HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: HIGHLIGHTS FROM KAISER/HMA 50 STATE MEDICAID SURVEY

HMA ROUNDUP: ILLINOIS RECEIVES CMS APPROVAL FOR COOK COUNTY EARLY EXPANSION WAIVER; WASHINGTON STATE RECEIVES CMS APPROVAL FOR MFFS DUALS DEMONSTRATION; WASHINGTON D.C. TO RELEASE MEDICAID MANAGED CARE RFP SOON; NEBRASKA RELEASES RISK-BASED BEHAVIORAL HEALTH RFP; WISCONSIN ANNOUNCES MLTC CONTRACT AWARDS

OTHER HEADLINES: STATE TAX REVENUES SHOW SOFTENING GROWTH; WELLCARE TO ACQUIRE UNITEDHEALTH'S SOUTH CAROLINA MEDICAID BUSINESS; WELLCARE AWARDED HAWAII BEHAVIORAL HEALTH CONTRACT

OCTOBER 31, 2012

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

---

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

Contents

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

Andrew Fairgrieve
312.641.5007
afairgrieve@healthmanagement.com

IN FOCUS: HIGHLIGHTS FROM KAISER/ HMA 50 STATE MEDICAID SURVEY

This week, our *In Focus* section reviews highlights and shares key takeaways from the Kaiser Commission on Medicaid and the Uninsured's (KCMU) new report, ***Medicaid Today; Preparing for Tomorrow - A Look at State Medicaid Program Spending, Enrollment and Policy Trends - Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2012 and 2013***, released last Thursday, October 25, 2012. The report, published annually, was prepared by Vernon K. Smith, Ph.D., Kathleen Gifford and Eileen Ellis from Health Management Associates, and by Robin Rudowitz and Laura Snyder from the Kaiser Commission on Medicaid and the Uninsured.

The findings in this report are drawn from the 12th consecutive year of the KCMU and HMA budget survey of Medicaid officials in all 50 states and the District of Columbia. This survey reports on trends in Medicaid spending, enrollment and policy initiatives for FY 2012 and FY 2013. The report describes policy changes in reimbursement, eligibility, benefits, delivery systems and long-term care, as well as detailed appendices with state-by-state information, and a more in depth look through four state-specific case studies of the Medicaid budget and policy decisions in Massachusetts, Ohio, Oregon and Texas. Links to the Executive Summary and full report are provided below:

Link to Executive Summary (PDF)

Link to Full Report (PDF)

Report Summary Points

- Medicaid spending slowed in FY 2012 to a near-record low as the economy began to improve and enrollment growth slowed. Slow program growth is expected to continue for FY 2013.
- Cost containment remained a strong focus for Medicaid, but with small improvements in the economy, a number of states were able to make some targeted program improvements, including continued expansions of community-based long-term care options.
- Medicaid eligibility levels remained stable in most states, as the ACA maintenance of eligibility (MOE) provisions limited states from restricting Medicaid eligibility standards, methodologies or procedures. Despite tight budgets, a number of states reported targeted eligibility expansions or enrollment simplifications.
- Medicaid programs are engaged in a range of delivery system changes, including managed care reforms and care coordination strategies. Some of the most significant of these are initiatives to better deliver care for those dually eligible for Medicare and Medicaid.
- Looking ahead, states are preparing for the implementation of the ACA and are making decisions about the Medicaid expansion in the context of upcoming elec-

tions as well as potential Medicaid implications from an intense national debate about the federal budget deficit.

Key Report Highlights

State Fiscal Conditions and the Recession

- State tax revenue collections across all states have grown for ten consecutive quarters. The unemployment rate has fallen but remains high, resulting in sustained demand for public programs like Medicaid.
- Total revenue collections in states for the second quarter of calendar year (CY) 2012 grew by 1.8 percent compared to one year earlier.
- During the height of the Great Recession, the decline in state revenues was a more significant factor than the increase in Medicaid spending on state budgets.
- The expiration of the ARRA funds at the end of FY 2011 meant a large increase in state spending to replace the loss in federal financing in FY 2012.

Medicaid Spending and Enrollment Growth Rates

- FY 2012 total Medicaid spending increased at one of the lowest annual rates on record, on average by 2.0 percent across all states. Spending growth varied across the states, with 16 states experiencing declines and 33 states experiencing increases. The only state fiscal year when total Medicaid spending growth was lower in the last 15 years was in FY 2006 when Medicare Part D assumed responsibility for pharmacy expenditures for dual eligible beneficiaries, and enrollment growth was virtually flat.
- For FY 2013, legislatures authorized total spending growth on average of 3.8 percent across all states. While higher than FY 2012, 3.8 percent is one of the three lowest rates of growth in total Medicaid spending in the past 15 years. Ten states budgeted for actual declines in Medicaid spending for FY 2013.
- Medicaid enrollment growth slowed in FY 2012 to 3.2 percent, the lowest rate of growth since 2008 at the beginning of the recent recession and below initial projections for the second year in a row. Slower growth was primarily attributed to a gradual improvement in the economy. For FY 2013, states expected enrollment to continue to grow at an even slower pace than in FY 2012, with average growth across all states projected at 2.7 percent.

Medicaid Policy Initiatives for FY 2012 and FY 2013

- In FY 2012, 48 states implemented at least one new policy to control Medicaid costs and 47 states plan to do so in FY 2013. Many states reported program reductions in multiple areas.
- As in previous years, provider rate restrictions were the most commonly reported cost containment strategy. A total of 45 states restricted provider rates in FY 2012 and 42 states reported plans to do so in FY 2012. A few states increased or imposed new provider taxes that mitigated provider rate cuts in some cases.

- Restrictions to Medicaid eligibility or enrollment and renewal processes are generally prohibited under the MOE requirements in the ACA. For FY 2012, 32 states made enhancements to eligibility standards or enrollment and renewal processes, and 21 states have plans to do so in FY 2013. Due to some exceptions in the ACA MOE requirements, two states reduced eligibility in FY 2012 and six states reported eligibility cuts planned for FY 2013.
- The same number of states (18) reported benefit cuts for FY 2012 as in FY 2011, while a much smaller number of states (8) reported eliminating, reducing, or restricting benefits in FY 2013.
- This year's survey shows that the 20+ year trend in most states of expanding HCBS service options continues, although a few states are taking steps to apply new service limits. In FY 2012 and FY 2013, 29 and 34 states, respectively, took actions that expanded long term care (LTC) services (primarily expanding HCBS programs). Conversely, a total of 10 states in FY 2012 and seven states in FY 2013 took action to constrain LTC services.
- Notable among the many actions states are taking to refine and improve their pharmacy programs, eight states plan to adopt the "Actual Acquisition Cost" reimbursement methodology for pharmacy ingredient costs, nine states have adopted a new a "carve-in" strategy with regard to prescription drugs and capitated managed care arrangements and 11 states reported on efforts to better control behavioral health drug utilization.

Delivery System and Quality Initiatives and Waivers

- Twenty states in FY 2012 and over two-thirds of states in FY 2013 reported expanded use of managed care, primarily by adding eligibility groups, expanding managed care into new geographic areas or by implementing new managed LTC initiatives. In FY 2012, a total of 14 states adopted new quality improvement strategies, and for FY 2013, a total of 23 states indicated new strategies will be implemented.
- States are implementing a range of other initiatives to coordinate and integrate care, including health homes, patient-centered medical homes, and Accountable Care Organizations (ACOs), as well as other efforts to coordinate physical and behavioral health, and long-term care and acute care services. New care coordination efforts are underway in all but six states in FY 2012 and FY 2013.
- Twenty-five states are actively working with CMS to develop dual eligible financial alignment demonstrations (including 15 states that received $1 million planning contracts), and nine other states are working on additional strategies related to services for this population.
- A total of 19 states indicated that they plan to implement a comprehensive Section 1115 waiver initiative in FY 2013. Most frequently, these states reported that these initiatives involve delivery system and provider payment reforms for individuals with disabilities and special health care needs.

Looking Ahead: Perspectives of Medicaid Directors

When asked to identify the top issues and challenges for FY 2013 and beyond, Medicaid directors listed the following:

- Making decisions about the ACA Medicaid expansion and preparing for the expansion in Medicaid coverage in 2014.
- Development of new information technology systems related to eligibility (designed to move to the new Modified Adjusted Gross Income ("MAGI") rules, to streamline and simplify enrollment and to coordinate enrollment with new insurance Exchanges), MMIS, payment reform, quality strategies, and other health information technologies to support new program initiatives.
- Development of new strategies to improve care, quality and outcomes, including new requirements for managed care organizations, patient-centered medical homes, health homes, managed long-term care, coordination and integration of physical health and behavioral health care, and new quality improvement strategies integrated with reimbursement methodologies.
- Development of new systems of care and reimbursement for seniors and persons with disabilities, including managed care and coordinated systems for dual eligible beneficiaries. These initiatives are designed to better serve high need populations but are complex and difficult to design and implement.

HMA MEDICAID ROUNDUP

Colorado

HMA Roundup – Joan Henneberry

The statewide membership association for health plans, Colorado Association of Health Plans (CAHP), developed a set of guiding principles around policy and operations for consideration by the Colorado Health Benefit Exchange (COHBE) board. CAHP staff and members have been represented on COHBE committees and were active in the early stages of exchange planning in Colorado. Key principles include:

- COHBE should not add additional participation or regulatory requirements that may limit the number of carriers and plans that want to sell Qualified Health Plans (QHPs) in the exchange.
- Brokers should continue to play a key role in the sale of health insurance inside and outside of the exchange.
- The SHOP exchange (for small employers) should maintain the small group standard requiring 75 percent participation of "eligible employees" if a small business wants to purchase through the SHOP. The requirement should rise to 100 percent if the employer covers the entire premium. COHBE should maintain the small group standard requiring employers to contribute at least 50 percent of the employee premium.
- COHBE should evaluate all available funding sources to support continuing administrative and operational expenses including grants, fees, and taxes in addition to assessments on exchange carriers. If carrier assessments are necessary, a PMPM assessment on plans in the individual and SHOP exchanges are preferable to a percent of premium assessment. The full document is available here.

District of Columbia

HMA Roundup – Theresa Sachs

The District of Columbia has announced that it will issue a RFP to reprocure Medicaid managed care contracts in DC. This announcement comes in the wake of DC Chartered, the District's largest managed care plan, being placed into receivership. The RFP is projected to be released as early as today, October 31, or within the coming days. Proposals would likely be due within four to six weeks, with contract awards to be announced in early January. It is anticipated that three to four plans would be awarded contracts. Currently, managed care contracts are held by DC Chartered Health Plan, UnitedHealthCare Community Plan, and MedStar Family Care.

In the news

- **Chartered Health Plan irregularities total $4 million, D.C. officials say**

  The District's largest health-care contractor had about $4 million in questionable financial transactions last year that went unreported to regulators until recently, District officials said Thursday. The disclosures concerning Char-tered Health Plan were made at

a D.C. Council hearing on the city's recent takeover of the company, which billed the District $358 million last year to manage the care of about 110,000 low-income residents. Wayne Turnage, director of the Department of Health Care Finance, said Chartered executives told him at a meeting this month that the company had booked $3 million in "unsourced" receivables while transferring about $1 million out of the company. (Washington Post)

Illinois

HMA Roundup – Jane Longo & Matt Powers

Cook County Waiver

It was announced this week that the Cook County early expansion waiver was approved by CMS. The waiver expands Medicaid coverage to patients within the Cook County Health and Hospitals System (CCHHS) and a network of community provider partners. As many as 115,000 currently uninsured individuals are expected to enroll in the waiver. Many of these anticipated enrollees are receiving uncompensated care in the CCHHS system. This waiver is one of the larger Medicaid early expansions authorized under the Affordable Care Act. We will provide a detailed look at the Cook County Waiver in an upcoming In Focus section.

State Budget Crisis Task Force Report

Last week, the State Budget Crisis Task Force released its report on the state of Illinois. The report addresses Illinois' bond rating (the lowest in the country), the state pension system, and more than $8 billion in unpaid bills, according to the State Comptroller's office. One section of the report focuses on the state's Medicaid program, contending that growth in Medicaid spending over the past decade, allowed in part by budgeting tricks, such as putting off payments to the following fiscal year, has contributed significantly to the state's budget crisis. The report acknowledges that the Medicaid cost-savings implemented last year by the legislature are a step in the right direction, but cautions that many issues remain in the program. The State Budget Crisis Task Force, chaired by Richard Ravitch and Paul Volckler, focuses on budget crises in six states. Illinois is the second state report to be released by the Task Force. (Link to State Budget Crisis Task Force Illinois Report)

Dual Eligible Demonstration RFP

Last week, the state indicated that contract awards in the duals RFP would be announced this week. While there is a strong likelihood that the state will announce awards this week, given the history of continued delays over the last few months, it should not be viewed as a certainty.

Michigan

HMA Roundup – Esther Reagan

On October 31, 2012, the leaders of Henry Ford Health System and Beaumont Health System announced they have begun exclusive negotiations to combine their operations into a new $6.4 billion organization. These are two of the state's largest health systems, both

with facilities in southeast Michigan. Henry Ford has 23,000 employees and operates seven hospitals as well as 30 medical centers, and its Health Alliance Plan subsidiary is the second largest health care insurer in the state behind Blue Cross Blue Shield of Michigan. Beaumont has 18,000 employees and operates six hospitals and medical centers as well as four nursing care facilities. Beaumont has reportedly been seeking a partner for several months and talked with other hospital groups before agreeing to a deal with Henry Ford.

In the news

- **Detroit Medical Center completes ProCare Health acquisition**

  Detroit Medical Center has completed the purchase of ProCare Health Plan, a Medicaid managed-care company that the hospital system says will play an important role in its quest to provide better and more coordinated care. The system operates one of 32 accountable care organizations selected by the CMS Innovation Center for its Pioneer ACO model. Carrie Harris-Muller, ProCare Health Plan president and CEO and senior vice president of Nashville-based Vanguard Health Systems, which acquired DMC in 2011, said the deal will position the hospital for expanded Medicaid enrollment under healthcare reform. (Modern Healthcare)

Nebraska

HMA Roundup

Nebraska's Department of Health and Human Services, Division of Medicaid and Long-Term Care (MLTC), has issued a RFP to select one qualified bidder to operate a statewide pre-paid inpatient health plan (PIHP) providing Mental Health and Substance Use Disorder services to children, youth, and adults enrolled in the Nebraska Medicaid/CHIP programs. The program will be referred to as the Nebraska Behavioral Health (BH) Managed Care program. Proposals are due January 7, 2013, with the contract award to be announced on April 15, 2013. The BH Managed Care program will go live on September 1, 2013, with a contract term through June 30, 2016, and an option to renew for an additional two periods of one year each. Link to procurement website.

Texas

HMA Roundup – Gary Young

NEMT Assessment RFP

The Texas Health and Human Services Commission (HHSC) has issued a RFP for a vendor to provide an assessment of the state's Non-emergency Medical Transportation waiver. The assessment is to include a review of access to services under the waiver, quality of services delivered under the waiver, and cost effectiveness of the waiver. Proposals are due on November 5, 2012, with contracts expected to start two weeks from the due date, on November 19, 2012.

Department of Aging and Disability Services Appointment

HHSC Executive Commissioner Kyle Janek, M.D., today announced that Jon Weizenbaum will be the next commissioner of the Department of Aging and Disability Services

(DADS). Weizenbaum has been deputy commissioner at DADS since 2006 and has twice served as the agency's interim commissioner.

In the news

- **How the Election Will Affect Health Care in Texas**

  If President Obama wins a second term and the Affordable Care Act stays in place, the debate will likely turn to whether Texas will join an expansion of Medicaid. Gov. Rick Perry says Texas will opt-out of that expansion. But Anne Dunkelberg of the Center for Public Policy Priorities, a liberal state policy think-tank, says the state's largest counties — which have the most to gain monetarily from joining the program — may band together to force the expansion. Conservatives hope a victory for Mitt Romney would be the end of federal health care reform. But it could be the beginning of new Medicaid block grants. Arlene Wohlgemuth of the conservative Texas Public Policy Foundation says multiple states have asked the federal government for the freedom to spend Medicaid dollars as they wish. She says one example of block-grant savings would come from instituting a sliding scale in which families would make modest co-pays for coverage based on their income. (Texas Tribune)

Washington

HMA Roundup – Doug Porter

Washington's dual eligible integration demonstration memoranda of understanding (MOU) with CMS was published last Thursday, October 25. Washington state's dual demonstration proposal includes a capitated model in the counties that want to use risk based managed care and a managed fee-for-service (MFFS) model in the rest of the state. The MOU signed last week addresses only the MFFS model. While an MOU for the capitated model has not yet been executed, the state has indicated that the counties under consideration for the capitated model are King (Seattle), Snohomish (Everett) and Whatcom (Bellingham). The only county that will definitely be included in the capitated model is Snohomish. King and Whatcom counties are still being debated or evaluated. (Link to Washington MFFS MOU).

Key summary points from the MOU follow:

- Start date: April 1, 2013
- Eligibility: Full dual eligibles that reside in the counties that are participating in the MFFS model and are eligible for participation in a Health Home.
  - To be eligible for the Health Home program, a beneficiary must have at least two chronic conditions, one chronic condition and risk for another, or one serious and persistent mental illness.
  - Beneficiaries enrolled in Medicare Advantage plans, PACE or receiving hospice services are not eligible to participate.
  - American Indians/Alaskan natives will not be passively enrolled but can participate on a voluntary basis.

- Enrollment: Beneficiaries eligible to participate will be passively enrolled but can opt-out at any time.
- Providers will receive FFS payment from CMS for Medicare services and FFS and capitated payments from the State for Medicaid services.
- Health Home providers will receive a per member per month (PMPM) payment from the State for individuals eligible for and receiving Medicaid health home services from a qualified health home provider.
- The State will be eligible to receive a retrospective performance payment based on quality and savings criteria if the program achieves overall federal savings incorporating both Medicare spending and the federal portion of Medicaid spending.

In the news

- **Candidates Talk Medicaid In Washington Governor's Race**

  In Washington State, Chris Gregoire, the current Democratic governor, chose to continue with plans for Medicaid expansion. But Gregoire is not seeking reelection, and whoever is elected governor this fall could change that course. The issue is playing out in an extremely tight race pitting Democrat Jay Inslee, an eight-term congressman from Seattle, against Republican Rob McKenna, the attorney general. Inslee voted for the health law in Congress and he would follow Gregoire's lead, expanding Medicaid as mandated by the Affordable Care Act. McKenna says he's for expansion, but with restrictions. For example, he'd like to require current as well as new Medicaid beneficiaries to share costs. (Kaiser Health News)

Wisconsin

HMA Roundup

Last Tuesday, October 23, Wisconsin's Department of Health Services (DHS) made award announcements in the state's Medicaid managed long term care RFP for the Family Care and Family Care Partnership programs. Family Care and Family Care Partnership are health and long-term care programs for low-income frail elders and adults with developmental or physical disabilities who have long-term care needs. Family Care provides managed long term care benefits, while Family Care Partnership provides integrated managed long term care and acute care benefits. Awardees in each service area (GSR) are listed below.

Family Care Awards (move on to certification process):

- GSR 1 (Chippewa, Dunn, Eau Claire, Pierce, St. Croix):
  - Southwest Family Care Alliance
- GSR 2 (Buffalo, Clark, Jackson, La Crosse, Monroe, Pepin, Trempealeau, Vernon):
  - Western Wisconsin Cares, Care Wisconsin
- GSR 3 (Crawford, Grant, Green, Iowa, Juneau, Lafayette, Richland, Sauk):
  - Southwest Family Care Alliance

- GSR 4 (Langlade, Lincoln, Marathon, Portage, Wood)
    - Community Care of Central Wisconsin
- GSR 5 (Columbia, Dodge, Green Lake, Jefferson, Marquette, Washington, Waukesha, Waushara)
    - Southwest Family Care Alliance, Milwaukee Dept. of Family Care, Care Wisconsin
- GSR 6 (Ozaukee, Sheboygan, Walworth, Washington, Waukesha)
    - Community Care, Inc., Milwaukee Dept. of Family Care, Care Wisconsin

Family Care Partnership Awards (move on to certification process):

- GSR 1 (Chippewa, Dunn, Eau Claire, Pierce, St. Croix)
    - *No Award Issued*
- GSR 3 (Sauk)
    - Care Wisconsin
- GSR 5 (Columbia, Dodge, Jefferson)
    - Care Wisconsin
- GSR 6 (Ozaukee, Washington, Waukesha)
    - Community Care, Inc., Care Wisconsin

OTHER HEADLINES

Alabama

- **Gov. Robert Bentley creates commission on Medicaid costs**

  Gov. Robert Bentley created a commission to look for ways to rein in Medicaid costs that now consume about one-third of the state's General Fund budget. Bentley signed an executive order creating the Alabama Medicaid Advisory Commission. The group is tasked with evaluating how the state funds Medicaid and to look for ways to tackle one of the state's biggest budget bears. (AL.com)

California

- **Assembly Committee Examines State's Moves to Medi-Cal Managed Care**

  The Assembly Committee on Health last week asked for a progress report and assurances from Department of Health Care Services officials that the state was not only ready to move many Medi-Cal beneficiaries into managed care, but also ready to evaluate the process. Chair of the Assembly Committee on Health, Richard Pan, said the health committee wanted to make sure all of those transition programs had metrics in place ahead of time, so that success of those programs can be measured, he said, "with clearly defined outcomes, and sufficient evaluation tools in place." Toby Douglas, director of DHCS, said the department is looking at a wide array of measurements – from patient satisfaction surveys and beneficiary complaints to clinical outcomes. (California Healthline)

- **Health insurers line up to compete in California's exchange**

  California's health insurance exchange said more than 30 plans are expected to vie with one another for spots in the state-run marketplace opening next fall. The exchange, branded Tuesday as Covered California, will negotiate with insurers for the best rates and will assist consumers and small businesses in choosing a plan by separating them into five categories based on cost and level of benefits. California's four largest insurers in the individual market — Kaiser Permanente, Anthem Blue Cross, Blue Shield of California and Health Net Inc. — have indicated interest in the exchange. Smaller insurers and large hospital systems may offer health plans in specific areas. (Los Angeles Times)

- **California to start regaining control of prison healthcare**

  Seven years after federal courts took control of California's prison healthcare system, citing care so poor that inmates were dying needlessly, they will start the long process Friday of turning operations back over to the state. J. Clark Kelso, the court-appointed overseer, said he could foresee a full resumption of state control in about two years. He will begin Friday with a test: handing over authority to staff and equip new care facilities, including a $1-billion project in Stockton, and the sensitive job of making sure inmates get to doctors, clinics and hospitals. (Los Angeles Times)

Georgia

- **Georgia faces big decision on insurance exchanges**

  Georgia must soon decide whether it will build a new health insurance "exchange," or marketplace — where hundreds of thousands of consumers will shop for coverage — or cede control of it to the federal government. For months now, Gov. Nathan Deal and other Republican governors have put off major decisions tied to the Affordable Care Act in hopes the health law will be repealed if Mitt Romney wins election. But on Nov. 16 states must declare whether they will build and run state-based health insurance exchanges, a cornerstone of the law, or leave it to the federal government. While Deal has yet to announce a decision, experts say even if Georgia wants to do its own exchange there likely isn't enough time to build it and have it up and running by the Jan. 1, 2014 deadline. (Atlanta Journal Constitution)

Ohio

- **Ohio's high Medicaid cost estimates questioned by some experts**

  Gov. John Kasich's administration says it is bracing for a billion-dollar hit. Officials say it'll come from 400,000 new Medicaid clients in the 24 months after the Affordable Care Act begins requiring most people to have health insurance. These are folks who are currently eligible for Medicaid but have never signed up. Just across the border, however, state Medicaid officials in Indiana and Michigan see things much differently. They expect drastically smaller numbers of people to climb aboard their programs -- just 15,000 in Michigan and 92,000 in Indiana -- when the so-called individual mandate for health coverage begins in 2014. "I don't know what they're assuming, but that would be a very, very high estimate," said John Holahan, director of the Health Policy Center at the Urban Institute, a national nonpartisan research group studying the impact of Obamacare across the country. The Kasich administration defends its figures, saying they are the "best estimates" based largely on an actuarial report. Officials say the estimates will be refined as the months pass, and call criticism of the numbers premature. (Cleveland Plain Dealer)

Vermont

- **Vermont Pushes State Employees To Use CHIP Program For Their Kids**

  The administration of Vermont Gov. Peter Shumlin is encouraging state employees with children to consider dropping their kids from their parents' health care plan and instead enrolling them in Dr. Dinosaur, Vermont's version of the state-federal health insurance program for low-income children. The administration says the change could save state employees a lot of money — and it could reduce the state's health care costs by millions of dollars. Several weeks ago, 2,100 state employees with children who meet certain income thresholds received a memo from the Shumlin administration outlining how this option would lead to savings both for the employee and for the state. If half of the eligible state employees made this change, Vermont could save more than $5 million a year. (Kaiser Health News)

National

- **Don't Expect Too Much from Dual Eligible Demonstrations, Kaiser Study Suggests**

  Despite the rush to test ways to reduce the cost of caring for the nation's most frail and poor population — people enrolled in both Medicare and Medicaid, a new review of such efforts commissioned by the Kaiser Family Foundation suggests that policy makers should expect modest, if any, savings. The analysis for Kaiser was done by Randall Brown and David R. Mann at Mathematica Policy Research. They conclude that "generating modest net Medicare savings and better outcomes for dually eligible beneficiaries is possible, but will require tailoring, targeting and monitoring." CMS has been criticized for moving ahead with such widespread demonstrations so quickly, particularly those that will rely on managed care models. But although up to two million beneficiaries would eventually be part of the pilots, the head of the new coordination office has said that these demonstrations will be rolled out gradually. (CQ Healthbeat)

- **Reconciliation Could Deliver One-Two Punch to Health Law**

  It would be blunt force trauma, to be sure. But reconciliation, the budgetary maneuver that allows deficit reduction legislation to pass the Senate by a simple majority, appears to offer Republicans a way to strike down the parts of the health law they find most objectionable if on Nov. 6 voters hand Republicans control of the White House and Senate along with the majority in the House. However, there's plenty that's problematic in the use of reconciliation. First, it takes months, not weeks or days. Second, its reach is unclear, except for the likelihood that it probably couldn't be used to strike down the entire law. That's because doing so would increase the deficit, and reconciliation can't be used if that's the case. Third, what's left standing in the health care overhaul would create big headaches for policy makers and the public. (CQ Healthbeat)

- **States' Tax Revenues Show Further but Softening Growth**

  States' tax collections grew for the tenth straight quarter in the second quarter (April-June) of 2012. Yet total state tax collections were still below the peak levels reported in 2008. Also, the growth in state tax collections has been softening and may weaken further in the coming months, according to the latest State Revenue Report from the Rockefeller Institute of Government. Preliminary July-August figures from 44 early reporting states suggest revenue gains would continue for an eleventh consecutive quarter. Overall collections showed growth of 8.7 percent in the July-August months of 2012 compared to the same months of 2011. However, September is the most important month in the quarter and these early results may not reflect the full quarter. The report also analyzes states' current fiscal position. Though most states have now reported growth in tax revenue collections for the last two state fiscal years, states still have a long road for full fiscal recovery. At the end of fiscal 2012, overall tax collections nationwide were still below peak levels in real terms. "In sum, while state tax revenue is recovering, it remains well below where previous trends would have suggested. Furthermore, recent economic and revenue trends suggest tax revenue may weaken in coming months. While the worst may be behind states, they are not out of the woods," according to the report. (Rockefeller Institute)

COMPANY NEWS

- **WellCare to Acquire UnitedHealthcare's Medicaid Business in South Carolina**

  WellCare Health Plans, Inc. today announced that it has entered into an agreement to acquire UnitedHealthcare's Medicaid business in South Carolina from UnitedHealth Group. The transaction is subject to regulatory approvals, and WellCare anticipates that the transaction will close during the fourth quarter of 2012. As of October 2012, UnitedHealthcare's Medicaid business in South Carolina serves approximately 65,000 Medicaid members in 39 of the state's 46 counties, including the Columbia and Greenville metropolitan areas, through the South Carolina Healthy Connections Choices program. It has a network that includes more than 30 hospitals, 1,800 primary care physicians, and 2,000 specialists. (WellCare News Release)

- **WellCare's 'Ohana Health Plan Selected To Provide Behavioral Health Services To Medicaid-Eligible Adults With Serious Mental Illnesses In Hawaii**

  WellCare Health Plans, Inc. today announced that 'Ohana Health Plan ('Ohana) has been awarded a Hawaii statewide contract to case manage, authorize and facilitate the delivery of behavioral health services to Medicaid-eligible adults who have serious mental illnesses, and who are participants in the state's QUEST Expanded Access (QExA) health program. The Hawaii Med-QUEST Division anticipates that services will start in early 2013. The contract term is expected to run through June 6, 2015, and would include a possible extension until June 30, 2018. Based on currently available information, it is estimated that this program serves between 800 and 1,000 residents of Hawaii. 'Ohana, along with another managed care plan, currently provides other services to these members through the QExA program. (WellCare News Release)

RFP CALENDAR

Below is an updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
October-November 2012	Illinois Duals	Contract awards	136,000
October-November 2012	Massachusetts Duals	Contract awards	115,000
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	Michigan Duals	RFP Released	198,600
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	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona	Capitated	98,235	N/A+	N/A+	N/A		1/1/2014
California	Capitated	685,000**	X	3/1/2012	4/4/2012		6/1/2013
Colorado	MFFS	62,982					1/1/2013
Connecticut	MFFS	57,569					12/1/2012
Hawaii	Capitated	24,189					1/1/2014
Illinois	Capitated	136,000	X	6/18/2012	Oct.-Nov. 2012		4/1/2013
Iowa	MFFS	62,714					1/1/2013
Idaho	Capitated	17,219	March, 2013	Q2 2013	July 2013		1/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	Oct.-Nov. 2012*	X	4/1/2013
Michigan	Capitated	198,644					1/1/2014#
Missouri	MFFS‡	6,380					10/1/2012
Minnesota	Capitated	93,165					4/1/2013
New Mexico	Capitated	40,000		Cancelled - as of August 17, 2012			
New York	Capitated	133,880					1/1/2014
North Carolina	MFFS	222,151					1/1/2013
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12		4/1/2013
Oklahoma	MFFS	104,258					7/1/2013
Oregon	Capitated	68,000		Certification process			1/1/2014
Rhode Island	Capitated	22,737		Apr-May 2013	6/1/2013		1/1/2014
South Carolina	Capitated	68,000	Nov. 2012		7/30/2013		1/1/2014
Tennessee	Capitated	136,000					1/1/2014
Texas	Capitated	214,402		Late 2012	Early 2013		1/1/2014
Virginia	Capitated	65,415	Dec. 2012		July 2013		1/1/2014
Vermont	Capitated	22,000	11/1/2012	1/1/2013	2/28/2013		1/1/2014
Washington	Capitated/MFFS	115,000		Feb. 2013	July 2013	MFFS Only	1/1/2014
Wisconsin	Capitated	17,600	X	8/23/2012	10/1/2012		4/1/2013
Totals	**20 Capitated 6 MFFS**	**2.4M Capitated 485K FFS**	***5***			***2***	

** 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

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

Linda M. Follenweider – Presenter

November 30, 2012

Naperville, Illinois