HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Investment Services Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS MEDICAID MANAGED CARE ENROLLMENT REPORT

HMA ROUNDUP: ILLINOIS ANNOUNCES DUAL ELIGIBLE DEMONSTRATION AWARDS; HEALTH POLICY IMPLICATIONS OF PUERTO RICO ELECTIONS; DEADLINES FOR DUAL ELIGIBLE MCOS TO FILE WITH CMS FOR 2014; DEADLINE FOR STATES TO SUBMIT INSURANCE EXCHANGE PLANS PUSHED BACK

OTHER HEADLINES: STATES CONTEMPLATE INSURANCE EXCHANGE, MEDICAID EXPANSION OPTIONS

NOVEMBER 14, 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

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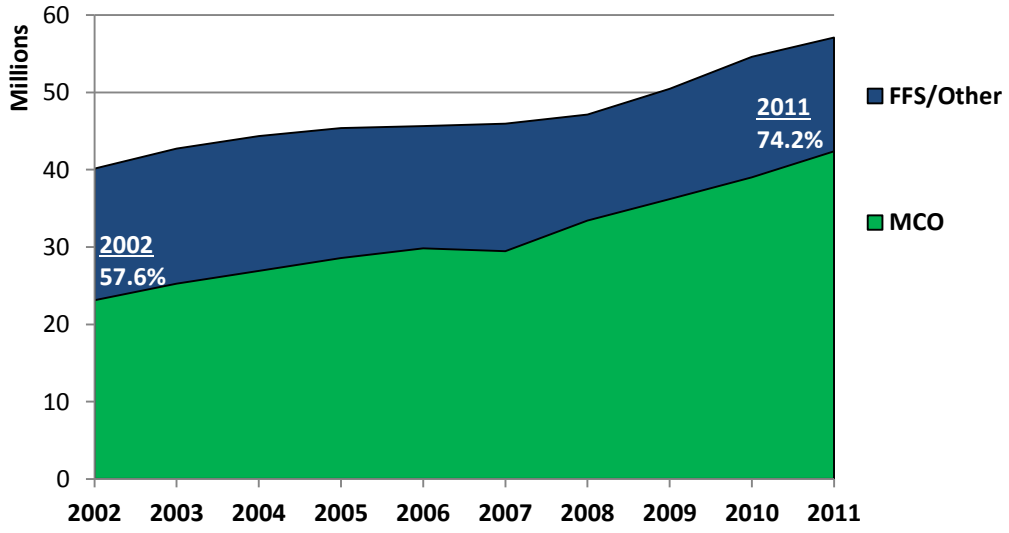
IN FOCUS: CMS MEDICAID MANAGED CARE ENROLLMENT REPORT

This week, our *In Focus* section presents some key takeaways from the Centers for Medicare & Medicaid Services (CMS) *Medicaid Managed Care Enrollment Report*, released last week with data as of July 1, 2011. The delay in publication of this data is due largely to delays in state reporting of enrollment data to CMS, which must then be verified and cleaned up by CMS. This report, released annually, provides details on Medicaid managed care programs including:

- State and Plan-specific enrollment and characteristics
- Historical managed care enrollment numbers and rates
- Dual eligible population totals and managed care enrollment

At a high level, the report shows the continued trend toward greater managed care penetration in the Medicaid market. The chart below shows consistent growth in not only total numbers of Medicaid managed care enrollees, but consistent year-over-year growth in the share of Medicaid managed care. As a note, Chart 1 includes all forms of managed care, including: traditional commercial and Medicaid-only managed care organizations (MCOs), primary care case management (PCCMs), prepaid inpatient and ambulatory health plans (PIHPs and PAHPs), and program of all-inclusive care for the elderly (PACE) plans. Chart 2 has a more detailed breakout of the forms of managed care.

Chart 1 – Medicaid Managed Care Enrollment (2002-2011)



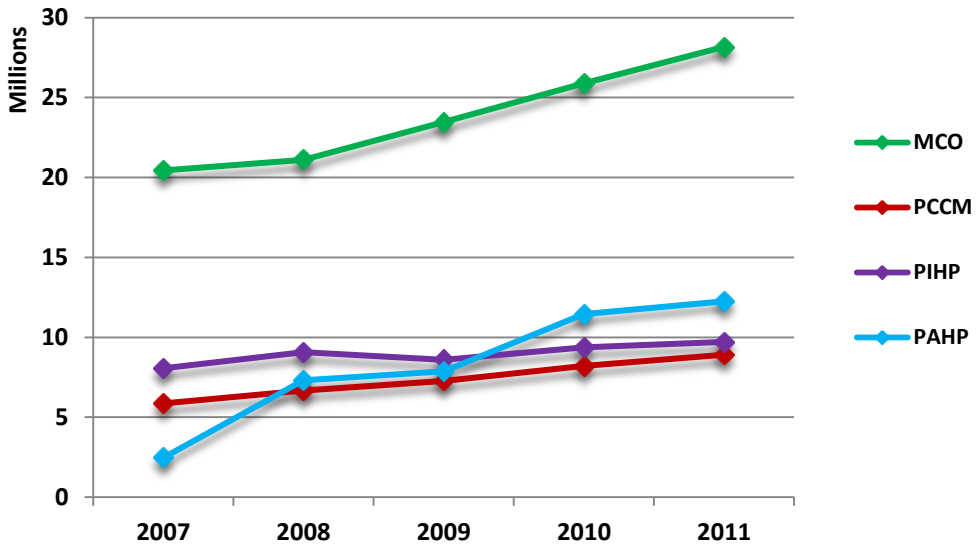
Source: "Medicaid Managed Care Enrollment Report." Centers for Medicare & Medicaid Services. Data as of July 1, 2011.

As Chart 1 shows, in the past five years, absolute Medicaid managed care enrollment has increased by roughly 17 million enrolled lives, more than 40 percent. As a percentage of total Medicaid, enrollment in some form of managed care has increased 21.6 percentage points from 57.6 percent of total enrollment in 2002 to 74.2 percent of total enrollment in 2011.

Managed Care Enrollment

As of July 1, 2011, nearly 42.4 million out of 57.1 million total Medicaid beneficiaries were enrolled in some form of Medicaid managed care. More than 28 million of these managed care enrollees were enrolled in either a commercial or Medicaid-only MCO plan, up from just over 20 million five years ago. This is an increase of more than 40 percent in the past five years. As the chart below shows, MCO plans make up the majority of the managed care market, and while PCCM and PIHP plan enrollment has remained relatively stable, PAHP plan enrollment has grown significantly in the past five years. It is important to note that the CMS data may include duplicated counts for individuals enrolled in more than one type of managed care plan receiving comprehensive and limited benefits.

Chart 2 – Medicaid Managed Care Enrollment by Plan Type (2007-2011)



Source: "Medicaid Managed Care Enrollment Report." CMS. Reports from 2007-2011.

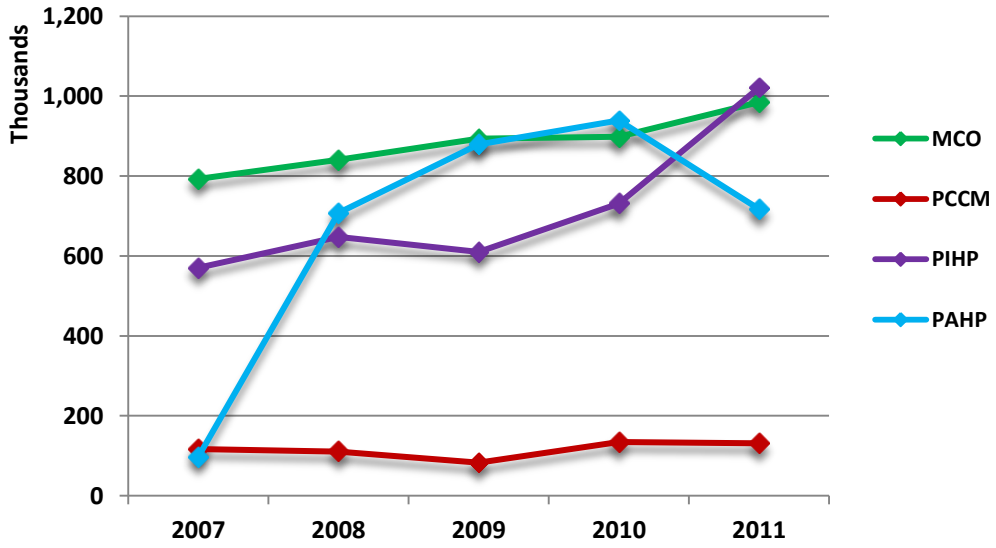
Since the time of this report, Medicaid MCO enrollment has experienced organic growth through new managed care program implementations and expansions of existing programs. Expansions in Texas, Washington, and Missouri, among other states, have driven MCO enrollment numbers even higher. Louisiana shifted most of its FFS Medicaid population into MCO plans in 2012, while New Hampshire is planning to do the same, likely in early 2013.

Additionally, many states have indicated their intention to enroll all or nearly all of the more than 16 million estimated newly eligible Medicaid beneficiaries under the ACA's Medicaid expansion into managed care, potentially driving MCO enrollment up by 50 percent or more. At the same time, PCCM enrollments could drop significantly. Illinois has the nation's largest PCCM program, enrolling close to 1.7 million Medicaid beneficiaries, nearly 19 percent of the national total. Illinois' legislature passed a Medicaid reform law requiring at least 50 percent of the Medicaid population be enrolled in managed care and the state's Medicaid administration has indicated that the current PCCM program will not meet the requirements under the law.

Dual Eligible Managed Care Enrollment

The CMS report contains total dual eligible enrollments by state, as well as enrollment of duals into managed care plans. Out of more than 9.1 million duals nationally, more than 10 percent, 985,000, were enrolled in a traditional MCO plan in 2011 for their Medicaid benefits. In total, 19 states, as well as D.C. and Puerto Rico, enrolled dual eligibles in traditional MCO plans. Thirty-eight states, as well as D.C. and Puerto Rico, enrolled dual eligibles in any form of managed care. Chart 3 below shows the same growth seen in the broader managed care population of PAHP enrollment for duals over the past five years. In the dual eligible population, however, there is also significant growth in PIHP enrollments, which surpassed MCO enrollments in 2011. As with the total population, the CMS data may include duplicated counts for individuals enrolled in more than one type of managed care plan receiving comprehensive and limited benefits.

Chart 3 – Dual Eligible Managed Care Enrollment by Plan Type (2007-2011)



Source: "Medicaid Managed Care Enrollment Report." CMS. Reports from 2007-2011.

Chart 3 above is likely to change enormously over the next two years as states look to transition more than two million dual eligible beneficiaries into managed care plans under the CMS capitated dual eligible alignment demonstrations. So far, Ohio, California, Massachusetts, and Illinois have awarded contracts to MCOs in the dual eligible demonstrations, and Massachusetts has completed the memoranda of understanding (MOU) process with CMS.

Note: CMS Report includes managed care enrollment report by plan, by state, as well as dual eligible managed care enrollment by plan, by state.

Link: ***CMS Medicaid Managed Care Enrollment Report, 2011 (PDF)***

Medicaid Managed Care Enrollment as of July 2011, By State

State	Medicaid Total	Managed Care Total	%	MCO	%	Dual Eligibles	Duals MCO	%
Alabama	930,736	568,332	61.1%	0	0.0%	196,313	0	0.0%
Alaska	120,611	0	0.0%	0	0.0%	13,879	0	0.0%
Arizona	1,351,988	1,198,818	88.7%	1,198,818	88.7%	153,637	107,344	69.9%
Arkansas	608,332	477,060	78.4%	0	0.0%	116,855	0	0.0%
California	7,580,978	4,553,090	60.1%	3,564,248	47.0%	1,188,551	102,546	8.6%
Colorado	583,618	551,972	94.6%	46,962	8.0%	82,104	2,789	3.4%
Connecticut	578,620	396,960	68.6%	396,425	68.5%	121,149	0	0.0%
Delaware	200,810	161,655	80.5%	154,904	77.1%	24,403	0	0.0%
D.C.	201,777	136,003	67.4%	137,424	68.1%	14,458	82	0.6%
Florida	3,069,456	1,958,679	63.8%	1,249,264	40.7%	637,738	29,821	4.7%
Georgia	1,548,090	1,413,643	91.3%	951,408	61.5%	233,374	0	0.0%
Hawaii	272,218	268,645	98.7%	266,819	98.0%	30,839	27,083	87.8%
Idaho	230,725	230,725	100.0%	0	0.0%	19,054	0	0.0%
Illinois	2,787,200	1,888,500	67.8%	213,417	7.7%	327,851	0	0.0%
Indiana	1,055,779	741,744	70.3%	705,708	66.8%	145,859	0	0.0%
Iowa	440,993	401,785	91.1%	0	0.0%	77,874	0	0.0%
Kansas	354,664	310,036	87.4%	181,540	51.2%	72,505	0	0.0%
Kentucky	823,133	735,978	89.4%	171,142	20.8%	174,351	13,772	7.9%
Louisiana	1,208,859	789,871	65.3%	0	0.0%	181,277	0	0.0%
Maine	357,706	176,335	49.3%	0	0.0%	93,914	0	0.0%
Maryland	986,304	735,859	74.6%	735,856	74.6%	110,648	0	0.0%
Massachusetts	1,566,222	832,064	53.1%	510,355	32.6%	254,449	15,835	6.2%
Michigan	1,818,312	1,606,688	88.4%	1,211,393	66.6%	263,576	0	0.0%
Minnesota	847,638	556,665	65.7%	556,665	65.7%	127,651	52,296	41.0%
Mississippi	621,607	541,854	87.2%	51,626	8.3%	144,764	0	0.0%
Missouri	895,998	875,227	97.7%	406,796	45.4%	168,335	0	0.0%
Montana	106,493	81,085	76.1%	0	0.0%	21,314	0	0.0%
Nebraska	237,484	202,189	85.1%	100,972	42.5%	33,994	0	0.0%
Nevada	297,640	248,819	83.6%	168,851	56.7%	43,522	0	0.0%
New Hampshire	135,092	0	0.0%	0	0.0%	28,153	0	0.0%
New Jersey	1,098,608	853,645	77.7%	853,645	77.7%	195,802	27,196	13.9%
New Mexico	551,017	401,318	72.8%	401,318	72.8%	65,637	32,793	50.0%
New York	4,925,236	3,777,868	76.7%	3,725,644	75.6%	706,454	5,807	0.8%
North Carolina	1,488,263	1,238,563	83.2%	0	0.0%	301,493	0	0.0%
North Dakota	66,698	42,423	63.6%	0	0.0%	14,226	0	0.0%
Ohio	2,129,706	1,605,821	75.4%	1,605,042	75.4%	301,063	0	0.0%
Oklahoma	684,387	591,850	86.5%	0	0.0%	105,532	0	0.0%
Oregon	652,846	640,912	98.2%	496,987	76.1%	96,210	35,280	36.7%
Pennsylvania	2,134,956	1,740,659	81.5%	1,152,069	54.0%	322,835	2,774	0.9%
Rhode Island	197,248	135,253	68.6%	135,049	68.5%	37,280	0	0.0%
South Carolina	862,145	862,145	100.0%	428,765	49.7%	143,325	0	0.0%
South Dakota	120,474	91,268	75.8%	0	0.0%	17,846	0	0.0%
Tennessee	1,218,676	1,218,676	100.0%	1,174,007	96.3%	236,408	136,574	57.8%
Texas	3,943,189	2,786,985	70.7%	1,872,383	47.5%	615,435	134,319	21.8%
Utah	269,643	268,984	99.8%	51,486	19.1%	33,767	197	0.6%
Vermont	177,108	103,529	58.5%	103,529	58.5%	33,453	257	0.8%
Virginia	915,038	532,292	58.2%	532,292	58.2%	168,354	0	0.0%
Washington	1,182,587	1,041,904	88.1%	730,592	61.8%	158,096	1,596	1.0%
West Virginia	326,749	166,555	51.0%	166,555	51.0%	74,765	0	0.0%
Wisconsin	1,173,355	747,046	63.7%	711,043	60.6%	182,499	12,327	6.8%
Wyoming	69,947	0	0.0%	0	0.0%	9,923	0	0.0%
Puerto Rico	1,089,058	896,562	82.3%	1,040,493	95.5%	245,208	244,491	99.7%
National Total	**57,096,017**	**42,384,539**	**74.2%**	**28,161,492**	**49.3%**	**9,168,002**	**985,179**	**10.7%**

Source: "Medicaid Managed Care Enrollment Report." Centers for Medicare & Medicaid Services. Data as of July 1, 2011.

HMA MEDICAID ROUNDUP

Colorado

HMA Roundup – Joan Henneberry & Paul Niemann

ACC Savings: According to a press release issued by the Colorado Department of Health Care Policy and Financing on November 8th, the state's Accountable Care Collaborative (ACC) program reduced Medicaid health expenditures by $20 million in its first year in existence, with nearly $3 million returned to state and federal taxpayers. The ACC program has approximately 132,000 Medicaid clients enrolled which represent about 21 percent of the total Medicaid population.

The Department identified three key performance indicators to measure improvement among those clients enrolled in the ACC, compared to clients not yet enrolled:

- **Hospital Readmissions:** There was an 8.6 percent reduction in readmissions among ACC clients
- **Emergency Room Utilization:** Overall, there was a 1 percent increase among Medicaid clients, but only a 0.23 percent increase among ACC enrollees
- **High Cost Imaging:** 3.3 percent decrease among ACC clients

Georgia

HMA Roundup – Mark Trail

At the Department of Community Health (DCH) Board meeting on November 8, 2012, DCH Chief Financial Officer Vince Harris noted that there had been no comments on the public notice notifying providers of DCH's intent to update the DRG Grouper that is in place for inpatient hospital payments to the most current DRG Grouper. The Board unanimously voted for approval of the notice. The Board also approved the payment methodology change for outpatient services. It replaces the current payment methodology with the same methodology used by Medicare – the APC Grouper. Finally, the Board approved the notices to reduce the Nursing Home Fair Rental Value Adjustment factor, which is used as a method to reimburse nursing homes for the costs of implementing capital improvements. The proposed reductions are as follows:

- Effective April 1, 2013 – DCH will lower the factor from 1.078 to 0.201. This would save an estimated $11.1 million in total funds/$3.8 million in state funds for FY13
- Effective July 1, 2013 – DCH would change the factor to 0.206. This would save an estimated $44.6 million on total funds/$15.2 million in state funds for FY14.
- Additionally, the notice would allow DCH to no longer recognize certain improvements – such as increasing number of beds, as capital improvements that would be eligible for the Fair Rental Value Adjustment.

Georgia's net tax collections for October totaled $1.38 billion for an increase of $83.5 million, or 6.4 percent, compared to October 2011. Through four months, net revenue collections totaled $5.6 billion — an increase of $258.5 million, or 4.8 percent, compared to last year.

In the news

- **On the road to merger? Piedmont Healthcare-WellStar form joint venture**

  Piedmont Healthcare and WellStar Health System will partner to save costs. The two hospital networks will create the Georgia Health Collaborative to share clinical care best practices and leverage economies of scale for better pricing on supplies and insurance reimbursement. The joint venture, sources say, could foreshadow a possible acquisition. (Atlanta Business Chronicle)

Illinois

HMA Roundup – Jane Longo & Matt Powers

Last Friday, November 9, the Illinois Department of Healthcare and Family Services (HFS) announced awards in the Medicare-Medicaid Alignment Initiative (MMAI), the state's capitated dual eligible integration demonstration. HFS announced awards to six health plans in the Greater Chicago area, consisting of Cook, Lake, Kane, DuPage, Will, and Kankakee counties:

- Aetna Better Health
- IlliniCare Health Plan (Centene)
- Meridian Health Plan of Illinois
- HealthSpring
- Humana Health Plan
- Blue Cross/Blue Shield of Illinois

These plans will share the estimated 118,000 dual eligible enrollees (before opt-out) in the Greater Chicago region. Molina Healthcare and the Community Care Alliance of Illinois (wholly owned subsidiary of Chicago-area health plan, Family Health Network) were unsuccessful bidders in the Greater Chicago Region.

HFS announced awards to two health plans in the Central Illinois, which includes Knox, Peoria, Tazewell, McLean, Logan, DeWitt, Sangamon, Macon, Christian, Piatt, Champaign, Vermilion, Ford, Menard, and Stark counties:

- Molina Healthcare of Illinois
- Health Alliance

These two plans will share an estimated 18,000 dual eligible enrollees (before opt-out) in the Central Illinois region. Humana Health Plan and Meridian Health plan of Illinois were unsuccessful bidders in the Central Illinois region.

Additionally, HFS has previously indicated that these awarded plans in both regions may enroll Medicaid-only seniors and persons with disabilities under separate contracts with the state, although timing for these enrollments is has not been publicly announced.

Pennsylvania

HMA Roundup – Izanne Leonard-Haak & Matt Roan

Innovations Planning Grant: At a recent Pennsylvania Medical Assistance Advisory Committee meeting, Dr. David Kelley, the Medical Director for Medicaid in Pennsylvania, reported that Pennsylvania Medicaid had collaborated with the Department of Health (DOH) and other Pennsylvania state agencies in submitting an application for a State Innovations Planning Grant. The Pennsylvania DOH has the lead on the multi-agency grant request for $2.2 million in planning monies. The initiative is to pull together a cross section of stakeholders to address payment re-design, delivery system re-design, cost containment, transition of care strategies, Medical Home, telemedicine, EHR and risk-sharing arrangements.

In the news

- **Highmark, West Penn Allegheny leaders meet to resurrect merger**

  Three days after a judge ruled that West Penn Allegheny Health System must remain in a merger deal with Highmark Inc., top leaders of the two organizations discussed plans to get the $475 million transaction back on track. In a joint statement issued on Monday, West Penn Allegheny and Highmark said they have met with the health system's bondholders and more meetings are planned. (Pittsburgh Tribune-Review)

Puerto Rico

HMA Roundup – Juan Montanez

Since the early 1990s the Government of the Commonwealth of Puerto Rico has operated the Government Health Insurance Plan (GHIP), which in 2010 was rebranded as MISalud (My Health).

- 1.6 million residents – more than forty percent of the Commonwealth's population – are enrolled in MISalud, which is funded by a combination of Medicaid, CHIP and local government funds and is comprised of "Medicaid", "CHIP", "Commonwealth" and "voluntary" populations.
- Every MiSalud enrollee is automatically assigned to one of two physical health MCOs and a BHO based on where they reside – for program management purposes the Territory is divided into eight geographic regions and only one physical health MCO is awarded a contract in each region. The Commonwealth is able to operate the program in this manner without a CMS waiver because the Medicaid funding the Commonwealth receives is capped - the current cap is approximately $900 million.
- Two physical health MCOs and a single BHO were selected in 2010 to operate in a capitated managed care arrangement. All services authorized under the MISalud program are included in this arrangement, with some pay-for-performance stipulations built into the reimbursement arrangement.
- In 2011 one of the two MCOs failed, and the island's Blue Cross Blue Shield organization took over for that MCO on a TPA/fee-for-service basis.

- The current MCO and BHO contracts expire in the fall of 2013. It was expected that a health plan re-procurement would have been conducted in 2013 had the current Governor been reelected.
- Currently the program's total spend is approximately $2 billion. Changes in the amount of federal funding available to the program effective July 1, 2011 could impact the level of spend - the Medicaid federal contribution ceiling for Puerto Rico is almost tripling relative to FFY2011 levels (post stimulus) through September 30, 2019. Moreover, in response to this influx of federal funds CMS is requiring the Commonwealth to recalibrate the GHIP's benefit package to include services such as non-emergency transportation and – potentially – nursing home care. Historically the Commonwealth has maintained that it could not include these services in the GHIP benefit package because of funding constraints.

In a somewhat unexpected development, the pro-commonwealth Popular Democratic Party (PDP) won the Gubernatorial election held on November 6. The PDP also won strong majorities in both legislative chambers. Over the last four years, the PDP – in its role as opposition party – has been critical of the changes made to the GHIP by the current administration headed by pro-statehood Governor Luis Fortuno. That notwithstanding, a review of the PDP's health care campaign platform is not clear on whether or how the PDP would alter the existing MiSalud model. Governor-elect Alejandro Garcia Padilla did run on an ambitious health care reform platform that refers to "universal access" to health care resources and incentivizing the creation of safety net "integrated health systems" as key programmatic objectives.

Washington, D.C.

HMA Roundup – Lillian Spuria

The Medicaid and CHIP Payment Access Commission (MACPAC) will hold its next public meeting on November 15 in Washington, D.C. Agenda items include the following:

- Session 1: Health care delivery system challenges and opportunities for Medicaid beneficiaries with disabilities
- Session 2: Update on Medicaid primary care physician payment increase
- Session 3: Options related to Medicaid, CHIP, and exchange interactions
- Session 4: Medicaid capitation payments to PACE and D-SNPs
- Session 5: Overview of the Medicaid/Medicare dually eligible population
- Session 6: State Medicaid Payment Policies for Medicare Cost Sharing

November 14 was the deadline for health plans interested in participating in dual eligible demonstration programs in 2014 to submit a Notice of Intent to Apply (NOIA) to CMS.

Last Friday, November 9, HHS announced an extension in the deadline for states to submit health insurance exchange "blueprint" documents. While states must declare their intentions by November 16, formal plans will not be due at this time. States pursuing a state-based exchange will have until December 14, while states seeking a federal partnership exchange will have until February 15, 2013.

OTHER HEADLINES

Alabama

- **Gov. Bentley says Alabama won't set up exchange, expand Medicaid**

  Gov. Robert Bentley, in a show of continued resistance to the Affordable Care Act, said this afternoon that he will not set up a state health care exchange and he will not expand Medicaid under the federal healthcare overhaul. (AL.com)

Arizona

- **Big decision looms for Arizona governor on exchange**

  Gov. Jan Brewer is being pulled one way by major business groups and another by fellow conservatives as she faces a fast-approaching deadline to decide whether to implement a key part of the federal health care law. The decision, due Friday, will determine if Arizona creates a state-run, online marketplace for consumers to use when choosing health plans, or lets the federal government create and run a so-called "exchange" for the state. Brewer is among the Republican governors who oppose the law, but she has yet to indicate what course she'll take. (Arizona Capitol Times)

Arkansas

- **Ark. Medicaid faces 'significant' cuts in services**

  Arkansas would stop paying for thousands of seniors in nursing homes, eliminate an insurance program for low-income workers and cut rates for providers to fill a $138 million shortfall in the state's Medicaid program, even if lawmakers support a proposal to boost funding, an official said Tuesday. Department of Human Services Director John Selig told members of the Joint Budget Committee that the cuts are needed to make up for a deficit in the state share of its Medicaid program, which serves nearly 800,000 Arkansans. The shortfall grows to $460 million, when factoring in the amount of federal funding the state receives through a match. Gov. Mike Beebe has proposed $160 million in new state money for the program, with $90 million coming from general revenue and $70 million from the state surplus to help. A lower than expected growth in the program's costs and other savings kept the shortfall lower than officials initially expected, Selig said. The budget proposal also factors in $15 million that DHS says Medicaid will save next year through an effort to curb the program's costs by changing the way it pays for services. (Associated Press)

California

- **California speeds revamp of health insurance market**

  With President Obama's reelection lifting a potential roadblock, California officials are rushing to implement the federal healthcare law and revamp the insurance market for millions of Californians starting next fall. Wednesday, California officials disclosed plans to spend nearly $90 million next year on marketing and outreach to millions of consumers who may become eligible for premium subsidies and other assistance under the federal law starting in 2014. (Los Angeles Times)

Connecticut

- **Connecticut ready for 'Obamacare'**

  Connecticut doesn't have to worry about meeting next month's deadline to tell the federal government whether it will participate in the Affordable Care Act. The state is already implementing "Obamacare." Gov. Dannel P. Malloy and the General Assembly have created a cabinet-level department to oversee the law, and the state has staffed the Connecticut Health Care Exchange, which will create a new online marketplace where those without health insurance can purchase affordable policies. (Connecticut Post)

Florida

- **Florida moving to work on implementing health-care law**

  With the Affordable Care Act more certain than ever, some lawmakers are calling for a careful look at how to implement it here. Even Florida Gov. Rick Scott, a staunch opponent, appeared to be softening his longstanding refusal to acknowledge the law. "Just saying 'no' is not an answer," he said in a statement released by his press office late Friday. "We need to focus on how Obamacare affects each of our families," he said, adding he is concerned about the impact for cost, access and quality of care. (Palm Beach Post)

Michigan

- **Gov. Rick Snyder: It may be too late to create Michigan health insurance exchange**

  Gov. Rick Snyder on Tuesday said he may not ask House Republicans to reconsider their opposition to setting up a Michigan-run health insurance exchange, despite the federal government extending some deadlines to implement a pillar of the Affordable Care Act. (MLive.com)

- **Blue Cross official stresses urgency of overhaul**

  Blue Cross Blue Shield of Michigan officials argued Tuesday that they will face "serious challenges" selling health insurance next year if state lawmakers don't quickly approve legislation that would transform the organization from a charitable trust to a customer-owned nonprofit. Meanwhile, critics of overhauling the state's largest insurer countered that the urgency is overblown and that moving too rapidly might be more harmful to Blue Cross' 4.4 million customers. (Lansing State Journal)

Minnesota

- **Election clears path for Minnesota health insurance exchange**

  Republican lawmakers who refused to help Gov. Mark Dayton develop Minnesota's online health insurance marketplace while they hoped for a changing of the guard in Washington will now be on the sidelines while Democrats move ahead. Tuesday's results confirmed the federal health care law is here to stay. And with the Democrats winning control of the Minnesota Legislature, Dayton can continue moving forward with creating the state's health care exchange, a key requirement of the law. (Duluth News Tribune)

Missouri

- **Missouri, Kansas Reject State-Run Health Insurance Exchanges**

  Immediately after the presidential election, and more than a week ahead of the Nov. 16 deadline, Missouri Gov. Jay Nixon, a Democrat, announced he had made up his mind. The state would not be setting up its own health insurance exchange. Next door in Kansas, Gov. Sam Brownback, a Republican, made a similar announcement. These governors' moves open the door for increased federal involvement in health care in both states. (Kaiser Health News)

Nevada

- **Nevada Quietly Moves Ahead On Health Law**

  Nevada has one of the highest rates of uninsured people in the nation – more than one in five Nevadans lack coverage. The state voted to reelect President Barack Obama by a margin of almost 7 points, but the president's health law has been as controversial in Nevada as it has been in most states led by a Republican governor. Nevada was one of the 27 states that challenged the constitutionality of the Affordable Care Act in court. But now Gov. Brian Sandoval is moving forward on a key part of the law. Right now, the Silver State Health Insurance Exchange is little more than a website and a staff of eight working in Carson City. The state is using federal dollars to set up the exchange, but the goal is for it to be self-sufficient in the future. (Kaiser Health News)

- **Still no Sandoval decision on Medicaid expansion proposal**

  Gov. Brian Sandoval said Tuesday he has not yet decided whether to expand the Medicaid program to cover residents earning slightly more than poverty-level wages and might not make that decision until Jan. 16, the date he delivers the State of the State address. (Las Vegas Review-Journal)

North Carolina

- **Medicaid changes put lodging for 2,000 in group homes at risk**

  About 2,000 people with mental disabilities are in danger of losing their lodging in group homes on Jan. 1, their evictions triggered by changing Medicaid rules. State officials and advocates for the disabled have been talking about the problem for months but have not come to a resolution. The new regulations have group home operators and state health administrators talking about strategies that could keep group homes open when a vital source of income is threatened. (The News & Observer)

Ohio

- **Ohio to let federal government run insurance exchange required by health care law**

  Lt. Gov. Mary Taylor said Ohio plans to let the federal government run the new health insurance exchange required to be up and running in 2014. Following a speech Tuesday to the Columbus Association of Health Underwriters, Taylor said state officials will send a letter Friday telling the federal government that it can run the exchange, but the state wants to retain its traditional regulatory authority. For example, the state would still decide who is eligible for Medicaid in Ohio. (Cleveland.com)

Oklahoma

- **Fallin weighs Medicaid expansion, health insurance exchange**

  A spokesman for Gov. Mary Fallin says she isn't rushing into a decision about accepting federal funding for a state Medicaid expansion under the provisions of the federal Affordable Care Act - although her own milestone for that decision has now come and gone. (Tulsa World)

South Carolina

- **With election over, SC healthcare debate takes new tone**

  Gov. Nikki Haley and state health agency leaders have made it clear, they don't plan to create a South Carolina-specific health insurance exchange and they want to opt out of Medicaid expansion. The state Legislature is expected to make a decision on expansion in the 2013 session. (The State)

South Dakota

- **SD health care providers urge Medicaid expansion**

  Now that President Barack Obama's re-election has cleared the way for the full implementation of his health care law, doctors and hospitals in South Dakota are urging the state to expand its Medicaid program so thousands of additional low-income residents can receive coverage. But Gov. Dennis Daugaard says any expansion of coverage is unlikely for at least several years while the potential costs are examined. The South Dakota Association of Health Care Organizations said about 48,000 uninsured residents will be left behind if South Dakota doesn't ease its eligibility requirements for Medicaid. (CBS News)

Tennessee

- **TN to decide on health exchanges next week**

  Gov. Bill Haslam said his administration will decide whether Tennessee should set up its own health insurance exchanges next week, just ahead of a Nov. 16 deadline set by the federal health care reform law. Haslam said Thursday that TennCare officials are still waiting for federal regulators to clarify some of the rules for an exchange, envisioned under the Affordable Care Act as a marketplace where the uninsured can buy health coverage at affordable rates. (The Tennessean)

Virginia

- **Post-election, McDonnell says Virginia will default to federal health insurance exchange**

  Virginia will sign onto a federal health insurance exchange to meet its obligations under the federal health care overhaul, Gov. Bob McDonnell said after seeing his hopes of repeal likely die with President Barack Obama's re-election. McDonnell said defaulting to the federal exchange option is preferable to expanding the state's Medicaid program or establishing a state-based benefits program. (Washington Post)

Wisconsin

- **Pressure on Walker increases over health exchange**

  Gov. Scott Walker faced pressure Tuesday from both liberal Democrats and tea-party Republicans on a decision due this week over whether Wisconsin will establish its own state-run health insurance exchange or cede control to the federal government. Walker spokesman Cullen Werwie said the governor would announce his decision Thursday or Friday. Walker has been meeting privately with the state Insurance Commissioner Ted Nickel, Department of Health Service Secretary Dennis Smith and other top advisers to chart a path. (LaCrosse Tribune)

- **Wis. Gov. Walker eyes federal health insurance option**

  Gov. Scott Walker indicated Thursday he may let the federal government run a new state health insurance exchange. The Republican governor said despite his philosophical objections to the Affordable Care Act, Wisconsin will have a federally mandated health insurance exchange. (Winona Daily News)

Wyoming

- **Wyoming lawmakers advance managed Medicaid plan**

  A panel of Wyoming lawmakers endorses reforming the state's Medicaid program to cut costs. The Legislature's Joint Labor, Health and Social Services Committee on Monday voted to proceed with a series of possible reforms to try to curb Medicaid costs. The state and federal governments currently spend more than $500 million a year on the health care program for low-income people. The committee wants to study the possibility of paying private organizations to take over program management. (Billings Gazette)

National

- **Some question administration's ability to set up state insurance exchanges**

  With a growing number of state leaders saying they will leave it to the federal government to handle a crucial element of President Obama's health-care law, even supporters of the statute are wondering if the administration is up to the job. The administration has released few details about the complex computer systems needed to operate exchanges for states that don't want to run them. The exchanges — online marketplaces for consumers and small businesses to buy insurance — are supposed to be up and running by Oct. 1, 2013, for coverage that will begin in January 2014. (Washington Post)

- **How Higher Education Could Save Medicaid**

  As states undertake the gigantic tasks of reforming their Medicaid systems to be more fiscally sustainable and preparing for a significant enrollment expansion under the Affordable Care Act (ACA), an unlikely partner could be emerging to help them shoulder the immense administrative burden of doing so: the public university system. The idea of public universities working with state agencies isn't necessarily new, but three states (Maryland, Massachusetts and Ohio) have taken the extra step and made their higher education institutions full-pledged partners in administering the Medicaid program. What do they do? The schools research policymaking decisions, conduct evaluations of

new initiatives and prepare the next workforce that will serve Medicaid patients in the future. Officials in those states say the partnership has been a big win for both sides. And given the challenges facing state Medicaid agencies in the coming years, it's one that more states should be considering. (Governing Magazine)

- **HHS Secretary Provides More Time for States to Decide on Exchanges**

  State officials interested in running their own health insurance exchange or partnering with the federal government will have more time to give the Department of Health and Human Services information about the type of marketplace they want, according to a letter Secretary Kathleen Sebelius sent Friday to governors. States had faced a Nov. 16 deadline to submit their applications to HHS officials if they want to operate a state-only exchange. Instead, states will still have to notify HHS by Nov. 16 that they hope to run their own exchanges. But they will have until Dec. 14 to send in their blueprint document, which asks for specifics on how the market will be operated and overseen. (CQ HealthBeat)

- **Health Care Law's Insurance Market Rules Might Provoke More Battles in the States**

  The next big hurdle for implementation of the health care law: States must adopt the overhaul's major changes to how consumers purchase health insurance, which are due to take effect in 2014. But tough new standards on guaranteed issue, age rating and more might also provoke a new round of fights in Republican-controlled states where officials have been so resistant to implementing the overhaul that they've refused to set up state health insurance exchanges. Insurers, health policy experts, state regulators and others are watching to see if proposed rules are issued dealing with insurance market regulations. (CQ HealthBeat)

- **Election alters House plans for reform repeal: Boehner**

  House Speaker John Boehner (R-Ohio) said Tuesday's presidential election alters the lower chamber's plans to repeal the Patient Protection and Affordable Care Act. "I think the election changes that," Boehner told Diane Sawyer on Thursday in an exclusive interview on ABC's World News Tonight. "It's pretty clear the president was re-elected. Obamacare is the law of the land." But the Ohio Republican hinted that some provisions of the controversial 2010 healthcare law are still vulnerable on Capitol Hill. (ModernHealthcare)

COMPANY NEWS

- **Allscripts considers selling itself**

  Healthcare IT firm Allscripts Healthcare Solutions Inc said it is evaluating strategic alternatives, sending its shares up 10 percent in extended trade. "We are confirming today that in light of the ongoing interest expressed in the company by third parties, the company is evaluating strategic alternatives," Allscripts Chief Executive Glen Tullman said. The company, which reported a lower third-quarter profit on Thursday, had spoken to several private equity firms including Blackstone Group LP, Bloomberg reported in September. (Crain's Chicago Business)

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
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	Washington Duals	RFP Released	115,000
December 1, 2012	Texas Rural STAR+PLUS	RFP Released	110,000
December 3, 2012	District of Columbia	Proposals due	165,000
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 21, 2013	California Rural	Applications due	280,000
January 28, 2013	Arizona - Acute Care	Proposals due	1,100,000
January, 2013	District of Columbia	Contract Awards	165,000
Feburary 25, 2013	California Rural	Application Approvals	280,000
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	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	District of Columbia	Implementation	165,000
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 Rural	Implementation	280,000
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
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
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	11/9/2012		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	Nov. 5th 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	1/7/2013	3/11/2013	4/1/2013		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, as reported to CMS. **Link**

Delivery of Very Low Birth Weight Infants in 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 (VLBW) 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