HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: LOUISIANA RELEASES MANAGED LTSS CONCEPT PAPER

HMA ROUNDUP: MICHIGAN MEDICAID EXPANSION BILL SENT TO GOVERNOR FOR SIGNATURE; TEXAS ANNOUNCES CONTRACT AWARDS FOR STAR+PLUS RURAL SERVICE AREAS; INDIANA ANNOUNCES ONE-YEAR EXTENSION OF HEALTHY INDIANA PLAN; MAINE HOSPITALS TO RECEIVE $490M IN BACKLOGGED MEDICAID PAYMENTS; NEW YORK PROVIDES ADDITIONAL DETAILS ON FIDA PROGRAM; WASHINGTON APPROVES TWO MORE PLANS FOR EXCHANGE PARTICIPATION

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HMA NEWS: UPCOMING APPEARANCES BY MONA SHAH, JOAN HENNEBERRY, AND BARBARA MARKHAM SMITH

SEPTEMBER 4, 2013

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: LOUISIANA RELEASES MANAGED LTSS CONCEPT PAPER

This week, our *In Focus* reviews a concept paper released by the Louisiana Department of Health and Hospitals (DHH) on August 30, 2013, detailing the initial design for a managed long-term supports and services (MLTSS) program in the state. The concept paper, available here, provides the foundation for a transition to MLTSS and calls for additional stakeholder guidance in key areas as DHH prepares to procure managed care organizations to provide better coordinate and integrated care for Medicaid and dual eligible populations receiving Medicaid-funded long term care supports and services.

MLTSS Transition Taking Shape

- **Competitive procurement through RFP.** DHH will procure MLTSS plans through a competitive request for proposals (RFP) process, although as noted below, the schedule for the release of the RFP is unclear at this time. DHH indicates that scoring of RFP responses will place "significant value" on bidders' previous experience with LTC populations, including provider network development, proven clinical tools, and engagement with stakeholders and advocacy groups.
- **Dual Eligibles to be included.** There are roughly 100,000 individuals in Louisiana dually eligible for Medicaid and Medicare. It is DHH's intention to include these individuals in the MLTSS program, along with those Medicaid-only LTSS recipients.
- **Persons with developmental disabilities included, seeking input on procurement, timing.** Covered benefits and services under the proposed MLTSS program will include in-home services and employment supports. As such, DHH believes that the program will greatly benefit those persons with developmental disabilities (DD population), who are typically excluded from managed LTC programs. DHH is seeking stakeholder input on the timing for the transition of the DD and elderly populations into MLTSS. Additionally, DHH is seeking input on whether to pursue the option of a separate procurement for MLTSS for the DD population.
- **Mandatory enrollment.** DHH will pursue mandatory enrollment for the MLTSS program and under the proposed mandatory enrollment model seeks to provide outreach and education and a strong emphasis on consumer choice of MCOs.
- **Limited service carve-outs, behavioral health carved-in.** Responses from the RFI and additional stakeholder comment to DHH indicates that benefit/service carve-outs should be as limited as possible, and that behavioral health benefits should be a covered benefit under the MLTSS program.
- **No dual eligible financial alignment demonstration at this time.** DHH is not committed to a fully integrated approach with Medicaid and Medicare at this time. However DHH is seeking stakeholder input on how to best coordinate Medicaid benefits and services with Medicare for dual eligible beneficiaries enrolled in the MLTSS program.

- **Emphasis on care management for chronic conditions, behavioral health.** The RFP will likely be structured to emphasize care coordination and care management for populations with chronic conditions. RFI responses indicated a high prevalence of beneficiaries with co-existing conditions whose needs may be met through a fully integrated care management model.
- **Timing unknown, public comment desired, advisory group to be formed.** DHH is not providing a timeline for the RFP or MLTSS start date as of now. Rather, the concept paper is intended to kick off public and stakeholder comment and discussion regarding the state's plans. An advisory group will be formed consisting of advocates, consumers, government, and provider representatives. Information on future public meeting notices will be provided here at a later date.

Managed LTSS Transition Background

On November 29, 2012, DHH issued a request for information (RFI) for input on transforming the Medicaid long-term care system in Louisiana. A link to the RFI is available here. Responses from 18 organizations were made public in February 2013 and are provided as a link below.

1. Advocacy Center
2. Aetna Better Health
3. Amerigroup Louisiana, Inc.
4. Alere
5. AmeriHealth Mercy
6. Community Health Solutions of Louisiana
7. The Council on Quality and Leadership
8. Humana
9. Louisiana Developmental Disabilities Council
10. Louisiana Health Care Quality Forum
11. Louisiana Healthcare Connections
12. Louisiana Nursing Home Association
13. Magellan Health Services
14. Maximus
15. Peoples Health
16. Seniorlink
17. UnitedHealthcare Community Plan
18. WellCare Health Plans, Inc.

Existing LTSS Structure

Medicaid Managed Care. Louisiana implemented the Bayou Health Medicaid managed care program on a statewide basis in early 2012. Dual eligibles, individuals residing in facilities, and certain Medicaid waiver enrollees were excluded from enrollment in the program. Additionally, although Medicaid-only individuals with LTSS needs are enrolled in Bayou Health managed care organizations (MCOs), the MCOs are not responsible for the provision of LTSS benefits for this population. Under the Bayou Health Medicaid managed care program, LTSS are carved out of the capitated rate and paid under Medicaid fee-for-service (FFS). Bayou Health enrollment by MCO from August 2013 is detailed in the table below.

	August 2013 Enrollment	% of Total
United Healthcare	257,359	25.9%
Louisiana Healthcare Connections (Centene)	254,932	25.7%
Community Health Solutions	202,659	20.4%
LaCare (AmeriHealth Caritas)	147,465	14.8%
Amerigroup (WellPoint)	131,036	13.2%
Total Bayou Health Enrollment	**993,451**	

Source: State Enrollment Data

Medicaid Behavioral Health. Today, the state operates a separate Medicaid behavioral health program, called the Louisiana Behavioral Health Partnership. Beginning in 2012, Magellan Health Services has provided behavioral health services to more than 1 million adults and children as the sole contractor under the Behavioral Health Partnership.

PACE Programs. Louisiana operates two Program for All-Inclusive Care of the Elderly (PACE) plans, one in New Orleans and one in Baton Rouge. As of August 2013, each plan enrolled less than 150 enrollees.

HMA Medicaid Roundup

Alabama

HMA Roundup

HHS Finds Alabama Has Been Overpaid by $88M Over Two Years. A recent report by the Office of the Inspector General found that the US Department of Health & Human Services overpaid the state of Alabama more than $88 million for its Medicaid program. State officials miscalculated the number of children enrolled in the program between 2009 and 2010 by more than 92,000, reporting an annual total rather than rolling monthly averages. As a result, Alabama received nearly one third of all bonus payments ($295 million) paid by CMS: $95 million instead of $7 million. State officials are uncertain if the state can repay the overage.

California

HMA Roundup—Jennifer Kent

Covered California Online Comparison Tool Now Available. On Thursday, August 30, 2013, Covered California launched an online price comparison tool that allows consumers to get more specifics on the premiums of different plans on the exchange. Previously, the online tools only offered general estimates of statewide premiums, without adjustments for plan, zip code, and age of qualified beneficiaries.

Democrats Propose $200M in Additional Funds for Correctional Health. On August 28, 2013, Democratic State Senate leaders proposed spending more than $200 million in additional funds on rehabilitation, drug treatment, and mental health services in exchange for a three year extension on Federal judges' December 31, 2013 deadline for reducing state inmates by 9,600. Governor Jerry Brown had proposed spending more than $1.1 billion through the end of 2015 to pay for temporary additions to the state's prison capacity. Brown castigated the Senate proposal for kowtowing to prison plaintiffs who generally favor early release of inmates. The legislature's last meeting day is September 13, 2013, leaving little time for an agreement that would satisfy Federal judges?

Colorado

HMA Roundup—Joan Henneberry

Healthcare Driving Much of the Hiring in Colorado. The Colorado Department of Labor and Employment has posted the 10 employers with the most online help-wanted ads in July to fill positions in the state. According to an article in the Denver Business Journal, five of the top ten companies are healthcare providers or organizations: Centura Health, Exempla Healthcare, Health One, Banner Health, and Brookdale Senior Living.

Mobile App Launched for Consumers. The Colorado Consumer Health Initiative recently launched the Blue Guide, a mobile app for Android devices that helps people search for health insurance or clinicians throughout the state. The Blue Guide web tools and mobile apps empower consumers to identify the best and most appropriate health plans and providers based on location, medical condition, language and other criteria.

Connecticut

HMA Roundup

DSS Announces Extension of Medicaid and Food Stamp Benefits. As an unfortunate result of an IT modernization effort designed to streamline eligibility applications and renewals, the Department of Social Services (DSS) recently experienced glitches in the scanning of paperwork into its system, impacting access to records. As a result, on August 29, 2013, DSS announced a temporary extension of Medicaid and Food Stamp benefits for about 15,500 households, some of whom had received earlier notices about their potential loss in benefits. The Department's scanning vendor has recently expanded staff and hopes to address the backlog in documents by the end of this week.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Managed Long Term Care Program Goes Live in Southwest Florida. On September 1, 2013, as part of the overall transition of nearly all Florida beneficiaries to Medicaid managed care, the managed long-term care program went live for more than 13,000 beneficiaries in twelve southwest Florida counties. The state is progressing in its transition of nearly 90,000 Medicaid long-term care beneficiaries into the new program.

RAND Study Finds that ACA is Unlikely to Cause Individual Premiums to Spike. A recent RAND Corporation study concluded that the Affordable Care Act is unlikely to cause a spike in health insurance premiums in the individual market, in contrast to statements made by the Florida Insurance Commissioner, Kevin McCarty. In late July, McCarty projected that premiums would increase by 30 to 40 percent for the 5 percent of Floridians who purchased their own policies (rather than participating in employer-sponsored, group-coverage, or Medicaid) due to guaranteed issue. RAND concludes that premiums for individual policies and small group plans would not rise materially, if at all, due to an influx of healthy young people due to the individual mandate and tax credits that would offset out-of-pocket costs.

Florida Has the Second Highest Rate of Uninsured Non-Seniors. In a Census report released on August 29, 2013, Florida has the second highest rate of uninsured residents under the age of 65. About 3.8 million people, or nearly a quarter of the state's population, are uninsured, including nearly 750,000 in Miami-Dade County alone. Miami-Dade has a 34.4 percent uninsured rate among non-seniors, second highest among the 67 counties in Florida. Democrats called on the legislature to approve Medicaid expansion to address the uninsured problem.

Georgia

HMA Roundup – Mark Trail

Reform Committee Meets: On August 28th, the Joint Study Committee on Medicaid Reform held its first meeting and included a presentation by Department of Community Health (DCH) Commissioner Clyde Reese and Medicaid Division Chief Jerry Dubberly. In the presentation, DCH identified the key impacts of the Affordable Care Act on the Georgia Medicaid program including:

- DCH expects 46,000 Georgians in FY14 and 65,000 in FY15 to enroll in Medicaid who are currently eligible but not enrolled ("woodwork effect"). DCH estimates the state cost to be $14.3 million in FY 2014 and $40.9 million in FY 2015.
- DCH estimates the cost of increasing capitation payments to MCOs to offset the federal premium tax on managed care companies to be $29.3 million in FY 2015.
- Based on the increase in the minimum income eligibility threshold for Medicaid from 100 percent of the federal poverty limit to 138 percent, DCH estimates approximately 59,000 children will switch from PeachCare (CHIP) to Medicaid.
- DCH will conduct 12 month eligibility reviews for adults and children at a cost of $9.7 million in FY 2014 and $28.7 million in FY 2015. DCH currently conducts 6 month eligibility reviews for adults and children.

Indiana

HMA Roundup—Cathy Rudd

Pence Announces One-Year Extension of Healthy Indiana Plan. On September 3, 2013, Governor Mike Pence announced CMS approval for a one-year extension of the Healthy Indiana Plan (HIP) through December 31, 2014. Debra Minott, Secretary of Indiana Family and Social Services Administration praised the agreement for preserving the consumer-driven Healthy Indiana Plan whose five-year waiver granted in 2008 had been slated to end on December 2013. CMS stipulated that eligibility would be limited to adults under 100 percent of the federal poverty level (rather than the current 200 percent) and the state must develop a transition plan for current enrollees who would no longer qualify under the new income limits, estimated at nearly 10,000 of the 37,000 currently on the program. On the other hand, HIP will be able to enroll thousands of new residents from the waiting list, which currently stands at more than 50,000.

Indiana Moving Toward Changing Medicaid Disability Eligibility. The Journal Gazette reports that Indiana is on the verge of changing its Medicaid disability eligibility process in an effort to streamline administration and save money. After more than a decade of consideration, the Indiana Family and Social Services Administration (FSSA) appears on the brink of filing for Federal approval to transition from a 209 (b) state to a 1634 state. Section 209(b) of the Social Security Amendments of 1972 allows states the option of using their own criteria for Medicaid. Under Section 1634 of the Social Security Act, states may automatically enroll Supplemental Security Income recipients in Medicaid disability benefits. Disability advocates have been pushing to state toward 1634 status for years, which would help some 18,000 SSI-eligible residents access Medicaid. Debra Minott, head of the FSSA, believes that the request will be submitted to CMS soon, with an expected switchover by April 2014. FSSA projects $23.6 million in savings in the first full year of implementation, due to lower administrative costs.

Maine

HMA Roundup

Democrat Vitelli Defeats Republican Benoit in Special Election. On August 27, 2013, Democrat Eloise Vitelli narrowly defeated Republican Paula Benoit by a vote of 4,621 to 4,339 in a special election in Senate District 19. The election was viewed as meaningful given the district's history of switching representatives between the parties and preserved the Democrats' 19-15 edge in the Maine state Senate. Medicaid expansion was a key contentious issue, with Vitelli supporting it and Benoit opposing it, in line with Governor Paul LePage. It is expected that Medicaid expansion legislation will emerge again in 2014 and the election result slightly improves the prospects of a veto override.

Maine Hospitals to Receive $490M in Backlogged Medicaid Payments. On September 3, 2013, Governor Paul LePage announced the sale of $183.5 million in state bonds that will go toward paying down $490 million owed to hospitals (adjusted up from $484 million under a recent audit). The payment to the hospitals will trigger about $307 million in Federal Medicaid matching funds. State Controller Terry Brann expects the payments to be made by mid-September.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

ACO Benefits Spillover to General Population. According to a study recently published in the Journal of the American Medical Association, the benefits of accountable care organization (ACO) participation by physicians often extend beyond the covered patient population. Researchers determined that medical groups' participation in Blue Cross Blue Shield of Massachusetts' (BCBSMA) Alternative Quality Contract (AQC) often generated substantial spillover effects in Medicare savings, implying positive externalities from systemic improvements in overall patient care, such as enhanced technological tools and coordination of care.

Michigan

HMA Roundup – Esther Reagan

Medicaid Expansion Passes House; Sent to Governor for Signature. On September 3, 2013, the Michigan House gave final approval for Medicaid expansion in a 75-32 vote, which followed the previous week's 20-18 vote in the Senate. The bill goes to Governor Rick Snyder, who had loudly advocated for Medicaid expansion throughout 2013. However, the version of the legislation does not have "immediate effect", meaning that the measure will only take effect 90 days after the final day of the legislative session in December. As a result, the expansion will not go into effect until late March, rather than January 1, 2014. It is expected that just under half a million Michigan residents will be added to the Medicaid rolls, with full Federal funding for the expansion population. Michigan Department of Community Health Director Jim Haveman estimates that the delay in implementation costs the state about $7 million per day in foregone Federal funding, but Republican legislators dispute the figure.

Minnesota

HMA Roundup

Minnesota Comprehensive Health Association to Be Shut Down. On September 3, 2013, Minnesota will move forward with a plan to close the Minnesota Comprehensive Health Association, which had covered patients with pre-existing conditions. Starting in 2014, the program will stop accepting new enrollments and will close for all enrollees by the end of 2014. Given guaranteed issue, participants will be directed to the state's health exchange, MNsure, or to access individual coverage through a broker. Advocates appear pleased by the flexibility in the transition plan, including an appeals process for individuals having trouble finding appropriate coverage outside MCHA.

New Hampshire

HMA Roundup

New Senate President Has an Open Mind on Medicaid Expansion. Last week, in a unanimous vote by Senate Republicans, Senator Chuck Morse was elected the chamber's new Senate President, effective September 3, 2013. Morse replaced Senator Peter Bragdon, who had faced criticism for taking a position as executive director of the Local Government Center. Morse had previously chaired the Senate Finance Committee. Morse believes that New Hampshire has to fully study Medicaid expansion to determine if it is in the state's best interest, but awaits the findings of the Medicaid commission on October 15.

New York

HMA Roundup—Denise Soffel

NY Duals Demonstration: Additional Details. In a webinar held on August 29, 2013, state officials offered additional details about the Memorandum of Understanding that was signed between the state and CMS for the Fully Integrated Dual Advantage demonstration. The webinar can be replayed and slides downloaded at http://www.health.ny.gov/health_care/medicaid/redesign/

Below are some of the key issues raised during the question and answer session:

- **FIDA plans will be required to have alternative payment arrangements with all providers.** "By December 1, 2014, FIDA plans will be required to develop a plan for a fully integrated payment system through which providers would no longer be paid on a traditional fee-for-service basis but would instead be paid on an alternative basis (e.g., pay for performance, bundled payment). After state approval and no earlier than January 2015, FIDA plans will be required to implement the approved plans, which will remain in effect throughout the duration of the demonstration." (MOU p. 11)
- **Provider credentialing will be uniform for all FIDA plans.** No providers will be grandfathered; every provider will have to go through a standardized credentialing process. "In order to minimize administrative burdens on FIDA Plans and providers, FIDA Plans must employ a single, uniform provider credentialing application that will be developed with the input from FIDA Plans and stakeholders, meet Medicare contracting requirements, and be approved by NYSDOH." (MOU p. 68).
- **Consumer direction must be included in every FIDA plan.** It is an explicit intent of the demonstration to increase consumer direction.
- **The state will establish a Participant Ombuds program** that will provide participants with assistance in accessing care, understanding their rights and responsibilities, and appealing adverse decisions. New York State (NYS) applied to CMS for funding for the Participant Ombuds program in August and expects a decision this month.
- **The FIDA demonstration for individuals with developmental disabilities has not yet been approved.** NYS and CMS will sign a separate MOU providing the details of that demonstration.
- **25 plans have moved into readiness review**; the state anticipated readiness review will be finalized the first quarter of 2014.
- **New York negotiated to have low savings targets.** New York's anticipated savings are low because the state sees the goal of the demonstration as improving care, not saving money.
- **Many aspects of the demonstration remain undecided.** Details of the passive enrollment algorithm are not worked out, except that it is to be an "'intelligent assignment' algorithm for passive enrollment (e.g. that prioritizes continuity of providers and/or services)." (MOU p. 59). Marketing guidelines have not been finalized. Solvency requirements are in final clearance and should be released soon.

Ohio

HMA Roundup

Michigan Medicaid Expansion Inspires Ohio Supporters for a Ballot Initiative. While Governor John Kasich has pushed the legislature to send him a Medicaid expansion bill by October, there appears limited momentum and various alternative bills that promise further delays in a definitive vote. However, following a successful Medicaid expansion vote in Michigan, many supporters of expansion are calling for the Ohio to follow suit. The Ohio Alliance for Health Transformation has launched a campaign to place Medicaid expansion on the November 2014 ballot, should the legislature fail to pass legislation.

Pennsylvania

HMA Roundup – Matt Roan

PA Nearing a Plan for Medicaid Expansion. Pennsylvania Welfare Secretary Bev Mackereth told a south central Pennsylvania civic group last week that the state is closing in on a plan for Medicaid expansion. The Secretary reported that within a month the details of the plan would be announced. Governor Tom Corbett has said that Medicaid expansion is not sustainable without significant reforms to the program. Among the reforms expected to be included in the plan are changes to the way long term care services are delivered, requiring some Medicaid recipients be looking for work, and a streamlining of benefit packages aimed at tailoring less comprehensive coverage for recipients with fewer health needs. No formal plan has been submitted, but the Secretary has been in ongoing discussions with CMS on the conceptual framework for the State's approach. Implementation of any plan for expansion is not expected until 2015.

PA pushes Feds for an Answer on CHIP Program. Governor Corbett is demanding answers from HHS on provisions of the ACA which require certain CHIP eligible children to be transferred into the Medicaid program. The Corbett administration has contended that shifting these children would disrupt services and may require children to change providers. Corbett is looking for HHS to grant a waiver to allow Pennsylvania to maintain current CHIP enrollees in the CHIP program. Children's advocates have observed that the benefit package available in Medicaid is more generous than that offered in CHIP and that shifting to Medicaid would improve services to children. While the state has not formally requested a waiver Corbett has demanded direction from HHS within a week to inform planning related to potential Medicaid expansion.

Texas

HMA Roundup—Dianne Longley and Linda Wertz

Texas Announces STAR+PLUS Contract Awards. On September 3, 2013, Texas announced tentative contract awards for the STAR+PLUS Medicaid managed care program, covering rural service areas, to Amerigroup, HealthSpring, Superior HealthPlan (Centene), and UnitedHealthcare. The STAR+PLUS program covers acute and long-term services and supports to the aged, blind, and disabled population. The three-year awards are contingent upon the successful negotiation with the state and would commence on September 1, 2014.

Washington

HMA Roundup – Doug Porter

Two New Insurers with 10 Plans Approved for Health Benefit Exchange. Following public pressure and an extension offered by CMS, Washington Insurance Commissioner Mike Kreidler approved 10 plans offered by Community Health Plan of Washington and Kaiser Foundation Health Plan of the Northwest for the state's health benefit exchange. Community Health Plan of Washington will feature three plans in 26 counties, while Kaiser will offer seven plans in Clark and Cowlitz Counties. Kreidler previously denied five of the companies that applied to offer coverage because he determined that they failed to meet state and Federal requirements for coverage and/or pricing. Community Health Plan of Washington removed its two-tier pricing structure for co-payments, while Kaiser amended its rate information. Coordinated Care Corporation and Molina have filed appeals.

Washington to Institute Home- and Community Based Behavioral Health Program. On August 29, 2013, Washington state agreed to overhaul its provision of behavioral health services for troubled children and youth. In a class action settlement, the state has agreed to implement intensive in-home and community-based care for at-risk youth, who would otherwise be placed in foster homes or institutions. Approximately 3,000 to 6,000 youth covered by Medicaid will gain access to intensive mental health services delivered in their homes and communities, subject to funding by the Legislature. The state will use the Child and Adolescent Needs and Strengths (CANS) assessment tool and coordinate care among providers, with additional support and stabilization services.

National

HMA Roundup

OIG Report Calls Out CMS for Inadequate Fraud Responses. On September 3, 2013, the Office of the Inspector General released a report that reviewed the Recovery Audit Contractor (RAC) program. RACs identified more than $1.3 billion in improper payments in the 2010 and 2011 time frame, but CMS did not respond to certain referrals of fraud and did not evaluate the effectiveness of its corrective actions, allowing many improper payments to continue. According to the report, CMS failed to institute metrics that evaluated RACs' performance on all contract requirements.

Transitional Care Programs Reduce Readmissions. A recent study published in Health Affairs by Community Care of North Carolina finds that Medicaid transitional care programs, which help recently discharged patients understand how to care for themselves and enhance communication with primary care physicians, have helped reduce hospital readmissions. More than 13,000 Medicaid patients with chronic health conditions who enrolled in the statewide transitional care program between 2010 and 2011 were compared to 8,000 patients who received extra help at discharge. Nearly one readmission was averted for every six patients in the transition program. However, for the sickest patients, one readmission was averted for every three in the program.

INDUSTRY NEWS

Cigna Acquires Alegis Care. On September 3, 2013, Cigna announced the acquisition of Alegis Care from Triton Capital Partners. Alegis Care serves the chronically ill and elderly with physician services and comprehensive care coordination in the patient's home. Cigna plans to deploy Alegis Care services for its Medicare Advantage customers.

MVP and Hudson Health Plan Approved for Merger. On September 3, 2013, MVP Health Care and Hudson Health Plan announced final approval from New York State's Department of Health. Hudson has become a member of the MVP family of companies, which collectively serve more than 730,000 members. MVP is participating in health exchanges, while Hudson will share its expertise in working directly with consumers.

WellCare Management Changes. On August 29, 2013, WellCare announced Kelly Munson as president of its Kentucky operations, responsible for Medicaid and Medicare Advantage businesses, as well as future business initiatives. Munson had been COO of WellCare of Kentucky since August 2012. Munson joined WellCare in 2006, focusing on WellCare Ohio's operations and regulatory compliance. Previously, Munson had worked with World Classics, HomeTown Health Network and Medical Mutual of Ohio.

On September 4, 2013, WellCare announced that Michael Polen has been promoted to the company's newly created position of senior vice president, operations. As a member of WellCare's senior management team, Polen will be responsible for member and provider operations, customer service, acquisition integration, and related activities. He will continue to report to Alec Cunningham, CEO. Polen joined WellCare in 2005, and most recently held the position of vice president, corporate initiatives and strategy. In conjunction with the change, WellCare also announced the departures of Walter Cooper, Chief Administrative Officer, and Dan Paquin, President National Health Plans.

Walgreen Announces Agreements with Orlando and Indianapolis Health Systems. Last week, Walgreen announced clinical collaboration agreements with health systems in Orlando and Indianapolis to provide screenings, immunizations, and management of certain chronic conditions in its in-store clinics. Electronic health records will be deployed to improve coordination of care.

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
TBD	Wisconsin MLTC (Select Regions)	Contract awards	10,000
September 3, 2013	Michigan Duals	Proposals Due	70,000
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
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	9/3/2013	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 Capitated	115,000	X X	5/15/2013	6/6/2013	MFFS Only	7/1/2013 1/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model				
Totals	**14 Capitated 6 MFFS**	**1.5M Capitated 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 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

"Goals and Challenges of Current State Innovation Models"

Driving Transformation in Medicaid (Sponsored by Treo Solutions)

Joan Henneberry, Panelist

September 18, 2013

New York, New York

"Health Insurance Exchanges"

American Institute of CPAs Healthcare Industry Conference

Barbara Markham Smith, Presenter

November 15, 2013

New Orleans, Louisiana