HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

PENNSYLVANIA RELEASES DRAFT APPLICATION FOR 1115 DEMONSTRATION REFORMING MEDICAID

This week, our *In Focus* section comes to us from Matt Roan in HMA's Harrisburg office. Matt provides an overview of Pennsylvania's draft application for Medicaid reforms and expansion. The Pennsylvania Department of Public Welfare (DPW) has released a draft application for an 1115 Demonstration which will implement reforms to the Commonwealth's Medicaid program and expand coverage to Pennsylvanians with incomes up to 133% of FPL. The package of reforms is the cornerstone of Governor Corbett's Healthy PA initiative which seeks to improve the healthcare system with Pennsylvania-specific approaches. Through the 1115 demonstration, Pennsylvania will make changes to the current adult Medicaid benefit packages, implement cost sharing reforms including elimination of most co-pays and the establishment of a premium structure, and enact work search requirements as a condition of Medicaid eligibility. The plan also provides coverage options for the Medicaid Expansion population through premium subsidy for private insurance options available through the federally facilitated health insurance Marketplace, employer sponsored insurance, and directly from commercial insurance carriers.

Information about the 1115 demonstration application can be found at: http://www.dpw.state.pa.us/healthypa/index.htm

Below, we have highlighted some of the major changes included in the 1115 Demonstration application:

Medicaid Program Changes:

- Consolidation of the 14 current Medicaid benefit packages available to adults into 2 alternative benefit packages that are designed to more closely resemble coverage available through employer sponsored health plans. Most adults currently enrolled in Medicaid will be enrolled in the Low Risk Benefit Package. Enrollees determined to have complex needs via a health risk assessment will be enrolled in the High Risk Benefit Package. Both packages have new benefit limits with a process for requesting a benefit limit exceptions.
- Most Adult Medicaid Enrollees will have two new conditions of eligibility:
    - **Work Search Requirements:** Enrollees will be required to register with a state system for job searches and training and to complete 12 work search activities each month to maintain Medicaid eligibility. Enrollee eligibility will be terminated if the required work search activities are not completed over a six month period. TANF recipients are automatically deemed to meet these requirements, and certain adult populations are exempt including the disabled, pregnant women, and enrollees under 21 years of age.
    - **Premium Payment:** Enrollees with incomes above 50% of FPL will be subject to monthly premium payments. Failure to pay premiums for three consecutive months will result in eligibility termination. Premiums may be reduced by as much as 50% through engaging in healthy behaviors and maintaining employment. Healthy Behaviors that qualify for premium reduction in the first year of the demonstration include:
        - Completing a health risk assessment
        - Completing an annual physical exam
        - Paying premiums on time (during the most recent six months)

New Private Coverage Option for the Uninsured

- New coverage options will be made available to Pennsylvanians with incomes up to 133% of FPL through state-subsidized premiums for private insurance coverage.
- Private insurance carriers, including Qualified Health Plans on the Marketplace will enter into agreements with the DPW to serve the Private Coverage Option population. These agreements will address the enrollment process, premium payment process, and reporting to support Federal Medicaid payments.
- Some currently eligible populations, including the State-only General Assistance category will be moved from traditional Medicaid coverage to the new Private Coverage Option.
- Individuals who are determined to be medically frail will have the option to be served under the traditional Medicaid program in the High Risk Benefit Package.
- 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 will be eligible for the new Private Coverage Option.

Public Feedback Process

The draft application has been released for public comment. Interested parties may submit written comments to the Department through January 13, 2014. Additionally, DPW has announced a series of public hearings and webinars on the draft application. Information about submitting comments and the schedule of public hearings and webinars can be found at: http://www.dpw.state.pa.us/healthypa/index.htm.

To learn more about Healthy PA and how HMA can help your organization understand and plan for the proposed changes, contact HMA's Harrisburg office at 717-260-7760, or email aderr@healthmanagement.com.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Alana Ketchel

California Exchange Faces Backlog of 25,000 Paper Applications for Resubmission. On December 9, 2013, Mercury News reported that Covered California is dealing with a backlog of 25,000 paper applications that must be resubmitted online. Although officials believe the problem could be resolved by the end of the week, observers fret that the extended wait times at call centers portend delays in enrollment. The issue sprung from a portal designed for certified insurance agents which was not functional until Nov. 19 and other technical glitches which increased the manual filing of 32-page forms for clients. Covered California has asked that insurance agents complete the process online to relieve the backlog. Read more.

Northern California Health System Charged with Driving Up Costs. A New York Times article from December 2, 2013 characterized Sutter Health as leveraging its market power to raise prices and limit competition in northern California. Sutter's pricing has also reportedly created a "ripple effect" as smaller hospitals in the region have been able to charge more. Sutter responded that it charges higher prices to cover costs of care for uninsured and under-insured patients as well as to improve facilities and health technologies. Read more.

CalPERS Reference Pricing Initiative Yields Savings on Targeted Services. A December 5, 2013 report from the Center for Studying Health System Change reviews CalPERS' experience with reference pricing, or setting a maximum allowed price, for hip and knee replacements. CalPERS saved $2.8 million in the first year without significant disruption to enrollees and catalyzed market competition based on price. Read more.

Stanford Launches Narrow Network Health Plan. In a December 6, 2013 article, the San Francisco Business Times profiled the imminent launch of a narrow network "ACO-style" health plan by Stanford University, Stanford Hospital & Clinics, and Lucile Packard Children's Hospital aimed at up to 50,000 eligible Sanford employees and dependents. Blue Shield of California will help launch the Stanford Healthcare Alliance plan leveraging Stanford's own hospitals and doctors and certain other providers. This effort mirrors the mid-2013 launch of an HMO plan by Sutter Health. Read more.

Some Covered CA Plans Narrowing Provider Networks. NPR and Kaiser Health News published a December 9, 2013 article highlighting the narrower networks of some health plans offered on the Covered California exchange. Blue Shield includes half the doctors and three-quarters of the hospitals in its 2014 network as compared to its current provider network in the individual market. The California Association

of Health Plans points to the expanded essential health benefit requirements of the Affordable Care Act which have pressured health plans to negotiate harder with providers to keep premium increases under control. Read more.

Early Preference for Big-Name Plans in Covered California. According to October enrollment data, 96 percent of enrollees to Covered California selected four health plans – Anthem, Kaiser, Blue Shield, and Health Net. Seven other carriers split the remaining 4 percent of enrollees in October. The "big four" issuers offered plans across the state and significantly expanded their market opportunities. Read more.

Colorado

HMA Roundup—Joan Henneberry

Colorado Enrollment Pace Accelerating. On December 5, 2013, Connect for Health Colorado posted a blog entry that noted accelerating enrollment pace with 1,090 people having signed up for private insurance on the previous day alone. As a result, the exchange informed the public that wait times were highest between 9:30 and 11:30AM, particularly on Mondays and Tuesdays. In anticipation of increased demand around the December 23 deadline for January 2014 coverage, the exchange added customer service center availability on Sundays (December 8, 15, and 22) from 9AM to 6PM to accommodate more customers. Customers have until January 10, 2014 to send their first month's premiums for January 2014 coverage. Read more.

Colorado Rejects Reinstating Canceled Health Plans. Last week, Colorado Insurance Commissioner Marguerite Salazar announced that the vast majority—95 percent—of the 250,000 Coloradans who had received health plan cancellation notices have the option to renew their plans through 2014. However, for those whose plans were already canceled, Salazar rejected forcing carriers to reinstate the plans, which would have left little time for plans to do an "11th hour reset". Read more.

District of Columbia

DC Exchange Phishing Scam Exposed. The Hill posted a December 6, 2013 blog entry about a phishing scam that attempted to divert health plan seekers to a fraudulent web site. However, DC Health Link communications director Richard Sorian noted just two reports of this problem and highlighted the successful enrollment of thousands of Capitol Hill staffers and congressmen on the site. Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Andy Gardiner Named Florida Senate President. On December 10, 2013, Florida Senate Republicans named Andy Gardiner as the next president of the chamber, succeeding Don Gaetz for the 2015-16 legislative sessions —assuming Republicans maintain their majority status at that time. The conservative Gardiner struck a deal with rival (and moderate) Jack Latvala to win sufficient support for his candidacy. Read more.

Woodwork Effect Has Not Taken Hold in Florida. While most states have already demonstrated an increase in Medicaid enrollment of people who had already been eligible but had not signed up (the "woodwork" effect), Florida's October Medicaid applications by adults actually dropped slightly from the average for July to September. Due to technological problems, Florida has not received Medicaid applica-

tions from the federal healthcare.gov website. In a December 5, 2013 report, the Commonwealth Fund noted that Florida's potential share of Medicaid expansion costs in 2022 would be less than a quarter of its projected tax incentives aimed at attracting companies to Florida. Read more.

Florida Legislators Propose Policies to Meet Growing Health Needs in the State. On a December 5, 2013 Florida Chamber of Commerce webinar, key Republican legislators proposed the expansion of telemedicine and increased latitude for nurse practitioners to deliver primary care services. Rep. Travis Cummings said he is working on legislation that would boost telemedicine usage, although he does not anticipate mandating "parity" of reimbursements with in-person visits. Rep. Jose Oliva expounded on the potential for allowing nurse practitioners greater autonomy in delivering primary care services, particularly in rural areas. That proposal, however, is opposed by the Florida Medical Association. Read more.

UCF College of Medicine Supports Expansion of Trauma Centers. At a December 4, 2013 hearing in Orlando, the University of Central Florida and various suburban for-profit hospitals offered support for a Department of Health proposal to expand the number of trauma centers from 25 to 43, while certain large medical centers opposed the move due to the potential for diminishing the pool of medical providers at the hospitals. Read more.

Orlando Health and Florida Blue Announce an ACO. On December 10, 2013, Orlando Health Physician Partners and Florida Blue announced a January 1, 2014 launch of an accountable care organization (ACO) in Central Florida that would involve 500 doctors and eight hospitals. Dr. Wayne Jenkins, President of Orlando Health Physician Partners, dubbed ACOs "the future of the health care delivery system," while Pat Geraghty, chairman and CEO for Florida Blue, spoke of the potential of improving outcomes and lowering costs. Read more.

Georgia

HMA Roundup – Mark Trail

Georgia Delays Implementation of Managed Care for Foster Kids to March 2014. On December 6, 2013, the Department of Community Health told Georgia Health News that the state would delay the move of 27,000 kids in child welfare programs into managed care due to time constraints. Rather than the original January 1, 2014 transition, the state is now targeting March 3, 2014 to move children in foster care, adoption assistance, and the juvenile justice system state into an Amerigroup plan. DCH still believes that managed care will bring better coordination of care, fewer disruptions in provider access, and a reduction in the overreliance on psychotropic drugs. Read more.

Hawaii

Hawaii Health Connector Enrollment Remains Scant and Expensive. On December 6, 2013, at a Hawaii Health Connector board meeting, it was announced that 574 Hawaii residents had enrolled in plans on the exchange, more than doubling the 257 figure from November 15, 2013, but representing about a half of one percent of the state's population. The article calculates each sign-up as costing $348,000 based on the $200 million allocation in establishing the exchange. On December 6, 2013, Coral Andrews stepped down from her position as executive director of the exchange. Read more.

Indiana

HMA Roundup—Cathy Rudd

Indiana Extends Healthy Indiana Plan Through April 2014 for 10,000 Hoosiers. In a December 10, 2013 press release, the Indiana Family and Social Services Administration (FSSA) announced it would allow more than 10,000 current members of the Healthy Indiana Plan (HIP) to continue in the program through the end of April 2014 given the challenges in enrolling in health plans on the federally facilitated exchange, healthcare.gov. The effected HIP members are those between 100 and 200 percent of federal poverty income levels whose HIP coverage would otherwise have been discontinued on January 1 due to lower income thresholds approved by CMS in the most recent HIP waiver. The state HIP trust fund may be on the hook for as much as $11 million for this temporary extension. Read more.

Incumbents Retain Urological and Incontinence Contract. In late November, the FSSA recommended that incumbent contractors, Binson's Hospital Supplies and J&B Medical Supply Co., be selected for the state's Medicaid urological, incontinence, and colostomy supplies procurement. The estimated total value of this four year award is $46.4 million. Read more.

Insurance Commissioner Rejects Reinstatement of Canceled Plans; Encourages Finding Plans Outside the Exchange. In late November, Indiana Insurance Commissioner Stephen Robertson announced that the state would not require insurance carriers to reinstate canceled health plans. Robinson noted that some carriers had already taken advantage of an "early renewal option" allowing for proper rate setting and contract language well in advance of 2014. Robertson also reminded Hoosiers that, despite the technological glitches associated with healthcare.gov, those individuals who are not eligible for federal premium tax credits should consider enrolling in plans outside the exchange. Read more.

Iowa

Iowa Medicaid Expansion Plan Approved But Strikes Premiums for Participants Under Poverty Level. On December 10, 2013, just three weeks before coverage would kick in, CMS approved Iowa's waiver application to implement the Iowa Health and Wellness Plan. The approval allows Iowa to tap into 100 percent federal matching funds to expand Medicaid coverage to adults earning up to 138 percent of the federal poverty level using premium subsidies for plans on the state's exchange. CMS Administrator Marilyn Tavenner praised Iowa for being a "pioneer" in its innovative state-based solution for Medicaid expansion. However, CMS rejected a provision of the waiver that would have charged a modest premium to Medicaid participants making more than 50 percent of the federal poverty level who did not engage in wellness activities such as annual exams. CMS noted that no premiums would be permissible on beneficiaries making less than the federal poverty level. Iowa Gov. Terry Branstad must determine whether or not to accept the CMS decision or continue negotiations with HHS about a path forward for premiums without the loss of coverage. With the expiration of the IowaCare program on January 1, 2014 and the 60,000-70,000 sign-ups for the Iowa Health and Wellness Plan, Branstad will be under significant pressure to accept the CMS decision. Read more.

Kansas

Medicaid Managed Care for Developmentally Disabled Sparks Controversy. On December 5, 2013, Kaiser Health News and the Washington Post published an article about the January 2014 absorption of home and community based benefits for developmentally disabled Kansans into KanCare, the state's Medicaid managed care program. Advocates fear that the three plans (Amerigroup, United Healthcare, and Centene's Sunflower State Health Plan) administering the program do not have experience with this population on a statewide basis. While managed long-term care programs have been applied to the HCBS benefits of seniors or mentally/physically disabled beneficiaries, the specialized needs of the developmentally disabled have generally rendered this group off limits for managed care. State officials insist that they will maintain strict oversight and payment holdbacks to ensure performance objectives are met. Still, families and advocates fear that changes in the system will unduly affect this vulnerable population. Read more.

Louisiana

Louisiana Doctors Face Penalties for Steering Medicaid Patients. In a December 1, 2013 emergency rule, the Jindal Administration established strict guidelines and penalties to deter physicians from steering Medicaid patients into particular Bayou Health plans. Physicians could potentially be removed from the program with fines of $5,000 per beneficiary improperly steered into a plan for reasons other than health care. The state medical society is concerned that the policy interferes with doctor-patient communications. Read more.

Maine

Maine DHHS Commissioner Reiterates Opposition to Medicaid Expansion. On December 4, 2013, Department of Health and Human Services Commissioner Mary Mayhew said that MaineCare enrollment and costs have doubled over the last 12 years and threaten to crowd out other necessary services in the budget. Mayhew noted that the department is aiming to drive greater efficiency in the Medicaid program and to deliver services that enable beneficiaries to return to independence. Read more.

Maryland

Maryland Health Exchange Still Working on Fixes. On December 10, 2013, Lt. Gov. Anthony Brown promised to focus on fixing Maryland's health exchange to ensure that health reform works for state residents. Brown pointed to management changes—including the resignation of the executive director, Rebecca Pearce—and more accountability for the exchange's vendors. With nearly 800,000 uninsured residents, Maryland's enrollment of 5,200 through the exchange (as of December 7, 2013) stands as a controversial disappointment. Read more.

Exchange Executive Director Resigns. On December 6, 2013, the Maryland Health Benefit Exchange accepted the resignation of Rebecca Pearece, the exchange's executive director. Carolyn Quattrocki, who led Gov. Martin O'Malley's office for health reform, was appointed interim executive director. While many observers pointed to state-run health exchanges in New York, Kentucky, and California as relative models of efficiency, Maryland's error-ridden experience has stood out in marked contrast. Read more.

Massachusetts

HMA Roundup—Rob Buchanan

$8 Million in Grants to Boost Behavioral Health Services in the State. On December 5, 2013, Attorney General Martha Coakley announced the opening of an application period for $8 million in grants aimed at improving mental health services. The behavioral health grant program taps J&J settlement funds recovered related to the illegal marketing of Risperdal. The maximum grant amount is $2 million over a two-year period for each applicant. The range of projects under consideration for these grants include the following:

Direct Care Models

- Direct provision of mental health and substance abuse services, treatments, or therapies for underserved populations such as homeless, veterans, victims of violence, children, and senior citizens;
- Services in settings other than healthcare facilities such as schools, courts, and shelters;
- Integrated mental health and substance abuse treatment for patients with complex or chronic comorbidities that place the patient at increased risk of emergency hospitalization.

Intervention, Testing, Coordination and Referral

- Crisis intervention services to evaluate and stabilize individuals in emergency situations involving violence or threats of violence or suicide;
- Community mental health workers to coordinate effective care and treatment adherence and transitions;
- Early intervention and school-age screening to support treatment of children with mental health conditions and victims of abuse and their families and caregivers.

Education and Training

- For health care professionals, law enforcement, youth workers, and educators to identify untreated or undertreated mental health or substance abuse conditions;
- To address the stigma and discrimination experienced by individuals with mental health and substance abuse conditions.

Applicants must be from local, county or statewide government bodies, non-profit organizations or law enforcement, public safety or criminal justice entities in Massachusetts. The deadline to apply is 4PM on January 30, 2014. Read more.

Health Connector Beset with Enrollment Problems. Despite pioneering the health exchange years ago, Massachusetts' Health Connector has been plagued by technological and operational problems that have thwarted the enrollment of thousands of Massachusetts residents who need to choose plans by the end of March 2014. A December 7, 2013 Boston Globe article profiled the lingering technical problems that have wasted more than two months of the open enrollment period, limiting the number of people who have selected a plan to 1,700. Since the state will not process payments until December 23, 2013, not a single person has made it through the en-

rollment process to date. The website was built by CGI, the primary contractor on the federal healthcare.gov site. Read more.

Minnesota

Article warns of inaccurate, incomplete health Marketplace data. In a December 8, 2013 article published by Kaiser Health News and Minnesota Public Radio / NPR, the plight of Minnesota's MNsure exchange is profiled. Insurers offering health plans on the exchange complain about inaccurate and incomplete data with little time to fix the technology problems of the marketplace. The design of the site initially allowed for individuals to submit multiple applications, included curious data fields, and omitted vital personal information that would bring the enrollment process to a halt. The health plans seek more frequent and meaningful communications with MNsure officials to address problems in a timely manner. Read more.

New Hampshire

Area Agencies and Non-Profits Oppose Managed Care for Non-Medical Long-Term Care Services. In a December 5, 2013 article, the Nashua Telegraph highlighted a packed meeting involving area agencies on aging and non-profit providers who are challenging the application of managed care to their services. In a class action lawsuit, Wallace v. New Hampshire, 10 area agency plaintiffs are suing to prevent managed care from applying to their services. They argue that people with developmental disabilities would lose their ability to choose providers in violation of a 2011 law that specifically protected the agencies from managed care. Advocates fear that for-profit entities will undermine the services necessary to support vulnerable populations. Read more.

New York

HMA Roundup—Denise Soffel

New York Enrollment in Private Plans on the Exchange Surge Past Medicaid Enrollments. On December 10, 2013, New York State released enrollment figures that highlight a dynamic that is rare among the states: more enrollees in private plans than Medicaid (69,519 vs. 31,362) since October 1, 2013. Previously, the state had reported an almost even split between private plan enrollment and Medicaid enrollment, but it turns out that the previous week's figures had overstated Medicaid enrollment by 10,000 due to duplicate applications. An additional 314,000 New Yorkers had completed applications with only plan selection standing in the way of coverage. Read more.

Hospital Inpatient Cost Transparency Data Posted. NYS recently posted hospital-specific information on the cost of care for the last three years. This is part of the state's ongoing efforts on open government and transparency. The dataset posted contains information submitted by New York State hospitals as part of the New York Statewide Planning and Research Cooperative (SPARCS) and Institutional Cost Report (ICR) data submissions. The dataset contains information on the volume of discharges, All Payer Refined Diagnosis Related Group (APR-DRG), the severity of illness level (SOI), medical or surgical classification the median charge, median cost, average charge and average cost per discharge. The variations in cost may be attributed to such factors as overall volumes, teaching hospital status, geographic region, and quality of care. Nonetheless, the hospital industry has expressed its displeasure, as reported in Crain's, and argues that the data are not meaningful to con-

sumers. Read more.

1115 Waiver Amendment Status Update. Recently, New York State's Medicaid Director, Jason Helgerson, conducted a webinar on the status of negotiations with CMS regarding an amendment to its 1115 Medicaid waiver, the Partnership Plan. Helgerson began with an update of Medicaid Redesign Team (MRT) efforts to date. NYS is in the 3rd year of a 5-year plan to transform its Medicaid program. The state faces challenges in its effort to achieve the goals of the Triple Aim. Safety net providers, both institutional and non-institutional, are struggling, and access to care is at risk in some of the most medically underserved areas across the state. The primary care infrastructure is inadequate and health disparities remain a problem. The success of the NYS health exchange further highlights the need for a robust delivery system. NY will need to make targeted investments to support a delivery system that is both efficient and sufficient to meet the health care needs of vulnerable populations. Helgerson argues that the waiver amendment, requesting $10 billion in reinvestment over 5 years, is essential to achieving the 5 year action plan.

New York first submitted a waiver amendment request to CMS in August 2012. CMS has indicated that five of the requested areas for funding were un-fundable through the waiver: capital, housing subsidies, regional health planning, HIT, and evaluation of the MRT process. Further, CMS indicated that its preferred funding approach is through a Delivery System Reform Incentive Payment (DSRIP) plan, although the state is also proposing a state plan amendment and changes in its managed care contracts as additional funding approaches. DSRIP would identify a statewide list of projects focused on reducing avoidable hospitalizations; safety net institutions would then select from that CMS-approved list the project(s) they wish to implement. As with DSRIP plans in other states, payments are performance-based as project milestones are met. The intent is to build in a much higher degree of accountability than was the case in previous NYS waivers. The list of projects has been shared with the hospital community and is being finalized. It is estimated the list will include 30 projects. NY is encouraging hospitals to work collaboratively with community-based providers in developing projects. Funding through DSRIP would total $7.375 billion. DSRIP projects will be determined through an RFP process.

In addition to DSRIP, NY is proposing funding for health home development grants totaling $525 million through a state plan amendment. Finally, the state is envisioning changes to Medicaid managed care contracts that would allow funding to flow to primary care development and technical assistance; health workforce retraining, recruitment and retention; home and community based services; and 1915(i) services for the Medicaid managed care product for individuals with serious mental illness (Health and Recovery Plans or HARPs). $2.1 billion would flow to plans which would be contractually required to contract for these services.

Financing for the waiver will largely be through the use of intergovernmental transfers as the local source of the federal match. New York's public hospitals and the local government unit behind them will generate $8.4 billion in financing. This includes New York City's Health and Hospitals Corporation, the public hospitals in Erie, Nassau, and Westchester Counties, and the two hospitals operated under the auspice of the State University of NY (SUNY). Helgerson noted that DSRIP is exempt from UPL and DSH cap limits because they are performance-based payments. The remaining $1.6 billion will come through Designated State Health Programs (DSHP) funding. The state intends to submit its new proposed waiver amendment to CMS by the end of this week. A recording of the webinar and presentation materials can be found on the MRT website: Read more.

DISCO Update. New York continues discussions with CMS regarding its plan to move individuals with intellectual/developmental disabilities into care management through Developmental Disabilities Individual Supports and Care Coordination Organizations (DISCOs). In response to a question raised during the MRT webinar, Medicaid Director Helgerson said the DISCO RFA would be out "in the very near future" and that the October 2014 start date is a firm date. DISCOs would initially capitate long-term services and supports as well as services provided through OPWDD; the eventual goal is to include acute care services and behavioral health creating a completely integrated health plan. Helgerson noted that approval for the Office for People with Developmental Disabilities Fully Integrated Duals Advantage (OPWDD FIDA) demonstration, the component of the demonstration project to integrate care for dual eligible individuals targeted to people with developmental disabilities, was delayed as the state works with CMS on readiness review for the main FIDA program.

Basic Health Program. In his 2014 budget, Governor Cuomo established a working group to consider issues pertaining to the federal option to establish a basic health program (BHP). The workgroup was tasked with evaluating federal guidance related to basic health programs; discussing fiscal, consumer, and health care impacts of a basic health program; and considering benefit package, premium and cost-sharing options for a basic health program. The work group was to report back to the Governor by November 2013.

The group has delayed finalizing recommendations to the Governor while awaiting the federal release of the final payment rule for the BHP (expected this month). In addition, the Urban Institute is conducting a simulation study which will assess the BHP impact on costs to the state, on enrollment through the Exchange, and on numbers of uninsured. Given system modifications that will be required, New York expects enrollment for the BHP would begin in October 2015.

The state's November presentation of the group's current thinking about a basic health plan's features is accessible here.

North Carolina

North Carolina Auditor Cites 3,200 Defects in NC Tracks Claims System. On December 9, 2013, North Carolina released an audit of the Medicaid claims system, NC Tracks, which has been a source of consternation for many healthcare providers in recent months. The report cites more than 3,200 defects since its July 1, 2013 launch, with nearly 20 percent of them still unfixed as of November 5, 2013. In addition, the audit points out that 12 of 14 changes required by the legislature or federal government did not meet target dates. The Department of Health and Human Services defended the system by saying that NC Tracks' defect rate was lower than average for such a complex system. Read more.

Medicaid Reform Now Focused on Regional Managed Care Plans. A new proposal for changing North Carolina's Medicaid program would have medical and insurance networks serve regions rather than bidding out statewide managed care contracts to large insurers. The December 5, 2013 proposal would allow for existing local provider networks to bid for contracts rather than relying on large national managed care companies. Rep. Nelson Dollar—who sits on the Medicaid advisory panel—reiterated his preference for Community Care of North Carolina, a local care management network. Read more.

Carolinas HealthCare System Projects a Loss in 2014. The Charlotte Observer published an article that highlights Carolinas HealthCare System first projected loss (in 2014) in nearly 30 years. The primary culprit is the drop in payment rates which no longer meet the cost of delivering appropriate care. CEO Michael Tarwater told his board of commissioners on December 10, 2013 that charity care and bad debt grew by 26 percent in the 9-month period ended September 30, 2013. Since North Carolina rejected Medicaid expansion, that figure does not appear to look better in the year ahead. Read more.

Ohio

Ohio Launches Online Enrollment for Medicaid. On December 9, 2013, Ohio launched its website for the enrollment of residents newly eligible for Medicaid in 2014. The web site evaluates Medicaid eligibility through a questionnaire and refers individuals to the healthcare.gov site, if they are ineligible. The state enrolled more than 1,000 people on the site on Monday alone. Read more.

Oregon

Cover Oregon warns enrollments behind schedule. The Statesman Journal reported this week that Bruce Goldberg, interim director for Cover Oregon, the state's health insurance Marketplace, acknowledged that the state is delayed in getting many of Marketplace applicants processed and enrolled in their qualified health plan. Nearly 10,000 people have enrolled in a health plan in Oregon, out of 28,000 paper applications processed. This is roughly 15 percent of the total 65,000 people who have completed paper applications. Cover Oregon's website is still not functioning as an enrollment portal. Read more.

Pennsylvania

HMA Roundup –Matt Roan

Transition of Kids from CHIP to Medicaid Delayed. Governor Corbett has indicated that the Federal Government does not plan on immediately enforcing provisions of the Affordable Care Act which require certain low-income children to transition from the State's CHIP program to Medicaid effective January 1, 2014. Corbett had requested HHS to allow these children to remain in CHIP, but Secretary Kathleen Sebelius responded that she could not waive the provision. HHS has expressed a willingness to work with Pennsylvania on a phased transition of this population. A spokesperson for Governor Corbett said that the Administration will release details on a notice that will be sent to the families of impacted children later in the week. Read more.

South Carolina

Medicaid Director projecting lower than anticipated spending. South Carolina's Medicaid Director Tony Keck communicated to a Senate panel this week that his agency, the Department of Health and Human Services, is projected to spend $250 million less than anticipated this fiscal year. However, along with his initial budget request for the upcoming fiscal year of $6.9 billion, Keck cautioned that implementation of the Affordable Care Act will create budget uncertainty. This is the second consecutive fiscal year with a Medicaid budget surplus in South Carolina. Read more.

Tennessee

Governor requests HHS response on TennCare reform plan. Governor Bill Haslam has formally requested a response from Federal HHS officials on the approval or denial of a plan to reform and expand the state's Medicaid program, known as TennCare, under the Affordable Care Act. Haslam's administration has proposed to expand Medicaid but only if HHS grants the flexibility to charge higher co-payments and change provider reimbursement structures to incentivize healthier behaviors. Despite Haslam's request to HHS, his administration has yet to formally submit a Medicaid waiver proposal. Read more.

Texas

Texas Medicaid physician payment increase design receives federal approval. Texas' program design to implement the Affordable Care Act's Medicaid physician primary care payment increase has been approved by HHS administrators. Physicians will be able to submit documentation to receive retroactive payments for primary care Medicaid services delivered in 2013. The delay in approval is believed to be due to the arrangement for passing payment increases through the state's managed care organizations which serve the majority of the Medicaid population. Read more.

Vermont

Vermont Health Connect reports 75 percent of small business employees enrolled in qualified health plans. Vermont's state-based health insurance Marketplace, known as Vermont Health Connect, has enrolled nearly 30,000 of the nearly 40,000 employees of small businesses impacted by the Affordable Care Act. Of the 30,000, roughly two-thirds have been enrolled in qualified health plans offered by either Blue Cross Blue Shield of VT or MVP Health Care based on their employer's selection. The remaining one-third are covered by employers that will be enrolled in the plan that most closely resembles their current coverage offering. Read more.

West Virginia

West Virginia Medicaid Director discusses Medicaid coverage for inmates. West Virginia Medicaid Director Nancy Adkins spoke with the state's joint committee on Regional Jail and Correction Facility Authority on Monday, December 9, 2013, regarding the rules and regulations surrounding coverage of inmates under Medicaid. Under the state's plan, inmates who are hospitalized will be eligible for Medicaid coverage after 24 hours. Read more.

Kaiser Health News reports on West Virginia, Virgin Island Medicaid MMIS partnership. West Virginia and the U.S. Virgin Island began a partnership earlier this fall to share a Medicaid Management Information System (MMIS) which processes Medicaid claims and pays providers. The combined MMIS is administered under a contract with Molina Healthcare which administered Medicaid claims in West Virginia before the partnership. The goal of the MMIS partnership is to achieve administrative savings. While West Virginia and the Virgin Islands are the first to launch a partnership, Michigan and Illinois will begin a partnership in 2014. Read more.

Wyoming

Governor requests $20 million to reduce Medicaid Developmental Disability Waiver waiting list. This week Wyoming Governor Matt Mead proposed an additional $20 million in Medicaid funding to reduce the waiting list for the state's Developmental Disability (DD) Waiver program. Currently, an estimated 600 individuals are on the waiting list. The state is currently reviewing the DD Waiver to determine if it is being run efficiently and could also identify savings to be used to reduce the waiting list in the longer term. Read more.

National

Republicans seek input from Medicaid directors on Medicaid expansion strains. Republican members of the House Energy and Commerce Committee sent letters to state Medicaid directors this week requesting feedback on the impact of the Affordable Care Act's Medicaid expansion. The letter cites concerns that Medicaid expansion would further strain the health care system and exasperate waiting times to see providers that have already increased in recent years for Medicaid beneficiaries. Read more.

HHS announces $50 million funding for community mental health. The U.S. Department of Health and Human Services (HHS) announced this week the opportunity for $50 million in Affordable Care Act funding available to community health centers with the purpose of establishing or expanding behavioral health services for people living with mental illness and drug and alcohol abuse issues. According to HHS, "Community Health Centers will be able to use these new funds….for efforts such as hiring new mental health and substance use disorder professionals, adding mental health and substance use disorder services, and employing team-based models of care." It is estimated these awards will support behavioral health expansion in approximately 200 existing health centers nationwide. Read more.

MACPAC meeting scheduled for December 12-13. The next public meeting of the Medicaid and CHIP Payment and Access Commission (MACPAC) will be held Thursday, December 12 and Friday, December 13 in Washington, DC. At the upcoming meeting, the Commission plans to finalize recommendations for its March 2014 Report to Congress. Topics under consideration include the future of CHIP, churning between Medicaid and the health insurance exchanges, pregnancy-related coverage and non-Disproportionate Share supplemental payments to hospitals. The full agenda and meeting information are available here.

Industry News

MAXIMUS announces planned retirement of CFO. MAXIMUS, a leading provider of government services worldwide, announced today that David N. Walker plans to retire from his role as Chief Financial Officer and Treasurer of MAXIMUS upon the successful completion of an executive search. Mr. Walker plans to continue on as a full-time employee to ensure a successful transition until approximately December 2014, whereupon he will assume a part-time support role to the Chief Executive Officer. Read more.

Centene's Cenpatico subsidiary partners with University of Arizona Health Network. Centene's behavioral health subsidiary, Cenpatico of Arizona, is negotiating a partnership with the University of Arizona Health Network, Centene announced this week. Cenpatico serves as the contracted Regional Behavioral Health Authority for Cochise, Gila, Graham, Greenlee, La Paz, Pinal, Santa Cruz and Yuma counties, while University of Arizona Health Network is a Medicaid managed care organization in 10 counties in Arizona. Read more.

Addus HomeCare completes acquisition of Coordinated Home Health Care, LLC New Mexico assets. Addus HomeCare Corporation, a provider of home-based social and medical services focused on the elderly dual eligible population, announced today that the Company closed on its acquisition of the previously announced purchase of substantially all of the assets of Coordinated Home Health Care, LLC and certain of its subsidiaries effective as of December 1, 2013. Coordinated Home Health Care was owned by Transition Capital Partners of Dallas, TX. This acquisition includes fifteen offices located in southern New Mexico and further expands the Company's presence in that state. New Mexico is a leader among the states in the transition of its long-term care services to managed care. Read more.

RFP Calendar

Date	State	Event	Beneficiaries
December 1, 2013	New Hampshire	Implementation	130,000
December 1, 2013	Florida LTC (Region 11)	Implementation	17,257
December 16, 2013	Tennessee	Contract Awards	1,200,000
December 30, 2013	Delaware	RFP Release	200,000
January 1, 2014	Massachusetts CarePlus (ACA)	Implementation	305,000
January 1, 2014	Massachusetts Duals	Implementation	115,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	Virginia Duals	Implementation	79,000
January 1, 2014	Texas Duals	Implementation	214,400
January 22, 2014	Texas NorthSTAR (Behavioral)	RFP Release	406,000
February 1, 2014	Illinois Duals	Implementation	136,000
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 17, 2014	Texas NorthSTAR (Behavioral)	Proposals due	406,000
May 1, 2014	Washington Duals	Implementation	48,500
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 30, 2014	Delaware	Contract awards	200,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
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
July 7, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	406,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
January 1, 2015	Vermont Duals	Implementation	22,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	406,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2013 and 2014.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	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	2/1/2014	5/1/2014	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			TBD	Blue Cross of Idaho
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	70,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
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	9/1/2014	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	60 days prior to passive	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	X			10/25/2013		7/1/2014	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013		5/1/2014	
Vermont	Capitated	22,000	10/1/2013	TBD	TBD Dec. 2013			1/1/20115	
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013		5/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**13 Capitated 6 MFFS**	**1.5M Capitated 485K FFS**	***9***			***8***			

** 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

"Clinical Management Apps: Creating Partnerships Between Providers and Patients"
The Commonwealth Fund

Sharon Silow-Carroll, Author
Barbara Markham Smith, Author

The market for health applications, or apps, on mobile devices is growing rapidly with over 40,000 currently in use. One type of app technology—clinical management apps—enable patients and providers to work together to manage chronic conditions, particularly diabetes and asthma. Challenges to broader adoption of apps include the lack of objective research to evaluate outcomes, uncertainty about how to pay for and encourage the use of cost-effective apps, and the absence of a regulatory framework that standardizes development to ensure performance. If this infrastructure is developed, apps may serve as a catalyst to stimulate the transformation of health care generally and target low-income populations to expand access to care and help reduce health disparities. Link to Report.

"Stewards of Affordable Housing for the Future - Health and Wellness Outcomes Measurement"
Presented to Stewards of Affordable Housing for the Future

Mike Nardone, Author
Matt Roan, Author
Linda Trowbridge, Author

Over the past year, SAHF has engaged HMA to assist in developing a common set of health and wellness outcome measures, to provide an overview of the current healthcare landscape, and advise on potential financing strategies for engaging the healthcare system to support housing as a vehicle to improve health outcomes. This is part of a broader effort SAHF and its members are undertaking to gather, aggregate, and apply outcome measures across five topic areas to determine the impact and cost implications of the resident services they provide. This spring, HMA finalized a report highlighting the effort to date. View the full report here.