HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: NEVADA MEDICAID MCO REBID REQUIRES EXCHANGE PLAN OFFERING

HMA ROUNDUP: PENNSYLVANIA RELEASES BEHAVIORAL HEALTH RFP; FLORIDA ANNOUNCES LONG TERM CARE ITN BIDDERS BY REGION; COLORADO TO LAUNCH ALL PAYERS CLAIMS DATABASE; TEXAS AWARDS RAC CONTRACTS; MICHIGAN GOVERNOR PROPOSES NEW ORGANIZATIONAL STRUCTURE FOR BCBS MI

OTHER HEADLINES: ARKANSAS GOVERNOR TO PURSUE MEDICAID EXPANSION; STATES CONSIDER ESSENTIAL HEALTH BENEFITS PLAN OPTIONS; KANSAS LAUNCHES ON-LINE MEDICAID APPLICATION PORTAL

HMA WELCOMES: MARGARITA PEREYDA – SOUTHERN CALIFORNIA

UPCOMING EVENTS: HMA TO PARTICIPATE IN COWEN AND CO. CONFERENCE CALL: "DUAL ELIGIBLES: PACE AND PROCESS"

SEPTEMBER 12, 2012

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

---

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

Contents

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

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

IN FOCUS: NEVADA MEDICAID MCO REBID REQUIRES EXCHANGE PLAN OFFERING

This week, our *In Focus* section reviews the Nevada Division of Health Care Financing and Policy's (DHCFP) request for proposals (RFP) to rebid their Medicaid managed care program. Nevada operates a mandatory Medicaid managed care program in two regions – Washoe County (Reno) and Clark County (Las Vegas) – Washoe County being the Northern region, and Clark County the Southern region. Together, these two regions represent nearly 170,000 of the 220,000 total Medicaid beneficiaries statewide. The two regions are currently served by Amerigroup and the Nevada Health Plan (United Healthcare). In addition to serving Medicaid beneficiaries, the two plans also serve a combined 18,500 children in the Nevada Check Up (CHIP) program.

The managed care RFP, released September 7, 2012, rebids these current contracts, and also includes opportunities for future managed care expansions. Particularly noteworthy is that Nevada is one of the first states to include details in an RFP about how the Medicaid program and the state's Exchange will work together in 2014.

RFP Key Elements

Exchange Plan Requirement

In addition to providing all required covered services as a Medicaid managed care plan, bidders are required to offer a minimum of two plans in the state Health Insurance Exchange. Bidders must offer at least one Gold and one Silver Qualified Health Plan (QHP). The Gold and Silver tiers indicate the ratio of out-of-pocket expenses an individual may be responsible for under their plan. Bidders must provide a statement of their willingness to comply with this requirement to be considered. The QHPs required under this RFP must meet the qualifications of a MCO Transition QHP, intended to meet the needs of individuals as they transition from Medicaid eligibility to the Exchanges and vice-versa, as detailed below:

- Be certified as a QHP in accordance with the criteria determined by the State-designated HIX;
- Be able to accept enrollees during the initial open enrollment of the State-designated HIX beginning October 1, 2013 for an initial effective date of coverage of January 1, 2014;
- Use the same provider network as is available to those eligible for Medicaid in addition to any network adequacy standards set by the State-designated HIX;
- Be available to consumers in the same geographic area as the geographic area served by the Medicaid MCO plan;
- Coordinate prior authorizations and edit patterns for members who transition between the MCO and the QHP;

- Use a formulary that is similar to that of the Medicaid MCO. If a drug or its generic equivalent is covered by the MCO but is not covered by the QHP, the QHP must cover that drug as it would any other similar tier drug (same cost sharing) for a period of time as determined by a transition plan dictated by medical necessity, potential side effects, etc.;
- Cover any benefit required to be covered by Medicaid MCOs, that is not otherwise part of Nevada's Essential Health Benefits package, for a period of time as determined by a transition plan dictated by medical necessity, potential side effects, etc.; and
- Be priced reasonably as compared to other QHPs available on the Exchange. To be "priced reasonably," QHP premiums (before the Federal Advanced Premium Tax Credit is applied) must be no more than 15 percent greater than the median premium offered on the Exchange for similarly situated individuals (based on age, smoking status, family size and geographic location).

Expansion Opportunities

While DHCFP's RFP does not expand Medicaid managed care elsewhere in the state, it does leave the door open for future expansions to be folded into these contracts, without an additional procurement. This could significantly expand the size of contract if DHCFP pursues these options. There are roughly 50,000 Medicaid beneficiaries in fee-for-service Medicaid in the rest of the state.

- The RFP indicates that other areas of the state may become mandatory Medicaid managed care regions during the course of this contract and would be considered covered under this current RFP.
- The RFP also indicates that if the state were to expand mandatory managed care to the Medicaid aged, blind, and disabled (ABD) population, those lives would also be included in the current contracts.
- Finally, the RFP invites bids to serve the Public Employee Benefits Program as an HMO plan.

Other Key RFP Elements

- DHCFP will award contracts to two plans for a period of four years, from July 1, 2013 to June 30, 2017, with an optional one year extension.
- Individuals will be able to select one of the two managed care plans during an open enrollment period at least once per year.
- The auto-assignment algorithm will favor new plans or the smaller plan in the region, with one-third of auto-assignments going to the larger plan in the region, and two-thirds of auto-assignments to the smaller plan in the region.

Timeline

The RFP provides the following timeline for the procurement process.

Timeline	Date
Deadline for submitting first set of questions	September 26, 2012
Answers posted to website	Approx. October 04, 2012
Deadline for submitting second set of questions	October 15, 2012
Answers posted to website	Approx. October 24, 2012
Deadline for submittal of Reference Questionnaires	November 14, 2012
Proposals Due	November 15, 2012
Vendor Selection	December 19, 2012
Implementation	July 01, 2013

Current Medicaid Market & RFP Opportunity

The current managed care program, covering both Medicaid and the Nevada Check Up program, is served by Amerigroup and United Healthcare's Nevada Health Plan.

Enrollment Category	Amerigroup	United Healthcare	Total
Medicaid	78,500	91,400	169,900
Nevada Check Up	6,500	12,000	18,500
Total	**85,000**	**103,400**	**188,400**

Source: Estimated based on various sources, including Nevada Check Up enrollment date, Amerigroup Q2 Financial Statements, and Nevada DHCFP Medicaid enrollment data.

Based on current enrollment in the managed care program, and estimate per-member-per-month (PMPM) rates of $160 for Medicaid and $120 for Nevada Check Up, we estimated annual spending for the rebid population at more than $350 million. Nevada has estimated that their Medicaid population may increase by as much as 62 percent[1] under the ACA's Medicaid expansion, which we estimate could add an additional 105,000 Medicaid managed care enrollees, with annual spending of more than $200 million. Optional expansions, whether geographically, or to the ABD population, would only grow this opportunity further.

[1] Nevada DHCFP's Section 1115 Waiver Request, April, 2012. Available at: https://dhcfp.nv.gov/caremgmt/Nevada's%20Comprehensive%20Care%20Waiver%20Application.pdf

HMA Medicaid Roundup

Colorado

HMA Roundup – Joan Henneberry

Claims Database: Colorado will launch the All-Payers Claim Database (APCD) website on November 1st, 2012. The APCD is a tool that will aggregate claims payment detail across all providers and payers. For the initial launch, the APCD will contain three years of claims data from the largest commercial payers plus Medicaid, representing approximately two million unique covered lives. Over the next year and a half, additional payer claims, including Medicare, will be added to the database so that eventually health care claims information for over 90% of Coloradans covered by insurance will be included. The state expects that the APCD will be a valuable tool for payers, providers, businesses and eventually consumers looking to make informed decisions regarding the cost and quality of health care.

CHIP: The Department of Health Care Policy & Financing is proposing a rule calling for passive enrollment of children into a managed care organization upon determination of eligibility for CHP+ rather than choosing a managed care organization during the application process. The intent of the rule is to ensure that children are attached to a medical home as quickly as possible, and reduce confusion for families. Currently, families that do not choose a managed care organization at the time of application risk being denied eligibility for CHP+ if this selection is not made within 30 days. Children that are redetermining eligibility for CHP+ will be re-enrolled into their previous managed care organization rather than having an enrollment period in the State's Managed Care Network. This will ensure continuity of care for children that continue to remain eligible for CHP+. The State believes that the rule change will simplify the process for families applying for CHP+, allow for faster enrollment with a managed care organization, and that children will no longer be denied eligibility for CHP+ due to not selecting a managed care organization.

Essential Health Benefits Benchmark Plan: COHBE, DOI, and the Governor's office are seeking feedback for the essential benefits benchmark plan. In their letter to stakeholders, they recommended Colorado's largest small group plan (Kaiser Ded/CO HMO1200D) as the benchmark plan. Public comment is open through September 10.

In the news

- **Key Medicaid reform effort in Colorado shows promising savings**

  Colorado's key Medicaid-reform effort — matching thousands of state-supported patients to "medical homes" and careful case management — is showing promising savings, health officials will report to the legislature this fall. More than 128,000 Medicaid clients are enrolled in seven case management regions, and preliminary data for the first six months of billing shows a 14 percent drop for inpatient hospital stays among children, state officials said. Other categories showed lesser but still financially important drops in usage through better preventive care and weeding out duplicative services. (Denver Post)

Florida

HMA Roundup – Elaine Peters

Long term care invitation to negotiate (ITN): On August 29, the state posted the plans that submitted responses to the LTC ITN by region. The table below identifies the bidding plans and the regions where they are interested in participating.

	1 Pensacola	2 Tallahassee	3 Gainesville	4 Jacksonville	5 St. Petersburg	6 Tampa	7 Orlando	8 Sarasota	9 Palm Beach	10 Ft. Lauderdale	11 Miami
Advantage Florida Health Plan											X
All Florida Healthcare Services	X										X
American ElderCare	X	X	X	X	X	X	X	X	X	X	X
Amerigroup						X				X	X
Coventry Health Care	X	X	X	X	X	X	X	X	X	X	X
Florida Healthcare Plus											X
Freedom Health	X				X	X	X	X	X	X	X
Humana	X	X	X	X	X	X	X	X	X	X	X
Molina	X			X	X	X		X	X	X	X
Simply Healthcare Plans										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
WellCare of Florida	X	X	X	X	X	X	X	X	X	X	X
Total responses per region	**9**	**6**	**6**	**8**	**9**	**10**	**8**	**9**	**9**	**11**	**14**

In terms of the timeline, we note that negotiations with the plans will begin on November 13 and run through January 4, 2013. The anticipated date for contract award announcements is January 15, 2013.

Payment reform: On August 29, Navigant presented its recommendations for converting the hospital payment model to a DRG-based system in conjunction with a legislative mandate passed last year. The consultant recommendations are available here. AHCA is required to submit a DRG plan to the Governor and Legislature by January 1, 2013 with a goal of completing full implementation by July 1, 2013.

Statewide Medicaid Managed Care: The following organizations responded to the state's request for information (RFI) to inform the upcoming statewide Medicaid managed care ITN. Responses were due on August 15, 2012.

- All Children's Hospital
- Amerigroup
- Central Florida Behavioral Health Network, Inc.
- Florida Alcohol and Drug Abuse Association
- Florida Council for Community Mental Health
- Humana, Inc.
- Molina Healthcare of Florida
- Simply Healthcare
- Sunshine State Health Plan
- Treo Solutions
- United Healthcare
- WellCare

In the news

- **Health plans ready to vie for Medicaid contracts**

  With Florida gradually moving toward a statewide Medicaid managed-care system, 14 health plans are ready to compete for contracts to provide long-term care to seniors. The health plans met a deadline last week for submitting documents that will be used by the state Agency for Health Care Administration as it works to award contracts in 11 different regions of the state. (News-Press)

Georgia

HMA Roundup – Mark Trail

Budget: The Department of Community Health will hold its next Board meeting on Thursday, September 13 at which we expect more detailed plans for achieving the Governor's targeted budget reductions to be revealed. HMA expects to see a strong emphasis on utilization management, potentially by folding in new eligibility categories into mandatory managed care. We believe revisions to provider reimbursement methodologies may also be considered in this budget cycle.

In other budget news, Georgia's net tax collections for the month of August totaled $1.32 billion for an increase of $24.5 million, or 1.9 percent, compared to August 2011. The increase was driven by a $13.5 million, or 3.1 percent increase in Net Sales and Use Tax collections.

In the news

- **Ga. switching mental health care providers**

  Georgia officials are switching health care providers months after an audit found problems in a $13 million program meant to provide better treatment for the mentally ill. The Department of Behavioral Health and Developmental Disabilities is booting out California-based Anka Behavioral Health and giving its contracts to local agencies. Georgia is nearly at the halfway point in a five-year agreement with federal officials to move patients institutionalized in hospitals into community-based treatment programs. (Sacramento Bee)

Michigan

HMA Roundup – Esther Reagan

Claims tax: Last week, Governor Snyder's proposed 1 percent tax on paid health care claims was upheld a federal judge, who ruled that it is not pre-empted by the Employee Retirement Income Security Act (ERISA). As a reminder, the proposed the claims tax was designed to replace the HMO use tax on Medicaid managed care organizations that was not expected to be renewed by CMS. Under the new claims tax, all health insurers, third-party claims administrators and stop-loss insurers will pay the tax which supports the Medicaid program. The Self-Insurance Institute of America Inc. (SIIA) had challenged the law, arguing that it is barred by an ERISA provision that pre-empts state and local laws and rules related to employee benefit plans. U.S. District Court Judge Julian Abele Cook of the Eastern District of Michigan wrote that the Michigan law "does not act exclusively on ERISA plans or single them out for different treatment, but rather treats them the same as other entities" that make payments to health care providers. The SIIA intends to appeal the ruling …

BCBS Michigan: On September 11, 2012 Michigan Governor Rick Snyder made public a proposal to dramatically reform how Blue Cross Blue Shield of Michigan (BCBSM) is structured and regulated. Currently BCBSM is regulated under separate statutory authority (Public Act 350 of 1980) from other insurance companies. PA 350 exempts BCBSM from State and local taxation but establishes the company as the state's designat-

ed "insurer of last resort" and requires greater regulatory scrutiny over any proposed change in BCBSM's premium rates. The Governor proposes the following:

- Abolition of PA 350 and a restructuring of BCBSM as a nonprofit mutual (member-governed) insurance company regulated under the state Insurance Code.
- Creation of a nonprofit organization (funded by BCBSM at $1.5 billion over 18 years) with a mission to improve the health of Michigan residents.
- A freeze of current "Medigap" premium rates provided through BCBSM for four years.
- Elimination of the tax-favored status that BCBSM currently enjoys.
- An end to the requirement that BCBSM serve as insurer of last resort as of January 1, 2014 when the Affordable Care Act is implemented.

The proposal will likely be reviewed by the Michigan Legislature in the coming months. As the dominant insurer in the state, any efforts to dramatically reform its role in the insurance market will be heavily scrutinized by competing insurers, business interests, consumer organizations, advocates and labor unions.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Behavioral Health RFP: RFP 16-12, HealthChoices Behavioral Health Services, was issued on September 5, 2012. This is a Behavioral Health Managed Care solicitation for its 23 county North/ Central Zone which includes Bradford, Cameron, Centre, Clarion, Clearfield, Columbia, Elk, Forest, Huntington, Jefferson, McKean, Northumberland, Juniata, Mifflin, Montour, Potter, Schuylkill, Snyder, Sullivan, Tioga, Union, Warren, and Wayne Counties. These are primarily rural counties. This solicitation is the reissue of a previous one from November 2011. The state has not given an official explanation of the reasons for the withdrawal of the previous RFP. In the interim, the contract with the current vendor, Community Care BHO, was extended. Pennsylvania "carves out" all its behavioral health services. The Pre-proposal Conference is scheduled for September 17 at noon. Bids are due on October 18, 2012. The RFP states the contract term extends from July 1, 2013 through June 30, 2018 and allows for one 3 year extension at the discretion of the state. More information can be found at link

Insurance exchange: In a letter to HHS dated August 23, 2012, Michael Consedine, the Pennsylvania Insurance Commissioner, outlined a series of questions Pennsylvania wants answered before it will continue any planning related to an Insurance Exchange. Citing that "significant concerns remain pertaining to what type of burden the operation of an exchange in Pennsylvania will place on our taxpayers and the state's budget", Commissioner Consedine's letter outlines 26 questions concerning the timing and content of the final HHS rules re exchanges, the impact of a Federally-Facilitated Exchange (FFE), what the potential is that a partnership with HHS would dictate that the state must also expand its Medicaid program, what additional costs the state must assume, and the impact on Pennsylvania's CHIP program, among others. In closing the Commissioner

noted that, "it would be imprudent for (Pennsylvania) to continue extensive planning efforts until we receive answers…" Letter

Children's Health Report: A report published by the Pennsylvania Partnerships for Children, "The State of Children's Health Care in Pennsylvania," identified gaps in children's health care, even among the 1.3 million commonwealth children who are insured through Medicaid or Pennsylvania's Children's Health Insurance Program (CHIP):

- Fewer than 60 percent of children insured through these publicly funded programs receive the appropriate number of wellness visits between birth and 15 months – visits that are crucial to preventive health care.
- Thousands of children lack access to primary care providers and specialists, which can lead to delayed diagnoses of physical or behavioral health issues.
- About 1 in 4 children fail to receive appropriate immunizations against preventable illnesses such as polio, tetanus or hepatitis.
- Nearly half do not receive annual dental checkups.

The report was published Wednesday, September 12, 2012, and is available at the Pennsylvania Partnerships for Children website here.

In the news

- **Will doctor see you now?**

  If you're a Pennsylvanian who is enrolled in the state's Medicaid health-insurance program for the poor, only 2 out of 3 physicians in the state are willing to see you, new research shows. Those odds are almost exactly in the middle of the pack - a better chance than you'll find in the nation's most populous states, such as New Jersey, but far worse than rural states in the heartland where almost all physicians accept new Medicaid patients. Medicaid has low reimbursement levels compared with private insurance and the federal Medicare program, which covers seniors and the disabled. This means that doctors don't get paid as much for providing services to Medicaid patients. That means some primary-care physicians simply won't take on new Medicaid patients or have opted out of Medicaid altogether, which is a concern for public-health advocates. Nationally, about 64.7 percent of primary-care physicians accept new patients with Medicaid. That's well below the acceptance rate for new patients with private insurance, which is about 81 percent for all physicians, including specialists. (Philadelphia Inquirer)

Texas

HMA Roundup – Gary Young

On September 5, 2012, the Texas Health and Human Services Commission (HHSC) announced that it awarded Recovery Audit Contractor (RAC) contracts to CGI Federal Inc. and Health Management Systems Inc. Awards are contingent on successful contract negotiation. More details on the RAC procurement are available at the HHSC procurement website here.

OTHER HEADLINES

Alabama

- **Williamson: Few Medicaid options if Sept. 18 vote fails**

  If voters on Sept. 18 reject the constitutional amendment aimed at shoring up the General Fund, which provides a significant portion of the state's Medicaid funding, the budget likely will be significantly cut, with major effects on Medicaid and the state Department of Corrections. Gov. Robert Bentley last week ruled out any new taxes or revenues to shore up the General Fund. That, State Health Officer Don Williamson said, would leave the agency just two choices. One, which he called the "drunken sailor" option, would involve spending Medicaid's funding until it ran out sometime about August 2013. The other would be cutting programs considered optional to Medicaid, such as dialysis or hospice care. Williamson said either option would have consequences for the state. Medicaid could attempt to make smaller cuts to the program to keep it going as long as possible, but the well running dry could force the closure of hospitals and nursing homes. (Montgomery Advertiser)

Arkansas

- **Ark. governor supporting expansion of Medicaid**

  Gov. Mike Beebe said Tuesday he supports expanding Medicaid eligibility in Arkansas under the federal health care law after officials assured him the state could later opt out, setting up a potentially heated fight with Republican lawmakers as they try to win control of the state Legislature. Beebe, a Democrat who had said he was inclined to support the expansion, said he decided to back it after receiving those assurances in writing from the federal government. Beebe noted that the expansion will still require support from state lawmakers next year. (San Francisco Chronicle)

- **Officials ask AARP to lobby for Medicaid expansion, payment reform**

  State Department of Human Services officials on Wednesday urged the AARP to lobby the state Legislature in support of expanding the state Medicaid program and overhauling the state's health care payment system. DHS Director John Selig and state Medicaid Director Andy Allison made their pitches for the two proposals at a summit on long-term care co-sponsored by DHS and AARP Arkansas at the Clinton presidential library. (Arkansas News)

California

- **California's bid to end U.S. control of prison healthcare denied**

  A judge has again rejected the state's request for a speedy end to federal control of prison healthcare. In an order issued Wednesday, U.S. District Judge Thelton Henderson said he would require tougher reviews than the state wanted before agreeing to dissolve the receivership that has run inmate medical care for six years. The receivership was imposed when Henderson said prison healthcare was unconstitutionally poor and qualified as cruel and unusual punishment. Earlier this year, the state sought to end the receivership in 30 days. When that request was rejected, it asked for six months. That was turned down in Wednesday's order. (Los Angeles Times)

Idaho

- **Idaho could save $380M with Medicaid expansion**

  Idaho's taxpayers could save $380 million over six years by agreeing to expand Medicaid coverage for more low-income people under President Barack Obama's health care overhaul, according an analysis by the Spokesman-Review. Currently, costs of caring for Idaho's indigent population - often poor, single men with no children who don't currently qualify for Medicaid - are borne by counties and the state as part of Idaho's "Catastrophic Health Care Fund." The total bill is expected to top $60 million next year. Catastrophic fund managers estimate Idaho will spend $61 million next year on indigent medical care, split between county property taxes and state general funds. With costs expected to escalate by at least 7 percent annually for the next six years, the cost for the program would be $436 million. (Idaho Statesman)

Illinois

- **Illinois to decide on essential health benefits**

  Gov. Pat Quinn has less than a month to choose which benefits will be required in basic health insurance plans sold to individuals and small businesses in Illinois under the federal health care law, an important decision that will determine the cost of future premiums and how broad coverage will be for many patients. Although the governor hasn't been able to push through some needed legislation, he doesn't need the Legislature to OK his choice of a benchmark to assure that Illinoisans receive "essential health benefits." Illinois is behind only nine other states that have already chosen a benchmark plan or have a preliminary recommendation. The deadline for states to select those basic plans is Sept. 30. (Bloomberg Businessweek)

Kansas

- **State launches Medicaid, HealthWave application portal**

  State officials unveiled an online portal designed to help low-income Kansans apply for Medicaid and HealthWave. The online portal also is meant to let applicants know if they're likely eligible for Medicaid or HealthWave. HealthWave is the state's health insurance program for children in low- and modest-income families. The Customer Self-Service Portal marks the first phase of the of a multi-year initiative — called Kansas Eligibility Enforcement System, or KEES — aimed at streamlining the process for applying for public assistance. (Kansas Health Institute)

- **Insurance Commissioner urges health care law plans**

  The state of Kansas needs to decide soon what services it will provide in a health insurance exchange required by the federal health care law, even if the future of the exchanges hinges on the outcome of the presidential election, Kansas Insurance Commissioner Sandy Praeger said. During a meeting Wednesday with health care officials, Praeger said she hoped to make recommendations on which "essential health benefits" should be included in Kansas' insurance exchange after public comments end next week. Praeger said the state is approaching a "soft deadline" of Sept. 30 to establish a benchmark insurance plan that includes which services must be covered by all other plans on the exchange. (The Daily Union)

Maine

- **DHHS will wait for federal OK before telling Medicaid recipients they're losing coverage**

  MaineCare Services director Stefanie Nadeau told members of the Legislature's Appropriations Committee on Friday that DHHS will await an OK from the federal Centers for Medicare and Medicaid Services or the outcome of court action Maine has taken to force federal officials to sign off on about $20 million in cuts to Maine's Medicaid program before notifying recipients of reductions in Medicaid benefits. In August, Health and Human Services Commissioner Mary Mayhew told lawmakers her department planned to send notices to about 12,000 low-income parents to alert them that they might lose Medicaid coverage, pending federal approval. The 12,000 are among 36,000 total who would lose coverage if Maine receives federal permission to trim its Medicaid rolls. The federal Centers for Medicare and Medicaid Services has indicated the cuts for those 12,000 parents are likely consistent with federal law, while the remaining cuts might not be allowed under the Obama administration's Affordable Care Act. (Bangor Daily News)

Massachusetts

- **Hawthorn Medical leaves Partners HealthCare System to link up with Steward Health Care**

  Hawthorn Medical Associates, the largest multi-specialty practice in the New Bedford area, disclosed Wednesday that it has signed a 10-year affiliation deal with Steward, a Boston-based chain of 11 hospitals and other medical care facilities across Eastern Massachusetts. The agreement takes effect Jan 1. Hawthorn doctors will be covered by insurance contracts negotiated by Steward Health Care Network, many of them so-called global contracts that put providers on annual budgets for delivering care and reward them financially for better results that come in under budget. For-profit Steward, backed by New York private equity firm Cerberus Capital Management, has been aggressively wooing doctors practices in the communities where it operates. (Boston Globe)

Missouri

- **St. Louis area clinics' program called model for expanded Medicaid under ACA**

  The Affordable Care Act remains a contentious political issue in Missouri, but St. Louis is already a leader in demonstrating one positive effect of the reform law, according to speaker at a forum Saturday. Bethany Johnson-Javois, CEO of the St. Louis Integrated Health Network, says St. Louis is giving the public what amounts to a front-row view of how health reform will unfold in 2014 under ACA. She was referring to the federal demonstration grant, called Gateway to Better Health, which is to serve an estimated 30,000 uninsured residents in St. Louis and St. Louis County from now until ACA takes full effect in 2014. The number represents about one-fifth of all of the uninsured in the city and county. She says the grant is a test of the effectiveness of ACA's Medicaid expansion model. The goal of the pilot program "partly is to help us understand what will take place hopefully in 2014. St. Louis is now the leader in helping us understand what will happen in the future." (St. Louis Beacon)

Montana

- **Montana to vote on blocking ACA Nov. 6**

  On Election Day, Montana residents will vote on a measure that would ban the state or the federal government from ordering Montanans to purchase health insurance. Its passage would be a largely symbolic rebuke of the Affordable Care Act's coverage requirements and would mirror similar laws and proposals in other states. (Politico)

New Jersey

- **Horizon NJ Health Slashes Medicaid Reimbursements for Home Healthcare**

  A 10 percent reduction in Medicaid reimbursements from Horizon NJ Health (a Blue Cross Blue Shield of New Jersey company) has caused an uproar in the home health community, which fears that the cut in reimbursements will hamper agencies' ability to handle more clients just when demand is expected to soar due to a change in how Medicaid is administered. Horizon NJ Health, the largest of four managed care companies that administer the state's Medicaid system, sent a letter to agencies that provide personal care assistance saying that it would cut reimbursement rates by 10 percent, from $15.50 per hour to $13.95 per hour, beginning October 1. Providers were told they had until September 4 to agree to the changes or they would have to leave the healthcare network. The deadline was later extended to September 14. (WNYC News)

New York

- **U.S. Court Halts Some Cuts for Medicaid Home Care**

  While not ruling on the merits of the case, a federal judge in Manhattan decided on Tuesday that the plaintiffs had a "substantial likelihood" of proving that New York City and New York State had violated federal law in cutting back on Medicaid-financed personal care for hundreds of New Yorkers since last year. The judge, Shira A. Scheindlin, issued a preliminary injunction ordering the city to stop reducing or terminating so-called split-shift care for certain reasons, except when a physician had personally examined the patient and found a change in medical condition or if the city submitted a declaration that a mistake had been made. The judge wrote that there was strong evidence that care had been reduced or terminated in many cases without proper notice to patients and because of confusing and contradictory interpretations of state rules for Medicaid, the government health care program for the poor. The city and state can appeal the ruling, reach a settlement with the plaintiffs or continue to fight the suit. The city's Human Resources Administration, which administers the Medicaid personal-care program, issued a statement on Wednesday saying, "While we respectfully disagree with some of the court's finding, we will, of course, comply with the court's order." The State Health Department said it was reviewing the decision. (New York Times)

North Carolina

- **Medicaid Program In the Black – Just**

  Spending in the state's Medicaid program is down slightly in the past two months, a state health official told lawmakers Tuesday. During a meeting of the Health and Human Services oversight committee at the state legislature, Medicaid chief business of-

ficer Steve Owen told lawmakers that compared to budget projections, the program had spent about $4 million dollars less than forecast. Lawmakers expressed their satisfaction with the trend. Last year, the state Medicaid program had an overrun of more than $275 million, out of a total budget of more than $4.5 billion state dollars. Owen told the panel the program was seeing more activity from the "aged, blind and disabled" patient pool, a group that costs on average $1422 per month to cover, while seeing substantially decreased activity in children patients, who cost only about $177 per month. (North Carolina Health News)

South Carolina

- **South Carolina's View: The Affordable Care Act's Medicaid Expansion Is The Wrong Approach**

  In blog post for Health Affairs, South Carolina's Medicaid director, Anthony Keck, lays out his opposition to the Medicaid expansion, explaining, "There is sufficient money currently in the health care system — we need to do the hard work to shift it from non-productive to productive uses. We rely on a three-pronged strategy of payment reform, clinical integration, and targeting hotspots and disparities to allow for investment in other health-producing activities while lowering the cost of care per person to increase affordability of coverage." (Health Affairs)

Utah

- **Advocates: Utah's managed care plan isn't true 'accountable care'**

  Accountable Care Organizations are touted as a new take on managed care that can cure out-of-control costs and improve America's health. But Utah's plan to try ACOs for low-income Medicaid patients isn't true accountable care, say advocates who want stricter patient safeguards added to the state's managed care contracts. The state Department of Health is in contract negotiations with four managed care groups that, starting in January 2013, will oversee care for 70 percent of the 252,000 Utahns on Medicaid. The experiment is expected to save taxpayers $770 million over seven years. But advocates, some providers and Utah's Medicaid Inspector General want assurance that those savings won't come on the backs of the state's working poor adults and children. The Inspector General is preparing an audit detailing weaknesses in draft contracts released last month. Advocates and providers, meanwhile, are pressing to delay negotiations until adequate patient safeguards and quality benchmarks are in place. (Salt Lake Tribune)

Wisconsin

- **Community Health Partnership to cease programs**

  A long term health care organization with nearly 3000 members will cease operations at the end of the year. WEAU.com learned Community Health Partnership, Inc will cease operating the Partnership and Family Care programs as of Jan 1, 2013. The 2700 people affected by this will have help coming from the Wisconsin Dept. of Health Services. DHS will contract with at least one, if not more new managed care organizations to provide help to members starting in 2013. (WEAU.com)

National

- **Medicaid to Lose $1.26 Trillion Under Romney Block Grant**

  Republican presidential nominee Mitt Romney would strip Medicaid of $1.26 trillion over nine years as part of a plan to do away with the open-ended approach to funding the U.S. health-insurance plan for the poor, a Bloomberg Government study found. Romney proposes to convert Medicaid to a fixed allotment of money from an entitlement tied to economic indicators and a state's caseload. Payments from the federal government would grow at 1 percentage point above inflation a year, creating the funding reduction, in exchange for fewer rules on how states use the money, according to the study released yesterday. The Medicaid proposal has drawn less attention in the campaign than Romney's ideas for Medicare, the U.S. health plan for the elderly and disabled. The Medicaid plan could be implemented as soon as 2014 and involves more money. Romney has said Medicare beneficiaries wouldn't face changes until 2022. (Bloomberg Businessweek)

- **Romney says he would keep some parts of Obama's health-care law**

  Republican presidential candidate Mitt Romney says that while he intends to dismantle the Obama administration's health-care law if elected, he will retain several key provisions, including coverage for preexisting conditions. In an interview aired Sunday on NBC's "Meet the Press," Romney said his health-care overhaul will also allow families to cover adult children with their policies through age 26 and include access to coverage for unemployed people seeking insurance. Both are part of the Patient Protection and Affordable Care Act, signed into law by Obama in 2010. (Washington Post)

- **With Medicaid, Long-Term Care of Elderly Looms as a Rising Cost**

  Many states faced with rising Medicaid costs and budget deficits are already trying to cut the cost of long-term care by profoundly changing Medicaid coverage, through the use of federal waivers. Waivers sought or obtained by 26 states, including New York, California, Illinois and Texas, would affect some three million people, most of them eligible for both Medicaid and Medicare. Plans vary, but typically they try to cut costs by giving private managed-care organizations a fixed sum for a lifetime of care, from doctor and hospital visits to help at home to nursing home placement, expecting that more care will take place in less expensive settings. Overall, 31.5 percent of Medicaid's $400 billion in shared federal and state spending goes to long-term care for the elderly and the disabled. That ranges from less than 8 percent in Hawaii, where nursing home use is low, to more than 60 percent in North Dakota. (New York Times)

- **States Try Different Routes to Cut Medicaid Eligibility**

  Earlier this year, Maine and Illinois officials had a similar goal: to scale back the number of people who were eligible for Medicaid in their states. Each wanted to get around rules in the 2010 health care law that require states to maintain, until 2014, Medicaid eligibility policies that are at least as generous as those in place when the overhaul was signed in March 2010. Many states have complained that those "maintenance of effort" rules are too restrictive at a time when state budgets are in turmoil and legislators are looking for cuts. But federal officials say the requirements have prevented millions of people from losing coverage during the national economic downturn. The health care

overhaul provides a way for states to bypass the maintenance-of-effort rules by getting an exception. To get one, state officials have to show that they are facing a budget deficit. They also cannot narrow eligibility for just anyone. State officials can only cut off coverage for adults who aren't pregnant or have disabilities and who have incomes higher than the federal minimum of 133 percent of the federal poverty level, which this year is $19,090 for a family of three. Both Illinois and Maine could have used this route to drop people from their rolls. (CQ Healthbeat)

- **Video Dial-a-Doctor Seen Easing Shortage in Rural U.S.**

  As part of a state-wide initiative, rural Ware County, Georgia has installed videoconferencing equipment at all 10 of its schools to give its 5,782 students one-on-one access to physicians. Telemedicine sites for adults have also sprung in the area. Instead of taking a full day off from work or school, residents can now regularly see their specialist online. The program places Georgia among a half-dozen U.S. states turning to telemedicine to address a shortage of doctors in rural areas, a gap the Obama administration has said is a serious health-care shortcoming. At the same time, it is allowing companies such as medical provider Sentara Healthcare and MDLive, a remote technology developer, to get a toehold in a new and growing market. (Bloomberg News)

- **Health Exchange Navigators Still an Unknown for Most States**

  With roughly two months left to submit their health exchange plans to the feds, and a little over a year away from opening enrollment, states are confronting a key piece of the online insurance marketplaces that has so far received little attention: navigators, the insurance brokers and/or non-profit groups that will explain to the general public just what exactly an "exchange" is, anyway. The navigators are "an absolute core value" of the marketplaces, says Christine Ferguson, executive director of the exchange in Rhode Island, a state that is further along in its planning than most. As conceived under the Affordable Care Act (ACA), navigators will be people's first contact point with the exchange. They'll explain how to apply and what insurance options are available, guiding (or "navigating") consumers through the system. They could be insurance brokers or non-profit organizations: states that develop their own exchanges are responsible for selecting and contracting navigators. Some states, including California and Nevada, have already drafted recommendations about what their navigator programs will look like. States will need those kinds of details to secure conditional approval for their exchanges in January, according to final rules released by the U.S. Department of Health and Human Services (HHS) in August. Applications are due Nov. 16. (Governing Magazine)

COMPANY NEWS

- **WellCare Approved to Participate in Florida's Long-Term Care Community Diversion Pilot Project in 19 Counties**

  WellCare Health Plans, Inc. today announced that the Florida Department of Elder Affairs has approved WellCare of Florida to participate in 17 counties in support of the state's Long-Term Care Community Diversion Pilot Project. On June 28, 2012, WellCare announced that it had received approval to provide services in Escambia and Santa Rosa Counties and began serving members on July 1, 2012. This approval of an additional 17 counties is effective immediately. (WellCare News Release)

- **Amerigroup Expands Medical Home Initiative in Georgia**

  The Amerigroup Foundation announced its support of the Georgia Academy of Family Physicians' (GAFP) second generation of its Patient-centered Medical Home (PCMH) University, granting $50,000 to assist in successfully implementing the project. The GAFP proposes to recruit up to 20 primary care practices interested in PCMH transformation and up to 10 currently recognized by the National Council for Quality Assurance as PCMH practices. (Amerigroup Press Release)

- **WellCare to Acquire Easy Choice Health Plan in California**

  WellCare Health Plans, Inc. today announced that it has entered into an agreement to acquire Easy Choice Health Plan, Inc. As of September 2012, Easy Choice serves approximately 34,000 Medicare Advantage plan members in Los Angeles, Orange, Riverside, and San Bernardino Counties in Southern California. This includes approximately 12,000 Medicare Advantage dual special needs plan (D-SNP) members, making Easy Choice one of the largest D-SNPs in Los Angeles County. (WellCare News Release)

- **Nation's largest Catholic health system seeks control of Wichita's Via Christi**

  Ascension Health Alliance would gain operational control of Via Christi Health and two other Catholic health systems under a tentative agreement announced Wednesday. St. Louis-based Ascension is the largest Catholic health system in the nation, operating more than 1,400 facilities in 21 states and the District of Columbia. Wichita-based Via Christi is the largest provider of health care services in Kansas. The non-profit health care system owns or manages 12 hospitals and several senior care facilities across the state and has more than 10,000 employees. Currently, Via Christi is affiliated with both Ascension and the Marian Health System. (Kansas Health Institute)

- **Ministry Health Care may join Ascension Health**

  Ministry Health Care, which has 14 hospitals in Wisconsin and one in eastern Minnesota, could become part of Ascension Health Alliance, the parent of Columbia St. Mary's Health System and the country's largest Catholic health system, under a tentative agreement announced Wednesday. Marian Health System, parent of Ministry Health Care and two other health systems, and Ascension said they would begin working toward a definitive agreement to combine the two systems. (Journal Sentinel Online)

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
September 12, 2012	Idaho Behavioral	RFP Released	200,000
September 20, 2012	Ohio Duals	Contracts finalized	122,000
September 21, 2012	Massachusetts Duals	Contract awards	115,000
September, 2012	Illinois Duals	Contract awards	136,000
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 15, 2012	Nevada	Proposals due	188,000
November 20, 2012	New Mexico	Proposals due	510,000
November, 2012	Arizona - Acute Care	RFP Released	1,100,000
November, 2012	Washington Duals	RFP Released	115,000
December 5, 2012	Idaho Behavioral	Proposals due	200,000
December 19, 2012	Nevada	Contract Awards	188,000
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	Ohio	Implementation	1,650,000
January 1, 2013	Vermont Duals	Proposals due	22,000
January 7, 2013	New Mexico	Contract awards	510,000
January 15, 2013	Florida LTC	Contract Awards	90,000
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	Nevada	Implementation	188,000
July 1, 2013	Michigan Duals	Implementation	198,600
July 1, 2013	Idaho Behavioral	Implementation	200,000
July 30, 2013	South Carolina Duals	Contract awards	68,000
July, 2013	Virginia Duals	Contract awards	65,400
July, 2013	Washington Duals	Contract awards	115,000
July, 2013	Idaho Duals	Contract awards	17,700
October 1, 2013	Florida LTC	Implementation	90,000
October 1, 2013	Arizona - Maricopa Behav.	Implementation	N/A
January 1, 2014	New York Duals	Implementation	133,880
January 1, 2014	Arizona Duals	Implementation	120,000
January 1, 2014	New Mexico	Implementation	510,000
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	8/27/2012	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…

Margarita Pereyda, Principal – Southern California

Margarita Pereyda joined HMA on September 10, 2012, as a Principal in the Southern California office. Margarita comes to us from Share Our Selves (SOS) Community Health Center where she has served as the Chief Medical Officer for the last eight years. In this role, Margarita played a critical role in converting this 32-year old institution from a free, volunteer-based and donor-dependent clinic to one of the most highly regarded Community Health Centers in California. She also led the Center's FQHC application process, and the Center's status as a FQHC was recently approved. SOS is known for delivering high quality care, being an early adopter of technology, and being the lead advocacy organization for systemic change in Orange County. Since 2009, Margarita has also served as the Associate Director of Community Medicine at Hoag Hospital Memorial Presbyterian where she has assisted in directing and managing Hoag's Community Benefit Program. Prior to her time at SOS, Margarita spent a year as a Staff Physician at Gateway Medical Group in Anaheim, California, and two-and-a-half years as the Medical Director of South County Community Health Center in East Palo Alto. Margarita earned her Bachelor of Science degree at University of Arizona, her MD/Doctor of Medicine at University of Michigan, and did her Internal Medicine Residency Program at Stanford University Hospital.

UPCOMING EVENTS

Cowen and Company Conference Call: "Dual Eligibles: Pace and Process"

HMA Principals Greg Nersessian and Jennifer Kent will join Christine Arnold and the Cowen and Company Health Care Team on a conference call to discuss the pace and process for moving the dual eligible population into managed care,

Date: Thursday, September 13, 2012 at 12:00pm ET.

Dial-In Numbers. Domestic toll free callers: 888-778-8903; International callers: 913-312-1503

.

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 implement a state option under the Affordable Care Act to implement health homes for Medicaid beneficiaries with chronic conditions. Almost half of the nine 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

More info here.

Current Issues Series at Denver University

"Election 2012 Issues: Health Care Policy"

Joan Henneberry – Panelist

September 24, 2012

Denver, Colorado