HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: UPDATES AND TIMELINE FROM HHS ON EXCHANGE DEVELOPMENT

HMA ROUNDUP: OHIO FINALIZES DUAL ELIGIBLE RFA SCORING; FLORIDA RELEASES LIST OF HEALTH PLANS SUBMITTING LETTERS OF INTEREST FOR MANAGED MEDICAL ASSISTANCE PROGRAM; MICHIGAN DEPARTMENT OF COMMUNITY HEALTH DIRECTOR RESIGNS; INDIANA HIP PROGRAM RECEIVES ONE-YEAR EXTENSION; ELIGIBILITY SYSTEM REDESIGNS VENDORS SELECTED IN TEXAS, INDIANA

OTHER HEADLINES: AETNA ANNOUNCES INTENT TO ACQUIRE COVENTRY (HMA SERVED AS AN ADVISOR TO AETNA ON THE TRANSACTION); KINDRED HEALTHCARE SIGNS DEFINITIVE AGREEMENT TO ACQUIRE INTEGRACARE; UNITEDHEALTH TERMINATES SE WISCONSIN MEDICAID CONTRACT

RFP CALENDAR: NEW MEXICO CANCELS DUALS INTEGRATION PLANS

HMA WELCOMES: DOUG PORTER - WASHINGTON

AUGUST 22, 2012

Research and Consulting in the Fields of Health and Human Services Policy, Health Economics and Finance, Program Evaluation, Data Analysis, and Health System Restructuring

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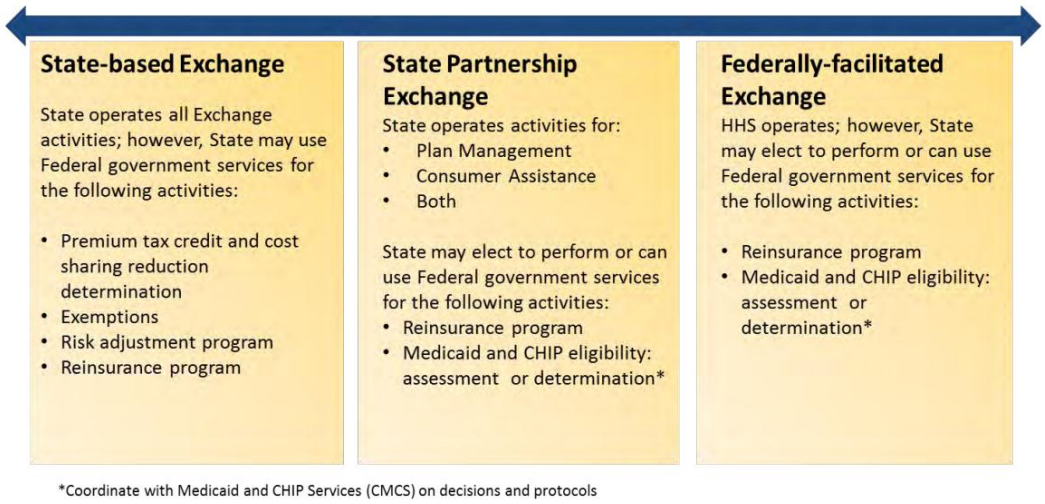
IN FOCUS: UPDATES AND TIMELINE FROM HHS ON EXCHANGE DEVELOPMENT

This week, our *In Focus* section provides an update on Exchange timelines from the Health and Human Services (HHS) Affordable Care Act (ACA) Regional Implementation Forum. HHS held two public forums last week, August 14, in Washington, DC, and August 15, in Atlanta, Georgia. An additional two forums were held this week, August 21, in Chicago, Illinois, and August 22, in Denver, Colorado. The first forum, on August 14, coincided with the release of the Blueprint for approval of state-based exchanges (SBEs) and state partnership exchanges. As a reminder, HHS provided states with three options on the structure of their Exchange, beginning January 2014:



Source: HHS Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges.

The Blueprint consists of a state's declaration of whether it will pursue a SBE, Partnership, or Federally-Facilitated Exchange (FFE). Additionally, the Blueprint includes an Exchange application that will allow HHS to determine readiness to implement a SBE or Partnership Exchange. Blueprint applications are due to HHS on November 16, 2012. Below, we have assembled a timeline based on milestones discussed and dates provided at the Chicago Regional ACA Implementation Forum. Additionally, where possible, we have indicated the responsible party for a given milestone—HHS, states, or potential Exchange health plans. Items in bold are discussed in further detail below the document.

Exchange Implementation Timeline

Date	Milestone	State/HHS/Plans
August 14, 2012	HHS Released Blueprint for State-Based Exchanges (SBEs) and State Partnership Exchanges	HHS
End of August 2012	**HHS provides Essential Health Benefits (EHB) info to states**	**HHS**
Early September 2012	Regional conference calls on consumer experience in Exchange	HHS
September 2012	HHS to release Actuarial Value (AV) "Calculator"	HHS

Date	Milestone	State/HHS/Plans
End of September 2012	**States notify HHS of EHB Benchmark plan**	**State**
Fall-Winter 2012	Public comment period on EHB Benchmark plan proposals	State
October 19, 2012	**Deadline for states to submit Declaration Letter and Exchange Application consulting with HHS**	**State**
November 16, 2012	**Deadline for states to submit Blueprint to HHS**	**State**
Early 2013	Issuers submit notice of intent (NOI) to operate as Exchange plan	Plans
October 1, 2013	Open enrollment period begins	
November 18, 2013	Blueprint deadline for states wishing to transition to SBE or Partnership Exchange effective January 1, 2015	State
January 1, 2014	Exchange enrollments go live	
November 18, 2014	Blueprint deadline for states wishing to transition to SBE or Partnership Exchange effective January 1, 2016	State

Exchange Blueprint – Due November 16, 2012

States seeking to operate a State-based Exchange or participate in a State Partnership Exchange must first indicate in a Declaration Letter, which model they intend to pursue. The letter is followed by the Exchange Application, detailed in the Blueprint document posted on August 14, 2012 (available here). So far, HHS reports that one state has already submitted its Exchange Blueprint.

States must complete the Exchange Blueprint no later than 30 business days prior to the required approval date of January 1. If a State's Declaration Letter is received more than 20 business days prior to the submission of its Blueprint (deadline of October 19, 2012), the state may request an Exchange Application consultation with CMS regarding preparation of its application for approval as a State-based Exchange or State Partnership Exchange. HHS recommends Exchange Application consulting for states considering operating a State-based Exchange or a Plan Management Partnership.

States that do not submit a Declaration Letter or a complete Exchange Blueprint will automatically be designated as a FFE state.

Essential Health Benefits – Benchmark Proposal due end of September 2012

Last December, HHS outlined the ten categories of Essential Health Benefits package that Exchange plans would be required to provide:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral

6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

The Essential Health Benefits outlined by HHS must be minimally met by the state's selected Benchmark plan. The Benchmark plan established in each state will serve as the criteria that a qualified health plan (QHP) must meet to participate in the Exchange. HHS has provided the following options for a state to select from in determining the Benchmark plan:

- One of the state's three largest small-group plans
- One of the state's three largest state employee plans
- One of the state's three largest federal employee plans
- The largest HMO in the state's commercial market

Size of plan is determined by enrollment as of March 31, 2012. In a state where state-mandated benefits are in place, and to the extent that those mandated benefits are in excess of the Essential Health Benefits package, financial responsibility for those benefits will fall to the states in an Exchange. By the end of the month, HHS will provide further information to states on the Benchmark plan determination process. States will then notify HHS by the end of September of their proposed Benchmark plan. A public comment period will follow through Fall and Winter 2012. Benchmark plans will be in place for plan years 2014 and 2015.

Status of Exchanges and Continued Updates from HHS

As of August 1, 2012, sixteen states have indicated they will operate a SBE, three states have indicated they will pursue a Partnership Exchange, and seven states have decided they will not operate an Exchange and will thus be FFE states. The remaining 24 states will have to decide by November 16, 2012. After the Exchange Applications and Benchmark plan selections have passed, it is likely HHS will turn to focus on guidance and requirements for plans, as well as the plan application process. HHS will continue to provide updates and rulemaking through the Center for Consumer Information & Insurance Oversight (CCIO), at http://cciio.cms.gov/.

Will Establish SBE		Will Not Establish SBE	Seeking Partnership
California	Nevada	Alaska	Arkansas
Colorado	New York	Florida	Delaware
Connecticut	Oregon	Louisiana	Illinois
District of Columbia	Rhode Island	Maine	
Hawaii	Utah	New Hampshire	
Kentucky	Virginia	Texas	
Maryland	Washington	South Carolina	
Massachusetts	West Virginia		

Source: Kaiser Family Foundation, as of August 1, 2012.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

Last Thursday, Governor Brown sent a letter to the legislature calling for a special session to be held in December to address a number of key healthcare initiatives related to the implementation of the ACA. One of the possible items that will be revived in the special session is the Basic Health Plan which did pass out of a critical fiscal committee during the regular session but remains a topic which the Brown Administration would like to "revisit". Also, the Administration is wanting more time to enact statutory measures regarding operational aspects of ACA implementation including Medi-Cal eligibility and how the state's Exchange will interact with the county eligibility systems, citing lack of adequate federal guidance. We note that it is unusual for a Governor to call a special session this far in advance and it is unclear at this time how the Legislature will respond to the request.

Also in California, the Department has released a draft RFA for the Medi-Cal managed care expansion into rural areas. The expansion covers 25 counties and roughly 305,000 beneficiaries in the North and East parts of the state with implementation scheduled for June 1, 2013. It is our opinion that since the RFA is structured as an application rather than a competitive procurement, it suggests that existing Medi-Cal vendors will be better positioned to compete for this business.

In the news

- **Legislators, Advocates Urge Care in Healthy Families Transitions**

  Legislators and advocates urge Health and Human Services Director to reexamine the plan to eliminate Healthy Families. The program covers children of low-income families with incomes too high to qualify for Medi-Cal. The program was eliminated as a cost saving measure, estimated to save $13 million this fiscal year, $54 million the next, and $78 million to following year. The letter asks the Brow Administration to develop a transition plan that carefully dismantles the program and takes place over four years. Brown will announce the transition plan no later than Oct. 1 2013. (California Healthline)

- **Brown to call special legislative session on healthcare law**

  Gov. Jerry Brown has told legislative leaders he intends to call a special session to deal with issues related to the federal healthcare law signed by President Obama in 2010. California has been one of the key laboratories for preparations to implement the law. State leaders hope by January 2014 to be able to expand coverage to millions of Californians who currently do not have health insurance. Brown said a special session, which he plans for December, will allow the state to continue its progress by giving him and lawmakers a way to keep working this year on healthcare proposals that have failed in the current session, which ends Aug. 31. Bills passed in a special session can take effect within 90 days of passage rather than at the beginning of the following calendar year. (Los Angeles Times)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

In response to objections from prospective bidders, the Agency for Healthcare Administration (AHCA) published an addendum to the Long-Term Care Invitation to Negotiate (ITN) allowing for relevant experience by the bidding company's parent organization, affiliate or subsidiary to be accepted and counted toward the requirement that bidders submit three references. As a reminder, last week Aetna challenged the initial form of the requirement, which would have prohibited bidders from using references from corporate affiliates. Our sense is that this change in the requirement potentially favors respondents that are part of companies that have managed long term experience in other states that can augment Florida experience. We note that the deadline for proposal submissions for the Florida LTC program is next Tuesday, August 28th.

Also this week, the state published the list of plans that submitted non-binding letters of intent (LOI) related to the Managed Medical Assistance (MMA - acute care) ITN that is scheduled for release by January 2013. Below, we list the plans and the regions for which they have indicated non-binding interest.

	1	2	3	4	5	6	7	8	9	10	11
	Pensacola	Tallahassee	Gainesville	Jacksonville	St. Petersburg	Tampa	Orlando	Sarasota	Palm Beach	Ft. Lauderdale	Miami
Amerigroup	X	X	X	X	X	X	X	X	X	X	X
Care Access											
Community Health Solutions of America	X	X	X	X	X	X	X	X	X	X	X
Freedom Health	X	X	X	X	X	X	X	X	X	X	X
Florida True Health	X			X			X		X		
Healthy Palm Beaches									X		
Humana	X	X	X	X	X	X	X	X	X	X	X
Integral Quality Care	X		X			X	X	X			
Magellan Complete Care		X		X	X				X	X	X
Max Care	X	X	X	X	X	X	X	X	X	X	X
Molina	X			X	X	X	X		X	X	X
PPSC USA	X	X	X	X	X	X	X	X	X	X	X
Prestige Health Choice	X	X	X		X	X	X	X	X		X
Salubris									X	X	X
Sunshine State (Centene)	X	X	X	X	X	X	X	X	X	X	X
UnitedHealthCare	X	X	X	X	X	X	X	X	X	X	X
Universal				X	X	X	X	X	X	X	X
WeCare Health Plans	X	X	X		X	X	X	X	X		
WellCare of Florida	X	X	X	X	X	X	X	X	X	X	X
Total responses per region	**13**	**11**	**11**	**12**	**13**	**13**	**14**	**12**	**16**	**12**	**13**

In the news

- **Hospitals battle Medicaid rule changes over undocumented immigrants**

  Hospitals throughout Florida are challenging a state rule that limits payments to treat undocumented immigrants. The hospitals say the Agency for Health Care Administration made the rule without following the proper procedures and unfairly wants them to reimburse the state for some of the Medicaid payments used to treat immigrants who are in the United States illegally. AHCA's position is that Medicaid covers emergency care for undocumented patients, but not the ongoing treatment needed to keep the patient stable. (Tampa Bay Times)

Georgia

HMA Roundup – Mark Trail

Tomorrow, the Department of Community Health (DCH) Board will present its budget recommendations to the Governor. As we have noted, DCH has been asked to comply with an additional 3% savings target for the current fiscal year projections and an additional 2% 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% 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% Medicaid rate increase to offset the cost of the tax for hospitals' Medicaid revenue. We believe an extension of this tax, which is scheduled to expire on June 30, 2013, and the associated Medicaid rate increase may come into play as part of the budget negotiations. At issue is the impact the expiration or extension of this tax would have on hospitals with different case mixes, since hospitals with higher Medicaid admissions benefit from the rate increase while hospitals with fewer Medicaid admissions do not.

Indiana

HMA Roundup – Cathy Rudd

On August 17th, the Indiana Family and Social Services Administration (FSSA) announced that it has received authorization from CMS to extend the Healthy Indiana Plan (HIP) for one year until December 31, 2013. The state had been seeking a five year extension for the HIP plan which covers approximately 42,000 low income parents and childless adults. The state noted that CMS did not rule on the state's request to use the HIP program as a vehicle to cover Medicaid expansion beneficiaries in 2014. According to the CMS letter, that decision will depend in part on the result of the most recent evaluation of the program which was due in May 2012. Link

In other Indiana news, FSSA has recommended that the contract for eligibility determination services be awarded to Deloitte Consulting. Deloitte beat out CapGemini and Xerox for the business despite generating the lowest cost score. Link

In the news

- **Pence Rejects State-Managed Health Insurance Market Place.**

  Republican Gubernatorial Candidate Mike Pence sent letter to current Indiana Governor, Mitch Daniels, expressing concern over implementing a state based exchange and recommend that Indiana not spend state money on planning an exchange. Earlier this year, Daniels asked for the advice of gubernatorial candidates on whether or not the exchange he established with an executive order should be certified as the state plan. The Democratic candidate, John Gregg will meet with Daniels this week and the libertarian candidate will announce his plan on Friday. (NWI Times)

- **Pence meets with Daniels on Affordable Care Act implementation**

  Republican gubernatorial hopeful Mike Pence met with Gov. Mitch Daniels on Wednesday morning to talk about issues in implementing the federal Affordable Care Act and said he'll publicly release his recommendations for the state in the coming days. The meeting came after Daniels sent a letter to Pence, Democrat John Gregg, and Libertarian Rupert Boneham asking for their opinions regarding whether the state should operate its own health insurance exchange under provisions of the federal health care law. (Evansville Courier & Press)

Michigan

HMA Roundup – Esther Reagan

On Wednesday August 15th, Governor Rick Snyder announced the resignation of Olga Dazzo, Director of the Department of Community Health (DCH). Dazzo plans to return to the private sector after having served as the DCH Director since December 2010. Replacing Dazzo will be Jim Haveman, who previously served as the DCH Director from 1996 to 2003 and was the state's Mental Health Director from 1991 to 1996. Link

Ohio

HMA Roundup – Alicia Smith

On August 16th, Franklin County judge Richard S. Sheward threw out Aetna's lawsuit challenging Ohio's decision to rescind its preliminary Medicaid managed care contract award. Aetna was originally awarded a contract to cover the state's non-dual Medicaid managed care beneficiaries in April, but the state subsequently rescinded the decision on the basis that Aetna had mischaracterized some of its out-of-state business as fully insured rather than fee-based. Aetna challenged the decision, but the judge ruled in the state's favor allowing the selected plans, UnitedHealth, CareSource, Paramount, Molina and Centene, to begin operating statewide under the new contracts. The contracts were to begin on January 1, 2013, though that start date may get delayed.

Also this week, the state finalized its managed contract awards for the dual eligible RFA. As a reminder, the Office of Health Transformation (OHT) published the results of its Integrated Care Delivery System (ICDS) RFA on June 28th. Plans were allowed to protest the scores they received, and five MCOs did—WellPoint, CareSource Paramount, UnitedHealthcare and WellCare. After reviewing the protests and seeking additional clarification from the plans, on August 21st OHT published the final scores. While there were some relatively minor changes to certain scores, the plan rankings remained intact. Aetna, Molina, CareSource and UnitedHealth are expected to secure ICDS contracts, assuming they meet all of the CMS requirements and pass the readiness reviews. The next step in the process is for each plan to select the three regions in which they intend to participate. After that, readiness reviews will be conducted at an unspecified time, with implementation/enrollment currently scheduled for April 1, 2013. Link

In the news

- **Kasich Administration Will Not Create Ohio Obamacare Exchange, Unlikely to Expand Medicaid**

  Despite the Supreme Court's decision to uphold the individual mandate, Ohio Department of Insurance Director Mary Taylor announced Ohio will not create a health insurance exchange as directed by President Obama's health care law. In a press call following the U.S. Supreme Court's decision upholding most of the law, Taylor—a Republican who also serves as Ohio's lieutenant governor—said the state will allow the U.S. Department of Health and Human Services (HHS) to implement a federal exchange in Ohio rather than comply with the law's expansive regulations regarding state-operated exchanges. (Heartlander)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

This month Pennsylvania nears $150 million in payouts to eligible professionals and hospitals under the Electronic Health Record (EHR) Incentive program. As of August 14, 2012, Pennsylvania had made payments of $69.9 million to eligible professionals and a little over $76 million to hospitals. Over 4,000 eligible professionals and 129 eligible hospitals in Pennsylvania have received payments. Pennsylvania launched its EHR Incentive Program in June 2011.

In the news

- **Formal Review Sought for State Medicaid Proposal**

  Two Ranking House members are requesting a review of the proposed changes to Medicaid eligibility as put forth by the Department of Public Welfare starting Sept 1. The proposed changes could affect thousands of Pennsylvanians including a large number of adults with disabilities. Representatives Mark Cohen and Gene DiGorolamo are requesting that the Independent Regulatory Review Committee. They also raised concerns that these changes to Medicaid eligibility will violate the Affordable Care Act. (The Times Tribute)

Texas

HMA Roundup – Gary Young

On August 20th, the Texas Health and Human Services Commission announced that it has awarded a tentative contract for Texas Integrated Eligibility Redesign System (TIERS) Data Center Services to Northrop Grumman Systems Corporation. The award is contingent upon the successful negotiation and execution of a contract. In the event negotiations are unsuccessful, HHSC may initiate negotiations with the next successful vendor or vendors. Link

In the news

- **Texas Drills Down on Medicaid Dental Fraud**

  Last year, the Texas Medicaid program paid out $1.4 billion to dentists and orthodontists—a roughly fourfold increase since 2006, according to state records. The federal government reimburses Texas for 60% of its spending on dental and orthodontic procedures. About 3.3 million of 26.4 million Texans are currently enrolled in Medicaid, according to the Texas Health and Human Services Commission. Increased Medicaid funding as a result of the settlement has "created a window for fraud," said Stephanie Goodman, a spokeswoman for the Texas HHS. But as the state has begun aggressively targeting the alleged fraud, some Texas orthodontists say the poor have become unintended victims. Some practices have stopped taking Medicaid patients, while others have shut down amid scrutiny by state investigators. (Wall Street Journal)

OTHER HEADLINES

Arkansas

- **Arkansas Medical Society endorses Medicaid expansion**

  A statewide association of physicians said Thursday it supports expanding Medicaid under the federal Affordable Care Act. The Arkansas Medical Society said it opposes certain parts of the Affordable Care Act, but it "looked beyond" that opposition to consider a provision that proposes expansion of Medicaid to include people up to 138 percent of the federal poverty line. The society's board of trustees voted Wednesday to adopt a motion supporting the expansion. The group said it concluded that the expansion would be good for Arkansas patients, would help physicians meet their obligations to care for Arkansas' poorest citizens and would be affordable. (Arkansas News)

- **Potential new Medicaid enrollees: Who are they?**

  The debate over expanding the state Medicaid program centers on providing free basic health care for up to 250,000 Arkansans between 19 to 64, most of whom work but can't get or can't afford health insurance through their employers. For the most part, "it's people who simply don't have access to insurance, because a lot of employers in Arkansas can't afford to offer it, or have access but they simply don't make enough money to be able to afford it," said John Selig, director of the state Department of Human Services. "There are a lot of people working full-time jobs at minimum wage who would fit into that category," Selig said. Officials with DHS and the Arkansas Center for Health Improvement did not have an estimate of the percentage of people who would become eligible for Medicaid who have full-time jobs. Gov. Mike Beebe has said he is inclined to support the expansion but has acknowledged that appropriating the money would require legislative approval. Republican legislators have expressed reservations about the expansion. (Arkansas News)

District of Columbia

- **D.C. submits plan for health-benefits exchange to feds**

  The D.C. government submitted a detailed proposal to the federal government on Wednesday outlining its vision for a consumer-friendly marketplace of insurance plans as part of President Obama's health care law, a controversial package of reforms that the District embraced from the start while other states wait for its legal and political narrative to play out. The lengthy document offers a window into efforts the District has taken to set up its health-benefit exchange since Mayor Vincent C. Gray set up an implementation committee in early 2011, well before the U.S. Supreme Court weighed in on the most controversial components of Mr. Obama's signature health care law in June. (Washington Times)

Iowa

- **Health Care Advocate Hopeful of Medicaid Expansion**

  Iowa State Senator Jack Hatch, chair of the State's Health and Human Services Budget Committee, says he'll propose a Medicaid expansion plan after the general election that he believes the republicans will have a difficult time opposing. Currently the HHS budget committee estimates it will cost $237 million to cover the 181,000 new enrollees over 8 years that equals to $161 per new enrollee per year. Hatch hopes that passing this plan in the Legislature will force Governor Branstad to come around on Medicaid expansion. (The Muscatine Journal)

Kansas

- **Feds Accept KanCare Waiver Request**

  CMS has accepted Kansas's 1115 waiver and will accept public comments until Sept. 20. If approved, the waiver would allow Governor Sam Brownback to proceed with KanCare, the plan to use three Health Plans to manage the day-to-day services of state's Medicaid Program. The anticipated cost savings equal about $1 billion over 5 years. They have already identified and written contracts with three health plans: Amerigroup Kansas Inc., Sunflower State Health Plan, which is a subsidiary of Centene, and United Healthcare of the Midwest. This is the second time Kansas has filed this waiver; they withdrew their first application because they did not seek required input from two officials at Indian Health facilities. (Kansas Health Institute)

- **KanCare MCOs to take on Case Management Role**

  Case Managers for the physically disabled and elderly Medicaid patients are being encouraged by the state government to apply for similar jobs at Amerigroup, United Healthcare and Sunflower State Health Plan, who are, pending federal approval, set to provide coverage for Medicaid Patients under KanCare. If approved, KanCare will take all responsibility for case management for elderly and disabled Medicaid patients. The plans will hire between 120-150 case managers. (Kansas Health Institute)

Maine

- **MaineCare to Warn Recipients it Plans to Cut Their Benefits**

  Thousands of Maine residents will receive notice that they will lose their benefits under MaineCare, the state's Medicaid program. The Department of Health and Human services faces budget cuts aimed at balancing the state budget. Medicaid eligibility will now be 133% FPL; it was previously 200%. About 12,000 people stand to lose their coverage Oct. 1 (Bangor Daily News)

- **Maine Democrats challenge Medicaid cut plan**

  Maine Democratic legislators are challenging claims made by the Republican governor in his request to federal officials to allow Medicaid cuts. Sen. Dawn Hill and Rep. Peggy Rotundo on Wednesday disputed Gov. Paul LePage's claims that the cuts were needed in order to forestall a budget deficit. A federal waiver is needed in order for LePage to implement cuts in Medicaid affecting non-disabled, non-pregnant adults, people ages 19 and 20, and people in the Medicare Savings Program. (Boston Globe)

Maryland

- **Maryland hospitals push for insurers to pay Medicare and Medicaid cost shift**

  Maryland hospitals and regulators are discussing raising hospital prices for private insurers and businesses by hundreds of millions of dollars a year to make up for suggested cuts from Medicare and Medicaid. A proposal by the Maryland Hospital Association circulated to policymakers in recent weeks details a plan to shift costs to private payers by raising the rates they pay hospitals by 7 percent over three years while giving sharp discounts to the Medicare program for seniors and the Medicaid program for the poor. (Washington Post)

Montana

- **Montana Weighs Expansions of Medicaid Rolls to Include Tens of Thousands of People**

  Montana lawmakers are examining whether or not to spend the $119 million to expand Medicaid. The legislator does not meet again until January but has been advised by consulting groups to conduct several studies, including one to identify whether or not physicians can handle to influx of patients. The expansion could potentially cover 57,000 new patients. (The Republic)

Nebraska

- **Medical professionals say expanding Medicaid in Nebraska would create 'significant returns'**

  A new report by the University of Nebraska Medical Center says expanding Medicaid as part of the federal health care law would strengthen the state's economy. Health officials say expanded Medicaid coverage could provide health care access to more than 90,000 new enrollees over a six-year period, attract roughly $3 billion from the federal government and generate $700 million in economic activity. The report obtained by The Lincoln Journal Star says the expansion would cost the state $140 million to $168 million. (The Republic)

Nevada

- **Board OKs $72M to set up Nevada insurance exchange**

  A state board approved a $72 million contract Tuesday to implement a health insurance exchange in Nevada under the federal Affordable Care Act, but Gov. Brian Sandoval said the program will need to become self-sustaining if it is to continue. The contract approved by the Board of Examiners is with Xerox State Healthcare to set up the computer system and operations needed to begin enrolling people by October 2013. Startup costs are being funded through federal grants. So far, Nevada has received $25 million and state officials are awaiting approval, expected in the next few days, on another $50 million. (Bloomberg Business Week)

New Mexico

- **New Mexico Revises Medicaid Overhaul Plan**

  Governor Martinez asked the Federal Government to approve the New Mexico Plan to overhaul Medicaid, which covers about one-fourth of the population. The overhaul will extend eligibility to low-income pregnant women and disabled New Mexicans who are working. The plan also requires Native American's to receive their care through managed care organizations. (The Denver Post) *The revised plan also cancelled the state's plan to implement a duals integration demonstration (see Duals Calendar).*

New York

- **Amid Budget Squeeze, N.Y. Sells Nursing Homes**

  The national recession may be over, but local governments around the country are still hurting. Core services and programs are being scaled back, cut or privatized. In Upstate New York, county officials are scrambling to sell off nursing homes that have been taxpayer-funded for generations. At least 10 county-run nursing homes have already been sold, and county officials say they expect another dozen to be privatized in New York in the next couple of years. But critics say it's unclear what will happen if some of these private companies go out of business, or stop taking residents who rely on Medicaid. (NPR)

Tennessee

- **'Dialing for TennCare' Sign-up is set for Sept. 13**

  Tennessee will open phone lines for the fifth time allowing low-income individuals to call in and sign up for TennCare. The lines will open at 6pm and close once 2,500 people are registered. TennCare has coverage available for 3,500 enrollees, but enrollment usually sits at 1,000, leaving budgeted money unspent. TennCare is available to low-income individuals with high, unpaid medical bills. To be eligible, the household must have a monthly income less than $241 for an individual or $392 for a family of five. The household must also not have resources that exceed $2,000 for an individual or $3,000 for a family of two. (The Tennessean)

Virginia

- **Virginia Moving on Implementing Health Reform**

Virginia has passed new insurance regulations to prepare for federal health reform and is updating the computer system for determining Medicaid eligibility. Virginia has not created an exchange and it remains unclear if they will participate in the Medicaid expansion. It is one of ten states being tracked by the Robert Wood Johnson Foundation as part of a national study on health reform. (Richmond Time Dispatch)

West Virginia

- **W. Va Health Services Contracts Spur Questions**

West Virginia Lawmakers expressed concern over several entities that received HHS contracts. The Delmarva Foundation received an HHS contract to monitor the 3 health plans providing managed care in the state's Medicaid program. Annual reports from Delmarva suggest sub-par performance from Carelink Health Plans, The Health Plan of the Upper Ohio and Unicare. Health Outcomes among their patients have not improved, including rates of diabetes, one of the most prevalent chronic diseases in WV. (The San Francisco Chronicle)

Wisconsin

- **United Healthcare Ends BadgerCare Contract with State**

United HealthCare will end its contract to cover 174,000 people under BadgerCare on October 1, sighting the states payment rates are prohibitive to care as the reason. Wisconsin has implemented budget cuts to balance the budget, many of which directly affected BadgerCare. The state says that those receiving coverage from United Healthcare will still have access to coverage, as the state will pay hospitals and providers for their care. (Milwaukee Journal Sentential)

National

- **GAO: States Spending More on Medicaid Supplemental Payments.**

The GAO says that combined, states spent $32 billion on supplemental payments in 2010, a significant increase from the amount spent in 2006. Supplemental payments are divided into two groups: payments that go to hospitals that serve low-income patients (DSH payments) and payments that go to other organizations and health providers as determined by state criteria (non-DSH payments) . DSH payments totaled $17.6 billion, which is the Federal cap. Non-DSH payments totaled $14.4 billion, and $8 billion increase from 2006. Most of these payments went to inpatient services. There is a great disparity between states on the percentage of the Medicaid budget spent of supplemental payments. (Governing Magazine)

- **GOP Govs Fight with Hospitals over Medicaid Opt-In**

When the Supreme Court decided states could not be penalized for not expanding Medicaid under Obamacare, Republican Governors Bobby Jindal of Louisiana, Rick Perry of Texas, and Rick Scott of Florida quickly announced that their states would not participate. The three governors, whose states have among the highest uninsured populations and some of the most limited Medicaid programs in the country, say their states can't afford Medicaid expansion and don't want the federal government interfering with their programs. Texas, for example, spent over $27 billion in 2010 on Medicaid—fully seven percent of the all U.S. Medicaid spending. Florida spent over $17.3

billion, and Louisiana spent $7 billion. But hospitals in those states say they stand to lose money, and are urging their state leaders to reconsider. (The Fiscal Times)

- **Medicaid shapes up as major battleground**

  Mitt Romney's choice of Rep. Paul Ryan (R-Wis.) as his running mate has reignited a debate over the future of Medicare. But Ryan's proposed cuts to Medicaid could have quicker and more far-reaching consequences, with the potential to dramatically affect state budgets and health care for millions of people. Ryan has proposed scaling back the nation's four-decade-old insurance program for the poor and disabled — bringing down the cost by $810 billion over 10 years. The measure is part of a budget he has said aims to avert "an epic collapse of our health and retirement programs that would devastate our nation's most vulnerable citizens." But experts say the cutbacks are so dramatic that it would be impossible for states to innovate their way out of massive cuts to a program that in 2010 served some 54 million Americans, roughly 6 million more than Medicare. (Washington Post)

- **Tax Revenues Continue to Grow in Early 2012**

  State tax revenues grew by 4.7 percent in the first quarter of 2012, according to Rockefeller Institute research and Census Bureau data. This is the ninth consecutive quarter that states reported growth in collections on a year-over-year basis. Overall state tax revenues are now above prerecession as well as peak levels that came several months into the Great Recession. In the first quarter of 2012, total state tax revenues were 4.8 percent higher than during the same quarter of 2008. However, after adjusting to inflation, state tax revenues were still 1.6 percent lower compared to the same quarter of four years ago, in 2008. (Rockefeller Institute)

COMPANY NEWS

- **Aetna Enters into Agreement to Acquire Coventry Health**

  Aetna and Coventry Health Care, Inc. announced on Monday that Aetna will purchase Coventry for $7.3 billion including the assumption of Coventry debt. The agreement has been approved by both sets of board of directors. Aetna is expected to significantly increase their Medicaid "footprint" and is now well positioned for Medicaid expansion and will add over 5 million new members (Aetna)

- **Kindred Healthcare Signs Definitive Agreement to Acquire Home Health and Hospice Company**

  Kindred Healthcare, Inc. announced today that they will acquire IntegraCare, Inc. for $71 million in cash with an additional $4 million earn out depending on 2013 earnings. IntegraCare, a portfolio company of Flexpoint Ford, Inc. is a home health, hospice, and community services provider with 47 locations in Texas. Kindred currently runs nursing and rehabilitation centers, acute long term care facilities, inpatient rehabilitation centers and a hospital based unit within the existing service areas of IntegraCare. This transaction is subject to several other approvals and conditions and is expected to be complete by the end of the 3rd quarter of 2012. (Kindred Healthcare, Inc.)

- **Steward Health Care to Buy Mercy Hospital in Portland Maine.**

  Steward Health Care System LLC made its intentions clear of second purchase of an out of state hospital today, signing a letter intent to purchase Mercy Health System of Maine from a Catholic hospital group. The letter does not make the financial terms of this agreement clear. The agreement is still subject to approval from Maine state regulators and Vatican officials. (The Boston Globe)

- **PeaceHealth to Merge with Colorado's Catholic Health Initiative**

  PeaceHealth and Catholic Health Initiative announced on Friday their plan to merge, creating a new system with 16 hosptials, 26,000 employees, and $4 billion dollars in revenue. CHI is based in Colorado and runs hospitals in Oregon and Washington. PeaceHealth is based in Vancouver and runs hospitals across the Northwest. (The Oregonian)

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 23, 2012	Wisconsin Duals	Proposals due	17,600
August 27, 2012	Ohio Duals	Plan Selection Meeting	122,000
August 28, 2012	Florida LTC	Proposals due	90,000
August, 2012	Illinois Duals	Contract awards	136,000
August, 2012	Nevada	RFP Released	170,000
September 20, 2012	Ohio Duals	Contracts finalized	122,000
September 21, 2012	Massachusetts Duals	Contract awards	115,000
September, 2012	Arizona - Maricopa Behav.	RFP Released	N/A
October 1, 2012	Pennsylvania	Implementation - New West Zone	175,000
October 1, 2012	Florida CHIP	Implementation	225,000
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
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	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		CANCELLED as of August 17, 2012		
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 WELCOMES…

Doug Porter, Principal – Olympia, Washington

As reported in the Washington State Wire:

Doug Porter, Director of Washington State's Health Care Authority, has been hired as a Principal with Health Management Associates (HMA), a national health care policy and consulting firm, HMA representatives announced today.

Porter has been at the head of Washington's Medicaid program for the past ten years. Under his leadership, the program made nationally recognized advances in children's health insurance, managed care, program integrity, development of a new Medicaid Management Information System, related payment issues and national health care reform.

"Under Doug's leadership, Washington State has consistently been a model program, most recently looking for innovative approaches and implementing changes at the forefront of the Medicaid expansion and the Health Benefits Exchange – two key features in the march toward health care reform," said Marilynn Evert, HMA's chief executive officer.

Porter announced on August 6 that he was resigning from his current post, effective August 17, and would soon announce his future plans. After a bit of rest and relaxation with family, he will officially join HMA on Monday, October 1.

As a Principal with HMA, Porter will be involved in health policy research and consulting for HMA clients around the country. He also will open HMA's sixteenth office in Olympia, where he will be based.

Porter, who earlier directed Medicaid programs in Maine and California, has led the Washington State program since December of 2001, when it was part of the Department of Social and Health Services.

In 2010, Washington Governor Chris Gregoire announced a plan to merge Medicaid and the existing Health Care Authority, putting Porter also in charge of the state's other large health care purchasing program, the Public Employees Benefits. That move, completed in 2011, helped streamline and standardize state health care programs as well as bend the health cost curve, helping restrain annual medical cost inflation to less than four percent by eliminating waste and inefficiencies.

HMA Recently Published Research

Implications and Options for State-Funded Programs Under Health Reform

Theresa Sachs, Managing Principal, Business Development
Diana Rodin, Consultant

A number of states and the District of Columbia currently administer health coverage programs for low-income uninsured individuals who either exceed maximum Medicaid income eligibility thresholds or who are not categorically eligible for the Medicaid program, such as childless adults. The majority of individuals currently covered through these programs will be eligible for other coverage pursuant to the Affordable Care Act (ACA). This issue brief, from SHARE grantee Theresa Sachs and her research team at Health Management Associates, reviews the objectives and structure of 11 health coverage programs in six states and documents the legal, technical, and policy issues that states are already addressing, or need to address, as they review options for transitioning program enrollees to new coverage options under the ACA. The authors also present possibilities for new uses of state dollars freed up by the infusion of federal funds in 2014. **(Link to Report – State Health Access Data Assistance Center)**

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)**

HMA Upcoming Appearances

"Election 2012 Issues: Health Care Policy"

Current Issues Series at Denver University

Joan Henneberry – Panelist

September 24, 2012

Denver, Colorado