HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: WISCONSIN'S VIRTUAL PACE PROGRAM TO SERVE DUALS

HMA ROUNDUP: NEW YORK DETAILS $10B IN HEALTH CARE REINVESTMENTS UNDER WAIVER; ILLINOIS EXCHANGE PROCURING IT VENDOR, RELEASES NAVIGATOR REPORT; COLORADO APPROVES ADDITIONAL EXCHANGE GRANT REQUEST; TEXAS MEETING ON MEDICAID WAIVER IMPLEMENTATION DRAWS HUNDREDS

OTHER HEADLINES: CALIFORNIA BILL WOULD INCLUDE PACE IN DUALS DEMO; KANSAS LOOKS TO ACCELERATE DD ENROLLMENT IN MEDICAID MCO EXPANSION; OHIO TO INCREASE QUALITY MEASURES AS PART OF MEDICAID NURSING HOME PAYMENTS; HHS ISSUES FINAL GUIDANCE TO STATES ON EXCHANGES

RFP CALENDAR: OHIO DUALS PLAN SELECTION MEETING FRIDAY, AUGUST 17

AUGUST 15, 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

ATLANTA, GEORGIA • AUSTIN, TEXAS • BOSTON, MASSACHUSETTS • CHICAGO, ILLINOIS • COLUMBUS, OHIO
DENVER, COLORADO • HARRISBURG, PENNSYLVANIA • INDIANAPOLIS, INDIANA • LANSING, MICHIGAN • NEW YORK, NEW YORK
BAY AREA, CALIFORNIA • SACRAMENTO, CALIFORNIA • SOUTHERN CALIFORNIA • TALLAHASSEE, FLORIDA • WASHINGTON, DC

Contents

In Focus: Wisconsin's Virtual PACE Program to Serve Duals	**2**
HMA Medicaid Roundup	**6**
Other Headlines	**9**
Company News	**16**
RFP Calendar	**17**
Dual Integration Proposal Status	**18**
HMA Recently Published Research	**19**
HMA Upcoming Appearances	**20**

Edited by:
Gregory Nersessian, CFA
212.575.5929
gnersessian@healthmanagement.com

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

Health Management Associates (HMA) is an independent health care research and consulting firm. HMA operates a client service team, HMA Investment Services, that is principally focused on providing generalized information, analysis, and business consultation services to investment professionals. Neither HMA nor HMA Investment Services is a registered broker-dealer or investment adviser firm. HMA and HMA Investment Services do not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients, including clients of HMA Investment Services.

IN FOCUS: WISCONSIN'S VIRTUAL PACE PROGRAM TO SERVE DUALS

This week, our *In Focus* section reviews Wisconsin's dual eligible integration plan, known as Virtual PACE. On July 27, 2012, Wisconsin's Department of Health Services (DHS) released the application for Integrated Care Organizations (ICOs) interested in serving the dual eligible nursing home population. The Virtual PACE program is not a traditional Programs of All-Inclusive Care for the Elderly (PACE) program, but shares many of the same goals of integrated care across Medicaid and Medicare for elderly and disabled individuals.

Initial applications are due on Thursday, August 23, 2012, at 5:00 PM.

Eligible Population

The Virtual PACE program will serve a much smaller population than originally envisioned in the dual integration program design, primarily due to the exclusion of Medicaid managed care enrollees in Wisconsin's Family Care program. Virtual PACE enrollment eligibility is limited to individuals who are:

- Ages 18 and over
- Full dual eligible
- Receiving fee-for-service (FFS) Medicare and Medicaid benefits, and
- A resident of a participating skilled nursing facility

This primary population will be passively enrolled into a selected ICO in their region. However, there will be voluntary enrollment for individuals enrolled in Medicaid FFS and a Medicare managed care plan, provided they otherwise meet the eligibility criteria above.

Medicaid and Medicare FFS Average Monthly Enrollment	#	%
Elderly	12,740	74%
Disabled	1,318	8%
Disabled/Elderly	2,110	12%
Other	1,000	6%
Total	**17,168**	

Source: http://www.dhs.wisconsin.gov/wipartnership/pace/pdf/changemembmonths072012.pdf

There are roughly 17,000 eligible duals statewide, however, DHS may only roll out ICOs in selected pilot counties or regions, at least initially. As such, the enrolled population could be significantly smaller. This does not include an additional 547 eligible duals in Medicare managed care plans who may elect to enroll voluntarily.

The eligible passive enrollment population (FFS) accounted for more than $950 million in combined Medicare-Medicaid spending in 2010, with the voluntary enrollment population adding another $25 million in combined spending.

Region	FFS/MCO	Avg. Enrollment	Medicaid PMPM	Medicare PMPM	Total PMPM	Total Spending
Northern	FFS	2,215	$3,544	$967	$4,511	$119,891,748
	MCO	*43*	*$2,776*	*$285*	*$3,060*	*$1,564,415*
Southern	FFS	3,040	$3,634	$926	$4,560	$166,333,112
	MCO	*121*	*$3,506*	*$1,128*	*$4,633*	*$6,743,926*
Western	FFS	3,074	$3,601	$890	$4,492	$165,662,397
	MCO	*51*	*$2,816*	*$844*	*$3,660*	*$2,250,851*
Northeastern	FFS	4,638	$3,706	$773	$4,479	$249,292,686
	MCO	*124*	*$3,198*	*$179*	*$3,376*	*$5,019,690*
Southeastern	FFS	4,202	$3,763	$1,200	$4,962	$250,220,754
	MCO	*208*	*$3,481*	*$276*	*$3,758*	*$9,369,777*
Total Passive	FFS	17,168	$3,668	$950	$4,618	$951,400,695
Total Voluntary	*MCO*	*547*	*$3,305*	*$497*	*$3,802*	*$24,948,658*
Total		**17,715**	**$3,656**	**$936**	**$4,593**	**$976,349,353**

Source: State data, CY 2010

While the historical per member per month (PMPM) spending data above suggests PMPM rates for the FFS population of more than $4,600, actual capitation rates paid to Virtual PACE applicants will likely be lower. From the ICO application:

> *"Virtual PACE rates will include savings assumptions that yield up-front savings to each of CMS and DHS. Preliminary work at DHS and with DHS' contracted actuaries attempts to estimate the feasible savings, or range of savings, in each service area. Savings are expected primarily from reduced utilization due to improved care management and aligned financial incentives. DHS envisions that estimating savings assumptions to be applied to rates will also include estimates of any new care management and administrative costs, which will offset a portion of the savings from reduced service utilization. This series of estimates will result in a net savings estimate, a portion of which will be taken from the rate as up-front savings. It is vital that state input be incorporated into these savings estimates, and that all of the assumptions described above are clearly documented so that the process is transparent for all stakeholders."*

ICO Application Process

DHS plans to certify and contract with ICOs rather than procure ICOs under a standard RFP process. In a question an answer document released August 15, DHS clarified how ICOS are to specify their proposed service area. ICOs are to indicate the full service area in which they would seek certification. The state has been divided into five service areas, but applicants can propose to serve a subset of counties within a service area. This response should also include the applicant's proposed timeline for expansion throughout their proposed service area. Applicants should indicate the extent to which their proposed service area and timeline can be altered if the pilot area and expansion timeline negotiated between DHS and CMS in the MOU vary from the original DHS proposal.

DHS will approve ICO implementation in three phases:

> **Phase One – Initial Application:** Entities interested in becoming ICOs must complete this application. DHS will review the ICO's plans for the Virtual PACE program and grant approval to proceed to subsequent phases.

Phase Two – Documentation of ICO Capacity: Following approval of initial applications and prior to signing three-way contracts, ICOs will be asked to provide additional documentation of their capacity to operate the Virtual PACE program. DHS and CMS may agree on additional requirements for ICOs in their MOU negotiations.

Phase Three – Readiness Reviews: DHS and CMS will jointly conduct readiness reviews to verify that ICOs are prepared to implement the program and begin serving enrollees. If an ICO fails readiness review, no members will be enrolled in the ICO; either passive enrollment will be cancelled and the members will remain in their existing FFS systems, or enrollments will be shifted to another ICO if there are multiple ICOs in the region.

Wisconsin Family Care / PACE / SSI Medicaid

Wisconsin's Family Care program serves adults and the elderly with long-term care needs in 57 of Wisconsin's 72 counties. The MCOs operating in the Family Care program are all local plans, many of them not-for-profit. Family Care enrolls more than 34,000 long-term care lives, though data on the number of dual eligible Family Care enrollees is unavailable. As noted above, Family Care duals were initially slated to be included in the Virtual PACE program, but were excluded based on recommendations from an advisory committee and stakeholder input.

Family Care	June 2012 Enrollment	% Total
Milwaukee County Department of Family Care	7,783	23%
Community Care Family Care	7,674	22%
Western Wisconsin Cares	3,870	11%
Care Wisconsin	3,513	10%
Community Care of Central Wisconsin	3,276	10%
Lakeland Care District	2,723	8%
NorthernBridges	2,063	6%
Southwest Family Care Alliance	2,014	6%
Community Health Partnership	1,203	4%
Total Family Care	**34,119**	

Source: State Enrollment Date, June 2012

Also excluded from the Virtual PACE population are nearly 4,800 Family Care Partnership and standard PACE enrollees.

Family Care Partnership and PACE	June 2012 Enrollment	% Total
Partnership Health Plan, Inc	1,548	33%
Care Wisconsin Health Plan	1,285	27%
Community Care Health Plan – PACE	824	17%
Community Care Health Plan - Partnership	578	12%
Independent Care (ICARE)	524	11%
Total Family Care Partnership and PACE	**4,759**	

Source: State Enrollment Date, June 2012

The Virtual PACE program excludes Supplemental Security Income (SSI) Medicaid recipients enrolled in a managed care plan under Wisconsin's broader Medicaid managed care program. United Healthcare is the largest plan serving the SSI Medicaid population. Centene, Molina, and WellPoint also enroll some of the nearly 34,000 SSI Medicaid beneficiaries.

SSI Medicaid	June 2012 Enrollment	% Total
United Healthcare of Wisconsin	13,432	40%
Independent Care (ICARE)	8,701	26%
Managed Health Services (Centene)	5,703	17%
Network Health Plan	2,573	8%
Group Health COOP Eau Claire	1,738	5%
Molina Healthcare	1,664	5%
CompCare (WellPoint)	156	0%
Total SSI Medicaid	**33,967**	

Source: State Enrollment Date, June 2012

While the populations detailed above are excluded from the Virtual PACE program, these managed care plans have established themselves in the Wisconsin market serving similar populations. This may provide insight into potential applicants, although the nationwide attention on dual eligible integration initiatives is likely to draw interest from plans not currently operating in Wisconsin.

Implementation Timeline

Based on DHS' proposal to CMS, Virtual PACE would go live in the Southeastern region on January 1, 2013, with the remaining regions to follow in 2014 and 2015. However, we have continually heard from states that CMS is not beginning any dual eligible integration demonstrations prior to April 1, 2013. DHS also received input during the public comment period on their proposal to CMS suggesting that Virtual PACE should be delayed until 2014, but it does not appear that DHS is delaying to 2014 at this time. The Southeastern implementation date has not been revised by DHS.

Date	Region(s)	2010 Avg. Enrollees	2010 Annual Spending
April 1, 2013*	Southeastern	4,410	$259,590,530
January 1, 2014	South, Northeastern	7,923	$427,389,413
January 1, 2015	Northern, Western	5,382	$289,369,411

**Based on CMS comments to other states on duals demonstration start dates*

Links

Virtual PACE home page (updated August 15, 2012):
http://www.dhs.wisconsin.gov/wipartnership/pace/index.htm

Virtual PACE ICO Application (Word):
http://www.dhs.wisconsin.gov/wipartnership/pace/pdf/ipoapplication.doc

HMA Medicaid Roundup

Colorado

HMA Roundup – Joan Henneberry

The legislative review committee, established in 2011 as part of the Colorado Health Benefit Exchange enabling legislation, approved the submission of a second Level One grant for Colorado that will allow the exchange staff to move forward in planning and operations. The $43 million grant will be submitted by the August 15, 2012 deadline to CMS for a new round of funding allowing the exchange to hire additional staff and continue building out the IT and customer service functions. The committee members asked several questions about the financial sustainability plan for the exchange beyond 2014, and several expressed concern about moving forward when key decisions have yet to be made. Board chair Gretchen Hammer stated that the board of the exchange had begun discussing long term financing but that a full financial model has not been created. "It is important to note this in no way changes my fundamental objection to Obamacare itself," Republican Rep. Bob Gardner of Colorado Springs said in a statement issued after the approval.

In the news

- **Colorado Pursues Insurance Exchange—But Keeps Fighting About It**

  A special legislative committee gave Colorado the green light on Thursday to continue working on its health insurance exchange by allowing it to apply for a $43 million federal grant. But first the lawmakers had to fight about it. The latest skirmish follows the most controversial and contentious fight of the 2011 Colorado legislative session, which was about the so-called exchange bill. The bill said Colorado should move forward with creating an Internet marketplace where people could choose health coverage plans once such insurance is mandated by the federal health care law. Republican Amy Stephens, the former House majority leader, corralled enough Republican votes for the bill to pass the General Assembly by arguing that Colorado needed to set up its own exchange, because if it didn't, the federal government would set one up for the state. (Kaiser Health News)

Georgia

HMA Roundup – Mark Trail

Jerry Dubberly, Chief of the Medicaid Division, announced at the DCH Board meeting last Thursday, August 9 that they will work to extend the current Care Management Organization (CMO) contracts for up to two years (through June 30, 2016). This confirms what was reported by WellCare on its quarterly earnings call the previous week. He also said they would use the extension with the incumbent CMOs to negotiate the changes that DCH wants to implement, including value-based purchasing, credentialing collaborative, PCMH, and foster care.

In the news

- **Medicaid: Flood of funds awaits OK in Georgia**

  Gov. Nathan Deal is facing a $40 billion dilemma. The federal health care law would inject that gigantic sum into Georgia's health care economy over 10 years by adding more than 650,000 low-income Georgians to the Medicaid program. Deal, a strong opponent of the law, is wary of the proposition. The state projects that Georgia's share of the law's $40 billion cost for a fully expanded Medicaid program would reach $4.5 billion over a decade, a sum the governor fears would break a state budget already stretched by health costs. From a political perspective, Deal could safely turn down the expansion since the law is wildly unpopular among Republicans. In fact, Republican governors in at least five states have already announced they will do just that. (Atlanta Journal Constitution)

Illinois

HMA Roundup – Matt Powers & Jane Longo

At the July 20, 2012 Medicaid Advisory Committee (MAC) meeting, Department of Healthcare and Family Services (HFS) officials indicated that Illinois would announce awards in the dual eligibles integration RFP during the first half of August. There is no indication that HFS is considering delays or postponement to implementation, and we expect awards to be announced in the next few weeks.

The Department of Insurance posted questions and answers pertaining to the Health Insurance Exchange IT RFP this week. The due date for responses has been extended from August 30, 2012 to September 6, 2012. The Q&A also clarifies that, at this time, the Illinois Exchange will be a Federal-State Partnership in 2014, working towards a State Exchange in 2015. In other Exchange news, HFS presented a report on the design of the Health Insurance Exchange's Navigator program at the MAC's Public Education subcommittee meeting on August 9. State Exchanges are required to institute grant programs to fund Navigators who would perform outreach functions that support consumers in accessing the expanded subsidized health insurance coverage programs and reformed and re-organized insurance markets that will result from the Patient Protection and Affordable Care Act (ACA). The report, prepared for the Illinois DOI by Health Management Associates, is available here.

The legislature is due back in session on August 17, 2012. They are not expected to move any legislation related to the Exchange.

New York

HMA Roundup – Denise Soffel

New York State submitted its request for an amendment to its 1115 waiver, the Partnership Plan, on August 6, 2012. Many of the details of the amendment were already known, as the state had held several webinars presenting details of the amendment, and had circulated a draft for public comment prior to submission. As previously indicated, the amendment requests $10 billion in federal funds for reinvestment in New York's delivery system, to enact proposals identified by the state's Medicaid Redesign Team, and to

achieve CMS's "Triple Aim" of improving quality, improving health, and reducing per capita cost. The proposal includes thirteen areas for consideration, including $500 million in funding to evaluate the effectiveness of the MRT initiatives and waiver activities. The table below indicates the areas for funding, and the amount of funding over the five years of the waiver request.

Many of the elements of the waiver call for a competitive solicitation, requiring providers and other organizations to develop innovative strategies for the transformation of the delivery system. A considerable amount of funding is targeted to safety net institutions and initiatives, recognizing the number of financially fragile hospitals and their significance in providing care to the Medicaid population and the uninsured.

A number of the proposed initiatives are likely to be met with skepticism by CMS, particularly the proposed investment in supportive housing. While the federal government is willing to fund supports and services provided at home and in the community, particularly through the Home and Community Based Services waiver program, they have been reluctant to define housing as a Medicaid benefit.

Federal Funds Uses ($ Millions)	2013	2014	2015	2016	2017	5 Year Total
Total	**$1,663**	**$2,057**	**$2,195**	**$2,148**	**$1,937**	**$10,000**
Primary Care Expansion	$330	$295	$235	$215	$175	$1,250
Health Home Development Fund	$150	$150	$113	$75	$38	$525
New Care Models	$23	$75	$93	$75	$110	$375
Expand the Vital Access Provider Program and Safety Net Provider Program	$100	$150	$200	$300	$250	$1,000
Public Hospital Innovation	$240	$200	$300	$360	$400	$1,500
Medicaid Supportive Housing Expansion	$150	$150	$150	$150	$150	$750
LTC Transformation & Integration to Managed Care	$191	$226	$159	$134	$129	$839
Capital Stabilization for Safety Net Hospitals	$296	$350	$390	$355	$330	$1,721
Hospital Transition	$65	$120	$170	$110	$55	$520
Ensuring the Health Workforce Meets the Needs in the New Era of Health Care Reform	$0	$125	$125	$125	$125	$500
Public Health Innovation	$63	$75	$87	$85	$86	$395
Regional Health Planning	$11	$22	$30	$30	$30	$125
MRT and Waiver Evaluation Program	$44	$118	$144	$134	$60	$500

Negotiations with CMS began last week. The state expects negotiations to be concluded by the end of the year, and spending to begin January 2013.

Texas

HMA Roundup – Gary Young

The Texas Health and Human Services Commission (HHSC) hosted a two-day meeting in Austin to provide technical assistance to stakeholders regarding implementation of the Section 1115 Transformation and Quality Improvement demonstration waiver. HHSC also updated participants regarding on-going negotiations with the Centers for Medicare and Medicaid Services (CMS) concerning the structure of provider incentive programs under the waiver. About 300 people attended and another 200 viewed the webinar.

In the news

- **Parkland ousts interim CEO, hires for-profit hospital exec**

  Crisis-plagued Parkland Memorial Hospital is replacing its interim chief executive with a retired vice president from Tenet Healthcare, a large for-profit health care chain that has survived big troubles of its own. Debbie Branson, chairwoman of Parkland's governing board, disclosed the move Tuesday. She and the new interim CEO, Robert (Dallas News)

OTHER HEADLINES

Arizona

- **Brewer advisers form health pact to push to expand Medicaid**

  Two key advisers to Gov. Jan Brewer are attempting to create a coalition of hospitals, insurance plans, providers and other players to push Arizona to expand Medicaid under federal health-care reform. Last week, the board of a statewide group of human-services providers agreed to hire Chuck Coughlin and Peter Burns, and the state's largest hospitals and health plans are considering signing on. The pair would bring political and technical savvy to the complex realm of health care, with the goal of marshaling a united front of heavy-hitting businesses to push Medicaid expansion through the Legislature next session. Brewer, whose spokesman was unable to say whether the governor was aware of Coughlin and Burns' coalition efforts, has been a vocal opponent of the federal health-care law, and she led efforts to cut state Medicaid programs in prior years. But she has recently indicated a willingness to consider expansion. (AZ Central)

California

- **Will Basic Health Program Hurt, Help Exchange?**

  The nascent Basic Health Program, if passed by the Legislature, would target a large percentage of possible exchange participants. So the question lawmakers have been wrestling with is: Would that be a good or a bad thing for the exchange, and for Californians? That's the question tackled by the exchange itself. On Monday, it released an independent analysis by the UC-Berkeley Labor Center and the UCLA Center for Health Policy Research, which was commissioned by the exchange board. The analysis made four main points: (1) The BHP would siphon between 720,000 and 950,000 partic-

ipants from the exchange, which could limit the exchange's bargaining power. (2) BHP would not affect the risk mix in the exchange. (3) The number of Californians with health coverage would rise under the BHP, with a bump in covered individuals reaching between 60,000 and 120,000 Californians, in a base scenario. (4) The analysis assumes BHP premium costs for individuals would be set at $20 per person per month. (California Healthline)

- **Including PACE in Dual Eligible Options**

  Legislators are about to weigh in on one detail of the state's dual-eligible pilot program known as the Coordinated Care Initiative: An Assembly bill calling for the inclusion of a popular program for Californians at-risk of nursing home care is up for a vote on the Senate floor. AB 2206 by Toni Atkins (D-San Diego) would require the Department of Health Care Services to include PACE -- the Program of All-Inclusive Care For The Elderly -- as one of the alternatives to Medi-Cal managed care in the eight counties where the CCI pilot is starting. The bill cleared its last committee obstacle, the Senate Committee on Appropriations on Monday, on a 7-0 vote. It has now been introduced on the Senate floor and a floor vote on it is expected soon. The idea, Atkins said, is to make sure beneficiaries know about PACE and the program option is included in all CCI mailings, informational seminars and training. (California Healthline)

- **Lawmakers seek audit of mental health initiative**

  Two lawmakers on Wednesday requested a detailed audit to determine whether the state has spent mental health funding from a 2004 ballot initiative the way voters intended. The request came in response to an investigation by The Associated Press last month that found tens of millions of dollars raised under Proposition 63 have gone to programs designed to help those who have not been diagnosed with any mental illness. Those programs include yoga, gardening, art classes and horseback riding. (Sacramento Bee)

Connecticut

- **Health care advocates remain wary of LIA changes, even as DSS scales back restrictions**

  After advocates for mentally ill and disabled residents warned that a new plan to limit the number of people receiving state Medicaid benefits would hurt that population in particular, the state has somewhat modified its plan. The first draft of the application would have made adults ages 19-26 who live with their parents ineligible, provided that their income and their parents' income exceeded 55 percent of the federal poverty level. Advocates said that would effectively remove virtually all recipients in that age category still living with their parents. But the department is revising the application it will submit later this month. It no longer will count any parental income unless it's more than 185 percent of the federal poverty level. Any portion above that would be added to the young adult's earnings to see if the sum exceeds 55 percent of the poverty level. (Connecticut Mirror)

Florida

- **Preliminary figures show nixing Medicaid expansion would cost Fla. billions to save millions**

  Florida would save mere nickels, dimes or pennies for every federal dollar it passes up should the state heed Gov. Rick Scott's call to reject Medicaid expansion under the national health care overhaul, preliminary figures show. State economists met Tuesday to review the numbers developed by the Agency for Health Care Administration, which oversees the joint state-federal program. The figures show Florida would pass up $2.1 billion in federal money while saving just $3.9 million in the next budget year if everyone eligible for the expanded program participated. The state's share would increase over time, but even by the 2020-21 budget year Florida would pay just $487 million compared to the federal government's $4.2 billion contribution. (The Republic)

Kansas

- **Changes underway for determining in-home Medicaid services**

  State officials are changing the way they determine which in-home Medicaid services are provided to the frail elderly and people who are physically disabled. The new system will rely on a single agency or organization with a presence in each of the state's 105 counties to assess what services a person will receive. Currently, there are more than 30 organizations involved with the process. Some assess only the elderly. Others focus solely on the physically disabled. State officials said their aim is to create a "one-stop shop," so that services will be determined in the same place regardless of a person's condition. (Kansas Health Institute)

- **KanCare: Ready Or Not?**

  Less than five months from now, the Kansas Medicaid program is scheduled to convert to a privatized system called KanCare. In January, three for-profit, managed-care organizations will take over the federal/state program that pays for health care for low-income children, seniors and people with disabilities. State officials have been conducting meetings across the state to help people prepare for the change. (Kansas Health Institute)

- **Pilot project would speed DD program exposure to KanCare**

  The Kansas Department for Aging and Disability Services has begun the process for putting together a pilot project aimed at letting programs for the developmentally disabled contract with the KanCare managed care companies next year instead of waiting until 2014. Earlier this week, the agency issued a formal 'request for information' on how the project might work. Suggestions or proposals are due Aug. 28. Agency officials also have convened a 13-member advisory group to help design the pilot project. Earlier this year, lawmakers agreed to exclude non-medical services for the developmentally disabled from KanCare after families and advocacy groups protested their inclusion. Both groups cited concerns that services would be cut to ensure the managed care companies' profits. (Kansas Health Institute)

Maryland

- **Ready, or Not, for Obamacare**

  One of the first to pass a law establishing an exchange, back in April 2011, Maryland moved swiftly to begin building a $51 million computer system that citizens will use to shop for insurance online as they do for airline tickets on Expedia (EXPE). "We want to be the model," says Lieutenant Governor Anthony Brown, who oversees the state's health-care reform efforts. Yet even with its early lead, Maryland faces big challenges as it tries to assemble all the pieces of the massive law. That computer system the state's building? It will have to connect seamlessly with both Maryland's Medicaid system and the federal government's computers. No easy task, given the government's less-than-inspiring history of information sharing—and made harder because the law requires states to start enrolling residents by October 2013. (Bloomberg Business Week)

Massachusetts

- **Health law benefits some Mass. hospitals, penalizes others**

  Steward Health Care System, which includes struggling Carney Hospital, will not qualify for millions of dollars in special payments under the new Massachusetts health care law, because legislators said they did not want to subsidize a for-profit company. The provision is one of several buried in the 350-page bill that penalize or benefit certain hospitals. The cost-control law also targets three Harvard--affiliated hospital systems — Partners HealthCare, Boston Children's Hospital, and Beth Israel Deaconess Medical Center — to pay a one-time $60 million tax to fund health programs. Legislators rewarded three small hospitals considered too isolated or too specialized to fail: Athol Memorial, Fairview in Great Barrington, and Franciscan Hospital for Children in Boston will get boosts in Medicaid payments. In order to receive a share of $155 million set aside mostly to help community hospitals invest in technology, control costs, and better coordinate patient care, providers will have to make their case to a commission being set up to oversee the law's implementation. (Boston Globe)

Minnesota

- **3,100 Minnesotans lose state health insurance after an audit**

  About 3,100 Minnesotans have lost state-provided health insurance after a special audit of public employees and their dependents, but hundreds may have been cut off simply because they failed to submit required paperwork. The audit, conducted by the Minnesota Management and Budget agency, was designed to save the state money by weeding out relatives ineligible for state coverage. But up to half may have lost insurance because they missed the deadline or submitted incomplete or improper documentation. In some cases, a termination letter was the first notice families had of the audit, said Eliot Seide, executive director of AFSCME Council 5, a large union representing state employees. The union is filing a class-action grievance on behalf of 12 state workers who say their dependents are eligible but lost their insurance due to technicalities. (Minneapolis Star Tribune)

- **New Medicaid payment method will save money, MN officials say**

Minnesota is the first state in the nation to receive federal approval for a new way of paying for health care in its Medicaid program. Minnesota will pay some hospitals and clinics based on how well their patients do medically and their ability to cut costs. Right now Medicaid pays HMOs to provide coverage or pays medical clinics directly by the procedure or test. Experts say that "fee-for-service" approach does nothing to rein in costs. But under the "shared savings" program, the state will contract directly with clinics. Minnesota Human Services Commissioner Lucinda Jesson said if those clinics meet quality standards, patients get healthier, and cut costs, they'll be able to share any cost savings with the state. (Minnesota Public Radio)

North Carolina

- **Lawmakers Grill State and Local Officials Over Western Highlands Losses**

State legislators grilled leaders of the Department of Health and Human Services, as well as the interim head of Western Highlands Network, at a legislative oversight hearing at the capitol Tuesday. The discussion was held in response to WHN's recent revelation that the mental health agency had come up $3 million short in the six months since converting to a managed care organization in January. Legislators also learned that consultants had warned DHHS officials last fall of problems at WHN as the organization prepared for making the transition, but state health leaders allowed the changes to go forward anyway. But some at the meeting defended the agency, which was only the second mental health local management entity (LME) to make the switch from being providers of care to managing what is essentially a small insurance company. (North Carolina Health News)

Ohio

- **Ohio Medicaid Program Raises Stakes For Nursing Homes**

Under Ohio's new approach, almost 10 percent of the Medicaid payments to nursing homes will depend on factors including residents' satisfaction, rates of medical complications and the number of nurses on staff. Seven other states have programs of this sort, but Ohio's will be the largest. (Medicaid, a federal-state health program for low-income people, is the largest funder of nursing home services in the nation.) Meanwhile, Medicare, the federal health plan for seniors, plans to roll out a similar program for nursing homes nationally over the next several years, after government officials evaluate results of a three-year demonstration project in Arizona, New York and Wisconsin that ended July 1. (Medicare pays for short nursing home stays for some patients who need skilled care after a hospitalization.) (Kaiser Health News)

- **Trial begins over how state awarded Medicaid contracts**

With billions in state Medicaid work at stake, dozens of attorneys filled a Franklin County courtroom yesterday to duke it out over how Ohio awarded contracts to health-care plans vying for the work. Common Pleas Judge Richard S. Sheward, after a trial expected to last through the week, will decide whether the five final winners will keep their contracts or the outcome will change. Sheward put the contracts on hold in June at the request of Aetna Better Health Inc. of New Albany. The company was

among the initial list of five winners in April, but was one of the two health plans later stripped of a preliminary contract after the state agreed to rescore bid submissions. In a lawsuit filed against the Ohio Department of Job and Family Services, attorneys for Aetna said that the state violated procurement laws by changing contract criteria after receiving protests from two unsuccessful bidders. But state attorneys said Aetna lost its preliminary contract after it was discovered that the company had incorrectly stated that it assumed full risk for business in several other states, allowing Aetna to receive a higher score for its bid than it should have. Sheward also allowed the companies awarded contracts to join the case to protect their interests, which could be affected by the decision. (Columbus Post Dispatch)

Oregon

- **In Oregon, health reform is welcome**

American Public Media's Marketplace looks at Oregon's Care Coordination Organization (CCO) implementation, including interviews with key state officials and CCO management. (Marketplace)

Washington

- **Porter out, Lindeblad in at state Health Care Authority**

Doug Porter is leaving the state Health Care Authority to take a job in the private sector, and Gov. Chris Gregoire today named MaryAnne Lindeblad to replace him at the helm of the agency with the second-largest budget in state government. Porter leaves Aug. 17. He said in a letter to staff that a health care consulting firm is in the "final stages" of hiring him. Lindeblad is an administrator at the Department of Social and Health Services, where she leads the Aging and Disability Services Administration, overseeing aid to the elderly, developmentally disabled and mentally ill, including Western State Hospital, whose top job is also about to be vacant. (The Olympian)

National

- **HHS Outlines Final Guidance for State Health Insurance Exchanges**

The U.S. Department of Health and Human Services (HHS) has finalized its guidelines for states to develop their health insurance exchanges created under the Affordable Care Act (ACA) and set a Nov. 16 deadline for states to submit their plans. As previously detailed, HHS is giving states three options: establishing a state-run exchange; participating in a partnership exchange (in which states would oversee plan management and/or customer service); or having a federal-run exchange. States must submit two components in their application: a declaration letter (stating which exchange model a state plans to pursue) and then a complete exchange blueprint (due Nov. 16). Tuesday's guidance explained that states that submit a declaration letter more than 20 days before the November deadline can request a consultation with HHS to obtain further federal guidance on their exchange blueprint application. HHS also outlined for the first time how states could transition from one exchange model to another in later years, an option that the department had previously indicated states could pursue. States wishing to alter their exchange model in 2015 would be asked to submit an ex-

change blueprint by Nov. 18, 2013; for 2016, applications would be due Nov. 18, 2014. (Governing Magazine)

- **Medicaid: Block grants preferred by some states**

  While five Republican governors have flatly refused to expand Medicaid under the Affordable Care Act, another five have said there's one way the expansion could work. Those governors want "block grants," which limit the amount of federal dollars states get to one lump sum but have fewer rules on how it must be spent. Officials are then free to figure out what works best in their states. Under the current system, federal funding is open ended — increasing if enrollment or health care costs go up — but comes with a lot more instructions. (Atlanta Journal Constitution)

- **Hash, Mann, Offer Guidance on CMS Coverage Expansion Efforts Under Health Care Law**

  State officials will have to plunge deep into the weeds to find the path to create their own insurance exchanges and to expand Medicaid under the health care law. On Tuesday, the two federal health officials best suited to guiding them appeared publicly and answered numerous questions about how to proceed. Michael Hash, who heads Health and Human Services' exchange effort, provided a new layer of detail about the federal effort to ensure access to the new marketplaces. Cindy Mann, who runs the Medicaid expansion at the Centers for Medicare and Medicaid Services (CMS), outlined factors states should consider in deciding whether and when to expand the health program for the poor. The officials spoke at the first of four regional meetings this month where state and other officials are invited to ask questions about implementing coverage provisions of the health law (PL 111-148, PL 111-152). Tuesday's meeting was held at HHS headquarters in Washington and was also streamed live on the Web. Meetings were held earlier this month in Chicago and Denver and the final one is scheduled for Wednesday in Atlanta. (CQ Healthbeat)

- **Home Health Workers Worry About Reality of Obama's Pay Rule**

  Because of a 38-year-old amendment to the Fair Labor Standards Act, home health aides and personal care aides in many states can be paid less than the federal minimum wage — $7.25 an hour — and not receive overtime pay when they work more than 40 hours in a week. So after years of failed efforts to change the guidelines, President Barack Obama in December announced plans to modify the exemption and extend overtime and minimum wage protections to home-care workers employed by private companies. Nearly 1.8 million workers in 29 states would likely see a pay boost under the proposal, according to government estimates. But after twice extending the public comment period, the U.S. Department of Labor has yet to finalize the rule change, which must be approved by the White House and then published in the National Register before it takes effect. The delay is making labor activists nervous. When the Clinton administration tried to close the exemption in late 2000, incoming President George W. Bush killed the effort. Unless the Obama administration acts soon, labor groups fear that if Republican Mitt Romney wins the White House in November, he would heed industry and GOP calls to scuttle the proposal yet again. (Governing Magazine)

COMPANY NEWS

- **A Giant Hospital Chain Is Blazing a Profit Trail**

During the Great Recession, when many hospitals across the country were nearly brought to their knees by growing numbers of uninsured patients, one hospital system not only survived — it thrived. In fact, profits at the health care industry giant HCA, which controls 163 hospitals from New Hampshire to California, have soared, far outpacing those of most of its competitors. The big winners have been three private equity firms — including Bain Capital, co-founded by Mitt Romney, the Republican presidential candidate — that bought HCA in late 2006. HCA's robust profit growth has raised the value of the firms' holdings to nearly three and a half times their initial investment in the $33 billion deal. The financial performance has been so impressive that HCA has become a model for the industry. Its success inspired 35 buyouts of hospitals or chains of facilities in the last two and a half years by private equity firms eager to repeat that windfall. HCA's emergence as a powerful leader in the hospital industry is all the more remarkable because only a decade ago the company was badly shaken by a wide-ranging Medicare fraud investigation that it eventually settled for more than $1.7 billion. Among the secrets to HCA's success: It figured out how to get more revenue from private insurance companies, patients and Medicare by billing much more aggressively for its services than ever before; it found ways to reduce emergency room overcrowding and expenses; and it experimented with new ways to reduce the cost of its medical staff, a move that sometimes led to conflicts with doctors and nurses over concerns about patient care. (New York Times)

- **N.M. Blue Cross Adds Medicare/Medicaid Unit**

Health Care Service Corp. of Chicago is basing a new business unit at its Blue Cross and Blue Shield of New Mexico subsidiary in Albuquerque to help grow the Medicare and Medicaid business in the four states where HCSC operates. The new government programs unit will hire about 30 people by the end of the year for health coordinator, consumer advocate, case management and medical director positions, BCBSNM Chief of Staff Janice Torrez said Friday. Blue Cross and Blue Shield is planning to hold a job fair to find staff for the unit in a few weeks. Torrez said HCSC decided New Mexico offered the talent, the office space and the technical infrastructure the unit required. The new unit will focus on providing Medicare and Medicaid beneficiaries with care coordination and early intervention, case and condition management, and medical review and utilization management in collaboration with the HCSC Blue Cross and Blue Shield plans in New Mexico, Texas, Oklahoma and Illinois. Tom MacLean, BCBSNM vice president of health care management, will run the operation. (Albuquerque Journal)

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 Medi-Cal and Healthy Families 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

"Election 2012 Issues: Health Care Policy"

Current Issues Series at Denver University

Joan Henneberry – Panelist

September 24, 2012

Denver, Colorado