HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS ISSUES FINAL RULE ON MEDICAID AND EXCHANGES

HMA ROUNDUP: NEW YORK, ILLINOIS ANNOUNCE MARKETPLACE QHPS; MASSACHUSETTS SIGNS DUAL ELIGIBLE DEMO CONTRACTS; FLORIDA BEGINS MMA NEGOTIATIONS; ILLINOIS DUAL ELIGIBLE DEMONSTRATION START DATE PUSHED BACK; NEW YORK MEDICAID DIRECTOR PROVIDES UPDATE ON PROGRAM REDESIGN; NEW MEXICO WAIVER RECEIVES FEDERAL APPROVAL

INDUSTRY NEWS: UNITEDHEALTH, MAXIMUS WIN MARKETPLACE CALL CENTER CONTRACTS; NEW YORK HOSPITALS ANNOUNCE MERGER PLANS

JULY 17, 2013

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IN FOCUS: CMS ISSUES FINAL RULE ON MEDICAID AND EXCHANGES

This week, our *In Focus* section comes to us from Juan Montanez and Chad Perman in HMA's Washington, D.C. office. Amidst the drive to the implementation of major components of the ACA in January 2014, CMS released a wide-ranging Final Rule on July 5, 2013. This rule addresses a host of health insurance coverage issues related to the Exchanges (also known as Marketplaces) and Medicaid. The rule finalizes numerous provisions from a notice of proposed rulemaking (NPRM) issued in January of this year.

At over 600 pages, the rule responds to highly technical comments that CMS received following the proposed rule. The Final Rule mostly modifies existing administrative policies for the Exchanges and state-administered Medicaid and CHIP programs. Even though regulation regarding key provisions of the law is still pending, this rule attempts to crystallize numerous procedures for providing affordable health coverage for millions of Americans beginning in 2014.

The rule breaks down into six main areas: **(1)** Medicaid/CHIP Eligibility & Enrollment; **(2)** Medicaid Benefit Standards; **(3)** Medicaid Cost Sharing; **(4)** Premium Assistance Coverage Model for Medicaid Expansion; **(5)** Exchange – Medicaid/CHIP Eligibility Coordination; and **(6)** Exchange Eligibility & Enrollment. Link to CMS Fact Sheet.

Since the passage of the Affordable Care Act, HMA has been closely following the continuous release of federal regulations in preparation for the October 1, 2013 open enrollment period. Please do not hesitate to contact HMA for additional guidance as it pertains to this CMS Rule.

Summary of Key Provisions

Medicaid/CHIP Eligibility & Enrollment

5 Percent Income Disregard

- The 5 percent income disregard based on Modified Adjusted Gross Income (MAGI) will only be applied to determine eligibility for the highest-income category that an individual is eligible for in Medicaid. Previously, the 5 percent disregard was to be applied across the board.
- This amended ruling is expected to result in states obtaining the full federal matching funding for additional new eligibles, instead of determining individuals as "existing eligibles," which would come at reduced funding. The 5 percent disregard is not applied to determination of eligibility categories.

CHIP Waiting Periods

- The rule limits the waiting period for coverage for eligible children to 90 days maximum, but states have the option to eliminate or shorten the time period. Premium lock-out periods are also limited to 90 days.
- There is no CHIP waiting period if a child loses Medicaid or Advanced Payment of Premium Tax Credit (APTC) coverage, an employer drops coverage, or the

cost of employer sponsored insurance exceeds 5 percent of household income for a child or 9.5 percent for a family.

Medicaid Benefit Standards

Alternative Benefit Plans (ABPs)

- ABPs, replacing the term "benchmark", are alternative benefit designs modeled or benchmarked after a public employee or commercial plan in the state.
- The Medicaid expansion population is required to be enrolled in Alternative Benefit Plans (ABPs) unless individuals are among exempted groups.
- ABPs must include all Essential Health Benefits by January 1, 2014 (CMS has indicated that it will be flexible with this implementation date with states that demonstrate progress towards implementing this provision).

Presumptive Eligibility

- Presumptive Eligibility is expanded to include not just children, but also low-income adults. This provision permits hospitals and other "qualified entities" with prior approval by state Medicaid to make presumptive eligibility determinations to enroll uninsured adults in Medicaid when seeking care.

Medically Frail

- Definition expanded to include those with substance use disorders.
- Beneficiaries will have a choice of ABP or Medicaid State Plan.

Medicaid Cost Sharing

- Amends current levels and permits targeted cost-sharing for higher-income Medicaid groups.
- Creates a single set of rules for Medicaid premiums and cost sharing.
- Permits states to establish higher cost-sharing for prescription drugs (specifically non-preferred drugs, even for exempt groups) and for non-emergency use of the emergency department, and updates the maximum allowable cost-sharing levels.
- Caps out-of-pocket expenses at 5 percent of household income

Premium Assistance Coverage Model for Medicaid Expansion

Medicaid programs may purchase coverage in the individual market with premium assistance.

- This is an optional program for beneficiaries, who may still choose "traditional" Medicaid.
- Medicaid must provide wrap-around services to ensure individuals receive all Medicaid benefits.
- Cost-sharing and administrative costs must be comparable to "traditional" Medicaid.

Exchange – Medicaid/CHIP Eligibility Coordination

Eligibility and Appeals Determinations

- Eligibility determinations and appeals determinations must be coordinated between the Exchange and the Medicaid/CHIP programs starting October 1, 2013.
- A state may delegate power to the Exchange to make Medicaid determinations of applicants using MAGI or a state-set determination.

Notices

- Requires availability of electronic notices for consumers regarding eligibility for all insurance affordability programs from the Exchange/Marketplace starting on October 1, 2013, and from state Medicaid and CHIP agencies no later than January 1, 2015.

Open Enrollment

- Medicaid and CHIP agencies will begin accepting the single streamlined application as of October 1, 2013, and accept electronic account transfers of individuals who applied via Exchanges (note: some states will have agreements with CMS for "work around" processes starting October 1, as they will not be able to accept application information electronically).

Exchange Eligibility & Enrollment

Verification of Employer-Sponsored Coverage

- Individuals applying for Advance Premium Tax Credits (APTCs) and Cost Sharing Reductions (CSRs) in the Exchanges will self-attest to employer-based coverage, cost, and comprehensiveness during the application process.
- Subsequently, the Exchange/Marketplace will attempt to verify attestation.
- Employers are not required to submit information, but may be contacted for additional verification.

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Alabama

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No Alabama Counties Left Behind in the Health Exchange. Alabama's Insurance Department announced that all 67 counties would have health plan options offered on the federally-operated health exchange, with Blue Cross Blue Shield and United Healthcare filing for statewide coverage. Humana has proposed a plan encompassing 50 of the state's counties. As such, Alabama is in a better position than neighboring Mississippi, where nearly 40 percent of the counties have no health exchange plan options.

California

HMA Roundup—Jennifer Kent

Health Exchange Plan Premiums Approved. On July 15, 2013, the Department of Managed Health Care announced the approval of proposed premium rates for individual health plans offered on the state's health exchange following a determination by state actuaries that prices were reasonable. The actuaries evaluated anticipated medical and administrative costs, utilization assumptions, and profitability of the plans. Covered California, the state's Exchange, should ink final contracts with the health insurers by the end of July.

Colorado

HMA Roundup—Joan Henneberry

Colorado Wins $119 Million in Grants for Health Exchange and Health Centers. On Wednesday, July 10, 2013, Colorado secured a $116 million Federal grant that should fund the state's exchange through the end of 2014. This represents a figure approximately $9 million less in Level II exchange grant funds than the state had applied for in May. The funding will underwrite the systems investments required to offer multiple levels of health plans, customer service call centers, statewide navigator sites, and training costs. In addition, the state was granted $3 million toward 17 community health centers' enrollment and eligibility efforts for exchange-plans and Medicaid.

Physician Health Partners Switching from Pioneer ACO to Medicare Shared Savings. On July 17, 2013, Physician Health Partners (PHP) announced it was one of seven organizations leaving the Medicare Pioneer ACO project and switching to the Medicare Shared Savings model, in which there would be less risk and lower levels of upside. PHP reports that the group of patients it was serving had higher than expected mortality rates and limited savings opportunities since the "low hanging fruit" had already been addressed. PHP noted that the Pioneer ACO financial risk structure was constraining due to geographic considerations, timelines, and risks associated with patients consulting with unaffiliated physicians.

Denver Health Medical Center Downsizing. This week, Denver Health Medical Center announced a workforce reduction of 300 to lower personnel costs by $18 million over the next year. The cuts will be a combination of layoffs, attrition, and a reduction in new hires. The public safety net hospital blames the federal sequester, funding cuts, a flat contribution from the city of Denver to cover uncompensated care, and the lack of a profitable group or chain to financially back the hospital.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

AHCA Issues Managed Medical Assistance Letters to Negotiate. Starting the week of July 1, 2013, the Agency began sending letters to selected plans that are candidates for negotiations for the Managed Medical Assistance (MMA) program that meet or exceed the requirements of the invitation to negotiate (ITN). Letters were first sent to Specialty Plans with two meetings scheduled, one last week and one this week. The distribution of letters to negotiate with standard MMA plans (HMO and PSN) started this week. It is anticipated that all invitations to negotiate will be mailed within 10 days. The Agency will schedule meetings with plans for selected Regions over the next couple of months. The negotiation period will run from July 8 to September 6, 2013. It is anticipated that notices of intent to award contracts will be posted on September 16, 2013.

Georgia

HMA Roundup – Mark Trail

DCH Overhangs Greet New DCH Commissioner. With the July 1 arrival of Clyde Reese as commissioner of Georgia's Department of Community Health (DCH) comes two overhanging issues that the department must address immediately. The state's hospital provider tax, which was signed by Gov. Nathan Deal earlier this year, expired on July 1, 2013, absent the expected approval of the program by CMS. DCH has continued its practice of issuing 11.8 percent in additional Medicaid reimbursement. CMS continues to review the provider tax. In addition, DCH still has to pick winning contractors to administer the State Health Benefit Plan for some 650,000 state and local employees, retirees, and dependents.

Idaho

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Idaho Exchange Announces New Staff and Outreach Efforts. On July 15, 2013, Idaho's Health Exchange announced Jody Olson as communications and marketing director, and Alberto Gonzalez as operations project manager. In addition, the exchange hired Gallatin Public Affairs to help with outreach activities to eligible consumers. The $200,000 contract award through August 16, 2013 will entail state-wide market research, the creation of an initial Exchange website, the development of a communication strategy, the development of educational materials, and a branding effort.

Illinois

HMA Roundup – Andrew Fairgrieve

UnitedHealth Opts Out, Leaving Five Insurers to Serve Illinois Exchange. It was reported this week that UnitedHealth will not participate in Illinois' Exchange in 2014. This leaves only five insurers to serve the roughly 500,000 individuals and small businesses are expected to participate in the Exchange in its first year. Those insurers expected to participate are Blue Cross Blue Shield of Illinois, Humana, Health Alliance, Aetna, and the Land of Lincoln Health Inc. Co-Op plan. Aetna will offer plans under both the Aetna and Coventry name. Illinois is operating a partnership exchange in 2014, but legislation is in the works to authorize a state-based exchange for 2015 and beyond.

Updated Timing for Care Coordination Rollout. At the Illinois Medicaid Advisory Committee (MAC) meeting on Friday, July 12, 2013, the Department of Healthcare and Family Services (HFS) provided an updated timeline for launching the state's various Medicaid care coordination initiatives. A Medicaid reform law requires HFS to transition a minimum of 50 percent of the Medicaid population to care coordination by 2015.

- The state's duals demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI), will begin accepting voluntary enrollments on January 1, 2014, with passive enrollment to begin April 1, 2014.
- Expansion of the state's Integrated Care Program, enrolling non-dual eligible seniors and persons with disabilities in Medicaid MCOs, began July 1 in the Rockford area and will roll out in three other regions over the remaining months of 2013 and in Chicago in the first half of 2014.
- Care coordination for Medicaid children and families and the newly eligible "new ACA adults" population will begin in July 2014.

Iowa

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Iowa to Hold Public Hearings on the Iowa Health and Wellness Plan. Following a bipartisan compromise to establish the Iowa Health and Wellness Plan as an alternative to expanding the existing fee-for-service Medicaid program, the Iowa Department of Human Services held public meetings prior to the formal written plan. The first meeting will be held in Des Moines on July 29, and the second will be held on July 30 at Iowa Western College in Council Bluffs. These public hearings are a necessary part of the process to gain CMS approval for this proposal, which would use Federal Medicaid expansion funding to underwrite health coverage for residents making less than the Federal poverty level of income.

Kansas

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Public Hearings on Inclusion of LTSS in KanCare. On July 15 and 16, 2013, state officials hosted public hearings to discuss the inclusion of long-term supports and services in the managed care plans under KanCare. Certain healthcare advocates are pushing for opt-out clauses for beneficiaries with developmental disabilities given that the program is unproven in the delivery of such services. The KanCare pilot programs for Kansans with intellectual and developmental disabilities have attempted to align managed care organizations, providers, and individuals to deliver better outcomes at lower costs.

Kentucky

In the news

- **"Kentucky's Rush Into Medicaid Managed Care: A Cautionary Tale For Other States"**

  Kaiser Health News and the Washington Post report on issues for patients and providers in Kentucky's transition to Medicaid managed care. The article cautions that issues of patient access, quality of care for the mentally ill, and denial of payments to providers could occur in other states pursuing rapid managed care transitions. (Kaiser Health News)

Louisiana

HMA Roundup

Jindal's Veto of Disability Waiver Expansion Riles Advocates. Last Wednesday, July 10, 2013, Gov. Bobby Jindal reiterated that the Legislature would not override his veto of a $4 million expansion to the New Opportunity Waiver, which offers at-home care for the developmentally disabled. An advocacy group, called Override the Veto, met Health and Hospitals Secretary Kathy Kliebert to discuss this and other vetoes that affect the disabled. There are more than 10,000 Louisiana residents on a 10-year waiting list to receive services under the NOW program. Kliebert has indicated that the disability waiver's list will change from a first-come, first-served approach to a needs-based one, with input from advocates for the disabled and their families. Advocates warn against a sudden change, particularly as it relates to families that have been on a waiting list for years. Although the House of Representatives voted for an override session, the Senate rejected the plan.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Patrick Agrees to Repeal State's Employer Mandate. On Thursday, July 11, 2013, Gov. Deval Patrick announced that he would not veto the repeal of the state mandate for employers to provide health insurance, despite the Obama Administration's delay of the Federal employer mandate to 2015. The 2014 state budget included the repeal of the mandate to remove redundant or conflicting provisions with the Affordable Care Act.

Patrick previously noted that the repeal of this provision would not likely have a significant impact on the provision of employer-sponsored health insurance in the state.

One Care Disabilities Duals Demo Contracts Signed with Three Plans. On July 16, 2013, MassHealth and CMS announced signed contracts with three health plans to participate in the One Care duals demonstration pilot for adults with disabilities: MassHealth plus Medicare - Commonwealth Care Alliance (CCA), Fallon Total Care (FTC), and Network Health. The announcement highlighted that each of the plans had experience covering dual eligible individuals 65 and older in the Senior Care Options program.

MassHealth projects that more than 90,000 individuals will have one or more One Care plans servicing their area. One Care will not be offered in counties without a plan, namely, Barnstable, Berkshire, Bristol, Dukes, and Nantucket. Auto-assignment will occur in Hampden, Hampshire, Suffolk and Worcester Counties. Voluntary enrollment will be used in Essex, Franklin, Middlesex, Norfolk, and Plymouth Counties. The chart below highlights the counties where each plan will operate. Enrollment is slated to begin October 1, 2013. MassHealth has hired a public relations firm to launch a campaign to build awareness of the program, with mailings targeted to go out by September 2013.

County	CCA	FTC	Network Health	Number of Plans	Auto Assignment?
Barnstable				0	
Berkshire				0	
Bristol				0	
Dukes				0	
Essex	X			**1**	N
Franklin	X			**1**	N
Hampden	X	X		**2**	**Y**
Hampshire	X	X		**2**	**Y**
Middlesex	X			**1**	N
Nantucket				0	
Norfolk	X			**1**	N
Plymouth	X (partial)			**1**	N
Suffolk	X		X	**2**	**Y**
Worcester	X	X	X	**3**	**Y**

Michigan

HMA Roundup—Esther Reagan

Bipartisan Workgroup to Meet with Senate Committee. With Medicaid expansion still unresolved, the Senate Government Operations Committee is slated to meet with a bipartisan workgroup evaluating the House's legislation that would overhaul the Medicaid program. A full Senate session is planned, but the committee meetings are expected to be procedural. Gov. Rick Snyder, health advocates, and small business groups have been barnstorming the state to rally support for expansion, while more conservative groups have been countering with advertisements and town hall meetings promoting "sustainable healthcare" and free market alternatives.

Missouri

In the news

- **"Large insurers opt out of health exchange in Missouri"**

  Missouri joins the list of states in which UnitedHealth has announced it will offer qualified health plans on the exchange in 2014. Cigna and AssurantHealth join UnitedHealth as large health insurers who will not participate in the Missouri exchange, it was announced this week. It is not yet announced which plans will officially participate. (St. Louis Post-Dispatch)

New Mexico

HMA Roundup

Centennial Care Receives CMS Approval. On July 12, 2013, CMS formally approved New Mexico's Centennial Care demonstration project, effective January 1, 2014 to December 31, 2018. This 1115 waiver was issued to enable the state to pursue comprehensive Medicaid managed care to coordinate the services of eligible beneficiaries, implement modest co-payments for certain health services, and institute incentives for healthy behavior. Native American Medicaid beneficiaries have the option of continuing on the fee-for-service system, although nursing home services will be delivered under a managed care arrangement. Beneficiaries enrolled in the developmental disabilities waiver will receive acute care services through Centennial Care, but continue to receive waiver services. Centennial Care will replace current Medicaid managed care programs such as CoLTS and Salud!. Enrollees under the Personal Care Options program must participate in Centennial Care to continue receiving personal care services. Users of the PACE (Program of All-Inclusive Care for the Elderly) program will not be affected.

In the news

- **"Federal agency says NM funding suspension of mental health care providers didn't violate rules"**

  Federal CMS officials have indicated that New Mexico's funding suspension of 15 mental health providers following an audit did not violate federal Medicaid rules. Several of the mental health providers had sued the state to have funding restored. A state contractor's audit revealed substandard care, millions of dollars in overbilling of Medicaid, and evidence of possible fraud. (The Republic)

New York

HMA Roundup—Denise Soffel

Cuomo Announces Approval of NY Health Exchange Plan Rates. On July 17, 2013, Gov. Andrew Cuomo announced that the Department of Financial Services (DFS) has approved health insurance plan rates for 17 insurers that will offer plans on New York's Health Benefits Exchange. New York State Health Commissioner Nirav R. Shah, M.D., M.P.H. reiterated that the state is on target to enroll consumers and small business owners and their employees in health insurance coverage beginning October 1, 2013. The governor's announcement claims that 2014 rates for even the gold and platinum plans

represent a 53 percent reduction compared to individual rates available in 2013. Tax credits would reflect an even greater reduction in out-of-pocket expenditures for qualified beneficiaries. Surprisingly, despite per capita health care costs in the state that are 18 percent higher than the national average, New York's benchmark individual "silver plan" rates are nearly 10 percent lower than the nationwide average previously forecasted by the Congressional Budget Office (CBO). In addition, the approved small group rate in New York for the benchmark "silver plan" is nearly 32 percent lower than the nationwide average previously forecast by the CBO. The following 17 companies had plan rates approved by DFS:

- Aetna
- Affinity Health Plan, Inc.
- American Progressive Life & Health Insurance Company of New York
- Capital District Physicians Health Plan, Inc.
- Health Insurance Plan of Greater New York
- Empire BlueCross BlueShield
- Excellus
- Fidelis Care
- Freelancers Co-Op
- Healthfirst New York
- HealthNow New York, Inc.
- Independent Health
- MetroPlus Health Plan
- MVP Health Plan, Inc.
- North Shore LIJ
- Oscar Health Insurance Co.
- United Healthcare

Medicaid Redesign Housing Initiatives for 2013-2014 Unveiled. The New York Medicaid Redesign Team ("MRT") Affordable Housing Work Group has allocated $86 million in 2013-14 for various supportive housing initiatives, including $36.376 million toward capital investments in supportive housing units for high cost Medicaid populations.

Medicaid Redesign Team Update. This past week, Jason Helgerson, NYS Medicaid Director, provided an update on the implementation of activities generated by the Medicaid Redesign Team process he inaugurated in January 2011. Slides from his presentation can be found **here.**

- **Savings -** Helgerson presented data showing that NYS has experienced a sizeable decline in Medicaid spending, particularly in New York City, where average per capita spending is down from a high of $8,183 in 2011, to $7,810 in 2012. He particularly highlighted home and community-based long-term care where they have instituted an episodic payment system and mandatory managed long-term care (MLTC) for certain groups of beneficiaries as an area where spending has come down. Enrollment in MLTCs has expanded dramatically since the mandatory enrollment program began, and over 100,000 Medicaid beneficiaries are now enrolled in MLTCs. The number of plans has grown from 16 to over 40 in the last two years. Helgerson also shared preliminary health home data indicating savings on inpatient and emergency department care.

- **ACA Implementation -** Helgerson then reviewed anticipated changes for 2014. As part of ACA implementation, New York expects to enroll an additional 510,000 individuals in Medicaid, of which only 15 percent are newly eligible; the overwhelming majority are already eligible but not enrolled. Simultaneous with the launch of New York's health insurance exchange is the on-going state takeo-

ver of Medicaid administration, gradually eliminating the role of local county social service departments in Medicaid eligibility and renewal determinations.

- **MRT Waiver Amendment** - Helgerson provided an update on negotiations with CMS for an Medicaid Redesign Team (MRT) waiver amendment that would allow the state to reinvest $10 billion in savings generated as a result of MRT program changes, which the state argues is essential to fully implement the redesigned Medicaid system. Talks were stalled, but Helgerson stated that he is feeling optimistic about obtaining approval, hopefully by the end of the year.
- **Duals Demonstration** - New York's duals alignment initiative, Fully Integrated Dual Advantage (FIDA), is scheduled for an April 2014 start date. Of New York's 700,000 dual eligibles, 170,000 will participate in the FIDA demonstration program. The enrollment process will rely on a "conversion in place" approach, under which duals currently enrolled in MLTCs as part of the mandatory program will have their Medicare benefit added to their current MLTC plan product. The demonstration is estimating savings of $1 billion per year, to be reinvested in the program. Under the demonstration, plans will develop shared savings agreements with their providers. Twenty-five plans are moving through due diligence to become FIDA participants. CMS has not yet approved the FIDA proposal, but the state is working on an MOU, which they expect will be approved in July 2013.
- **Behavioral Health Carve-In –** As part of the objective of more effective integration of behavioral health with physical health services, New York will be carving in all behavioral health benefits as of April 2014. In addition to requiring that all mainstream Medicaid managed care plans demonstrate the capacity to provide and coordinate all services for individuals with serious and persistent mental illness, the state is creating a specialized managed care plan with an expanded benefit package, HARP (Health and Recovery Plan). The HARP will include many community-based services, including peer support, respite, crisis, and employment. By the end of 2014 HARP plans will be responsible not just for health care, but for the social needs and social determinant needs of their members. The state is developing performance metrics on non-health care measures, which will be monitored closely.

In addition, Helgerson previewed the following future policy issues:

- **Shared Savings –** New York believes that it has begun to shift the cost curve in Medicaid, and that spending will come in below the global cap. The state is now interested in exploring mechanisms for sharing savings with providers. One key concern of the state is assuring that vital safety net providers remain financially viable as they experience declines in utilization. Helgerson described two approaches to shared savings. Under a global shared savings arrangement, the state would keep savings by reducing managed care rates as costs decline, and then make payments to providers either directly or through the plans. Alternatively, under a managed care shared savings model, the state would require that the health plans develop shared savings arrangements with providers in their net-

work, and the state would approve and enforce those arrangements. This is the proposed approach to shared savings under the FIDA demonstration.

- **Health Care Purchasing** – The state is exploring how it can leverage its purchasing power by aligning payment policies across Medicaid and Exchange plans, and possibly other payers as well. New York is unique in that its exchange is administered by the same agency that runs the Medicaid program, facilitating the ability to align quality incentives.
- **Leveraging HIT** – The state has invested significant resources in encouraging the universal adoption of an EHR, and establishing the All Payers Claims Database. Currently 50 percent of the population of NYS has an EHR, which allows the state to think about collecting population-wide health and public health outcomes measures, and about how to use data to improve health outcomes.

Pennsylvania

HMA Roundup –Matt Roan

PA EHealth Partnership to Implement Community Shared Services Platform. The Pennsylvania EHealth Partnership Authority, the state agency tasked with setting up a statewide health information exchange, awarded a contract to Truven Analytics to implement a Community Shared Services Platform which will enable providers and regional health information exchanges to share data statewide. The platform will include registries, indexing services, and security functions that allow for more efficient sharing of health information among the provider community.

Texas

HMA Roundup—Dianne Longley and Linda Wertz

Plus ACO Confirms Withdrawal from Pioneer ACO Program. On Tuesday, July 16, 2013, Plus ACO—formed by Texas Health Resources and North Texas Specialty Physicians— has informed CMS of its withdrawal from the Pioneer ACO program. THR noted that it supports the goals of ACOs, but could not sustain the potential $6-$9 million penalty due to Medicare's quality and cost performance benchmarks.

In the news

- **"Health Providers Bracing for Medicaid Enrollment"**

  Despite not expanding Medicaid at this time, Texas health providers are bracing for an influx of Medicaid patients who are currently eligible but unenrolled. The state is estimated that as many as 440,000 could enroll in 2014 and 2015 as individuals attempt to enroll in the health insurance exchange and discover they already qualify for Medicaid. A representative for community health centers anticipated they have the capacity to handle the influx of patients, but the greater challenge will be in helping patients navigate coverage options. (New York Times)

Vermont

HMA Roundup

Vermont Secures $42 Million to Establish Health Exchange. Last week, the state of Vermont received $42 million in grants from the Federal Government to set up and maintain its health exchange. In total, the state won more than $150 million in Federal grants to build out Vermont Health Connect. The funding will allow the exchange to ensure the technological and operational capacity to manage the complex information exchanges between the web site, call centers, and in-person assisters, effective the October 1, 2013 debut.

In the news

- **"Vermont Releases Final Health Insurance Rates"**

  Vermont's health insurance exchange, called Vermont Health Connect, will offer slightly lower rates than anticipated. The state's Green Mountain Care Board announced this week it had negotiated rate cuts between 4.3 percent and 5.3 percent for plans offered on the individual and small business exchanges by Blue Cross Blue Shield of Vermont and MVP Health Care. (WebMD News)

National

HMA Roundup

Seven Pioneer ACOs Switching to Medicare Shared Savings Program. On July 16, 2013, CMS announced that all 32 Pioneer ACOs delivered good results on quality measures and earned incentive payments. However, seven of the ACOs did not achieve savings in the first year and will be shifting to the Medicare Shared Savings Program model. Two others will leave the accountable care program entirely. Only 13 of the 32 Pioneer ACOs delivered enough savings ($87.6 million in 2012) to save $33 million for the Medicare program. Two Pioneer ACOs suffered losses totaling about $4 million. CMS confirmed that the following ACOs will not continue into the second year of the Pioneer program: Primecare Medical Network, University of Michigan, Physician Health Partners, Seton Health Alliance, Plus (North Texas Specialty Physicians and Texas Health Resources), HealthCare Partners Nevada ACO, HealthCare Partners California ACO, JSA Care Partners and Presbyterian Healthcare Services.

House to Vote on a Delay in the Individual Mandate. The House of Representatives has scheduled a vote on July 17, 2013 that would delay the individual mandate until 2015, parallel to the Obama Administration's decision to delay the employer mandate. GOP leaders argued that ordinary Americans should receive the same flexibility to avoid penalties as large businesses.

Navigator Rules Finalized. On Friday, July 12, 2013, the Health and Human Services Department issued final rules for the "navigators" who will assist consumers in picking appropriate health plans in the newly formed health exchanges. Navigators, certified application counselors, and in-person assisters must be credible sources of objective information about qualified plans, eligibility for tax credits, and other relevant criteria and considerations. Federal navigators and assistance staff serving federal exchange states

must have 30 hours of training and pass tests demonstrating proficiency. States running their own exchanges may establish more rigorous training criteria. In addition, each state must establish training programs for "certified application counselors," who may assist applicants in enrolling for health coverage, but are not on federal or state payrolls.

INDUSTRY NEWS

MAXIMUS Signs Contract To Operate DC Exchange Contact Center. MAXIMUS announced this week that it has signed a contract, effective July 11, to operate the DC Health Link Contact Center, which includes call center, fulfillment and command center services. The contract has four consecutive one-year extension options through September 2017. The contract is worth roughly $25 million for the whole contract term.

United's Connextions Subsidiary Wins Rhode Island Exchange Call Center Contract. Last Thursday, July 11, 2013, HealthSource RI, the state's health exchange, confirmed it had chosen Connextions—a United Health Group subsidiary—to run its call center. The call center is scheduled to open September 1 with an operational start date of October 1. The 30-month contract, worth nearly $24 million, is designed to assist Rhode Island residents in the navigation of the online marketplace. Dell, Faneuil, Maximus, and Xerox were unsuccessful bidders for the contract.

Hospital System Merger to Create Largest Private System in NYC. In two votes on July 15 and 16, 2013, the boards of Mount Sinai Medical Center and Continuum Health Partners approved a merger to create the largest private hospital system in New York City. Upon closing in the fall, the Mount Sinai Health System will span seven campuses across three boroughs, totaling more than 3,300 beds. Combining the specialty services of Mount Sinai with the primary care focus of Continuum results in an integrated health system better equipped for the transition away from fee-for-service toward bundled payments and accountable care.

Active Day/Senior Care Acquires Guardian Programs Adult Medical Day Care. In a deal that closed late last month, Active Day/Senior Care acquired Adult Medical Day Care, reflecting the 11th add-on acquisition since Clearview Capital made its initial 2005 investment in Active Day/Senior Care. Active Day has 79 adult day care centers in eleven states featuring a program of nursing care, social services, meals, and recreational activities to elderly and disabled adults.

Superior Vision Merges with Block Vision. On July 16, 2013, Superior Vision and Block Vision, both leaders in managed vision care, announced plans to merge. Kirk Rothrock, President of Superior Vision characterized the deal as one to drive national scale and opportunities, rather than operational efficiencies. The combined company would offer a comprehensive suite of vision benefit plans to more than 8.5 million across the US. Block's 6 million members are largely Medicare or Medicaid beneficiaries in the mid-Atlantic, Midwest, and Texas markets. Superior Vision boasted the nation's largest vision provider network (46,000), which will further expand to nearly 55,000 in all 50 states. The new company plans to address emerging market opportunities, including health exchanges, employer groups, and direct-to-consumers.

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	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	Florida LTC (Regions 3,4)	Implementation	16,700
April 1, 2014	Idaho Duals	Implementation	17,700
April 1, 2014	New York Duals	Implementation	133,880
April 1, 2014	Washington Duals	Implementation	48,500
July 1, 2014	South Carolina Duals	Implementation	68,000
July 1, 2014	Michigan Duals	Implementation	70,000
September 1, 2014	Vermont Duals	Implementation	22,000
September 1, 2014	Texas Rural STAR+PLUS	Operational Start Date	110,000
October 1, 2014	Florida acute care	Implementation (All Regions)	2,800,000

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					11/1/2013
Connecticut	MFFS	57,569					TBD
Hawaii		24,189	Not pursuing Financial Alignment Model				
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	X	1/1/2014
Iowa	MFFS	62,714					TBD
Idaho	Capitated	22,548	June 2013	TBD	August 2013	7/25/2013	4/1/2014
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		7/1/2014
Tennessee		136,000	Not pursuing Financial Alignment Model				
Texas	Capitated	214,402					1/1/2014
Virginia	Capitated	78,596	X	5/15/2013	6/27/2013	X	1/1/2014
Vermont	Capitated	22,000	10/1/2013	TBD	TBD	7/15/2013	9/1/2014
Washington	MMFS	115,000	X			MFFS Only	7/1/2013
	Capitated		X	5/15/2013	6/6/2013		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 Upcoming Appearances

"Medicaid Expansion: Considerations for States"
Women In Government – Healthcare Reform Task Force

Joan Henneberry – Presenter
July 21, 2013
Boston, Massachusetts

HMA will present the current status of state policy decisions on Medicaid expansion, including states negotiating alternative and hybrid approaches to expanding Medicaid under the ACA. HMA will also facilitate a group discussion with attendees, members of state legislatures, on future policy decisions needed to successfully implement a Medicaid expansion.

"Building the Foundation - A Refresher on Federal Programs, Grants, and Reporting"
National Association of State Human Services Finance Officers Annual Conference

Mark Trail – Presenter
July 28, 2013
Columbus, Ohio

Mark Trail will co-present with Trinity Tomsic of Federal Funds Information for States.

"Medicaid Expansion – Hot Topics in Information Technology"
National Association of State Human Services Finance Officers Annual Conference

Juan Montanez – Presenter
July 31, 2013
Columbus, Ohio

The presentation will discuss the challenges of modernizing IT systems for human service programs in a time of exceptional transformation and complexity. Lessons learned from state IT transformations will be discussed, and best practices will be shared for states contemplating similar efforts.