HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: PRIVATE HEALTH INSURANCE EXCHANGES

HMA ROUNDUP: SACRAMENTO COUNTY APPROVED FOR MEDICAID COVERAGE EXPANSION INITIATIVE; VANGUARD'S MEDICAID MCO ACQUISITION IN MICHIGAN RECEIVES APPROVAL; ILLINOIS DELAYS DUAL ELIGIBLE AWARDS ANOTHER WEEK; FLORIDA STATE AGENCIES SUBMIT BUDGET REQUESTS

OTHER HEADLINES: DC CHARTERED ENTERS RECEIVERSHIP; CENTENE FILES SUIT IN KENTUCKY OVER RATES; MOLINA WARNS IT MAY EXIT SOUTHEAST WISCONSIN; MISSISSIPPI REJECTS 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: PRIVATE HEALTH INSURANCE EXCHANGES

This week, our *In Focus* section explores the private health insurance exchange market with a guest brief from two of our colleagues in the HMA Denver office – Joan Henneberry and Paul Niemann. Within the past month, private health insurance exchanges made headlines with the news that Sears Holding Corp. and Darden Restaurants Inc. would transition to providing employees with a fixed sum to purchase health insurance in an online health insurance market operated by Aon Hewitt. The brief below reviews the background and current state of private health exchanges, as well as looks ahead to future developments in the market and the impending interaction between private and state-based exchanges, currently in development.

HMA Brief: Private Health Insurance Exchanges

While the health policy and health insurance world have been primarily focused this past year on states' progress toward building health insurance exchanges as part of the Affordable Care Act (ACA), privately run electronic markets, resembling exchanges, have been around since prior to passage of the ACA. Insurance brokers have long used the internet to provide customer friendly websites where consumers can search and select available products. These sites provide seamless product marketing, sales, and delivery to customers. As a result of the ACA and the consequent attention on health insurance exchanges, more organizations are transforming themselves or their internet presence to more closely resemble health insurance exchanges as defined in the ACA.

These private health insurance exchanges, similar to publically run counterparts, provide a virtual market for consumers to review, compare, and purchase health insurance coverage. Unlike publically run exchanges, private exchanges are run by private, non-governmental entities and can be started by or partially owned by an insurance carrier.

These private exchanges have the potential to dramatically change the way large employers provide health insurance to employees and the way employees select insurance in the future. This note provides a brief overview of private health exchanges and the impact they may have on the health insurance market in the U.S.

Recent Private Exchange Activity

There has been a flurry of activity surrounding the creation of private health exchanges, for example:

- WellPoint is in the process of developing an exchange product called Anthem Health Marketplace for introduction in 2013, expecting to have more than 30 midsize and large employers participating by early 2013.
- In addition, in January 2011, WellPoint, Blue Cross and Blue Shield of Michigan, and Health Services Corp. bought an ownership stake in Minneapolis-based host Bloom Health with the intent to launch a private exchange available to consumers nationwide.

- On September 27, 2012, Sears Holding Corp. announced that it will provide its 90,000 eligible employees with a fixed allowance to purchase health insurance through the Aon Hewitt private health insurance exchange.
- Additionally, 45,000 eligible Darden Restaurants Inc. employees will also receive a fixed allowance to purchase insurance through the Aon Hewitt exchange. According to the Insurance Journal, nine national and regional carriers, including United HealthCare, Cigna, and Health Care Services Corp. will provide plans on the exchange.
- Towers Watson & Co. in May 2012 bought Extend Health Inc., an online marketplace used by employers to hook retirees up with Medicare coverage. It plans to expand the marketplace to include active workers buying individual plans, starting in 2014.

Private Exchange Design

Generally, private exchanges can be grouped into one of two types:

- Single carrier exchanges offer products from a single carrier, sometimes referred to as "roadside stands." They are usually run by the carrier but could be run by a contracted independent administrator.
- Multiple carrier exchanges, also referred to as "farmers' markets," offer products from a variety of participating carriers. Multiple carrier exchanges are typically run by an independent administrator.

Private exchanges may be financed through several mechanisms. Exchange operators can charge a monthly fee to participating employers or to participating consumers/employees. Operators of multiple carrier exchanges can also collect commissions from insurance carriers. Exchange operators can also utilize any combination of these mechanisms to finance the operation of a private exchange.

Private Exchange Growth and Opportunities

Currently, there are several factors driving the growth of private exchanges. One primary driver is increasing interest from employers in moving from the traditional defined benefit model of providing health insurance for employees to a defined contribution model. In this model employers provide employees an allowance to use toward the purchase of health insurance through an approved exchange. Employees would be able to choose among a set of approved coverage options and would make up any difference between the employer allowance and the premium from their paychecks. One of the attractions of the defined contribution plan for employers is that it transfers financial risk from employers to insurance carriers when there are higher than expected claims. On the other hand, employees may resist the change to a defined contribution model due to a concern that the corresponding increase in wages won't keep up with the growth in health insurance costs, particularly for moderate income workers.

It is anticipated, but by no means clear, that under the defined contribution model employers will be able to maintain their tax deduction on their contribution to employee health insurance as well as avoid the penalties imposed by the Affordable Care Act

(ACA) on employers with more than 50 full time equivalent employees that do not provide a certain level of health coverage to their employees.

A recent decision by CMS allows federal subsidies to consumers to be used to purchase insurance through private exchanges, preventing a situation in which individuals are forced to choose between an allowance provided by their employer through a private exchange and federal subsidies accessible only through public exchanges.

The growth of the private health insurance exchanges also creates opportunities for some participants in the current health insurance market to strategically preserve or define their roles in the new publicly designed and financed exchanges. This may be especially true for intermediaries such as brokers and benefit consultants, whose roles in exchange driven markets are unclear or perceived to be threatened. For some carriers, developing customer loyalty now to both the administrative services provided by the exchange, and to the products sold in the exchange, might prevent the migration of customers to the public exchanges once they are fully operational.

To date, activity around private exchanges has largely been targeted at large employers. Since public exchanges will be governed by federal regulations that initially apply also only to the individual and small group insurance markets, there is an opportunity for large group insurance carriers and related intermediaries to prepare for a changing marketplace before public exchanges are up and running. Because of this, private exchanges are not expected to directly compete with public exchanges in the near term. Public exchanges have the option of entering large group markets in 2017.

Interaction with State-Based Exchanges

Once public state-based exchanges are operational, they could enter into direct competition with private exchanges in the small group market. If this happens, competition between private and public exchanges for small group customers could be fierce. Because public exchanges must comply with federal regulations and the principles in the ACA, private exchanges may be more nimble and consequently draw a significant amount of the small group market away from public exchanges.

The proliferation of private exchanges may lead to other unintended impacts to public exchanges. As more exchanges become available for employers to choose from, it is likely that fewer employers will participate in public exchanges. Employers with workforces perceived to be healthier will be actively courted by both private and public exchanges.

If employers with healthier employees, or healthier individuals, are more likely to participate in private exchanges in greater numbers, public exchanges would have less healthy consumers, normally leading to increased premiums. However, Section 1301(a)(1)(C)(iii) of ACA requires that insurers "charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent."

Private Exchange Outlook

Proponents of private exchanges claim that exchanges will lead to a reduction in health care costs. The claim is based on the hypothesis that the creation of an electronic competitive market in health insurance will drive down health insurance premiums. Proponents

point to other electronic markets, such as iTunes, as examples of how virtual markets can drive prices down. However, the markets that have seen the greatest reduction in consumer prices are largely characterized by products that have an extremely small cost to add an additional customer. This is not necessarily true in the insurance market in which characteristics of an additional consumer can drive significant impacts to the sustainability of a particular product or insurance carrier. To a large extent, hopes for health care cost reductions as a result of private exchanges are based on the assumption that insurers are a significant driver of high health care costs. To the extent that insurers have the capacity to absorb reductions in their administration, some savings may be realized through private exchanges. However, it is axiomatic that as the number and costs of claims increase, so must premiums charged by insurers.

Actual savings may be realized as a result of shifting administrative activities related to the provision of health insurance from employers to exchange administrators, especially in the case of multiple carrier exchanges. The centralization and likely reduction of the number of plan administrators at employers could lead to system-wide savings. However, it should be noted that the savings may come at the cost of lost jobs or at the least, reassignment of duties of staff providing these services at the impacted employers.

While there is no consensus on the impact to consumers, employers, and public exchanges from private exchanges, it is certain that the questions raised and the possibility of unintended consequences warrant further research and monitoring as the exchange markets continue to develop.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Stan Rosenstein and Jennifer Kent

On October 17th, Sacramento County was approved by the Department of Health Care Services (DHCS) to launch a Low Income Health Program (LIHP) as a Medicaid Coverage Expansion initiative. Molina will administer the program and select community health clinics including local Federally Qualified Health Centers (FQHC), Sutter Health and Dignity Health are part of the contracted LIHP network. Kaiser Permanente has agreed to participate in LIHP pending successful completion of contract negotiations which are scheduled to begin later this month. Under the county's plan, 10,000-14,000 childless adults between 19-64 years of age whose income is less than 67% FPL will be enrolled in the LIHP beginning November 2012. Under the current health reform legislation, LIHP enrollees will transition into Medi-Cal Managed Care coverage beginning January 1, 2014.

In the news

- **Commissioner: CO-OPs Important Option for Low-Income Californians**

  California Insurance Commissioner Dave Jones has high hopes for Consumer Owned and Operated Plans (CO-OPs), a new form of health insurance that will be allowed in the state starting Jan. 1. The not-for-profit, member-governed plans are designed for individuals and small groups, including small businesses. CO-OPs are required to be not-for-profit organizations, so they can provide value to members through lower premiums, lower cost-sharing or expanded benefits. The state's new regulatory framework would allow CO-OPs to get federal funding and offer insurance products in the Health Benefit Exchange by the end of 2013. (California Healthline)

Florida

HMA Roundup – Elaine Peters

Primary Care: On October 22, 2012, the Florida Agency for Healthcare Administration (AHCA) announced that it has awarded $35 million in grants to twenty-eight projects to be used toward innovative programs to enhance the quality of care and health of low income populations. Approximately $20 million was awarded to new programs, with nearly $15 million going toward enhancement of existing primary care programs. These funds are available as via the Low Income Pool program and entities to receive funds include hospitals, federally qualified health centers, county health departments and other community based provider access systems. A full list of awardees can be viewed here: Link

Awardees will use the funds to increase access to primary care by:

- hiring additional staff such as OB/GYN physician and pediatric physicians, dentists and dental assistants,

- increasing the access points for the uninsured and underinsured low income populations by partnering with local health centers, free clinics and local outreach community centers, and
- extending clinic hours to allow greater access during non-traditional business hours, which allow greater access to pediatric urgent care and dental services.

Agency Legislative Budget Requests FY 2013-14: State agencies submitted their Legislative Budget Requests (LBR) for Fiscal Year 2013-14 on October 15, 2012 to the Executive Office of the Governor. Agencies were required to include a priority listing of possible reductions to equal 5 percent of the current budget. The Medicaid program budget consisted primarily of issues related to statewide expansion of managed care; legal representation for potential lawsuits; LTC managed care awards; managed care network verification enhancements; managed care enrollment broker; continuation of a Medicaid reform waiver consultant; and consolidation of funding for LTC waivers. The proposed budget reductions consisted of the following:

- 8.8 percent Rate Reductions – Hospital Outpatient, Nursing Homes, ICF/DD and Clinic Services
- 2 percent Rate Reductions – Occupational, Respiratory, and Speech Therapy Services
- Service Reductions – Eliminate Chiropractic and Podiatric Services
- Eligibility Reductions – Limit Medically Needy to 138% of poverty and Pregnant Women eligibility to 150% of poverty as a result of these beneficiaries being able to purchase health insurance in the Exchanges effective January 1, 2014.

Illinois

HMA Roundup – Jane Longo & Matt Powers

At the Illinois Medicaid Advisory Committee Access Subcommittee meeting on Wednesday, October 24, Healthcare and Family Services (HFS) Director Julie Hamos indicated that the state will be making award announcements in the dual eligible alignment initiative RFP within the next week. The awards announcement has been continually delayed for weeks, at least partially due to ongoing discussions with CMS.

Additionally, HFS and Department of Human Services (DHS) staff were on hand to discuss the progress in establishing the Medicaid benchmark benefit package, or the benefits that will be provided to the newly eligible Medicaid population beginning in 2014. The state presented draft materials and benefit design options, available on the HFS Medicaid Advisory Committee website here. The three proposed benchmark options are:

- Full alignment between Benchmark Medicaid and Standard Medicaid. Includes long term services and supports (LTSS), and assumes rigorous determination of need (as for current seniors and persons with disabilities – SPDs).
- Partial alignment between Benchmark Medicaid and Standard Medicaid. Covers same medical and behavioral health services, but no LTSS.

- Partial alignment between Benchmark Medicaid and Standard Medicaid. Covers same medical and behavioral health services, as well as "LTSS light," a package of home and community based services targeted to the needs of the new eligibles (assumes rigorous determination of need). This option is expected to be clarified in federal guidance anticipated in late November 2012.

HFS and DHS staff noted that any benefit package will need to be approved by HHS Secretary Kathleen Sebelius as well as the Illinois legislature.

In the news

- **IL Gov. bypasses big hospitals for not-for-profits to pilot Medicaid programs**

  Illinois Gov. Patrick Quinn's administration passed over University of Chicago Medicine and the University of Illinois hospital to run pilot programs designed to cut Medicaid costs, picking six ventures mostly led by not-for-profits. Mercy Hospital & Medical Center on the Near South Side and Nashville, Tenn.-based Vanguard Health Systems, which operates four hospitals in the Chicago area, also were not chosen among 20 total bidders in the first phase of a plan to enroll half of the state's 1.2 million Medicaid recipients into programs where providers share some of the financial risk of care. Instead of such well-known hospitals, the winning bidders include a venture featuring two Chicago safety-nets, Norwegian American Hospital and Methodist Hospital of Chicago. (Modern Healthcare) *(HMA Note: The Modern Healthcare article inaccurately reports Illinois' Medicaid enrollment at 1.2 million. As of FY2011, Illinois Medicaid enrolled more than 3 million beneficiaries.)*

Michigan

HMA Roundup – Esther Reagan

With approval of the Michigan Office of Financial and Insurance Regulation, on October 22, 2012 the Detroit Medical Center and its Nashville-based parent, Vanguard Health Systems, Inc., finalized their purchase of Pro Care Health Plan, Inc., a Detroit-based HMO that covers Medicaid beneficiaries in Wayne County. Pro Care was licensed as an HMO in 2000 and has approximately 2,200 Medicaid members.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak

In conjunction with the planned roll-out of the New East Zone of the HealthChoices program, Pennsylvania's Department of Public Welfare (DPW) issued a notice last week reminding providers that the ACCESS Plus Enhanced Primary Care Case Management program (administered by APS) and the United Healthcare Community Plan Voluntary Physical Health (PH) managed care program will end effective February 28, 2013 in twenty-two counties of Northeast Pennsylvania. Medicaid beneficiaries currently served by these programs will move to one of three new MCOs in the new New East Zone, AmeriHealth Mercy, Geisinger or Coventry, effective March 1, 2013. The state's notice indicated that approximately 190,000 people will move from ACCESS Plus and 16,000 people will move from UnitedHealth's voluntary MCO. The open enrollment period will begin in January 2013.

As we mentioned last month, there was some disappointment with the implementation of the New West Zone (which went live on October 1, 2012) because the selection rate among eligible beneficiaries was lower than expected at 33% (with 2/3 of eligible beneficiaries having been auto-assigned). We expect that the consumer subcommittee and the consumer representatives on the Medical assistance advisory committee will continue to push for enhanced outreach efforts in order to improve the selection rate for the New East Zone.

On the employment front, Pennsylvania's seasonally adjusted unemployment rate was 8.2 percent in September, up one-tenth of a percentage point from the August rate of 8.1 percent and 40 basis points above the national unemployment rate of 7.8.%. In May 2012, Pennsylvania's unemployment rate was 7.4% compared to the national rate of 8.2%.

In the news

- **Deal may reinstate Pennsylvania residents dropped from Medicaid**

  More than 100,000 Pennsylvanians who lost Medicaid benefits last year can reapply within the next 30 days, thanks to a settlement between a Philadelphia legal team and the state Department of Public Welfare. Applicants who lost their benefits last year and incurred medical bills could see those bills resolved if the state determines they were eligible for Medicaid all along. (Philadelphia Inquirer)

OTHER HEADLINES

Connecticut

- **Attorneys seek injunction to stop Medicaid eligibility changes**

  Attorneys representing Medicaid recipients are seeking an injunction to stop the state from moving forward with plans that could cause up to 13,000 poor adults to lose health care coverage. They argue that the changes the state is pursuing could worsen delays in processing paperwork for all Medicaid recipients and applicants. The motion, filed in federal court in Hartford Thursday, is the latest attempt to fight changes in Medicaid eligibility intended to save $50 million in this year's state budget. (The Connecticut Mirror)

District of Columbia

- **Health plan takeover in D.C. eases concerns but doesn't erase them**

  Insurance regulators seized control of Chartered Health Plan on Friday, weeks after firm representatives notified city officials of serious "irregularities" in the company's accounting. The company, owned by embattled businessman Jeffrey E. Thompson, manages the care of about 110,000 city residents eligible for federal Medicaid benefits and a local insurance program. The move will allow Chartered to continue operating through April, when its contract is set to expire, easing concerns that a more rapid withdrawal would have thrown patients and providers into chaos. But David A. Catania, chairman of the D.C. Council's health committee, said he did not expect Chartered to survive the government takeover as a city contractor. "This receivership is the epitaph for Chartered," he said. "The time Chartered may have had to find a purchaser, that time has passed." Catania said he thinks a new solicitation, expected to be issued by month's end, will attract "larger, more established, better capitalized organizations" than Chartered, whose only client was the District. (Washington Post)

- **D.C. to seize assets, control of Chartered Health Plan**

  In an extraordinary move, District Mayor Vincent Gray's administration on Friday seized D.C. Chartered Health Plan Inc. — the city's largest Medicaid managed-care contractor — from its owner, embattled political fundraiser and Gray donor Jeffrey Thompson. Insurance regulators had been closely watching Chartered since its assets dwindled below legal minimums six months ago. But their attention turned to action this month when a government-ordered audit uncovered "a transfer of cash out of the company that was not reported to [regulators] of a significant nature," said Wayne Turnage, director of the Department of Health Care Finance, which manages the Medicaid program. A D.C. Superior Court judge approved Insurance Commissioner William White's emergency request for "full control over all the assets of Chartered and the authority to operate the company free of any control of Chartered's holding company," according to a statement. (Washington Business Journal)

Kentucky

- **Kentucky Spirit files lawsuit alleging state provided faulty Medicaid data**

  Gov. Steve Beshear's administration rushed to privatize Medicaid management last year and, in its haste, provided incorrect cost information to the bidders, according to a lawsuit filed Monday in Franklin Circuit Court. Kentucky Spirit, one of three Medicaid managed-care companies outside of Louisville, said the faulty information has contributed to losses of $120 million since its work began Nov. 1, 2011. Kentucky Spirit last week told the Cabinet for Health and Family Services that it intends to terminate its three-year contract a year early and fire its 200 employees in Lexington. By suing, Kentucky Spirit hopes the court will let it end its contract in July 2013 without paying the damages that Health and Family Services Secretary Audrey Haynes has said the state will pursue. The cabinet says Kentucky Spirit cannot cancel its contract during the initial three-year term, which ends in July 2014. (Lexington Herald-Leader)

- **Medicaid Issues Leave Heavy Burden on WellCare**

  The departure of one of three statewide Medicaid operators next year is once again raising concerns about adequate medical coverage in parts of the state. Earlier this year, coverage was one of the issues brought up between Coventry Cares, another operator, and hospital chain Appalachian Regional Healthcare in a lawsuit over contract issues. At the time, state officials pointed to the other two operators as proof of coverage. But now one of those operators, Kentucky Spirit, is leaving next July. And with Coventry still without contracts for many doctor and hospital groups in the eastern part of the state, WellCare is essentially left as the only operator. Choice is one of the key terms from the federal government when states turn to a managed care system. And if WellCare isn't able to handle the bulk, it could put the program at risk in a lawsuit. (WFPL News)

- **Medicaid Operators Look to Take Place of KY Spirit**

  As the fallout continues from the announced departure of statewide Medicaid operator Kentucky Spirit, many other Medicaid operators are already looking to take their place. Kentucky Spirit announced last week they would break their contract with the state early. State officials say they won't re-open those statewide contracts to replace Kentucky Spirit until the current contracts expire. (WEKU news)

Maryland

- **Nursing Home Patients Returning To The Community**

  As of July, Maryland has moved 1,336 disabled or elderly low-income Marylanders out of nursing homes and other institutional settings as part of a national program called Money Follows the Person. The goal is to return them to the community. Maryland's program is doing well compared with efforts in most of the 43 participating states and the District, having already moved 55 percent of its original target of 2,413. But the same is not true for the District and Virginia. As of July 2, only 126 people had moved in the District, just 11 percent of its original five-year goal of 1,110. In Virginia, where the latest figures are from May, 362 people had moved, 35 percent of the original goal of 1,041. Many states have fallen far short of early, optimistic projections. Five years in-

to the program, about 22,500 people nationwide have left institutional settings and transitioned back into community settings. The states' goal had been 35,380, a target that federal officials now say was unrealistic. (Kaiser Health News)

Mississippi

- **Mississippi Medicaid expansion costly in 2017-25, study says**

  Expanding Medicaid would bring Mississippi more federal money from 2014 through 2016 but could cost the state millions of dollars from 2017 through 2025, according to a study released Monday by the state's University Research Center. The University Research Center study says in 30 to 40 years "the benefits of Medicaid expansion might outweigh the costs." Using the 95 percent participation rate, the study shows that 310,039 people could be added to Mississippi Medicaid by 2025. In that year, the state would spend $159.1 million more on Medicaid than it is spending now, while the state would receive an additional $63.3 million in revenue. That puts the state's loss of money at $95.8 million. The study notes that more than half of Mississippi's 82 counties had a shortage of doctors, nurses, dentists and other health care professionals in 2011. (The Mississippi Press)

- **Miss. says no thanks to Medicaid expansion dollars**

  Leaders of the deeply conservative state say that even if Mississippi receives boatloads of cash under President Barack Obama's health care law, it can't afford the corresponding share of state money it will have to put up to add hundreds of thousands of people to the government health insurance program for the poor. GOP Govs. Rick Scott of Florida, Bobby Jindal of Louisiana, Nathan Deal of Georgia, Nikki Haley of South Carolina and Rick Perry of Texas have said they, too, will reject a Medicaid expansion, calling it too expensive. Some advocates suspect the governors' stand is not about the money at all, but about politics, saying the Republicans are using the Medicaid issue to attack the Obama administration. (Picayune Item)

New Jersey

- **N.J. Legislature approves online health exchange, Christie refuses to sign it before election**

  As the Legislature cast the final vote to create a health exchange — an online marketplace where hundreds of thousands of residents would shop for insurance — supporters of the bill urged Gov. Chris Christie to stop stalling and embrace the reforms Congress approved more than two years ago. The Assembly approved the legislation 44-33 with two abstentions and sent it to the governor for his signature. But Christie has said he won't budge until after the Nov. 6 election because Mitt Romney, the Republican presidential nominee, has insisted he will repeal the Affordable Care Act, known as Obamacare, if he wins. (NJ.com News)

New York

- **Cuomo's Medicaid Changes Are at Washington's Mercy**

  Gov. Andrew M. Cuomo persuaded health care providers and major health worker unions to live within a strict Medicaid spending limit last year, and to accept an ambitious Medicaid redesign that promises better health outcomes at a lower cost. The governor

takes credit for $2 billion in federal savings already, and projects that $15.1 billion more will be saved over five years. He is asking federal authorities for a waiver that would give $10 billion of the federal savings back to New York to help pay for the overhaul, to "permanently restructure our health system and continue to make New York a national model." But on Capitol Hill, another side of New York's Medicaid image is on display. In a scathing report and in a hearing this fall, the House Committee on Oversight and Government Reform showcased $15 billion in federal Medicaid overpayments to the state's centers for developmentally disabled people over the past two decades, at reimbursement rates 5 to 10 times higher than cost. (New York Times)

Oregon

- **Up to 200,000 Oregonians Could Still be Uninsured in 2019**

A 2010 report published by the Oregon Office of Health Policy Research estimates that 35 percent of currently people lacking insurance would remain uninsured by 2019, despite expanded coverage by the Affordable Care Act. The publication does not give the raw numbers of Oregonians with insurance versus those without. But comparing it with data released by Kaiser Family Foundation that same year -- which says about 565,000 Oregonians currently lack insurance -- it can be extrapolated that about 200,000 people will be uninsured in 2019. Some – about 24 percent – fall into a gap where they're exempt from the mandate, but still do not qualify for subsidies. The report also predicts that 42 percent of the uninsured will ignore the individual mandate and pay the penalty instead, whereas the rest – 34 percent – are undocumented workers. (The Lund Report)

South Carolina

- **Initial Medicaid budget for 2013-14 seeks extra $194M; Keck knows 'that's not going to fly'**

The director of South Carolina's Medicaid agency said Monday he realizes his preliminary budget calling for nearly $200 million more from state taxes in 2013-14 is likely an impossible request. The increase would eat up all of the state's growth for the next fiscal year, according to long-term predictions issued last spring. The additional $193.5 million detailed in [Department of Health and Human Services director Tony] Keck's report for Medicaid is due to the federal health care overhaul, general inflation and the loss of tobacco money. It would represent an 18 percent increase over the state's current match for the joint state-federal program. (The Republic)

Tennessee

- **Tennessee Plan Would Help Medicaid Families Keep Health Coverage**

In Tennessee, where nearly all Medicaid enrollees are covered by a managed care plan, state officials are seeking federal approval for a program called "one family, one card." A longstanding problem in the Medicaid program, churn not only causes loss of coverage, but higher administrative costs and disruptions in ongoing medical treatments. It also makes it difficult for doctors to invest in preventive health care programs and for researchers to study their effects on patients. Under its proposal, Tennessee would ask the managed care companies that provide Medicaid coverage to also offer an insurance

plan that covers 70 percent of health care costs. It would be offered through the health care exchange, required under the new federal law, and would be available only to families with at least one member covered by Medicaid. The network of doctors and hospitals available to the family under this plan would be identical to the network that serves Medicaid patients. (Gant Daily)

Utah

- **Utah's Medicaid managed care plan gets green light**

Utah Medicaid's managed care experiment is now on firmer footing, says the state's Inspector General. The Utah Department of Health is in contract negotiations with four health plans that, starting in January, will manage care for 70 percent of the 252,000 Utahns on Medicaid. The "accountable care" experiment was touted for its potential to save taxpayers $770 million over seven years. (The Salt Lake Tribune)

Wisconsin

- **Is BadgerCare Plus in trouble in southeastern Wisconsin?**

The system of managed care for the almost 300,000 children and adults covered by BadgerCare Plus in southeastern Wisconsin may be crumbling. At issue: At least three of the four organizations managing the BadgerCare Plus program in the region say they are losing money on it. One of the organizations, United HealthCare, is dropping its contract with the state at the end of this month. Now a second, Molina Healthcare Inc., is warning it may soon have to do the same, for the same reason: It's losing millions of dollars on the program because the state isn't paying it nearly enough to cover the medical claims filed by its BadgerCare Plus patients. A third provider, Children's Community Health Plan, has said it lost money on its contract with the state last year. The fourth, CommunityConnect Health Plan, has not commented. The state cut payment rates to the managed care organizations by 11% in 2011 and then again this year as it struggled to balance its budget. The Wisconsin Department of Health Services said it is working to develop rates for next year to ensure that adequate networks are in place. (Journal Sentinel)

National

- **Studies Show Medicaid Expansion Lowers Death Rates, Improves Health Outcomes**

Benjamin Sommers of the Harvard School of Public Health tracked data from New York, Arizona, and Maine as they expanded coverage to about a half million people between 2000-2005. "When you expanded Medicaid, more people got coverage, more people had access to care and said they didn't have to worry about cost when they were trying to get medical care, they said their health was better and survival improved." Based on his findings, Sommers estimated a Medicaid expansion in Georgia would save about 3,000 lives per year. "At a population level, this is large. There are not a lot of policies we have that can reduce mortality by six percent over a five-year period." (WABE News)

- **Questions Linger About Implementing Doctors' Medicaid Pay Raise**

Starting Jan. 1, primary care doctors when treating patients on Medicaid, the state-federal health insurance program for the poor, will get the same rates they are paid

when caring for seniors in the Medicare program. The higher rates will last for two years. While Medicaid fees vary by state, they are generally far below Medicare and private plans. The change, which will cost $11 billion and will be paid by the federal government, means a 64 percent average pay increase, according to an Urban Institute analysis of the rates in 2010. With two months to go, doctors, state officials, and Medicaid managed care plans say there are numerous details still to be worked out. The Obama administration has yet to issue final rules for the pay hike and most industry officials don't expect one until after Election Day. In addition, some states have been hesitant to promote the provision because Republican presidential nominee Mitt Romney has vowed to repeal the health law if he is elected. (Kaiser Health News)

- **Debate brings attention to states' Medicaid plans**

  GOP presidential candidate Mitt Romney has pushed for Medicaid block grants that would significantly cut program spending and provide states with the ultimate flexibility to design the health care program without Washington meddling. The Romney Medicaid plan would cap the growth of the program's spending to the consumer price index plus 1 percent and essentially give states a lump sum to spend as they see fit. The Rhode Island and Arizona Medicaid programs, while enjoying more flexibility, are still backstopped by the federal government. (Politico)

- **Proposed Medicare change to allow disabled and chronically ill to keep getting rehab services**

  Thousands of Medicare patients with severe chronic illnesses such as Alzheimer's would get continuing access to rehab and other services under a change agreed to by the Obama administration, advocates said Tuesday. The proposed agreement in a national class action suit would allow Medicare patients to keep receiving physical and occupational therapy and other skilled services at home or in a nursing home so they can remain stable. (Washington Post)

- **Why Does Medicaid Spending Vary Across States: A Chartbook of Factors Driving State Spending**

  This detailed chartbook provides an illustrative overview of some of the key factors that contribute to the substantial variation in Medicaid spending across states today. The chartbook provides a broad range of state-by-state data on subjects including state revenue and spending, the demand for public services, health care markets, and state Medicaid policy choices. Understanding this variation can be important for assessing state fiscal issues, the differences across states and their implications for federal and state policy changes to the Medicaid program. Link to the report: (Kaiser Family Foundation)

- **State Races Will Affect Medicaid, Exchanges**

  Beyond the impact next month's presidential elections will have on the nation's health care policy, the winners of gubernatorial contests will have an important role in implementing the federal overhaul. The outcomes of three tight state races in particular [New Hampshire, Montana, Washington] will determine the future of Medicaid and health insurance marketplaces in those states. If former Massachusetts Gov. Mitt Rom-

ney becomes president, he is likely to try to stall or derail the 2010 health care law. However, unless the GOP wins a majority in the Senate, Romney would likely not be able to get an outright repeal of the law and governors would still face significant choices about health care in their states. In the November elections, Republicans are favored to expand their gubernatorial advantage over Democrats — which could mean fewer states might accept the Medicaid expansion the health care law calls for than under the current lineup of governors. (CQ Healthbeat)

- **States Seek to Keep Seniors Out of Nursing Homes**

  Managed long-term care is the first step toward a coordinated approach on dual eligibles. Of the 26 states set to initiate dual-eligibles demonstration projects, 15 say they plan to move forward next year; the other 11 say they will to start theirs in 2014. Tennessee was one of 15 states to receive a $1 million federal grant to plan its demonstration. The state plans to integrate Medicare benefits into its managed-care system. Patients would have a single insurance card and a single care management office to oversee their needs. Savings are expected for both Medicare and Medicaid within three years if the demonstration is successful. (Governing Magazine)

COMPANY NEWS

- **AdvantEdge Healthcare Buys Medrium**

  AdvantEdge Healthcare Solutions, a provider of medical billing, practice management, and coding services, has acquired Medrium Inc. Delaware-based Medrium is a medical billing and practice management company. Terms of the deal were not released. (PE HUB)

- **KKR, Apax, Madison Dearborn Bid for Heartland Dental**

  Private equity firms KKR & Co., Apax Partners and Madison Dearborn Partners are bidding for Heartland Dental Care Inc., one of the largest U.S. dental practice management companies and which could be worth around $1.3 billion, according to people familiar with the matter, Reuters wrote. The buyout firms submitted final bids on Monday for Heartland Dental, which has been exploring a sale after hiring investment banks Jefferies and Moelis earlier this year, the people said. Heartland Dental, in which Chicago-based private equity firm CHS Capital Partners has a stake, has about $120 million in annual earnings before interest, tax, depreciation and amortization and could be sold for 10 to 12 times EBITDA, Reuters reported previously. (PE HUB)

- **Centene Appoints Robert T. Hitchcock As Executive Vice President Of Health Plan Business Unit**

  Centene Corporation announced today that it has appointed Robert T. Hitchcock as Executive Vice President, Health Plan Business Unit, effective immediately. Mr. Hitchcock will oversee operations for all of Centene's health plans and will report to Michael F. Neidorff, Chairman and CEO of Centene. (Centene Press Release)

- **Trinity Health, Catholic Health East Announce Plans To Merge**

  The boards of two leading Catholic health systems, Trinity Health and Catholic Health East, have announced plans to join forces in 2013. The consolidated Catholic health system would include 82 hospitals and 89 continuing care facilities, home health and hospice programs. The two health systems together have nearly 2.8 million visits each year across 21 states. They employ more than 87,000 employees, including 4,100 doctors. The merger is aimed, in part, at preparing for a new system of care that is moving away from fee-for-service medicine and toward a focus on population-based health, where providers are offered financial incentives to keep patients healthy and lower costs through better-coordinated care. (Kaiser Health News)

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, 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 1, 2012	Texas Rural STAR+PLUS	RFP Released	110,000
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 1, 2013	Texas Rural STAR+PLUS	Proposals due	110,000
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
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
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

Key Lessons from Hospitals with Low Readmissions

Sharon Silow-Carroll, MSW, MBA, Managing Principal

Jennifer Edwards, DrPH, Managing Principal

Health Management Associates, with support from The Commonwealth Fund, examined hospitals that achieved exceptionally low readmission rates to identify clinical and operational strategies, as well as the organizational, cultural, and environmental factors, that lead some hospitals to create or adopt "best practices" and achieve greater success. We studied four hospitals within the top 3 percent in terms of low readmission rates for at least two of the following: heart attack, heart failure, and pneumonia patients, as reported to CMS. **Link**

Delivery of Very Low Birth Weight Infants Georgia: Improving Performance

Donna Strugar-Fritsch, BSN, MPA, CCHP, Principal

Lori Weiselberg, MPH, Senior Consultant

Mark Trail, M.Ed, Managing Principal

The Georgia OBGyn Society contracted with Health Management Associates (HMA) to conduct an analysis of factors contributing to the state's low performance on the national maternal-child health measure related to very low birth weight infants and their delivery hospital within the state's Regional Perinatal System (RPS). The RPS designates and funds six Regional Perinatal Centers (RPCs) across the state. HMA conducted extensive research, including a literature review, interviews with state and national maternal child health and region perinatal system experts, a survey of the state's OBGyn physicians, and analysis of four sources of data on VLBW births to Georgia residents. **(Link to Report - Presented to OBGyn Society of Georgia)**

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

California Assembly Committee Oversight Hearing:
Evaluation and Monitoring of Medi-Cal Programs

Lisa Maiuro – Panelist

October 25, 2012

Sacramento, California

Metropolitan Chicago Healthcare Council APRN/PA Educational Summit:
Billing, Reimbursement & Documentation

Linda M. Follenweider – Presenter

November 30, 2012

Naperville, Illinois