HMA

HEALTH MANAGEMENT ASSOCIATES

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

**IN FOCUS:** NEW YORK FINALIZES DUALS DEMONSTRATION MOU WITH CMS

**HMA ROUNDUP:** MICHIGAN SENATE PASSES MEDICAID EXPANSION BILL; PUERTO RICO ADVANCES HEALTH REFORMS; REGENCE WITHDRAWS FROM IDAHO DUALS DEMONSTRATION; COLORADO, RHODE ISLAND, NEW YORK, NEBRASKA ANNOUNCE EXCHANGE HEALTH PLANS; NEW HAMPSHIRE REVISES MEDICAID MANAGED CARE IMPLEMENTATION DATE; CALIFORNIA SENDS BRIDGE PLAN PROPOSAL TO CMS; WASHINGTON OFFICIALS DELAY VOTE ON EXCHANGE HEALTH PLANS

**HMA NEWS:** HMA ORGANIZES TEXAS SIM CONFERENCE FOR STAKEHOLDERS; HMA-AUTHORED REPORT FOR SAMHSA-HRSA LOOKS AT HEALTH HOMES; UPCOMING APPEARANCES BY MONA SHAH, BARBARA MARKHAM SMITH

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

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# IN FOCUS: NEW YORK FINALIZES DUALS DEMONSTRATION MOU WITH CMS

This week, our *In Focus* reviews the finalized Memoranda of Understanding (MOU) between New York State and the Centers for Medicare & Medicaid Services (CMS) on New York's dual eligibles financial alignment demonstration. New York is the sixth state to finalize a capitated model MOU behind Massachusetts, Ohio, Illinois, California, and Virginia. New York's demonstration will serve full dual eligibles individuals ages 21 and older in eight New York counties. Below, we review the New York demonstration and highlight key elements of the MOU. (Link to New York MOU)

For more information on the New York duals demonstration and MLTC plans, see the HMA Weekly Roundup from June 6, 2012, available here.

## New York Financial Alignment Demonstration Overview

New York and CMS will jointly contract with Fully Integrated Duals Advantage (FIDA) plans to serve duals in eight counties: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, and Westchester. In additional to being at least 21 years of age and fully dual eligible, individuals in these eight counties must meet one of the following criteria for enrollment into the demonstration:

- Nursing Facility Clinically Eligible and receiving facility-based long-term services and supports (LTSS);
- Eligible for the Nursing Home Transition and Diversion section 1915(c) waiver; or
- Require community-based long term care services for more than 120 days of the year.

Across the eight FIDA counties, there more than 178,000 duals expected to be eligible for enrollment. These dual eligibles will select or be passively enrolled into a FIDA plan in their region. New York and CMS will review applications by FIDA plans and select those meeting all requirements to serve in the demonstration.

## FIDA Plan Selection

To be selected as a FIDA plan, plan applicants must meet the following minimum requirements:

- Score 70 or higher on the Model of Care section of the CMS Capitated Financial Alignment Demonstration application;
- Have submitted an acceptable response to the New York-specific Model of Care element on "use of self-directed services" by May 7, 2013; and
- Have received a certificate of authority to operate a managed long-term care (MLTC) plan in New York by May 14, 2013.

Those plans that apply and meet the above requirements will be subject to a readiness review by CMS and New York before a three-way contract can be finalized.

## Dual Eligible Enrollment

Enrollment into the FIDA plans will be phased in, with community-based dual eligibles enrolled first. The timeline below details opt-in and passive enrollment start dates for community-based and facility-based dual eligibles.

| Implementation | Date |
|---|---|
| Community-based (Opt-In) | July 1, 2014 |
| Community-based (Passive) | September 1, 2014 |
| Facility-based (Opt-In) | October 1, 2014 |
| Facility-based (Passive) | January 1, 2015 |

After a two-month opt-in period, the passive enrollment process will begin and extend over the following four months. This means that the enrollment process, which is set to begin July 1, 2014, will continue into early 2015. As with all dual eligible demonstrations, enrollees may opt out of enrollment at any time. Individuals enrolled in a current New York Medicaid MLTC plan that becomes a FIDA plan will be passively enrolled into their current plan. Other passive enrollments will account for historic provider utilization.

## New York Comprehensive Care Management Requirements

In addition to meeting all CMS Model of Care requirements, FIDA plans must also meet the New York comprehensive care management requirements, which are outlined in the MOU and will be included in the three-way contract.

- Enrollees will receive a comprehensive assessment performed by a registered nurse in the individual's home or nursing facility within 30 days of the date of enrollment.
- Assessments will be performed at least every six months or under the following circumstances:
    - As requested by the enrollee, provider, or caregiver;
    - A change in enrollee health status;
    - In the event of a hospital admission, transition between care settings, change in functional status, loss of caregiver, change in diagnosis; or
    - As requested by a member of the interdisciplinary team (IDT).
- A Person-Centered Service Plan will be developed following the assessment and will address coordination of all medical services as well as educational, financial, and other services as needed. FIDA plans will be responsible for ongoing monitoring of the plan.
- The Interdisciplinary Team (IDT) will be supported by the FIDA plan and led by a care manager working with the enrollee and other providers, including primary care providers, behavioral health professionals, home care aides, and other providers as needed. The IDT will be responsible for implementing the Person-Centered Service Plan. Decisions made by the IDT will serve as service authorizations and may not be modified by the FIDA.

## Payments to FIDA Plans

As with other capitated dual eligible demonstrations, rate setting will occur between CMS and the state of New York. Medicare and Medicaid will each contribute to the capitation rate, consistent with projected baseline spending projections. Aggregate savings percentages will be applied equally to the Medicaid and Medicare A and B components of the capitation rate. Additional quality withhold percentages will be deducted from the capitation rate to be earned back based on a set of quality measures. The FIDA plan demonstration years, aggregate savings, and quality withhold percentages are detailed in the table below.

| | Demonstration Year | Aggregate Savings | Quality Withhold |
|---|---|---|---|
| **1** | July 1, 2014 - December 31, 2015 | 1.0% | 1.0% |
| **2** | January 1, 2016 - December 31, 2016 | 1.5% | 2.0% |
| **3** | January 1, 2017 - December 31, 2017 | 3.0% | 3.0% |

It is worth noting that the aggregate savings percentages for demonstration years two and three are lower in New York than in any of the other states with finalized MOUs. Massachusetts, Ohio, California, and Virginia have set aggregate savings of two percent in year two and four percent in year three, while Illinois set savings at three percent in year two and five percent in year three.

Medicaid rates will be based largely on existing Medicaid MLTC capitation rates, with non-MLTC covered services and non-MLTC eligible duals accounted for in the Medicaid portion of the rate setting. The MOU states that there are two proposed rate cells for the entire demonstration area:

1. Community Non-Nursing Home Certifiable for those duals who require more than 120 days of community-based long-term care but do not meet a Nursing Home Level of Care standard; and
2. Nursing Home Certifiable for those who do meet the Nursing Home Level of Care standard.

Additionally, each of the two rate cells above will be risk adjusted for each FIDA plan based on each FIDA plan's relative risk for each rate cell as compared to the regional average risk for the entire demonstration area.

## Current Medicaid MLTC Plans – Demonstration Area (August 2013)

| Nassau County (12 MLTC Plans) | New York County (25 MLTC Plans) *Includes: Bronx, Kings, Queens, Richmond* | | Suffolk (11 MLTC Plans) | Westchester (13 MLTC Plans) |
|---|---|---|---|---|
| COMPREHENSIVE CARE MGMT | ARCHCARE SENIOR LIFE | GUILDNET | COMPREHENSIVE CARE MGMT | COMPREHENSIVE CARE MGMT |
| AETNA BETTER HEALTH | COMPREHENSIVE CARE MGMT | HHH CHOICES | AETNA BETTER HEALTH | AGEWELL NEW YORK |
| AGEWELL NEW YORK | AETNA BETTER HEALTH | HIP OF GREATER NEW YORK | AGEWELL NEW YORK | ARCHCARE COMMUNITY LIFE |
| CCM SELECT | AGEWELL NEW YORK | INDEPENDENCE CARE SYSTEMS | CCM SELECT | CCM SELECT |
| ELDERPLAN | ALPHACARE | INTEGRA | ELDERPLAN | ELDERPLAN |
| ELDERSERVE | AMERIGROUP | METROPLUS | ELDERSERVE | ELDERSERVE |
| FIDELIS CARE AT HOME | ARCHCARE COMMUNITY LIFE | SENIOR HEALTH PARTNERS INC | FIDELIS CARE AT HOME | FIDELIS CARE AT HOME |
| GUILDNET | CCM SELECT | SENIOR WHOLE HEALTH | GUILDNET | GUILDNET |
| HIP OF GREATER NEW YORK | CENTERS PLAN FOR HEALTHY LIVING | UNITED HEALTHCARE | HIP OF GREATER NEW YORK | HHH CHOICES |
| SENIOR HEALTH PARTNERS INC | ELDERPLAN | VILLAGE CARE | VNS CHOICE | HIP OF GREATER NEW YORK |
| VNS CHOICE | ELDERSERVE | VNS CHOICE | WELLCARE | SENIOR HEALTH PARTNERS INC |
| WELLCARE | EXTENDED MLTC | WELLCARE | | VNS CHOICE |
| | FIDELIS CARE AT HOME | | | WELLCARE |

# HMA Medicaid Roundup

## *Alabama*

### HMA Roundup

**Alabama Adopts Money Follows the Person Program to Support Home and Community-Based Care.** Since July, Alabama officials have been meeting to discuss the implementation of the Money Follows the Person (MFP) program. MFP aims to divert Medicaid beneficiaries from nursing homes and have them remain in their home or community with long-term supports and services. It is estimated that the MFP program could assist as many as 600 people in leaving nursing homes for home and community-based care, potentially saving the state $11 million annually. Alabama did not apply to be part of the program until 2012 because of concerns that it would result in Medicaid program expansion.

**Medicaid Expansion Would Save State on Correctional Health Costs.** If Alabama agreed to Medicaid expansion, it could save on much of its annual $113 million budget for correctional healthcare by shifting costs from the Department of Corrections to Medicaid for many of its 25,000 inmates in state prisons. WSFA 12 News points to a study from The Sentencing Project that highlights how states can apply the additional federal Medicaid funds to underwrite health services, which could contribute to reducing recidivism and incarceration. The state would be projected to benefit from an additional $1.5 billion annually to cover the newly eligible Medicaid beneficiaries under the Affordable Care Act should the governor and state legislators agree to Medicaid expansion.

## *Arizona*

### HMA Roundup

**Opponents to Medicaid Expansion Claim Momentum on Ballot Initiative.** The *Arizona Daily Star* reported, this week, that the United Republican Alliance for Principled Conservatives believes it is on track to collect the 86,405 signatures required to place a voter referendum on Medicaid expansion on the November 2014 ballot. The signatures are required by a September 11, 2013 deadline.

## *California*

### HMA Roundup—Jennifer Kent

**Exchange Enrollment May Not Be as Large as Originally Expected.** Covered California has recently begun informing health insurers about a potential delay in having its online marketplace fully operational by the target October 1, 2013 date. As a result, Exchange enrollment may not be quite as large as originally anticipated. That said, Covered California Executive Director Peter Lee emphasizes that other enrollment options will be available, including call centers, counselors, and agents.

**California Sends Bridge Plan Demonstration Proposal to CMS.** On August 20, 2013, Covered California submitted a bridge plan demonstration proposal to CMS for its approval. The Bridge Plan would promote continuity of care from Medicaid managed care

plans by allowing them to offer coverage to three Exchange-eligible target populations with incomes under 250 percent of Federal Poverty Level. The three populations covered under the demonstration project would be new California Exchange enrollees who had previously been covered by a participating Medicaid managed care plan, family members who are part of households that include enrollees in participating Medicaid managed care plans, and parents or related caregivers of children in Medi-Cal. Bridge plans would likely be the lowest cost silver plan option, ensuring that consumers have a more affordable alternative for enrollees. The Exchange will offer a schedule for certifying Bridge qualified health plans and will not require plans to have options in all metal tiers.

**Anthem Class Action Lawsuit Filed.** On August 19, 2013, a class action lawsuit was filed in Los Angeles County Superior Court alleging that Anthem Blue Cross faces violated California law by refusing to cover eating disorder treatments. The named plaintiff, Shelby Oppel, had sought treatment for bulimia nervosa, which is characterized as a severe mental illness under the state's Mental Health Parity Act of 1999. The lawsuit seeks $4,000 for each PPO policy holder that had been denied treatment for eating discorders since 2009.

**Passage of Legislation to Prioritize Licensing of Physicians Focused on Underserved.** On August 23, 2013, the California legislature passed AB 1288, a bill that would mandate the state's Medical Board and Osteopathic Medical Board to prioritize applications for physician licenses for those who treat medically underserved segments of the population.

**DHCS Issues Plan to Cut Medi-Cal Provider Rates.** On August 14, 2013, the Department of Health Care Services released a plan to implement the state-ordered 10 percent cut to Medi-Cal providers' reimbursement rates. Starting on September 5, medical transportation and dental providers will face the cuts followed by DME providers on October 24, 2013. Pharmacies, physicians, clinics, and nursing homes will be cut on January 9, 2014. The following categories will be exempt from the cuts: not-for-profit dental pediatric surgery centers, distinct part Level B nursing facilities, and certain high-cost prescription drugs.

**Duals Demonstration Project to Begin No Earlier than April 2014.** On August 14, 2013, the DHCS announced a three-month delay in the implementation of CalMediConnect. The duals demonstration program is now expected to start no earlier than April 2014. The three-year demonstration project will transition approximately 450,000 dual eligible beneficiaries to managed care plans, unless the beneficiaries actively opt out.

## *Colorado*

### HMA Roundup—Joan Henneberry

**Kaiser Permanente Debuts Healthcare IT Center in Colorado.** On August 22, 2013, Kaiser Permanente announced the opening of its healthcare IT center in Greenwood Village, employing nearly 350 today and an expected 700 by 2015. Kaiser now employs more than 6,000 staff in the state. Kaiser has been recognized for its widespread implementation of electronic health records system, covering more than 9 million members across the country.

**Colorado Exchange Plan Rates Made Public.** On August 16, 2013, Colorado released rates for the 150 individual plans and 92 small business plans available on the state's Exchange, Connect for Health Colorado. Rates vary based on age, location, and tobacco use; however, the cheapest catastrophic coverage plan features rates as low as $135.57 per month, while platinum plans approach $1,000 per month in the small group market. Rocky Mountain HMO features 52 individual and 30 small group plans followed by Kaiser Permanente with 27 individual and 24 small group plans. The Colorado health insurance cooperative, Colorado Health OP, will offer eight individual and six small business plans.

## *District of Columbia*

### HMA Roundup

**CMS Approves Retroactive Payments to Former Medicaid Plans**. On August 26, 2013, the Centers for Medicare and Medicaid Services (CMS) approved a $32 million retroactive rate hike for the District's former Medicaid plans, D.C. Chartered Health Plan and UnitedHealthcare Community Plan. Chartered has been under court-appointed receivership and has not paid providers since closing in April. Chartered will receive $18 million to settle part of its $48 million in outstanding claims, while the District will distribute $30 million in local funds to cover the remaining claims. United will receive the other $14 million in CMS-approved funds.

## *Florida*

### HMA Roundup – Gary Crayton and Elaine Peters

**Representative Castor asks State Legislature to Restore State's Regulation of Rates.** On August 20, 2013, US Representative Kathy Castor wrote to Florida Senate President Don Gaetz and House Speaker Will Weatherford to restore the state's power of the State's Insurance Commissioner to negotiate and regulate health insurance rates. Castor accused the Legislature and governor of being misinformed about the Federal Government's role in establishing rates under the state Exchanges. Castor further characterized Senate bill 1842 as a "cynical attempt to saddle Florida consumers with higher insurance rates" and to sabotage the Affordable Care Act. PolitiFact notes that the Federal Government is not empowered to deny rate increases but Florida, nonetheless, eliminated its ability to regulate rates for Exchange plans. Republicans argue that the uncertainties associated with the law preclude the state from taking responsibility for the Exchanges.

**Florida Hospital Announces Joint Venture with Health First Health Plan.** On August 27, 2013, Florida Hospital and Health First Health Plan announced a joint venture to provide Medicare and private health insurance across 11 Florida counties, with final contract terms to be hammered out. The partnership will launch its first product, Florida Hospital Care Advantage, in Volusia and Flagler Counties in January 2014, with enrollment beginning in mid-October. Florida Hospitals will focus on clinical and physician support while Health First will administer the plan.

**Florida Approves Reorganization of Florida Blue.** On August 16, 2013, Florida regulators approved a reorganization of Jacksonville-based Florida Blue, the state's biggest health insurer, subject to final approval from policyholders. Under the structure, the mutual insurance holding company would be a non-profit corporate parent overseeing all subsidiaries, including the insurance company. Florida Blue members must still vote for final approval of the deal and a meeting is tentatively scheduled for September 10th.

**Governor Scott Questions Health Privacy Associated with Navigators.** Last week, Governor Rick Scott raised privacy issues related to the navigators hired to help individuals understand and enroll in health plans under the Affordable Care Act. In particular, Scott expressed uncertainty about how individual information will be shared among federal agencies and with outside groups. Florida Attorney General Pam Bondi wrote to HHS Secretary Kathleen Sebelius to seek assurance that consumer information will be adequately protected. CMS officials note that individual information is not stored in a single database but will be accessible real-time via a data hub.

**Shands Settles with Department of Justice.** On Monday, August 19, 2013, the US Department of Justice (DOJ) announced a $26.2 million settlement with Florida Shands Healthcare related to allegations of fraudulent Medicare, Medicaid, and TRICARE claims. The DOJ indicated that outpatient services from 2003 to 2008 were billed at higher inpatient rates.

## *Georgia*

### HMA Roundup – Mark Trail

**Judge Rejects United Request to Halt Blue Cross and Blue Shield State Health Plan Implementation.** On August 21, 2013, Superior Court Judge Kimberley Adams rejected UnitedHealthcare's request for an injunction to prevent the state from moving forward with its contract award of a State Health Benefit Plan (SHBP) contract to Blue Cross and Blue Shield (BCBS) of Georgia. United accused the Department of Community Health (DCH) of conducting an unfair "secret" bidding process. DCH argues that the BCBS contract will generate savings to the state. Providers have expressed concerns that a single statewide insurer for the SHBP could depress rates and limit access to care.

**Budget update:** On August 22nd, The Department of Community Health (DCH) approved proposing budget changes to the Governor for consideration in the 2014 Legislative Session. Among the highlights of the meeting were:

- The DCH ended FY 2013 with positive cash balances in all areas
    - Notable was $81 million in the ABD Medicaid budget line. DCH attributed this outcome to fewer members and some downturn in service utilization
    - No budget cuts have been proposed in either AFY 2014 or FY 2015.
- AFY 2014 budget includes proposal to pay the capitation payment withheld in FY 2012, to the CMOs.
- FY 2015: DCH proposes $29M in state funds to offset the Medicaid portion of the premium tax that applies to managed care companies.

# *Idaho*

## HMA Roundup

**Regence Withdraws from Duals Demonstration.** On August 26, 2013, the Idaho Department of Health and Welfare, Division of Medicaid, announced that Blue Cross of Idaho was approved to participate in the state's Medicare-Medicaid Coordinated Plan Demonstration for dual eligible beneficiaries. At the same time, the Department announced the withdrawal of Regence Blue Shield from the demonstration.

# *Indiana*

## HMA Roundup—Cathy Rudd

**Governor Pence Uses National Address to Tout Healthy Indiana Plan.** On August 24, 2013, Indiana Governor Mike Pence delivered the national weekly Republican address and touted the Healthy Indiana Plan (HIP) for delivering "improved outcomes" and 95% satisfaction. Pence reiterated his efforts to secure Federal approval of HIP as the vehicle to tap Medicaid expansion funds.

# *Iowa*

## HMA Roundup

**Iowa Files Waiver Request for Medicaid Expansion.** On August 23, 2013, Governor Terry Branstad submitted a waiver request with Federal officials that would expand Medicaid. The state has requested expedited approval for the hybrid approach, which would expand traditional Medicaid coverage for individuals earning up to 100 percent of the Federal Poverty Level (FPL) while fully subsidizing the purchase of private insurance for those making up to 138 percent FPL. Rather than co-pays, the state will require modest contributions toward premiums for all those earnings at least 50 percent FPL.

# *Louisiana*

## HMA Roundup

**Jindal Opts Out of Community First Choice.** On August 19, 2013, the Jindal Administration withdrew its application to participate in the Community First Choice Program, aimed at diverting Medicaid beneficiaries from institutional settings into home and community-based settings. The program would have boosted federal funding for home health care services from 62 percent to 68 percent. Calder Lynch, director of the Louisiana Department of Health and Hospitals, said the key challenge in the program was expanding eligibility to 21,000 more Medicaid recipients, which was deemed as fiscally untenable for the state.

**Medicaid Primary Care and Mental Health Waiver Program Extended.** On August 23, 2013, the Louisiana Department of Health and Hospitals announced a one-year extension on a Medicaid waiver program that allows up to 60,000 of otherwise Medicaid-ineligible people to receive primary care and mental health care at 40 area clinics. DHH will extend $6.1 million in funding to the Greater New Orleans Community Health Connection in re-

turn for dropping the income threshold to 100 percent (from the previous 200 percent) of federal poverty level and reducing provider rates by 13 percent.

**Changes to Medicaid Eligibility Criteria:** DHH announced that effective January 1, 2014 the income thresholds for the following eligibility groups will change:

- **LaMOMS (pregnant women):** Income limits for pregnant women eligible for LaMOMs will reduce from up to 200 percent of the Federal Poverty Level (FPL) to 133 percent.
- **Medicaid Purchase Plan (MPP):** Income limits for individuals eligible for MPP, often referred to as the "Ticket to Work" program for working people with disabilities, will reduce from 250 percent FPL to 100 percent. Income and resources for spouses, previously not considered to determine eligibility, will count beginning January 1, 2014. Also, the resource limit will reduce from $25,000 to $10,000, and all life insurance policies, medical savings accounts, and retirement accounts will no longer be disregarded. DHH anticipates this change will affect nearly 1,200 individuals enrolled in the program, with 700 of that number having Medicare coverage as their primary insurance.
- **Disability Medicaid:** The Disability Medicaid program, which was implemented in 2007, currently provides coverage to individuals 65 or older, or that meet the disability requirements as defined by the Social Security Administration (SSA), and whose income is below the Supplemental Security Income (SSI) program limit (currently $730 per month for an individual). On January 1, the Disability Medicaid program will end. Individuals, who receive SSI cash benefits, are automatically enrolled in Medicaid. Therefore, the more than 9,200 individuals currently enrolled in the Disability Medicaid program are urged to apply for SSI as soon as possible. If these individuals are not determined to be eligible for SSI, or another Medicaid program, by January 1, they will no longer receive Medicaid effective December 31, 2013. Applicants who apply for Medicaid on or after January 1, 2014 will be referred to SSI if the applicant appears to meet the eligibility criteria for SSI.

## *Michigan*

### HMA Roundup—Esther Reagan

**Senate Approves Medicaid Expansion.** On August 27, 2013, after a failed vote earlier in the day, the Senate passed a substitute version of HB 4714, which would expand Medicaid and create the Healthy Michigan Plan. The Senate substitute will be transmitted to the House for concurrence. House Speaker Jase Bolger said in a statement that the House will vote September 3, 2013 to concur with the Senate version so the bill can be quickly presented to Governor Rick Snyder. The bill, as passed by the Senate, does not authorize "immediate effect" for implementation, meaning that Medicaid expansion in Michigan would not be take effect until April of 2014.

The bill requires nondisabled enrollees to have co-payments after six months on the program and absorb greater cost sharing after four years on Medicaid. In addition, the newly expanded eligible population would be dropped if savings from the expansion do not

cover the state's cumulative costs, which the Senate projects to be around 2027. One change to the House's version of Medicaid expansion, passed overwhelmingly in June 2013, was that hospitals could not charge uninsured individuals with income below 250 percent (rather than 500 percent) of the Federal Poverty Level (FPL) more than 115 percent of Medicare reimbursement.

## *Nebraska*

### HMA Roundup

**Four Insurers to Offer Exchange Plans**. On August 21, 2013, the 11-member Nebraska Exchange Stakeholder Commission met for the first time. Martin Swanson, assistant state insurance director, said that the state Department of Insurance was reviewing four insurance carriers that filed their intentions and proposed rates for the exchange: Blue Cross Blue Shield of Nebraska, Coventry Health Care, CoOpportunity Health and Health Alliance Midwest. The review process should be complete by the end of August and rates would then be made available online. In September, the companies will obtain final approval from the US Department of Health and Human Services. United Health Group did not choose to participate in the exchange this year.

## *New Hampshire*

### HMA Roundup

The Department of Health and Human Services announced that the state's Medicaid managed care program is now scheduled to go live on December 1, 2013. Centene, Meridian Health Plan and BMC HealthNet were awarded Medicaid managed care contracts in April 2012. The program was originally scheduled to start in July 2012 but was subsequently delayed due to contracting challenges between health plans and local providers.

## *New York*

### HMA Roundup—Denise Soffel

**Helgerson Offers Timeline on Transition of Behavioral Health Services.** In mid-August, NYS Medicaid Director Jason Helgerson offered an update on the transition of Behavioral Health Services. The Medicaid Redesign Team (MRT) recommended a transformation of the current fee for service system to Medicaid Managed Care for Medicaid enrolled individuals with Substance Use Disorder (SUD) and Mental Health (MH) treatment needs. Due to significant feedback from multiple stakeholders the state had to delay final Request for Qualification (RFQ) specifications and rate development for Health and Recovery Plans (HARPs) and non-HARP plans. The revised dates are as follows:

- January 1, 2015: Implementation BH Adults in NYC (HARP and Non HARP)
- July 1, 2015: Implementation BH Adults in Rest of State (HARP and Non HARP)
- January 1, 2016: Implementation BH Children Statewide

**Court Extends Halt on Plan to Bid-Out Health Insurance for City Workers.** Following a court ruling that halted New York City's plan to evaluate bids to cover city employee's health benefits earlier in August, the initiative will remain on hold until September 16,

when the court can hear more arguments. Mayor Bloomberg had hoped to solicit bids in August.

**Health Exchange Dubbed New York State of Health.** Last week, New York's health exchange was rebranded as "New York State of Health". The exchange director, Donna Frescatore, announced the participating health and dental plans available in the new marketplace, including Affinity Health Plan, American Progressive, Capital District Physicians Health Plan, EmblemHealth, Empire BlueCrossBlueShield, Excellus BCBS in Central New York and Univera in Western New York, Fidelis Care, Freelancers Co-Op, Healthfirst, HealthNow, Independent Health, MetroPlus Health Plan, MVP Health Plan, North Shore-LIJ, Oscar Insurance Corp., United Healthcare, and Oxford.

**Aetna Withdraws from Individual Exchange.** Absent from the list of participating health plans was Aetna, which had originally filed to offer plans in April, but subsequently withdrew. This action mirrors the company's withdrawals from multiple other state exchanges. Aetna indicated it would continue to offer small-group and large-group plans, in addition to individual plans outside the exchange.

**Brooklyn Judge Orders Removal of LICH from SUNY Downstate.** On August 20, 2013, Brooklyn Supreme Court Judge Carolyn Demarest issued an order that removes Long Island College Hospital from SUNY Downstate's control, rescinding a previous order she issued in May 2011 transferring LICH from Continuum Health Partners to SUNY. Demarest acted on her own accord, rather than in response to matters before the court, and blasted SUNY for trying to shut down the hospital. Continuum expressed no interest to assume management of LICH. The judge proffered that a caretaker or receiver might be appointed if Continuum refused to manage the hospital.

**Interfaith Remains Open Through mid-September.** On August 26, 2013, a bankruptcy court ruled that the Interfaith Medical Center could remain open through September 11. New York State had previously moved to shut down the Bedford Stuyvesant hospital given its extensive losses, but failed to conduct the legally required 90-day review. Some 1,544 doctors, nurses and other staffers are slated to be laid off on Sept. 11.

## *Pennsylvania*

### HMA Roundup –Matt Roan

**Democrats Worry About Drop in CHIP Enrollment; Optimistic About Medicaid Expansion.** Senator Jay Costa (D-Allegheny County) has expressed concerns over a drop in Children's Health Insurance Program (CHIP) enrollment, which Senate Democrats are attributing to the arduous process required for CHIP eligibility renewals and initial applications. The Pennsylvania Department of Insurance, which administers the CHIP program says that the drop in enrollment is more likely due to decreased marketing of the program as television and radio advertisements have been cut due to budget constraints. The continuing existence of the CHIP program has been called into question with the implementation the exchange on January 1, 2014. If the state decides to pursue Medicaid Expansion, CHIP enrollees with the lowest incomes will be transitioned to the Medicaid program. Governor Corbett has said that he wants to maintain these children in the CHIP program and has asked HHS to grant a waiver to allow this. Thus far HHS has indicated

that they do not have the authority to approve such an approach. Meanwhile, Senator Costa has expressed optimism that the Governor will moderate his position on Medicaid expansion to soften his image in light of a difficult re-election campaign next year. The Department of Public Welfare has been in negotiations with HHS to reach a deal on a plan that the Governor is comfortable with to move forward with expansion. The Department has not released any details of the plan.

**Independence Blue Cross Marketing Directly to Uninsured.** As insurers prepare to sell individual policies to the uninsured through the Exchange, which will be implemented on October 1, 2013, Independence Blue Cross has taken their marketing message to the people. Using sophisticated targeting data, Independence Blue Cross (IBC) has identified neighborhoods with high concentrations of the uninsured and is deploying a mobile marketing operation that can be set up at festivals, athletic events, and community gatherings. IBC has indicated that they will also canvass neighborhoods door to door to try to capture this new market of potential enrollees. The IBC approach may be more aggressive than other insurers who have relied on pop-up retail store fronts and more traditional direct mail and mass media advertising.

**Geisinger Criticizes Highmark for Unfair Contracting.** While the dispute between Highmark and the University of Pittsburgh Medical Center (UPMC) about provider contracting have been ongoing, a health system in Central Pennsylvania has entered the fray by leveling charges in the media that Highmark is engaging in unfair contracting practices. Geisinger Health System has taken ads out in newspapers across central Pennsylvania criticizing Highmark for its tiering approach for provider contracts. Under the approach, Highmark provides incentives to its members in the form of lower out-of-pocket costs to seek care at facilities that are deemed to be low cost. Geisinger Health System has been tiered as a high-cost hospital system and contend that the policy will require Highmark members to pay more or travel long distances to receive services. In the Pittsburgh area, UPMC has accused Highmark of using the policy to drive volume away from UPMC facilities and into facilities in the West Penn Allegheny Health System, which was recently purchased by Highmark.

**Health Partners of Philadelphia to Re-Enter Medicare Advantage Market.** Health Partners of Philadelphia, a hospital-owned health plan that currently serves the Medicaid population in Southeastern Pennsylvania, has announced that it is applying to become a Medicare Advantage Plan. Health Partners had previously owned a Medicare Advantage plan called Senior Partners which it sold to Elder Health Inc. of Baltimore, MD in 2007 and was eventually purchased through a chain of acquisitions by Cigna. Health Partners has stated that with an increasing focus on coordination of Medicaid and Medicare benefits and with an aging population, getting back into the Medicare business makes sense for the organization.

# *Puerto Rico*

## HMA Roundup – Juan Montanez

The administration of Governor Alejandro Garcia Padilla continues to make progress towards implementing the vision for health care reform that it has laid out. Implementation of reform will include piloting a different service delivery and payment model and it may include a public health insurance exchange. Progress to date includes:

- **Appointment of Dr. Jorge Sanchez to serve as Governor Garcia Padilla's Senior Health Policy Advisor.** Both Gov. Garcia Padilla and Dr. Sanchez have stated repeatedly that the public policy of the Garcia Padilla administration is to find mechanisms to reduce or eliminate the uninsured population in Puerto Rico and to improve the cost-efficiency of health care overall by creating a "universal access" health care system.
- **Establishment of a Health Reform Commission.** The Commission is a multidisciplinary group that is reviewing the current health care system of Puerto Rico, especially with regards to the uninsured and the high-cost Government Health Insurance Plan (or GHIP, locally known as MI Salud). The current goal is to have this Commission issue a report by October/November and for the proposed pilot to start early next year.
- **Submission of a Health Care Innovation Award grant application.** The goal of the grant application is to obtain "seed" funding for implementing and testing the aforementioned pilot. It is believed that this model has elements of a patient-centered medical home, but the model itself has not been finalized or announced publicly. The population within the scope of the model is also not finalized.
- **Renegotiation of contracts with the entities responsible for administering benefits within the GHIP.** The Health Insurance Administration (known as ASES, by its Spanish acronym) is the public corporation responsible for managing the GHIP. In the spring, it renegotiated benefit administration contracts for the GHIP. The outcome of these negotiations was:
    - An extension of its contract with APS to continue operating as the managed behavioral health organization for all nine GHIP regions.
    - Triple-S, the insurance company which has been administering physical services for six of the nine GHIP regions under an ASO arrangement for two years, was awarded the other three regions effective October 1st. Concomitantly, the contract which ASES had with Humana for administration of physical services for those three regions would expire October 1st. While Humana has expressed concerns about the negotiation process, it has not officially protested the decision. Perhaps more significantly, the New York Regional Office of CMS has gone public expressing concerns about these changes.
- **Public Health Insurance Exchange.** The Commonwealth is still exploring the option of establishing a health insurance exchange and using $925 million earmarked in the ACA to Puerto Rico for offering premium subsidies within such

an exchange (Puerto Rico has the option to treat these as Medicaid funds). The deadline for Puerto Rico to commit to setting up an exchange is October 1; technically this is also the date by which the exchange would have to be established such that open enrollment can begin on that day.

- **Information Systems Initiatives.** A Medicaid Management Information System (MMIS) capability acquisition initiative has been underway for over a year, with limited progress to date. Ernst & Young has replaced Sellers Dorsey as the primary U.S. based consulting firm working on this initiative. Several MMIS solution providers made presentations in May to officials from ASES and the Department of Health. An Implementation Advance Planning Document (IAPD) detailing the commonwealth's strategy for acquiring MMIS capabilities is tentatively scheduled for submission in September. At present Puerto Rico does not possess MMIS capabilities.

## *Rhode Island*

### HMA Roundup

**RI Exchange Plan Rates Released.** On August 20, 2013, HealthSource RI released monthly rates for the 28 plans from three insurers that will be offered on the state's health exchange. Blue Cross & Blue Shield of Rhode Island, UnitedHealthcare and Neighborhood Health Plan of Rhode Island are the three insurers participating in the exchange.

## *South Dakota*

### HMA Roundup

**MMIS Implementation Timing Still Uncertain.** Five years after signing a $62 million contract with CNSI to upgrade the state's Medicaid management information system, South Dakota officials remain unclear on when work will resume on the project. In 2010, the state cancelled the contract, but both parties have agreed to resume the project, subject to negotiations over timing and milestones.

**Task Force Finds Medicaid Expansion Could Have Mixed Effects.** On Tuesday, August 20, 2013, a task force appointed by Gov. Dennis Daugaard to study Medicaid expansion released a report that concluded that the state would enjoy greater economic activity and cover thousands more lives. On the other hand, state spending would increase by more than $100 million through 2020 and a shortage of physicians could be exacerbated.

## *Utah*

### HMA Roundup

**Governor Puts Off Medicaid Expansion Decision Until 2014.** Utah Governor Gary Herbert announced that he will not make a decision on whether to expand the state's Medicaid program until at least early 2014. Governor Herbert reasoned that his decision timing would align with the state's legislature, which convenes in January 2014. Utah is one of several states yet to decide on whether it will expand Medicaid.

# *Washington*

## HMA Roundup – Doug Porter

**Exchange Board Delays Vote on Finalizing Plans.** Washington's health insurance exchange board postponed a vote scheduled for August 21, 2013 to finalize the plans that would be available through the exchange. Several board members expressed their concerns that the Insurance Commissioner did not approve enough plans for the exchange to provide sufficient options for enrollees. Commissioner Mike Kreidler has been criticized for rejecting five out of the nine plans that applied: Molina, Centene, Community Health Plan of Washington, Kaiser, and Moda. At least three of the rejected plans have appealed the Commissioner's decision. Advocates are pushing Kreidler to request additional time from the federal government to work with rejected plans to meet the standards to be included in the exchange.

# *Wisconsin*

## HMA Roundup

**Wisconsin Budget Increases Ability to Recover Assets for Medicaid LTC Costs.** A provision in the Wisconsin state budget is causing concern among advocates for elderly Medicaid recipients. The provision was intended to restrict the ability of individuals to protect assets in trusts or through other methods from being subject to Medicaid spend-down requirements. The provision eliminates exemptions on transferring assets to family members and, according to *Modern Healthcare*, "means a Wisconsin resident seeking Medicaid coverage for long-term care would have to sell his or her assets, such as a share of a family business or farmland, for full market value even if it was going to a child."

# *National*

## HMA Roundup

**150,000 Medicaid Enrollees Could Lose Coverage Next Year, Kaiser Reports.** As many as 150,000 current Medicaid enrollees in four states may lose coverage next year, even as states expand Medicaid under the Affordable Care Act. According to *Kaiser Health News*, Maine, Rhode Island, Wisconsin, and Vermont all plan to reduce their Medicaid rolls, either through changing eligibility thresholds, eliminating waiver programs, or transitioning enrollees to the private insurance market.

**Hospitals among Thousands Applying to Help in Exchange Enrollment.** The Department of Health & Human Services (HHS) announced that it has received more than 1,000 applications from organizations interested in serving as Certified Application Counselors to help individuals enroll in the health insurance exchanges. The *American Hospital Association News* reports that hospitals are among the applicants.

## 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 |
|---|---|---|---|
| August, 2013 | Wisconsin MLTC (Select Regions) | Contract awards | 10,000 |
| September 1, 2013 | Idaho Behavioral | Implementation | 200,000 |
| September 1, 2013 | Florida LTC (Regions 8,9) | Implementation | 14,000 |
| September 16, 2013 | Florida acute care | Contract awards | 2,800,000 |
| September 20, 2013 | Massachusetts CarePlus (ACA) | Contract Awards | 305,000 |
| Summer 2013 | Rhode Island Duals | Contract Awards | 22,700 |
| Summer 2013 | South Carolina Duals | RFP Released | 68,000 |
| Summer 2013 | Michigan Duals | RFP Released | 70,000 |
| October 1, 2013 | Massachusetts Duals | Implementation | 115,000 |
| October 1, 2013 | Arizona - Acute Care | Implementation | 1,100,000 |
| October 1, 2013 | Arizona - Maricopa Behavioral | Implementation | N/A |
| October 1, 2013 | Tennessee | RFP Released | 1,200,000 |
| November 1, 2013 | Rhode Island Duals | Implementation | 22,700 |
| November 1, 2013 | Florida LTC (Regions 1,2,10) | Implementation | 13,700 |
| November 1, 2013 | Hawaii | Proposals Due | 292,000 |
| December 1, 2013 | New Hampshire | Implementation | 130,000 |
| December 1, 2013 | Florida LTC (Region 11) | Implementation | 16,400 |
| "Early 2014" | North Carolina | RFP released | TBD |
| January 1, 2014 | Massachusetts CarePlus (ACA) | Implementation | 305,000 |
| January 1, 2014 | Illinois Duals | Implementation | 136,000 |
| January 1, 2014 | California Duals | Implementation | 456,000 |
| January 1, 2014 | New Mexico | Implementation | 510,000 |
| January 1, 2014 | Wisconsin MLTC (Select Regions) | Implementation | 10,000 |
| January 1, 2014 | Virginia Duals | Implementation | 79,000 |
| January 1, 2014 | Texas Duals | Implementation | 214,400 |
| January 6, 2014 | Hawaii | Contract Awards | 292,000 |
| February 1, 2014 | Florida LTC (Regions 5,6) | Implementation | 19,500 |
| March 1, 2014 | Florida LTC (Regions 3,4) | Implementation | 16,700 |
| April 1, 2014 | Ohio Duals | Implementation | 115,000 |
| April 1, 2014 | Idaho Duals | Implementation | 17,700 |
| April 1, 2014 | Washington Duals | Implementation | 48,500 |
| July 1, 2014 | South Carolina Duals | Implementation | 68,000 |
| July 1, 2014 | New York Duals | Implementation | 178,000 |
| July 1, 2014 | Michigan Duals | Implementation | 70,000 |
| September 1, 2014 | Vermont Duals | Implementation | 22,000 |
| September 1, 2014 | Texas Rural STAR+PLUS | Operational Start Date | 110,000 |
| October 1, 2014 | Florida acute care | Implementation (All Regions) | 2,800,000 |
| January 1, 2015 | Hawaii | Implementation | 292,000 |

# 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 | Health Plans |
|---|---|---|---|---|---|---|---|---|
| Arizona | | 98,235 | Not pursuing Financial Alignment Model | | | | | |
| **California** | Capitated | 456,000 | X | 3/1/2012 | 4/4/2012 | 3/27/2013 | 4/1/2014 | 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 |
| **Colorado** | MFFS | 62,982 | | | | | 11/1/2013 | |
| **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 | 1/1/2014 | Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina |
| **Iowa** | MFFS | 62,714 | | | | | TBD | |
| **Idaho** | Capitated | 22,548 | June 2013 | TBD | August 2013 | | 4/1/2014 | Blue Cross of Idaho |
| **Massachusetts** | Capitated | 109,636 | X | 8/20/2012 | 11/5/2012 | 8/22/2013 | 1/1/2014 | Commonwealth Care Alliance; Fallon Total Care; Network Health |
| **Michigan** | Capitated | 70,000 | X | 8/26/2013 | TBD | | 7/1/2014 | |
| **Missouri** | MFFS‡ | 6,380 | | | | | 10/1/2012 | |
| 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 | 4/1/2014 | |
| **North Carolina** | MFFS | 222,151 | | | | | TBD | |
| **Ohio** | Capitated | 114,000 | X | 5/25/2012 | Scoring: 6/28/12 | 12/11/2012 | 4/1/2014 | Aetna; CareSource; Centene; Molina; UnitedHealth |
| **Oklahoma** | MFFS | 104,258 | | | | | TBD | |
| Oregon | | 68,000 | Not pursuing Financial Alignment Model | | | | | |
| **Rhode Island** | Capitated | 22,700 | X | 3/27/2013 | August 2013 | | 11/1/2013* | |
| **South Carolina** | Capitated | 68,000 | Summer 2013 | TBD | TBD | | 7/1/2014 | |
| Tennessee | | 136,000 | Not pursuing Financial Alignment Model | | | | | |
| **Texas** | Capitated | 214,402 | | | | | 1/1/2014 | |
| **Virginia** | Capitated | 78,596 | X | 5/15/2013 | 6/27/2013 | 5/21/2013 | 1/1/2014 | Humana; VA Premier; WellPoint/Amerigroup |
| **Vermont** | Capitated | 22,000 | 10/1/2013 | TBD | TBD | | 9/1/2014 | |
| **Washington** | MMFS<br>Capitated | 115,000 | X<br>X | 5/15/2013 | 6/6/2013 | MFFS Only | 7/1/2013<br>1/1/2014 | Regence BCBS/AmeriHealth; UnitedHealth |
| Wisconsin | Capitated | 5,500-6,000 | X | Not pursuing Financial Alignment Model | | | | |
| ***Totals*** | **14 Capitated<br>6 MFFS** | **1.5M Capitated<br>485K FFS** | ***9*** | | | ***7*** | | |

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

*** Wisconsin is completing a comment period on a draft MOU with CMS. Finalized MOU will determine implementation date.*

*‡ Capitated duals integration model for health homes population.*

## HMA News

### HMA Organizes Texas SIM Conference for Stakeholders

On August 20-21, HMA's Austin-based consultants organized a State Innovation Models (SIM) conference for 200 stakeholders in Austin, Texas, to present and discuss potential approaches and models under consideration for the State Healthcare Innovation Plan that Texas will submit to CMS before the end of the year. HMA's Linda Wertz, Dianne Longley, Lisa Duchon and Glenda Stepchinski were program speakers and panel moderators. Included in the program were. Dr. Art Jones, from HMA's Chicago office also made a conference presentation called, "Building the Bridge from Fee-for-Service to Accountable Care." HMA is supporting the state in conducting stakeholder engagement and in developing its plan.

### HMA-authored Report for SAMHSA-HRSA Looks at Health Homes

The SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) engaged Health Management Associates (HMA) to outline key areas of a recently enacted provision of the Affordable Care Act that permits Medicaid coverage of health homes, a service delivery model supporting care coordination and related supports for individuals with chronic conditions, including those with mental and substance use conditions.

HMA's team of Managing Principal Jennifer N. Edwards and Principals Katharine V. Lyon, Juan Montanez, and Alicia D. Smith created "Financing and Policy Considerations for Medicaid Health Homes for Individuals with Behavioral Health Conditions: A Discussion of Selected States' Approaches." (Link to Report)

## HMA Upcoming Appearances

*"Assuring Innovation in the Era of Healthcare Reform"*

**Sponsored by: Healthcare Businesswomen's Association and Deloitte**

**Mona Shah, Panelist**

*September 12, 2013*

*Costa Mesa, California*

*"Health Insurance Exchanges"*

**American Institute of CPAs Healthcare Industry Conference**

**Barbara Markham Smith, Presenter**

*November 15, 2013*

*New Orleans, Louisiana*