HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS REPORT HIGHLIGHTS GROWTH OF MANAGED LTSS

HMA ROUNDUP: CALIFORNIA PUBLISHES DRAFT RFP FOR QUALIFIED HEALTH PLANS IN EXCHANGE; FLORIDA DRAFT MCO RATES RELEASED; INDIANA AWARDS MMIS CONTRACT TO INCUMBENT HP; NEW YORK MEDICAID MCO EXPANSION PLANS DETAILED

OTHER HEADLINES: SUPPORTERS ADVOCATE FOR MEDICAID EXPANSION IN TEXAS, GEORGIA AND LOUISIANA; MOLINA NAMES NEW CALIFORNIA PLAN PRESIDENT; PERSONAL HEALTH RECORDS FOR FLORIDA MEDICAID BENEFICIARIES ACCESSIBLE ON-LINE

RFP CALENDAR: ILLINOIS DUALS CONTRACT AWARDS EXPECTED SOON; MASSACHUSETTS DUALS CONTRACT AWARDS DELAYED INDEFINITELY

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

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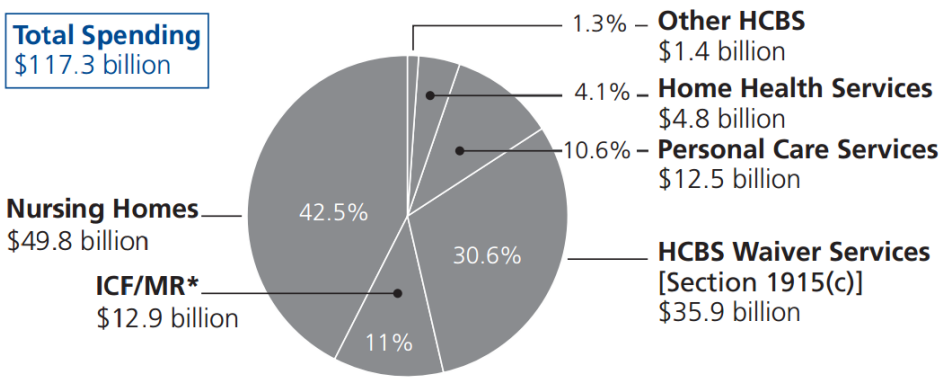
IN FOCUS: CMS REPORT HIGHLIGHTS GROWTH IN MANAGED LTSS

This week, our *In Focus* section presents key takeaways from a Center for Medicare & Medicaid Services (CMS) white paper on the growth of managed long-term services and supports (MLTSS). Medicaid covers a wide range of LTSS, including personal care and other services that address limitations in performing routine activities of daily living (ADLs) such as bathing, dressing, getting around one's home, and preparing meals. The chart below, prepared for a February 2012 report by the National Health Policy Forum, details total (MLTSS is only a subset) Medicaid spending on LTSS in 2010.

Figure 1 – Medicaid LTSS Spending, FY 2010



Source: National Health Policy Forum. "National Spending for Long-Term Services and Supports (LTSS)." February 23, 2012. http://www.nhpf.org/library/the-basics/Basics_LongTermServicesSupports_02-23-12.pdf

The white paper, prepared with Truven Health Analytics, details the growth in size and scope of MLTSS from 2004 to 2012. MLTSS refers to a capitated payment structure, like Medicaid managed care, in which states contract with health plans to provide LTSS to Medicaid beneficiaries. Some states operate separate MLTSS managed care programs, while others include MLTSS in a broader Medicaid managed care program.

The CMS white paper, *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update*, released in July 2012, is available at:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/MLTSSP_White_paper_combined.pdf

MLTSS Report Highlights

Highlights from the CMS report include the following:

- MLTSS programs have grown significantly since 2004. There were eight states with MLTSS programs in 2004. As of 2012, the number has doubled to 16 states, with enrollment in MLTSS growing from 105,000 to 389,000.
- MLTSS programs are highly diverse, with states taking different approaches to populations covered, geography covered, local vs. national health plans, and the degree of care integration.

- Eight states have mandatory enrollment, seven have voluntary enrollment, and one has both. Among voluntary states, only one (Washington) has passive enrollment with opt-out provision.
- Private for-profit health plans have the largest share of enrollment nationally, at 44 percent. United Healthcare is present in eight of the 10 states currently contracting with national for-profit plans.
- The report notes that development of the MLTSS market was initially hampered by a limited supply of health plans with both the experience and the ability to accept risk for LTSS contracts. Since 2004, this market has grown, giving states a greater selection of organizations willing and able to serve the population.
- Five states have fully integrated Medicare benefits with their MLTSS contracts, while another five require coordination with Medicare services. Two states (Arizona, Texas) require plans to be a Dual Special Needs Plan (D-SNP).
- By 2014, an additional 10 states are projected to have MLTSS programs in place. Six states with current MLTSS programs are planning to expand or implement additional MLTSS programs.
- Twelve of these 16 new or expanded MLTSS states are planning full integration with Medicare benefits, while four states have not made formal decisions on Medicare integration. This shift toward greater Medicare integration is the result of states implementing dual eligible integration demonstrations.
- Additionally, there is a greater shift in the new and expanded MLTSS programs toward passive enrollment with an opt-out, previously in place in only one state. This is consistent with what we have seen in many states' dual integration proposals.

Current MLTSS Programs by State

The table below was compiled from the CMS report, which provides comparisons across the 16 states on numerous MLTSS characteristics. This table is not inclusive of every characteristic included in the report. The report also includes an appendix with individual state profiles. A few takeaways from the table:

- MLTSS enrollment nearly quadrupled (370 percent) between 2004 and 2012. This growth was driven by enrollment growth in existing MLTSS states including Arizona, Florida, Massachusetts, New York, Texas, and Washington. New programs in New Mexico and Tennessee have also driven national enrollment growth, enrolling 22,000 and 31,000 MLTSS beneficiaries, respectively.
- As noted above, United Healthcare has market presence in the greatest number of states, operating in eight of the 10 states with national MLTSS health plans. Amerigroup has presence in five of the 10 states. Centene and Molina Healthcare have presence in three and two of the 10 states, respectively.

Table 1 – Current MLTSS Program Enrollment and Characteristics – 2011/2012

	Enrollment (2004)	Enrollment (2011/12)	Enrollment	Geographic Reach	Primarily National/Local Plans	National Plan Market Presence	Medicare Requirements
Arizona	39,152	52,251	Mandatory	Statewide	Mixed	UnitedHealthcare Centene	D-SNP Required
California	N/A	2,304	Voluntary, Opt-in	Minority of Counties	Local		Fully Integrated
Delaware	N/A	4,800	Mandatory	Statewide	National	UnitedHealthcare	N/A
Florida	3,070	19,283	Voluntary, Opt-in	Majority of Counties	Mixed	UnitedHealthcare Amerigroup Centene	Care Coordination
Hawaii	N/A	6,830	Mandatory	Statewide	National	UnitedHealthcare	Care Coordination
Massachusetts	100	15,568	Voluntary, Opt-in	Majority of Counties	Mixed	UnitedHealthcare	Fully Integrated
Michigan	32,841	41,272	Mandatory	Statewide	Local		N/A
Minnesota	3,910	32,693	Other	Statewide	Local		Fully Integrated
New Mexico	N/A	22,446	Mandatory	Statewide	National	UnitedHealthcare Amerigroup	Care Coordination
New York	7,078	47,292	Voluntary, Opt-in	Minority of Counties	Mixed	Amerigroup	Fully Integrated
North Carolina	N/A	4,699	Mandatory	Minority of Counties	Local		N/A
Pennsylvania	N/A	90	Voluntary, Opt-in	Minority of Counties	Local		N/A
Tennessee	N/A	31,200	Mandatory	Statewide	Mixed	UnitedHealthcare Amerigroup	Care Coordination
Texas	10,671	71,239	Mandatory	Minority of Counties	National	UnitedHealthcare Amerigroup Centene Molina Healthcare	D-SNP Required
Washington	N/A	413	Voluntary, Opt-out	Minority of Counties	National	Molina Healthcare	Care Coordination
Wisconsin	8,642	37,010	Voluntary, Opt-in	Majority of Counties	Local		Fully Integrated
US Total	**105,464**	**389,390**					

Source: CMS White Paper, "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Environmental scan conducted by Truven Health Analytics. July 2012.

Projected MLTSS Programs, 2014

Ten states currently without MLTSS programs in place are projected to implement MLTSS by 2014. Of these 10 states, seven are including capitated Medicare benefits in the MLTSS program. Six states with current MLTSS programs in place are implementing additional MLTSS by 2014. Five of the six will feature capitated Medicare benefits in the program.

As an example of new MLTSS program implementation, Illinois plans to implement MLTSS for both the dual eligible integration demonstration population as well as Medicaid-only seniors and persons with disabilities (SPD).Enrollment for the Medicaid-only SPDs would be mandatory. The State is also exploring mandatory MLTSS enrollment for the dual eligible population, while still allowing opt-out of managed care enrollment for the remaining medical benefits. Illinois is expected to announce dual eligible contract awards in the coming weeks. Those plans awarded contracts would also serve the Medicaid-only MLTSS population in the Greater Chicago and Central Illinois regions.

Additionally, we expect to see contract awards in Massachusetts in the coming weeks for its dual eligible integration RFP. Massachusetts is projected to expand MLTSS and fully integrate it with capitated Medicare benefits, proposing voluntary enrollment with opt-out for MLTSS. Ohio, which is not a current MLTSS state, finalized contract awards last month with Aetna, CareSource, United Healthcare, Molina Healthcare, and Centene. Ohio is projected to require mandatory enrollment in MLTSS.

Table 2 – Projected MLTSS Programs, 2014

	New/ Expanded	Enrollment	Include Capitated Medicare?
California	Expanded	Mandatory	Yes
Florida	Expanded	Mandatory	No definite plan
Idaho	New	Mandatory	Yes
Illinois	New	Varies	Yes
Kansas	New	Mandatory	No definite plan
Massachusetts	Expanded	Voluntary, Opt-out	Yes
Michigan	Expanded	Voluntary, Opt-out	Yes
Nevada	New	Undecided	No definite plan
New Hampshire	New	Mandatory	No definite plan
New Jersey	New	Mandatory	Yes
New York	Expanded	Varies	Yes
Ohio	New	Mandatory	Yes
Rhode Island	New	Voluntary, Opt-out	Yes
South Carolina	New	Voluntary, Opt-out	Yes
Virginia	New	Voluntary, Opt-out	Yes
Washington	Expanded	Voluntary, Opt-out	Yes

Source: CMS White Paper, "The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update." Environmental scan conducted by Truven Health Analytics. July 2012.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Caroline Davis

On Tuesday, September 25 the California Health Benefit Exchange issued a draft RFP for Qualified Health Plan (QHP) selection. The draft RFP is intended to solicit stakeholder comments to guide a final RFP, with a targeted release of October 18, 2012. Under the timeline presented in the draft RFP, a revised draft will be released on October 11, allowing an additional week of comment and review before the final release. Plans interested in applying to be a QHP must submit a required non-binding letter of intent (LOI) by October 12, 2012. These LOI responses will not be made public. Final RFP responses are tentatively due to the Exchange on January 4, 2013, with QHP selections to be finalized by March 30, 2013. To qualify as a QHP, plans must be certified as a health plan by the California Department of Managed Health Care or as an insurer by the California Department of Insurance by the selection date, March 30, 2013. The draft RFP is available at: http://www.healthexchange.ca.gov/Solicitations/Pages/QHPSolicitation.aspx

In the news

- **Adult day care rejection rate questioned**

  California health officials fielded pointed questions Monday from legislators angry over the way the state has handled the transition from Adult Day Health Care into a new, smaller version of the program for the elderly and disabled, with one East Bay lawmaker saying that Bay Area seniors are being turned away at far higher rates than in other regions. Adult Day Health Care and its new incarnation, Community-Based Adult Services, are meant to keep low-income elderly, disabled and frail adults out of nursing homes and hospitals by offering medical care, physical therapy, counseling and exercise at hundreds of centers throughout the state. The new program is the result of a legal settlement reached after the state tried to eliminate adult day care entirely as a way to save the state about $90 million a year. (San Francisco Gate)

- **DHCS Says State Is Ready for Adult Day Care Transition**

  Advocates for seniors and the disabled filed a motion on Saturday asking a U.S. District Court judge in San Francisco to intervene in some implementation details of the settlement agreement it signed eight months ago with the Department of Health Care Services. State officials last week answered some of the questions about the Oct. 1 implementation of the Community Based Adult Services program. Some advocates worried about confusion around the launch of the CBAS program since the state is holding training sessions for the CBAS changeover in October for both health plans and physicians. (California Healthline)

Florida

HMA Roundup – Elaine Peters

Prepaid Health Plan Draft Rates: Draft rates were released last week for the reform and non-reform programs.

- **Non-Reform:** The rate book (assembled by Milliman) lists two sets of rates by region. The first is the straight rate change which factors in the impact of hospital cuts in the current fiscal year. Recall the legislature passed a 5.64% hospital rate cut effective 7/1/12-6/30/13. The straight rate change across all counties including this cut is -1% overall. The range is from -11.3% in region 10 to +8.4% in region 7.

  The analysis also estimates what the percent rate change would be without the hospital cut. This analysis was performed by the actuary is to reflect the underlying rate change assuming the MCO can pass through the hospital cut. Under this baseline scenario, the weighted average rate change across all regions is +3.9%.

  The document also describes the targeted MLRs by region. Overall the state is targeting MLRs of 87% in FY 2012-2013 which is unchanged from last year.

- **Reform:** The reform county draft rates were compiled by Mercer. We will have more insight on the reform rates following the rate meeting on Thursday (9/27) of this week.

Managed Medical Assistance (ITN) Data Book: AHCA released the data book for the upcoming MMA (acute care) ITN scheduled for release in January. Link

In the news

- **Medicaid health records available online in Fla.**

  Florida Medicaid recipients can now access their personal health records online. State health officials said Wednesday that beneficiaries can use the My Florida Health eBook to track information about their doctor's visits, procedures, medications and immunizations. They can also update the records with notes about allergies and chart personal health information such as their weight, blood pressure and blood sugar levels. (Sacramento Bee)

Illinois

HMA Roundup – Jane Longo & Matt Powers

The Illinois Medicaid Advisory Committee (MAC) met last Friday, September 21. At the meeting, the State provided an updated timeline on the care coordination procurements currently under review. The State intends to award a first round of Care Coordination Entity (CCE) and Managed Care Coordination Network (MCCN) contracts by the end of this week. The CCEs and MCCNs are provider-based care coordination entities intending to serve adult Medicaid-only seniors and persons with disabilities (SPD) on a smaller scale than a broader managed care procurement. Additionally, the State is hoping to announce contract awards for the dual eligible integration RFP either this week or next

week. They have said they will award up to five contracts in the Greater Chicago region, and two contracts in the Central Illinois region. Contract awards will be contingent on a signed memoranda of understanding (MOU) between Illinois and CMS. The State does not expect a MOU to be released until after December 1, 2012.

Additional updates on contract awards and next steps may be provided at the MAC's Care Coordination Subcommittee meeting, scheduled for October 2, 2012, in both Chicago and Springfield.

In the news

- **Special Report: The unkindest cuts of Medicaid**

  The impact is beginning to be felt after the Illinois General Assembly and Gov. Pat Quinn this spring approved $1.6 billion in cuts affecting some of the state's neediest residents and those who tend to their medical needs. Reporters from three GateHouse Newspapers analyze what is known so far about the implementation and its effects. Thousands of Illinoisans stand to lose health-care services because of more than $1.6 billion in cuts to state programs that serve the poorest residents. But almost three months after bipartisan legislation approved by the Illinois General Assembly and Gov. Pat Quinn took effect, the real impact of cuts to Medicaid and other programs for the elderly, the disabled and low-income parents is unclear. The cuts include the elimination of payments for most adult dental services, the end of the popular Illinois Cares Rx program for senior citizens and disabled Illinoisans, new limits on prescription drugs, reduced eligibility for the Family Care program covering low-income parents, and tighter controls on Medicaid eligibility overall. The cuts could backfire and result in more costs for the state and community hospitals, according to Lawrence Joseph, director of the fiscal policy center at Chicago-based Voices for Illinois Children. (Rockford Register Star)

Indiana

HMA Roundup – Cathy Rudd

On September 24, the Family and Social Services Administration announced the winner of the MMIS procurement. Incumbent Hewlett Packard ("HP Enterprise Services") retained the $198 million contract. The only other bidder was Accenture. Out of a possible 102 points, HP scored 89.39 and Accenture scored 79.83. Link to Announcement

In the news

- **State's Medicaid costs could rise $600M**

  The state of Indiana's Medicaid costs could rise by as much as $600 million over the next seven years, as the deadline for the new federal health care law approaches. That's according to new numbers presented to legislators by the state's Family and Social Services Administration. It's because of what the agency calls "the woodwork effect," administrators told the state's Health Finance Commission Wednesday. Because the new law mandates individual health insurance, the agency expects up to 123,000 already eligible Hoosiers to "come out of the woodwork" and enroll in the program. That could cost the state an additional $600 million by 2020. (WISH TV News)

Massachusetts

HMA Roundup – Tom Dehner

Managed care contract awards for the dual eligible demonstration were scheduled to be announced last Friday, September 21, but have been delayed indefinitely.

New York

HMA Roundup – Denise Soffel

Transition to Mandatory Medicaid Managed Care: The NYS Department of Health announced that the last five counties to adopt a mandatory Medicaid managed care program for most Medicaid beneficiaries will be converting this fall. In October, Jefferson County (13,300 Medicaid beneficiaries), Lewis County (3,000 Medicaid beneficiaries), St. Lawrence County (15,700 Medicaid beneficiaries) and Warren County (6,100 Medicaid beneficiaries) will become mandatory. The final county, Chemung (13,900 Medicaid beneficiaries) will convert in November. New York State began the roll-out of its mandatory Medicaid managed care program in 1997.

The State also release estimated figures related to spending in the "Care Management for All" (CMA) programs, which include the capitated managed care programs for duals and non-duals. Specifically, the State estimates total Medicaid spending for the 2012/13 fiscal year of $54.1 billion, of which $6.3 billion is out of the scope of MCOs. Of the remaining $47.8 billion, $21.6 billion is already in MCOs, an additional $3.8 billion will transition in 2012/13, $14 billion in 2013/14 and $5.7 billion in 2014/15 (most of which relates to duals). By April 1, 2016, an estimated $45.6 billion will be through MCOs or 84% of all Medicaid spending.

Summary of New York State Fee-for-Service (FFS) Transition to Care Management for All (CMA)

		Total (Non-Duals and Duals)		Non-Duals (Medicaid-Only)		Duals (Medicare and Medicaid)	
	Base Population and Transition Timeline	Enrollees	Medicaid Expenditures	Enrollees	Medicaid Expenditures	Enrollees	Medicaid Expenditures
A	Total Projected Spend Projected for SFY 12/13		$ 54,192,056,674				
B	Net "offline" payments and rebates that can not effectively be transitioned to MCOs (e.g., DSH payments)		$ 6,308,261,088				
C	Total Base Medicaid Population and Projected Spend (Recipients Enrolled in Medicaid FFS and/or CMA as of April 1, 2012)	5,066,405	$ 47,883,795,586	4,287,640	$ 28,551,506,322	778,765	$ 19,332,289,264
D	Enrolled in CMA as of April 1, 2012 (includes some estimates)	3,915,584	$ 21,593,904,480	3,850,117	$ 19,064,868,778	65,468	$ 2,216,710,676
E	SFY 12/13 Transition (inc voluntary counties)	141,392	$ 3,809,761,802	75,139	$ 900,035,511	66,253	$ 2,974,163,390
F	SFY 13/14 Transition	26,310	$ 1,440,900,629	15,984	$ 1,205,726,318	10,326	$ 217,556,629
G	SFY 14/15 Transition	93,499	$ 5,733,517,967	8,039	$ 379,329,400	85,460	$ 5,498,482,980
H	SFY 15/16 Transition	370,845	$ 1,351,118,654	13,639	$ 228,789,932	357,206	$ 1,149,567,876
I	People Not Included in Transition Timeline (status TBD, all of whom are believed to be moving to CMA)	151,764	$ 1,417,279,666	140,919	$ 1,075,821,928	10,845	$ 329,473,206
J	OPWDD Population (Note: OPWDD is pursuing a care management implementation under the People First waiver.)	93,403	$ 10,209,551,760	45,310	$ 3,653,881,910	48,093	$ 6,668,087,851
K	Total Population and Spend in CMA after April 1, 2016	4,792,798	$ 45,556,034,959	4,149,147	$ 26,508,453,776	643,651	$ 19,054,042,610
L	Populations and Benefits Remaining in FFS after April 1, 2016	273,607	$ 2,327,760,627	138,493	$ 2,043,052,545	135,115	$ 278,246,654
O	Total Medicaid Dollars Remaining Outside CMA after April 1, 2016		$ 8,636,021,715				

Source: New York Medicaid Redesign Team (MRT)

Pharmacy Carve-In: At a recent Department meeting, several unidentified health plans said they may need to withdraw from the Medicaid managed care market as a result of the pharmacy carve-in. These plans say the rates established by the Department of Health are inadequate. The Department has agreed to revisit the rates and has begun review by its actuarial consultants. The Department has expressed its belief that the plans that are threatening withdrawal from the market were on precarious grounds prior to the pharmacy carve-in, although the pharmacy change may be the straw that broke the camel's back.

Consumer direct: The transition of the Consumer Directed Personal Assistance Program into managed care (both mainstream managed care and managed long term care) was scheduled for October 1, 2012. The implementation date for this transition will be delayed to November 1, 2012. The State continues to work with the Workgroup to resolve all outstanding issues and documents in order to implement a smooth transition of this benefit and population.

In the news

- **Feds cut Medicaid reimbursements for disabled New Yorkers by 80%**

  The reimbursements New York receives from the federal government each year for caring for certain developmentally disabled Medicaid patients will be cut by 80 percent, a senior federal health official told House lawmakers Thursday. New York's current reimbursements are "excessive and inappropriate," Penny Thompson, deputy director of the Center for Medicaid and CHIP Services, told members of the House Committee on Oversight and Government Reform. The committee estimates the state overbilled the federal government $15 billion in Medicaid costs over the last 20 years. Overbilling in 2011 alone amounted to $1.27 billion for 1,313 patients at New York facilities. Reducing New York's Medicaid reimbursements by 80 percent will cost the state slightly more than $1 billion a year. (Democrat and Chronicle)

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

Pennsylvania's Insurance Department announced on September 20 that it will be issuing a solicitation on October 1, 2012 for a vendor to act as a "CHIP Eligibility Administrator". Not a lot of details were forthcoming, but it appears that this contract will be for an enrollment broker who will confirm eligibility and assist consumers eligible for PA's standalone CHIP program to select a managed care plan. Currently the managed care companies that have contracts for CHIP in PA do their own eligibility determination and plan enrollment.

Because of the increasing clamor over proposed co-payments for families of eligible children with mental and physical disabilities, the Secretary of Welfare in PA issued a statement earlier this week defending the Department's position. He noted that these families currently cost the Commonwealth over $700 million annually, yet many of the families receiving this care have the ability to pay their fair share. About 80 percent of these families have incomes above 200 percent of the federal poverty level and one in four have an income above $100,000 a year. The Secretary noted that targeting co-payments for this

Medicaid category based on ability to pay will enable the Department "to continue to effectively serve those Pennsylvanians who need it most." Eligible families are those earning more than 200 percent of the federal poverty level who fall into the eligibility category of Medical Assistance often referred to as the "loophole" category.

Texas

HMA Roundup – Gary Young

On August 23, the Health and Human Services Commission (HHSC) released the Administrator's Statement related to the current and next biennium budget requests. Highlights include:

- Base expenditures for the current, FY 2012-13 biennium are estimated to be $45.4 billion in all funds of which $18.2 billion is state funds.
- The budget assumes $3.6 billion in additional state funds needed for Medicaid and $83.7 million for CHIP related to a five-month funding shortfall that was passed as part of the biennial budget passed in 2011.
- As expected, the Administrator's Statement does not include a funding request to expand the Medicaid program as allowed under the Affordable Care Act (ACA).
- The budget does not include the $247 million in additional federal funding to compensate for the difference between Medicaid and Medicare reimbursement levels for primary care physicians. The legislative appropriations request (LAR) cites the "timing of the Supreme Court decision and LAR presentation" for not including this increased amount of federal funding. However the 2014 – 2015 budget request does include a 2% rate restoration (state funds) for primary care providers to pre-ACA levels so that they will be eligible for the enhanced federal payments.
- Regarding the 2014-2015 budget, base expenditures for the FY 2014-15 biennium are estimated to be $48.8 billion in all funds of which $19.1 billion is state funds. This represents a 5% increase over the 2012-2013 biennium.
- Some preliminary projections are included for caseload growth in 2014/2015. Specifically, HHSC estimates that an additional 131,070 children will enroll in 2014 and 298,446 will enroll in 2015 due to the individual mandate. Since these are currently eligible but not enrolled beneficiaries, the normal federal match rates (59.8% Medicaid, 71.9% CHIP) will apply.
- Two cost containment initiatives are proposed for the 2014 - 2015 biennium
    - Expanding STAR+PLUS services into the remaining rural regions where it is not in place yet.
    - Carving four months of nursing home services into the STAR+PLUS contracts

- There is a placeholder in the budget for the dual eligible demonstration program, but costs have not been estimated due to the need for more information from CMS.
- The Administrator's Statement cites ongoing funding challenges for Medicaid in advocating for the additional flexibility that would come with converting the program to a federal block grant structure.

In the news

- **Protesters take fight over Medicaid expansion to Gov. Perry**

  Hundreds of uninsured Texans converged on the state Capitol on Friday, chanting, "We want health care now" and "Open the doors," outside the governor's office, which was blocked by state troopers, in a protest against Gov. Rick Perry's refusal to expand Medicaid. Buses began arriving at the Capitol about 3 p.m. from San Antonio, Dallas and Houston. They were carrying about 400 protesters unhappy about the governor's shunning of an estimated $13 billion in federal money under the Affordable Care Act that would have expanded Medicaid for up to 2.3 million Texans, according to state officials. Perry has said that Medicaid is broken and that adding millions more Texans to it could financially ruin the state. (The Austin American-Statesman)

- **Interactive: Mental Health Treatment at State-Funded Centers**

  Texas has a severe shortage of mental health professionals: 202 out of 254 counties do not have enough psychiatrists, clinical psychologists, social workers, psychiatric nurse specialists and family therapists to treat the needs of the population, according to the U.S. Department of Health and Human Services. The Texas Department of State Health Services oversees 39 different organizations, called Mental Health Authorities, which receive state funding to plan and develop a network of mental health professionals in various regions of the state. The MHAs, which are often referred to as mental health centers, can use state funding to provide mental health services directly to patients or to contract other mental health professionals in the region. Ultimately, the goal is to ensure that patients in need have access and choices when seeking out mental health care services. Although the National Institute of Mental Health estimates that one in four adults experience a diagnosable mental illness in any given year, less than 1 percent of the Texas population received care from state-funded mental health centers in 2011. (Texas Tribune)

OTHER HEADLINES

Arkansas

- **In Arkansas, governor changes course on health care to help uninsured, struggling Democrats**

  Gov. Mike Beebe, the first Southern governor to back the law's expansion of Medicaid, has become an unlikely advocate for a central part of the overhaul that would expand Medicaid, a position made easier by the fact that he's not seeking re-election. The expansion still faces a tough road in Arkansas. Approval will require a three-fourths vote in both the state House and Senate, a number that would be difficult to reach even with the current Democratic majorities. Beebe has said he thinks lawmakers will support expanding eligibility when they see the broad benefits. The state Department of Human Services has estimated expanding the state's Medicaid rolls by 250,000 people will save the state $372 million over the next several years. Republicans have expressed skepticism about that figure, noting that it factors in savings from other parts of the federal health overhaul. (Washington Post)

- **A New Health Care Initiative in Arkansas**

  Arkansas ranks near the bottom among states in health and income. But it's much closer to the top when it comes to rising health care costs — they've doubled in just the past decade. Reduced benefits and lower provider fees have not halted the escalation. Last year Governor Mike Beebe decided to try something entirely new. On October 1, Arkansas will launch what's called the "Health Care Payment Improvement Initiative," aimed at taming runaway costs by offering doctors financial incentives to provide more efficient care. In Arkansas, private insurers are joining with Medicaid to create a united front. Customers with private insurance will receive the same kind of care under the same billing rules as those who qualify for Medicaid. Medicare, the federal health plan for seniors, is also considering joining the initiative. (Stateline)

Colorado

- **Insurance company bets on benefits of integration**

  In a new experiment set to start next spring in western Colorado, the nonprofit health insurance company, Rocky Mountain Health Plans, will give hefty "umbrella payments" to three primary care practices that are already working to integrate behavioral health. Also known as "global payments," the funding will replace traditional "fee-for-service" payments that reimburse doctors for each visit with a patient or each test they order. The insurance company will then encourage the health providers to give patients excellent integrated care. That will vary from site to site and will depend on patients' needs. Care could include a traditional office visit with a doctor or a health coach, email exchanges, telephone counseling or a typical counseling session. Patients will get all the care in the familiar setting of their primary care office. At the same time, Rocky Mountain will give the control groups — three other primary care practices that are also trying to integrate behavioral health — reimbursements under the traditional "fee for service" model, where providers bill for appointments and procedures. (Health Policy Solutions)

Georgia

- **Conservatives try again to lower health costs by minimizing lawsuits**

  A proposal gaining support among conservatives seeks to check the pace of health inflation by reforming the medical-liability exposure that prompts doctors to perform expensive tests they don't need to make their diagnosis. A survey by the Gallop organization this summer found that 26 percent of all healthcare spending here is on unnecessary tests. Georgia doctors ring up $15 billion annually in avoidable costs when they practice so-called defensive medicine to create evidence in case they are sued. Just in the state's Medicaid program, that amounts to $4 billion yearly that taxpayers swallow on top of their own elevated premiums, according to BioScience Valuation in a study sponsored by the Atlanta-based advocacy Patients for Fair Compensation. (Athens Banner-Herald)

- **Backers planning push for Medicaid expansion**

  If the state expands its Medicaid program, more than 600,000 lower-income people will become eligible for coverage. That represents a "huge impact'' in terms of numbers of people, Judith Solomon of the Washington-based Center on Budget and Policy Priorities told consumer advocates and health care officials Thursday at an Atlanta event hosted by Healthcare Georgia Foundation. Attendee Cindy Zeldin of the group Georgians for a Healthy Future said a grass-roots coalition of advocates, managed care companies and medical providers have come together to work toward promoting Medicaid expansion. Gov. Nathan Deal recently came out in opposition to Medicaid expansion. Later, through a spokesman, Deal qualified his stand a bit, saying the state might be willing to consider expansion if the Medicaid program is converted to a block grant, giving states more flexibility on how to run it. (Georgia Health News)

Kansas

- **Insurance regulator asks Brownback to set health exchange 'benchmark'**

  Kansas' insurance regulator is asking Gov. Sam Brownback to spell out the requirements for health coverage to be sold in a new online marketplace mandated by the federal health care overhaul. However, Brownback still plans to make no decisions until after the presidential election. Insurance Commissioner Sandy Praeger made her recommendations public Tuesday, a day after she sent the conservative Republican governor a letter containing her proposals for the "benchmark plan" that companies must offer to participate in the online marketplace. Praeger's proposal calls for requiring companies to offer the same coverage Blue Cross Blue Shield of Kansas does in its comprehensive plan for small groups, along with additional coverage for children's eye and dental care. The commissioner noted in her letter that if Brownback does not set the state's requirements by the end of September, the U.S. Department of Health and Human Services could do it for the state. (The Kansas City Star)

- **KanCare to allow self-directed care**

  Under Kancare, frail elders and the physically disabled will continue to have a say in who cares for them in their home. "That's not going to change," said Kansas Department for Aging and Disability Services Shawn Sullivan. In recent weeks, advocates for

the disabled have wondered if the processes for choosing a caregiver would be taken over by the KanCare managed care companies. Sullivan said they will not. (Self-directed care) will remain an option for people who are already on the wavier, and it will be an option for those going on the wavier after Kancare's proposed Jan. 1 startup. (Kansas Health Institute)

- **Wichita group proposes new statewide health care cooperative**

  If all goes according to the plans of some local health care and business professionals, Kansas Health Cooperative, Inc. would be the first health insurance cooperative in the state under the Affordable Care Act, and the co-op would offer insurance to individuals and small businesses that may have had difficulty getting insurance in the past. The Affordable Care Act, the federal law that remains politically controversial even after the Supreme Court upheld most of its requirements, contains a provision for the establishment of health care co-ops in all 50 states. The Consumer Operated and Oriented Plan Program will "foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets," according to the U.S. Department of Health and Human Services. So far, no one else in the state has applied to operate such a co-op. (The Wichita Eagle)

Kentucky

- **Managed Care Official Criticizes Kentucky's Approach to the Medicaid System**

  The CEO of a major Medicaid MCO is criticizing Kentucky for the way the state deals with businesses like his. Michael Neidorff is the CEO of Centene, which operates Kentucky Spirit, one of three statewide MCOs that has managed Medicaid patients for the state since last year. In a recent call with Wall Street investors, Neidorff criticized Kentucky officials and the mindset they have about what managed care can do for the state. The call also revealed that Kentucky Spirit had originally bid and initially accepted a contract to run Medicaid in the Louisville region, which is currently up for bidding. But Neidorff said because the state was unwilling to change some terms, Kentucky Spirit dropped out of the bidding. The Louisville contract is expected to be finalized soon, since new MCOs will be required to start providing service next year. (WKU Public Radio)

Louisiana

- **Medicaid expansion rejected by Louisiana may be pursued in New Orleans**

  With Gov. Bobby Jindal's administration opting out of the Medicaid expansion offered in the federal Affordable Care Act, New Orleans officials say they are looking for ways to go it alone. They are encouraged by a Medicaid waiver that has allowed the city to provide preventative care at no charge to uninsured low-income residents and at sliding scale, based on income, for others. That waiver expires in 2014, and the city hopes it will be able to continue to provide universal coverage through expansion of Medicaid envisioned by the health-care overhaul law, Health Commissioner Karen DeSalvo said. In a statement, Louisiana Department of Health and Hospital Secretary Bruce Greenstein didn't say whether his agency would reject a proposed New Orleans Medicaid expansion but called adding eligibility a "bad idea and expensive for taxpayers." (The Times-Picayune)

Michigan

- **Mich. panel discusses Blue Cross overhaul plan**

The Michigan Legislature took its first steps Wednesday toward tackling a proposed overhaul of the state's largest health insurer, Blue Cross Blue Shield of Michigan. Senate Insurance Committee Chairman Joe Hune introduced bills that would end the nonprofit health insurer's tax-exempt status and align it with competitors. The proposals come at the recommendation of Republican Gov. Rick Snyder, who said last week he aims to "level the playing field" for insurers and modernize the only Michigan company that has to provide insurance coverage regardless of a customer's health status. In exchange for operating as the state's so-called insurer of last resort, the charitable trust that serves about 4.4 million Michigan residents has saved about $100 million in local and state taxes annually. Under the legislation, Blue Cross would pay those taxes and contribute about $1.5 billion over 18 years to a nonprofit entity that would take on some of Blue Cross' "social mission" work — improving public health and health care access, particularly for children and the elderly. (Modern Healthcare)

Missouri

- **Gov. candidates don't call for Medicaid expansion**

Neither Democratic Gov. Jay Nixon nor Republican challenger Dave Spence are calling for expanding the state's Medicaid program as called for under the federal health care law. Under the health care law, the federal government would pay 100 percent of the cost for making more people eligible for Medicaid starting in 2014. States later would pick up part of the tab. The Republican Spence said during a debate Friday that before expanding Medicaid, he first wants to attack what he called "rampant fraud" and other abuses. Nixon says Missouri needs to determine the best fit for the state, saying he plans to work with the lawmaker to develop plans for improving the state's health care system. (Sacramento Bee)

Oregon

- **Q&A: In Oregon, a $1.9 Billion Medicaid Experiment**

Oregon has promised the Obama administration that it can slow Medicaid's growth to a rate comparable to the rest of the economy over the next two years. That means reducing Medicaid cost growth, on a per capita basis, by 2 percent. If Oregon fails, it stands to lose $1.9 billion in federal funds meant to jump-start that process. As Oregon Gov. John Kitzhaber, put it, the challenge is "to change how you do business in order to survive." The new business plan, he says, is to pay doctors for the quality of health care they provide, rather than the quantity. Oregon's revamped program launched this month. Gov. Kitzhaber spoke at length about its risks, how it's going and whether it can be expected to improve the health of Medicaid recipients. (The Oregonian)

South Carolina

- **Battle over numbers in debate over expansion of Medicaid in S.C.**

Strains of disagreement are building against the backdrop of a campaign by Gov. Nikki Haley's administration to build opposition to an expansion. Generally opposed by Republicans and favored by Democrats, the debate over whether to expand the Medicaid

program in the states is set to play out in many statehouses across the country. That's because a June Supreme Court ruling made the extension of coverage optional. In the Palmetto State, advocates for the expansion contend Haley's administration is emphasizing the costs and underselling offsetting economic benefits of an expansion. Lawmakers are meeting with Haley's S.C. Department of Health and Human Services and beginning to formulate their stances on whether or not the state should expand Medicaid and take the huge pot of federal money that would come with it. On the line is health insurance for an estimated 350,000 to more than 600,000 needy South Carolinians. (The Post and Courier)

Washington

- **Group Health CFO resigns; layoffs on the horizon**

  Group Health Cooperative is reorganizing in the midst of grim financial results, with the resignation of its chief financial officer and a notice to employees that job cuts are down the road. The Seattle-based health system needs to cut annual expenses by $250 million by the end of 2013, CEO Scott Armstrong said in an email to employees. Richard Magnuson, executive vice president and chief financial and administrative officer, is leaving in the next few weeks. Group Health officials said Magnuson's resignation was prompted by a larger reorganization already in motion. Group Health is a cooperative, nonprofit health care system that coordinates care and coverage through partnerships with hospitals. Group Health doesn't have hospitals, but contracts with them, and one "significant" factor contributing to the organization's financial struggles has been the rising cost of those partnerships, Michael Foley, a Group Health spokesman said. (Puget Sound Business Journal)

National

- **Kids' prescriptions often going unfilled**

  A large share of medication prescriptions to children on Medicaid may go unfilled, a new study suggests. Researchers found that of nearly 17,000 prescriptions made to kids at two urban clinics, 22 percent were never filled. That's similar to what's been seen in studies of adults - among whom anywhere from 16 percent to 24 percent of prescriptions go unfilled. Antibiotics and other drugs for infections were filled 91 percent of the time, versus 65 percent of prescriptions for vitamins and minerals. (Reuters)

- **Medicaid Consumes More of Federal Aid to States and Localities**

  Over the last three decades, Medicaid has swallowed more and more of federal support to states, according to a new report from the Government Accountability Office, increasing from 15 percent of federal grants to state and local governments in 1980 to 45 percent in 2011. In sheer dollars, federal Medicaid payments in 1980 equaled $33.7 billion and overall grants to state and local governments were $220.6 billion. By 2011, federal Medicaid contributions had ballooned to $274.9 billion, and overall grants sat at $606.8 billion. Medicaid outlays now makes up 7.6 percent of the entire federal budget, up from 2.4 percent in 1980. (Governing Magazine)

- **Liking It or Not, States Prepare for Health Law**

  Like many Republican governors, Jan Brewer of Arizona is a stinging critic of President Obama's health care law. Yet the Brewer administration is quietly designing an insurance exchange — one of the most essential and controversial requirements of the law. Officials in a handful of other Republican-led states say they are also working to have a framework ready by Nov. 16, the deadline for states to commit to running an exchange or leave it to the federal government to run it for them. That is just 10 days after Election Day, which is likely to decide the future of the law. Given that the health care overhaul remains a lightning rod — just last week, Oklahoma revised a lawsuit against it — even the most tentative discussions about carrying it out in Republican states tend to take place behind closed doors or "underground," as the leader of a health care advocacy group in the South put it. (New York Times)

- **Strict Federal Rules for Health Exchange Data Rankle States**

  To determine eligibility for Medicaid coverage or tax subsidies on the health insurance exchanges created by the Affordable Care Act, states are gaining access to Internal Revenue Service data that they have never seen before. It's called modified-adjusted gross income (MAGI), and it helps determine whether an individual or family qualifies for public insurance or tax subsidies from the federal government to pay for private coverage. But the IRS has decided that states cannot use that data for any other state-administered programs outside the exchanges that use income as a basis for enrollment: food stamps, Temporary Assistance for Needy Families (TANF) and others. Some states hope to eventually fold their entire eligibility process for social services into the exchanges. Rhode Island, for example, has outlined a long-term plan to integrate eligibility determination for all of its human services programs into the technology platform the state is creating for its exchange. Other states are planning to achieve the same goal down the road—it's an ideal that most state human services agencies have long been aiming for. But as things stand now, they won't have the IRS data to do it. (Governing Magazine)

COMPANY NEWS

- **Molina Healthcare Names New President for California**

  Molina Healthcare, Inc. announced that Richard Chambers has been named president of its subsidiary, Molina Healthcare of California. Former president of Molina Healthcare of California, Lisa Rubino, was recently promoted to senior vice president of the Western Region for Molina Healthcare. Prior to joining Molina, Chambers was the chief executive officer for CalOptima, a county organized health system providing publicly-funded health coverage programs for low-income families, children, seniors and persons with disabilities in Orange County, CA. (Molina 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 26, 2012	Wisconsin LTC	Proposals due	38,800
September, 2012	Arizona - Maricopa Behavioral	RFP Released	N/A
September-October, 2012	Illinois Duals	Contract awards	136,000
September-October, 2012	Massachusetts Duals	Contract awards	115,000
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 Behavioral	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 Behavioral	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 Behavioral	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	Initial Proposal Released	Proposal Date	Submitted to CMS	Comments Due	RFP Released	RFP Response Due Date	Deadline for Plans to submit applications	Contract Award Date	Enrollment effective date
Arizona	Capitated	115,065	X	4/17/2012	5/31/2012	7/1/2012	N/A[+]	N/A[+]	N/A[+]	N/A	1/1/2014
California**	Capitated	685,000	X	4/4/2012	5/31/2012	6/30/2012	X	3/1/2012	5/24/2012	4/4/2012	6/1/2013
Colorado	MFFS	62,982	X	4/13/2012	5/31/2012	6/30/2012			N/A		1/1/2013
Connecticut	MFFS	57,569	X	4/9/2012	5/31/2012	6/30/2012			N/A		12/1/2012
Hawaii	Capitated	24,189	X	4/17/2012	5/25/2012	6/29/2012			TBD		1/1/2014
Illinois	Capitated	136,000	X	2/17/2012	4/6/2012	5/10/2012	X	6/18/2012	5/24/2012	October 2012	4/1/2013
Iowa	MFFS	62,714	X	4/16/2012	5/29/2012	6/29/2012			N/A		1/1/2013
Idaho	Capitated	17,735	X	4/13/2012	5/31/2012	6/30/2012		Q2 2013	N/A	July 2013	1/1/2014
Massachusetts	Capitated	109,636	X	12/7/2011	2/16/2012	3/19/2012	X	8/20/2012	5/24/2012	Imminent*	4/1/2013
Michigan	Capitated	198,644	X	3/5/2012	4/26/2012	5/30/2012		Feb. 2013	TBD	March 2013	1/1/2014[#]
Missouri	Capitated[‡]	6,380	X		5/31/2012	7/1/2012			N/A		10/1/2012
Minnesota	Capitated	93,165	X	3/19/2012	4/26/2012	5/31/2012			5/24/2012		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	5/25/2012	6/30/2012			TBD		1/1/2014
North Carolina	MFFS	222,151	X	3/15/2012	5/2/2012	6/3/2012			N/A		1/1/2013
Ohio	Capitated	122,409	X	2/27/2012	4/2/2012	5/4/2012	X	5/25/2012	5/24/2012	8/27/2012	4/1/2013
Oklahoma	MFFS	79,891	X	3/22/2012	5/31/2012	7/1/2012			N/A		7/1/2013
Oregon	Capitated	68,000	X	3/5/2012	5/11/2012	6/13/2012		Certification process			1/1/2014
Rhode Island	Capitated	22,737	X		5/31/2012	7/1/2012		Apr-May 2013	TBD	6/1/2013	1/1/2014
South Carolina	Capitated	68,000	X	4/16/2012	5/25/2012	6/28/2012	10/29/2012		TBD	7/30/2013	1/1/2014
Tennessee	Capitated	136,000	X	4/13/2012	5/17/2012	6/21/2012			TBD		1/1/2014
Texas	Capitated	214,402	X	4/12/2012	5/31/2012	6/30/2012	N/A	N/A	TBD	N/A	1/1/2014
Virginia	Capitated	65,415	X	4/13/2012	5/31/2012	6/30/2012	Oct. 2012		TBD	July 2013	1/1/2014
Vermont	Capitated	22,000	X	3/30/2012	5/10/2012	6/10/2012		1/1/2013	TBD	2/28/2013	1/1/2014
Washington	Capitated	115,000	X	3/12/2012	4/26/2012	5/30/2012		Feb. 2013	TBD	July 2013	1/1/2014
Wisconsin	Capitated	17,600	X	3/16/2012	4/26/2012	6/1/2012	X	8/23/2012	5/24/2012		4/1/2013
Totals	**21 Capitated 5 MFFS**	**2.4M Capitated 485K FFS**	***26***		***26***		***5***				

** Massachusetts was scheduled to award on Friday, September 21, 2012. The state has said the selection process is ongoing and we expect awards any day.*

*** 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.

 # State's proposal refers to enrollment beginning in 2013, but CMS 9/5/2012 presentaion "Status of the Capitated Financial Alignment Demonstrations" refers to Michigan as a 2014 state.

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

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

Mike Nardone – Panelist

September 27, 2012

Webinar

Cain Brothers, General Catalyst Partners, Health Management Associates, Sentinel Capital Partners, and Nixon Peabody LLP Presents:
Investing in Health Care: Current challenges and opportunities

Greg Nersessian – Featured Speaker

October 11, 2012

New York, New York

Lansing Regional Chamber of Commerce
Top 10 Issues to Watch in Preparing for ACA Implementation

Janet Olszewski – Keynote Speaker

October 11, 2012

East Lansing, Michigan

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