HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS/MASSACHUSETTS DUAL ELIGIBLE DEMONSTRATION MEMORANDUM OF UNDERSTANDING (MOU) DETAILS

HMA ROUNDUP: OHIO FINALIZES DUAL RFP AWARDS; LOUISIANA CARVES PHARMACY BENEFITS INTO MCO CONTRACTS; GEORGIA DCH COMMISSIONER PLEDGES NO REDUCTION IN PROVIDER RATES; ILLINOIS AWARDS CLIENT ENROLLMENT BROKER CONTRACT TO MAXIMUS

OTHER HEADLINES: KANSAS MCOS ANNOUNCE SUBCONTRACTORS FOR PHARMACY, OTHER BENEFITS; NEW HAMPSHIRE MCO IMPLEMENTATION STILL UNDER FEDERAL REVIEW; TEXAS RIO GRANDE VALLEY WAIVER NEARING FINALIZATION; LAWSUIT HALTS VIRGINIA BEHAVIORAL HEALTH MANAGED CARE CARVE-IN; WELLPOINT CEO STEPS DOWN

RFP CALENDAR: NEVADA RFP EXPECTED SOON

AUGUST 29, 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: CMS/MASSACHUSETTS DUAL ELIGIBLE DEMONSTRATION MEMORANDUM OF UNDERSTANDING (MOU) DETAILS

This week, our *In Focus* section reviews the Memorandum of Understanding (MOU) between the Commonwealth of Massachusetts and the Centers for Medicare & Medicaid Services (CMS) on the dual eligible integration demonstration capitated care model. This is the first MOU between a state Medicaid authority and Federal CMS to be established and publicly available. The MOU lays out the key fundamentals of the dual integration plan and establishes the guidelines and framework that will be a part of the three-way contract between the state, CMS, and participating health plans. Below, we review the key elements of the Massachusetts MOU, and where relevant highlight those elements of the MOU that we believe will be present in virtually any state participating in a capitated dual integration demonstration.

Massachusetts Duals Population and Enrollment

The Massachusetts duals demonstration will enroll roughly 110,000 fully dual eligible individuals between the ages of 21 and 64 in Integrated Care Organizations (ICOs) to deliver both Medicare and Medicaid benefits. There are more than 270,000 dual eligibles statewide. Individuals with other private or public health insurance (excluding Medicaid and Medicare) are not eligible for the demonstration. However, those dual eligible individuals enrolled in a Medicare Advantage plan, PACE, Employer Group Waiver Plans (EGWP) or other Employer-Sponsored Plan may voluntarily enroll in the demonstration. At least initially, individuals in home and community-based waiver programs will not be enrolled.

Based on this MOU and other demonstration plans, it appears that most, if not all, capitated models will offer voluntary enrollment for Medicare Advantage and PACE enrollees, while passively enrolling other eligible duals with an opt-out period. Under passive enrollment, individuals who do not select a plan will be auto-assigned to a plan in their service area with the opportunity to opt-out of coverage. Beneficiaries may elect to choose a different Demonstration Plan, a Medicare Advantage Plan, to receive care through Medicare Fee-For-Service (FFS) and a Prescription Drug Plan, and to receive Medicaid services in accordance with the Commonwealth's approved State Plan and any approved waiver programs. Massachusetts will work to develop an "intelligent assignment" algorithm for passive enrollment (one that prioritizes continuity of providers and/or services).

The MOU indicates that beneficiaries may disenroll or switch plans on a month-to-month basis at any time during the year. This is per CMS policy as announced by Melanie Bella, Director of the Medicare-Medicaid Coordination Office, in Congressional testimony.

Timeline

The timeline provided in the MOU provides significant insight into future state demonstrations beginning in 2013. Massachusetts voluntary enrollment will begin January 1, 2013, however, plans will not begin coverage of voluntary enrollees until April 1, 2013. This date has been accepted as the earliest date any state's capitated duals demonstration would begin. The Massachusetts MOU reveals that while voluntary enrollment begins April 1, plans will not begin receiving passive enrollments until July 1, 2013.

Date	Milestone
January 1, 2013	Voluntary open enrollment
April 1, 2013	Earliest date plans can accept voluntary enrollment
July 1, 2013	Passive enrollment phase 1 begins
October 1, 2013	Passive enrollment phase 2 begins
October 2014 and 2015	Passive enrollment aligned with open enrollment
December 31, 2016	Demonstration period ends

The April 1, 2013 start date extends the first year of the demonstration to a total of 21 months, from April 1, 2013 to December 1, 2014. The second year runs from January 1, 2015 to December 1, 2015, and the third, and final, year of the demonstration runs from January 1, 2016 to December 1, 2016.

Payment Model & Rate Structure

CMS will make separate payments to the Participating Plans for the Medicare A/B and Part D components of the rate. Massachusetts will make a payment to the Participating Plans for the Medicaid component of the rate. For every state's capitated model, we anticipate Medicare and Medicaid will each contribute to the total capitation payment consistent with baseline spending contributions. Other key points regarding the payment model and rate structure:

- Medicare baseline will be established annually based on a blend of Medicare Advantage payments and Medicare FFS weighted by enrollment of duals transitioning to demo, which will be predominantly FFS. Baseline will include quality bonus payments for applicable Medicare Advantage plans.
- Medicaid baseline will be determined by Commonwealth and its actuaries using historic costs. CMS will and validate the Medicaid baseline data to ensure compliance with federal rate setting requirements.
- The Commonwealth and its actuaries will provide the estimated baseline spending and underlying data for each year of the Demonstration at the beginning of the Demonstration period to the CMS contracted actuary, who will validate the estimate of projected costs in Medicaid. In other words, the Medicare baseline is re-set every year, the Medicaid baseline is set only once at the beginning of the demo (but it can be revisited at any time if the Commonwealth and CMS decide to do so).
- Part D baseline will be set at the Part D national average monthly bid amount.

The MOU identifies four ratings categories for the purposes of establishing payment levels:

F1: Facility-based Care.
   a. Includes individuals identified by MassHealth indication as having a long-term facility stay of more than 90 days.

C3: Community Tier 3 - High Community Needs.
   a. Includes individuals who do not meet F1 criteria, and for whom an MDS-HC assessment indicates:
      i. Have a skilled need to be met by the ICO seven days a week;
      ii. Have two or more Activities of Daily Living (ADL) limitations AND three or more days a week of skilled nursing need to be met by the ICO; or
      iii. Have four or more ADL limitations.

C2: Community Tier 2 – Community High Behavioral Health.
   a. Includes individuals who do not meet F1 or C3 criteria, and who have specified Behavioral Health diagnoses, validated by medical records, reflecting an ongoing, chronic condition such as schizophrenic or episodic mood disorders; psychosis; or alcohol or drug dependence not in remission.

C1: Community Tier 1 - Community Other.
   a. Includes individuals in the community who do not meet the F1, C2 or C3 criteria.

Given the specific eligibility groups covered under the Massachusetts model, we would not expect these ratings categories to be the same as those identified in future MOUs.

Aggregate savings percentages will be applied equally to the Medicaid and Medicare A/B components. While it is not certain whether other states will be identical, these savings percentages should be a good indicator of what range to expect in further MOUs. Some states, such as California, were anticipating significantly higher savings estimates than what has been included in the Massachusetts MOU. We view these savings projections as favorable for participating health plans.

Demonstration Year	Savings Percentage
Year 1 (2013-2014)	1%
Year 2 (2015)	2%
Year 3 (2016)	4%

Risk adjustment will follow the Medicare CMS-HCC methodology and Medicare Part D RxHCC methodology. For Medicaid, a portion of the Medicaid rate will be withheld and placed into a risk pool. Medicaid risk adjustment methodologies are likely to vary by state.

Demonstration Year	Quality Withhold
Year 1 (2013-2014)	1%
Year 2 (2015)	2%
Year 3 (2016)	3%

Under the Demonstration, both Medicaid and Medicare will withhold a percentage of their respective components of the capitation rate. The quality withhold amounts will be repaid subject to Participating Plans' performance consistent with established quality thresholds. We note that these quality withhold amounts are in addition to the savings discounts discussed above and are likely to be similar in future MOUs in our opinion.

The Massachusetts MOU outlines the following risk corridors in place for the duals demonstration in Year 1 of the demonstration only. The Medicare and Medicaid contributions to risk corridor payments or recoupments will be in proportion to their contributions to the capitated rates, not including Part D, with the maximum Medicare payment/recoupment equaling 1% of the risk-adjusted Medicare baseline. All remaining payments once Medicare has reached its maximum obligation shall be treated as Medicaid expenditures eligible for FMAP. Risk corridors will consider both service and care management costs. Our understanding is that the inclusion of risk corridors is voluntary on the part of the state so we would expect this component of the rate setting methodology to vary in future MOUs.

Risk Corridor Gain/Loss	Outcome
Greater than 10.0%	Participating Plans would bear 100% of the risk/reward
Between 5% and 10%	Participating Plans would bear 50% of the risk/reward; the Commonwealth and CMS would share in the other 50%
Between 0% and 5%	Participating Plans would bear 100% of the risk/reward

Continuity of Care

ICOs must allow enrollees to maintain their current providers and service authorizations at the time of enrollment for a period of up to 90 days, unless the assessment is done sooner and the enrollee agrees to the shorter time period; or until the ICO completes an initial assessment of service needs, whichever is longer.

The ICO must maintain the enrollee's existing providers at their current provider rates and honor prior authorizations issued by MassHealth, its contracted managed care entities, and Medicare.

Model of care:

All ICOs (in partnership with contracted providers) will be required to implement an evidence-based model of care (MOC) having explicit components consistent with the Special Needs Plan Model of Care. CMS' Demonstration Plan MOC approval process will be based on scoring each of the eleven clinical and non-clinical elements of the MOC. Plans must receive a minimum score of 70% to participate.

- Plans that score >85% granted a 3 year approval
- Plans that score 75-84% granted a 2 year approval
- Plans that score 70-74% granted a 1 year approval

Plan oversight

Plan oversight, coordinated between Commonwealth and CMS, will be at least as rigorous as existing procedures for Medicare Advantage, Part D, and the Commonwealth's

Medicaid managed care programs. Part D oversight will continue to be a CMS responsibility, with appropriate coordination and communication with the Commonwealth. Demonstration Plans will be included in all existing Medicare Advantage and Part D oversight activities, including (but not limited to) data-driven monitoring, secret shopping, contracted monitoring projects, plan ratings, formulary administration and transition review, and possibly audits.

Plan selection

Plan selection will be conducted jointly by Commonwealth and CMS, taking into account previous performance in Medicare and Medicaid and ensure that bidder meet's all CMS' requirements.

Supplemental and Waiver Benefits

The following supplemental and waiver benefits are included in the Massachusetts MOU:

Behavioral	Community	State plan services
Community crisis stabilization	Day services	Dental
Community support program	Home Care services	Personal care assistance
Partial hospitalization	Respite care	DME
Acute treatment services for substance abuse	Peer support/ counseling/ navigation	
Clinical support services for substance abuse	Care transitions assistance	
Psychiatric day treatment	Home modifications	
Intensive outpatient program	Community Health workers	
Structured outpatient addiction program	Medication management	
Program of assertive community treatment	NEMT	
Emergency services program		

Network Adequacy

Network adequacy requirements in the MOU follow Medicare Advantage for Acute benefits**.** Massachusetts set further rules for LTC and other Medicaid benefits, requiring two providers for each benefit within 15 mile radius.

Marketing rules

Marketing rules in the MOU appear to follow Medicare Advantage requirements and as such would be expected to be the same in future states' MOUs.

Next steps:

We note that Illinois, California and Ohio are the other three states that would like to begin their demonstration programs in 2013. We expect that the next MOU CMS releases will be with one of these three states.

Link to Massachusetts MOU:

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MassMOU.pdf

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

The California Healthcare Foundation released two reports analyzing the shift of Seniors and Persons with Disabilities into Medi-Cal managed care plans. According to a summary of the reports, the findings included:

- DHCS adopted 23 new contract standards for health plans serving Medi-Cal enrollees in areas such as network adequacy and care coordination.
- DHCS and its partners conducted extensive outreach, including 30,000 monthly calls to beneficiaries; community meetings; and staff trainings.
- Many health plans and other stakeholders trained staff to prepare for the transition and collaborated throughout.

Challenges included:

- Beneficiaries had trouble reading materials and were confused about the process for requesting temporary exemptions from the managed care mandate.
- Providers who accepted new enrollees did not receive patient information in a timely fashion and health plans reported difficulty recruiting fee-for-service providers.
- Performance goals were not established at the outset, making it impossible to evaluate the effectiveness of the transition.

The authors concluded that longer planning periods, more communication with beneficiaries, improved provider outreach, and the establishment of quality improvement benchmarks should be encouraged when moving additional populations into Medi-Cal managed care. Link

In the news

- **Why Basic Health Plans Failed and COOPs May Succeed**

  After the legislature effectively killed the Senate bill outline the Basic Health Plan, a plan to offer low cost health care to patients receiving their care from public hospitals and clinics, Assembly Member Richard Gordon introduced a new bill outlining a COOP (consumer operated and oriented plan). The COOP would be part of the California Exchange as a not-for-profit consumer-governed plan. While his bill does not establish the actual COOP, it provides a legislative framework for these types of plans. The Federal government has made available $3.8 billion dollars in loans for state to establish co-ops; 12 states have established co-ops. Gordon says the COOP would offer Californians an alternative to large state-wide plans while still being cost effective for consumers. (California Healthline)

- **California's Health Exchange Considers a New Name**

  Officials on the California Health Benefit Exchange Board are considering a new name for their online market place, knowing that the current name is long and hard to say. Names under consideration were CaliHealth, Wellquest, Health Hub, Eureka, and Condor. One Board member voiced support for "Avocado: a uniquely California approach to affordable health care." Several believe naming it Avocado provoked a uniquely California image, as they produce 90 percent of the nation's avocados. Avocado growers are welcoming the free publicity. (The Los Angeles Times)

- **Health Plan Pays Record Settlement**

  SCAN, a health plan out of Long Beach California, will pay $320 million in a settlement with the state and federal governments. The allegations against SCAN say that the health plan has been overpaid by Medi-Cal since 1985. They will pay an additional $3.8 million in a whistle-blower settlement. SCAN says that the state is responsible for the errors and once they were aware an error was made, they were happy to reimburse Medi-Cal. The US attorney responsible for the case claims that there was no evidence to suggest SCAN knowingly defrauded Medi-Cal. (The Los Angeles Times)

- **Hospital Chain Accused of Kick Back Scheme to pay $16. 5 million**

  A Los Angeles hospital has agreed to pay $16.5 million to the government in response to accusations that its subsidiaries provided kickbacks and unnecessary services to homeless patients they recruited. The US Attorney's office will drop the criminal charges if the settlement is paid in full by 2017. Los Angeles Doctor, Inc., a subsidiary, has agreed to plead guilty to conspiracy charges in connection with this case. (Los Angeles Times)

Colorado

HMA Roundup – Joan Henneberry

The Denver Health and Hospital Authority appointed Arthur Gonzalez as the new chief executive officer, replacing Patty Gabow who had held the position for 20 years. Gonzalez joins Denver Health after having served as Chief Executive Officer at Hennepin Healthcare System, Inc., a renowned public safety net healthcare system in Minneapolis, Minnesota.

Georgia

HMA Roundup – Mark Trail

On August 23rd, the Board of Community Health held a policy committee meeting to discuss its amended FY 2013 and FY 2014 budget proposals. Below are our notes from the meeting. The Department of Community Health (DCH) has still not articulated its plan for meeting the state budget savings targets. The next DCH board meeting is scheduled for September 13th.

Medicaid: DCH noted that membership has continued to increase in spite of the declining unemployment rate, suggesting that many people remain at least 'under-employed'.

It was noted that Medicaid now makes up about 17 percent of the State fund budget, and covers one in five Georgians.

DCH reported an expected AFY13 deficit of $355 million in state funds, attributed to:

- current underfunding in appropriations;
- need to catch up on the 12th CMO capitation payment;
- incurred but not reported NICU payments;
- membership growth; and
- a member merge settlement.

FY2014 projected deficit was estimated at $392 million in state funds driven by the same issues noted in Amended FY2013, along with movement of current PeachCare members into Medicaid, the added ACA federal premium tax, primary care rate increase, and resulting 'woodwork effect'. Additionally, DCH will have to plan for a $60 million state fund cut in Amended FY2013 and $100 million state fund cut in FY2014 to accomplish the proposed reductions of 3 percent and 5 percent for the two years.

The DCH Board indicated it will propose to request additional state funds to cover the noted deficits, and propose certain cost savings/reductions measures to accomplish the required 3 percent and 5 percent reductions. However, the Commissioner only offered very general ideas to areas they are considering and no specific reductions were described. Commissioner Cook noted that there were no real opportunities to save in the area of eligibility. He also noted that saving opportunities in optional services were limited, but may be considered. He clearly stated that there would not be any provider rate cuts to accomplish the savings. Finally, he noted that considerations related to utilization had opportunity, but the traditional route of hiring a separate administrative entity to manage utilization had its struggles in that additional administrative dollars had to be obtained and it would take more time to accomplish than available to accomplish the immediate budget targets.

PeachCare (CHIP): Similar to Medicaid the program has deficits resulting from inadequate appropriations, continued membership growth, and the 12th capitation payment owed to the CMOs. Projected deficits for Amended FY2013 are $19 million and FY2014 at $5 million (lower in FY2014 due to anticipated shift in membership from CHIP to Medicaid. Adding the require 3 percent and 5 percent cuts bring anticipated deficits to $21 million in Amended FY2013 and $9 million in FY2014. Actual cost reductions where not described, as was the case above.

In the news

- **Deal: No Medicaid Expansion for Georgia**

  In an interview Tuesday morning, Governor Nathan Deal reaffirmed his position that Georgia should not expand its Medicaid program, citing cost as his main concern. He said that he did not foresee a reason to change his position short of legislative changes at the federal level. Gov. Deal is supportive of a block grant which would allow Georgia to spend the money on Medicaid as state officials see fit. (The Atlanta Journal-Constitution)

Illinois

HMA Roundup – Matt Powers and Jane Longo

On August 23, The Illinois Department of Healthcare and Family Services announced its decision to award a client enrollment broker contract to MAXIMUS Health Services. Under the contract, MAXIMUS will be responsible for educating Medicaid Participants on their choice of Health Plans, facilitating client enrollment based on client choice, if no active client choice is made, maintaining an algorithm to auto-assign Potential Enrollees to a primary care provider, preparing client materials and communicating client enrollments to the appropriate Health Plan. MAXIMUS Health Services, Inc., was the highest scoring vendor in response to the Request for Proposal. The initial five year term of the contract has an estimated value of $36.7 million with five additional renewal year options at $5.8 million per year. Link

In the news

- **Cook County Hospital Makes Big Bet on Medicaid Expansion**

  Cook County Health and Hospitals system is counting on an early Medicaid Expansion waiver to boost annual revenue by 11 percent or $712 million. The 2013 budget, released last week, outlines a proposal to accommodate the Medicaid expansion and the expected 115,000 new patients, by hiring 200 new employees. The Medicaid expansion will also change billing practices, switching from a fee-for-service system to a fixed rate of $300 per patient per month. Another big concern facing the county hospital is the decline in revenue from Medicaid as beneficiaries go to other hospitals for care. The proposed budget relies on an increase in patients and the county is engaging in an aggressive outreach effort. The proposed budget also outlines $25 million in spending cuts. (Modern Health Care)

Louisiana

HMA Roundup

On August 24, the Louisiana Department of Health and Hospitals (DHH) announced it will be carving pharmacy benefits into its contracts with prepaid health plan. During the initial phase-in of the Medicaid managed care program, pharmacy was one of several services that were "carved out" of the prepaid health plan contracts. Now, DHH is moving forward with adding pharmacy as a benefit for recipients in the three BAYOU HEALTH prepaid plans, Amerigroup, LaCare (AmeriHealth Mercy) and Louisiana Healthcare Connections (Centene). These plans will begin managing pharmacy services on October 1. The other two plans, Community Health Solutions and United Healthcare Community Plan, are enhanced primary care case management networks. Pharmacy benefits for recipients in these networks will continue through the legacy Medicaid fee-for-service program. Link

Massachusetts

HMA Roundup – Tom Dehner

On August 9, 2012, the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) issued a request for information (RFI) regarding the Comprehensive Primary Care Payment Reform initiative. The purpose of this initiative is to support primary care delivery transformation by giving primary care providers greater flexibility and resources to deliver care in the best way for their patients. The payment mechanism MassHealth plans to implement to support this delivery model is a comprehensive primary care payment combined with a shared savings/risk arrangement and quality incentives. The deadline for RFI responses is September 7, 2012.

Michigan

HMA Roundup – Esther Reagan

On Thursday August 16, Governor Rick Snyder announced that Michigan will not move forward with legislation to create a Michigan-run health insurance exchange, and his administration will now pursue the federal-state partnership model. Governor Snyder had supported a state operated exchange but was not able to garner support from the House Republican caucus. The federal deadline for states to decide on their plans for a state, federal or partnership exchange is November 16.

Ohio

HMA Roundup – Alicia Smith

On August 27, the Ohio Office of Health Transformation (OHT) announced the final tentative selection of Integrated Care Delivery System (ICDS) Health Plans. Aetna, CareSource, United, Molina and Centene were each selected to participate in three regions. The table below lists each of the regions the plans selected and the pro-rata share of dual eligibles each will enroll assuming equal distributions across each plan in the region. Importantly, we note that Ohio has not yet received CMS approval to move forward with the demonstration. Moreover, each of the selected plans will have to pass what we anticipate will be a rigorous readiness review with both the state and CMS. Link

Total duals in demo	Northwest 9,884	West Central 12,381	Southwest 19,456	Central 16,029	Northeast 31,711	East Central 16,226	Northeast Central 9,285	Total 114,972
Molina		6,191	9,728	8,015				23,933
UnitedHealth					10,570	8,113	4,643	23,326
CareSource					10,570	8,113	4,643	23,326
Aetna	4,942		9,728	8,015				22,685
Centene	4,942	6,191			10,570			21,703

OTHER HEADLINES

Alabama

- **Medicaid Crisis If September 18 Vote Fails, Chief Medical Officer Says**

  Voters in Alabama will be deciding on a constitutional amendment that would allow the State to move $145.8 million out of a trust fund each year for three years to help balance the budget. Don Williams, temporarily heading the Medicaid program, says they will face a $100 million deficit if the amendment does not pass. He also warns that Medicaid beneficiaries are not the only ones who will suffer; hospitals could be forced to shut down and the State stands to lose federal funding if they do not meet their outlined obligations. (Montgomery Advertiser)

Connecticut

- **Connecticut Moving Ahead with New Health Care Exchange**

  This week, CMS awarded Connecticut a $107 million grant in the planning of their exchange. So far, Connecticut has received $116 million in planning grants. They are one of five states to receive a Level Two Establishment Grant. The Exchange expects to be operational by the October 2013 enrollment period. (Ventura County Star)

Florida

- **Medicaid Plan will Transform Health Care in Florida**

  Several studies have found that under the budget plans supported by Romney and Ryan, Florida stands to lose about one-third of its federal funding for the state's Medicaid program. Last year, the state's Medicaid budget was about $21.3 billion, with the federal government paying almost half. If Romney's budget plans were to go into effect, Florida would lose $35 billion by 2022, one-third less than the projected spending. Opponents of Romney's plan say the impact would be devastating, especially to disabled and nursing home patients who make up 13 percent of Medicaid spending. Since 2007, Florida Medicaid enrollment has grown from 2.1 million to 3.2 million. (Sun Sentinel)

Kansas

- **KanCare MCOs announce their benefit-package subcontractors**

  Officials for the three managed care companies hired to run the Kansas Medicaid program announced today the firms that they will use to provide their transportation, dental, vision, and pharmacy benefits. The subcontractors were mentioned during a two-hour informational meeting put on today in Topeka by the Kansas Department for Aging and Disability Services. (Kansas Health Institute)

  The companies and their benefit management firms:

Centene	United Healthcare	Amerigroup
Vision – Opticare	Vision – Vision Service Plan	Vision – Ocular Benefits
Dental – Dentaquest	Dental – Scion Dental	Dental – Scion Dental
Pharmacy – US Script	Pharmacy – OptumRX	Pharmacy – Caremark
Transportation – MTM	Transportation – Logisticare	Transportation – Access2Care

Maryland

- **State Unveils New Name, Logo for Insurance Exchange Under Federal Health Law**

  Maryland has unveiled the Maryland Health Connection and its new logo on Thursday. The site is set to go live in October 2013, with more than 100,000 Marylanders expected to enroll. The state also won an additional $123 million dollar establishment grant this week to complete the project. (The Washington Post)

Minnesota

- **Minn. seeks OK to change Medicaid health plan, save $151 million**

  Gov. Mark Dayton wants federal permission to make changes to Minnesota's Medicaid programs that are expected to save $151 million over the next 5 years. Key savings include: $89 million to expand Medicaid coverage for patients at Anoka Metro Regional Treatment Center, leading to shorter hospital stays; $15 million to tighten standards for aid to childless applicants; $9.2 million to increase options for home-based care. (Minneapolis Star Tribune)

New Hampshire

- **Feds Still Reviewing NH Medicaid Care Management Plan**

  CMS is still reviewing New Hampshire's plan to put all of its 130,000-140,000 Medicaid enrollees into one of three Managed Care Organizations. CMS has expressed concern over ensuring adequate access, something New Hampshire has had problems with under their existing Medicaid program. Ten hospitals across the state filed a suit claiming that budget cuts had made accessing services impossible for Medicaid patients. New Hampshire's HHS commissioner wrote a letter to CMS claiming the state has no such access issue and the lawsuit is unrelated, claiming the managed plan was launched long before the suit or any claiming of inadequate access. If approved, New Hampshire aims to start implementation of managed care January 1, 2013. (Foster's Daily Democrat)

New York

- **New York's Model for Medicaid Managed Care**

  New York state officials are considering terminating their contract with WellCare, a Medicaid managed care organization with about 75,000 enrollees in the state. WellCare's poor performance put them on a six month probation period and for the third straight year their outcomes have been extremely low, especially for quality of care, doctors' visits for children, and chronic disease management. The last year this data was available was 2009, however, when New York's Medicaid managed care organizations ranked higher than any other states. (Bloomberg Businessweek)

North Carolina

- **State Reaches Agreement with Feds over Treatment of Mentally Ill**

  North Carolina came to an agreement with the federal government that will allow thousands of people a way out of institutions and adult care homes by proving housing, job training, and mental health care. North Carolina Department of Health in Human Services will spend an estimated $287 million over the next eight years on the

program. In exchange, the state will not have to defend itself in a federal lawsuit concerning violations of the American's with Disabilities Act. The settlement outlines requirements for housing for 3,000 people within eight years. This year, North Carolina's legislature set aside roughly $10 million in funding for housing for between 100 and 300 people. (Newsobserver.com)

Pennsylvania

- **PA Internal Budget Guidelines Warn of Cost Increase, Declining Federal Dollars**

  This week, the annual budget guidelines went out to all of the Pennsylvania state agencies. In addition to outlining the fiscal challenges facing the state, the guidelines made it clear that they could not replace federal money with state funds. They are already looking at the 2013-2014 budget and expecting even more significant spending cuts. (Daily Times)

- **With Contract Out to Bid, Prison Health Care Questioned**

  Philadelphia may be strongly reconsidering who to contract with for inmate health care services. The city has been contracting with Corizon for 17 years, paying them $196 million for providing care to prisoners. Corizon has been sued continuously by inmates and the city has paid $1 million to settle suits brought by inmates for inadequate health care services since 1995. Corizon provides health care to inmates in 29 states and there have been similar complaints and suits filed in many of these states as well. The Prison Commissioner says they will decide on a contract in the near future. (The Inquirer)

Texas

- **Valley Building New Template for Medicaid Waiver**

  Rio Grande Valley officials have spent most of this year finalizing the details on a Medicaid waiver program expanding managed care into the South region of Texas, which is disproportionately affected by Medicaid underpayment and large Medicaid caseloads. Federal and state officials reached an agreement which continued to provide $2 billion in federal funds, despite the transition to managed care. In exchange, the Valley must adopt a results based Medicaid program focused on innovation and programs improving care. Texas could potentially qualify for $802 million in federal funds, however, qualifying for the whole allotment is unlikely unless they come up with the $300 million to match it and implement major changes. (The Monitor)

- **Texas Counties Consider Going it Alone for Medicaid Expansion**

  Officials in several Texas counties are considering the possibility of expanding Medicaid on their own, despite Gov. Rick Perry's decision not to do so. The six most populous counties in Texas already provide care to families with incomes well above the federal poverty line in a program that costs about $2 billion a year. Both hospital officials and counties say they are willing to look at this option. In order for this plan to be implemented, they would need approval from the Texas legislature as well as CMS approval to waive the requirement that Medicaid standards be applied statewide. Bexar County estimates this plan could save up to $53 million a year. (The Washington Post)

- **Proposed Medicaid Fraud Rules Worry Providers**

  Texas Health and Human Services Commission is seeking approval of the new rules attempting to limit Medicaid Fraud. Doctors are expressing concern over these rules, claiming that it denies their due process and expands the government's ability to withdraw funding. The HHSC Office of the Inspector General has been increasingly using the ACA's rules allowing them to freeze funding and claims their process gives investigators the tools necessary to fully investigate claims. (Texas Tribute)

Utah

- **Utah Medicaid Stops Paying for Hospital Errors but Data Spotty**

  Utah's Medicaid program has decided to stop paying hospitals and health care providers for "provider preventable conditions" such as infection and on-site falls; the Medicaid agency has outlined 17 conditions to date and could possibly add to this list. The names of hospitals committing errors are kept confidential and reporting of errors in not necessarily mandatory; it is possible that providers contributing to this problem are not punished very severely or at all. There is no data on how much tax payer money this will save. (The Salt Lake Tribute)

Virginia

- **Legal Battle Stalls Health Program**

  The Virginia plan to transition Medicaid behavioral health services into managed care has been stalled due to a lawsuit filed by the Community Health Partnership of Virginia. The partnership, which includes about 40 organizations, filed suit against the Virginia Department of Medical Assistance for disqualifying it as a bidder. Virginia cites a potential conflict of interest as the reason for disqualification, and even though the original injunction halting the procurement process has been lifted, officials in Virginia say they won't move forward until litigation is fully resolved. This carve-in of behavioral health services is predicted to save Virginia about $17 million by 2014. (Richmond Times-Dispatch)

National

- **States Fail to Set Up Verification for Medicaid Long Term Care**

  A 2008 federal law required states to implement an electronic system determining eligibility for Medicaid long-term care. According to a recent report by the GAO, no state has fully implemented this program. According to the timeline outlined by the law, 25 states were supposed to have the system fully implemented by the end of 2011; only 18 states had even begun the process at that point. According to the report, 32 states have claimed to not have the resources and 18 states said their financial institutions would not participate. Currently, long-term care patients make up 6 percent of the Medicaid population nationally but account for $144.7 billion, or almost half of Medicaid spending. (Governing Magazine)

- **Hospitals Look to Become Insurers, As Well As Providers of Care**

  About 20 percent of hospital systems nationwide are exploring the option of becoming an insurer as well as a provider of care, says a study by the research firm, The Advisory Board. Twenty percent of existing networks already function this way. The intense pressure by public and private forces to lower costs has hospitals looking different ways to manage care and keep costs low. Proponents of this idea say that paying for patients, not profiting from them, will encourage hospitals to focus on preventative and cost-saving services. Opponents say that the insurance and health care businesses are very different and the potential for fraud and litigation is very high. (Kaiser Health News)

- **States Continue to Move Forward, Build Affordable Exchanges**

  HHS announced that California, Connecticut, Hawaii, Iowa, Maryland, Nevada, New York, and Vermont will receive new grants to assist in the planning of their exchanges. California, Hawaii, Iowa, and New York received Level One grants and Connecticut, Maryland, Nevada, and Vermont received Level Two grants. In total, 34 states have applied for grants through HHS to establish exchanges. (HHS.gov)

- **US Hospitals: What's Going on with Medicaid?**

  In a letter to HHS Secretary Kathleen Sebelius, the CEO of the American Hospital Association asked for clarifications around the Medicaid expansion. The questions asked in the letter include whether individuals with incomes between 100 percent and 138 percent FPL will be eligible for Exchange subsidies, and whether or not the states can expand coverage to certain populations, such as parents of CHIP enrollees, but not others. Many hospital executives supported the ACA, but were counting on the Medicaid expansion and are uncertain about what to do if states do not expand. (Business Courier)

COMPANY NEWS

- **WellPoint Chair and CEO Angela F. Braly Steps Down**

  WellPoint, Inc. announced that it is actively searching for a candidate to succeed Angela F. Braly as the President and Chief Executive Officer of WellPoint, who has stepped down from those positions today. The Board of Directors has established a search committee to consider both internal and external candidates, with the assistance of a search firm. In the interim, John Cannon, the Company's Executive Vice President, General Counsel, Corporate Secretary and Chief Public Affairs Officer, will serve as interim President and CEO. WellPoint also announced that Jackie M. Ward, WellPoint's Lead Director, has been named the Non-Executive Chair of the Board of Directors effective immediately. (WellPoint Press Release)

- **IASIS Partners with Aurora Health Care on New Cancer Center**

  IASIS, one of the nation's largest private hospital companies, and Aurora Health Care, a not-for-profit provider in eastern Wisconsin and northern Illinois, are partnering to build a new cancer center in Kenosha, Wisconsin. The new 11,000 square-foot facility will increase patient access to radiological oncology across the region. (Nashville Business Journal)

- **Multi Year Commitment to CMS Innovation Center's Comprehensive Primary Care Initiative In New York and Ohio**

  Aetna joins CMS and 500 primary care physicians in launching a new Home Health Initiative to begin this fall. The Comprehensive Primary Care (CPC) initiative aims to lower costs and improve quality of care by increasing millions of Americans' access to primary care. Under this initiative, CMS will pay primary care practices a management fee, initially $20 per patient per month, to support care coordination on behalf of Medicaid beneficiaries. Some activities that the enhanced care coordination will include are: offering longer and more flexible hours, using electronic health records, delivering preventive care, coordinating care with patients' other providers, engaging patients and caregivers in managing their own care, and providing individualized care for patients who have multiple chronic diseases. The initiative will launch November 1, 2012 for Aetna members. (Aetna)

- **Health Care REIT to acquire Sunrise Senior Living**

  Health Care REIT and Sunrise Senior Living announced that Sunrise would now become part of Health Care REIT's portfolio. Health Care REIT will purchase all outstanding common stock for $14.50 a share. Pending all regulatory approval, the deal should be finalized in early 2013. (peHUB)

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 28, 2012	Florida LTC	Proposals due	90,000
August, 2012	Nevada	RFP Released	170,000
September, 2012	Illinois Duals	Contract awards	136,000
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	Sept. 2013	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 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

HMA Seminar: FQHCs in the New Paradigm of Accountable Care

"Change in the Organization and Financing of Care Delivery under ACA"

Doug Elwell - Speaker

"Population-Based Model of Care and the Role of the FQHC"

Art Jones, MD - Speaker

"Transitions and Collaborations in the Care Model: Primary Care Coordination with Behavioral Health, Inpatient, Emergent, Specialty, Home Health and Long-Term Care"

Terry Conway, MD and Linda Trowbridge - Speakers

"Governance Models for Accountable Care in the Safety Net"

Catherine Rudd, JD - Speaker

"How Do We Assure the 'Triple Aim'?"

Art Jones, MD - Speaker

"The Path to Moving toward Integrated Care Models: How Do We Get Started?"

Pat Terrell – Speaker

September 14, 2012

Chicago, Illinois

Current Issues Series at Denver University

"Election 2012 Issues: Health Care Policy"

Joan Henneberry – Panelist

September 24, 2012

Denver, Colorado