HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 5, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Jim Kumpel, CFA
Email

Andrew Fairgrieve
Email

THIS WEEK

IN FOCUS

DELAWARE ISSUES MEDICAID MCO RFP

This week, our *In Focus* section reviews the Delaware Division of Medicaid and Medical Assistance's Request for Proposal (RFP) to re-procure contracts for the state's Medicaid managed care program. Delaware operates two Medicaid managed care programs – Diamond State Health Plan (DSHP) and Diamond State Health Plan Plus (DSHP Plus) – both currently served by Aetna's Delaware Physicians Care, Inc. subsidiary and United Healthcare. Under the RFP, Delaware leaves open the possibility of awarding a total of three contracts to serve both DSHP and DSHP+ if deemed financially viable.

Diamond State Health Plan (DSHP) has offered Medicaid MCO options for Delaware Medicaid enrollees since 1996. Since 2002, the state has operated Diamond State Partners, a managed fee-for-service (MFFS) option for enrollees who do not wish to be enrolled in one of the MCOs. However, declining Diamond State Partners enrollments

led the state to propose eliminating the program in mid-2014. The proposal to eliminate Diamond State Partners was included in the state's 1115 Waiver renewal application, which was approved on September 30, 2013.

Diamond State Health Plan Plus (DSHP Plus), implemented in April 2012, added managed long term supports and services (LTSS) and carved in the dual eligible populations, adding approximately 10,000 new beneficiaries to the combined DSHP and DSHP Plus programs.

DSHP and DSHP Plus Covered Population

As of December 2012, the DSHP and DSHP Plus combined population was approximately 178,000 Medicaid beneficiaries, comprised of an estimated 10,000 DSHP Plus beneficiaries and 168,000 DSHP beneficiaries. As of December 2012, only 2,881 individuals were enrolled in the Diamond State Partners MFFS option. In accounting for the Medicaid expansion under the Affordable Care Act, the Kaiser Family Foundation and the Urban Institute estimate an additional 37,000 beneficiaries could enroll in Medicaid and be covered by the awarded MCOs by 2022, with 16,000 of those newly eligible and 21,000 currently eligible "woodwork" enrollees. *(Source: The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis, November 2012. Available at: http://kff.org/health-reform/report/the-cost-and-coverage-implications-of-the/)*

Per the enrollment data below, Aetna's Delaware Physicians Care enrolled nearly two-thirds of the DSHP and DSHP Plus population as of December 2012, with United covering more than one-third and Diamond State Partners enrolling just 1.6 percent of the population. The RFP document appears to indicate that incumbent plans awarded a new contract would likely retain existing enrollments. In the event of a new MCO plan in the market, auto-assignment mechanisms would ensure minimum enrollment levels are achieved, as determined by the state.

Managed Care Organization	DSHP and DSHP Plus Combined Enrollment	
	# (December 2012)	%
Delaware Physicians Care, Inc. (Aetna)	113,129	63.5%
UnitedHealthcare	62,107	34.9%
Diamond State Partners (MFFS)	2,881	1.6%
Total	**178,117**	

Source: Delaware 1115 Waiver Renewal Application.

Populations excluded from DSHP and DSHP Plus enrollment are as follows:

- ICR/MR residents or individuals with ICF/MR level of care residing in the community;
- The inmate population, unless hospitalized in a non-department of corrections facility;
- Program of All-Inclusive Care for the Elderly (PACE) enrollees and individuals receiving Medicare cost-sharing;
- Presumptive eligibility pregnant women; and
- Medicaid Breast and Cervical Cancer Program (BCCP) enrollees and presumptive eligibility BCCP enrollees.

Timing and Contract Term

Per the timeline below, interested plans may submit an optional notice of intent to bid by the date of the pre-bid meeting on February 14, 2014. Proposals are due to the state on April 4, 2014, with announcements of intent to award tentatively scheduled for June 12, 2014. As noted above, the state is considering awarding two or three contracts, depending on the state's determination of financial viability of three MCOs. Contracts will begin on July 1, 2014, with implementation on January 1, 2015. The RFP indicates that contracts will be for a three-year term, with the option of extensions of any length, not to exceed a total contract term of five years.

Milestone	Date
Issue RFP	January 31, 2014
Pre-Bid Meeting/Notice of Intent to Bid Due *(Optional)*	February 14, 2014
Submission of Questions	February 21, 2014
Responses to Questions	March 14, 2014
Proposals Due	**April 4, 2014**
Selection/Intent to Award *(Tentative)*	June 12, 2014
Contract Start Date	July 1, 2014
Implementation	**January 1, 2015**

Market Opportunity

DSHP and DSHP Plus annual premiums were estimated at nearly $1.83 billion for 2013, per state 1115 Waiver budget neutrality documents. We conservatively estimate that Medicaid expansion enrollments could add $280 million in annual premiums at higher participation rates. Assuming half of that Medicaid expansion impact is achieved by 2015, the combined annual spend of the DSHP and DSHP Plus programs under this RFP is roughly $2 billion.

Evaluation and Scoring Criteria

The following table details the technical proposal scoring criteria for evaluation of RFP responses. Additional information on required proposal elements are contained in the RFP document.

Area	Weight	Sections
Qualifications and Experience	**15**	Qualifications and Experience
Covered Services and Members	**15**	Covered Services
		Pharmacy
		Enrollment/Disenrollment
		Marketing
		Member Services
Coordination	**20**	Care Coordination
		Case Management for DSHP Plus LTSS
		Service Coordination
Providers	**15**	Provider Network
		Provider Participation Agreements
		Provider Payments
		Program Integrity

Area	Weight	Sections
Quality and Related	**20**	Utilization Management
		Quality
		Grievance and Appeal System
		Financial Management
		Staffing
		Reporting
Claims and Information Systems	**15**	Claims Management
		Information Systems
Total	**100**	

Link to RFP website: http://bids.delaware.gov/bids_detail.asp?i=2357&DOT=N

HMA Medicaid Roundup

Alaska

Democrats Unveil Medicaid Expansion Proposal. On January 30, 2014, Alaska Democratic State Senators and representatives unveiled a proposal to expand Medicaid as long as the federal government pays for at least 90 percent of the cost of the expansion population. Governor Sean Parnell has consistently opposed Medicaid expansion and Republican leaders continue to fret that the federal government will ultimately renege on its commitments. Democrats argue that forgoing the enhanced federal funding will result in unnecessary deaths of Alaskans, which can be avoided by receiving the enhanced funding. Read more.

Arizona

Arizonans Find Limited Provider Choices on Exchange Plans. On January 29, 2014, the Arizona Republic reported on the limited provider choices available to Arizonans in health plans available on the state's exchange. While urban centers feature fewer provider choices, the cheapest plans in certain frontier areas might not have participating providers anywhere near the beneficiaries. Since the federal marketplace requires preferred provider organizations (PPOs) to offer plans statewide, some plans may not have providers in every community. Read more.

Arkansas

Governor Beebe Argues that Legislature Should Fund Arkansas' Private Option Plan. In a February 4, 2014 interview with Roby Brock from Talk Business Arkansas, Governor Mike Beebe pointed to a "multiplicity" of reasons for the state legislature to fund the state's private option plan, which passed with bipartisan support in 2013. With renewal funding at-risk in February 2014, Beebe noted that the state should save between $80 million and $90 million from lower funding for hospitals providing uncompensated care. Beebe expects a close vote, but believes that "logic and money" will ultimately result in funding for the private option. Aside from providing health coverage for 100,000 more Arkansans under Medicaid, the private option saves businesses $38 million in penalties and supports hospitals that would suffer from the reductions in disproportionate share (DSH) payments. Read more.

California

HMA Roundup—Alana Ketchel

Cal MediConnect to Expand Plan Options in LA. On February 4, 2014, the Department of Health Care Services announced its intention to expand Cal MediConnect plan offerings in Los Angeles County beyond LA Care and Health Net. Because LA Care did not achieve the quality measure benchmark, it was unable to receive passive enrollment into the dual eligible demonstration by the July 2014 start date. Instead, for Cal MediConnect only, California will passively enroll beneficiaries directly into CareMore, Care 1st, Molina, and Health Net. Once LA Care improves its Medicare quality rating, that plan would be eligible to begin receiving passive enrollment. In addition, DHCS announced that beneficiaries in Riverside, San Bernardino, and San Diego counties will have a 30-day voluntary period during April, with passive enrollment beginning in May 2014. Passive enrollment in San Mateo County will begin in April, as will enrollment in Medi-Cal managed care for long-term services and supports in a few counties. Read more.

Youth Mental Health Hospitalizations on the Rise. On February 2, 2014, the Sacramento Bee reported that mental health hospitalizations of California residents under 21 rose 38 percent between 2007 and 2012. Some attribute this spike to inadequate access to quality mental health services prior to crisis and after discharge from the hospital. Experts cite a decline in the number of group-home beds as one contributor. As a result, more youth are using emergency rooms to receive mental health treatment. Read more.

Medical Home Model Shows Promise to Reduce Costs over Time. A January 29, 2014 report by the UCLA Center for Health Policy Research suggests that providing health care coverage can reduce costly use of emergency departments. The study evaluated the California Health Care Coverage Initiative, finding that ED visits increased in the first year of coverage but declined in the two following years. The program emphasized care coordination and use of the medical home model so participating patients had access to quality care. Read more.

San Francisco Hopes ACA Will Cut Costs and Crime. On January 29, 2014, the Washington Post published a story highlighting San Francisco's view that the Affordable Care Act could reduce the cost of healthcare for prisoners and recidivism rates by enrolling many of the 31,000 people booked in its jail annually. Last week, Sheriff Ross Mirkarimi submitted a bill to the city's Board of Supervisors that would allow his office to apply for coverage under the ACA, saving San Francisco taxpayers about $2,500 per year for each inmate enrolled in a plan. Read more.

Colorado

HMA Roundup—Joan Henneberry

Colorado Healthcare Co-Op Touts 7,438 Enrollees in its Plans. Last week, the Colorado HealthOP, a member-run health insurance co-op, announced that 7,438 Coloradans have signed up for its health insurance plans . The HealthOP is the only insurance carrier in the state to announce enrollment numbers, with both the state's exchange (Connect for Health Colorado) and the Colorado Association of Health Plans declining to announce enrollment figures for other plans. However, given that 67,000 individuals or small business employees have enrolled in private plans through the exchange as of late January, Colorado HealthOP's enrollment figures would represent more than 10 percent market share. Read more.

Colorado Exchange Expects to Be Self-Sustaining. Last week, Connect For Health Colorado, the state marketplace, informed the General Assembly's Legislative Health Benefit Exchange Implementation Review Committee that expects to be self-sustaining by the time federal subsidies run out in 2015. According to Connect For Health CEO Patty Fontneau, current fees on premiums are not projected to increase in the near-term. Lawmakers on the Exchange's review committee recently voted to approve Connect for Health's financial and operational plans. Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

AHCA Permits Prestige Health Choice to Move Forward with Medicaid Contract. On January 31, 2014, Florida's Agency for Health Care Administration moved forward with its award of a contract to Prestige Health Choice, overriding the January 2 recommendation by an administrative law judge to rescind the contract on the grounds that it was not a provider service network (PSN). AHCA Secretary Elizabeth Dudek wrote, in the agency's final order, that Judge Van Landingham misinterpreted two sections of the managed-care Medicaid program. Furthermore, the order also noted that if the judge were correct in his findings, the company issuing the challenge—Care Access—would likewise be ineligible to win a contract award. Care Access indicated that it would appeal the agency's decision to the First District Court of Appeals. Read more.

Florida to Launch State-Run Florida Health Choices Exchange. In a February 3, 2014 statement, Florida Health Choices CEO Rose Naff indicated that Florida's state-run health insurance marketplace is days away from launching. The Exchange plans to offer discount and prepaid plans for specific health services, such as prescription drugs and dental care, with a focus on small business owners and individuals caught in the "coverage gap", making too much income for Medicaid coverage and too little to qualify for federal health Exchange premium subsidies. The Exchange needs about 67,000 customers to break even financially. By comparison, Healthcare.gov had processed 560,000 insurance applications for Floridians between October 1 and December 31, 2013, with about 158,000 actual enrollments. Currently, the website (www.FloridaHealthChoices.net) is not yet functioning and the plans would not be comprehensive to avoid potential federal fines. Read more.

Legislature Working on Telemedicine Bill. According to the Florida Current, Senator Aaron Bean—chairman of the Senate Health Policy Committee—is working on the Florida Telemedicine Act, which would aim to address a physician shortage in the state. The legislation would set regulatory standards for telemedicine and require the same Medicaid reimbursement for telemedicine visits as are paid for face-to-face visits. Bean plans a vote for February 11, 2014. Read more.

Georgia

HMA Roundup – Mark Trail

Georgia General Assembly Hearing Highlights Opposition to ACA. On February 3, 2014, ongoing opposition toward the Affordable Care Act was openly expressed at a Georgia General Assembly hearing, echoing the rhetoric and fury of 2009 and 2010 town meetings. House Bill 707 (The Georgia Health Care Freedom and ACA Non-Compliance Act) was introduced to prevent state institutions from implementing ACA provisions, including the sponsorship of navigators or the establishment of a health

exchange. Representative Jason Spencer characterized federal actions under the ACA as "repugnant" to the Constitution, while another representative cited a figure of 400,000 Georgians who had lost individual health policies for not meeting ACA essential health benefit requirements. Supporters of the ACA noted, however, that 58,000 Georgians had enrolled in exchange plans in the first three months of open enrollment and that the proposed legislation could have unintended consequences. Read more.

Piedmont Healthcare Strikes 3-Year Deal with Aetna/Coventry. On January 31, 2014, Piedmont Healthcare agreed to a 3-year deal with Aetna/Coventry that will allow for five Piedmont hospitals, its outpatient centers and physicians to remain as in-network providers for the plans that cover more than 600,000 beneficiaries in Georgia. Read more.

Illinois

HMA Roundup – Andrew Fairgrieve and Erika Wicks

Accountable Care Entity RFP Awards Expected Later This Month. At the February 4, 2014 Medicaid Advisory Committee (MAC) Care Coordination Subcommittee meeting, the Department of Healthcare and Family Services (HFS) announced that Accountable Care Entity (ACE) RFP responses were still being reviewed and that awards were expected to be made by the end of February. ACEs are provider-led managed care entities that will cover Medicaid children, families, and new ACA adults beginning July 1, 2014. A list of ACE RFP applicants is available here.

First Duals Demonstration Client Notices Sent. Also at the MAC Care Coordination Subcommittee, it was announced that approximately 40,000 notification letters were sent by MAXIMUS, the state's client enrollment broker, on January 29, 2014 to dual eligibles in greater Chicago and Central Illinois regions. The notice includes information about the duals demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI), the call center information, participating plans, as well as informing recipients the program is optional. This is the first of several notices, with an enrollment packet to be sent at a later date. The first effective date of voluntary opt-in enrollments is set for March 1 with passive opt-out enrollments to begin June 1.

Governor Quinn Requests Budget Address Delay. Crain's Chicago Business is reporting this week that Illinois Governor Pat Quinn is requesting the legislature approve a delay in his budget proposal from February 19 until March 26, 2014, which is after the Republican gubernatorial primary. Governor Quinn's administration is requesting additional time to put together a five-year budget blueprint. Read more.

Kansas

KanCare Now Covering HCBS for Developmentally Disabled. On January 30, 2014, Governor Sam Brownback announced that the state had received federal approval to deliver home- and community-based services for 8,500 developmentally disabled Kansans through the state's KanCare Medicaid managed care program, effective February 1, 2014. While Brownback emphasized the potential for better coordination of services, advocates fret about potential service cuts and delayed provider payments. Shawn Sullivan, secretary of the Department for Aging and Disability Services, emphasized the potential to improve employment opportunities and shrink waiting lists. Read more.

Kanasas Corrections Department Focused on Plan to Shift Inmate Health Costs to Medicaid. According to a January 29, 2014 article from Kansas Health Institute, the Kansas Department of Corrections is developing a plan that could save Kansas jails between $1.2 million and $2.4 million a year by billing Medicaid for inmate healthcare costs. Viola Riggin, director of health care services at the Kansas Department of Corrections (KDoC), notes that Medicaid already covers about $750,000 of the department's healthcare costs annually for a limited number of patients: the elderly, the disabled, pregnant women, and young offenders under 19. The KDoCis working with the Kansas Department of Health and Environment (the Medicaid agency), the Kansas Association of Counties and the Kansas Sheriff's Association to implement a revised plan by July 1, 2014. Read more.

Maine

Maine Care Reducing Emergency Room Use. A January 30, 2014 article on WCSH News' website focuses on efforts by Maine Care to lower emergency room use, saving the state $8 million in one year. The Department of Health and Human Services implemented its ER Care Management program, which has reduced the use of ERs for non-emergency care through improved transportation and care coordination services for about 1,700 patients currently. Read more.

Maryland

Maryland Medicaid Enrollments Already Surpassed Mid-2014 Projections. Last week, Maryland officials announced a total of 121,000 individuals have newly enrolled in Medicaid, beating out projections of 110,000 by the end of June 2014. The state's Deputy Health Secretary, Chuck Milligan, credited early preparation and the state's Primary Adult Care program that automatically transferred members into enrollment on January 1, 2014, according to the *Baltimore Business Journal*. Milligan said the state does not yet know the percentage of enrollees who are newly eligible versus those previously eligible for Medicaid. Read more.

Massachusetts

HMA Roundup – Rob Buchanan

MassHealth COO Named President of ElevateHealth. MassHealth's chief operating officer, Corbin Marie Petro, was named the president of ElevateHealth last week. ElevateHealth is the coordinated care network formed in a joint venture of Harvard Pilgrim Health Care, Darthmouth-Hitchcock and Elliot Health System. ElevateHealth is currently only offering ESI products, but anticipates offering to the individual market and through the health insurance marketplaces in the future, according to the New Hampshire Business Review. Read more.

Mississippi

Hospital Association Opposes Managed Care Expansion. The Mississippi Hospital Association announced their opposition this week to a proposal by the state's Medicaid director that would expand Medicaid managed care beyond the current allowed enrollment level. State law has imposed a ceiling on the percentage of Medicaid beneficiaries that can be enrolled in managed care, currently set at 45 percent. The state's Medicaid director, David Dzielack, told members of the Senate Public Health and Welfare Committee last week that expanding Medicaid managed care could save the state up to $40 million. Read more.

New Jersey

HMA Roundup—Karen Brodsky

Alternative Benefit Plan Coverage under New Jersey's Medicaid Expansion. Beginning January 1, 2014, New Jersey's Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) expanded its NJ FamilyCare (NJFC) program to offer healthcare to parents, single adults and childless couples ages 19 to 64, with incomes up to 133 percent of the Federal Poverty Level (FPL). Previously, the only childless adults covered by the State of New Jersey were those who qualified for the General Assistance (GA) program. Covered individuals categorized as Aid to Families with Dependent Children (AFDC), Aged, Blind and Disabled (ABD), Long Term Care, and Juvenile Services programs were not affected by the expansion. There is also no impact to benefits offered under NJFC Plans A, B, C, and D. DMAHS issued a provider newsletter to detail the coverage under the Alternative Benefit Plan for the expansion group and the impact this has on the aforementioned plans. Read more.

New Jersey-Based ACO Saved Medicare at Least $10 Million. On January 30, 2014, the Centers for Medicare & Medicaid Services (CMS) announced performance data from its delivery system reform initiatives, including Accountable Care Organizations. Medicare ACOs were created as part of the Affordable Care Act, with an aim of reducing waste in the Medicare system through improvements in patient care. According to the New Jersey Health Care Quality Institute, the state has 18 Medicare ACOs, but most have not operated long enough to generate savings. Hackensack Alliance is one of 29 Medicare ACOs nationwide that generated shared savings, out of 114 Medicare ACOs that were launched nationally in 2012 and 2013. Hackensack Alliance started in April 2012 and is reported to have saved Medicare at least $10 million through 2013. Under the shared savings arrangement, Hackensack will receive half of the Medicare savings it generated, or at least $5 million. Nationally, ACOs generated $128 million in net savings for the Medicare Trust Fund.

NHQI identified the following eighteen Medicare ACOs based in New Jersey:

1. ACO-PA (Jefferson Health System)
2. Advocare Walgreens Well Network
3. Allegiance ACO
4. Atlantic Health System ACO, LLC
5. AtlantiCare Health Solutions
6. Barnabas Health ACO-North, LLC
7. Central Jersey ACO, LLC
8. Hackensack Physician-Hospital Alliance ACO, LLC
9. Holy Name Medical Center Hospital/Physician ACO
10. JFK Population Health Company, LLC

11. Lourdes Health System Health Network, LLC
12. Meridian Accountable Care Organization, LLC
13. NEPA ACO Company, LLC
14. NJ Physicians ACO
15. Optimus Healthcare Partners
16. Partners In Care ACO, Inc.
17. Robert Wood Johnson Partners (RWJ Hospital and Health System with Rutgers University)
18. Summit Health-Virtua, Inc. (Doing business as VirtuaCare)

Read more.

New Mexico

New Mexico Health Exchange Projects Lower Enrollment. On January 30, 2014, Mike Nunez, interim chief executive officer of the New Mexico Health Insurance Exchange, said that the state's health exchange was significantly reducing its projected enrollment from 83,000 to about 40-50,000. The state health exchange had just 934 enrollments in November 2013, but that figure grew to 7,668 by December 28, 2013. Read more.

New York

HMA Roundup—Denise Soffel

People First Waiver Update. In April 2013, New York State submitted a combined Section 1915 b/c waiver, a.k.a. People First. Section 1915(b) is the Medicaid managed care waiver, while Section 1915(c) is the home and community based care waiver. The People First waiver would establish Developmental Disabilities Individual Services and Care Coordination organizations (DISCOs) and would capitate the Medicaid payment for those services currently funded through the Office for People with Developmental Disabilities (OPWDD). Negotiations on the waiver have been delayed because of the need to re-vamp the rate methodology for developmental disability providers. CMS is in Final Management Review of the state's proposed rate methodology, which CMS continues to deem as excessive. CMS has submitted its findings and the state has requested 90 days to respond. Medicaid Director Helgerson continues to plan for DISCOs to begin enrollment in October 2014, although the RFA has not yet been released.

NYS 1115 Waiver Update. Discussions between CMS and NYS regarding its $10 billion waiver request have accelerated. CMS has completed drafting the special terms and conditions that would define the waiver. New York needs to respond to the draft so that negotiations can begin. The waiver includes a large Delivery System Reform Incentive Payment (DSRIP) program. The menu of projects is still being discussed. CMS has indicated the need for hospitals to demonstrate community involvement in the development of DSRIP proposals, as well as in the implementation. Any successful bid must address how the community will be included, both in establishing and in operating the project. CMS has also indicated that more emphasis must be placed on primary care and community-based care. Plans that direct all the funding to hospitals are unlikely to be approved.

NY Records $851 Million in Medicaid Recoveries. On February 3, 2014, Governor Andrew Cuomo announced the largest single year of recoveries in the history of the Office of the Medicaid Inspector General (OMIG). Preliminary calculations show the administration recovered more than $851 million dollars for 2013. This brings the three-

year total to more than $1.73 billion, a 34 percent increase over the previous three years. OMIG's recoveries are the highest on record for any state Medicaid program integrity unit. OMIG has worked to eliminate fraud through aggressive responses to allegations of fraud in social adult day care, excluding unscrupulous providers, and focusing on ineligible individuals. Among the improvements in fraud and abuse prevention established under the Cuomo administration are the creation of pre-claim reviews – specialized reviews of home health claims and inventory reports – improved practices for reviewing pharmacy operations, and strong data sharing and coordination with federal, state, and local partners. Read more.

New York State of Health Reports 381,000 Enrollees. On February 3, 2014, New York state officials report that 380,747 New Yorkers have enrolled in a health plan through the state's exchange, up 65 percent since December 24, 2013. The mix continues to be about two-thirds private health plans (241,241) and one-third Medicaid (139,505). NY State of Health executive director Donna Frescatore reported that 657,137 New Yorkers have completed applications since the launch of the Marketplace on October 1, 2013 and New York is on track to meet or exceed its year-end 2016 enrollment goal of 1.1 million people. Read more.

Shah Confirms Basic Health Option is Untenable without Federal Rules. On February 3, 2014, NY State Health Commissioner Nirav Shah testified that the state is unable to implement a "basic health option" plan to cover up to 486,000 people without federal guidance. The option intends to fill a gap of coverage, but would not likely be operational in 2014, despite its inclusion in Governor Andrew Cuomo's budget plan. Read more.

Pennsylvania

HMA Roundup – Matt Roan

Governor Corbett's Proposed Budget Boosts Home and Community-Based Services, Touts Healthy PA. On February 4, 2014, Governor Tom Corbett presented his proposed budget for SFY 2014-15 to a joint legislative session, laying out a spending plan for $29.4B from the State General Fund. The budget, which includes no new taxes, will make targeted investments in specific program areas while relying on cost savings to fill funding gaps left by decreases in external funding sources and lower than projected state revenues. After the Governor's address, Bev MacKereth, Secretary of the Department of Public Welfare presented highlights of the Department's budget which include:

- $322M reduction in Federal matching funds for Medicaid as a result of the annual federal calculation of matching rates. Pennsylvania's matching rate will go from 53.2 percent to 51.82 representing the largest year to year reduction in more than 30 years.
- The replacement of $130M in General Fund dollars used for Home and Community Based Services with Lottery revenues and an additional commitment of $32.6M in Lottery funds to support HCBS.
- $75M in new federal funding for the Balancing Incentive Program which leverages federal funds to increase the number of people with intellectual and physical disabilities and the elderly to receive home and community based services.
- $67.9M in new funding to expand services to individuals with disabilities, people with autism and the elderly.

- $63.6 million in state funds to support Health Insurers Providers fee increase in Medicaid managed care rates
- $394M in savings by implementing a 1 month delay in capitation payments to Medicaid physical health and behavioral health managed care plans.
- The budget assumes implementation of the Healthy PA program which expands coverage for the uninsured and reforms the existing Medicaid program for adults on January 1, 2015. Savings for 6 months of Healthy PA is assumed in the budget as $125M. Projected savings from Healthy PA in SFY 15-16 is $616M.
- $63M in state funds are earmarked to cover the health insurer provider fee for Medicaid MCOs.

Secretary MacKereth reported that the Department will submit its 1115 waiver application for Healthy PA to CMS by the end of February. She also indicated that the Department's views on elements of the waiver has evolved significantly, through the public hearing process and ongoing discussions with the federal government. Read more.

Governor Establishes Long Term Care Commission, Appoints Membership. Last week, Governor Tom Corbett signed an Executive Order establishing the Pennsylvania Long Term Care Commission. The Commission is charged with developing recommendations to improve the current long term care system focused on achieving better coordination of services and improving the quality of care for seniors and people with disabilities. The 25 member commission includes cabinet officials, providers, advocacy groups, LTC consumers and their families. The Commission is expected to issue a report with its recommendations by the end of 2014. Read more.

Independence Blue Cross Makes Investments in Healthcare Start-ups. In a February 4, 2014 article, the Philadelphia Inquirer noted that Independence Blue Cross is making investments to position Philadelphia as the "Silicon Valley" of healthcare innovation. The IBC Center for Healthcare Innovation will invest up to $50M in health related venture funds and individual start up companies. Half of the funding will go to partnerships with regional venture funds, the city and local universities. Read more.

Departure of Top Corbett Aide Announced. During a briefing on the state budget, Department of Public Welfare Secretary Bev MacKereth announced that Todd Shamash is leaving the administration. Shamash has been Governor Tom Corbett's Deputy Chief of Staff, with responsibility for agencies including the Department of Health and the Department of Public Welfare. The Secretary recognized and thanked Shamash for the significant contributions he has made to State Government during his tenure. Shamash has played a pivotal role in shaping the Governor's healthcare agenda, including the Healthy PA initiative. Sources have confirmed that Shamash is leaving state government to pursue an opportunity in the private sector. Prior to working in the Governor's office, Shamash served as Senior Counsel and Director of Government Affairs for Jefferson Health System and has also held positions with Capital BlueCross and the Pennsylvania Insurance Department.

Puerto Rico

Puerto Rico Issues *MI Salud* RFP. Puerto Rico has released a RFP for the *MI Salud* program, the government-run medical assistance program that incorporates Medicaid and CHIP federal funds and serves more than 1.6 million residents of the Commonwealth. According to the Puerto Rico Health Insurance Administration (PRHIA) announcement, all entities interested in submitting a proposal will have to submit a written certification authorized by its Board of Directors with its official corporate seal, stating their interest in submitting a proposal, legal and financial capacity and an authorization to receive the RFP.

The RFP will be available February 5th and 6th of 2014 in CD format at the PRHIA headquarters between the hours of 8:00 am and 5:00pm. Interested entities may also obtain an electronic version of the RFP via e-mail by contacting PRHIA at RFP2014@asespr.org.

Responses to the RFP are due on March 21, 2014, with awards anticipated on April 11, 2014, and a targeted implementation date of July 1, 2014. We previously reported on the *MI Salud* RFI in our December 18, 2013 Roundup, available here.

South Dakota

Governor Intends New Partial Medicaid Expansion Waiver Request to HHS. South Dakota Governor Dennis Daugaard announced last week that he had sent a letter to Health and Human Services Secretary Kathleen Sebelius, indicating that South Dakota is interested in expanding Medicaid up to 100 percent of the federal poverty level, provided they are working or became unemployed in the last 12 months. The Governor's previous request for partial expansion was denied by HHS last year. Read more.

Vermont

Governor's Budget Proposal Includes Doubling Health Care Claims Tax, Boosting Medicaid Payments. Governor Peter Shumlin's proposed FY 2015 budget includes doubling the state's existing 0.8 percent tax on all health insurance claims to 1.6 percent, according to the *Vermont Press Bureau*. The additional revenue from the tax would help fill a $14 million budget gap and increase Medicaid provider payments by 2 percent. Read more.

National

CBO Publishes Revised Projections of Medicaid, Exchange Enrollments. The Congressional Budget Office (CBO) issued revised projections for 2014 through 2024 of the impact of the Affordable Care Act on insurance coverage nationwide. The February 2014 Baseline estimates now project an increase in Medicaid and CHIP enrollment of 8 million in 2014, with 6 million projected to enroll in the Exchanges. Despite the widespread issues with enrollment in the Exchanges, these estimates are down less than 15 percent from the May 2013 Baseline estimates released last spring, which forecasted 9 million new Medicaid and CHIP enrollees and 7 million Exchange enrollees. Read more.

Industry News

Centene's Magnolia Health Plan One of Two Statewide Contracts Awarded in Mississippi. On February 3, 2014, Centene announced that its Mississippi subsidiary, Magnolia Health Plan, was awarded one of two statewide contracts to serve the MississippiCAN Medicaid managed care program. Magnolia Health Plan, an incumbent, has held a MississippiCAN contract since 2011. Read more.

HCA Sees Positive ACA Impact, says CFO. During their earnings conference call this week, HCA Chief Financial Officer William Rutherford indicated that the hospital group anticipates between 7 and 9 percent of its existing self-pay or uninsured business to receive either Medicaid coverage or coverage through an Exchange plan. Despite lingering uncertainty around the implementation of the Affordable Care Act, the company anticipates a net positive impact on revenues in 2014. Read more.

CareSource Names Ohio Market President. On February 3, 2014, CareSource announced the appointment of Steve Ringel to the position of president of the Ohio market. Ringel previously was senior vice president of the market and product group and has been with the company since 2011. Read more.

Humana Reports on Exchange Enrollee Age Distribution. Humana CEO Bruce Broussard reported on the company's annual earnings conference call that roughly 35 percent of their Exchange enrollments were between the ages of 21 and 40. Broussard reported that this distribution was skewed younger than anticipated. Read more.

Centene Announces 2013 Year-End Results. On February 4, 2014, Centene Corp. announced 2013 fourth quarter and year-end results. As of December 31, 2013, Centene covered more than 2.7 million managed care beneficiaries, an increase of 12 percent over the previous year, and 2013 revenues of $10.5 billion, up 37 percent from 2012. Read more.

Kindred Healthcare Appoints VP/CFO. On February 3, 2014, Kindred Healthcare, a provider of post-acute care services, announced the appointment of Stephen D. Farber as vice president and chief financial officer. Farber has more than 20 years of healthcare experience, including serving as Chief Financial Officer for Tenet Healthcare Corp. Most recently Farber led the successful financial restructuring of Rural Metro, the nation's second-largest ambulance and fire service operator, and has been involved in various private equity efforts, including as a healthcare executive-in-residence with Warburg Pincus. Read more.

LHC Group to Acquire Deaconess HomeCare. LHC Group has announced a $60 million deal to acquire Deaconess HomeCare, which operates 33 home health, hospice, and community-based service agencies. Deaconess is currently owned by BioScrip, a provider in pharmaceutical and home care solutions. Deaconess operates in Mississippi, Tennessee, Kentucky, Illinois, and Nebraska. Read more.

RFP CALENDAR

Date	State	Event	Beneficiaries
TBD, Early 2014	Texas NorthSTAR (Behavioral)	RFP Release	406,000
February 27, 2014	Georgia ABD	Proposals Due	320,000
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
March 21, 2014	Puerto Rico	Proposals Due	1,600,000
April 1, 2014	California Duals	Passive enrollment begins	456,000
April 1, 2014	Ohio Duals	Passive enrollment begins	115,000
April 4, 2014	Delaware	Proposals Due	200,000
April 11, 2014	Puerto Rico	Contract Awards	1,600,000
April 17, 2014	Texas NorthSTAR (Behavioral)	Proposals due	406,000
May 1, 2014	Virginia Duals	Passive enrollment begins	79,000
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
June 1, 2014	Illinois Duals	Passive enrollment begins	136,000
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 12, 2014	Delaware	Contract awards	200,000
July 1, 2014	Puerto Rico	Implementation	1,600,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Passive enrollment begins	68,000
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	New York Duals	Passive enrollment begins	178,000
September 1, 2014	Washington Duals	Passive enrollment begins	48,500
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Delaware	Implementation	200,000
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	350,000	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 (CareMore)
Colorado	MFFS	62,982						7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	3/1/2014	6/1/2014	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	X	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	105,000	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	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	3/27/2013	August 2013			TBD	
South Carolina	Capitated	68,000	X			10/25/2013	2/1/2014	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	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	7/1/2014	9/1/2014	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	**12 Capitated 6 MFFS**	**1.2M Capitated 520K FFS**	***12***			***9***			

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

‡ Capitated duals integration model for health homes population.

HMA News

HMA's Accountable Care Institute Releases New Toolkit

HMA's Accountable Care Institute (ACI) is continually working to assist publicly funded health care systems transition into the realm of integrated, accountable systems of care. Unmatched expertise, shared experiences, and practical tools converge in HMA's ACI – a venue to develop, support, and disseminate innovations in accountable care. Check out the resources available in the ACI Toolkit: Link to ACI Toolkit.