HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

MACPAC PUBLISHES REPORT ON MEDICAID LONG-TERM SERVICES AND SUPPORTS (LTSS)

This week, our *In Focus* section reviews the Medicaid and CHIP Payment and Access Commission (MACPAC) *Report to the Congress on Medicaid and CHIP*, dated June 2014. MACPAC reports twice annually to Congress on a set agenda of topics related to the Medicaid and CHIP programs. In the June 2014 report, one of the topics is "Medicaid's Role in Providing Assistance with Long-Term Services and Supports (LTSS)." We review several key takeaways from the MACPAC report, including an overview of Medicaid's role in LTSS, variation across states in how individuals become eligible for LTSS, characteristics and spending by LTSS users, and MACPAC's role going forward as more states turn to managed LTSS (MLTSS).

Link to MACPAC Report, June 2014: MACPAC Report

Medicaid's Role

According to MACPAC, total national spending for LTSS in FY 2012 was around $220 billion, of which Medicaid accounted for $134.1 billion, nearly two-thirds of all spending. This is despite LTSS enrollees making up less than 7 percent of all Medicaid beneficiaries.

Under Medicaid state plans, states must provide nursing facility and home health services, including nursing, home health aides, and medical supplies/equipment. Many states have opted to expand the breadth of home health services provided under the LTSS benefit, either through state plan amendment or via waivers.

The MACPAC report argues that the Medicaid LTSS landscape has grown increasingly complex over time as states implement individualized waiver programs, federal and state lawsuits mandate changes to LTSS delivery, and legislation, such as the Affordable Care Act's Community First Choice option, add to the diversity and individuality of state LTSS environments.

State Eligibility Pathways

The MACPAC report outlines seven pathways through which individuals may become eligible to receive LTSS. How an individual is determined eligible to receive LTSS may impact what services are available to them under the LTSS benefit. Additionally, MACPAC notes that simplified eligibility criteria under the ACA do not apply to the LTSS population, requiring states to maintain two separate eligibility determinations.

Medicaid LTSS Users – Characteristics and Spending

MACPAC provides national-level data on the LTSS population, broken down by dual eligibility status, nursing facility vs. HCBS status, and how they became eligible for LTSS. Below, we cover some of the takeaways from the data.

- Approximately half of the Medicaid LTSS population is aged (age 65 or above), with most of those under 65 qualifying on the basis of a disability.
- A majority of the Medicaid LTSS population (68 percent) are dual eligibles enrolled in both Medicaid and Medicare. Dual eligible Medicaid LTSS beneficiaries were more likely to be receiving institutional care than non-dual LTSS recipients.
- Of the 2.8 million dual eligible LTSS beneficiaries (as of FY 2010):
    - More than 2 million were age 65 or older, averaging nearly $39,000 in annual Medicaid LTSS spending per beneficiary.
    - Those under age 65 were more likely to use HCBS and had higher non-LTSS Medicaid spending.
    - Roughly 75 percent of dual eligible LTSS beneficiaries were determined eligible through SSI or special income level/other.
- Of the nearly 1.4 million non-dual LTSS beneficiaries (as of FY 2010):
    - Nearly 250,000 were under age 21, eligible on the basis of a disability, averaging nearly $56,000 in annual Medicaid LTSS spending per beneficiary.

- 280,000 were under age 21, but eligible on a basis other than disability, averaging less than half the annual spending per beneficiary as those eligible on basis of a disability.
- Nearly 690,000 (roughly 50 percent of all non-dual LTSS beneficiaries) were adults (age 21-64) eligible on the basis of a disability, averaging more than $63,000 in annual Medicaid LTSS spending per beneficiary.
- Although the non-dual LTSS population as a whole spends more on HCBS than on institutional services, those eligible on the basis of disability were higher utilizers of HCBS, while those eligible on another basis were higher utilizers of institutional services.
- The non-dual LTSS population were high users of non-LTSS Medicaid services as well, particularly those eligible on the basis of a disability.
- As with the dual-eligible population, most gained LTSS eligibility through SSI or special income level/other basis.

MACPAC Role Going Forward

As MACPAC sets its agenda for topics to review in the coming year, they intend to review four in-depth topics around Medicaid LTSS.

- **Managed LTSS (MLTSS):** MACPAC will conduct a study of five states that have implemented risk-based managed care for the Medicaid LTSS population.
- **HCBS Waivers:** MACPAC will continue to evaluate state HCBS waiver programs, as well as consider ways to balance state desires with CMS oversight of waivers.
- **Eligibility Assessments:** MACPAC will monitor trends in standardization of functional eligibility assessments for LTSS, with a goal of creating a more streamlined, equitable Medicaid LTSS eligibility assessment.
- **Medicaid LTSS Data:** Finally, MACPAC is looking to address better ways to collect, organize, and evaluated existing and new data sources on the Medicaid LTSS population, particularly as it relates to HCBS waiver data, currently difficult to compare across states and programs.

HMA Medicaid Roundup

California

HMA Roundup – Alana Ketchel

Contra Costa Health Plan Out of Exchange in 2015. On June 19, 2014, the *San Jose Mercury News* reported that Contra Costa Health Plan will not participate in Covered California next year. The local insurer cannot meet the Federal requirement that the same version of a plan must be offered inside and outside of the Exchange due to prohibitive administrative cost. Contra Costa Health Plan currently serves 1,100 members that will be transitioned to a different plan for 2015. Read more

Bill Introduced to Restore Adult Day Care Center Funding. On June 18, 2014, *Reuters* reported that California lawmakers advanced a bill to restore Medi-Cal benefits for Adult Day Health Services. The program links disabled residents to nurses, therapists, and social workers who provide medical care and supports for daily activities. The services were cut in 2011 due to state budget concerns. The bill now goes to the full Senate for approval. Read more

Managed Risk Insurance Board to Cease Operations June 30. On June 17, 2014, the *Sacramento Business Journal* reported that the Managed Risk Medical Insurance Board (MRMIB) will stop operations on June 30 under a provision of the state budget plan. MRMIB was established 24 years ago to serve Californians who could not access health insurance due to pre-existing conditions. As part of the budget, the state will convene a meeting by August 1 to determine how to cover state residents who remain uninsured. Read more

Officials Investigate Anthem and Blue Shield in Response to Customer Complaints Regarding Provider Access. On June 20, 2014, the *Los Angeles Times* reported that officials at the California Department of Managed Health Care are investigating whether Anthem Blue Cross and Blue Shield of California beneficiaries were misled by inaccurate provider lists. Many policyholders reported difficulties finding a physician in their network. Both Anthem and Blue Shield have acknowledged errors in documenting the network status of providers; the companies have together received over 200 provider-related complaints from January to early June. Read more

Colorado

HMA Roundup – Joan Henneberry

Connect For Health Exchange Enrollment Reaches 137,000. On June 24, 2014, the *Denver Post* reported that 137,000 Coloradans have now enrolled in private health insurance plans through the Connect for Health online insurance

exchange. This includes late enrollment (i.e. after the official end date of open enrollment on March 31) from enrollees who experienced "changes in circumstance" such as changing employment status, marital status, location, and new pregnancies. Insurance companies have not yet reported to the exchange how many enrollees have paid their first premium. Read more

Connecticut

New Haven Agencies Earn $9.7 Million Grant from CMS to Establish Care Coordination Program. On June 17, 2014, the *New Haven Register* reported that New Haven, Connecticut's social services agencies, led by the Clifford Beers Clinic, Inc., won a $9.7 million grant from the CMS Innovation Center to develop a care coordination program for local residents. Health Management Associates worked closely with the Clifford Beers Clinic to develop and submit a Health Care Innovation Award application, which was one of only 12 grants awarded by CMS. The pilot program, called WrapAround New Haven, will deliver evidence-based, culturally-appropriate integrated medical, behavioral health, and community-based services coordinated by a multidisciplinary team. At least 2,250 New Haven-area residents are expected to participate in the program. The grant includes funding for staff, including social workers and other professionals who will improve care delivery and increase communication between residents and providers. The program is expected to launch in September. Read more

District of Columbia

D.C. Health Link Insurers Proposing Premium Increases for 2015 Plans. On June 23, 2014, the *Washington Post* reported on 2015 premium rate proposal data released by the D.C. Department of Insurance, Securities and Banking. The data shows that CareFirst BlueCross BlueShield, the largest health insurer in the district, is proposing across-the-board increases to the plans it offers on the D.C. Health Link insurance exchange. Meanwhile, UnitedHealthcare is proposing an across-the-board 8 percent cut to its small business plans, and Aetna and Kaiser Permanente are proposing mixed adjustments. D.C.'s premiums on exchange plans are currently slightly below the national average. Read more

Florida

HMA Roundup – Elaine Peters

Judge Affirms DOH on Trauma Rule. On June 20, 2014, Health News Florida reported that a judge from the Florida Division of Administrative Hearings has ruled that the state Department of Health (DOH) acted within its legal right to revamp the state's system for establishing new trauma centers. Opponents of the DOH's proposed rule to open up more trauma centers around the state argue that doing so will dilute the talent pool required at such facilities and financially endanger existing facilities. Read more

Georgia

HMA Roundup – Mark Trail

New Data Shows Developmentally Disabled at Risk During Transition from State Hospitals to Community Homes. On June 23, 2014, *Georgia Health News* reported that nearly 10 percent of the 480 people with developmental disabilities who have moved out of state hospitals since July 2010 died after placement in community residences. State officials also documented 76 reports of physical or psychological abuse, 48 of neglect and 60 accidental injuries in community homes; the disturbing reports prompted an independent reviewer to conclude that the state does not provide adequate supervision of patients with developmental disabilities being transferred from hospitals into community homes. Read more

DCH Releases Public Notice Regarding Elderly and Disabled Waiver Rate Increases and Incentive Program. On June 12, 2014, the Georgia Department of Community Health (DCH) released a public notice of a draft proposal for increased rates for Enhanced Case Management, Alternative Living Services and Personal Support Services. The proposed rate increases are very similar to the nursing home quality set of payments rate increase, which resulted in improved patient satisfaction and quality of care. The rate increase for Personal Support Services and Alternative Living Services is funded through the third quarter of SFY 2016. The rate increase for Enhanced Case Management is funded through a legislative appropriation approved in the Governor's budget in May 2014. DCH also intends to implement a tiered add-on provider quality incentive payment of up to 3 percent for outcomes achieved by eligible enhanced case management agencies. The quality incentive is earned by a combination of baseline quality measures, program measures and consumer measures. DCH invites public comment on this notice until June 26. Comments will be provided to DCH prior to the July 10 Board meeting. Read more

Personal Care Home Shut Down for Abuse and Neglect. On June 20, 2014, *WTXL* reported that the Uplift personal care home in Brooks County was shut down due to allegations of patient abuse and neglect. Six people affiliated with the facility, including the facility's owner, another employee, two volunteers, and two residents were arrested. The Georgia Bureau of Investigation reported that the owner also misused his clients' food stands and social security benefits. Read more

Counseling Center Charged with Medicaid Fraud, Filed Over 3,000 False Claims. On June 13, 2014, the Georgia Department of Law reported that the owner of a therapy and counseling service center plead guilty to Racketeering, Medicaid Fraud and Conspiracy to Defraud the State in Cobb County Superior Court. Garry Hankerson, Jr. and his co-defendants obtained over $622,000 through the fraudulent billing of Georgia Medicaid and the Amerigroup Corporation for services provided at First Step Counseling Services, Inc. of Marietta. The defendants used patients' Medicaid numbers to bill far in excess of the services provided, even billing when patients were no longer in the state. State officials identified over 3,000 false claims over a five-year period. Read more

Illinois

HMA Roundup – Andrew Fairgrieve

Medicaid Managed Care Auto-Assignment Details Publicized. At the June 24, 2014, meeting of the Illinois Medicaid Advisory Committee (MAC) Care Coordination Subcommittee, Healthcare and Family Services (HFS) officials outlined the auto-assignment algorithm for the Family Health Programs (children and families) and ACA Adults Medicaid managed care rollout, to begin later this summer.

- Eligible individuals who do not make a plan selection will be assigned to a MCO or Accountable Care Entity (ACE) that includes their current primary care provider (PCP) in-network.
- Additionally, if an individual is currently enrolled in CountyCare (Cook County's early expansion waiver program), they will be auto-assigned to CountyCare absent a plan selection.
- If an individual's PCP is in multiple networks, ACEs will be favored in the auto-assignment algorithm until their minimum enrollments have been reached (40,000 in Cook County, 20,000 in suburban counties, 10,000 in downstate counties).
- If a patient does not have a PCP, which HFS expects may be likely in the Medicaid expansion population, an attempt to establish a doctor-patient relationship through claims data will be initiated.
- Absent sufficient claims data, enrollees will be auto-assigned based on the closest PCP to their current address.
- Finally, auto-assignment will also favor MCOs with the lowest enrollments in the region, in an attempt to equalize enrollment across plans.

Indiana

Governor Pence Names Dr. John Wernert as FSSA Secretary, Michael Gargano as Deputy Secretary of Operations and HIP 2.0. On June 25, 2014, Governor Mike Pence named Dr. John J. Wernert as Secretary of Indiana's Family & Social Services Administration (FSSA). Dr. Wernert is the first medical doctor to serve in this role. He is currently the Medical Director of Medical Management at Eskenazi Health in Indianapolis as well as the Medical Director for Behavioral Health Integration for the Franciscan Alliance system in Indiana. Governor Pence also named former FSSA Secretary Michael Gargano as Deputy Secretary for Operations and the Health Indiana Plan (HIP) 2.0. As Deputy Secretary, Gargano will lead preparations for the implementation of HIP 2.0 (if approved by federal officials). Read more

State Budget Committee in Support of Health Indiana Plan 2.0. On June 20, 2014, *AP*/the *Chicago Sun-Times* reported that officials from Governor Mike Pence's administration presented the Governor's "Healthy Indiana Plan 2.0" to the State Budget Committee for detailed review. State Medicaid Director Joe Moser said the cigarette tax and an increase in the recently approved hospital assessment fee would cover the expansion's cost of $1.5 billion to the state over the next six years. The federal government will cover the remaining $16.5 billion

in program costs. After review of the financial details of the proposal, including a Medicaid reimbursement increase, the Committee voiced its support for the plan. Pence will submit the plan to CMS later this month as part of a Medicaid expansion waiver. Read more

IU Health Plans Consolidation of University Hospital and Methodist Health. On June 21, 2014, *AP*/the *Chicago Sun-Times* reported that Indiana University Health plans to merge the services of University Hospital and Methodist Hospital in a single building. It is not yet clear whether one of the existing hospitals will move its operations into a new building or a new building will be constructed; hospital officials hope to make that decision by this fall. The hospitals have already begun consolidating emergency room operations at Methodist Hospital. Read more

Maine

Federal Officials Terminate Certifications for Penobscot Nursing Home. On Jun 19, 2014, the *Bangor Daily News* reported that Penobscot Nursing Home in Penobscot will lose its health insurance benefits agreement and certification in the federal healthcare programs as of June 30. Federal officials explained in a letter to the facility that it failed "to achieve and maintain substantial compliance" in fixing several deficiencies identified by the Maine Department of Health and Human Services during a series of inspections earlier this year. The facility has one week from the receipt of this letter to notify all Medicare and Medicaid residents of the termination and must develop a closure plan. Read more

Mainers Pay Average of $99 per Month for Exchange Premiums. On June 18, 2014, the *Bangor Daily News* reported that Mainers who signed up for insurance through Healthcare.gov paid an average of $99 per month in premiums. According to the Kaiser Family Foundation, that is about a third of the $282 per month Maine customers paid for premiums in 2010. Nearly 90 percent of 44,000 exchange enrollees qualified for federal subsidies, which covered 78 percent of premium costs on average. Read more

Massachusetts

Massachusetts to Require Medicaid Coverage of Transgender Medical Services. On June 20, 2014, the *Boston Globe* reported that Massachusetts Medicaid will now cover transgender medical services, including gender reassignment surgery, as a standard benefit. Massachusetts is the third state in the nation (after California and Vermont) to cover these services under Medicaid. The administration of Governor Deval Patrick also wants to prohibit private insurers from denying coverage for gender reassignment surgery or other treatments that are medically necessary for transgender patients. Read more

Massachusetts Health Connector to Pay $35 Million to Sever Ties with Technology Vendor CGI. On June 20, 2014, the *Republican* reported that the Massachusetts Health Connector will pay another $35 million to CGI as part of an agreement allowing the state to sever ties with the company. CGI was hired by the exchange to create its health insurance exchange, but major technological glitches left many of the site's functions unusable, impeding health insurance

enrollment across the state. The payout includes $20 million to cover services CGI and its subcontractors have already provided, as well as $15 million to cover the continuing cost of operating and maintaining the exchange as well as the cost of sharing CGI's knowledge of the system with the state's new technology vendor, Optum. The state announced in March that it would cut ties with CGI; the exchange is currently employing a "dual track" approach in which it is developing a new state-based exchange while simultaneously preparing to join the federal health exchange if the state-based option is not ready by the next open enrollment period. Read more

State Extends Health Coverage Through December. On June 17, 2014, *South Coast Today* reported that the state has received approval to extend both the Commonwealth Care (CommCare) and Temporary Coverage through Mass Health FFS Standard and Limited programs through December 31. The programs are being extended to ensure that beneficiaries can keep health insurance while technical problems with the Health Connector exchange are being resolved. Members currently enrolled in these programs will receive notification by mail this week. Read more

Montana

Medicaid Expansion Initiative Will Not Make the November Ballot. On June 19, 2014, the *Independent Record* reported that a Medicaid expansion initiative will not be included on the November ballot. "Initiative 170" (I-170) fell short of the 32,000 signatures required to qualify it for the ballot. Republican majorities in the state Legislature blocked expansion bills last year, citing that expanding Medicaid to 70,000 low-income Montanans would cost the state too much money. Read more

New Hampshire

State MMIS Medicaid Claims Management System Still Having Glitches. On June 19, 2014, *Government Technology* reported that problems with New Hampshire's Medicaid Management Information System (MMIS) have led to major delays in hospitals getting paid for Medicaid claims. Hospitals around the state have blamed the system for billing errors, spurious denials and delays in payment processing. The claims system has cost more than $117 million to create and maintain so far, and that cost is now escalating as the state and federal governments and vendor Xerox work to fix operational issues. Read more

Court Overturns State's Decision to Ban Harbor Homes from Medicaid Provider List. On June 18, 2014, *AP*/the *Daily Reporter* reported that the New Hampshire Supreme Court ruled that the state Department of Health and Human Services (DHHS) violated Medicaid provisions when it determined that Harbor Homes was ineligible to receive reimbursements. Three years ago, Harbor Homes did not renew its interagency agreement with the Greater Nashua Mental Health Center; DHHS determined that because of this, Harbor Homes was not qualified to provide services to Medicaid patients. The decision forced 140 Harbor Homes clients to seek other mental health providers and led the agency to lay off 90 employees. Read more

New Jersey

HMA Roundup – Karen Brodsky

Public Notice Released on Changes to Nursing Facility Reimbursement Beginning July 1, 2014. On June 23, 2014, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) issued public notice of its plans to submit a State Plan Amendment to CMS to implement a change to the nursing facility rate setting system. This change is the result of the state's plans to implement MLTSS and the role MCOs will have in paying nursing facilities for custodial care for their members. The notice addresses revised reimbursement procedures for private, county and special care nursing facilities. Written comments are due by July 30 and should be sent to: Division Director, Division of Aging Services, PO Box 715, Trenton, New Jersey 08625-0715. Read more

MLTSS Billing Code Crosswalk. On May 19, 2014, DMAHS posted a draft crosswalk of MLTSS uniform billing codes for providers to refer to when they begin billing managed care organizations for the first time beginning July 1, 2014. The crosswalk identifies the former service codes and service descriptions used to bill for services under the Medicaid waivers prior to July 1, and what the new MLTSS billing codes and service descriptions should be to bill managed care organizations beginning July 1. The crosswalk varies by service. In some instances:

1. One service code has been replaced by another service code;
2. One service code has been replaced by multiple service code options; or
3. More than one service code has been replaced by a single service code.

We provide an example of each in the table below:

Former Waiver Service	Former Code	MLTSS Service	MLTSS Code			MLTSS Code Description
			Code	Mod	Method/Unit	
Comprehensive Personal Care Home – 1 day (GO)	Y7573	Assisted Living Services – (CPCH-Comprehensive Personal Care Home)	T2031	U1	Per Diem	Assisted Living, waiver; per diem
Therapies through a CRS or Day Program – Speech Individual and Group (TBI)	Y7556	Speech, Language & Hearing Therapy(Group & Individual)	92507	U3	15 minutes	Speech therapy, per diem (Group - Maintenance Therapy) NOTE: For Free Standing Clinic or ANY therapy service provided out of the home*
			92508	U3	15 minutes	Speech therapy, per diem (Group - Maintenance Therapy) NOTE: For Free Standing Clinic or ANY therapy service provided out of the home*
			92507	U4	15 minutes	Speech Therapy: (Individual), 15 minutes: Rehabilitation for MLTSS members with TBI diagnosis. Free Standing Clinic or ANY therapy service provided out of the home**
			92508	U4	15 minutes	Speech Therapy: (Group), 15 minutes: Rehabilitation for MLTSS members with TBI diagnosis. Free Standing Clinic or ANY therapy service provided out of the home**
Assisted Living Residence – 1 day (GO)	Y9633, T2031	Assisted Living Services (ALR – Assisted Living Residence)	T2031		Per Diem	Assisted living, waiver; per diem
*EXISTING Codes should be used. THE MODIFIERS MUST be included.						
** EXISTING Codes should be used. THE MODIFIER(S) MUST be included on any claim where the service is for MLTSS members with TBI diagnosis. One Session per day.						

Click here for a complete list.

Fourth Health Plan Will Join the New Jersey Health Exchange Marketplace in 2015. United Healthcare has confirmed plans to sell health insurance in New Jersey to individuals through Healthcare.gov, the federal exchange, when open enrollment begins in November for calendar year 2015. Currently New Jersey residents have three health plan options under the federal marketplace: AmeriHealth New Jersey; Health Republic Insurance of New Jersey, a new co-op insurer financed with loans from the ACA; and Horizon Blue Cross Blue Shield of New Jersey. Read more

New York

Cuomo Signs Legislation to Combat Heroin and Opioid Epidemic. On June 24, 2014, Governor Andrew Cuomo signed legislation designed to combat the growing heroin and opioid epidemic in communities across the State. Last week, Cuomo and legislative leaders reached an agreement on several bills that include new programs and insurance reforms to improve treatment options for individuals suffering from heroin and opioid addition; measures to strengthen penalties and put in place additional tools for law enforcement to crack down on the distribution of illegal drugs; provisions to ensure the proper and safe use of naloxone, and overdose antidote; and support for enhanced public awareness campaigns to prevent drug abuse. The Governor also signed legislation granting "Good Samaritan" protections to individuals who administer naloxone, which can reverse the effects of a heroin overdose. Read more

North Carolina

House Leaders Present Medicaid Reform Bill to HHSC. On June 18, 2014, *WRAL/NC Capitol* reported that the House leaders have presented a Medicaid reform bill to the House Health and Human Services Committee. The bill includes much of the language from Governor McCrory's reform plan, which was based on developing accountable care organizations to treat and manage care of Medicaid patients. Under the House bill, providers would form organizations that would lead the Medicaid reform effort. The bill also calls for capitation of payment per Medicaid patient and tasks DHHS with developing the plans for Medicaid reform. Read more

Ohio

HMA Weekly Roundup Correction: In last week's *In Focus* section on duals demonstration enrollments, we incorrectly reported that the Ohio dual eligible financial alignment demonstration, MyCare Ohio, was providing Medicaid-only benefits at this time. MyCare Ohio has begun providing fully integrated Medicare and Medicaid benefits to dual eligible who have voluntary enrolled in the program. We have posted a corrected version of last week's Weekly Roundup here.

Duals Managed Care Demonstration Underway, Beneficiaries Voice Hesitation to Participate. On June 22, 2014, the *Columbus Dispatch* reported on the rollout of MyCare Ohio, a three-year demonstration program which will transfer nearly two-thirds of the state's dual eligible population into Medicaid managed care plans. The program aims to improve care coordination and reduce costs, but many enrollees worry that their current providers or

prescriptions may not be covered under the new managed care plans. Many providers have opted out of the demonstration because they fear managed care will lead to reduced payments. Read more

Pennsylvania

HMA Roundup – Matt Roan

Nine Insurers Apply for Healthy PA. On June 20, 2014, Governor Corbett issued a press release highlighting the level of interest among insurers to serve new enrollees through his alternative Medicaid expansion plan known as Healthy PA. A total of nine insurers have submitted applications to serve enrollees of the new program. Healthy PA divides the state into nine rating regions which align to the regions used by the Federal Health Insurance Marketplace. All nine regions received at least three applicant health insurers. Vista, a health plan run by Independence Blue Cross, applied to serve enrollees statewide, covering all nine regions. All of the successful applicants will be invited to negotiate contracts with the Department of Public Welfare. Qualifying applicants were required to meet the following criteria:

- Possess a current and valid Pennsylvania HMO Certificate of Authority or submit a plan to indicate how they would obtain one by August 4, 2014;
- Provide documentation that coverage provided would meet all applicable federal and state laws regulating health insurance coverage in individual market;
- Possess valid Pennsylvania Department of Health operational authority for all counties in the region(s) in which they applied or a plan to obtain one by August 4, 2014;
- Possess recent National Committee for Quality Assurance accreditation of "commendable" , "excellent" or "accredited,";
- Provide an acceptable Emergency Preparedness statement;
- Demonstrate financial stability or economic capacity to perform as a private coverage plan; and
- Provide a statement of net worth supported by a copy of filing with the Pennsylvania Insurance Department or a balance sheet attested to by an independent public accounting firm.

Healthy PA is scheduled for implementation on January 1, 2014, assuming that CMS approves of the state's proposed approach. Sources close to the discussions between the state and CMS have said that the parties are close to an agreement on the terms of CMS's approval of the plan. Read more

School for Autistic Students Sues State over Medicaid Funding. On June 23, 2014, the *Allentown Morning Call* reported that a central Pennsylvania private school for students with autism has filed a federal lawsuit against the Commonwealth, the Department of Education, the Department of Public Welfare (DPW), and Public Consulting Group of Boston, MA, a state Contractor, alleging breach of contract and fraud rising from a dispute over delayed Medicaid payments. The Vista School, based in Dauphin County, is seeking money it says that it is owed by DPW for Medicaid-funded school-based health

services. Vista is also alleging that DPW's contractor, PCG, charged Vista and other schools fraudulent processing fees. State officials recently reported that schools across the state are currently waiting for between $13 and $15 million in reimbursements. The payment delays are being attributed to paperwork requirements that the services first are billed to the student's primary insurance carrier, and a denial notice submitted to the state. Read more

Texas

HHSC Announces Tentative Award for Actuarial Consulting Services RFP. On June 23, 2014, the Texas Health and Human Services Commission (HHSC) announced a tentative contract award for the Actuarial Consulting Services RFP to Rudd and Wisdom, Inc. The vendor will be responsible for assisting the State by providing analysis, opinions and financial calculations on services provided by HHSC programs to Medicaid and CHIP. Read more

Lawmakers and Advocates Weigh in on the Viability of State-Supported Living Centers. On June 23, 2014, the *Texas Tribune* reported on an ongoing debate over whether to keep state-supported living centers open. The living centers care for people with mental disabilities, but the high costs, low popularity and often poor conditions of the centers have compelled some lawmakers and advocates to facilitate the transfer of patients from these institutions into community-based homes. But other advocates believe that some residents of living centers would not benefit from community home care, and that state-supported living centers represent a still-important venue for care. Read more

HHSC Announces Tentative Contract Awards for Electronic Visit Verification (EVV) RFP. On June 19, 2014, the Texas Health and Human Services Commission announced tentative contract awards for RFP# 529-14-0060 for Electronic Visit Verification (EVV) Services to Care Monitoring 2000, DataLogic, First Data, MEDsys Software Solutions and SanData. The RFP states that "EVV refers to various home visit tracking systems that verify service visits occur in the home or in the community and document the precise time the provision of service begins and ends." The awards are contingent upon the successful negotiation and execution of contracts. Read more

Vermont

State Spends Over $1 Million for Outside Legal Counsel to Revise Contract with Vermont Health Connect IT Vendor. On June 19, 2014, *VT Digger* reported that the state is spending over $1 million for legal counsel from a Boston law firm to revise the state's contract with technology firm CGI, which is working on the Vermont Health Connect online health insurance exchange. While the state typically asks the Vermont Attorney General's Office to examine state contracts, Department of Vermont Health Access Commissioner Mark Larson said the agency needed additional counsel to negotiate the massive contract. Read more

Virginia

McAuliffe Set on Expanding Medicaid, Despite Lack of Approval in the General Assembly. On June 20, 2014, *AP/Modern Healthcare* reported that Governor Terry McAuliffe has begun working with the federal government to expand Medicaid eligibility in Virginia, despite strong resistance from Republicans in the state's Legislature. He has ordered Secretary of Health and Human Resources Dr. William A. Hazel Jr. to present a plan no later than September 1 on how to expand Medicaid to 400,000 low-income Virginians. McAuliffe vetoed a Republican-backed proposal that would ban McAuliffe from expanding Medicaid without legislative approval, but the State House of Delegates quickly scrapped this veto. Despite efforts by General Assembly to prevent the Governor from expanding Medicaid, McAuliffe believes there are several ways in which he can legally institute expansion without their approval. Read more

Washington

HMA Roundup – Doug Porter

Governor Inslee Orders State Agencies to Identify 15 Percent Cuts. On June 17, 2014, *National Public Radio/NW News Network* reported that Governor Jay Inslee is directing all state agencies to identify 15 percent cuts in the next budget. The budget-cutting exercise is a response to a lawsuit filed against the State Legislature, which finds the state not in compliance with a constitutional requirement to adequately fund K-12 education. The state may need to come up with $2 billion or more to fund schooling for the next biennium. The Governor will therefore have to shift funds from other state agencies into education, a move that could significantly affect the health and well-being of state residents. Read more

National

GAO Calls for More Oversight of Managed Care Organizations. On June 18, 2014, the *Hill* reported that the Government Accountability Office (GAO) is calling for increased oversight of managed care organizations. According to a May 19 GAO report, state and federal Medicaid auditors have focused on curbing fraud and waste from fee-for-service payments, but have largely neglected managed care organizations. As more managed care programs are being implemented nationwide, the report recommends that CMS require states to audit payments to and by managed care organizations. Read more

Andy Slavitt Appointed Principal Deputy Administrator of CMS. On June 20, 2014, *Bloomberg* reported that Optum's executive vice president Andy Slavitt was named principal deputy administrator of CMS. Slavitt worked with the Obama administration as the top executive in charge of fixing the healthcare.gov website after the exchange's botched rollout last year. In his new role, Slavitt will be responsible for policy and operational coordination for all of CMS's operations, including ACA programs, Medicare, Medicaid and CHIP. DHHS will also hire a chief executive officer and chief technology officer for the insurance exchanges, although no candidates have yet been announced. Read more

AARP Survey of Long-Term Care Services Shows Variation in Cost and Quality from State to State. On June 19, 2014, *National Public Radio* reported on an AARP survey of the quality and availability of long-term care in each state. In collaboration with the Commonwealth Fund and the SCAN Foundation, AARP found that the cost and quality of long-term care varies dramatically from state to state. Minnesota, Washington, Oregon, Colorado and Alaska were ranked highest in the survey, while Indiana, Tennessee, Mississippi, Alabama and Kentucky were the lowest ranked. The report assessed each state on 26 variables, including affordability, well-being of family caregivers, and types of facilities where services were offered. Read more

More Provider-Owned Health Plans Showing Interest in Participating in Federal Insurance Exchanges. On June 18, 2014, the *California Healthline* reported on the growing number of provider-owned health plans participating in federal insurance exchanges across the country. There are currently over 100 provider-owned health plans participating in the exchanges, with about twelve more starting up each year. As hospitals are being tasked with managed more risk for patient care, many are seeing health plan ownership as an attractive way to mitigate this risk. Read more

Kaiser Survey Finds that Most Insurance Exchange Consumers Were Previously Uninsured. On June 19, 2014, *Kaiser Health News* reported that nearly six in 10 Americans who bought insurance this year through the ACA online marketplaces were previously uninsured, according to a new Kaiser Family Foundation survey of non-group health insurance enrollees. The survey also shows that 34 percent of enrollees say they have benefited from the law, often due to lower costs or better access to care, while 29 percent say they were negatively affected, largely due to increased costs. Read more

Exchange Enrollees Have More Health Conditions Than Non-Exchange Policyholders, Could Lead to Premium Increases. On June 24, 2014, the *Wall Street Journal* reported on health status of Americans who purchased exchange plans and how their health will affect premiums in the future. Early analysis of medical claims submitted by exchange beneficiaries shows that the group has higher rates of chronic conditions like diabetes and asthma than others with insurance. Meanwhile, individuals who opted to keep their "grandfathered" health plans rather than purchase an exchange plan utilized healthcare services the least. The dichotomy results in unequal distribution of risk, and could lead to increased rates for exchange plans in 2015 as insurers prepare to cover the relatively sick, high-risk exchange enrollees. Read more

CMS Official Discusses Potential Taxes on Insurers to "Bail Out" Unprofitable ACA Plans. On June 20, 2014, *Forbes* reported that the "bailout" for insurance companies who lost money participating in ACA insurance exchanges will be paid for by a new tax levies on profitable insurance companies. The plan will allow the entire insurer marketplace scheme to remain budget neutral. CMS Acting Administrator Mandy Cohen stated that if this plan is insufficient to cover losses experienced by ACA plans, CMS may opt to impose additional "user fees" on all health insurers, regardless of their participation in ACA exchanges. Read more

INDUSTRY NEWS

Neighborhood Health Plan of RI Names Peter M. Marino CEO. On June 18, 2014, Neighborhood Health Plan of Rhode Island announced the selection of Peter M. Marino as the health plan's new Chief Executive Officer. Marino will replace interim CEO Jim Hooley. Marino is currently the Director of the Rhode Island Office of Management and Budget. Neighborhood Health Plan, which serves more than 140,000 people, has experienced explosive growth over the past seven months due to the ACA. Read more

Five Points Healthcare Acquires BestCare Home Care. On June 2, 2014, home health and hospice services provider Five Points Healthcare announced that it acquired BestCare Home Care on April 30, 2014. BestCare is a home health provider for Medicare-certified, Medicaid-waiver and personal care services throughout northern and western Virginia. Read more

RFP CALENDAR

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
June, 2014	Indiana ABD	RFP Release	50,000
June, 2014	Washington Foster Care	RFP Release	23,000
June 30, 2014	Rhode Island (Duals)	Proposals due	28,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Implementation	68,000
July 14, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
July 16, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
Mid-July 2014	Texas STAR Kids	RFP Released	200,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
October 1, 2014	Washington Duals	Implementation	48,500
Late October 2014	Texas STAR Kids	Proposals Due	200,000
January 1, 2015	Michigan Duals	Implementation	70,000
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
January 1, 2015	New York Behavioral (NYC)	Implementation	NA
January 1, 2015	Texas Duals	Implementation	168,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa		62,714	Not pursuing Financial Alignment Model						
Idaho		22,548	Not pursuing Financial Alignment Model						
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	1/1/2015	4/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri		6,380	Not pursuing Financial Alignment Model						
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X			10/25/2013	7/1/2014	1/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	168,000				5/23/2014	3/1/2015	4/1/2015	Amerigroup, Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013	3/1/2014	5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	10/1/2014	1/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 6 MFFS**	**1.35M Capitated 513K FFS**	***12***			***11***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

‡ Capitated duals integration model for health homes population.

HMA News

HMA Webinar Replay: "The Value Proposition of Medicare ACOs"

Link to Webinar Replay

On June 18, 2014 HMA's Accountable Care institute (ACI) presented "Medicare Accountable Care Organizations: The Value Proposition," the third in a three-part webinar series. HMA Principal Dr. Art Jones, MD, a pioneer in the accountable care movement, explored the financial considerations for establishing a Medicare ACO.

The first two webinars in this series can be accessed at the following links:

"Becoming a Medicare Accountable Care Organization."

"The Medicare ACO: Effective Care Management and its Anticipated Implications."