the Legislature in 2009 and finally implemented this month, will erase barriers such as waiting periods and monthly insurance premium payments for some 16,000 children from lower-income families across the state. (Minneapolis Star Tribune)

North Carolina

- **State announces plan to overhaul treatment and services for the mentally ill**

  The state Department of Health and Human Services announced Thursday a $67 million plan to improve the treatment and services for people with mental illnesses by relocating them from assisted living centers. The plan is an attempt by the state to avoid being sued by the U.S. Department of Justice, which is now negotiating with the department over its failure to comply with the Americans with Disabilities Act. Reaction to the plan was tempered by the announcement that the program includes no agreement to make sure the state follows federal guidelines about care for people with mental illness. The plan would give some people with a mental illness now living in adult-care homes the option of relocating to community-based housing that provides personalized care. Many North Carolinians with mental illnesses are housed in adult-care homes, also known as assisted-living facilities, which are licensed by the state. The facilities are less medically intensive than nursing homes. Over the state program's eight years, the goal is to help at least 3,000 people move out of adult-care homes. At least 100 people will be moved by the end of the year. There are an estimated 5,800 people with a mental illness in adult-care homes around the state, though exact numbers are difficult to track. (News Observer)

Ohio

- **Ohio's Medicaid system to become a free-standing state agency, part of governor's cabinet**

  Gov. John Kasich's administration announced Friday that Ohio's Medicaid program, the federally supported health care system for the poor, will soon become its own free-

standing, cabinet-level state agency. Medicaid -- which at a cost $18.8 billion in 2012, including $6.4 billion in state funds -- is the state's largest expense. The bulk of the Medicaid program is currently housed under the Ohio Department of Job and Family Services, but at least four other state agencies also have some role in administering services, which has made the entire system clunky and inefficient, state officials have said. The decision to separately house the single largest state spending program under its own state agency is long overdue, officials said. Such a move had been recommended by bipartisan state study commissions in 2005 and 2006 but never acted upon. (Cleveland Plain Dealer)

- **Ohio court grants Aetna request to stop Medicaid contract process**

  Franklin County (Ohio) Common Pleas Court has granted Aetna Inc.'s request for a temporary restraining order to stop Ohio from moving ahead with its Medicaid contract process, The Wall Street Journal reports. Aetna said earlier this month that it was protesting the Ohio Department of Job and Family Services' decision alleging undisclosed communication between the state and a competing company swayed the state's decision, the newspaper reports. Hartford, Conn.-based Aetna filed suit last week against the Ohio Department of Job and Family Services seeking to reinstate its Medicaid contract with the state, which was re-awarded earlier this month to Clayton-based Centene Corp. and other bidders after the state of Ohio rescored the bids. In the lawsuit, Aetna argued its contract was rescinded after its score was improperly reduced based on the state's definition of whether it was fully at risk for claims expenses in other states. Aetna asked in its lawsuit that the court stop the state of Ohio from signing contracts with other providers until the suit is resolved and to force it to reinstate Aetna's contract award. (St. Louis Business Journal)

Oregon

- **Coordinated care organizations prepare to launch**

  Gov. John Kitzhaber and his health care chiefs have spent the past two years trying to convince anyone who will listen that they can fix some of the health care system's most vexing problems: out-of-control costs and less-than-stellar results. Starting this week, it's time to prove it. Oregon created new "coordinated care organizations" charged with taking a more active role in the care f low-income patients on the Oregon Health Plan. The first of those organizations go live on Wednesday with 260,000 patients, and more will launch in the months that follow. Eventually, they'll cover most of the 600,000 people on the Health Plan statewide. (Statesman Journal)

Tennessee

- **Tennessee Cuts Medicaid Benefit Funding For Some Long-Term Care Patients**

  In a unique experiment being watched nationally, Tennessee is revising its Medicaid long-term care options to make it harder for certain low-income elderly people to qualify for state-paid nursing home care. The state is focusing on seniors who officials say need assistance but not in a nursing home and not with an equivalent level of treatment in home or community-based services. The state TennCare Medicaid program will pay up to $15,000 a year to help these participants stay in their homes or receive meals and other services in adult day care facilities or other less restrictive community

settings. Under its old program, all participants qualifying for long-term care under TennCare—whether they were in a nursing home or other care—were entitled to benefits equal to the cost of a nursing home. The program, which has received federal approval and began this month, is the first of its kind in the nation because it creates this new category of patients who don't qualify for nursing home care. Up to now, under federal law, everyone who receives long-term care under Medicaid first had to qualify to be admitted to a nursing home. (Kaiser Health News)

Washington

- **Medicaid debate likely to be big one in Olympia**

  How far to expand Medicaid coverage for poor people under the new federal health-reform law is turning into a major question in many states. In Washington, it is shaping up as a major question for the Legislature next year. Majority Democrats and Republicans are sharply split, and their differences came into sharp focus last week during a legislative work session on health reform at the Capitol. At issue was how far the state should go in providing taxpayer-paid health care for poor people who, if uninsured, drive up costs for everyone else by going to hospital emergency rooms. Medicaid now serves nearly 1.1 million Washingtonians, and upward of 1 million more could enroll in January 2014 under the federal Affordable Care Act. Most of those costs would be paid by the federal government; the state's share would top out at 10 percent in 2020. (The Olympian)

Wisconsin

- **State to create coordinated care program for foster children**

  The Department of Health Services has received federal approval to create a foster care "medical home" program in southeastern Wisconsin, Gov. Scott Walker announced Monday. The initiative seeks to create a virtual "medical home" in which children will receive individualized treatment plans addressing their specific needs. A joint initiative of the Department of Health Services and the Department of Children and Families, the program will be implemented in Milwaukee, Waukesha, Racine, Kenosha, Ozaukee and Washington counties and is expected to reach 2,500 children. (Journal Sentinel)

National

- **Medicaid could be scaled back sharply under GOP plans**

  GOP governors, emboldened by the Supreme Court decision on President Obama's healthcare law, are already balking at expanding Medicaid to meet the goals of the Affordable Care Act. Some are rolling back coverage now, arguing that the program is ineffective and unaffordable. At the same time, congressional Republicans, backed by influential conservative activists, are renewing calls to convert Medicaid into a series of smaller grants to states, reprising the successful GOP strategy that cut cash welfare programs in the mid-1990s. (Los Angeles Times)

- **On Medicaid: Governors Want Answers on Expansion, But CMS Still Analyzing Court Ruling**

  The top federal Medicaid official said Monday that it will probably take states "several months" to decide whether they want to expand their Medicaid programs in 2014.

Cindy Mann, the deputy administrator of the Centers for Medicare and Medicaid Services (CMS), said that she wants to be careful about responding to the hundreds of questions state officials and health policy experts have pelted her with since June 28 when the Supreme Court ruled that states would not lose any existing federal Medicaid money if they refuse to expand Medicaid as the health care law envisions. (CQ Healthbeat)

- **Doctor Shortage Likely to Worsen With Health Law**

  Health experts, including many who support the law, say there is little that the government or the medical profession will be able to do to close the gap by 2014, when the law begins extending coverage to about 30 million Americans. It typically takes a decade to train a doctor. "We have a shortage of every kind of doctor, except for plastic surgeons and dermatologists," said Dr. G. Richard Olds, the dean of the new medical school at the University of California, Riverside, founded in part to address the region's doctor shortage. "We'll have a 5,000-physician shortage in 10 years, no matter what anybody does." Experts describe a doctor shortage as an "invisible problem." Patients still get care, but the process is often slow and difficult. In Riverside, it has left residents driving long distances to doctors, languishing on waiting lists, overusing emergency rooms and even forgoing care. (New York Times)

- **Medicaid Expansion Reduces Mortality, Study Finds**

  As states decide whether to expand their Medicaid programs to cover low-income childless adults, the impact of their choices became clearer today in a study showing a reduction of mortality in states that have already made that move. The research published in the New England Journal of Medicine found a 6.1 percent reduction in mortality among low-income adults between the ages of 20 and 64 in Maine, New York and Arizona — three states that expanded coverage since 2000, compared with similar adults in New Hampshire, Pennsylvania, Nevada and New Mexico, neighboring states that did not do so. The decline in mortality, by an overall 19.6 deaths per 100,000 adults, was especially pronounced among older individuals, minorities and residents of the poorest counties. The researchers analyzed data spanning five-year periods before and after the three states extended their Medicaid coverage to poor, childless adults. The study also found "improved coverage, access to care and self-reported health" among the newly covered adults. (Kaiser Health News)

COMPANY NEWS

- **Optimum Outcomes Expands National Presence with the Acquisition of Patient Financial Services and Absolute Collection Service**

  Optimum Outcomes, a leading provider of account resolution services to hospitals and hospital-based physician groups throughout the United States, announced today that it has acquired Patient Financial Services and Absolute Collection Service (collectively, "ACS") in a transaction that expands and enhances its comprehensive suite of revenue cycle services. Headquartered in Raleigh, North Carolina, ACS has approximately 275 employees and a strong base of clients across the United States, with a concentration in

the Southeast. ACS provides several services to its hospital clients, primarily extended business office (EBO) self-pay billing and account resolution, aged receivables (≥120 days) account resolution and data warehousing services for hospitals that are undertaking, or have recently completed, systems conversions. (Waud Capital News)

- **Acquisition may be first wave of Medicaid managed care consolidations**

  WellPoint's purchase of Amerigroup is expected to be the first of many deals that further will consolidate the Medicaid managed care market and could give the largest health plans even greater leverage in contract negotiations with physicians for all private plans. In a July 11 note to investors, Goldman Sachs investment analyst Matthew Borsch identified two reasons for that expected consolidation. First, companies such as WellPoint are trying to diversify. Second, the expansion of Medicaid outlined in the Affordable Care Act could call for major investments in infrastructure that the Medicaid-only health plans can't afford, but that the big insurers can. (American Medical Association News)

- **Molina Healthcare reports 2nd-qtr loss, Texas weighs**

  Health insurer Molina Healthcare Inc reported a second-quarter loss and warned that enrollment in its Texas health plans may decline in the third quarter as higher medical costs in the region eat into premium revenue. The company said higher costs in Texas "had a disproportionately large impact on its overall financial results" as the region contributed about a quarter of Molina's total premium revenue in the second quarter. Molina estimated its current monthly loss before taxes for the Texas health plan at $14 million. The company said that high utilization rates in Texas, specifically in El Paso and Hidalgo counties, have eaten into its profits. Molina said it expected its performance in Texas to improve when it gets premium rate increases there from September. Until then, it said it expects to incur costs of about $10 million. (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
August 13, 2012	Ohio Duals	Contract awards finalized	122,000
Mid-August, 2012	Illinois Duals	Contract awards	136,000
August 28, 2012	Florida LTC	Proposals due	90,000
September 20, 2012	Ohio Duals	Contracts finalized	122,000
September 21, 2012	Massachusetts Duals	Contract awards	115,000
September, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
October 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October 1, 2012	Florida CHIP	Implementation	225,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
December, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
Late 2012	New Hampshire	Implementation (delayed)	130,000
January 1, 2013	Kansas	Implementation	313,000
January 1, 2013	Kentucky - Region 3	Implementation	170,000
January 1, 2013	Florida acute care	RFP released	2,800,000
January 1, 2013	Florida LTC	Contract Awards	90,000
January 1, 2013	Ohio	Implementation	1,650,000
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
February 1, 2013	Ohio Duals, NW, NC, EC	Implementation	35,000
March, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
Mid-late March 2013	California Dual Eligibles	Implementation	500,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
April 1, 2013	Illinois Duals	Implementation	136,000
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	Ohio Duals, NE	Implementation	32,000
May 1, 2013	Ohio Duals, C, WC, SW	Implementation	48,000
October 1, 2013	Florida LTC	Implementation	90,000
October 1, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
January 1, 2014	New York Duals	Implementation	TBD
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	Hawaii Duals	Implementation	24,000
October 1, 2014	Florida acute care	Implementation	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

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

State	Model	Duals eligible for demo	Proposal Released by State	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Contract Award Date	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012	X	7/1/2012	N/A[+]	N/A[+]	N/A	1/1/2014
California	Capitated	685,000*	X	4/4/2012	X	6/30/2012	X	3/1/2012	4/4/2012	3/1/2013
Colorado	MFFS	62,982	X	4/13/2012	X	6/30/2012				1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	X	6/30/2012				12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	X	6/29/2012				1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	X	5/10/2012	X	6/18/2012	Mid Aug. 2012	4/1/2013
Iowa	MFFS	62,714	X	4/16/2012	X	6/29/2012				1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	X	6/30/2012		Q2 2013	July 2013	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	X	3/19/2012	X	8/20/2012	9/21/2012	4/1/2013
Michigan	Capitated	198,644	X	3/5/2012	X	5/30/2012		Feb. 2013	March 2013	7/1/2013
Missouri	Capitated[‡]	6,380	X		X	7/1/2012				10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	X	5/31/2012				1/1/2013
New Mexico	Capitated	40,000	X		X	7/1/2012		Q3 2012	Dec. 2012	1/1/2014
New York	Capitated	133,880	X	3/22/2012	X	6/30/2012				1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	X	6/3/2012				1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	X	5/4/2012	X	5/25/2012	Scoring: 6/28/12	1/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	X	7/1/2012				7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	X	6/13/2012		Certification process		1/1/2014
Rhode Island	Capitated	22,737	X		X	7/1/2012		Apr-May 2013	6/1/2013	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	X	6/28/2012			7/30/2013	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	X	6/21/2012				1/1/2014
Texas	Capitated	214,402	X	4/12/2012	X	6/30/2012		Late 2012	Early 2013	1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	X	6/30/2012			July 2013	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	X	6/10/2012		1/1/2013	2/28/2013	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	X	5/30/2012		Feb. 2013	July 2013	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	X	6/1/2012				1/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***4***			

**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 Recently Published Research

Financing County Medi-Cal Eligibility and Enrollment in California

Stan Rosenstein, Principal Advisor
Caroline Davis, Senior Consultant
David Fosdick, Consultant

Prepared for the California Health Care Foundation, this report examines how the State finances county administration of these programs and explores the potential impacts of several changes underway and on the horizon, such as budget cuts, a new methodology for determining Medi-Cal administrative payments to counties, and the transition of children from Healthy Families to Medi-Cal. Several implications of the Affordable Care Act (ACA) are also discussed, including:

- **Medicaid expansion and eligibility simplification.** Medi-Cal enrollment could grow by 1.8 million or more people beginning in 2014. At the same time, the ACA requires simplification of the enrollment and redetermination processes.
- **Role of California's Health Benefit Exchange.** Federal regulations will let California decide whether eligibility for most Medi-Cal applicants will be determined by the Exchange or Medi-Cal.
- **Eligibility determination systems.** Federal funding is available through 2015 to upgrade Medi-Cal eligibility determination systems to streamline eligibility across Medi-Cal and the Exchange.
- **Adoption of a Basic Health Program.** County workload may increase if the State elects to create a Basic Health Program for individuals with incomes up to 200% of the federal poverty level who do not qualify for Medi-Cal.
- **Realignment of health care programs.** The Governor's proposed budget discussed changing responsibilities for the funding and delivery of certain health care services in response to low-income, uninsured Californians moving out of county programs and into Medi-Cal or the Health Benefit Exchange.

Taken together, these programmatic changes will alter the landscape of funding for county administration of eligibility for public assistance benefits and provide an opportunity to rethink the role of counties. **(Link to Report – California Health Care Foundation)**

Comprehensive Hospital EHRs Improve Quality and Efficiency

Sharon Silow-Carroll, Managing Principal
Jennifer Edwards, Managing Principal
Diana Rodin, Consultant

HMA prepared a report for the Commonwealth Fund examining the experiences of nine hospitals with comprehensive electronic health record (EHR) systems. The report describes ways that the systems facilitate patient safety, quality improvement, and efficiency. The EHRs have contributed to faster, more accurate communication and streamlined processes, which improve patient flow, minimize duplicative tests, enable faster responses to patient inquiries, improve capture of charges, and generate federal incentive payments. The report presents challenges to EHR implementation and ways to alleviate them, and lessons for other hospitals and policymakers. **(Link to Report - The Commonwealth Fund)**

Medicaid-Financed Services in Supportive Housing for High-Need Homeless Beneficiaries: The Business Case

Mike Nardone, Principal

The Medicaid expansion under the Affordable Care Act will provide coverage to most of the estimated 1.2 million people who are homeless, including the roughly 110,000 individuals who are chronically homeless and more likely to suffer chronic, complex health conditions. This policy brief makes a case for states to explore the use of new Medicaid financing options available under ACA (e.g., health homes), as well as flexibilities afforded through Medicaid managed care, to support the funding of housing-based care management services in supportive housing for formerly homeless individuals. The research suggests that such an approach can improve care for these beneficiaries while lowering costs associated with avoidable hospitalizations and other crisis services. **(Link to Policy Brief - Center for Health Care Strategies)**

Public and Private Insurance Coverage for Chronic Hepatitis B Patients: Health Reform Will Facilitate Early Investments Providing Long-Term Benefits

Jack Meyer, Managing Principal
Gaylee Morgan, Senior Consultant
Vern K. Smith, Managing Principal

The implementation of national health reform in the U.S. provides important opportunities to increase the awareness, routine screening, and treatment of viral hepatitis. An estimated 2.2 million Americans are infected with chronic hepatitis B (HBV), yet nearly two-thirds of these people are unaware of their disease until they have developed liver cancer, cirrhosis, or liver failure many years later. A growing body of evidence indicates that when HBV is detected early and properly treated, these highly adverse outcomes can be delayed or avoided altogether.

Enrollment in health coverage is absolutely vital to this early detection and treatment. In fact, our research shows that liver transplants can be reduced by 58 percent and the death rate can be reduced by 20 percent when lower-income people are enrolled in insurance coverage and treated early in the course of their disease. This study projects that over 70,000 people with HBV will newly enroll in Medicaid under the Patient Protection and Affordable Care Act and about 75,000 more people with HBV will newly enroll in Health Insurance Exchanges. We find that a 5 percent reduction in liver transplants for HBV patients could finance more than 420,000 screenings. **(Link to Report - Center for Health Care Strategies)**