HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: COVERAGE EXPANSION IMPLICATIONS FOR PAROLEES AND EX-OFFENDERS

HMA ROUNDUP: OBAMA ADMINISTRATION ANNOUNCES ONE-YEAR DELAY OF EMPLOYER MANDATE; VIRGINIA AWARDS DUAL ELIGIBLE DEMONSTRATION MCOS; EXCHANGE PLANS REVEALED IN IOWA, VERMONT; MASSACHUSETTS MEDICAID DIRECTOR MOVING TO OMB; MISSISSIPPI REAUTHORIZES MEDICAID PROGRAM; NEW HAMPSHIRE HOSPITALS AGREE TO PARTICIPATE IN MEDICAID MANAGED CARE NETWORKS; UPGRADED MMIS SYSTEM LAUNCHES IN NORTH CAROLINA; WASHINGTON HEALTH HOMES PROGRAM LAUNCHED

INDUSTRY NEWS: CENTENE EXITS KENTUCKY CONTRACT EARLY; MOLINA ASSUMES LOVELACE MEMBERS IN NEW MEXICO

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

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IN FOCUS: COVERAGE EXPANSION IMPLICATIONS FOR PAROLEES AND EX-OFFENDERS

Over the last decade, Health Management Associates has developed a robust practice in correctional health care, working with state prison systems, county and city jails, policy makers in the justice arena, and companies that deliver health care, mental health, and prescription drug services within prisons and jails. Through this experience, we have become aware that ex-offenders potentially comprise a very large portion of Medicaid and Exchange plan expansion populations.

This week, our *In Focus*, authored by HMA Principal Donna Strugar-Fritsch, provides an opportunity for Medicaid agencies, Exchanges, and health plans to learn about this new population and to begin to prepare for the challenges and opportunities covering ex-offenders will present. It provides background on the volume of ex-offenders in expansion populations, information on the unique health characteristics of ex-offenders, identifies challenges that providers and payers may face, and describes important public health and public safety opportunities that communities can seize by assuring that ex-offenders are enrolled in coverage at release/parole.

Ex-Offenders: Numbers and Health Characteristics

About 9 million adults cycle through the nation's city and county jails every year. Many post bail or are released quickly, but about 3 million spend between several weeks and a year in the county or city jail. An additional 750,000 adults are released from state and federal prisons each year. The offender population is almost exclusively low income and many will, therefore, qualify for Medicaid coverage beginning in 2014. In states that do not expand Medicaid, many ex-offenders will qualify for subsidized Exchange plans, especially where they can enroll as family members. Ex-offenders will make up a significant portion of the Medicaid expansion population, and in large urban areas, that portion may be even greater.

In 2012, the Minnesota Department of Corrections found 70 percent of incarcerated women had been dependent on at least one substance and 8 percent had a Substance Use Disorder (SUD). A SAMHSA analysis found that 26 percent of adults with an arrest in 2012 had a mental illness, and 14 percent had an SUD.

Incarcerated adults carry a very high burden of mental illness, chronic disease, substance abuse, and stress-related conditions. From a health care perspective, prison inmates over age 50 are considered elderly. Conservatively, 11 percent of inmates have serious and persistent mental illness and an additional 7 to 9 percent have mental illness of less severity. In the female population, many have been abused and the prevalence of mental health and substance use disorders is even higher. Incarcerated adults also carry a high incidence of infectious disease:

- Up to 50 percent are infected with Hepatitis C
- 7 percent have a positive TB test
- 1.5 percent are HIV positive

Health Care Behind Bars

Jails and prisons are required to evaluate medical, mental health, and dental needs of inmates immediately upon arrest. A comprehensive health assessment within 14 days of incarceration is required by correctional health care accreditation standards and many states' regulations. Throughout incarceration, inmate health conditions must be evaluated and treated in accordance with community standards of care in order to comply with the provisions of the 8th amendment to the U.S. Constitution established under the landmark 1976 lawsuit *Estelle v. Gamble,* which guarantees inmates the right to be free from "deliberate indifference to their health care needs."

Prisons and large jails typically offer daily triage of medical requests, sick call, urgent care, chronic care clinics, dental services, and a variety of behavioral health screening and treatment services on-site. Many operate infirmaries, and jails routinely oversee inmate detoxification from alcohol and other drugs. Inmates who need more extensive hospital, diagnostic, or treatment services are referred to community providers and escorted to providers under guard. Prescription and over-the-counter medications are also provided behind bars, and correctional prescription drug costs often exceed the cost of off-site health care services. At release/parole, even inmates with the most serious physical or mental illnesses are usually medically stable.

Coverage at Release/Parole

A large body of literature has documented that ex-offenders who have had adequate access to health care services at release or parole have significantly lower rates of recidivism. In response, prisons and jails are increasingly motivated - by the chance to reduce crime and improve public safety - to assure that health care coverage is effective for inmates *on the date of release/parole*. An additional motivator for Medicaid enrollment *during incarceration* is the federal Medicaid match available for inpatient hospitalizations and nursing home admissions. Currently, just 3 to 4 percent of inmates qualify for Medicaid. In 2014, nearly all will, and nearly every inmate's inpatient hospitalization will be eligible for 100 percent federal match funding if the inmate is enrolled in Medicaid. Many jails, counties, and states are counting on this "revenue" and included it in their Medicaid expansion fiscal estimates, even though they may not be collecting matching funds on eligible admissions today. A final incentive for enrolling inmates into Medicaid during incarceration is that as of March 2013, medical practices in corrections settings are eligible for EMR Meaningful Use incentives where 30 percent of a practice is enrolled in Medicaid. Prior to this change, there had been no funds available for expanding EMR use behind bars. These opportunities have combined to produce growing widespread interest within jails and prisons and among justice system policy makers to explore options to enroll inmates in Medicaid and/or in subsidized Exchange plans.

Prisons and jails have three incentives to enroll inmates in Medicaid or Exchange plans prior to release/parole:

- *Subsequent reductions in recidivism*
- *100 percent federal match for inpatient admissions*
- *Access to EMR Meaningful Use incentives*

Coverage at release/parole also can assure that inmates with serious infectious conditions such as tuberculosis and hepatitis can be maintained on drug therapies, closing a vexing and intractable gap in our public health system. Also, seamless care management and prescription drug treatment for inmates with serious mental illness can interrupt the cycle that so many people face – of committing a minor public offense, being jailed, becoming stabilized, being released, decompensating, and re-offending.

Prisons and jails face considerable challenges in establishing and carrying out practices to enroll inmates into insurance programs prior to release. Nevertheless, Medicaid agencies, health plans, and Exchanges should expect that beginning in early 2014 many new enrollees will be coming from prisons and jails.

The practice of enrolling incarcerated inmates into Medicaid will have significant implications for health plans. Where enrollment is effective upon release, capitated plans are at risk for expenses incurred by the new members from the moment they exit the prison or jail. Many ex-offenders have had little experience with an organized health system or coverage, so frequent and inappropriate emergency room visits are a strong possibility. These new members, especially those with significant medical and/or behavioral health conditions, are candidates for aggressive care coordination and case management to assure appropriate use of primary care, to maintain the clinical stability achieved behind bars, and to assure continuous compliance with clinical treatment and prescription drug regimens for behavioral health conditions and infectious diseases.

Strategies for Health Plans to address challenges of Parolee/Ex-Offender Population
Educate key clinical and administrative leaders about this new population.
Assess markets to identify areas likely to absorb large numbers of ex-offenders from city and/or county jails and state and federal prisons.
Identify key local prison, jail/sheriff/public safety, behavioral health, public health, and other community based partners who can support developing strong community-wide practices to help ex-offenders access health care, adhere to treatment plans, and attend scheduled appointments.
Develop and deploy in-reach care coordination and beneficiary support services prior to inmate release/parole. Develop process to: - *Identify soon-to-be-released inmates with serious conditions who have selected the health plan.* - *Confer with corrections health care providers re: clinical management, release date, and other relevant matters.* - *Transfer medical records.* - *Coordinate care with community mental health providers as appropriate.* - *Meet with inmates prior to release to establish a connection and teach how to use primary care, benefits, and services.* - *Establish initial primary care appointments, transportation, and access to prescriptions.* - *Track members who are ex-offenders and evaluate the effectiveness of plan interventions; find and spread best practices.*

In addition, Exchanges and Medicaid agencies can assure that enrollment practices enable inmate enrollment with effective coverage at the time of release/parole. Exchange plans and Medicaid should also assure that coverage can be suspended rather than terminated during incarceration.

HMA Medicaid Roundup

Arkansas

HMA Roundup

Three Appointed to Health Exchange Board. On Monday, July 1, 2013, Arkansas Senate President Pro Tem Michael Lamoureux announced three appointments to the board of the Arkansas Health Insurance Marketplace: Steve Faris, a member of the state Lottery Commission; Fred Bean, president of Bean Hamilton Corporate Benefits; and John Denery, executive vice president and director of life and health for Stephens Insurance. In Arkansas, the Senate president pro tem, the House speaker and the governor each make appointments to the exchange board. Faris has an eight year term, Bean has a six-year term, and Denery has a four-year term.

California

HMA Roundup—Jennifer Kent

Court Mandates Medi Cal to Cover Certain Services in FQHCs and RHCs. On July 5th, the Ninth Circuit Court of Appeals ruled in *California Association of Rural Health Clinics v. Douglas* that Medi-Cal is required to cover adult dental, podiatry, optometry, and chiropractic services in Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs). The basis for the ruling is that physician services under Medicaid are determined by the scope and definition of physician services under Medicare, which includes the aforementioned services. The state is reviewing options, including a hearing before a larger appeals panel, a review by the US Supreme Court, or compliance with the ruling.

Insurance Commissioner Challenges Exchange over Children's Dental Benefits. In a June 27 letter to Covered California (the state's exchange) Insurance Commissioner Dave Jones urged the exchange's board to require health plans to include pediatric dental benefits, consistent with the ACA's list of essential health benefits. The exchange countered that federal law does not require plans to include dental coverage for children if there are plans on the exchange that do provide them. On July 1, 2013, Covered California announced that nine dental-only plans for kids will range from $8 to $35 per month. The Exchange has also announced a hearing to discuss the pediatric dental issue on August 8.

California Mental Health Parity Hearing. During the first week in July, the California Senate held hearings on mental health parity, discussing the need for regulators to address denials of coverage, particularly in cases of autism. Shelley Rouillard, chief deputy director for the Department of Managed Health Care, notes that Federal guidance remains pending, tying the hands of state officials. Sen. Jim Beall, chair of the Senate Select Committee on Mental Health, cited a UCLA study that found inadequate coverage for mental health services for nearly three-quarters of the privately insured. Beall argued for his bill, SB 22, which would require every health plan to submit annual compliance reports to the Department of Managed Care and to the California Department of Insurance to ensure compliance with federal and state parity laws. SB 22 passed the full Senate on May 29. It passed the Assembly Health Committee on June 25 and was referred to the Assembly Appropriations Committee

Insurance Commissioner Worries About Limited Competition on Exchanges. On July 2, 2013, Insurance Commissioner Dave Jones expressed concern about the recent withdrawal of United Healthcare from the state's individual insurance market, coming on the heels of Aetna's withdrawal. Jones pointed to a tax break for Anthem and Blue Shield, amounting to more than $100 million annually, as a potential source of unfair advantage versus competing insurers. Jones fears that consumers may endure higher premiums due to a consolidation of individual and small group insurance policies among the three largest remaining health insurers: Kaiser, Anthem, and Blue Shield.

In the news

- **"California facilities put disabled at risk, audit finds"**

  An audit report claims that California's state-operated facilities for individuals with developmental disabilities put residents at risk through inadequate reporting of allegations of abuse, among other outdated policies. The state operates five facilities, serving nearly 1,500 developmentally disabled individuals (Los Angeles Times)

- **"Jails look to ACA to insure inmates"**

  California's counties are gearing up to get their inmate populations enrolled in Medicaid upon release. California estimates that 90 percent of their inmate population would be eligible for Medicaid upon release under the Medicaid expansion. (HealthyCal.org)

Colorado

HMA Roundup – Joan Henneberry

Colorado Medicaid Announces New HCBS/Home Health Case Management and Utilization Review Vendor. Effective July 1, 2013, Colorado changed vendors for the Single Entry Point agency contract for Home and Community Based Services and Long-Term Home Health case management and utilization review. InnovAge Longterm Care Options, also a PACE provider, has held the contract for many years but the new vendor will be Colorado Access, doing business as Access Long Term Supports Solutions (ALTSS). Colorado Access is also a third-party administrator for the CHP program, and holds the contract for three of the regional care coordination contracts (ACOs) for serving Medicaid. The Medicaid agency has developed a transition plan to ensure the protection of the case manager-client relationships and services. Clients and providers with transition questions are encouraged to review the Frequently Asked Questions document posted on the Department's website.

Global Payment Pilot Awarded to Rocky Mountain Health Plans. HB12-1281 gave the Department of Health Care Policy & Financing (Medicaid agency) the authority to fund at least one contract that pilots payment reform initiatives in Medicaid but keeping the foundation of the Accountable Care approach to service delivery in place. This week the Department announced the award of a global payment pilot program to Rocky Mountain Health Plans (RMHP). This pilot will be implemented over the next 12 months and will be limited to RMHPs' Regional Care Collaborative Organization (RCCO) geographic region.

Medicaid Enrollment in Colorado at All Time High. Medicaid enrollment in Colorado is now at 719,585 clients, the highest in the history of Medicaid in Colorado. An additional 68,506 clients are enrolled in CHP+. Monthly numbers for enrollment and expenditures can be found on the Department's Budget website.

Colorado Exchange Moves Forward Toward October 1 Debut. Despite the Federal move to delay the employer mandate for businesses with more than 50 employees, Connect for Health Colorado will continue to move forward with its October 1 debut for individuals and small businesses. At a Colorado Exchange Board meeting on Monday, July 8, 2013, CEO Patty Fontneau said, "To be honest with you, we can't undo our plan. To not offer choice would cripple us." As one of the 16 states running its own exchange, Colorado has invested to build the IT infrastructure required to comply with the ACA's multitude of regulatory requirements. In one respect, the delay in the employer mandate simplifies the exchange's rollout plans because it will not have to contend with burdensome reporting requirements related to the adequacy and affordability of large employer plans.

New Exchange Board Appointments. On July 5, 2013, Governor John Hickenlooper appointed two new board members to the Connect for Health board of directors: small businesswoman Ellen Daehnick and Sharon Lee O'Hara, executive vice president of the National Multiple Sclerosis Society's Colorado-Wyoming chapter. Hickenlooper also reappointed small businessman Richard Betts and Trizetto's Eric Grossman to the board. The other five members are not up for reappointment at this time. The board loses Anthem's Robert Ruiz-Moss and Beth Sobert, CEO of United Healthcare of Colorado, leaving just one health insurance executive on the board.

Multi-Payer Initiative Launched to Reduce Hospital Readmissions. The Colorado-based Center for Improving Value in Health Care announced the launch of a multi-payer, statewide initiative to reduce hospital readmissions and save $80 million in healthcare costs in Colorado. The Healthy Transitions partnership includes the Colorado Hospital Association, the Colorado Rural Health Center, the Colorado Health Care Association (nursing homes), and Colorado Foundation for Medical Care, the Medicare QIO. The two year initiative is an expansion of a successful pilot program that focuses on transitions from hospitals to home or other community settings. Communities in Colorado have seen improvements in reduction of readmissions rates when they use proven interventions such as Eric Coleman's Care Transitions Intervention.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

House Speaker Reiterates Opposition to Medicaid Special Session. In a recent television interview, House Speaker Will Weatherford reiterated his opposition to calling a special session on Medicaid, emphasizing his skepticism that the Federal Government will live up to its commitments of funding and support. Weatherford pointed to the delay in the employer mandate as proof that the Federal government is "not ready for prime time". Furthermore, with the employer mandate not effective until 2015, businesses may be less inclined to push lawmakers to expand Medicaid.

Florida Aims to Clarify Consumers' Health Choices. Amidst a national push by the Department of Health and Human Services to educate consumers about the imminent changes in health plan options, various Florida agencies and insurers are doing their part to similarly inform state residents. The Florida Department of Children and Families is responsible for enrolling families in Medicaid or low-cost insurance programs for children and is coordinating with state and federal entities to deal with a significant increase in Medicaid-related questions. Florida Health Choices, a state-based exchange formed before the passage of the ACA, will only be available to small businesses and has undertaken steps to redirect individuals to the federal exchange. Some insurers, such as Florida Blue, have begun opening retail centers across the state in advance of the October 1 enrollment of eligible beneficiaries on the federal exchange.

Georgia

HMA Roundup – Mark Trail

Department of Public Health Releases Infant and Maternal Mortality Data. Despite an improvement in infant mortality rates, Georgia has experienced an uptick in its maternal mortality rate. In a Department of Public Health Board meeting on Tuesday, July 9, 2013, the state presented a variety of health statistics noting a drop in its infant mortality rate from 8.4 infant deaths per 1,000 live births in the 2002-2006 period to 7.3 during the 2007-2011 period. However, Georgia's maternal death rate increased markedly from 20.8 per 100,000 live births in the 2001-2006 period to 35.5 in 2011.

Iowa

HMA Roundup

Six Health Insurers Apply to Offer Plans on Iowa's Exchange. On July 1, 2013, the Iowa Insurance Division announced that six health insurers have applied to offer health plans on the state's exchange: Coventry, CoOpportunity Health, Avera Health, Gunderson Health, Sanford Health, and Health Alliance Midwest. Notably, the state's largest insurer, Wellmark Blue Cross Blue Shield, will not offer plans in 2014. Coventry and CoOportunity Health look to offer individual plans statewide. Sanford Health and Health Alliance Midwest will offer just small group health plans. Avera Health Plans and Gunderson Health Plans will address both small group and individual markets in smaller regional areas. Four stand-alone dental plans will be offered by The Guardian Life Insurance Company, Dentegra, Delta Dental, and BEST Life and Health Insurance Company.

Kansas

In the news

- **"Public comment sessions scheduled on proposed Kansas Medicaid changes"**

  Kansas Medicaid officials have scheduled public comment session on the proposed changes to the KanCare program, which would begin coverage of long term supports and services for the developmentally disabled population on January 1, 2014, pending approval of an amendment to the state's 1115 Waiver. (Kansas Health Institute)

Kentucky

HMA Roundup

Lawsuit Challenging Medicaid Expansion Allowed to Proceed. On July 1, 2013, a Franklin Circuit Court judge dismissed objections from the Beshear Administration and allowed a tea party suit challenging Medicaid expansion to move forward. Judge Phillip Shepherd affirmed David Adams' right to contest whether Medicaid expansion violates the state constitution by sidestepping legislative approval. Governor Steve Beshear holds that he has authority to change regulations.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Medicaid Director Leaving for OMB. Dr. Julian Harris, the Massachusetts Medicaid director since 2011, will leave his position to become the Associate Director of the Federal Office of Management and Budget health office. Harris is a member of the Federal Long Term Care Commission, which is tasked with a proposal for the implementation of a comprehensive and coordinated system that ensures the long-term viability of long-term services and supports. Dr. Harris previously practiced primary care medicine at the Southern Jamaica Plain Community Health Center and hospitalist medicine at the Cambridge Health Alliance. He was a clinical fellow on the faculty at Harvard Medical School and a senior resident in internal medicine and primary care at the Brigham and Women's Hospital. In addition, Dr. Harris worked with the World Bank Institute's AIDS program and as a consultant at McKinsey & Company.

Advocacy Groups Urge Patrick to Maintain State Penalties for Employers. Following the passage of various state laws to conform to the implementation of the ACA, the Obama Administration's delay of the employer mandate has put Gov. Deval Patrick in a difficult position. Health care advocates are lobbying the governor to veto a provision in the budget that would repeal the state's fair share employer contribution law. Administration spokesmen have generally rejected the notion that this delay would have a significant impact on the provision of health benefits by large Massachusetts employers.

In the news

- **"Bill Would Allow Spouses To Qualify For Personal Care Pay"**

  A bill in Massachusetts would change the way the state pays for personal care attendants (PCAs) under MassHealth, allowing a spouse to be reimbursed by the state for PCA services. (WBUR.org)

Michigan

HMA Roundup—Esther Reagan

Michigan Medicaid Workgroup Convenes. The Healthy Michigan Workgroup, consisting of six Republican and two Democratic state senators, have begun meeting this week to develop a plan to reform and expand Medicaid that would be offered up to the Senate for consideration. After refusing to call a vote last month on Medicaid expansion, Senate Majority Leader Randy Richardville established the group. Both houses of the legislature

would have to approve of any proposal and Gov. Rick Snyder would have to evaluate its merits. Furthermore, any meaningful changes to the Medicaid program—as envisioned by the House—would require CMS review and approval. Richardville has publicly stated that there is a "good chance" a Medicaid expansion vote will be held before September. That said, the Senate only has six session days scheduled in July and August, without mandatory attendance until the last week of August.

Minnesota

HMA Roundup

Consortium of Rural Counties Chosen for State Pilot Program. A consortium of 12 rural counties has been selected to participate in a three-year pilot program run by the Minnesota Department of Human Services. Southern Prairie Community Care's plan involves coordination and communication between social workers, medical providers, mental health care providers, skilled nursing facilities and hospitals to deliver more efficient services to rural Medicaid beneficiaries. The program aims to address such issues as inactivity, obesity, and poverty through wellness, prevention, and services and supports that will ultimately deliver better care for a lower cost.

Mississippi

HMA Roundup

Medicaid Reauthorized Just in Time. On Friday, June 28, 2013, Mississippi lawmakers approved a plan to reauthorize the Medicaid program in a special session called by Gov. Phil Bryant, just in time to avoid the program's suspension on July 1. Democrats had previously held up the reauthorization in hopes of securing a Medicaid expansion vote, which ultimately was never held. The GOP-dominated House and Senate still needed votes from Democrats to secure a super-majority to approve of the $400 million in taxes to fund the state's share of Medicaid.

Missouri

HMA Roundup

Telemedicine Bill Signed by Nixon. On July 8, 2013, Missouri Gov. Jay Nixon signed into law a bill that requires health plans to cover telemedicine services, without charging higher rates or co-pays for such visits. If health plans cover services for in-person visits, they are now obligated to cover such services delivered remotely, effective January 1, 2014.

In the news

- **"Missouri's Medicaid sign-up system getting massive overhaul"**

  Missouri Medicaid has signed a $147 million contract with Florida-based EngagePoint to set up the state's web-based Medicaid enrollment system. EngagePoint is also designing eligibility and enrollment systems in Arkansas, Minnesota, and Maryland. (St. Louis Post-Dispatch)

Montana

HMA Roundup

Medicaid Expansion Ballot Initiative Effort Underway. At the end of June, an alliance of labor, health and advocacy groups established a ballot committee, dubbed the Healthy Montana Initiative, which aims to put Medicaid expansion on the 2014 ballot. The coalition of organizations include the AARP Montana; the Montana Nurses Association; MEA-MFT, which is the state's largest labor union; the Montana AFL-CIO; the Montana Primary Care Association; and the Association of Montana Public Health Officials. At least 24,175 registered Montana voter signatures are required by June 2014 to qualify an initiative for the ballot. However, even should the initiative pass muster with the voters, funding would still need to be appropriated by the 2015 legislature.

Nebraska

HMA Roundup

Full Risk Managed Behavioral Health to Be Implemented September 1. The Nebraska Division of Medicaid and Long Term Care announced that effective September 1, it will be moving to full-risk managed care for all behavioral health and substance use disorder services. Magellan Behavioral Health of Nebraska was awarded the contract and will begin paying claims for services provided as of September 1, 2013. As of 2010, there were approximately 265,000 Medicaid beneficiaries in Nebraska. (Link to Provider Bulletin)

New Hampshire

HMA Roundup

Hospitals Agree to Participate in Medicaid Managed Care. On Monday, July 1, 2013, Dartmouth-Hitchcock, New Hampshire's largest health care provider, signed contracts with Well Sense Health Plan, Granite State Health Plan and Meridian Health Plan of New Hampshire as part of the state's Medicaid managed care program. Gov. Maggie Hassan welcomed the agreement with an announcement that all of the state's hospitals had agreed to sign up for the program. Hospital participation appears tied to the new state budget's provision that requires participation in the managed care program to receive uncompensated care payments. The state aims to save about $48 million from the implementation of Medicaid managed care.

New Jersey

HMA Roundup

Legislation to Make Medicaid Expansion Permanent Vetoed by Christie. Gov. Chris Christie supports Medicaid expansion, but he doesn't want the expansion to made permanent without fallback options should the Federal Government change its funding in the future. As a result, on June 28, 2013, Christie vetoed a bill that would have removed the flexibility to opt out of the Medicaid expansion should the Federal Government change funding levels in the future. Medicaid expansion will be implemented as part of the budget.

New York

HMA Roundup—Denise Soffel

New HealthNow CEO Named. On July 9, 2013, HealthNow New York, the parent company of BlueCross BlueShield of Western New York, named David W. Anderson president and CEO. Anderson had been CEO of UnitedHealthcare's (UHC) Southern California Health Plan for the last seven years. Anderson was previously senior vice president and chief sales officer of Health Net of California from 2003-06. Prior to that, he had served as senior vice president for PPO products at Health Net Life Insurance from 2001-03 and president of Health Net Dental and Vision in 2000-02.

North Carolina

HMA Roundup

Upgraded MMIS System Launches in North Carolina. Nearly a decade after a contract was awarded to replace the state's Medicaid Management Information System (MMIS), North Carolina has finally implemented the new system as of July 1, 2013. The new system, known as NCTracks, is run by Computer Sciences Corp. Joe Cooper, Chief Information Officer for the Department of Health and Human Services DHHS, acknowledged that some providers have experienced some issues with the web portal and long waits at the call center, but that is to be expected with such a large complex systems transition. Furthermore, only 20% of providers attended training sessions prior to the July 1st launch. DHHS and CSC have scheduled interactive information sessions over the next few weeks and regional training sessions to familiarize providers with the system to ensure timely claims submissions and payment processing.

Ohio

HMA Roundup

Kasich Signs Budget; Medicaid Expansion in Hangs in Abeyance. On June 30, 2013, Gov. John Kasich signed the state's $62 billion budget, with a veto of a House/Senate provision that would have prevented Medicaid expansion without legislative approval. The veto allows discussions and debate around Medicaid expansion to continue. Every Democrat in both houses of the legislature voted against the budget, which had passed 53-44 in the House and 21-11 in the Senate.

Oregon

HMA Roundup

Universal Healthcare Study Commissioned by Legislature. On July 6, 2013, the Oregon Senate passed a universal healthcare study bill by a 20-10 vote, following up on a similar House vote in late June (37-23). The legislation authorizes the Oregon Health Authority to commission a study that would evaluate several different healthcare models and recommend the best model for financing healthcare in the state. Some advocates view this is a necessary step to effectuate a single payer system, which could be presented to voters in a ballot measure.

Pennsylvania

HMA Roundup –Matt Roan

PA Senate Attempt to Legislate Medicaid Expansion Fails in the House. Attempts to add Medicaid Expansion to the PA Welfare Code failed last week as Senate amendments to expand the program were stripped from the bill by the House of Representatives. The amended bill which would have enabled Medicaid Expansion to be implemented by July 1, 2014 won bi-partisan support in the senate with a 40-10 vote, but leaders in the House of Representatives pushed to strip the expansion provisions from the bill when it came to them for consideration. Final passage of the Welfare Code was mostly on party lines with the Republican majority sending the bill without expansion to the Governor's desk. Sen. Patricia Vance, Chair of the Senate Public Health and Welfare Committee, sponsored the Medicaid Expansion amendment and vowed to re-introduce expansion legislation in the fall. Sen. Vance commented that opposition to the bill was not based on good public policy, but was motivated by factions within her party that cannot bring themselves to support a program being pushed by President Obama.

PA Hands Over High Risk Insurance program to Feds. PA Fair Care, a high risk insurance program for Pennsylvanians with pre-existing conditions will be turned over to the Feds. The program, which is funded with federal dollars, was meant as a bridge until provisions of the ACA prohibiting insurers from excluding individuals with pre-existing conditions. Earlier this year, HHS notified the state that the appropriated funding was running out and that enrollment in the program would need to be capped. The State was given the option of continuing the program and covering any costs over what had already been appropriated, or turning the program over to the Federal government. PA chose to turn over the program, resulting in HHS administration of PA Fair Care until January 1, 2014. No new enrollees will be accepted. The Corbett administration has pointed to the premature phase out of this program as proof that Federal funding promises are not always kept, tying this issue with arguments against Medicaid Expansion.

Lottery Privatization Bid Gets Another Extension. Gov. Tom Corbett's efforts to privatize the state lottery continue despite the initial contract with British firm, Camelot Global Services, being deemed unconstitutional by the PA Attorney General. The PA lottery funds programs for Senior Citizens including home and community based services. Camelot has agreed to extend its bid until July 31st while they work with the Corbett administration to amend the contract and re-submit it to the Attorney General. PA Lottery officials reported record profits for FY 12-13, and opponents of privatization argue that the state-run program is performing well. Camelot has promised increase returns to the state if they assume administration of the lottery. So far an estimated $3 million in consultant and legal fees have been spent in the battle to privatize the program. If a contract with Camelot is executed, they will cover these costs.

South Carolina

HMA Roundup

Certificate of Need Program Suspended. In a surprise move, the South Carolina Department of Health and Environmental Control (DHEC) suspended the Certificate of Need (CON) program for one year, effective June 28, 2013, as result of the state legislature's vote to defund the program. Gov. Nikki Haley noted that 14 other states lack CON programs and she cited the program as an impediment to quality care. The DHEC filed a suit with the state's Supreme Court to issue an opinion on the action. DHEC will continue to license and inspect healthcare facilities.

Texas

HMA Roundup – Dianne Longley

Texas Medicaid Issues RFI for Non-Emergency Medical Transportation. The Texas Health and Human Services Commission issued a Request for Information (RFI) for Non-emergency Medical Transportation (NEMT) services. The state is seeking input from prospective vendors on the proposed structure and timing of a regional NEMT program beginning September 1, 2014. RFI responses are due July 26, 2013.

Vermont

HMA Roundup

Vermont Exchange Rates Released. On Monday, July 8, 2013, Vermont regulators announced monthly rates for health plans that will be sold on the Vermont Health Connect exchange. Individuals will pay a bit less than $395 per month for the Blue Cross Blue Shield plan and about $410 per month for the MVP Health plan. These figures do not include the effect of premium subsidies that will offset some of the cost to consumers who earn up to 400 percent of the federal poverty level. The Green Mountain Care Board cut 4.3 percent from the originally proposed Blue Cross rates and 5.3 percent from those proposed by MVP.

Vermont Officials Defend Exchange from Attacks. On July 2, 2013, Vermont officials defended the state law that established Vermont Health Connect. The US House Oversight and Government Reform Committee wrote the Department of Vermont Health Access to question the mandatory enrollment of individuals and small businesses in the exchange. The committee notes that the ACA legislation specifies that "nothing in this (law) shall be construed to prohibit" health plans from selling outside the exchange. The Shumlin Administration holds that states are allowed to regulate health insurance marketplaces above the "floor" set by the ACA. Rep. Mike Fisher, chairman of the Health Care Committee in the Vermont House, argues that the state's approach allows consumers to be better informed and comparison shop in a more transparent marketplace.

Virginia

HMA Roundup

State Awards Duals Contracts. On June 27, 2013, the Department of Medical Assistance Services (DMAS) completed its evaluation of the proposals received in response to its request for proposals. The Department intends to award contracts for the Medicare-Medicaid Alignment Demonstration to Humana, Healthkeepers, and VA Premier Health Plan.

Washington

HMA Roundup – Doug Porter

Health Homes Program Launched in 37 of 39 Counties. The Washington State Healthcare Authority and Department of Social and Health Services launched a Health Homes program on July 1. The Health Homes program targets Medicaid beneficiaries who suffer from select chronic conditions and who are at greater risk for costly and poorly coordinated health care services, including dual eligible, in 37 of 39 counties in the state. Dual eligible beneficiaries in the remaining two counties, King and Snohomish, will participate in a separate, risk-based managed care demonstration program next year. Community Health Plan of Washington, United Healthcare and Optum Regional Support Network have been selected to administer the Health Homes program in the 14 counties that launched on July 1, 2013. The remaining counties participating in the Health Homes program will launch on October 1, 2013. The organizations administering the program in those counties will be announced later this summer.

National

HMA Roundup

HHS Releases Key Rulemaking on Exchanges, Medicaid. On Friday, July 5, HHS issued a 606-page final regulation on several key provisions pertaining to the Medicaid expansion and the health insurance marketplaces. On the Exchange side, the regulations ease oversight of available employer coverage and individual income, delaying stricter verification system requirements until 2015. The rule also addressed Medicaid electronic notice requirements, cost-sharing limits, and how the 5 percent income disregard will be factored into eligibility determinations.

Administration Announces One-Year Delay of Employer Mandate, Clarifies Individual Mandate Exemptions. It was announced early last week that the requirement for employers with 50 or more employees to provide insurance will not be enacted until 2015. The administration cited a need to simplify the verification process as one of the reasons for the decision. The Treasury Department confirmed this week that employees will still have access to subsidies for the individual marketplaces based on their income. Under the mandate, employers would face a penalty of as much as $3,000 for every employee if they do not provide coverage. Since the announcement, Republicans have geared up to push for a delay in the individual mandate as well. As for the individual mandate, HHS issued a rule that will exempt individuals from the individual mandate who are below 138 percent FPL are not Medicaid eligible in states that elect not to expand Medicaid.

In the news

- **"Study reveals states in which primary care physicians are most likely to accept new Medicaid patients "**

  A new study in Health Affairs reveals that primary care physicians (PCPs) are less likely to accept Medicaid than office-based physicians. The study details Medicaid denial rates by PCPs by state, revealing higher rates in Alabama, California, Missouri, and New Jersey, as compared to the national average. Arkansas, Iowa, Minnesota, Nebraska, West Virginia, and Wisconsin had the highest rates of acceptance by PCPs. Millions of newly eligible Medicaid patients are anticipated to begin seeking care from PCPs beginning in January 2014. (Medical Economics)

- **"Advocates Urge More Government Oversight Of Medicaid Managed Care"**

  As states continue to expand their Medicaid managed care programs, advocacy groups are coming together to push for greater oversight of quality delivered under managed care. The push for greater oversight comes as many states are transitioning long term care and other vulnerable populations to managed care. (Kaiser Health News)

- **"British Company Is Awarded Contract to Administer Health Rollout"**

  HHS has awarded a contract to British company Serco to handle the administration of health insurance applications and tax credits under the health insurance marketplaces, launching October 1. The contract, worth $1.2 billion, is the firm's first in the health care market. Serco has existing contracts with the federal government in other fields, including reviewing visa applications for the U.S. State Department. (New York Times)

- **"Troubled Cities See Exchanges as Way to Unload Retirees"**

  Cities seeking to limit costs on retiree benefits, such as Detroit and Chicago, are looking to eliminate retiree health benefits for individuals who are under 65 and do not qualify for Medicare. Instead, cities can shift retirees into the exchanges and provide assistance with premiums, while still generating significant savings. (Bloomberg)

INDUSTRY NEWS

Molina to Assume Lovelace Community Health Plan's Medicaid Contract, 84,000 Enrollees. Molina Healthcare of New Mexico has entered into a definitive agreement to assume Lovelace Community Health Plan's contract for the New Mexico Medicaid Salud! Program (the state's Medicaid managed care program). Molina anticipates completing the transaction by August 1, 2013. Lovelace currently covers approximately 84,000 Medicaid beneficiaries in the state, while Molina serves more than 91,000 Medicaid enrollees. Molina Healthcare was awarded one of four consolidated Medicaid managed care contracts under New Mexico's Centennial Care program, which integrates the state's Salud! program, the CoLTS managed long term care program, and the state's managed behavioral health program.

Iowa's Largest Insurer to Sit Out Exchange in 2014. Wellmark Blue Cross and Blue Shield, the state's main health insurer, announced that it will not offer qualified health plans on Iowa's health insurance exchange in 2014. Wellmark intends to begin offering plans on the exchange in 2015.

Kentucky Court Ruling Allows Centene to End Kentucky Contract Without Penalty. A motion from the state's Medicaid department for an injunction was denied by a court of appeals, allowing Centene's Kentucky Spirit Health Plan to exit the program as of July 5, 2013. Centene contends that state data provided to the health plan led to contracted PMPM rates, which generated significant monthly losses for the firm.

"Inova renames Medicaid insurance plan" Inova Health System has renamed the Medicaid business it acquired in 2012 from Amerigroup Virginia LLC to INTotal Health. INTotal Health serves roughly 57,000 Medicaid enrollees throughout Virginia. (Washington Business Journal)

"Preferred Medical Plan Expands Medicaid Coverage to Monroe County" Preferred Medical Plan, which already serves Medicaid enrollees in Miami-Dade and Broward counties, announced last week that it has expanded service to Monroe County. (Baystreet.ca)

RFP CALENDAR

Below is an updated Medicaid managed care RFP calendar. The events are color coded by state/program and are listed in date order.

Date	State	Event	Beneficiaries
July 19, 2013	Wisconsin MLTC (Select Regions)	Proposals Due	10,000
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
August, 2013	Wisconsin MLTC (Select Regions)	Contract awards	10,000
September 1, 2013	Idaho Behavioral	Implementation	200,000
September 1, 2013	Ohio Duals	Implementation	115,000
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
Summer 2013	Rhode Island Duals	Contract Awards	22,700
Summer 2013	South Carolina Duals	RFP Released	68,000
Summer 2013	Michigan Duals	RFP Released	70,000
October 1, 2013	Rhode Island Duals - Medicaid Only	Implementation	22,700
October 1, 2013	Massachusetts Duals	Implementation	115,000
October 1, 2013	Arizona - Acute Care	Implementation	1,100,000
October 1, 2013	Arizona - Maricopa Behavioral	Implementation	N/A
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
December, 1 2013	Florida LTC (Region 11)	Implementation	16,400
"Early 2014"	North Carolina	RFP released	TBD
January 1, 2014	Illinois Duals	Implementation	136,000
January 1, 2014	California Duals	Implementation	456,000
January 1, 2014	New Mexico	Implementation	510,000
January 1, 2014	South Carolina Duals	Implementation	68,000
January 1, 2014	Vermont Duals	Implementation	22,000
January 1, 2014	Wisconsin MLTC (Select Regions)	Implementation	10,000
January 1, 2014	Virginia Duals	Implementation	79,000
January 1, 2014	Texas Duals	Implementation	214,400
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,500
March 1, 2014	Idaho Duals	Implementation	17,700
March 1, 2014	Florida LTC (Regions 3,4)	Implementation	16,700
April 1, 2014	New York Duals	Implementation	133,880
April 1, 2014	Washington Duals	Implementation	48,500
July 1, 2014	Michigan Duals	Implementation	70,000
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	2,800,000

DUAL INTEGRATION PROPOSAL STATUS

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Enrollment effective date
Arizona		98,235	Not pursuing Financial Alignment Model				
California	Capitated	456,000	X	3/1/2012	4/4/2012	X	1/1/2014
Colorado	MFFS	62,982					10/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189	Not pursuing Financial Alignment Model				
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	X	1/1/2014
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	June 2013	TBD	TBD		3/1/2014
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	1/1/2014
Michigan	Capitated	70,000	Summer 2013		TBD		7/1/2014
Missouri	MFFS‡	6,380					10/1/2012
Minnesota		93,165	Not pursuing Financial Alignment Model				
New Mexico		40,000	Not pursuing Financial Alignment Model				
New York	Capitated	133,880					4/1/2014
North Carolina	MFFS	222,151					TBD
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	X	9/1/2013
Oklahoma	MFFS	104,258					TBD
Oregon		68,000	Not pursuing Financial Alignment Model				
Rhode Island	Capitated	22,700	X	3/27/2013			10/1/2013*
South Carolina	Capitated	68,000	Summer 2013	TBD	TBD		1/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402			Early 2013		1/1/2014
Virginia	Capitated	78,596	X	5/15/2013	6/27/2013	X	1/1/2014
Vermont	Capitated	22,000	10/1/2013	TBD	TBD	7/15/2013	9/1/2014
Washington	Capitated/MFFS	115,000	X	5/15/2013 (Capitated	6/6/2013	MFFS Only	1/1/2014
Wisconsin	Capitated	5,500-6,000	X	8/23/2012	10/1/2012		TBD**
Totals	**14 Capitated 7 MFFS**	**1.5M Capitated 485K FFS**	***8***			***6***	

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

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

‡ Capitated duals integration model for health homes population.

HMA News

HMA Welcomes: Heidi Robbins Brown, Principal - Olympia, Washington

Heidi comes to us from Health Care Authority where she worked for several years. Her most recently position with HCA was Deputy Assistant Director, Division of Payment and Program Integrity. In this role Heidi was responsible for all payment and program integrity activities for the Washington State Medicaid Program which included provider review and audit, data mining and analytics, provider enrollment, and third party liability. She also operated and maintained the largest state payment system called "ProviderOne: Washington's Medicaid Management Information System" as well as a state of the art fraud and abuse detection system. Some of her accomplishments in this role included implementation of the Recovery Audit Contracts in both program integrity and third party liability and implementation of the provider enrollment requirements under the Affordable Care Act. While with HCA, Heidi also served as the Deputy Agency Director. She worked with the Director in carrying out the responsibility for policies and operations of the state's $6.5 billion consolidated health care purchasing agency covering state employees, retirees, and the low-income Medicaid population. Heidi was also charged with overseeing initiatives aimed at improving the state's record as a prudent purchaser of health care services relying on evidence based practices.

Additional roles in the Department of Social and Health Services that Heidi has held include Deputy Medicaid Director, Health and Recovery Services Administration; Director for the Division of Audit and Information Services; Director of the Payment Review Program; Administrator for the Adjudication and Policy Unity; Deputy Director of the Social Service Payment System Year 2000 Project; and Contracts Attorney.

Heidi received her Juris Doctor degree from Seattle University and holds a Bachelor of Arts degree in Political Science from Gonzaga University. She is also certified in LEAN/Six Sigma Green Belt and is a Certified Mediator.

HMA Welcomes: Deborah Gracey, Principal – Chicago, Illinois

Deborah comes to us most recently from Humana, Inc. where she served in several different roles during her 11+ years with them. She was the President of Humana Medicare, Great Lakes Region for the last four years of her tenure with Humana. In this role Deborah was responsible for the profitability and growth of Medicare Advance Individual and Group HMO, PPO, and PFFS plans in Illinois, Michigan, and Wisconsin. She was charged with overseeing complex provider relationships including risk partners, community relations, revenue enhancement, and cost containment. Prior to that, Deborah served as the Director of Medicare Performance and Process in Louisville, Kentucky. This role required her to create and run the new performance organization that was accountable for integrated, enterprise-wide Medicare performance management, process engineering, and planning for the purpose of creating an exemplary consumer experience for 4.5 million Medicare members. During her time with Humana, Deborah also served as the Director for Strategic Consultancy and the Director of the Center of Quality and Excellence.

Prior to joining Humana, Deborah worked for US Airways, Inc. for 22+ years. Her roles included Director of Airport Administration, Manager of Product Development, Manager of International Training, Manager of Airport Communications, and Rates Instructor. Deborah also did speaking engagements and provided consulting services through her company, Gracey Global Training and Consulting.

Deborah received her B.S. in Business Administration from the University of Maryland University College. She is certified in Six Sigma Green Belt through GE Aircraft Engines and participated in Health Care Leaders 2020 through the Humana Learning Institute.