HMA

HEALTH MANAGEMENT ASSOCIATES

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

**IN FOCUS:** MASSACHUSETTS DUALS PLAN READINESS REVIEW CHECKLIST

**HMA ROUNDUP:** CALIFORNIA RELEASES DUAL ELIGIBLE DATA REPORTS; ILLINOIS RELEASES DRAFT MANAGED CARE ROLL-OUT PLAN; FLORIDA SENATE ACA IMPLEMENTATION COMMITTEE MET THIS WEEK; GEORGIA PROVIDES ADDITIONAL DETAILS ON MEDICAID ABD CARE COORDINATION; LOUISIANA ISSUES LTC CARE COORDINATION RFI

**OTHER HEADLINES:** GOVERNORS, LEGISLATORS CONTINUE TO DEBATE, STAKE OUT POSITIONS ON MEDICAID EXPANSION; KANSAS OUTLINES DETAILS OF 'KANCARE' MEDICAID MCO EXPANSION; EXCHANGES MAY BE SUPPORTED FINANCIALLY BY FEE ON INSURERS; AMERIHEALTH MERCY ACQUIRES DC CHARTERED OUT OF RECEIVERSHIP

**HMA WEBINAR:** 'THE ECONOMICS OF THE MEDICAID EXPANSION' REPLAY AVAILABLE

**DECEMBER 5, 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: MASSACHUSETTS DUALS PLAN READINESS REVIEW CHECKLIST

This week, our *In Focus* section looks at the plan readiness review checklist, published last week by the Centers for Medicare & Medicaid Services (CMS) for the Medicare-Medicaid Capitated Financial Alignment Demonstration, often referred to as the Duals Demonstrations. CMS has released for public comment the readiness review checklist for Massachusetts. Before participating in the duals demonstrations, a plan must pass a joint readiness review conducted by CMS and the state, in addition to other qualifying requirements. The Massachusetts readiness review checklist is available **here**, and CMS is accepting public comment on the readiness review tool through December 12, 2012.

Moving forward, we expect to see readiness review checklists for each state after the memoranda of understanding (MOU) process has been completed with CMS. As of now, Massachusetts is the only state to finalize a MOU with CMS for a capitated model. Washington finalized a managed fee-for-service MOU last month. We expect to see MOUs for California, Illinois, and Ohio in the coming weeks. However, as with our review of the Massachusetts MOU in our August 29 Roundup, we believe this readiness review will be a good indicator of the readiness review process and many of the requirements in upcoming capitated duals demonstration states.

### Readiness Review Process

Each Medicare-Medicaid Plan (MMP) awarded a contract, either through a procurement or an application process, to serve the dual eligible population under a capitated duals demonstration will undergo a joint readiness review with two goals: to assess its ability to meet federal and state requirements, and to assess its capacity to provide and ensure access to care and quality services. The readiness review consists initially of a desk review of the items in the checklist and a separate network validation review. CMS and the states may determine the need for site visit reviews with a selected MMP based on evaluation of past Medicare and Medicaid experience, application or RFP responses, and results of the desk review.

### Readiness Review Checklist

Below, we summarize the 15 functional areas covered in the readiness review. For the full checklist, see the link above to the Massachusetts readiness review.

1. **Assessment Processes**

   The MMP must have in place adequate policies and procedures to assess newly enrolled dual eligible beneficiaries for behavioral and Long Term Supports and Services (LTSS) needs, as well as develop an integrated plan of care. Additionally, this section deals with the continuity of care policies for medical, behavioral, LTSS, and pharmacy services, as well as continuity of care policies for individuals currently served by an out-of-network provider.

2. **Care Coordination**

   Under this section, MMPs must outline how coordination will occur between the plan, primary care providers, and other providers, including behavioral, LTSS,

non-emergency medical transportation (NEMT), durable medical equipment repair, and dental providers. Settings of care transition requirements are also addressed.

3. **Confidentiality**

   MMPs must provide sample privacy notices for enrollees and providers.

4. **Enrollment**

   MMPs are to outline their enrollment and disenrollment procedures and employee policies, as well as provide examples of customer services pages and enrollment materials.

5. **Enrollee and Provider Communications**

   Hotlines and websites of plans and subcontractors must meet requirements for accessibility both in terms of minimum hours (for hotlines) and language and other communications barriers. Plans must maintain a Nurse Advice Line and meet requirements laid out for this 24/7 service.

6. **Enrollee Protections**

   Plans must outline their policies for handling appeals and grievances and how this will be communicated to the enrollee. Plans must also indicate how primary care provider choice policy and assignment policies will be communicated to the enrollee. Plans must provide assurances that emergency medical, LTSS, and behavioral services will be provided when needed.

7. **Financial Soundness**

   Financial documentation of solvency and solvency reserves.

8. **Organizational Structure and Staffing**

   In addition to broader organizational and staffing requirements, reviews will focus on utilization management and quality improvement committees in light of the change in composition of services provided by the plan, such as behavioral and LTSS.

9. **Performance and Quality Improvement**

   As a condition of payment, MMPs must comply with requirements on reporting Provider Preventable Conditions and prohibition of payment for these conditions. Provider contracts must include provisions on provider preventable conditions.

10. **Program Integrity**

    MMPs must demonstrate their compliance plan to address fraud and abuse, among other compliance issues.

11. **Provider Credentialing**

    MMPs must demonstrate policies on credentialing of providers, including laboratory and other contracted services providers. Additionally they must ensure the

percentage of board certified primary care providers and specialty physicians is equivalent to community average.

12. **Provider Network**

    MMPs must define expected number of enrollees and required number and type of providers to adequately serve both the population size and the anticipated population needs. The review tool focuses not only on network capacity, but also on provider accessibility and provider training specific to the target population.

13. **Qualifications of First-Tier, Downstream, and Related Entities**

    This section outlines requirements for all material subcontractor documentation required to be submitted to the state and CMS.

14. **Systems (Claims, Enrollment, Payment, etc.)**

    Plans will demonstrate system functionality to handle enrollment, claims processing and payment, as well as detail provider and pharmacy systems, encounter data systems, and care coordination systems.

15. **Utilization Management**

    Utilization management program includes CMS Medicare and state Medicaid definitions of medical necessity. Outline rationale for approval of services and prescription drugs. This section includes significant requirements on assurance of access to needed behavioral and LTSS services. Prohibits prior authorization requirements for a selection of services, particularly focused on behavioral health services and mental health crises.

As noted above, these readiness review requirements are open for public comment, and may differ slightly from the final checklist as a result. The Massachusetts readiness review checklist and future state checklists, as well as other updates, will be posted to the CMS Financial Alignment Incentive website, here.

# HMA Medicaid Roundup

## *California*

### HMA Roundup – Jennifer Kent and Stan Rosenstein

Last Thursday, November 29, the California Department of Health Care Services (DHCS) published several data reports on the dual eligible population. In an email from Jane Ogle, Deputy Director of Health Care Delivery Systems, the following key takeaway points from the data were presented:

- **The demonstration population is smaller than originally estimated.** California has about 1.2 million dual eligible beneficiaries, but less than half of those people (about 526,900) are eligible to participate in the demonstration. This lower estimate reflects all the populations excluded, such as beneficiaries with developmental disabilities or without full Medicare benefits. *(Medi-Cal's CCI Population, pages 4, 65)*
- **Many eligible participants already use managed care.** About one-third of the population is already enrolled in some form of managed care, either Medicare Advantage, Medi-Cal managed care, or both. *(Medi-Cal's CCI Population, page 67)*
- **Concurrent chronic conditions are common.** Among beneficiaries currently not enrolled in managed care, 44 percent were treated for three or more conditions. The complexity and cost of caring for people with multiple conditions is significant, with costs increasing by 50 percent from a person with one condition to someone with two conditions. County-specific disease burden information is provided and can be helpful guidance to health plans and community-based organizations. *(Profiles of Eight Counties, page 3)*
- **Use of long-term services and supports (LTSS) varies.** About 57 percent of the eligible participants currently in fee-for-service used no LTSS in 2010. About 36 percent used home-and community-based LTSS, and 5 percent were residents in a skilled nursing facility. *(Medi-Cal's CCI Population, pages 111-112, 161)*
- **Behavioral health conditions are highly prevalent and a major cost driver, with greater frequency for beneficiaries age 21-65.** The data on schizophrenia, mood disorders, depression and drug and alcohol dependency indicate a strong need to ensure that behavioral health care is properly integrated with a beneficiary's overall care. *(Medi-Cal's CCI Population, pages 114-121 and 128-130)*
- **The demonstration population is diverse.** English is the primary language for less than half of people eligible for the demonstration. Spanish, Vietnamese, Armenian and Cantonese are the most common languages spoken other than English. About 60 percent of eligible beneficiaries are women, 40 percent are disabled, 75 percent are age 65 or older, and 40 percent are age 75 or older. *(Medi-Cal's CCI Population, pages 85 - 87)*

The data summary and highlighted points above are available at the CalDuals website, here. The full reports are available at the DHCS duals demonstration website, here. At the time of our publication, the DHCS website was down.

## In the news

- **Changes to California children's healthcare won't be delayed, official says**

  A top official in Gov. Jerry Brown's administration said Tuesday that California will begin transferring poor children into a cheaper healthcare plan on Jan. 1, despite concerns from some lawmakers and advocates that the state's plan is inadequate. California is eliminating the Healthy Families program next year and shifting nearly 900,000 children into Medi-Cal, which reimburses doctors at lower rates, in hopes of saving $73 million annually. The transition will happen gradually, starting with the easiest cases. Diana Dooley, secretary of the Health and Human Services Agency, said children won't be shifted unless the state is sure they will still get healthcare under the new plan. (Los Angeles Times)

- **Healthcare law will have new California Legislature scrambling**

  When state lawmakers are sworn in Monday for the new legislative session, they will have little time to enjoy the pomp and circumstance. Facing a federal deadline, the Legislature must move quickly to pass measures to implement President Obama's healthcare law and revamp the state's insurance market. New legislation will help extend coverage to millions of uninsured Californians and solidify the state's reputation as a key laboratory for the federal law. Legislative leaders have said they also want to overhaul environmental regulations, curb soaring tuition at public colleges, and tweak the state's tax structure and ballot-initiative system. (Los Angeles Times)

- **Health insurance rates could shoot up**

  California health insurers are proposing double-digit rate increases for hundreds of thousands of policyholders, drawing criticism that health insurers are padding their profits as the nation prepares to carry out the federal health care law. Anthem Blue Cross, the state's largest for-profit health insurer, wants to raise rates an average of 17.5 percent for 744,000 members in February, with some Anthem policyholders seeing increases as high as 25 percent. Other insurers are also proposing hikes. Aetna is planning a nearly 19 percent raise in rates for about 69,000 members with individual policies in April, and Kaiser Permanente wants to raise rates by 8 percent for more than 220,000 members in January, according to filings with the state's two regulatory agencies, the Department of Insurance and the California Department of Managed Health Care. Also in January, UnitedHealth Group has proposed 10 percent hikes for 11,000 policyholders. California Insurance Commissioner Dave Jones said nothing prevents health insurers from setting those rates as high as they'd like. "The medical loss ratio merely requires that a certain percent of the rate goes to cover medical care. It does not stop them from raising rates," Jones said. (San Francisco Chronicle)

# *Florida*

## HMA Roundup – Gary Crayton and Elaine Peters

On December 3, the Florida Senate Select Committee on the Patient Protection and Affordable Care Act (Chaired by Senator Joe Negron) met to discuss issues related to the implementation of the ACA. This select committee is charged with analyzing this federal law and related regulations, assessing the potential impact of these regulations in Florida, evaluating the State's policy options, and recommending legislation necessary for implementation of the law in Florida. There were five presentations and an opportunity for public input. Topics covered included:

- Insurance Regulation: Discussion focused on the 3-to-1 limit on age band rates for benchmark plans
- Health Insurance Exchanges: Reviewed the Exchanges functions, options (state, federal partnership, federal) timeline and decision points.
- Medicaid Expansion: Discussion focused on eligibility changes (MAGI), enrollment and decision points.
- Financial Impact: The presenter reviewed the matching rate for Medicaid eligibility system changes (90% FFP) in addition to Medicaid expansion estimates and primary care rate enhancement estimates from the estimating conference. It was pointed out that roughly 20% of the estimated additional Medicaid enrollees are individuals who are currently eligible but not enrolled and that coverage of this population would generate a cost to the state whether Florida expands Medicaid or not.
- Impact on Employers: Discussion focused on the employer mandate and employer penalties, State Group Health Insurance and decision points.

## In the news

- **Judge mostly rejects Fla. prison medical outsourcing**

  For the second time in over a year, a state judge has ruled that the Florida Legislature violated the law when it tried to privatize the state's role in operating prisons. Leon County Circuit Court Judge John Cooper on Tuesday struck down an attempt by the Florida Legislature to privatize prison health care by using a budgetary process instead of making the change through a full vote of lawmakers. Gov. Rick Scott and the Department of Corrections said they will appeal the ruling, warning that the state now faces a $90 million deficit because they had counted saving that much over the next two years by having private contractors provide prison health care. Cooper said that the Legislature had the power to contract its prison health services to private, for-profit companies, but it went about it the wrong way. Rather than put the issue up for a full vote — and face likely defeat — legislative leaders chose to rely on the 14-member Legislative Budget Commission to authorize the change during its September meeting. (Miami Herald)

# *Georgia*

## HMA Roundup – Mark Trail

**Medicaid ABD RFP:** In a presentation delivered on November 27th, Georgia Dept. of Community Health (DCH) Director Jerry Dubberly provided some context around the state's plans to employ a fee-based care coordination model for the Medicaid Aged Blind and Disabled (ABD) population. Specifically, the state will select a single, statewide vendor through a procurement planned for the first quarter of 2013. Vendor selection is targeted for the second quarter with implementation planned for January 2014. Enrollment will be mandatory for all ABD members including dual eligibles, members receiving Home and Community-Based Services and resident of long-term institutions. Claims will continue to be paid on a fee for service basis but the care management vendor payments will incorporate a shared savings methodology.

**EHR Incentives:** Georgia's Medicaid Electronic Health Record (EHR) Incentive Program has issued more than $100 million to eligible providers through the end of November 2012. The program was launched on September 5, 2011. 114 eligible hospitals have received payments of $71 million while 1,511 providers have received payments of $31 million.

# *Illinois*

## HMA Roundup – Jane Longo and Matt Powers

On December 5, the Illinois Department of Healthcare and Family Services (HFS) posted on their website a draft care coordination roll-out plan, dated November 29, 2012. The roll-out plan details the phases the state will tentatively take in achieving enrollment of at least 50 percent of the Medicaid population in care coordination by January 2015, as mandated by the state legislature. In addition to the CCE/MCCN and dual eligible demonstration awards already announced, the roll-out plan indicates that beginning January 2014, Illinois Medicaid will begin to expand the care coordination program to the broader Medicaid population, including children, parents, and newly-eligible Medicaid enrollees. HFS expects that these populations will be enrolled in some or all of the current managed care players in the state, as well as others who are likely to apply. The draft roll-out plan table, presented below, is available on the HFS website, here.

**CARE COORDINATION ROLL-OUT PLAN: JANUARY 2013 - JANUARY 2015**

| Focus of Plan | Population | # of Clients | Geography | Beginning Date |
|---|---|---|---|---|
| Integrated Care Program: adding "Phase II" LTSS - by Centene/Aetna ("Phase III" for Persons with Developmental Disabilities approx. 1 year later) | SPD-Medicaid | 36,000 | Collar counties | Feb-13 |
| Care coordination for SPD adults, by provider-organized Care Coordination Entities (CCEs) and Managed Care Community Networks (MCCN) - initially 5 CCEs, 1 MCCN | SPD-Medicaid and Duals; family members | 16,000+ | 4 in Chicago area; 2 downstate - 6,000 initially (growth based on capacity) | Apr-13 |
| Care coordination for SPD adults in additional regions - by variety of managed care entities | SPD-Medicaid | 19,000 | Central IL, Rockford, Quad Cities | Apr-13 |
| | | 7,000 | Metro East | Jul-13 |
| | | 69,000 | Chicago | Jan-14 |

| | | | | |
|---|---|---|---|---|
| Care coordination for children with complex health needs - by CCEs and MCCNs | Children | 5,000+ | Statewide (growth based on capacity) | Jul-13 |
| Medicare-Medicaid Alignment Initiative - by MCOs | SPD-Duals | 136,000 | Chicago region/Central Illinois | Oct-13 |
| Care coordination for children/family and caregivers | Children/ families | 1,476,000 | Chicago region, central IL, Rockford, Quad Cities, Metro East | Jan-14 |
| Care coordination for "New Medicaid" clients under Affordable Care Act | Adults 19-64 | 237,000 | Chicago region, central IL, Rockford, Quad Cities, Metro East | Jan-14 |
| Clients in fee-for-service as of 1/1/15 (rural counties/Duals opting out, etc.) | various | 1,000,000+ | | |
| **TOTAL MEDICAID ENROLLMENT AS OF JANUARY, 2015** | | **3,000,000+** | | |

SPD = Seniors and Persons with Disabilities; LTSS = long-term supports and services

# *Louisiana*

## HMA Roundup

On November 29th, the Louisiana Department of Health and Hospitals (DHH) issued a Request for Information (RFI), seeking input and strategies to help the State Medicaid program more effectively coordinate long-term care services. As a reminder, individuals eligible for Medicaid long-term care supports and services were not enrolled in the Medicaid managed care program, Bayou Health, that DHH implemented earlier this year. DHH is now seeking input from stakeholders on how best to apply the same principles of care management and service coordination, which have been successful in Bayou Health, to long-term care supports and services. The key objectives of restructuring are to:

- Improve quality of services and health outcomes;
- Decrease fragmentation and improve coordination of care;
- Create a system that utilizes proven and/or promising practices;
- Refocus the system in order to increase choice and provide more robust living options for those who need long-term care and their families; and
- Rebalance the system in order to meet the growing demand for services within the existing level of expenditures for the long-term supports and services population.

The RFI is available here. DHH is accepting responses to the RFI through Monday, Jan. 28.

## In the news

- **La. floats inmate health plan**

  The Jindal administration told legislators Thursday that it is mulling over the possibility of buying private health insurance for the state's 40,000 prison inmates. "We believe this is certainly an alternative," state Corrections Secretary Jimmy LeBlanc said after briefing members of the Joint Legislative Committee on the Budget. Exactly what the

cost would be is unclear. LeBlanc said Alabama pays nearly $3 a day per inmate for a private medical plan. (The Advocate)

## *Michigan*

### HMA Roundup – Esther Reagan

**Children's Special Health Care Services :** In previous editions of the Weekly Roundup, we reported on the plan of the Department of Community Health (DCH) to enroll children (and a few adults) receiving services from both the Children's Special Health Care Services (CSHCS) program and Medicaid in Medicaid Health Plans (HMOs). Enrollment has begun. As of November 1, 2012, there were 1,487 CSHCS/Medicaid beneficiaries enrolled in the Medicaid HMOs to receive their Medicaid benefits. Of this total, 401 children were auto-assigned to an HMO and 1,086 voluntarily enrolled.

**Health Insurance Exchange:** Although Governor Rick Snyder had supported a Michigan-run exchange and the state received almost $10 million in federal grant funds to develop it, last week the House of Representatives would not appropriate the funds because of several members' objections to the ACA. Governor Snyder has advised the US Department of Health and Human Services (HHS) that Michigan wishes to collaborate on a state/federal partnership health insurance exchange, but noted in a press release that he would continue to work with the state legislature to explore establishment of a Michigan-run exchange if it is their will and there is time to do so.

**Health Insurance Claims Assessment (HICA):** In previous editions of the Weekly Roundup we have reported on the new Health Insurance Claims Assessment (HICA) Act, which required a one percent assessment on most paid health insurance claims beginning on January 1, 2012. The claims assessment replaced the six percent assessment on Medicaid Health Plans and the $1.2 billion it raised for the Medicaid program. In early September 2012, a spokesperson for the Michigan Department of Technology, Management and Budget (DTMB) announced that collections during the year have been lower than anticipated by about $130 million (that figure has now risen to $144 million).

## *Pennsylvania*

### HMA Roundup – Izanne Leonard-Haak and Matt Roan

**Medicaid Expansion:** Governor Corbett received a letter last week from 64 advocates and other groups urging him to consider moving forward with the Medicaid expansion. The letter, available here, was written by the Pennsylvania Health Access Network. At this time, Governor Corbett has not indicated by when a decision on the expansion would be made.

**Revenue Update:** Pennsylvania collected $1.7 billion in General Fund revenue in November, which was $23.1 million, or 1.4 percent, less than anticipated, Secretary of Revenue Daniel Meuser reported this week. Fiscal year-to-date General Fund collections total $9.8 billion, which is $59.1 million, or 0.6 percent, above estimate.

### In the news

- **Carlisle Regional Medical Center will not accept the Gateway Medicaid plan in 2013**

Carlisle Regional Medical Center will no longer accept Medicaid members of Gateway Health Plan as of Jan. 1, 2013. Margaret Worek, vice president of operations for Gateway, did not divulge specific information pertaining to the breakdown of negotiations but said Gateway mailed letters to its members mid-November about the contract termination. In the letter, members were advised to switch providers or Medicaid plans to avoid a lapse in coverage. Tara Mead, director of marketing at CRMC, explained a little about why contract negotiations failed. "Gateway has demanded that our hospital accept a contract renewal that decreased the rates to be paid to the hospitals substantially while hospital costs have continued to increase," Mead said. (The Sentinel)

## OTHER HEADLINES

### District of Columbia

- **AmeriHealth Mercy to buy D.C. Chartered Health Plan, bids on Medicaid contract**

The AmeriHealth Mercy Family of Cos. is in final negotiations with District insurance regulators to acquire D.C. Chartered Health Plan Inc. out of receivership, city and company officials confirmed Monday. The Philadelphia-based insurer also submitted a bid Monday to be one of the city's three Medicaid managed-care contractors beginning in May 2013, said Michael Flagg, a spokesman for the D.C. Department of Insurance, Securities and Banking. (Washington Business Journal)

### Kansas

- **More KanCare implementation details outlined**

Kansas officials have made public more details about how they would implement KanCare and say they plan to release more information as quickly as it becomes available. A federal decision on the state's plan to remake its Medicaid program is expected any day and the new information is evidence of the back-and-forth in the discussion between the federal Centers for Medicare and Medicaid Services as the administration of Gov. Sam Brownback continues its push for a Jan. 1 launch of the new program. Brownback officials so far have posted six section 1915c waiver amendments on the KanCare website and also within the last several days have posted six "implementation activities" reports that outline previously undisclosed details about how they expect KanCare to work. (Kansas Health Institute)

### Maine

- **Questions surround Maine's Medicaid shortfall**

Overly optimistic savings initiatives, budgeting based on still-unapproved cuts and a failure to forecast health care claims are all contributing to a projected $100 million shortfall in the state's Medicaid program. Shortfalls are not uncommon in MaineCare, the state's Medicaid program. But the magnitude and timing of the latest one stunned lawmakers on the Legislature's budget-writing committee, which learned of it Thursday, six days before the swearing-in of the new Democratic majority. (Portland Press Herald)

## Missouri

- **Missouri Governor Backs Medicaid Expansion**

  Missouri Gov. Jay Nixon wants the state to expand its Medicaid program, marking the strongest stance the Democratic governor has taken to date on the state's pending decision. Nixon previously said he was evaluating the issue to see what's best for Missouri. (Kaiser Health News)

## New Jersey

- **Change in eligibility rules leaves thousands of N.J. residents without healthcare, lawmakers say**

  More than 46,000 people in New Jersey lost health coverage since March 2010 because of a complicated change in eligibility requirements for NJ FamilyCare, the popular state-run HMO insurance program for the working poor, lawmakers and legal advocates say. Facing a wide budget gap in early 2010, the Christie administration announced it would not accept any more parents as new applicants and cut eligibility to only those families making no more 33 percent above the federal poverty rate, or $25,390 for a family of three, based on current income standards. Before the change, FamilyCare accepted parents if they had earned up to twice the poverty rate. In addition, if parents' income levels changed when reapplying each year, they would be deemed a new applicant — and rejected because the program was frozen. (NJ.com)

## Oregon

- **Gov. John Kitzhaber wants to add roughly 200,000 to Oregon Health Plan**

  A recent report by the Urban Institute for the Kaiser Family Foundation pegged Oregon's Medicaid expansion costs at $506 million over 10 years, but said it could also reduce government costs of providing other free care by $280 million. Oregon officials are working on another estimate, expected to be released in a few weeks. One question is whether the federal expansion will pick up the costs of 66,000 people already on the stripped-down state plan under the Oregon Health Plan called OHP Standard. If it does, 225,000 people in all are expected to be funded by the feds in the coming budget. If the federal decision goes against Oregon, it would cost the state $530 million over the next four years; that's on top of the Urban Institute estimate. (Oregon Live)

## South Dakota

- **S.D. Democrats say expanding Medicaid vital**

  Democratic leaders in the state House and Senate said Friday they will make expanding Medicaid to low-income residents a budget priority in the legislative session. Senate Minority Leader Jason Frerichs and House Minority Leader Bernie Hunhoff said the state should take advantage of federal money to expand the program by 40,000 to 50,000 low-income adults. (Argus Leader)

## Texas

- **Democrats Expect a Deal on Medicaid Despite Perry**

Despite Gov. Rick Perry's firm opposition to a central tenet of federal health reform — expanding the state's Medicaid program for those with low incomes — Texas Democrats remain optimistic that the 2013 legislative session can yield a deal that brings in billions of additional federal dollars. (New York Times)

## Wyoming

- **Mead says not enough info for Medicaid expansion**

Gov. Matt Mead is recommending that Wyoming not accept federal money for an expansion of the Medicaid program, a key component of the Affordable Care Act. Unveiling his budget proposal Friday in Cheyenne, Mead said the ultimate decision on whether to accept $50 million in federal funds for the Medicaid program expansion will fall to the Wyoming Legislature after lawmakers convene in January. (Billings Gazette)

## National

- **Health Plans Gear Up To Sell Directly To Consumers**

As the health care overhaul moves ahead, the nation's health insurers are scrambling to reinvent themselves, hoping to boost their image and entice millions of Americans to enroll, some for the first time. Blue Shield of California has opened a center inside Lucky Supermarket in San Francisco, offering wellness visits and consultations with a company "ambassador," who can answer questions and sign up people for coverage while they buy fruits and vegetables. Blues plans in Florida, Pennsylvania and three other states have also opened store-front sales centers. (Kaiser Health News)

- **Insurance Surcharges Will Fund Most Online Exchanges Created Under Health Law**

Republican governors in Florida, Virginia, Texas and several other states say they're reluctant to build the online insurance markets required by the federal health law because they're worried about getting stuck with the bills. But Democrat-controlled California, which will run the country's largest insurance market, will do so without taking a cent from the state treasury. Instead, operations of the market, also called an exchange, will be financed by a surcharge on the billions of dollars in insurance premiums sold in the exchange. That's the same way most state and federal exchanges will be funded, according to government officials and health consultants working with states. (Kaiser Health News)

- **HHS health rules no balm for states**

Sure, the Obama administration is dumping piles of Affordable Care Act rules in everyone's laps now. The danger, though, is that the rules have been held up so long that the states' insurance commissioners — even the ones that want to implement the law — may have trouble making up for lost time. That's the word from the National Association of Insurance Commissioners meeting near Washington, D.C., last week, where commissioners from around the country told POLITICO that the Department of Health and Human Services has left large holes in its guidance for states building insurance exchanges — online marketplaces for individuals to access subsidized insurance plans. (Politico)

- **State lawmakers gird for battle over Medicaid expansion**

  As state legislatures prepare to meet in January, lawmakers across the country are girding for a battle over whether to sign on to the health-care law's expansion of Medicaid. With barely a year before the expansion is scheduled to begin, only 14 states seem certain to join in. About 13 states seem likely to opt out because the GOP has a lock on both the governors's office and the legislature and many of these Republicans are dubious of expansion. But even here the outcome is often in doubt. For instance, Florida's Gov. Rick Scott (R) has been one of the most scathing critics of expanding Medicaid. But in an interview shortly after the election, Scott suggested he was open to trying to "get to yes" on the issue. Meanwhile, in more than a third of states, governors and state lawmakers have been so vague about their intentions, or so at odds, that it is impossible to predict how the debate will play out. (Washington Post)

- **Feds propose 3.5 percent fee on insurers who want to participate in new health care markets**

  Health insurance companies will have to pay to play in new health insurance markets coming under President Barack Obama's health care law, the administration said in a regulatory notice issued Friday. The Health and Human Services department is proposing a "user fee" amounting to 3.5 percent of premiums for health insurers who want to offer policies in new federal exchanges coming in 2014. The fee is to cover administrative costs of the new markets, which were designed to be self-supporting. (Washington Post)

- **Small Employers Weigh Impact of Providing Health Insurance**

  Most employers, even small businesses, already offer health insurance, and the federal law is not expected to have a significant impact on what they do over the next year or so. But businesses that rely heavily on low-income workers, many of whom do not make enough to afford their share of the cost of the insurance premiums, are being forced to rethink their business models. Almost half of retail and hospitality employers do not offer coverage to all their full-time employees, according to a recent survey by Mercer, a benefits consultant. (New York Times)

- **A Hospital War Reflects a Bind for Doctors in the U.S.**

  For decades, doctors in picturesque Boise, Idaho, were part of a tight-knit community, freely referring patients to the specialists or hospitals of their choice and exchanging information about the latest medical treatments. But that began to change a few years ago, when the city's largest hospital, St. Luke's Health System, began rapidly buying physician practices all over town, from general practitioners to cardiologists to orthopedic surgeons. A little over half of the 1,400 doctors in southwestern Idaho are employed by St. Luke's or its smaller competitor, St. Alphonsus Regional Medical Center. Boise's experience reflects a growing national trend toward consolidation. Across the country, doctors who sold their practices and signed on as employees have similar criticisms. In lawsuits and interviews, they describe growing pressure to meet the financial

goals of their new employers — often by performing unnecessary tests and procedures or by admitting patients who do not need a hospital stay. (New York Times)

- **Experts: Governors won't resist Medicaid expansion for long**

  Governors will eventually succumb to pressure to expand their Medicaid programs, a pair of health care experts predicted Thursday, arguing that the prospect of medical practices going out of business will force their hands. Gail Wilensky, who headed Medicaid for President George H.W. Bush, predicted that states resisting Medicaid expansion would reverse themselves within a few years — if only because the federal government plans to cover 100 percent of the costs for the first few years and 90 percent thereafter. (Politico)

- **Mismatched Data Hamper U.S. Accounting of Medicaid Costs**

  The full extent of U.S. spending on Medicaid, the $459 billion state-federal health insurance program for the poor, is unclear because of mismatches between government databases, auditors reported. A $43 billion gap showed up in a comparison of 2009 spending data from the states, which run Medicaid, and the U.S. Centers for Medicare and Medicaid Services, which pays for more than half the program, according to a report released today by the Government Accountability Office. In a separate report, the inspector general for the U.S. Health and Human Services department said the agency hadn't audited about $4 billion in payments to doctors and hospitals for installations of electronic record systems. (Bloomberg)

## COMPANY NEWS

- **Mansa Capital Raises $30 Million in Anchor Funding for Debut High-Growth Healthcare Private Equity Fund**

  Mansa Capital Management, LLC, a Boston-based private equity firm focused on the $2.5 trillion healthcare sector, announced today its debut healthcare growth fund has invested $7MM into Independent Living Systems as the fund's flagship investment. (Mansa Capital News)

- **WellCare CEO opens playbook**

  WellCare Health Plans Inc. has shown it's possible for businesses to do well by doing good. The managed health care company's sales and profit have soared, while it is working to improve access to quality care for its members, who are primarily seniors, children and the poor. "We've got the economic incentive to do that – that's the 'do well' I suppose – but by improving people's quality of lives, getting them into the right provider network, that's the 'do good,'" said Alec Cunningham, CEO, in an exclusive interview with the Tampa Bay Business Journal. (Tampa Bay Business Journal)

- **Walmart's New Health Care Policy Shifts Burden To Medicaid, Obamacare**

  Walmart, the nation's largest private employer, plans to begin denying health insurance to newly hired employees who work fewer than 30 hours a week, according to a copy of the company's policy obtained by The Huffington Post. Under the policy, slat-

ed to take effect in January, Walmart also reserves the right to eliminate health care coverage for certain workers if their average workweek dips below 30 hours -- something that happens with regularity and at the direction of company managers. Many of the Walmart workers who might be dropped from the company's health care plans earn so little that they would qualify for the expanded Medicaid program, experts said. In an emailed statement, company spokesman David Tovar said Walmart had "made a business decision" not to respond to questions from The Huffington Post and accused the publication of unfair coverage. (Huffington Post)

- **Aetna Launches New Managed Long-Term Care Program in Five New York Counties**

  Aetna Better Health of New York announced its participation in New York State's managed long-term care (MLTC) program. Aetna Better Health of New York, an Aetna Medicaid company, will serve people eligible for the state program in three New York City boroughs—Manhattan, Brooklyn and Queens—as well as Nassau and Suffolk counties on Long Island. (Aetna News Release)

- **Amerigroup Corporation Sells Virginia Health Plan**

  Amerigroup Corporation announced today that it has completed the sale of its Virginia health plan to Inova Health System Foundation. The sale divests all of Amerigroup's managed care operations in the Commonwealth of Virginia. (Amerigroup Press 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 |
|---|---|---|---|
| December 5, 2012 | Idaho Behavioral | Proposals due | 200,000 |
| December 19, 2012 | Nevada | Contract Awards | 188,000 |
| December, 2012 | Texas Rural STAR+PLUS | RFP Released | 110,000 |
| December, 2012 | Virginia Duals | RFP Released | 65,400 |
| TBD | Washington Duals | RFP Released | 115,000 |
| TBD | South Carolina Duals | RFP Released | 68,000 |
| TBD | Michigan Duals | RFP Released | 198,600 |
| 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 |
| TBD | 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 | Massachusetts Duals | Implementation | 115,000 |
| April 1, 2013 | New Hampshire | Implementation (delayed) | 130,000 |
| 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 | 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 |
| September 1, 2013 | Illinois Duals | Implementation | 136,000 |
| 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 |
| TBD | Michigan Duals | Implementation | 198,600 |
| 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 | | Fall 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 | 11/5/2012 | X | 4/1/2013 |
| **Michigan** | Capitated | 198,644 | TBD | TBD | TBD | | 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 | Jan. 2013 | TBD | TBD | | 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 | Early 2013 | | July 2013 | | 1/1/2014 |
| **Vermont** | Capitated | 22,000 | 1/7/2013 | 3/11/2013 | 4/1/2013 | Dec. 2012 | 1/1/2014 |
| **Washington** | Capitated/MFFS | 115,000 | TBD | TBD | TBD | 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 Webinar Replay

### The Economics of the Medicaid Expansion

On November 30, 2012, HMA hosted a webinar by leading independent Medicaid policy and financing experts Jack Meyer, Vern Smith, and Kathy Gifford. They offered an objective perspective on the direct and indirect fiscal considerations of the Medicaid expansion under the Affordable Care Act (ACA).

A video recording of the presentation and the presentation slide deck for this webinar are available here.

## HMA Recently Published Research

### 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

**Vernon K. Smith, PhD, Managing Principal**
**Kathleen Gifford, JD, Principal**
**Eileen Ellis, MS, Managing Principal**

The findings in this report are drawn from the 12th consecutive year of the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (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. **Link**

## HMA Upcoming Appearances

### Barclays Select Series 2012:
### *Healthcare Policy Forum – Post Election "D.C. Day"*

**Jay Rosen, Presenter**

*December 10, 2012*

*New York City*