HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: STATE PROGRESS TOWARD EXCHANGE ESSENTIAL HEALTH BENEFIT DECISIONS

HMA ROUNDUP: OHIO HEALTH HOMES PROGRAM RECEIVES CMS APPROVAL; FLORIDA DRAFT MEDICAID MCO RATES TO BE RELEASED THIS WEEK; PENNSYLVANIA NEW WEST EXPANSION DELAYED 1 MONTH, NEW EAST PROTEST RESOLVED; ILLINOIS EXCHANGE DEVELOPMENT RFP BIDDERS RELEASED; MASSACHUSETTS DUALS AWARDS DUE FRIDAY

OTHER HEADLINES: ALABAMA VOTERS APPROVE MEDICAID APPROPRIATION; STUDY ESTIMATES MEDICAID MANAGED CARE DRUG REBATE SAVINGS OF $1.6B; MINNESOTA TO DEVELOP STATE EXCHANGE; FLORIDA LEGISLATIVE PANEL APPROVES PRISON PRIVATIZATION PLAN

UPCOMING EVENTS: MACPAC MEETING THIS THURSDAY-FRIDAY, SEPTEMBER 20-21, WASHINGTON, DC

SEPTEMBER 19, 2012

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IN FOCUS: STATE PROGRESS TOWARD ESSENTIAL HEALTH BENEFIT DECISIONS

This week, our *In Focus* section explores states' progress toward one of the crucial decision points in the health reform and exchange implementation process, establishing Essential Health Benefit (EHB) requirements in the states. The determination of EHB requirements, through the selection of a Benchmark Health Plan, will shape the benefit package a health plan will be required to minimally offer within a state's exchange and outside of the exchange in the small group and individual markets. States have been provided flexibility under the Affordable Care Act in selecting the EHB Benchmark plan, a decision that must be made by October 1, 2012.

Essential Health Benefits and the Benchmark Health Plan

In late 2011, the Department of Health and Human Services (HHS) issued a bulletin describing how Essential Health Benefits would be defined (an obligation of the Secretary of HHS under the Affordable Care Act). HHS gave states flexibility to select an existing health plan in their state as the EHB Benchmark plan for the package of covered services included in the EHB. HHS outlined the following ten service categories, all drawn from the ACA itself, that must be included in any EHB package:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

These 10 benefits must be included in a state's selected EHB Benchmark plan. HHS has provided the following plan options for a state to select from in determining the Benchmark plan:

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

Size of plan is determined by enrollment as of March 31, 2012. On July 2, 2012, HHS released a document detailing the three largest small-group plans in each state (available here). In a state where state-mandated benefits are in place, and to the extent that those mandated benefits are in excess of the Essential Health Benefits package, financial responsibility for those benefits will fall to the states in an Exchange. States must notify HHS by October 1, 2012 of their proposed Benchmark plan. A public comment period

will follow through Fall and Winter 2012. Benchmark plans will be in place for plan years 2014 and 2015.

Impact on Exchange Plan Benefits, Cost

Plans sold inside and outside the Exchange will be required to offer coverage of equal or greater value to the selected EHB Benchmark. As a result, the Benchmark will also serve as minimum criteria for any qualified health plan (QHP) offered on the Exchange – although state QHP certification standards will include requirements in addition to that EHB-related requirement.

The selection of a EHB Benchmark plan will provide significant insight into the minimum package of health benefits that plans will be required to offer, and how much those benefits might cost, beginning in 2014. For example, Colorado has noted that their Benchmark plan selection costs a 40 year old non-smoker male $4,200 annually. However, there are several requirements that will impact eventual cost and pricing of a health plan – again both inside and outside of the exchange. Those ACA insurance reforms include: rating requirements, medical underwriting rules, and the additional required services, particularly the habilitative services package.

- The ACA limits the range of variation in rating between coverage groups to a maximum of 3:1 for most factors, and 1.5:1 for tobacco use. This could limit the presence of higher cost plans for individuals who currently pay higher rates for coverage. However, these rating rules will also increase rates for lower-cost rating groups.
- Underwriting requirements preclude denying coverage to individuals with preexisting conditions, guaranteed availability and renewability of coverage, and the prohibition of discrimination based on health status.
- If a required benefit category is entirely missing from the selected EHB Benchmark, a state is required to supplement the EHB Benchmark (by referring to another plan that does offer the benefit). HHS determined that three categories of benefits required to be in EHB by the ACA - pediatric oral services, pediatric vision services, and habilitative services - are not included in many health insurance plans and so has set up special rules for those benefits. Of these three benefits, habilitative services likely have the greatest potential to impact cost of plans offered. HHS has provided the following options for plans to include habilitative services as part of the Essential Health Benefits package[1]:
    1. *A plan would be required to offer the same services for habilitative needs as it offers for rehabilitative needs and offer them at parity.*
    2. *A plan would decide which habilitative services to cover and report the coverage to HHS. HHS would evaluate and further define habilitative services in the future. Under either approach, a plan would be required to offer at least some habilitative benefit.*

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[1] "Frequently Asked Questions on Essential Health Benefits Bulletin." US Department of Health and Human Services. Available at: http://www.statereforum.org/sites/default/files/ehb-faq-508_0.pdf

States' Progress

The table on the following page is pulled from the StateReforum.org project, supported by both the National Academy for State Health Policy (NASHP) and The Robert Wood Johnson Foundation. The table, up to date as of Tuesday, September 18, 2012, tracks progress in the 35 states that have taken action toward selecting a EHB Benchmark plan. Key takeaways from the table are highlighted below:

- In total, 35 states have taken some action toward establishing Essential Health Benefits and selecting a BHP.
- Of those, 31 states have formed a workgroup to explore the essential health benefits decision process.
- 28 states have conducted analysis of existing state benefit mandates (two states, New York and Utah are in the draft phase of this process).
- 30 states have assessed their benchmark plan options (again, New York and Utah are in the draft phase).
- 27 states have held a public comment period on the Essential Health Benefits, with Illinois, South Carolina, Washington, and DC closing public comments later this month.
- A total of 12 states have proposed a Benchmark plan, with six states proposing additional benefits, such as habilitative services and a pediatric dental supplemental plan.
- Of these 12 states, 11 of the proposed Benchmark plans are small group health plans, with only Utah proposing a state employee plan.

Please see the full table at StateReforum.org for the most up to date state progress going forward, as well as links to relevant documents and communication from the states as they plan their Essential Health Benefits.

Next Steps

As noted above, states are required to identify a EHB Benchmark plan for HHS review by October 1, 2012. If a state does not recommend an EHB, the default plan will apply. The default plan will be the largest small-group plan within the state. If the default plan is missing required benefit categories, the next largest small-employer plan or state employee plan will be used to set benefits in the missing categories. However, if none of the plans include the required benefits, the largest federal employee health benefit plan (FEHBP) will be used instead. After the state has made a recommendation to HHS, HHS will have a public comment period on the plan the state recommended as its benchmark. After the federal public comment period, the final selected EHB Benchmark plan will serve as the benchmark for a two-year period, through 2014 and 2015.

State	Formed a workgroup on essential health benefits	Conducted an analysis of existing state benefit mandates	Assessed benchmark plan options	Held a public comment period	Recommended benchmark plan	EHB benchmark plan type
AL		X	X	X		
AR	X	X	X		**EHB Benchmark Plan:** Any of the state's three small group plans *(preliminary recommendation)*	Small Group Plan
AZ		X	X	X		
CA	X	X	X	X	**EHB Benchmark Plan:** Kaiser small group HMO plan1 **Pediatric Dental Supplemental Plan:** Healthy Families (CHIP) Plan	Small Group Plan
CO	X	X	X	X	**EHB Benchmark Plan:** Kaiser Ded/CO HMO1200D (preliminary recommendation) **Pediatric Dental Supplemental Plan:** Colorado's Child Health Plan Plus (CHP+) (preliminary recommendation)	Small Group Plan
CT	X	X	X	X		
DC	X	X	X	X *(Comment period open until 9/28)*	**EHB Benchmark Plan:** BlueCross BlueShield CareFirst BluePreferred *(preliminary recommendation)*	Small Group Plan
DE	X	X	X	X	**EHB Benchmark Plan:** BCBS Small Group EPO plan (preliminary recommendation)	Small Group Plan
HI	X			X		
IA	X					
IL	X	X	X	X *(Comment period open until 9/19)*		
KS	X	X	X	X		
KY	X		X	X		
MA	X	X	X	X		
MD	X	X	X	X		
ME		X	X			
MI	X	X	X	X		
MN	X	X	X			
MS	X		X			
NC	X	X	X			
ND	X	X	X	X		
NE	X	X	X	X		
NH	X	X	X			
NM	X					
NV	X	X	X	X	**EHB Benchmark Plan:** Small Employer HMO Plan (preliminary recommendation, analysis is ongoing)	Small Group Plan
NY	X	X *(Draft)*	X *(Draft)*	X		
OR	X	X	X	X	**EHB Benchmark Plan:** PacificSource Preferred CoDeduct small group plan(preliminary recommendation) **Pediatric Dental Supplemental Plan:** HealthyKids Plan (preliminary recommendation) **Vision Supplemental Plan:** FEDVIP - BlueVision High Plan (preliminary recommendation)	Small Group Plan
RI	X	X	X	X	**EHB Benchmark Plan:** United Health Care - Choice Plus (preliminary recommendation) **Pediatric Dental Supplemental Plan:** FEDVIP MetLife (preliminary recommendation)	Small Group Plan
SC	X			X *(Comment period open until 9/21)*		
TN	X	X	X	X		
TX	X			X		
UT	X	X *(Draft)*	X *(Draft)*	X	**EHB Benchmark Plan:** Utah Basic Plus State Employee Plan (preliminary recommendation by	State Employee Plan
VA	X	X	X	X	EHB Benchmark Plan: Anthem Small Group PPO (preliminary recommendation) **Pediatric Dental Supplemental Plan:** Smiles for Children (current Medicaid dental plan for children) (preliminary recommendation) **Habilative Services Plan:** TBD	Small Group Plan
VT	X	X	X	X	**EHB Benchmark Plan:** Blue Cross Blue Shield Vermont (preliminary recommendation) **Pediatric Dental Supplemental Plan:** CHIP dental benefit plan (preliminary recommendation) **Habilative Services Plan:** State preliminarily recommends same coverage as rehabilative services	Small Group Plan
WA		X	X	X *(Comment period open until 9/18)*	**EHB Benchmark Plan:** Regence Innova Small Employer Plan	Small Group Plan
Total	31	28	30	27		

HMA Medicaid Roundup

California

HMA Roundup – Stan Rosenstein

We wanted to clarify and correct comments we made on a recent conference call. Rate negotiations between Medi-Cal health plans and the Department of Healthcare Services are ongoing for the FY 2013 rate year beginning October 1, 2012. This includes rates associated with the Seniors and Persons with Disabilities (SPD) population that transitioned to managed care beginning July 2011. We had previously suggested rate changes would be effective July 1, 2013.

In the news

- **California Tries to Guide the Way on Health Law**

  So far, only 13 states and the District of Columbia have told the Obama administration they intend to set up the insurance exchanges that are supposed to provide a marketplace for people to buy health plans. None are being watched as closely as California, whose singular challenges, from the size, diversity and geographic spread of its uninsured population to its vast budget problems, make it stand out. Many feel a successful rollout here could convince other states with high numbers of uninsured residents that the law can be made to work for them. The California Health Benefit Exchange has already hired 50 employees and is poised to hire 50 more. Construction of the Web portal through which some three million people are expected to buy insurance by 2019, and through which many others will likely enroll in Medicaid, is under way. This fall, the board will seek bids from insurers to sell plans through the exchange, and it intends to have the portal up and running by next summer, several months before enrollment starts in October 2013. (New York Times)

- **Long-Term Care A Big Time Worry in California, Study Finds**

  A new poll released Wednesday by The SCAN Foundation and the UCLA Center for Health Policy Research found that half of California voters say they'll need long-term care for a close family member in the next few years, but won't be able to afford it. Anxiety over the cost of long-term care, like the price tag of a nursing home stay, is going up. The percentage of California voters who said they couldn't afford more than three months of nursing home care increased to 73 percent from 66 percent in 2011, and 46 percent said they didn't have the money to cover a single month in a nursing home, about $6,800 in California. For Latinos, the prospect of paying for long-term care is even more grim: nine in 10 Latino voters said they couldn't afford more than three months of nursing home care and 86 percent couldn't afford more than three months of part-time care at home. (Kaiser Health News)

- **Promise, Peril of Duals Program**

  Advocates see potential for improvement but also are concerned about consumer protections in the transition of roughly 1.1 million Californians into Medi-Cal managed care. The state is launching a managed care pilot project for beneficiaries who are dual-

ly eligible for Medicare and Medi-Cal, California's Medicaid program. Fay Gordon, a NSCLC attorney in Washington, D.C., said one of the bigger consumer-protection issues in the duals project is enrollment choice. The federal government has made it clear that it will support passive enrollment, but that consumer choice also will be paramount, Gordon said. (California Healthline)

- **California Official Expects Hospitals to be Paid Medicare Rates in Duals Demo**

  The next high-profile demonstration project agreement affecting people who are dually eligible for Medicare and Medicaid will probably be completed in California within a month. A top state official said Wednesday that Medicare providers who care for dual-eligibles should assume that they will receive rates as high as those they now get under the health program for seniors and the disabled. Toby Douglas, director of the California Department of Health Care, said in response to questions from a reporter on Wednesday "that Medicare is going to be in many ways the floor" for payments to medical providers such as hospitals. Douglas spoke on a panel at a conference sponsored by the trade group America's Health Insurance Plans (AHIP). (CQ Healthbeat)

Colorado

HMA Roundup – Joan Henneberry

Integrated Physicians Network (iPN), one of the largest physician networks in Colorado, announced on Monday that it will sign a contract to join CORHIO's (Colorado Regional Health Information Organization) health information exchange network. CORHIO provides secure access to necessary clinical information, including lab test and pathology results; x-ray, MRI and other imaging reports; and physician transcription reports when necessary for patient care. By connecting to CORHIO's HIE, iPN providers will have the ability to access such data across systems outside of their local network with Centura Health hospitals—including Boulder Community Hospital, Longmont United Hospital, and other health care providers in the region.

Florida

HMA Roundup – Elaine Peters

Prepaid Health Plan Draft Rates: Medicaid managed care draft capitation rates for contract year 2012-2013 are scheduled to be released this week by the Agency for Healthcare Administration (AHCA). AHCA will host a draft rate meeting with the participating health plans to discuss the rates on September 27. The rates are effective October 1, 2012.

Budget: On September 12, the Florida Office of Economic and Demographic Research reported to the Legislative Budget Commission that it forecasts a $71.3 million surplus for the coming fiscal year (FY 2013/14). While the news of a projected surplus is positive, the magnitude is small relative to the total Florida budget of almost $70 billion.

Payment Reform: AHCA will be making decisions on the inpatient hospital DRG conversion process using a Governance Committee model. This committee has been formed, and it held its first meeting on August 29, 2012. The decisions that have been made (Link) are outlined below.

- Proceed with the recommendation to adopt APR-DRG model.
- For the initial model, use only one base rate;.
- For the initial model, include separate per claim add-on payments to distribute the automatic and self-funded IGTs, which are currently included as part of the inpatient per diem.
- Include adjustment for Medicare Wage Areas.

The next Governance Committee meeting will be held September 18, 2012.

Florida Healthy Kids ITN: The Florida Healthy Kids statewide pre-paid dental health plan ITN was released September 11, 2012. (Link) Key dates follow:

- Bidder's Conference – October 8, 2012
- Proposal Deadline – Nov 13, 2012
- Contract Award – January 2013
- Implementation – July 1, 2013

In the news

- **Panel okays privatizing inmate health care**

  A union for state workers is racing to sue Florida after lawmakers cleared the way Wednesday to privatize health care in prisons. A legislative panel voted 6-4 to allow the state's Department of Corrections to try and plug its $60 million deficit by turning inmate care over to private for-profit companies. The lawsuit could be filed as early as Thursday, said Doug Martin, spokesman for the American Federation of State, County and Municipal Employees, known as AFSCME. About 2,600 state workers who provide prescriptions, mental health and other medical services to prisoners find their jobs and benefits in limbo over the deal, which was vetted through a 14-member budget panel, with four members absent, rather than through the more rigorous legislative committee process. The Legislative Budget Commission hears agency requests for funding shifts between legislative sessions, and is taking on an unprecedented authority by approving the controversial change, said Sen. Nan Rich, D-Weston. (Miami Herald)

Georgia

HMA Roundup – Mark Trail

On September 13, the Board of Community Health (DCH) held a policy committee meeting in which it approved the adjusted FY 13 budget and FY 14 budget, which will be sent to the Governor's Office of Planning and Budget (OPB). Importantly, there were no specific budget reduction strategies for Medicaid and PeachCare described in the budget despite the requirement for 3% additional savings in the current year and another 2% in FY 14. In our experience, this is an unprecedented step for the Georgia DCH to not describe the specifics of the budget reductions, and it appears as though there is no consensus yet on the nature of the savings methodology. With the budget having been sent to the OPB, it is unlikely at this point that the specific savings strategies will be known until the second week of January, when the Governor introduces his budget to the legislature.

Illinois

HMA Roundup – Jane Longo & Matt Powers

Last Wednesday, September 12, the Illinois Health Care Reform Implementation Council met to discuss the Essential Health Benefits requirements for the Exchange. The Council is reviewing several plans that may be selected as the Benchmark Health Plan. The public comment period on the selection process closed at 5:00 p.m. on Wednesday, September 19, 2012. Governor Quinn has indicated that his administration will submit its Benchmark Health Plan to HHS by September 30, 2012.

On Thursday, September 13, 2012, the Illinois Department of Insurance posted the list of vendors that bid on the Health Insurance Exchange project. The RFP covered business services, technology infrastructure setup and operation, accompanying systems application development, and systems operation services associated with the establishment, ongoing operations, and maintenance of the Exchange. The Department received proposals from the following vendors:

- Infosys Public Services
- CGI Technologies & Solutions, Inc.
- Deloitte Consulting
- Xerox
- Cognizant Technologies Solutions

This Friday, September 21, the Illinois Medicaid Advisory Committee will meet in both Springfield and Chicago. The meeting will provide updates on the SMART Act implementation, which implemented numerous cost savings in the state's Medicaid program, as well as the Care Coordination Initiatives and Dual Eligible Medicare/Medicaid Care Integration Financial Model Project. The MAC meetings have previously provided updates on the Dual Eligible RFP process. Awards for this RFP were originally scheduled to be announced in late July and have been delayed nearly two months.

In the news

- **Republicans: Quinn too slow booting Medicaid cheats**

  Top Republican lawmakers on Monday accused Democratic Gov. Pat Quinn of moving too slowly at weeding out people who don't qualify from the state's Medicaid program as a way to avoid angering potential voters before the November election. House Republican leader Tom Cross said the Quinn administration should start scrubbing the Medicaid program by Oct. 1 as the state seeks to save an estimated $350 million a year. (Chicago Tribune)

Massachusetts

HMA Roundup – Tom Dehner

Managed care contract awards for the dual eligible demonstration are scheduled to be announced this Friday, September 21. We note that delays in contract award announcements have been common in Massachusetts, although this award announcement is a precursor to a wide range of activities between the state, CMS, and the selected plans, for

which the state and CMS have set a very ambitious timetable. The effective date for enrollment in the demonstration is April 1, 2013.

In the news

- **Supreme Judicial Court denies safety net hospitals' claims of unfair Medicaid payments**

  The Massachusetts Supreme Judicial Court decided Friday that a dispute between hospitals and the state over the adequacy of Medicaid payments is better resolved by the Legislature, as a lower court had suggested. Boston Medical Center had filed suit three years ago, saying the state had improperly cut payments to the hospital, which cares for a large number of poor patients. Holyoke Medical Center, Quincy Medical Center, and Brockton Hospital, all of which also serve large numbers of Medicaid patients, had joined a similar case and appealed a Superior Court decision that effectively dismissed the claims. (Boston Globe)

Ohio

HMA Roundup – Alicia Smith

On September 17, CMS approved Ohio's state plan amendment to create health homes for people with mental illness. Community mental health agencies will utilize an integrated, multidisciplinary team to deliver health home services and provide intensive care coordination for eligible consumer with serious and persistent mental illness to address both medical and non-medical needs. HMA worked with the Ohio Departments of Job and Family Services and Mental Health in designing the health home model. (Link to Announcement)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

At the September Medicaid Managed Care Subcommittee meeting, Joanie Morgan, the Director of the Bureau of Managed Care Operations for the Pennsylvania Medicaid program, announced that the state had resolved the protest over the New East Zone. The state has not provided any details on the protest or the resolution but confirmed that they were moving forward with the original target implementation date of March 1, 2013. We previously reported that the successful bidders in Pennsylvania for the New East Zone included AmeriHealth Mercy, Coventry and Geisinger Health Plan. The New East Zone includes an estimated 290,000 lives in 22 counties.

Pennsylvania continues to move forward with the expansion of the mandatory managed care program, HealthChoices, into the New West Zone effective October 1, 2012. Originally scheduled for September 1, implementation was moved back one month to allow more time for network development and to ensure that as many consumers as possible actively selected a plan to manage their services. The state just issued a final notice reminding providers that the old program, known as ACCESS Plus, will end effective September 30 for the 13 counties in the New West Zone. ACCESS Plus, an Enhanced Primary Care Case Management program, was administered by APS. Over 90,000 people are affected by the phase out of ACCESS Plus in the New West Zone. An additional 30,000

consumers will transition into HealthChoices from the voluntary managed care program in the North West effective September 1. The state's notice reminds providers that they are responsible for ensuring safe transition and continuity of care for Medicaid recipients under a course of treatment. (Link)

South Carolina

HMA Roundup

South Carolina posted the list of companies that responded to the Dual Eligible Request for information. The list includes four organizations currently operating in South Carolina Medicaid (Carolina Medical Homes, Community Health Solutions of America, Blue Choice Health Plan and Select Health Plan) and two organizations not currently participating in the state's Medicaid program (Humana and APS). (Link)

OTHER HEADLINES

Alabama

- **Alabama voters say spend the money in savings**

  What few Alabama voters went to the polls Tuesday agreed to let the state lawmakers borrow money to balance the General Fund Budget. The vote allows taking more than $487-million during the next three years to from a state savings account to avoid huge budget cuts. The single issue on the statewide ballot was the Alabama Medicaid Amendment that will allow lawmakers to borrow enough money from an Oil and Gas trust fund to meet the legal requirement for a balanced General Fund budget that takes effect October 1. Election officials reported about a half million of Alabama's 2.68 million voters showed up at the polls. They voted roughly 2 to 1 in favor of the measure. (Birmingham Examiner)

District of Columbia

- **Vincent Gray wants to extend 3 Medicaid contracts**

  D.C. Mayor Vincent Gray's administration plans to extend current Medicaid managed care contracts five months beyond their April 30, 2013, expiration date, a move that would steer an additional $250 million or more to the three incumbent insurers. The administration has also again delayed a solicitation seeking bids on new multiyear deals to administer the insurance program for the poor. The solicitation is now scheduled for later this fall, and the Department of Health Care Finance hopes to announce winners by January, but contracting officials would not guarantee that time frame. (Washington Business Journal)

Kansas

- **Kansas Wrestles With Whether To Decide Which Health Insurance Benefits Are Essential**

  Kansas insurance officials – trying to develop a recommendation for "essential health benefits" that individual and small group health insurance policies will be required to

offer under the 2010 federal health law – are running into a problem: the calendar. The state must settle on its plans for those benefits by Sept. 30, says Insurance Commissioner Sandy Praeger, or the federal government will dictate the coverage requirements. But Republican Gov. Sam Brownback, an ardent opponent of the health law, wants to wait until after the presidential election in November. (Kaiser Health News)

- **Kansas Helps Developmentally Disabled Get to Work**

  Much of the focus on growing Medicaid enrollment (up to 50.8 million, according to new Census figures) is on the people who can't find work so they need Medicaid. But what about the people who need Medicaid so they can work? That's the population that Kansas policymakers had in mind when they created the WORK program in 2006. They're mostly developmentally disabled adults who want to work, but require a little assistance around the house to stay independent. So the Kansas Medicaid office provides them with a cash allotment (averaging just under $1,700 per month) to pay for the help they need. WORK enrollees can hire an in-home aide or purchase other services themselves—or a state case worker will do the legwork for them. It's a small program—277 people were enrolled in June 2012—but it makes a big difference for its participants. And the early indication in Kansas is that the program's population is less costly to the state. A University of Kansas analysis found that the Medicaid office spent $1,933 per member per month in 2010 on WORK enrollees—significantly less than the $3,254 the state spent on a comparable population enrolled in more traditional home and community-based care. (Governing Magazine)

Maine

- **Federal court rejects Maine's Medicaid lawsuit**

  A federal appeals court on Thursday rejected Maine's lawsuit that demanded swift action from the federal government on the state's Aug. 1 request to eliminate Medicaid coverage for more than 20,000 residents. The 1st U.S. Circuit Court of Appeals in Boston declared the lawsuit premature because the federal Centers for Medicare and Medicaid Services had 90 days — until Nov. 1 — by statute to consider Maine's waiver request. The ruling came a little more than a week after the state of Maine sought an injunction. (Boston Globe)

Minnesota

- **Dayton moving ahead on health insurance exchange**

  Gov. Mark Dayton told legislative leaders Tuesday that he will seek federal approval to move forward on a Minnesota-made health insurance exchange, but he sought to assure Republican opponents that he will defer important policy decisions until after the November election. Dayton also said he was shifting responsibility for leading the "next phase" of the exchange to a new state agency. The actions are a sign of continued movement to set up a state-run exchange, a key component of President Obama's health care law. The exchanges are scheduled to launch nationwide in 2014 and aim to be competitive marketplaces for individuals and small businesses to comparison shop for health insurance. (Minneapolis Star Tribune)

Mississippi

- **Medicaid Expansion Part of Budget Discussions**

As Mississippi state agencies make final adjustments to budget proposals for the next fiscal year, one division of state government is already becoming a focal point for next week's Joint Legislative Budget Committee. "Medicaid expansion is going to be a part of the discussion next week, next year and probably for the next five years," said Lt. Gov. Tate Reeves. Reeves, a Republican, is opposed to any type of Medicaid expansion in the state. While he believes some type of reform is needed, Reeves says an expansion would have no long term benefit. (WTOK News)

North Carolina

- **Four adult care homes in state will lose Medicaid funding**

Four adult care homes heard this week they will lose Medicaid funding because they house too many mentally ill people. These four facilities are the first wave of adult care operations to receive notice that the insurance money that helps pay for residents' care is being cut off as part of a federal crackdown. Under federal rules, Medicaid cannot be used to pay for people who live in larger facilities where more than half the residents are mentally ill. After the state finishes evaluating adult care homes by the end of November, about 135 homes may lose their Medicaid funding. The residents are enrolled in the federal insurance program, but adult care homes collect the money and use it to pay employees and other operating costs. (News Observer)

Oregon

- **Governor Kitzhaber Seeks to Expand Coordinated Care Organizations**

With coordinated care organizations – better known as CCOs -- in full swing for the Medicaid population, Governor John Kitzhaber is setting his sights on the next targets – people on Medicare, the state's public employees and the private business sector. Coordinated care organizations, which emerged in August, represent a new way of delivering healthcare – physical, mental and oral health under one umbrella – while the focus is on prevention, lowering costs and improving quality. Eventually, each CCO will have a global budget for all these healthcare services with targeted goals. Thus far, 500,000 people formerly on the Oregon Health Plan have joined one of 13 CCOs around the state. (The Lund Report)

Texas

- **Medicaid Woes Subject of House Committee Hearing**

In an effort to curb costs last session, lawmakers expanded Medicaid managed care, the health plan that oversees care for impoverished Texans, to South Texas, the border region and previously underserved areas. They made two other budget-saving moves: reducing state reimbursement rates to providers who care for "dual-eligible" patients — people who qualify for both Medicaid and Medicare — and crafting a health budget that did not account for Medicaid enrollment growth. Without major action from the state Legislature, these changes "will erode our state's safety net of care," said Carlos Cardenas, who testified at the House Human Services Committee on behalf of the Texas Medical Association and the Texas Border Health Caucus. (Texas Tribune)

Utah

- **Hacking of Utah Health Exchange Raises Security Questions**

  With the news that the Utah health exchange -- one of just two state-run online insurance marketplaces in operation -- was recently hacked, states planning their own exchanges as prompted by the Affordable Care Act (ACA) might want to take a closer look at how they'll handle cybersecurity. The exchanges will hold digital records of a potential minefield of personal information -- Social Security numbers, federal tax and income data and more. To gain approval from the U.S. Department of Health and Human Services (HHS) for their exchange, states must prove they meet five provisions related to privacy and security. (Governing Magazine)

National

- **House panel readies bill to alter health law's medical loss ratio**

  A feature of President Obama's healthcare law often touted by Democrats would change under a House bill now ready for mark-up. The measure (H.R. 1206) from Rep. Mike Rogers (R-Mich.) would alter the law's medical loss ratio (MLR) by excluding insurance brokers' fees from counting as administrative costs under the requirement. The medical loss ratio mandates that insurers spend no less than about 80 percent of their premiums on medical care rather than administrative costs or profit, or rebate the difference to policyholders. Democrats and the Obama administration have praised the policy for producing more than $1 billion in consumer rebates this year. But Rogers's bill seeks to placate brokers unhappy that their fees are included in the MLR. (The Hill)

- **Medicaid Helps D.C. Clinic Care For Ex-Prisoners**

  The District of Columbia, along with several other states, has taken advantage of the opportunity to expand Medicaid early and, in doing so, has provided doctors and other community health providers the opportunity to be reimbursed for the first time for care provided to individuals after release from prison. Nearly all ex-prisoners meeting the income requirements will become eligible for Medicaid under the national coverage expansion in 2014. (Kaiser Health News)

- **States Seek a Middle Ground on Medicaid**

  A handful of states are considering only partially expanding their Medicaid programs under the federal health-care overhaul—a new twist on how states are interpreting the Supreme Court's ruling on the law. Indiana, New Mexico and Wisconsin are among the states asking the federal government to let them omit from the Medicaid expansion residents whose incomes put them just above the poverty level. The states hope to take advantage of provisions in the Affordable Care Act that offer a federal subsidy to help these residents buy private insurance, starting in 2014. (Wall Street Journal)

- **U.S. state officials in stealth mode on health exchanges**

  Mississippi insurance commissioner Mike Chaney is in a tight spot. By law, he is required to implement Democratic President Barack Obama's healthcare overhaul. But as a Republican from deeply conservative Mississippi -- one of 26 states that sued Washington over Obama's Affordable Care Act -- Chaney is a target of critics who say he is betraying his party. Chaney and health officials in as many as 24 Republican-controlled

states are working behind the scenes to set up insurance exchanges that provide a market for individuals and small businesses to shop for affordable health coverage. The states face a November 16 deadline to show they can do it, or the federal government steps in and takes on the job itself. (Reuters)

- **Medicaid Managed Care Drug Rebates Saved States, Feds $1.6 Billion in First Year**

  The Department of Health and Human Services Office of Inspector General (OIG) on Monday released a new report "States' Collection of Rebates for Drugs Paid through Medicaid Managed Care Organizations," which showed that 12 of the 22 States using a carve-in approach invoiced manufacturers and collected $1.6 billion in rebates for utilization in the second quarter of 2010 through the second quarter of 2011. The OIG surveyed states on the data collected from managed care organizations on pharmacy utilization and rebate submission to manufacturers during this period, the first five quarters for which statutory rebates on managed care pharmacy were available to states. (Herald Online)

Company News

- **KKR, Beecken Petty O'Keefe & Co. and Coastwood Senior Housing Partners Announce Agreement to Invest In Sunrise Senior Living Management Company**

  Kohlberg Kravis Roberts & Co. L.P. (together with its affiliates, "KKR"), Beecken Petty O'Keefe & Company ("BPOC") and Coastwood Senior Housing Partners LLC today announced the signing of a definitive agreement to acquire the management company business of Sunrise Senior Living, Inc. ("Sunrise"), a leading provider of senior living services and housing, for approximately $130 million. Health Care REIT ("HCN") will also invest approximately $26 million for a 20% interest in the business. The acquisition is expected to close immediately prior to HCN's previously announced acquisition of Sunrise. (KKR News Release)

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 20, 2012	Ohio Duals	Contracts finalized	122,000
September 21, 2012	Massachusetts Duals	Contract awards	115,000
September 26, 2012	Wisconsin LTC	Proposals due	38,800
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 12, 2012	Wisconsin LTC	Contract awards	38,800
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	Wisconsin LTC	Implementation	38,800
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 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

Current Issues Series at Denver University:
Election 2012 Issues: Health Care Policy

Joan Henneberry – Panelist

September 24, 2012

Denver, Colorado

Corporation for Supportive Housing:
Opportunities for Supportive Housing and Medicaid Partnerships

Mike Nardone – Panelist

September 27, 2012

Webinar

2012 National Conference on Correctional Health Care:
Inmate Health Care and the Affordable Care Act: Opportunities and Challenges

Donna Strugar-Fritsch – Presenter

October 24, 2012

Las Vegas, Nevada