
HMA

HEALTH MANAGEMENT ASSOCIATES

*HMA Weekly Roundup
Trends in State Health Policy*

IN FOCUS: PENNSYLVANIA ANNOUNCES PLAN FOR EXPANDING HEALTH INSURANCE COVERAGE

HMA ROUNDUP: SOUTH CAROLINA DUALS PLAN APPLICANTS REVEALED; MASSACHUSETTS ARIZONA, MAINE, WEST VIRGINIA, AND OKLAHOMA ANNOUNCE EXCHANGE PLANS; ARKANSAS ISSUES RFQ TO IMPLEMENT SHARED SAVINGS PILOT PROGRAM; FLORIDA MEDICAID MCO AWARDS EXPECTED MONDAY; KENTUCKY ANNOUNCES MEDICAID EXPANSION MCO AWARDS; CMS FINALIZES RULE ON MEDICAID DSH PAYMENTS; FEDERAL RULE MANDATES MINIMUM WAGE, OVERTIME PAY FOR HOME CARE WORKERS

INDUSTRY NEWS: DAVITA ANNOUNCES MERGER WITH ARIZONA INTEGRATED PHYSICIANS; MOLINA EXPECTS PARTICIPATION IN NINE STATE HEALTH EXCHANGES; FLORIDA BLUE REORGANIZATION APPROVED

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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: PENNSYLVANIA ANNOUNCES PLAN FOR EXPANDING HEALTH INSURANCE COVERAGE

This week, our *In Focus* reviews the recently announced plans for Healthy PA, Pennsylvania Governor Corbett's plan for reforming the state's Medicaid program and expanding health insurance coverage in the state. HMA's Matt Roan (Harrisburg, Pennsylvania) provides a summary of the Healthy PA plan.

Governor Corbett held a press conference on September 17, 2013, announcing the details of his plan to reform the healthcare system in Pennsylvania. The announcement of the reform, which has been dubbed Healthy PA, came after several days of speculation that the Governor would be making a statement about Medicaid expansion in the Commonwealth. Corbett administration officials have noted that the proposed reforms do not represent expansion to an entitlement program but are instead a set of policies aimed at implementing a new program to offer affordable health insurance to low-income Pennsylvanians. Healthy PA focuses on reforming the current Medicaid program and establishing a new private option program that will utilize federal expansion dollars to allow individuals to purchase insurance on the Federal Insurance Marketplace.

A description of the plan including related initiatives to improve Pennsylvania's healthcare system can be found [here](#).

Proposed Medicaid Reforms:

- Simplification of the 14 current Medicaid benefit packages available to adults into two alternative benefit packages that more closely resemble coverage available through employer-sponsored health plans.
- Improved personal accountability through the elimination of current co-pays (except for a \$10 copay on inappropriate ER visits) and the implementation of modest, income-based monthly premiums not to exceed \$25 per month for individuals or \$35 per month for households. An individual's monthly premium can be reduced through participation in health and wellness programs and by actively engaging in job search and employment training programs.
- Implementing work search requirements and job training resources for able bodied eligible adults. All working age, unemployed Medicaid beneficiaries will be required to register with PA's JobGateway system and engage in meaningful work search activities similar to those required to maintain unemployment compensation benefits.

New Private Option for the Uninsured

- Use federal funding through the ACA to pay private insurance premiums through the Federal Health Insurance Marketplace for uninsured individuals not currently eligible for Medicaid with incomes between 0 percent and 133 percent of the federal poverty level (FPL).
- Individuals in this income bracket who are determined to be "medically frail" would have the option to be served under the traditional Medicaid program, subject to the reforms outlined above.

- Current Medicaid Managed Care Organizations will be encouraged to establish Qualified Health Plans on the exchange to allow families to receive benefits through the same plan.
- Similar to the reformed Medicaid benefit packages, the private option will include monthly premiums based on income that can be decreased through participation in health and wellness or job training programs.
- The state estimates that approximately 520,000 Pennsylvanians would be eligible for the new private option.

The Governor's plan is contingent on a commitment from the federal government to sustain existing funding streams established by the ACA. If federal funding does not meet the levels set forth in the ACA, individuals in the new programs will lose coverage.

Federal Approval Required

The proposed plan requires HHS approval, which is uncertain despite ongoing discussions between the state and CMS. Aspects of the plan likely to be the focus of discussion in the negotiation between the state and federal government are whether the proposed premium structure is allowable under Medicaid rules, whether linking work requirements to health coverage is appropriate, and whether the structure of the proposed alternative benefits package is acceptable. Additionally, the concept paper released by the state is not clear on whether the private option is really an option, or whether enrolling in a Qualified Health Plan through the Marketplace will be mandatory for newly eligible adults who are not deemed "medically frail."

The governor said during the press conference that the proposed reforms will not require legislative approval and that they will be implemented quickly once federal approval is received. Sources familiar with the details of the plan are estimating that implementation could occur in the middle of 2014 at the earliest.

Governor Corbett Asks for Further Clarification on CHIP changes

After receiving a letter from HHS Secretary Kathleen Sebelius earlier in the month indicating that the ACA does not allow her agency the flexibility to approve a waiver for PA to maintain children from families with incomes less than 133 percent FPL in the CHIP program, Governor Corbett has requested additional clarification. In a letter from the Governor to HHS on September 13, 2013, Pennsylvania has requested clarification on the option for families with incomes over 300 percent of FPL to buy in to the CHIP program. With the availability of coverage through the new Health Insurance Marketplaces, the option to buy in to CHIP is supposed to be phased out, but the governor wants families to continue to have access to this option. Additionally, the governor is seeking clarification on ways that the state can structure its children's health programs in Medicaid and CHIP to provide a more seamless experience for families. Sebelius' letter earlier this month introduced an option to structure programs so that children are in the same program as their families, but would have access to differing benefits and cost sharing requirements depending on whether family income qualifies for Medicaid benefits or CHIP benefits.

HMA MEDICAID ROUNDUP

Arizona

HMA Roundup

Five Arizona Health Exchange Plan Rates Revealed. Recent filings with the Arizona Department of Insurance reveal health exchange plan rates for five participating carriers: Aetna, Blue Cross Blue Shield of Arizona, Cigna, Health Net and Meritus (previously known as Compass Health Cooperative). Depending on the insured's age, location, and metal tier, the range in individual plan premiums will be from slightly less than \$100 to more than \$1,700 per month, excluding the effect of federal subsidies. Three other carriers (Health Choice, Humana and University of Arizona Health Plan) plan to offer HMO-style plans in the exchange but were not required to disclose rates to Arizona regulators. CMS' Center for Consumer Information and Insurance Oversight must review and approve final contracts with plans.

Opponents Angle to Get Medicaid Expansion Vote on the Ballot. On September 12, 2013, following an unsuccessful effort to gather enough signatures to force a 2014 ballot initiative to repeal Medicaid expansion, the Goldwater Institute announced the filing of a suit to derail Medicaid expansion. The premise of the suit is that the hospital fee that helps to finance the Medicaid expansion was unconstitutionally delegated to the executive branch, as tax increases require a two-thirds vote by the Legislature.

Arkansas

HMA Roundup

Arkansas Issues RFQ to Implement Shared Savings Pilot Program. On September 17, 2013, Arkansas' Department of Human Services / Division of Medical Services issued a request for qualifications (RFQ) to implement the Medicaid primary care case management shared savings pilot program in the state's Delta Region to yield lower cost of care. The contract awardee will recruit an adequate number of primary care clinics in the Arkansas Delta Region for a two year program beginning January 1, 2014. A minimum of five thousand beneficiaries must be enrolled in the program. Beneficiary enrollment will begin January 1, 2014 and conclude on March 31, 2014. The PCCM will be paid on a PMPM basis and will have to return 25 percent of the administrative fee if savings are not generated. Questions are due September 25 and proposals are due on October 16, 2013.

California

HMA Roundup – Jennifer Kent

Legislature Passes Bills on Pharmacists and Therapists. This past week, the California Assembly and Senate approved two bills that will offer patients more unfettered access to pharmacists and physical therapists. S.B. 493 allows pharmacists to initiate certain prescriptions and engage in direct patient consultation and clinical advice. Both the Assembly and Senate passed the bill unanimously, sending the legislation to the governor for his signature. A.B. 1000 allows patients to begin treatment with a physical therapist

without first requiring a physician's diagnosis. While the bill was supported by the California Physical Therapy Association, some independent therapists fear that physicians may directly hire therapists and thereby profit on the work of other providers. In both bills, legislators aimed to address a potential primary care physician shortage as more Americans gain access to health coverage in 2014.

Hospital-Based SNFs to Avoid Medi-Cal Cuts with Passage of S.B. 239. On September 11, 2013, a comprehensive agreement was reached between the California state legislature, the Brown Administration, and the California Hospital Association (CHA) to eliminate future Medi-Cal payment cuts to skilled nursing facilities based in hospitals. S.B. 239 creates a hospital fee program that will generate additional matching federal funds, which will, in turn, yield supplemental Medi-Cal payments to hospitals. The legislation eliminates future Medi-Cal rate cuts to non-rural hospital-based SNFs and removes a rate freeze that would have otherwise been imposed. CHA estimates that this legislation will save 36,000 health care jobs and boost revenues for the State General Fund. Other Medi-Cal providers still face a 10 percent cut and must decide whether or not to pursue an appeal with the US Supreme Court.

Narrow Networks Gaining More Attention as Exchange Enrollment Approaches. In the first phase of announcements about California's health exchanges, most observers focused on the number of plans and rates. However, as the October 1 open enrollment period approaches, more critics are raising concerns about the far narrower networks offered by carriers in the exchange compared to those offered in the commercial group health market. For example, Blue Shield of California's statewide physician network in the exchange is about half that of its regular physician network. Network adequacy and potential delays in securing appointments will remain a focus for the exchange. California officials promise to monitor physician capacity to absorb new patients and take action to either require greater provider capacity or limit enrollment in certain plans.

County Supervisors Vote to Remove Kern Medical Center CEO. Last week, Kern County supervisors voted to fire Kern Medical Center CEO Paul Hensler, following reports about budget problems at the hospital. Through December, KMC is projected to be nearly \$10 million over budget in the current fiscal year. Moreover, the hospital may have to return \$27.5 million in overpayments by the state.

Colorado

HMA Roundup – Joan Henneberry

Connect for Health Colorado May Not Meet October 1 Data Sharing Target Date. Last week, the IT project manager for Connect for Health indicated that data-sharing with Colorado's Medicaid systems may not work by the October 1 target date. The exchange might have to shift to contingency plans. In addition, the Social Security Administration's data system likely will be offline for four hours every night from about 11 p.m. to 3 a.m. MST and all day on Sunday, possibly leading to delayed signups for health insurance until the federal system is back up. Exchange and Medicaid IT staff meet daily to resolve the data exchange and interoperability issues. More than 1,400 private brokers have signed up for training, and exchange staff are also training "health coverage guides," who will be working with consumers face-to-face at locations around the state.

Connecticut

HMA Roundup

“Medical Home” Now Addressing a Third of Medicaid Beneficiaries. According to data released earlier this month, Connecticut’s “medical home” program has reached almost 1,000 participating providers who see more than 200,000 Medicaid patients, or about a third of the current state Medicaid population. The program sends providers additional funds for adhering to standards aiming to expand access to care and improve outcomes, particularly care-coordination efforts and wellness initiatives.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Medicaid Managed Care MMA Awards Delayed to September 23. On September 16, 2013, the Agency for Health Care Administration (AHCA) delayed its target award announcements for all regions to September 23, 2013, due ostensibly to workload issues associated with last responses that were submitted on September 12, 2013.

Cardon Outreach Returns Federal Grant Following Navigator Controversies. On September 15, 2013, the Associated Press reported that Cardon Outreach had announced it would return more than \$800,000 in federal grant money that had been intended to fund the hiring of navigators. Navigators are expected to play an important role in helping millions of newly eligible Americans evaluate their health insurance options. In recent weeks, congressional Republicans had undertaken efforts to scrutinize and audit grant recipients’ budgets, training programs, and supervision. In addition, Florida Governor Rick Scott had ordered that county health departments deny navigators’ access to beneficiaries on their property. Cardon had originally planned to work with beneficiaries in Florida, Oklahoma, Utah and Pennsylvania.

Florida Health Choices Marketplace to Open in 2014. Amid the continuous news flow surrounding the opening of federally facilitated health exchanges around the country on October 1, the Florida Health Choices marketplace – a state marketplace that aims to offer plan options to businesses and individuals who are not eligible for federal tax subsidies – is poised to open soon but not likely before January 2014. Moreover, the Choices CEO Rose Naff claims that the state will likely charge a lower administrative fee.

Florida CFO Warns of Potential ACA Scammers. On September 13, 2013, Florida Chief Financial Officer Jeff Atwater issued a bulletin that warns Floridians about potential scammers attempting to capitalize on uncertainties surrounding the Affordable Care Act. In particular, Atwater notes that solicitors and callers have posed as government representatives seeking personal information as part of the Affordable Care Act. Florida’s Division of Consumer Services has launched ACA webpage and will offer webinars and consumer helpline specialists to address individual questions about eligibility, enrollment, and tax subsidy qualification requirements.

Court Clears Path for Challenges to Trauma Centers in Manatee and Pasco Counties. On September 12, 2013, the First District Court of Appeals ruled in favor of UF Health Jacksonville and other Tampa bay area hospitals, clearing a path for challenges to the continued operation of trauma centers approved by the Department of Health in Manatee and Pasco Counties. The suit alleges that the DOH had applied invalid rules in approving the new trauma centers.

Pinellas County Reaches Compromise with DOH on Navigators. Last week, Pinellas County officials reached an agreement with the Department of Health that allows navigators to operate within county offices in the same building, although not in the same offices as DOH staff. Pinellas County owns the buildings that house local DOH offices. Pinellas County and the local health department had jointly won a \$600,000 Navigator grant from the US Department of Health and Human Services.

Sebelius Touts ACA in Florida Despite Challenges with State Government. On September 16, 2013, HHS Secretary Kathleen Sebelius was back in Florida touting the Affordable Car Act, in part, to combat the actions taken by state government to undercut the program rollout. She cited the state for doing some "pretty unbelievable things," such as banning navigators from local health departments, refusing to establish state-run exchanges, refusing Medicaid expansion, and removing the Department of Insurance from rate review.

Scott Voices Concerns for Personal Information. On September 16, 2013, Governor Rick Scott voiced his concerns about personal privacy related to navigators in a letter to House Speaker John Boehner and Senate Majority Leader Harry Reid. He noted that a navigator in Minnesota gained access to 2,400 social security numbers from an employee at the state's exchange. Scott has come under fire from ACA supporters, who accuse him of politicizing the enrollment and educational function associated with the new law.

Georgia

HMA Roundup - Mark Trail

Five Georgia Health Centers Awarded Grants. On September 13, 2013, the US Department of Health and Human Services awarded \$19 million for the creation of 32 new health centers nationwide, including five in Georgia. These centers aim to improve access to preventive and primary care in traditionally underserved areas. Georgia's locations will be in Baldwin, Polk, Chattooga, Taylor and Houston counties.

Georgia Senators Back Bill to Prevent Unions from Receiving ACA Tax Subsidies. Last week, congressional Republicans introduced the "Union Bailout Prevention Act," which would ban the issuance of premium tax subsidies for multi-employer plans, jointly administered by unions and small companies. Georgia Senators Saxby Chambliss and Johnny Isakson are co-sponsors of the legislation, which would explicitly prevent an AFL-CIO resolution from being implemented by the Obama Administration. Chambliss and Isakson warned the Administration from engaging in favoritism toward labor unions. Other GOP senators wrote the Treasury Department characterizing the union proposal to give exchange subsidies to union workers as double dipping.

DCH Posts Changes to Medically Fragile Daycare Services. Last month the Department of Community Health posted changes to the Georgia Pediatric Program for Medically Fragile Daycare services delivered on or after January 1, 2014. With the renewal of the state's 1915(c) waiver for the Georgia Pediatric Program's Medically Fragile Daycare service, DCH has modified the Medically Fragile Daycare service definition to include assistance with the acquisition, retention, or improvement in self-help, socialization and adaptive behavior. Transportation to and from the daycare facility will be included in the service definition and rate. DCH proposes the full day rate to be \$248 per member per day, with the half-day rate to be \$124. Medically Fragile Daycare expenditures for the initial year of authorization are expected to increase within the ABD program by \$553,376 in total funding (\$190,583 in state funding).

Indiana

HMA Roundup – Cathy Rudd

Health Finance Commission Meeting Features Medicaid Expansion Commentary. On Monday, September 16, 2013, the Indiana General Assembly's Health Finance Commission meeting featured an update on Healthy Indiana Plan by Family and Social Services Administration Secretary Debra Minott. Minott stated that changes in income eligibility levels were sought by CMS, not the state, and resulted in the reduction of income eligibility from 200 percent of poverty level to 100 percent. Minott noted that Governor Mike Pence favored HIP as the Medicaid expansion vehicle but, in the meantime, had to focus on maintaining continuity of the HIP plan through an extension to avoid a protracted negotiation that might imperil the HIP program. Finally, Minott pointed to a teleconference with federal officials this week to address open issues from both sides, including HHS concerns about HIP's health savings accounts.

IU Health Layoffs Announced. On September 12, 2013, Indiana University Health announced plans to lay off 800 workers in an effort to reduce \$1 billion in costs over the next five years at its seven campuses. The layoffs will go into effect December 1, and workers will be notified in October. Some ACA supporters have pointed to the state's unwillingness to expand Medicaid as a root cause of these layoffs, which might otherwise have been avoided.

Kansas

HMA Roundup

Lieutenant Governor Views KanCare Implementation as "On Track". Last week, in a televised interview with KCPT, Lieutenant Governor Jeff Colyer characterized Kansas' Medicaid managed care initiative as "on track" to achieve the target \$1 billion in savings over five years. Colyer points to KanCare's coordination of care as critical to reducing waste and slowing Medicaid spending in the state. Despite criticisms about administrative burdens and slow payments, the KanCare program appeared to be progressing better than Colyer had expected.

Kentucky

HMA Roundup

Kentucky Signs Medicaid Managed Care Contracts with Three Carriers. Last Friday, September 13, 2013, the state of Kentucky signed contracts with Humana, Passport Health Plan, and Anthem Blue Cross Blue Shield of Kentucky to deliver Medicaid managed care services in seven of eight regions of the state to 300,000 newly eligible beneficiaries under Medicaid expansion. These contracts are in addition to existing Medicaid managed care contracts with Coventry and WellCare. The new awards cover 18 months initially, with three additional one-year renewal options.

Louisiana

HMA Roundup

Jindal Emphasizes Benefits of Privatization of Charity Hospital System. In visits around the state, Gov. Bobby Jindal has been touting the benefits of the state's privatization of Louisiana's charity hospital system. The state has phased in outsourcing deals that the Administration insists have reduced waiting lists, improved and opened clinics and operating rooms, and expanded access to care. The LSU health care system has taken the brunt of Medicaid funding cuts, ultimately outsourcing management of nine of its 10 hospitals, as well as their associated clinics. Jindal believes the new arrangements will save the state \$100 million annually.

Maine

HMA Roundup

MCHO and Anthem Confirm Final Federal Approval for Exchange Plans. On September 16, 2013, both Maine Community Health Options (MCHO) and Anthem Blue Cross and Blue Shield confirmed they had received final Federal approval to offer health plans on the state's exchange.

Maryland

HMA Roundup

State Owes \$21 Million to Federal Government. On September 13, 2013, a report from the Office of the Inspector General found that Maryland's lack of internal controls resulted in overcharging the Federal Government \$21 million from 2009 to 2012 for room and board for the developmentally disabled. Advocacy groups fear that the debt owed by the state would have deleterious effects on the developmentally disabled, many of whom are on waiting lists for services.

Massachusetts

HMA Roundup

New Adult Day Regulations to Require Inspections. On September 11, 2013, Massachusetts' Bureau of Health Care Safety and Quality proposed new regulations that would apply to adult day programs, many of which are currently unlicensed. The new rules would require inspections every other year and mandate minimum staffing levels, cleanliness standards, and separate areas to address seniors with advanced dementia. The Public Health Council will vote on the rules in the fall, following a public hearing.

State Launches Initiative to Prevent Provider Fraud. Last week, Secretary of Health and Human Services, John Polanowicz, announced a \$5 million program aimed at preventing provider fraud and waste in the state's Medicaid program. Payments will be frozen to those providers submitting suspicious claims. MassHealth will apply predictive modeling applications to identify outlier billing patterns and review each suspect claim individually before processing payments.

Health Connector Approves Ten Health and Five Dental Carriers. On September 12, 2013, the Health Connector's board of directors approved 10 health and five dental benefit carriers to be offered through the Health Connector. Overall, there will be 114 medical plan options and 24 dental plans, tiered-copay plans and expanded small group options. All nine incumbent Health Connector carriers plus one new player – Minuteman Health – were given a Seal of Approval, which signifies base rates that are nationally competitive. The Health Connector also selected seven carriers to offer its new "ConnectorCare" program, which offers a combination of federal and state subsidies to offset the cost of health premiums to eligible residents who have an income under 300 percent of the Federal Poverty Level. The seven carriers selected for ConnectorCare are:

- Boston Medical Center HealthNet Plan
- CeltiCare
- Fallon Community Health Plan
- Health New England
- Neighborhood Health Plan
- Network Health
- Minuteman Health

The five dental carriers:

- Altus Dental (individual and small group)
- BCBS MA (small group)
- Delta Dental ((individual and small group)
- Guardian (small group)
- Met Life (small group)

Michigan

HMA Roundup

Snyder Signs Medicaid Expansion into Law. On Monday, September 16, 2013, Gov. Rick Snyder signed Medicaid expansion into law, extending health insurance to more than 320,000 Michigan residents in March 2014, assuming Federal approval of the state's waiver application.

Physicians Health Plan Withdraws from Exchange. On September 16, 2013, just weeks before the opening of the Michigan Health Insurance Marketplace, Physicians Health Plan of Mid-Michigan decided to withdraw from the exchange, citing "too many uncertainties." PHP had offered health coverage under the state's high risk pool since 2010.

Minnesota

HMA Roundup

Minnesota Approved for Duals Demonstration. On September 12, 2013, Minnesota became the eighth state approved to run a duals demonstration project. Minnesota's approach builds on the Minnesota Senior Health Option, which uses health plans to offer beneficiaries comprehensive information about all their Medicare and Medicaid benefits. MSHO plans will be required to consolidate and streamline reporting measures and add new ones to better reflect the needs of dual eligible seniors.

Mississippi

HMA Roundup

Mississippi Mental Health and Medicaid Programs Seek More Funds for FY14-15. On Tuesday, September 17, 2013, agency officials representing the corrections system, mental health department and Medicaid agency appeared before the Joint Legislative Budget Committee to request additional funds for the current (FY14) and next fiscal years. The Department of Mental Health requested an additional \$1.7 million through June 2014, as well as a FY15 budget of \$243.1 million, up 2.4 percent over the original FY14 budget. The Medicaid program requires an additional \$77 million over its original \$840 million in state funds, as well as \$983 million in state money for FY15, up 17 percent of the original FY14 budget.

Missouri

HMA Roundup

Medicaid Work Group Concludes Missouri Wants Expansion and Reform. The Missouri House Citizens and Legislators Working Group on Medicaid Eligibility and Reform released a draft report that recaps public testimony, without making recommendations. However, the effort of the 52-member group may have still achieved something in concluding that Missourians want both Medicaid expansion and reform. Rep. Noel Torpey, the group's chairman, believes that the report could help Republicans in the next legislative session consider expansion, given appropriate types of reform.

New Hampshire

HMA Roundup

Harvard Pilgrim Partners with New Hampshire Hospital Systems. On September 9, 2013, Harvard Pilgrim announced a shared-risk collaboration with New Hampshire's Dartmouth-Hitchcock and Elliot Health System. ElevateHealth's narrower provider network aims to reduce premiums by at least 10 percent compared to more open network offerings from Harvard Pilgrim.

Special Commission on Hospital Taxes Offer Varied Views. On September 11, 2013, a special commission New Hampshire's hospital taxes noted general agreement on what hospital inpatient revenues are taxable, but there remains disagreement about outpatient revenues. The \$176 million in hospital tax revenue underwrites Medicaid and other services, but the Federal government allows states to apply their hospital taxes to 19 categories. Currently, the state applies the 5.5 percent tax to inpatient and outpatient hospital net revenues. Revenue Commissioner John Beardmore said his department considers revenue collected by hospitals for services that Medicaid would cover taxable, even if the services are ultimately covered by private insurance. Medicaid Director Katie Dunn added that if hospitals bill for services, even if not delivered in a hospital, they should be taxable.

Medicaid Beneficiaries Getting Notices. Recently, letters have gone out to Medicaid beneficiaries recommending that they choose one of three Medicaid managed care plans. Absent a choice, auto-assignments will begin on November 12. Meridian Health Plan, New Hampshire Healthy Families and Well Sense Health Plan are the participating plans. Exceptions to immediate managed care enrollment are applied to the developmentally disabled and those in nursing homes and receiving long-term care services.

New Jersey

HMA Roundup

Aetna Drops Out of NJ Exchange. Last week, Aetna decided to withdraw from the New Jersey health exchange, consistent with decisions to exit New York and other markets. The exchange will now feature just three insurers: Horizon Blue Cross Blue Shield, AmeriHealth New Jersey and Health Republic Insurance of New Jersey.

New Mexico

HMA Roundup

State Behavioral Health System in Turmoil. For the last few weeks, a sweeping criminal investigation into overbilling by 15 of New Mexico's largest behavioral health providers has thrown the system into turmoil. Systematic overbilling was unearthed in an audit, but providers are objecting that the Medicaid payments have been suspended even though the Medicaid billing contractor did not appear to offer observations of such problems prior to the audit. As a result, disruptions in service delivery and closings of certain businesses has created challenges for the beneficiaries in need of behavioral health services.

New York

HMA Roundup – Denise Soffel

Low-Income Housing for Medicaid Recipients. New York State plans to build low-income housing units for 5,000 Medicaid recipients, offering a safer and healthier home environment for those not requiring institutional care. Some \$47 million is targeted for constructing 12 new buildings over the next year and a half. Health Commissioner Nirav R. Shah notes that supportive housing for high-need Medicaid beneficiaries should ultimately help to reduce Medicaid costs through lower cost HCBS options.

North Carolina

HMA Roundup

Exchange Insurer Withdraws. On September 12, 2013, FirstCarolinaCare Insurance Company withdrew from the state's health care exchange, citing uncertainty about the healthcare system. Only Blue Cross and Blue Shield of North Carolina and Coventry remain as carriers posting plans in the exchange.

Oklahoma

HMA Roundup

Oklahoma's Individual Plan Exchange Rates Posted. Recently, Oklahoma posted rates for the 150 plans offered by three carriers of the five carriers on the state's exchange. Plans will be offered by five companies: Blue Cross Blue Shield of Oklahoma, Coventry Health and Life Insurance, Aetna Life Insurance, CommunityCare, and GlobalHealth. Rate filings for CommunityCare and GlobalHealth were not released since HMOs are subject to different disclosure requirements. Blue Cross' lowest rate is \$108 a month in a bronze plan and its highest is \$807 a month in a gold plan.

Pennsylvania

HMA Roundup –Matt Roan

PA denies 8 of 10 Welfare Applications due to Work Search Requirements. A new state rule implemented in 2012 requiring cash assistance applicants to document at least 3 employment applications prior to receiving TANF cash benefits has resulted in 8 of 10 applications being rejected so far in 2013. A study conducted by the Philadelphia Inquirer tied a spike in welfare denials to the implementation of pre-approval work search requirements which were implemented in the summer of 2012.

Rhode Island

HMA Roundup

Rhode Island Duals Enrollment Schedule Posted. On September 6, 2013, the Rhode Island Executive Office of Health and Human Services posted an enrollment schedule for its duals program. Consumers have approximately four weeks to select a health care option – either a Rhody Health Options health plan, Connect Care Choice *Community Partners*, or PACE. The effective date of enrollment is eight weeks from the date of the letter.

Letter and FAQ Mailing Date	Enrollment Effective Date	Enrollment Population Included
9/1/2013	11/1/2013	Phased enrollment of nursing home residents ½ of MME that were previously enrolled in Rite Care, Rite Share, Rhody Health Partners (RHP) or Connect Care Choice (CCC) Current RHP and CCC members (Medicaid only) with LTSS Current CCC members (Medicaid only) without LTSS
10/1/2013	12/1/2013	Phased enrollment of nursing home residents ½ of MME that were previously enrolled in Rite Care, Rite Share, RHP or CCC
12/1/2013	2/1/2014	1/3 of MMEs with LTSS living in the community 1/3 of MMEs without LTSS living in the community
1/1/2014	3/1/2014	1/3 of MMEs with LTSS living in the community 1/3 of MMEs without LTSS living in the community
2/1/2014	4/1/2014	1/3 of MMEs with LTSS living in the community 1/3 of MMEs without LTSS living in the community MME clients on the DD waiver MME clients with SPMI (severe mental illness) SPMI/DD clients who are nursing home residents (both MME and Medicaid only)

South Carolina

HMA Roundup

South Carolina Dual Plan Applicants Revealed. On September 16, 2013, the South Carolina Dual Eligible (SCDuE) work team posted an update on the enrollment of its dual eligible populations. The state wants to ensure that every prospective Coordinated and Integrated Care Organization (CICO) meets both State and Federal requirements to participate in the Demonstration. All prospective CICOs must pass a comprehensive joint CMS/State readiness review prior to the start of marketing or enrollment activities. The readiness review will further evaluate the capacity of each potential CICO to meet all Demonstration requirements (such as network adequacy). The following organizations have applied to participate in the program: Absolute Total Care, Advicare, Humana Health Plan, Molina Healthcare of South Carolina, Select Health of South Carolina, and WellCare of South Carolina.

Texas

HMA Roundup--Dianne Longley and Linda Wertz

Perry to Request Waiver to Reform Medicaid without Expanding Eligibility. On September 16, 2013, Gov. Rick Perry asked the Texas Health and Human Services Commission to file a waiver request with CMS to request a block grant to reform Medicaid as the state sees fit, without expanding eligibility. In a separate letter to the HHSC, Perry requested that the agency develop a mechanism to collect and analyze income and assets regarding Texas Medicaid applicants. Asset testing was explicitly removed by the ACA from eligibility determinations.

West Virginia

HMA Roundup

Highmark to Be the State's Sole Exchange Carrier for Individuals. On September 11, 2013, Highmark Blue Cross Blue Shield announced in a conference call that Carelink/Coventry had pulled out of West Virginia's exchange, leaving Highmark as the only individual exchange plan carrier left remaining. Highmark will offer 11 individual plans and 4 small business plans.

Wyoming

HMA Roundup

Department of Health Floats Medicaid Coverage Options. This past week, the Wyoming Department of Health has pitched a proposal in which residents could purchase a modified version of Medicaid coverage. The DOH Director noted an option to cover essential health benefits, as required under the ACA, with copays and deductibles to help the working poor. Gov. Matt Mead has left the decision on Medicaid expansion options to the legislature, which soundly rejected the concept in the most recent session.

National

HMA Roundup

Federal Long-Term Care Commission Divided on Financing Issue. A commission mandated by Congress to submit recommendations on improving long-term services and supports (LTSS) is set to reveal its final report Wednesday, September 18, 2013. The commission approved the report in a vote on Thursday, September 12, and released a summary on September 23, available [here](#). The report falls short of a definitive recommendation on financing, but does call for balancing public and private financing for LTSS. Some commission members blamed a short timeframe for their lack of a conclusive recommendation on the issue of financing.

CMS Finalizes Rule on Medicaid DSH Payments. Despite a push from hospitals for a delay in the Affordable Care Act-mandated cuts to the Medicaid disproportionate share hospital (DSH) payments program, CMS announced final rulemaking on the DSH reductions, which will cut \$500 million from the program in FY 2014 and \$600 million in FY 2015. The DSH program aims to compensate hospitals, at least partially, for care provid-

ed to uninsured individuals. The rationale behind cutting DSH was that Medicaid expansion and health insurance marketplaces would significantly reduce the level of uncompensated care cost related to the uninsured nationwide. However, as many states have opted not to expand Medicaid, hospitals in these states will not see anticipated reductions in uninsured costs, yet still face reductions in their DSH allotments. CMS did, however, leave the door open to revisit the DSH reduction methodology in coming years.

Federal Rule Mandates Minimum Wage, Overtime Pay for Home Care Workers. The Department of Labor announced a final rule this week, affirming that home health care workers be entitled to minimum wages and overtime pay beginning in 2015. Home health agency workers are currently exempt from federal labor laws, under which they were considered domestic workers, the same designation that applies to babysitters. Advocates for home care workers applauded the rule; however, some in the home health agency industry have raised concerns about the impact on home health costs and whether the rule could lead a reduction in home-based care and, in turn, greater institutionalization. Additionally, there has been concern raised about the impact on Medicaid costs and available funding for home health in the Medicaid program.

INDUSTRY NEWS

Davita's HealthCare Partner Announces Arizona Integrated Physicians Merger. HealthCare Partners, LCC, a subsidiary of DaVita HealthCare Partners announced a merger with Arizona Integrated Physicians (AIP), one of Arizona's largest physician networks with more than 700 doctors.

Molina Expects Participation in Nine State Health Exchanges. Molina Healthcare anticipates it will offer a qualified health plan in nine state exchanges, set to launch October 1, 2013. Per a recent 8-K filing, Molina expects QHPs to be available in California, Florida, Michigan, New Mexico, Ohio, Texas, Utah, Washington, and Wisconsin, subject to finalization of regulatory reviews.

WellPoint Names Two to Board of Directors. WellPoint has announced that John Short will join its Board of Directors effective September 18, 2013, while Elizabeth Tallett will join effective October 1, 2013. John Short is a principal of Short Consulting LLC, a health care consulting firm, and previously served as CEO of RehabCare Group. Elizabeth Tallett is a principal of Hunter & Partners LLC, also a health care consulting firm, and previously served as Lead Director at Coventry Health Care.

Florida Blue Reorganization Approved. On September 11, 2013, Florida Blue policyholders approved the reorganization of the health insurer, allowing the company to gain flexibility in pursuing mergers and acquisitions. The not-for-profit mutual insurance holding company will be allowed to oversee stockholder-owned companies to more flexibly pursue growth opportunities.

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 20, 2013	Massachusetts CarePlus (ACA)	Contract Awards	305,000
September 23, 2013	Florida acute care	Contract awards	2,800,000
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 2,10)	Implementation	11,935
November 1, 2013	Hawaii	Proposals Due	292,000
December 1, 2013	New Hampshire	Implementation	130,000
December 1, 2013	Florida LTC (Region 11)	Implementation	17,257
"Early 2014"	North Carolina	RFP released	TBD
January 1, 2014	Massachusetts CarePlus (ACA)	Implementation	305,000
January 1, 2014	Massachusetts Duals	Implementation	115,000
January 1, 2014	Illinois Duals	Implementation	136,000
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	19,538
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
April 1, 2014	California Duals	Implementation	456,000
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	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	9/10/2013	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	7/1/2014	
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	28,000	X	3/27/2013	August 2013		11/1/2013*	Neighborhood Health Plan of RI
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 4/1/2014	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

“Managed Care Environment and its Impact on PAC/LTC”

Sponsored by: American Health Care Association (AHCA)

Greg Nersessian, Presenter

October 8, 2013

Phoenix, Arizona

“Health Behind Bars: What Obamacare Means for Courts, Prison, Jails and the Justice-Involved (And How to Report the Story)”

Center on Media, Crime, and Justice

Donna Strugar-Fritsch, Panelist

October 21-22, 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

“Where Payor Meets Provider: Managing in a World of Managed Care”

HCap Conference sponsored by: Lincoln Healthcare Group

Greg Nersessian, Panelist

December 5, 2013

Washington, DC