HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: THE CBO'S ACA SPENDING AND COVERAGE PROJECTIONS FOLLOWING THE SCOTUS RULING

HMA ROUNDUP: GEORGIA NOTIFIES MCO OF PLANNED CONTRACT EXTENSION; FLORIDA INITIATES MEDICAL ASSISTANCE ITN PROCESS; NEW YORK SUBMITS 1115 WAIVER TO CMS; WISCONSIN RELEASES VIRTUAL PACE DUALS PROPOSAL; CALIFORNIA LEGISLATURE RECONVENES

OTHER HEADLINES: STUDY FINDS 31% OF PHYSICIANS DON'T ACCEPT MEDICAID PATIENTS; CMS SAYS STATES CAN OPT IN/OUT OF MEDICAID EXPANSION AT ANY TIME; ILLINOIS HOSPITALS RESIST ACQUIRED INFECTION RULE; MASSACHUSETTS REPORT ARGUES MEDICAID MCOS DON'T REDUCE PROVIDER FEES

RFP CALENDAR: OHIO, ILLINOIS DUAL ELIGIBLE AWARD ANNOUNCEMENTS EXPECTED SOON

AUGUST 8, 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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Edited by:

Gregory Nersessian, CFA
212.575.5929
gnersessian@healthmanagement.com

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

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In Focus: Summary of CBO Estimate Updates for Coverage Provisions in the Affordable Care Act

This week, our *In Focus* section reviews the new estimates for the insurance coverage provisions of the Affordable Care Act (ACA) updated for the recent Supreme Court decision. The summary below is provided by Lillian Spuria, Principal, from HMA's Washington, DC office.

On July 24, 2012 the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) issued new estimates for the insurance coverage provisions of the ACA updated for the recent Supreme Court decision. CBO characterizes the Supreme Court decision as having the effect of converting the ACA's Medicaid coverage expansion from a mandate to an option for States. By removing the Medicaid coverage mandate, CBO and JCT now anticipate that some states will not expand their programs at or will not expand coverage to the full extent authorized by the ACA. CBO and JCT expect that some states will eventually undertake expansions but will not do so by 2014 as specified in the ACA.

CBO and JCT Modeling Methodology

CBO and JCT estimates are not based on state-by-state predictions about Medicaid expansion under ACA. Instead, CBO and JCT estimates reflect an assessment of the probabilities of different outcomes that might occur and are, in their judgment, in the middle of the distribution of possible outcomes. Given the uncertainty of future legal or administrative action regarding ACA coverage provisions, CBO and JCT state that the analysis should not be viewed as representing a single definitive interpretation of how the ACA should or will be implemented in light of the Court's decision.

Revised Coverage & Enrollment Estimates

A summary of CBO and JCT's revised estimates are shown in the table below.

Changes in Budget Effects of Insurance Coverage Provisions in 2022 ($ in billions)

	March 2012 Baseline	July 2012 Estimate (Incorporating SCOTUS Decision)	Difference
Medicaid & CHIP Outlays	931	642	-289
Exchange Subsidies and Related Spending	808	1,017	210
Small Employer Tax Credits	23	23	*
Gross Cost of Coverage Provisions	1,762	1,682	-79
Penalty Payments by Uninsured Individuals	-54	-55	-1
Penalty Payments by Employers	-113	-117	-4
Excise Tax on High-Premium Insurance Plans	-111	-111	*
Other Effects on Tax Revenues and Outlays	-231	-231	*
Net Cost of Coverage Provisions	1,252	1,168	-84

On net, they estimate that the cost of coverage provisions will decline by $84 billion over 11 years (2012-2022), the impact of which is mainly concentrated in Medicaid and Exchange subsidies. They expect Medicaid outlays to decline by $289 billion, Exchange subsidies to increase by $210 billion, and revenues collected from penalties applied to uninsured individuals and employers are expected to increase by $5 billion. In terms of impact on coverage enrollment, CBO and JCT assume that by 2022, six million fewer individuals will enroll in Medicaid, three million more individuals will enroll in Exchange coverage, and three million fewer currently uninsured individuals will gain coverage.

Changes in Insurance Coverage in 2022 (Millions of nonelderly, by calendar year)

	March 2012 Baseline	July 2012 Estimate (Incorporating SCOTUS Decision)	Difference
Medicaid and CHIP	17	11	-6
Employer	-3	-4	*
Nongroup and Other	-3	-3	*
Exchanges	22	25	3
Uninsured	-33	-30	3

Key Factors in States' Decisions Regarding the Medicaid Expansion

CBO and JCT considered many factors that might affect a state's decision to expand Medicaid.

State incentives include:

- The enhanced federal contribution, which will cover 100 percent of newly eligible costs from 2014 to 2016, and then level off at 90 percent by 2020.
- Pressure from health care providers that stand to gain when more people have coverage. Hospitals in particular that will receive smaller disproportionate share hospital payments from Medicaid may exert pressure on states to make up those losses by expanding Medicaid eligibility.

State disincentives include:

- The state share of Medicaid expansion costs, even though a low percentage, represents a large extra cost for some states.
- Expanding Medicaid will lead to an increase in enrollment among those who would have been eligible for Medicaid prior to ACA (i.e., the woodwork effect). The coverage costs of these enrollees are not eligible for higher federal matching rates.
- States are concerned that CMS may in the future reduce federal funding for the Medicaid expansion population.

CMS flexibility

CBO also believe that state choices will also be shaped by how the current Administration and future ones respond to the Supreme Court's Decision. CBO anticipates that states will try to work with CMS to undertake partial expansions such as:

- Expanding Medicaid coverage up to 100 percent FPL.
- Delaying the Medicaid expansion by a year or more.
- Changing methodologies and procedures for determining eligibility.

Given these considerations, CBO and JCT estimates assume that that states decisions will span a wide range:

- Some states will forgo the expansion entirely.
- Some states will likely expand coverage to everyone whose income is below 138 percent FPL.
- If the flexibility is allowed, some states may choose partial expansions.

Further, states may be able to make those choices in any year after 2014.

Timetable for Medicaid Expansion

CBO and JCT project the Medicaid *coverage expansion* will unfold according to the following timetable:

- About one-third of the people who will ultimately become newly eligible for Medicaid reside in states that will expand their program beginning in 2014.
- About one-third of newly eligible people will reside in states that will delay their coverage expansion until 2015.
- The remaining one-third will reside in states that will delay longer than one year and expand coverage in 2016, 2017, or 2018.

Based on this timetable, the projected proportion of individuals that will become eligible for Medicaid is smaller in earlier years.

Key Assumptions behind CBO and JCT's Medicaid Estimates

- States that expand Medicaid coverage in 2014 are more likely to implement a full coverage expansion up to 138 percent FPL; while States that expand coverage in later years are more likely to seek a partial Medicaid expansion.
- Of the 6 million people who will not have Medicaid coverage in 2022 as result of the Court's decision:
    - About three-quarters would have been *newly eligible* for Medicaid under the ACA as estimated prior to the Supreme Court's decision.
    - About one-quarter would have been *eligible for Medicaid or CHIP under pre-ACA rules*, and, prior to the Court's decision, would have been expected to enroll in one of those programs.

- Among the people who would have been newly eligible for Medicaid under ACA prior to the Court's decision, about one-third will have incomes between 100 percent and 138 percent FPL and about two-thirds have income below 100 percent FPL.

Impact on Exchange Subsidies and other Revenues

- Most people with incomes between 100 percent and 138 percent FPL in states that do not expand Medicaid or defer expanding Medicaid will be eligible for subsidized coverage in the Exchange. CBO and JCT estimate that a significant portion of these individuals will obtain insurance offered through exchanges. Because they have lower than average income, they will qualify for higher federal subsidies for premiums and cost sharing.
- The additional enrollees are likely to spend more on health care, on average, than those previously expected to purchase insurance through the Exchanges. As a result, CBO and JCT now estimate that the premiums for health insurance offered through the Exchanges, along with premiums in the individual market, will be 2 percent higher than those estimated in March 2012.
- Although the number of low-income people without health insurance is expected to increase by three million, on average, CBO and JCT project only a slight increase, on net, in collections from penalty payments arising from the individual coverage requirement. CBO and JCT cite three reasons:
    - Many individuals who will not become eligible for Medicaid because of the Court's decision will have incomes that fall below the mandatory tax-filing threshold and be exempt from the penalties associated with the mandate.
    - The ACA exempts individuals who would have to pay more than 8 percent of their income for health insurance.
    - People who will not be exempt under those criteria will probably receive a hardship exemption from ACA.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

The legislature reconvened on August 6th with two key healthcare issues on the table. The first is the renewal of the gross premium tax which expired on June 30 and generates approximately $180 million of revenue. This tax was tied to the Healthy Families program which has been eliminated with those members having been transitioned into Medi-Cal. The state is negotiating the terms of the tax with the Medi-Cal plans that are seeking rate increases. The other issue being deliberated is the renewal of the nursing home fee which also expired on June 30. The state is considering renewing the fee for another year with the nursing home industry opposes.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Earlier this week, the Florida Agency for Health Care Administration requested that parties interested in the Managed Medical Assistance (acute care) component of the Statewide Medicaid Managed Care program submit non-binding letters of intent by August 17, 2012. This is the first step in moving forward with the acute care ITN that is scheduled for release by January 1, 2013.

In the news

- **Medicaid plan to challenge state**

  A newly formed managed-care plan late last week told state officials that it is ready to challenge the initial contract the state is drawing up as part of a move to hold down the cost of providing long-term care under the state's safety-net program. Aetna Better Health gave notice on Thursday to the state Agency for Health Care Administration that it intends to challenge the contract's requirement that managed-care companies provide as many as three references. The state is banning managed-care plans from using any references from corporate affiliates. (Health News Florida)

- **State ready to revamp Medicaid payments to hospitals**

  Lawmakers this year directed the Agency for Health Care Administration to develop the plan, which is designed to more accurately tailor Medicaid payments to the treatment each patient receives. It will replace a complex system that involves calculating per-diem rates for inpatient care. Consultants briefed state and health-care industry officials Thursday about work on the plan, which is required to be submitted to Scott and legislative leaders by Jan. 1 and is scheduled to take effect July 1, 2013. The changes have high stakes for hospitals, as some likely will wind up getting paid more under the new system and others will get paid less. Lawmakers required that the revamped system --- known in the hospital world as a system of diagnosis related groups, or DRGs --- not cost more than continuing the current system. (Florida Today)

Georgia

HMA Roundup – Mark Trail

WellCare disclosed on its quarterly earnings call on August 3, 2012 that the Department of Community Health (DCH) has indicated it intends to add two additional option years to managed care organizations' current contracts. Those contracts are currently scheduled to expire on June 30, 2014. DCH has not made an official announcement to that effect at this time but it will likely be addressed at the regularly scheduled DCH Board meeting tomorrow, August 9.

As we noted last week, DCH has been asked to comply with an additional 3 percent savings target for the current fiscal year projections and an additional 2 percent for the next fiscal year. DCH's recommendations will be disclosed in tomorrow's Board meeting with feedback to be collected over the next two weeks. The Board will then hold a subsequent meeting at which point the finalized recommendations will be submitted for the Governor's approval in early September. We note that the state currently imposes a 1.45 percent provider tax on all hospital revenue which generates $215 million in general revenue and $590 million in federal funds. When this provider tax was passed, the State also implemented an 11 percent Medicaid rate increase to offset the cost of the tax for hospitals' Medicaid revenue. We believe an extension of this tax and the associated Medicaid rate increase may come into play as part of the budget negotiations.

Indiana

HMA Roundup – Cathy Rudd

On July 30, Governor Mitch Daniels sent a letter to prospective Gubernatorial candidates (including former *Survivor* contestant Rupert Boneham) declaring that he will leave the decision on pursuing Medicaid expansion up to the next governor. He also requested that each candidate indicate their preference for a State or federal health insurance Exchange in order to comply with the September 30, 2012 deadline for determining the essential health benefits package.

New York

HMA Roundup – Denise Soffel

On August 6, 2012 Governor Cuomo announced that the State had formally submitted its 1115 waiver amendment to CMS. The waiver amendment is available here. For more information on the components of the waiver application, please see the New York Roundup of our June 6. 2012 Weekly Roundup available here.

Regarding the Health Home program, New York has not yet received CMS approval on its state plan amendment to begin operating the second and third phases of its health home initiative. The State is finalizing its response to questions raised by CMS about the proposal and hopes to submit its response before the end of the week. Despite this delay, the State has announced contingent awards for some of the Phase III health homes, which was scheduled to begin on July 1, 2012. They are asking all Phase II and III designees to send updated provider network information to the Department of Health so they can

start matching individuals to health homes. Although health homes cannot actually begin providing services until CMS approval had been received, the State will be sharing assignee lists on an informal basis so health homes can begin to prepare outreach to their members. Below is the list of designated health homes announced for Phase III.

Phase III Designated Health Homes

The NYS DOH has received 24 applications to serve 39 counties in Phase III. The applicants listed below are being contingently designated as Provider-led Medicaid Health Homes and must meet specified contingencies before receiving final approval. Additional announcements (for Albany, Allegany, Broome, Cattaraugus, Chautauqua, Otsego, Schoharie, Delaware and Chenango counties) will be made shortly.

Northern Region

- Hudson River HealthCare, Inc. (Columbia, Greene)
- St. Mary's Healthcare (Fulton, Montgomery)
- Samaritan Hospital (Rensselaer)
- Adirondack Health Institute (Saratoga)
- Glens Falls Hospital (Saratoga)
- Visiting Nurse Service of Schenectady and Saratoga Counties, Inc (Saratoga)

Central Region

- Thomas R. Mitchell, MD, PC (Chemung)
- Onondaga Case Management Services, Inc (Cortland, Madison, Onondaga, Oswego, Cayuga, Tompkins, Tioga)
- Upstate Cerebral Palsy, Inc. on behalf of the Central New York Health Home (Herkimer, Lewis, Madison, Oneida, Cayuga)
- Huther Doyle Memorial Institute, Inc. (Livingston, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates, Genesee, Orleans)
- North Country Children's Clinic, Inc. (Jefferson, St. Lawrence)
- St. Joseph's Hospital Health Center (Onondaga, Oswego, Cayuga, Madison)

Western Region

- Mental Health Services Erie County, Southeast Corp V (Niagara, Wyoming)
- Niagara Falls Memorial Medical Center (Niagara)

In the news

- **NY seeks waiver to invest Medicaid savings**

  State health officials say they have applied for a waiver that would enable them to use $10 billion of federal savings from Medicaid changes for other state initiatives meant to improve primary health care for poorer New Yorkers. The Cuomo administration projects saving $34 billion over five years in the government health care program, largely from a spending cap and better management. (Wall Street Journal)

Ohio

Contract awards for the dual eligible RFA are expected to be finalized by August 17. The state identified the highest scoring plans in each region on June 28th with Aetna, Molina, United and CareSource the highest scoring plans. On July 19, five plans submitted protest letters, WellPoint, CareSource, Paramount, United and WellCare.

Texas

HMA Roundup – Gary Young

On August 1, 2012 the Texas Department of Health and Human Services (HHSC) presented to the Senate Health and Human Services committee on the expected cost of the Medicaid expansion. Commissioner Suehs' presentation estimated that over the five-year period from 2013 to 2017, the cost of the Medicaid expansion would be $36.6 billion of which $32 billion would be federal funds and $4.6 billion would be State funds. The number of uninsured Texas residents would decline from 5.5 million (24 percent of the state population) to 2.9 million (12 percent). The State portion of the cost includes $595 million associated with the voluntary extension of the PCP rate increase to Medicare levels through 2017

Wisconsin

On July 30, 2012 Wisconsin released the initial application for Virtual PACE Integrated Care Organizations (ICOs), which are designed to cover dual eligible beneficiaries receiving long-term care services. The application is available on the Virtual PACE webpage:

http://www.dhs.wisconsin.gov/wipartnership/pace/index.htm

We will provide more detail on the program design in our next Weekly Roundup.

OTHER HEADLINES

California

- **California's LIHP a Big Success**

  The Low Income Health Program, launched 20 months ago, already has more than 400,000 Californians signed up. Health care experts gathered in Sacramento yesterday to discuss one of the successes in California's health reform effort. Only five states have formed a "Bridge to Reform" program like LIHP and none of them on the scale of California's effort, according to Diana Dooley, secretary of California's Health and Human Services Agency. (California Healthline)

- **State Delays Not-for-Profit Requirement for Adult Day Centers**

  The Department of Health Care Services extended the not-for-profit deadline for potential providers of the Community Based Adult Services program. Organizations providing adult day health care services now have until Jan. 1, 2013 to become not-for-profit, a new stipulation by the state to be eligible to receive Medi-Cal funding. The previous

deadline was July 1, 2012. The six-month delay in establishing not-for-profit status was done, in part, because the state will need a substantial number of former Adult Day Health Care providers to become CBAS providers. The department has granted eligibility to approximately 80% of former ADHC beneficiaries -- roughly 28,000 frail and elderly Californians. Another 2,194 people have filed appeals of eligibility, according to the Department of Social Services. (California Healthline)

Illinois

- **New health practice leading to better patient care?**

In January, Advocate Health Care, which includes 10 acute care hospitals and more than 250 other sites, created AdvocateCare, one of the nation's first and largest ACOs. There now are 380,000 patients insured by Blue Cross Blue Shield of Illinois enrolled in the program. While Advocate declined to provide specific financial data that would have shed light on whether the new model had resulted in cost savings, Advocate did release re-admission rates for its first year, which suggests that patients are receiving better care. That data shows that patients with chronic illnesses like diabetes or congestive heart failure who were part of the AdvocateCare program with BCBS and had the benefit of a transition coach— who follows their care upon discharge from the hospital— saw a 26 percent reduction in readmission rates compared to patients who did not have a transition coach. Hospital readmission rates for AdvocateCare patients who were sent to nursing facilities were also lower than the national average, 13.6 percent for AdvocateCare versus 20 percent nationally. (Chicago Sun-Times)

- **Hospitals fighting new rule on Medicaid patient care**

Hospitals, already adjusting to $1.6 billion in cost-cutting changes to Illinois' Medicaid system, are fighting what they call an extreme new emergency rule that could further jeopardize patient care and force even more providers to stop accepting Medicaid patients. Under the new rule, if a Medicaid patient incurs an infection or other hospital-acquired condition during the course of a hospital stay, the state will not pay for treating the infection. The new rule goes far beyond federal regulations, industry standards - which deduct the cost of treating the infection from the cost of the hospital stay - and legislators' intent when they passed Illinois' Medicaid reform laws in May, hospital officials say. Backed by their lobbying group, the Illinois Hospital Association, they're trying to get the rule suspended by the Joint Committee on Administrative Rules, a bipartisan legislative committee with the authority to review emergency rules. JCAR will take up the issue at its Aug. 14 meeting. (Peoria Journal-Star)

Iowa

- **Study: Medicaid expansion could help 182,000 Iowans**

Up to 182,000 Iowans could gain health insurance if Medicaid is expanded, according to a consultant's report released Tuesday. The report shows that it would be "financially irresponsible" to reject expansion of Medicaid, state Sen. Jack Hatch said in a Statehouse news conference. He said the average state cost of the expansion would be $161 annually per person over the first eight years. However, he acknowledged later that the state cost could climb to several hundred dollars per person by 2020. (Des Moines Register)

Kansas

- **Kansas resubmits Medicaid plan**

  Gov. Sam Brownback's administration announced Monday it had resubmitted to the federal government its proposal to overhaul the Kansas Medicaid program. Under the proposal, more than 350,000 Kansans will receive health care services through managed care plans run by private insurance companies. The administration had submitted its proposal to the Centers for Medicare and Medicaid Services in April. Lt. Gov. Jeff Colyer said the administration still hopes to implement KanCare by Jan. 1. (Lawrence Journal-World)

Louisiana

- **Response to Medicaid cuts divided LSU, Bobby Jindal administration**

  Internal documents from Louisiana State University show a divide between Gov. Bobby Jindal's administration, which sought to deal with Medicaid cuts through the sale of public hospitals, and the head of the university's health division, who proposed spreading the cuts throughout state health services and reversing course on the administration's rejection of a federal expansion of the Medicaid program. (The Times-Picayune)

Massachusetts

- **Medicaid managed care program doesn't reduce fees, report says**

  Insurers that contract with the state to manage the care of low-income Medicaid patients are expected to save money, in part by negotiating lower prices with health providers. But a new report by the state inspector general found that the plans pay higher fees to many hospitals and doctors than the traditional Medicaid program pays for the same services. In the 2011 fiscal year, the higher payments cost taxpayers $328 million, the -report said. Hospitals that dominate their region or have a highly recognizable name and strong reputation were paid the most, up to 2.5 times the standard Medicaid rate, the investigation found. (Boston Globe)

Mississippi

- **Mississippi gets a jump on creating Exchanges**

  While other Southern, Republican-dominated states such as Georgia have put the idea of a health insurance exchange on hold –- or have dismissed it entirely, due to its connection to the Affordable Care Act (ACA) — Mississippi has forged ahead in creating its own such online marketplace in 2014. "It's about time for Mississippi to be out in front,'' Therese Hanna of the Center for Mississippi Health Policy said Thursday in an interview with Georgia Health News. The state has been working on a health insurance exchange for a few years prior to the 2010 passage of the ACA. According to the Center for Mississippi Health Policy, about 275,000 Mississippians are expected to enroll in coverage through an exchange once the ACA is fully implemented in 2014. Out of those, an estimated 229,000 should be eligible for premium subsidies. Mississippi Insurance Commissioner Mike Chaney, a Republican, said in a July statement that no final decision on the exchange would be made till after the November elections. (Georgia Health News)

Missouri

- **Missouri officials mull impact of forgoing Medicaid expansion**

A new debate may be brewing as officials weigh the pros and cons of expanding Missouri's Medicaid program under a now-optional provision in the federal Affordable Care Act that Republican leaders strongly oppose. The federal law's impact on Disproportionate Share Hospital payments will give states an additional reason to "think hard about (Medicaid expansion)," state Medicaid director Ian McCaslin said at a MO HealthNet Oversight Committee meeting in Jefferson City this week. The federal government provides the DSH money for hospitals that serve significantly more low-income patients to help cover costs for treating the uninsured, but the payments are to be scaled back significantly under the federal health care law. Under the original plan, many of the patients would be covered by the Medicaid expansion, essentially reducing the need for DSH. (STL Today)

Pennsylvania

- **State-run health exchange will need manager**

State political leaders and experts say it's increasingly likely the federal government will have to set up and run Pennsylvania's health insurance exchange, as the marketplaces are called, because state lawmakers and Gov. Tom Corbett have so far failed to act. In the past two years, state officials have received more than $34 million in federal grant money, commissioned a lengthy consultant's study, held a series of public forums and publicly stated that Pennsylvania would be better off running its own exchange. But uncertainty this spring over a Supreme Court challenge to the 2010 Patient Protection and Affordable Care Act, along with continued waiting to see how the November presidential election will turn out, have stalled efforts. (Tribune-Review)

South Carolina

- **South Carolina allowing clinics to enroll as providers in Medicaid**

Beginning this month, South Carolina is allowing retail-based health clinics to enroll as providers in Medicaid, a move that will enable Medicaid patients to use clinics for wellness visits, preventive services and to treat acute ailments, according to a local news report. According to The Post and Courier, South Carolina Medicaid director Tony Keck said the move is designed to expand access to care and keep those patients with basic health issues from using high-cost emergency departments. The state currently has 25 retail-based health clinics, all of them CVS Caremark-owned MinuteClinics. (Drug Store News)

National

- **What Impact Will Health Care Have on 2012 State Elections?**

Eleven governor seats are up for grabs this fall, and winners will oversee much of their state's implementation of the ACA. To get a sense of the issue's impact, *Governing* analyzed campaign finance filings for two specific gubernatorial races: Indiana and North Carolina. Keep in mind that state legislative elections will also have a significant impact: more than 6,000 seats are in play. An example: the Arkansas News Bureau reported last month that Democratic Gov. Mark Beebe's chances of expanding Medicaid

would be severely hindered if Republicans can add to their majority in the state legislature in the November election. The Arkansas GOP has said it supports repealing the ACA in full. Many political analysts have indicated the Supreme Court decision specifically and health-care reform generally will impact the 2012 state elections. While the economy has consistently ranked as the most important issue for voters, a July 2012 Gallup poll found that 74 percent of Americans think making health care more affordable is "extremely or very important." (Governing Magazine)

- **Study: Nearly A Third Of Doctors Won't See New Medicaid Patients**

  About 69 percent of doctors nationally accept new Medicaid patients, but the rate varies widely across the country, according to a study published Monday in the journal Health Affairs. New Jersey had the nation's lowest rate at 40 percent, while Wyoming had the highest, at 99 percent, according to a survey last year of doctors by the U.S. Centers for Disease Control and Prevention. For years, some states have struggled to attract doctors to treat patients enrolled in the state-federal health insurance program for the poor, largely because of their low pay. New Jersey's reimbursement rate for Medicaid doctors, compared to what Medicare pays, is the lowest in the nation, according to the study. (Kaiser Health News)

- **Feds could outflank GOP governors who refuse to set up new state health insurance exchanges**

  The feds may be gaining on GOP governors who've balked at carrying out a key part of President Barack Obama's health care overhaul law. Opponents of the law say they won't set up new private health insurance markets called exchanges. But increasingly it's looking like Washington will just do it for them. It would happen through something called the federal exchange, humming along largely under wraps on a tight development schedule overseen by the Health and Human Services Department in Washington. (Washington Post)

- **CMS: States Could Adopt Medicaid Expansion, Then Drop It**

  States face no deadline for deciding when and if they will expand Medicaid under the Affordable Care Act (ACA), according to the Centers for Medicare and Medicaid Services (CMS), and states that initially choose to participate could later drop that coverage. Asked about comments made by Cindy Mann, deputy director for CMS, during the National Conference of State Legislatures (NCSL) summit in Chicago Monday, a CMS spokesperson confirmed to *Governing* that states can choose when and if they want to expand Medicaid. The spokesperson also said that a state could initially expand its coverage to the ACA's new standards but then later choose to reduce it, the first public confirmation that CMS will give states that option. (Governing Magazine)

- **Aging baby boomers face home health care challenge**

  Demand for home health care workers is soaring as baby boomers get older and states try to save money by moving people out of more costly nursing homes. But filling more than 1 million new home care positions over the next decade will be a challenge. At the same time, some states, including Ohio, are changing how they coordinate med-

ical care and trying to move some of the most expensive and hard-to-treat patients into home and community-based settings instead of nursing homes. (Business Week)

- **U.S. Officials Brace for Huge Task of Operating Health Exchanges**

  Federal and state officials and health policy experts expect that the federal government will run the exchanges in about half of the 50 states — a huge undertaking, given the diversity of local insurance markets. In running an exchange, federal officials face a delicate political task. They will encourage people to enroll, promoting the exchange as an important part of Mr. Obama's health care overhaul. But they do not want to feed fears of a federal takeover or alienate state officials whose help they need. Much work will be done by contractors. With public opinion deeply divided over the new law, the Obama administration has invited advertising agencies to devise an elaborate "outreach and education campaign" to publicize the federal exchanges and their potential benefits for consumers. In addition, federal officials are looking for private contractors to provide "in-person assistance" to consumers and to operate call centers. A contractor will also help the government decide who gets federal subsidies, expected to average $6,000 a person, and who is exempt from the tax penalties that will be imposed on people who go without insurance. Federal officials have turned to the American subsidiary of a Canadian company, the CGI Group, to provide information technology services to the federal exchanges under a contract that could be worth $93.7 million over five years. (New York Times)

- **Questions Remain About States' Ability to Oversee Managed Long-Term Care**

  An increasing number of states want to expand managed care, which is often used for relatively healthy populations in Medicaid and in employer-sponsored coverage, but until recently had not been widely considered for elderly people and those with disabilities who need long term care. At least 10 states are proposing to implement new managed long term care programs by January 2014, according to Mathematica Policy Research Senior Researcher Debra Lipson, who spoke at the forum. The AARP Public Policy Institute and Mathematica Policy Research released a report (link to AARP report) Friday with the seniors' group AARP that described managed care services in eight states. The report found mixed results in its examination of managed long-term care in Arizona, Massachusetts, Minnesota, New Mexico, New York, Tennessee, Texas, and Wisconsin. The report outlined normal practices, promising practices and policies that raised caution flags in the states they observed. They cited as one promising practice the use of so-called mystery shoppers in Tennessee and Texas to verify that physician offices are accepting new Medicaid patients. Another example was coverage in New Mexico of telehealth services in rural areas where there enough medical professionals may not be available. (CQ Healthbeat)

- **Senators Want to Halt Medicaid Reimbursements to Providers Who Owe Taxes**

  Senators called for additional steps to stop health providers from collecting Medicaid reimbursements while they owe federal taxes, citing a report that found that providers who owed $791 million in taxes received $6.6 billion in Medicaid payments. Currently, health care providers who owe federal taxes are not prohibited from participating in the Medicaid program. Five senators requested a report from the Government Ac-

countability Office (GAO) as part of efforts to track funds from the 2009 economic stimulus measure (PL 111-5), which boosted the federal share of Medicaid funding. The GAO found that 7,000 providers in Texas, New York and Florida owed at least $791 million in taxes while being paid $6.6 billion from the Medicaid program. The IRS agreed with the GAO's recommendation to explore "further opportunities to enhance collections of unpaid federal taxes from Medicaid providers." (CQ Healthbeat)

- **Health Care Law's Medicaid Expansion Costs Worry State Officials, GAO Finds**

  State budget directors are concerned about the cost and complexity of the Medicaid expansion included in the health care law, according to a Government Accountability Office report released Wednesday. The GAO, in response to a request from Sen. Charles E. Grassley, R-Iowa, surveyed states on how, by Jan. 1, 2014, they plan to implement the expansion of the joint federal-state Medicaid program to childless adults earning less than 138 percent of the federal poverty level. The budget directors' worries about costs centered on three areas. They said they're concerned about the administrative costs of managing enrollment, the price tag of new information technology and the cost of enrolling people in Medicaid who had been eligible in the past but hadn't applied. GAO report (CQ Healthbeat)

- **Dual-Eligible Demonstrations Push Forward After Court Ruling**

  States that want to begin their demonstrations in 2013 must finalized their plans by Sept. 20, according to an April presentation by the Medicare Payment Advisory Commission (MedPac). About half are expected to do so; the remainder will launch their demonstrations in 2014. To prepare for that deadline, MedPac projected that states would have to submit their initial proposals and seek public comment in the spring, then meet with health-care providers in June to get their input. While overturning the ACA would have invalidated the Duals offices and their funding, the dual-eligible issue would still have needed to be addressed, as spending for Medicaid and Medicare is projected to crescendo in the coming decades. The only option, state officials say, was to push forward despite the lack of assurance about the law's fate. (Governing Magazine)

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 17, 2012	Ohio Duals	Contract awards finalized	122,000
Mid-August, 2012	Illinois Duals	Contract awards	136,000
August 23, 2012	Wisconsin Duals	Proposals due	17,600
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
September, 2012	New Mexico Duals	RFP Released	40,000
October 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October 1, 2012	Florida CHIP	Implementation	225,000
October 29, 2012	South Carolina Duals	RFP Released	68,000
October, 2012	Michigan Duals	RFP Released	198,600
October, 2012	Virginia Duals	RFP Released	65,400
November 1, 2012	Vermont Duals	RFP Released	22,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
November, 2012	Washington Duals	RFP Released	115,000
December, 2012	Arizona - Maricopa Behav.	Proposals due	N/A
December, 2012	New Mexico Duals	Contract awards	40,000
January 1, 2013	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 1, 2013	Vermont Duals	Proposals due	22,000
January, 2013	Arizona - Acute Care	Proposals due	1,100,000
February 28, 2013	Vermont Duals	Contract awards	22,000
February, 2013	Michigan Duals	Proposals due	198,600
February, 2013	Washington Duals	Proposals due	115,000
March 1, 2013	Pennsylvania	Implementation - New East Zone	290,000
March, 2013	Arizona - Maricopa Behav.	Contract awards	N/A
March, 2013	Arizona - Acute Care	Contract awards	1,100,000
March, 2013	Idaho Duals	RFP Released	17,700
March, 2013	Michigan Duals	Contract awards	198,600
April 1, 2013	California Duals	Implementation	500,000
April 1, 2013	Illinois Duals	Implementation	136,000
April 1, 2013	Massachusetts Duals	Implementation	115,000
April 1, 2013	Ohio Duals NE, NW, NC, EC	Implementation	67,000
April 1, 2013	Wisconsin Duals	Implementation	17,600
April-May, 2013	Rhode Island Duals	RFP Released	22,700
May 1, 2013	Ohio Duals C, WC, SW	Implementation	48,000
May-June, 2013	Idaho Duals	Proposals due	17,700
June, 2013	Rhode Island Duals	Contract awards	22,700
July 1, 2013	Michigan Duals	Implementation	198,600
July 30, 2013	South Carolina Duals	Contract awards	68,000
July, 2013	Virginia Duals	Contract awards	65,400
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
October 1, 2013	Florida LTC	Implementation	90,000
October 1, 2013	Arizona - Maricopa Behav.	Implementation	N/A
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico Duals	Contract awards	40,000
January 1, 2014	Hawaii Duals	Implementation	24,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Idaho Duals	Implementation	17,700
January 1, 2014	Washington Duals	Implementation	115,000
January 1, 2014	Virginia Duals	Implementation	65,400
January 1, 2014	Texas Duals	Implementation	214,400
January 1, 2014	Rhode Island Duals	Implementation	22,700
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				4/1/2013
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	4/1/2013
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	10/29/2012		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	Oct. 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	X	8/23/2012		4/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***5***			

** Several states have reported that CMS will not begin any Capitated Duals Demonstrations until at least April 1, 2013*

*** 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

Health Homes for Medicaid Beneficiaries with Chronic Conditions

Mike Nardone, Principal
Alicia Smith, Principal
Eliot Fishman, Principal

This brief profiles four states that were the first to receive federal approval to take up a state option under the Affordable Care Act to implement health homes for Medicaid beneficiaries with chronic conditions. Almost half of the 9 million people who qualify for Medicaid on the basis of disability suffer from mental illness and 45 percent have three or more diagnosed chronic conditions. Health homes provide an important tool for states trying to manage and coordinate care more comprehensively for high-need, high-cost beneficiaries. Many states have demonstrated interest in the health homes option and some have received federal approval for their programs. The states profiled in the brief are Missouri, Rhode Island, New York and Oregon. **(Link to Brief – Kaiser Family Foundation)**

Financing County Medi-Cal Eligibility and Enrollment in California

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

Prepared for the California HealthCare 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. 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 HealthCare 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, ways to alleviate the challenges, and lessons for other hospitals and policymakers. **(Link to Report - The Commonwealth Fund)**

HMA Upcoming Appearances

"Moving Behavioral Health to the Next Milestone"

2012 FADAA/FCCMH Annual Conference

Katharine V. Lyon, PhD – Presenter

August 10, 2012

Orlando, Florida

"Health Reform, Medicaid and Behavioral Health: Significant Issues and an Uncertain Future"

2012 FADAA/FCCMH Annual Conference

Vern K. Smith, PhD – Presenter

August 10, 2012

Orlando, Florida

"Election 2012 Issues: Health Care Policy"

Current Issues Series at Denver University

Joan Henneberry – Panelist

September 24, 2012

Denver, Colorado