HMA

HEALTH MANAGEMENT ASSOCIATES

# *HMA Investment Services Weekly Roundup*
# *Trends in State Health Policy*

**IN FOCUS:** NEW JERSEY MEDICAID WAIVER RECEIVES CMS APPROVAL

**HMA ROUNDUP:** ARIZONA RELEASES MARICOPA BEHAVIORAL RFP; OREGON ISSUES QUALIFIED HEALTH PLAN RFA FOR THE EXCHANGE; WISCONSIN REVIEWS DUAL ELIGIBLE DEMONSTRATION APPLICATIONS; TEXAS NAMES NEW MEDICAID/CHIP DIRECTOR

**OTHER HEADLINES:** KENTUCKY AWARDS MCO CONTRACTS TO HUMANA, WELLCARE, COVENTRY, AND INCUMBENT PASSPORT HEALTH; TEXAS HOME HEALTH PROVIDERS HURT BY ENROLLEES SWITCHING MCO PLANS; DC TO DEVELOP COMBINED EXCHANGE FOR INDIVIDUALS, SMALL BUSINESSES; NEVADA, WYOMING UNDECIDED ON MEDICAID EXPANSION

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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: NEW JERSEY MEDICAID WAIVER RECEIVES CMS APPROVAL

This week, our *In Focus* section reviews the approved New Jersey Comprehensive Medicaid Waiver, which will consolidate several waiver populations under the State's existing managed care plans, while expanding the scope of managed care services to include managed long term services and supports (MLTSS), home and community based services (HCBS), and behavioral health services. New Jersey submitted its waiver application in September 2011 and finally received approval in a letter dated October 2, 2012. We previously reviewed the New Jersey waiver concept paper in our May 25, 2011 Weekly Roundup.

Below, we provide highlights from the consolidated waiver and including expanded MLTSS and HCBS as well as review the behavioral health administrative service organizations (ASOs). In addition to these elements, the waiver also provides for the following:

- Streamline eligibility requirements with a projected spend down for individuals who meet the nursing facility level of care;
- Eliminate penalties for beneficiaries who transfer assets prior to seeking nursing facility services and have income at or below 100 percent of the Federal Poverty Level ( FPL);
- Expand eligibility to include a population of individuals between ages 18 and 65 years who are not otherwise eligible for Medicaid and have household incomes between 25 and 100 percent of the FPL; and
- Furnish premium assistance options to individuals with access to employer-based coverage.

CMS denied a few requests under the waiver proposal, including the elimination of retroactive eligibility for the majority of Medicaid beneficiaries. CMS stated that this would constitute a more restrictive eligibility procedure that violates the Maintenance of Effort (MOE) provisions of the Affordable Care Act.

## Waiver Transitions and MLTSS/HCBS

Under the Comprehensive Waiver, two existing waiver populations currently covered by managed care are included in the Comprehensive Waiver population. The NJ FamilyCare waiver covers more than 700,000 children and close to 243,000 adults[1] and permits mandatory enrollment of disabled and foster care children into managed care organizations (MCOs). Additionally, New Jersey has a Duals waiver in place that has previously authorized the State to require dual eligible beneficiaries to enroll in a MCO. As of 2009, there were roughly 175,000 full-benefit dual eligibles in New Jersey.[2]

[1] "NJ FamilyCare/Medicaid Enrollment Statistics." September 2012. Available at: http://www.state.nj.us/humanservices/dmahs/news/reports/enrollment_2012_09.pdf

[2] Kaiser Family Foundation's StateHealthFacts.org. "Dual Eligible Beneficiaries, 2009." Available at: http://statehealthfacts.org/comparemaptable.jsp?ind=303&cat=6

Four additional waiver populations will be transitioned to into MCOs under the Comprehensive Waiver. MCOs will provide LTSS and HCBS services to these waiver populations currently under fee-for-service. The four waiver populations are:

- The Global Options (GO) waiver, serving Medicaid beneficiaries age 21 years and above meeting a nursing facility level of care for physical disabilities;
- The Community Resources for People with Disabilities (CRPD) waiver, serving Medicaid beneficiaries of all ages with activities of daily living (ADL) needs;
- The Traumatic Brain Injury (TBI) waiver, serving Medicaid beneficiaries ages 21 to 64 years with TBI who require assistance with at least three ADLs in the community; and
- The AIDS Community Care Alternatives Program (ACCAP) waiver, serving Medicaid beneficiaries diagnosed with AIDS and at risk of nursing home placement.

The six waivers listed above will be covered under the Comprehensive Waiver and the four waivers not currently in the managed care program will be transitioned into MCOs. CMS will require a transition plan from the State and readiness reviews of the MCOs prior to the transition of care for these individuals. Currently there are four MCOs serving the Medicaid population. As of December 2010, enrollments were broken out as follows:

| Medicaid Health Plan | Enrollment (Dec. 2010) | % |
|---|---|---|
| Horizon | 471,775 | 48.1% |
| UnitedHealthcare | 355,382 | 36.2% |
| Amerigroup | 131,164 | 13.4% |
| HealthFirst | 22,991 | 2.3% |
| **Total** | **981,312** | |

*Source: New Jersey Department of Human Services, "2010 HMO Performance Report."*

These are the most recent enrollments by plan available from the State. Since December 2010, approximately 150,000 additional aged, blind, and disabled and dual eligible beneficiaries have been transitioned into the MCOs. In August, New Jersey solicited letters of intent from MCOs interested in applying to serve the managed care population. Plans may submit LOIs at any time and begin the application process..

## Behavioral Health Administrative Service Organizations (ASOs)

Under the Comprehensive Waiver, coverage of behavioral health services will vary depending on population and level of care needs. Behavioral health benefits will be excluded from the MCO's covered benefits in most circumstances and instead will be covered through a contracted behavioral health ASO. The ASOs will not assume any risk initially; however, the waiver agreement with CMS permits the state to submit an amendment to the waiver to implement an at-risk arrangement in the future. New Jersey has not indicated a contracting process or a number of ASOs that may service the population at this time.

Dual eligibles enrolled in a SNP and individuals enrolled in a MLTSS MCO furnishing LTSS or HCBS services will be excluded from the ASOs.

Additionally, New Jersey is seeking to implement a behavioral health home model and is currently engaged in the State Plan Amendment process. Upon implementation of the health home, the ASOs will coordinate with the provider for comprehensive behavioral health care.

### New Jersey Comprehensive Waiver Information

The CMS letter of approval on the Comprehensive Waiver is available at:

http://www.state.nj.us/humanservices/dmahs/home/CMW_approval_letter.pdf

The Comprehensive Waiver Terms and Conditions document is available at:

http://www.state.nj.us/humanservices/dmahs/home/CMW_STCs.pdf

Additional background information on the Comprehensive Waiver is available at:

http://www.state.nj.us/humanservices/dmahs/home/waiver.html

## HMA Medicaid Roundup

## *Arizona*

### HMA Roundup

The Arizona Department of Healthcare Services (ADHS) released a managed behavioral health RFP for mental health services in Maricopa County. Magellan is the current incumbent vendor on this contract, which will be expanded to include integrated healthcare services for dual eligible beneficiaries with serious mental illness (SMI). Proposals are due January 8, 2013. Awards are expected in April 2013 and implementation is scheduled to begin October 1, 2013. Link

## *Georgia*

### HMA Roundup – Mark Trail

The Georgia Department of Community Health will be holding a meeting on October 11, 2012 to discuss cost-containment initiatives for the 2012/13 fiscal year. On the agenda are possible changes to the inpatient and outpatient payment methodologies. Georgia currently employs a percentage of cost methodology for outpatient services and a DRG system based on a percentage of cost for inpatient hospital services. Possible changes include an Ambulatory Payment Classification Grouper approach to outpatient hospital charges, rebasing the DRG system, and changes to the Fair Rental Value Adjustment in nursing home rates.

# *Michigan*

## HMA Roundup – Esther Reagan

**Co-Op:** Earlier this year, with the assistance of staff from Health Management Associates (HMA), 15 of Michigan's County Health Plans (CHPs) formed the Michigan Consumers Healthcare CO-OP (MCHCO) and submitted an application to the federal Centers for Medicare & Medicaid Services (CMS) in response to an announced start-up loan opportunity. MCHCO's application was successful and a $72 million loan was approved. More recently the MCHCO Board of Directors announced the selection of Dennis (Denny) Litos as Chief Executive Officer (CEO) on an interim basis (subject to federal approval). Denny is a seasoned hospital executive, rising through the ranks of hospital administrations to serve as CEO of two large hospital systems, including Ingham Regional Medical Center in Lansing (now McLaren Greater Lansing). Most recently Denny was a Principal at HMA.

**Dual eligibles:** The number of Medicaid beneficiaries dually eligible for Medicare (duals) who were enrolled in Medicaid HMOs through auto-assignment in August was 13,454; the number of duals enrolled on a voluntary basis was 11,806. If the 25,260 dual eligibles enrolled in Medicaid plans, Molina covers 8,567 (33%) and United Healthcare covers 6,084 (24%).

# *New York*

## HMA Roundup – Denise Soffel

Affinity Health Plan recently announced that Bertram Scott will join the organization as its President and CEO, effective November 1, 2012. He succeeds Maura Bluestone, who will retire after 30 years of leadership at Affinity. Mr. Scott most recently served as President of U.S. Commercial Markets for CIGNA.

## In the news

- **WellPoint unit to run Brooklyn clinics**

  Three New York City clinics for seniors enrolled in Empire BCBS's Medicare Advantage plans are opening in Brooklyn. The clinics will be run by California-based CareMore. Empire and CareMore are both subsidiaries of WellPoint, the Indianapolis insurance giant. The three Brooklyn medical practices will exclusively take Empire Medicare Advantage insurance, an Empire spokeswoman said, adding that a formal announcement will be made Oct. 15. There are no co-payments for Empire Medicare Advantage members who visit the centers' in-house doctors. But they are responsible for co-pays for specialists who are not at the centers. Empire expects to enroll about 1,500 members at each site. (Crain's Health Pulse)

# *Oregon*

## HMA Roundup

On October 1, 2012, the Oregon Health Insurance Exchange Corporation, now called Cover Oregon, released a Request for Application (RFA) to health insurance carriers wishing to offer health benefit plans to through the Oregon Health Insurance Exchange

Corporation. Applications are due December 31, 2012. Cover Oregon will evaluate each carrier's application and confirm with the Oregon Insurance Division that the carrier meets State requirements for licensure and solvency and is in good standing. The Exchange will then approve or disapprove the application using a pass/fail basis for the following items:

- Does the Carrier meet the federal minimum certification requirements?
- Does the application comply with all application requirements?

Cover Oregon will award a contract to any carrier whose application is approved. The contracts will be for two years so plans that fail to be awarded a contract will not be able to re-apply until 2016. Carriers can offer products to either individuals, small employer groups, or both. Carriers will offer a standard plan in the bronze, silver, and gold tiers in each service area in which it participates and may offer two additional, non-standard plans per metal tier per service area. In terms of rates, carriers will submit their rate filings with the Oregon Insurance Division for each plan they want to offer through the Exchange. The Insurance Division will use its regular rate review process to evaluate and approve/disapprove rates and will provide the Exchange with the approved rates for health plans from approved carriers. Link

## *Pennsylvania*

### HMA Roundup – Izanne Leonard-Haak

**Co-pays:** A week after confirming that it was moving ahead with the implementation of special co-pays for "Loophole" families (i.e., higher income families with disabled children), Department of Public Welfare (DPW) Secretary Gary D. Alexander announced on October5, 2012 that the State is delaying the initiative. DPW is considering replacing the co-payment model with a premium-based arrangement. We note that the co-pays were slated to be effective October 1, 2012 for newly eligible families and November 1, 2012 for existing families but those are indefinitely suspended. Link

**Block Grants:** On September 27, 2012 Governor Corbett announced that 20 counties had been selected to participate in the Human Services Block Grant program. The Human Services Block Grant initiative combines funding streams for seven State-funded programs and gives counties additional flexibility in how they are administered. The affected programs are:

- Mental Health Community Programs
- Intellectual Disabilities Community Base
- County Child Welfare Special Grants
- Homeless Assistance Program
- Act 152
- Behavioral Health Services Initiative
- Human Services Development Fund

### In the news

- **Pennsylvania delays plan requiring copay in care of autistic children**

  Last week, DPW sent letters to some 48,000 families informing them they would be required to make copayments as of Oct. 1, but many contained erroneous estimations of a family's gross income, and there was no consideration of out-of pocket costs already being paid. After more than a week of protests and news conferences -- not to mention amendments and new bills to block the copayments by legislators whose offices had been flooded with calls -- Department of Public Welfare Secretary Gary Alexander announced the department would delay imposing them until further notice. The department's cost-sharing initiative, which had been approved as part of the 2011 budget, was aimed at families with incomes 200 percent above the poverty line who were receiving coverage under Medicaid -- known as Medical Assistance in Pennsylvania -- to make an increasingly expensive program sustainable for the future, DPW officials said. (Pittsburgh Post-Gazette)

- **Highmark-WPAHS dealings complicated by bankruptcy scenario**

  Highmark Inc.'s suggestion -- its demand, as far as West Penn Allegheny Health System is concerned -- that WPAHS file for bankruptcy is not without precedent, as this Pittsburg Post-Gazette article notes. But interim West Penn Allegheny President and CEO Keith Ghezzi, who made the rounds to the various WPAHS facilities last week for town hall meetings, said he has found strong support for the board's unanimous decision to declare that Highmark had breached the affiliation agreement and to begin a search for other partners. (Pittsburgh Post-Gazette)

## *South Carolina*

### HMA Roundup

The South Carolina Department of Health and Human Services announced on September 28, 2012 that is delaying the planned release of its dual eligible demonstration RFP until later this year. In the meantime, South Carolina will release a second RFI in the coming weeks. As a reminder, the following six organizations provided responses to the first RFI which was released in July:

- APS Healthcare
- BlueChoice Health Plan
- Carolina Medical Homes
- Community Health Solutions of America
- Humana
- Select Health of South Carolina

### In the news

- **65,000 SC children to be enrolled in Medicaid**

  South Carolina's Medicaid agency announced Thursday that 65,000 children in the state's poorest households will be automatically enrolled in the government insurance

program by month's end. The state Department of Health and Human Services is enrolling children whose parents receive food assistance or welfare payments through the Department of Social Services, meaning their children are well under eligibility limits for Medicaid. The agency is informing parents of the enrollment in letters, starting this week in Richland County. All 65,000 children should be signed up by month's end. (Atlanta Journal Constitution)

## *Texas*

### HMA Roundup – Gary Young

On October 9, 2012 the Texas Health and Human Services Commission announced that Kay Ghahremani has been named the State's Medicaid and CHIP director. She has served as deputy director of the division for the past five years.

### In the news

- **Medicaid Patient Shift Squeezes Home Caregivers**

  The abrupt exodus of thousands of South Texas Medicaid patients from one managed care health plan is putting a financial strain on home health providers already struggling to stay in business after the state's transition to Medicaid managed care. In July, Molina Healthcare announced it was cutting its reimbursement rates and internal administrative costs by 10 percent. Because the relationship between Medicaid clients and home attendants is so close, patients switched health plans rather than lose their attendants. Since Molina announced the rate cut, 11,400 patients have switched from Molina to one of four other health plans offered in South Texas. There have been delays in getting authorizations for home health services while "the plans catch up on the paperwork for all the members who left Molina," Stephanie Goodman, a spokeswoman for the health commission said. State and health plan officials have assured providers they will be retroactively reimbursed for continuing services, but home care agencies fear that without prior authorization, there is no guarantee of payment. In August, Texas Visiting Nurse Service did not have authorization for 70 percent of its Medicaid clients and had to take out a multimillion-dollar credit line to ensure it could pay employees. (New York Times)

- **State rejects bid to privatize psychiatric hospital**

  The Department of State Health Services has rejected a bid by Geo Care to privatize Kerrville State Hospital. Last year, legislators told State Health Services it had to solicit proposals from mental health providers that wanted to run one of the state-run psychiatric hospitals. Those proposals had to show that the bidder could run the hospital for 10 percent less than its current budget. Boca Raton-based Geo Care was the only company to submit a proposal. Its bid was to run Kerrville State Hospital. Geo Care is a private company that runs mental health hospitals and prisons across the county. Its proposal alarmed mental health advocates because Geo has come under fire for its care of both patients and prisoners. The protests grew louder this year when the American-Statesman reported that State Health Services had fined Geo Care more than $107,000 for violations in a psychiatric hospital that the company runs for Montgomery County. (Austin American-Statesman)

## *Wisconsin*

### HMA Roundup

The Department of Health Services (DHS) announced that it has reviewed applications from four organizations interested in participating in the Virtual PACE program for dual eligibles. Of the four applicants, DHS has approved one applicant to proceed to Phase Two and will work with the other three to identify solutions to unmet Phase One requirements. Independent Care Health Plan (iCare), a joint venture between the Milwaukee Center for Independence and Humana, has met the minimum standards and will proceed to the phase two of the certification process. The organizations that did not meet the Phase One requirements were the Milwaukee County Department of Family Care, Southwest Family Care Alliance, and United Healthcare of Wisconsin. For more background on Wisconsin's Virtual PACE model, please refer to our August 15th Weekly Roundup (link).

# OTHER HEADLINES

### Arkansas

- **Medicaid: Docs Cautious About Arkansas Payment Plan**

  Doctors in Arkansas who treat Medicaid patients are trying their best to put on a happy face about a program there designed to reward quality and move away from a traditional fee-for-service payment model. The Health Care Payment Improvement Initiative, on which Arkansas Medicaid is partnering with two private insurers -- Arkansas Blue Cross and Blue Shield and Arkansas QualChoice -- rewards doctors who manage care and costs well but also withholds reimbursement for those who exceed historical cost levels. "We are not endorsing this plan. We have tried to be very clear about that," David Wroten, executive vice president of the Arkansas Medical Society, told MedPage Today. "What we are trying to do is to work with the Medicaid people to make sure if they're going to do this, that it's done in the least destructive way." State and national Medicaid officials are warning that the payment model is the way reimbursements are going. Arkansas is just the first to take such an aggressive approach. (MedPage Today)

### California

- **Ambitious Transition Plan for Healthy Families**

  State officials last week submitted a four-phase strategic plan to eventually move 875,000 children from the Healthy Families program into Medi-Cal managed care plans. Health care advocates have expressed some reservations and concerns about the transition. State officials have said they're confident they're ready to meet the deadlines that have been set for it. The new plan hopes to simultaneously improve quality of care for children and save the state money. It will happen quickly. On Jan. 1, the state plans to launch the first phase of the transition, shifting 415,000 of the Healthy Families kids to a managed care plan. There's a lot that goes into that kind of move, and the state

needs to spend the proper time to make that transition go smoothly, according to Kelly Hardy, director of health policy for Children Now. The project also still needs federal approval, and the state hopes to get that soon, preferably before the Nov. 1 deadline to start sending out notices to beneficiaries. (California Healthline)

## District of Columbia

- **DC to merge individual insurance market with small businesses under new health care law**

  The District of Columbia is combining its health care exchange markets for individuals and small businesses that have fewer than 50 employees. The D.C. Health Benefit Exchange Authority voted unanimously Wednesday to combine the health exchanges, despite opposition from businesses. Some said the exchange will lead to higher costs. D.C. officials say the decision was based on the city's small individual-insurance market. The city has few uninsured people. So D.C. Councilmember David Catania says the merger will create a sufficient pool for the health care exchange to bring down costs. (Washington Post)

## Florida

- **Nearly a million residents could gain health insurance without the state of Florida paying**

  Close to 1 million Floridians could gain access to health insurance without the state chipping in a penny, if state leaders agree to expand Medicaid temporarily. Gov. Rick Scott and other challengers won a key victory when the U.S. Supreme Court ruled that the Obama administration could not force states, under the Affordable Care Act, to spend precious state dollars to broaden Medicaid over a decade. But now the Department of Health and Human Services announced that Florida can, in essence, ride for free for three years, while the federal government pays the full freight. State leaders can decide to drop out of the expanded program in 2017, the first year states have to kick in a cent, without any penalty. (Palm Beach Post)

- **Florida's Medicaid program in limbo**

  Gov. Rick Scott and the Republican-led Legislature want to privatize the state's Medicaid program, but need the Obama administration's permission. The Obama administration wants to make more low-income Floridians eligible for Medicaid, but needs Scott and the Legislature to agree. The sides have been negotiating a package deal for more than a year and won't comment. Without a solution billions of federal dollars could go to other states and many uninsured Floridians will continue to receive their health care in emergency rooms — the most expensive, least effective place. Safety nets, like community health centers, say they don't have enough funding to keep up as more uninsured patients end up in their waiting rooms. (Sarasota Herald-Tribune)

## Idaho

- **Expert: Idaho has no time for state exchange**

  Idaho has run out of time to establish a state-run insurance exchange that's required by President Barack Obama's health care overhaul, meaning working with the federal government on an alternative is virtually unavoidable. That's according to a consultant

advising a 13-member panel organized by Gov. C.L. "Butch" Otter to gather information on what Idaho should do. But consultant Jack Rovner says it's possible for the state to meet the deadline by opting to create a nonprofit version of a health insurance exchange that would be run by business stakeholders. Robert Mitchell, a Denver-based consultant with KPMG LLC hired to help the state make its choice, said it's too complicated and risky to launch a state-run exchange, like neighboring states Washington and Oregon have done. (Idaho Statesman)

## Illinois

- **Quinn's 'bold' plan for care of developmentally disabled**

  Instead of relying on large state-run institutions that house hundreds of people, Quinn's administration wants to focus on smaller, more individualized settings. The idea is to allow people with developmental disabilities to live more independently with the help of caretakers, whether that be in small group homes or an apartment down the street. The state plans to close four of its eight centers for the developmentally disabled during the next two years. In all, 600 of the roughly 2,000 residents will be placed in new homes. Supporters say the move is long overdue, arguing that Illinois has continued to warehouse people at expensive and out-of-date facilities even as other states moved away from that approach. They say smaller settings within the community will allow those with developmental disabilities to have a better quality of life while ultimately saving the state money. But critics, including Illinois' largest employee union, contend that some residents simply are better served in institutionalized settings. They say specialized care simply isn't available in certain parts of the state, particularly after social service providers have struggled under years of state budget cuts. (Chicago Tribune)

## Kansas

- **Kansas Medicaid HIT incentives total $25.2 million**

  Nearly $25.2 million in Medicaid incentive payments have been awarded to 463 Kansas doctors and 31 hospitals for implementing electronic health record systems in the first six months of a federal program, officials at the Kansas Department of Health and Environment announced today. KDHE Secretary Dr. Robert Moser said that the doctors and hospitals implementing the electronic health records (EHRs) through the incentive program are helping improve health care delivery. (Kansas Health Institute)

## Kentucky

- **Passport Medicaid region to be split among 4 companies**

  Beginning Jan. 1, four companies will start managing the health care of roughly 175,000 Medicaid patients in the Jefferson County region — a major change that some say raises concerns about disrupting care. For the past 15 years, the nonprofit Passport Health Plan has served all Medicaid recipients in the 16-county region. But on Thursday, the state Cabinet for Health and Family Services said it had signed 18-month contracts with Passport and three other companies — Humana, WellCare of Kentucky and Coventry Cares — to manage Medicaid recipients' care starting next year. (Courier-Journal)

- **Kentucky Medicaid patients are prescribed narcotics more than any other drugs**

  Narcotics were prescribed to adult Medicaid patients in Kentucky more than any other class of drug during the 2000s, according to a new study by the University of Kentucky. In Eastern Kentucky, where abuse of pain pills has become an epidemic, Medicaid patients received double or triple the quantity of narcotics that patients got in most other Kentucky counties, the study found. The analysis by UK's Center for Business and Economic Research examined Medicaid prescriptions from 2000 to 2010. In all, more than 3.8 million prescriptions for narcotics were written for Kentucky adults on Medicaid during that time, the study found. (Lexington Herald-Leader)

## Minnesota

- **'Safety net' hospitals brace for potential cuts**

  Hennepin County Medical Center and other so-called "safety net" hospitals are preparing for a decline in federal funding due to the national health care overhaul. These hospitals are typically large urban hospitals that provide a significant amount of care to people who cannot afford to pay for it. The health care overhaul is reducing federal subsidies those hospitals have relied on for more than 20 years. The assistance is known as DSH payments, for Disproportionate Share Hospital. The theory is that hospitals will require fewer DSH subsidies because they'll be treating fewer patients who lack insurance. (Minnesota Public Radio)

## Mississippi

- **Mississippi Fights Over Health Law as States Resist Key Element**

  In Mississippi, where one in five people lack health insurance, two Republican elected officials are fighting over the best way to resist President Barack Obama's health-care overhaul. Insurance Commissioner Mike Chaney, 68, is proceeding with a key requirement -- creating health-care exchanges to help people without employer-provided coverage get policies -- saying he wants the least burdensome requirements. Governor Phil Bryant, 57, asked him to stop late last month, saying the state shouldn't advance any part of the Obama-backed law. (Bloomberg News)

## Nevada

- **Gov. Sandoval: No Decision Yet on Medicaid Expansion**

  Gov. Brian Sandoval says he won't decide whether expanding Medicaid eligibility as called for under the federal health care reform law will be part of his budget proposal until after the November election and state revenue projections are made in December. Speaking to reporters Tuesday in Carson City, the Republican governor said his administration is still awaiting guidance from the federal government on various aspects of the law. (KTVN News)

## Wyoming

- **Medicaid Expansion: Wyoming awaits data, postpones decisions**

  In the next six months, Wyoming must decide whether to extend Medicaid to people on the fringes of the healthcare system, giving medical coverage to thousands of adults who rarely see a doctor and often wait so long to seek treatment that their care costs

more than that of patients with medical insurance. A report for the Wyoming Department of Health prepared by Milliman, Inc., an actuarial consulting firm, forecasts the added costs of the program at $116 million to $148 million between 2014 and 2020, based on their best estimate of 28,200 new enrollees. The report said the enrollment could be as low as 17,000 and might exceed 44,000. Under the best estimate, Milliman expects about 3,700 "woodwork" cases that the federal government would reimburse at only 57 percent. (WyoFile)

## COMPANY NEWS

- **Allscripts gets first offers from PE group: report**

  Allscripts Healthcare Solutions Inc. received offers from a private-equity consortium including Blackstone Group LP and Carlyle Group LP, Bloomberg reported, sending the healthcare company's shares up 6 percent in premarket trade. Late last month, sources familiar with the matter said the company had held talks with private equity firms about the possibility of a leveraged buyout Bloomberg, quoting sources, said Allscripts wanted second-round offers within three to four weeks. (Crain's Chicago)

- **Hospital Company Ends Talks**

  The parent corporation of two local hospitals is searching for a new financial partner after deciding it does not want to join forces with Tennessee-based Community Health Systems. On June 6, board members for Ohio Valley Health Services & Education Corporation - parent company of Ohio Valley Medical Center and East Ohio Regional Hospital - announced they were going through a "due diligence" process to determine whether to partner financially with CHS. The move would have resulted in the hospitals being partially or wholly owned by CHS. At the time, board members believed a final deal would be reached this fall, but said Thursday the negotiations had ceased. (Wheeling News-Register)

## 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 |
|---|---|---|---|
| October 12, 2012 | Wisconsin LTC | Contract awards | 38,800 |
| October, 2012 | Illinois Duals | Contract awards | 136,000 |
| October, 2012 | Massachusetts Duals | Contract awards | 115,000 |
| October, 2012 | Michigan Duals | RFP Released | 198,600 |
| 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 | South Carolina Duals | RFP Released | 68,000 |
| 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 | Virginia Duals | RFP Released | 65,400 |
| 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 | Vermont Duals | Proposals due | 22,000 |
| January 7, 2013 | New Mexico | Contract awards | 510,000 |
| January 8, 2013 | Arizona - Maricopa Behavioral | Proposals due | N/A |
| 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 - 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 | 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, 2013 | Arizona - Maricopa Behavioral | Contract awards | N/A |
| 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 1, 2013 | California Duals | Implementation | 500,000 |
| June, 2013 | Rhode Island Duals | Contract awards | 22,700 |
| July 1, 2013 | Ohio | Implementation | 1,650,000 |
| 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 | Proposal Released | 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 | 6/1/2013 |
| **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 | Oct. 2012 | 4/1/2013 |
| **Iowa** | MFFS | 62,714 | X | 4/16/2012 | X | 6/29/2012 | | | | 1/1/2013 |
| **Idaho** | Capitated | 17,735 | X | 4/13/2012 | X | 6/30/2012 | March, 2013 | Q2 2013 | July 2013 | 1/1/2014 |
| **Massachusetts** | Capitated | 109,636 | X | 12/7/2011 | X | 3/19/2012 | X | 8/20/2012 | Oct. 2012* | 4/1/2013 |
| **Michigan** | Capitated | 198,644 | X | 3/5/2012 | X | 5/30/2012 | | | | 1/1/2014# |
| **Missouri** | Capitated‡ | 6,380 | X | | X | 7/1/2012 | | | | 10/1/2012 |
| **Minnesota** | Capitated | 93,165 | X | 3/19/2012 | X | 5/31/2012 | | | | 4/1/2013 |
| **New Mexico** | Capitated | 40,000 | X | | X | 7/1/2012 | | CANCELLED as of August 17, 2012 | | |
| **New York** | Capitated | 133,880 | X | 3/22/2012 | X | 6/30/2012 | | | | 1/1/2014 |
| **North Carolina** | MFFS | 222,151 | X | 3/15/2012 | X | 6/3/2012 | | | | 1/1/2013 |
| **Ohio** | Capitated | 122,409 | X | 2/27/2012 | X | 5/4/2012 | X | 5/25/2012 | Scoring: 6/28/12 | 4/1/2013 |
| **Oklahoma** | MFFS | 79,891 | X | 3/22/2012 | X | 7/1/2012 | | | | 7/1/2013 |
| **Oregon** | Capitated | 68,000 | X | 3/5/2012 | 5/11/2012 | 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 | Nov. 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 | Dec. 2012 | | July 2013 | 1/1/2014 |
| **Vermont** | Capitated | 22,000 | X | 3/30/2012 | X | 6/10/2012 | 11/1/2012 | 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 | 10/1/2012 | 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

### Making the Connection: The Role of Community Health Workers in Health Homes

**Deborah Zahn, MPH, Principal**

The development of health homes creates a unique opportunity to develop and implement care management models that meet the complex needs of high-need and high-cost patients. This brief explores options for incorporating community health workers (CHWs) into care management teams as an effective—and cost-effective—approach to achieving the goals of health homes. The brief assesses the roles and tasks CHWs perform that align with the six core services required of health homes and discusses how care management PMPM payments can provide the flexibility to hire CHWs without having to rely on unsustainable grant funding. **(Link to Report - NYS Health Foundation)**

## HMA Upcoming Appearances

### 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*