HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 23, 2014

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Kartik Raju
Email

THIS WEEK

IN FOCUS

The HMA Weekly Roundup will not publish next Wednesday, July 30, 2014. We will resume regular publication on Wednesday, August 6, 2014.

TEXAS HHSC ISSUES STAR KIDS RFP

This week our *In Focus* section reviews the STAR Kids request for proposals (RFP) released by Texas' Health and Human Services Commission (HHSC) on July 18, 2014. The RFP will establish the STAR Kids Medicaid managed care program for children and young adults with disabilities. We previously reviewed the draft STAR Kids RFP in our April 2, 2014 Weekly Roundup, which covered several Texas managed care initiatives.

Target Population

STAR Kids will mandatorily enroll children and young adults under 21 years of age receiving Social Security Income (SSI) or receiving services through the Home and Community-Based Services (HCBS) Waiver programs operated by

HHSC, the Department of Aging and Disability Services (DADS), and the Department of State Health Services (DSHS).

As of August 2013, there were approximately 175,000 STAR Kids eligible children and young adults served by Texas Medicaid. Around 85 percent are currently in a fee-for-service (FFS) arrangement, around 10 percent currently enrolled in a STAR+PLUS health plan, and less than 5 percent enrolled with a STAR health plan. Based on HHSC data in the table below, the STAR Kids eligible population accounted for nearly $2 billion in FY 2013 spending, equating to a per-member-per-month cost of a little over $1,000 in FFS expenditures and more than $600 in capitated STAR and STAR+PLUS expenditures.

STAR Kids Eligible Population and Spending, FY 2013			
Average Monthly Enrollment	FFS	STAR/STAR+PLUS	Total
	147,700	**26,800**	**174,500**
Claim Type	FFS	STAR/STAR+PLUS	Total
Dental	$1,369,000	$48,805,000	$50,174,000
Inpatient	$367,246,000	$49,025,000	$416,271,000
Outpatient	$870,452,000	$35,678,000	$906,131,000
Professional	$542,137,000	$63,716,000	$605,853,000
Behavioral Health	$110,331,000	$16,543,000	$126,874,000
Total Medicaid Expenditures	**$1,781,204,000**	**$197,225,000**	**$1,978,429,000**
Estimated PMPM	***$1,005***	***$613***	***$945***

Source: State Enrollment and Spending Data, FY 2013

Children and young adults in the Medically Dependent Children Program (MDCP) will receive all services, including long-term supports and services (LTSS), through STAR Kids. Enrollees in the following waiver programs will receive acute care services through their STAR Kids health plan, while waiver services will be delivered through current waiver providers:

- Home and Community-based Services (HCS)
- Community Living Assistance and Supports Services (CLASS)
- Deaf Blind with Multiple Disabilities (DBMD)
- Texas Home Living (TxHmL)
- Youth Empowerment Services (YES)

Children and young adults in foster care receiving SSI will be excluded from the STAR Kids population and instead will be served by the STAR Health managed care program for foster care populations currently under procurement.

RFP Timeline and Contract Term

Per the timeline below, there will be a vendor conference on July 31, 2014. For health plans seeking mandatory contract status (see section below on Texas' mandatory contracting rule) letters are due on September 2, 2014. Proposals are due to HHSC on October 31, 2014, with an award announcement date yet to be determined. Contracts are set to take effect September 1, 2015, with operations beginning one year later, on September 1, 2016. The initial contract term will run for four years, through August 31, 2019, with optional contract extensions of an additional four years.

Procurement Schedule	Date
RFP Release Date	July 18, 2014
Vendor Conference	July 31, 2014
Respondent Questions Due	August 5, 2014
Letters Claiming Mandatory Contract Status Due	September 2, 2014
HHSC Posts Responses to Respondent Questions	September 16, 2014
Proposals Due	October 30, 2014
Tentative Award Announcement	TBD
Contract Effective Date	September 1, 2015
Operational Start Date	September 1, 2016

Texas Mandatory Contracting Rule

In the timeline above, the due date for letters from health plans claiming mandatory contract status are due on September 2, 2014. Under Texas Government Code, health plans are eligible to automatically receive a managed care contract in their region if the health plan is wholly owned and operated by a hospital district in that region, or is operated by a nonprofit corporation working under contract with a hospital district in that region to serve the safety net population. Eligible health plans must submit a response to the RFP and meet all of the same terms and conditions as other bidders. Source: Link to TX Government Code 533.004

Evaluation Criteria

The evaluation criteria provided in the RFP do not provide a specific scoring structure, but provides four broad areas of evaluation presented in descending order of priority. In general, bidders who indicate how they will meet the HHSC priority objectives outlined below and demonstrate expertise in serving similar populations should be well positioned in the evaluation process.

	Evaluation Criteria (In Descending Order of Priority)

1	Meets HHSC's needs and the needs of the Members, including:
	• Proposal addresses HHSC's priority objectives:
	  ○ Network adequacy and access to care
	  ○ Continuity of care
	  ○ Providing consistent, integrated health home
	  ○ Behavioral health services
	  ○ Service coordination
	  ○ Timeliness of initial Texas Health Steps visit
	  ○ Timeliness of claims payments
	  ○ Quality
	  ○ Delivery of healthcare to diverse populations
	  ○ Disease management
	  ○ Individualized service planning
	• Acceptance of STAR Kids contract terms
	• Expertise in providing services to similar populations
	• Ability to retain, recruit, and maintain provider network
	• Flexibility, adaptability to STAR Kids population
	• Identification of positive outcomes and proposed structure for incentivized payments
	• Appropriate access to care in rural and medical shortage areas

2	Indicators of probable vendor performance, including: • Past performance in Texas or comparable experience in other states, including proven ability to integrate physical and behavioral services and

	acute and LTSS • Financial solvency • Coordination with HCBS waiver programs and delivery of community-based services • Organizational capacity and qualifications, including meeting Texas Department of Insurance approval
3	Effect on HHSC productivity, including: • Level of effort and resources required by HHSC to monitor the respondent's performance • Level of effort required by HHSC to maintain and good working relationship with the respondent
4	Delivery terms, including: • Ability to complete transition phase requirements and fully implement services by operational start date • Ability to maintain operations throughout initial contract period • Ability to comply with turnover requirements upon termination of the contract

Link to HHSC STAR Kids Procurement:

http://www.hhsc.state.tx.us/contract/529130071/announcements.shtml

HMA Medicaid Roundup

Arkansas

Arkansas Considers Plan to Make Some Medicaid Enrollees Fund Savings Accounts. On July 22, 2014, *Kaiser Health News* reported that Arkansas health officials are considering establishing Health Independence Accounts, which Medicaid beneficiaries would be required to contribute to each month in order to maintain certain benefits, such as avoiding typical cost sharing for medical services. Funds in the accounts may roll over from year to year, and participants may be able to use them to cover their medical costs if they leave the Medicaid program. Medicaid enrollees earning more than the poverty level could be refused services if they do not make their monthly contribution and do not make a copayment. Michigan and Indiana have already implemented such accounts into their Medicaid programs, with the understanding that the financial requirement will reduce frivolous utilization of care by Medicaid beneficiaries. A public comment period about the Arkansas proposal begins August 1. Read more

Arkansas Medicaid Patients Sue State for Restricting Access to Costly Cystic Fibrosis Drug. On July 16, 2014, the *Wall Street Journal* reported that the Arkansas Medicaid program has restricted access to Kalydeco, a cystic-fibrosis drug, because of its $300,000 per year cost. Three Arkansas residents have sued that state's Medicaid program, alleging that denying the drug was a violation of human rights. Arkansas officials have limited access to the drug to people who prove their disease has failed to benefit from older, less expensive treatments. The lawsuits highlight the difficulties the state faces in keeping its cash-strapped budget in line and may also be a sign of things to come as more expensive, niche drugs enter the market. Read more

California

HMA Roundup – Alana Ketchel

State Releases Plan for Addressing Medi-Cal Backlog. Only July 15, 2014 the California Department of Health Care Services (DHCS) revealed its plan to address the large backlog of pending Medi-Cal applications in response to an inquiry from the Centers for Medicare and Medicaid Services (CMS). DHCS cited the following as reasons for the delay: a large volume of applications, technology issues with CalHEERS, and duplicate cases and data entry errors stemming from use of the self-service online enrollment portal. DHCS outlined its plan to address the IT challenges, pledging to reduce the number of pending applications to about 350,000 within six weeks. Read more

LA County Votes to Implement Laura's Law. On July 15, 2014, the *Los Angeles Times* reported that Los Angeles County voted to fully implement Laura's Law, a statute that allows counties to pursue court-ordered treatment for those with serious mental illness. The existing voluntary outpatient treatment program in LA will be expanded from 20 to 300 slots and will include outreach to potential patients. The annual cost of the program, funded largely by state mental health funds and Medi-Cal, will be just under $10 million. Read more

Alameda Alliance Continues Under Conservatorship. On July 16, 2014, the *Contra Costa Times* reported that an Alameda Superior Court judge has decided to extend the state takeover of Alameda Alliance, a local health plan, for up to one year. The judge sided with state regulators who felt the plan's failure to process and promptly pay medical claims could have a detrimental impact on the health of its enrollees. A report from the current conservator, expected next month, will identify strategies to improve the plan's financial standing. Read more

Governor Signs Bill to Address Physician Shortage. On July 18, 2014, the *Sacramento Business Journal* reported that Governor Brown signed legislation to allow students to become doctors in three years instead of four, assuming they attend an accredited medical school program in California. This accelerated program would be an alternative to traditional medical school. Eligible students would have to demonstrate a high-level understanding of science and medicine. The bill takes effect January 2015. Read more

Medi-Cal Releases Initial Concepts for 1115 Waiver. In a July 18, 2014 e-mail sent to stakeholders, the Department of Health Care Services (DHCS) released a set of initial potential concepts for the Medi-Cal 1115 Waiver renewal. DHCS states that the focus of the renewal will be on "improving and reforming our Medi-Cal payment and delivery systems and ensuring ongoing support for the safety net". Some of the concepts include: shared savings initiatives, reform incentive payment programs, and safety net payment reforms. The State is aiming to submit the waiver renewal in early 2015 and is seeking stakeholder input. Read more

Colorado

Colorado Appoints State Commission for Affordable Health Care to Examine Rising Healthcare Costs. On July 17, 2014, the *Denver Business Journal* reported that the Colorado Commission for Affordable Health Care will begin a three-year effort to understand and devise solutions for dealing with rising healthcare costs in the state. The 12-person Commission will include physicians, hospital representatives, business and insurance executives along with several state officials serving as ex-officio members. Senator Irene Aguilar, who introduced the bill for the Commission late in the Legislative session, hopes that "having (the Commission members) all talk through it could break down walls and create ways to increase competition." Read more

Florida

HMA Roundup – Elaine Peters

State Releases MMA Managed Care Enrollment for Standard and Specialty Plans. This month, the state released its MMA Managed Care Enrollment numbers for standard and specialty plans. So far, MMA has been rolled out in eight out of 11 regions in the state.

	MMA Managed Care Enrollment by Plan - July 2014											
	MMA Health Plans	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11	TOTAL
1	Amerigroup					65,517	112,616					49,969	228,102
2	Coventry Health Care											43,907	43,907
3	Humana						26,321				44,129	64,539	134,989
4	Molina											24,991	24,991
5	Preferred Medical Plan											30,113	30,113
6	Sunshine			26,451	72,152	27,402	41,959		12,832		55,971	25,728	262,495
7	United			52,933	63,935							79,351	196,219
8	Wellcare/Staywell of FL		52,837	81,011	56,048	42,047	114,409		75,423			55,106	476,881
9	Better Health						18,811				65,725		84,536
10	Simply											68,893	68,893
11	First Coast PSN				65,537								65,537
12	Integral PSN						18,303		39,582				57,885
13	Prestige PSN		42,935	55,016		20,372	24,535		50,710			16,474	210,042
14	SFCCN - PSN										43,021		43,021
	Total	**0**	**95,772**	**215,411**	**257,672**	**155,338**	**356,954**	**0**	**178,547**	**0**	**208,846**	**459,071**	**1,927,611**
	Plans Awarded	2	2	4	4	4	7	6	4	4	4	10	
	Implementation Date	8/1/2014	5/1/2014	5/1/2014	5/1/2014	6/1/2014	6/1/2014	8/1/2014	6/1/2014	8/1/2014	7/1/2014	7/1/2014	

	MMA Managed Care Enrollment by Plan - July 2014											
	MMA Specialty Plans	Region 1	Region 2	Region 3	Region 4	Region 5	Region 6	Region 7	Region 8	Region 9	Region 10	Region 11	TOTAL
1	Clear Health Alliance - HIV/AIDS		245	487		865	729		529		896	2,456	6,207
2	Freedom Health - Duals Chronic conditions												0
3	Magellan Complete Care - Serious Mental Illness										3,649	9,057	12,706
4	Positive Healthcare Florida - HIV/AIDS										964	1,205	2,169
5	Sunshine Health Plan - Child Welfare		606	1,783	2,090	1,365	2,612		1,138		1,777	1,891	13,262
6	Children's Medical Services - Children with chronic conditions												
	Total Specialty Plans	**0**	**851**	**2,270**	**2,090**	**2,230**	**3,341**	**0**	**1,667**	**0**	**7,286**	**14,609**	**34,344**

Health Officials Ban Medicaid Marketing as State Shifts Medicaid Population to Privatized Managed Care. On July 22, 2014, *AP*/the *Miami Herald* reported that the state has banned health insurance companies from marketing their plans directly to Medicaid recipients as the state moves its Medicaid population into a managed care model. The Agency for Health Care Administration says the marketing ban will help keep the focus on enrollment and ensure patients do not experience lapses in care during the transition. In the past, marketing tactics by insurers have been aggressive and have even led some consumers to sign up for plans they did not fully understand. Read more

Florida Blue Hints Rate Hikes Possible in 2015. On July 21, 2014, *Kaiser Health News*/*Health News Florida* reported that premium rates for Florida Blue plans could increase next year due to the paucity of younger enrollees and the influx of older and sicker enrollees. According to CEO Patrick Geraghty, the insurer has enrolled an older and sicker population than it expected to. The nonprofit Blue Cross Blue Shield affiliate has enrolled one third of all ACA enrollees in the state to date. Read more

Georgia

HMA Roundup – Mark Trail

Amerigroup Wins CMS Innovation Award to Develop New Care Program for Foster Children. On July 21, 2014, *Business Wire* reported that Amerigroup's Georgia health plan has been named a Health Center Innovation awardee by CMS. As a recipient of this award, Amerigroup will receive a $5.8 million grant to implement its Coaching and Comprehensive Health Supports (COACHES) program, a transitional program to improve outcomes for young adults ages 17 to 20 who are transitioning out of foster care and who will receive health care coverage until the age of 26 for the first time under the ACA. Amerigroup will work with Families First, a non-profit family service agency in the state, to establish one-on-one coaches who will work with young adults over the three-year grant period to improve healthy behaviors. Read more

Hawaii

Hawaii Uninsured Rate Drops Below 6 Percent Since ACA. On July 21, 2014, *AP/Miami Herald* reported that the rate of people without health insurance in Hawaii has dropped below 6 percent since the implementation of the ACA. About 75,000 residents remain uninsured, down from well over 100,000 last year. About half of these people are expected to qualify for Medicaid, while the other half qualify for insurance through the Hawaii Health Connector online marketplace. Read more

Louisiana

Medicaid Program Funding to Undergo Big Changes, Says Jindal Administration. On July 18, 2014, the *Advocate* reported that the Jindal administration is moving towards converting the Bayou Health Medicaid managed care program to an entirely risk-based capitation model, eliminating the shared-savings networks that currently operates in competition with the risk-based MCOs. State Department of Health and Hospitals Secretary Kathy Kliebert explained that the move would provide more budget predictability and increased savings while simultaneously giving health plans more flexibility in the services they can offer patients. The RFP is expected to be released on July 28. Read more

Maine

LePage Administration to Use Medicaid Surplus to Help Financially Struggling Nursing Homes. On July 17, 2014, the *Portland Press Herald* reported that the LePage administration plans on using the state's Medicaid surplus to provide $13.1 million in additional funding to the state's 106 nursing homes. The state will provide $4.6 million of its surplus Medicaid funds, which will pull in another $8.5 million in federal matching dollars. Despite the benefits the funding will provide nursing homes, some state lawmakers believe LePage could have provided this assistance long ago. Read more

New York

HMA Roundup – Denise Soffel

New York Medicaid Update – NYS Medicaid Director Jason Helgerson Speaks at United Hospital Fund Medicaid Conference. Jason Helgerson, NYS Medicaid Director, gave the keynote address at the United Hospital Fund annual Medicaid conference. He began by reviewing the changes in New York that can be attributed to the Medicaid Redesign Team, which was established in January 2011. He noted that the cost curve for the Medicaid program has been bent significantly, reducing annual program growth to less than one percent. Even more notable is that per capita spending has actually declined, as the number of individuals enrolled in Medicaid continues to grow. Per capita spending peaked in 2009 at $9,574 per recipient; it was down to $8,504 in 2013. He noted the Care Management for All strategy, and said that when fully implemented, 95 percent of all Medicaid dollars will be running through managed care plans. He noted the renewed emphasis on patient-centered medical homes and health homes, which are a significant building block that has led to partnerships and communication across a wide variety of provider types.

New York has had a pay-for-performance component in its Medicaid managed care program since 2001, and quality metrics have continued to improve. Nonetheless, the most recent Commonwealth State Scorecard results indicate that New York ranks fairly low on avoidable hospital use and cost, at 34th in the nation. In fact, pay-for-performance represents $450 million out of a total Medicaid program of $54 billion, so its impact has been limited. As New York implements its DSRIP program, those incentive payments should bring enhanced accountability.

The state has an aggressive reform agenda over the next year. The nursing home benefit will be carved into managed care, beginning possibly as soon as August 2014 (the carve-in has been delayed several times as negotiations with CMS continue). Nursing home care is a major driver of avoidable hospitalization; transitioning this benefit will take several years, beginning with beneficiaries newly eligible for nursing home level of care. The state's duals demonstration program, Fully Integrated Duals Advantage (FIDA) is scheduled to begin in January 2015, and while the pilot is limited to 8 downstate counties, the intent is to implement the demonstration statewide, aligning these payors to coordinate care and increase accountability. The behavioral health carve-in and the establishment of Health and Recovery Plans (HARPs) for individuals with serious mental illness, representing a total of $8 billion in services, is scheduled for a January 1, 2015 roll-out in NYC, with the rest of the state following 6 months later. Finally, the state is moving ahead with plans for managed care for individuals with developmental disability (Developmental Disabilities Individual Support and Care Coordination Organization, or DISCO), tentatively scheduled for October 2015.

Helgerson noted that the state's health care infrastructure is not well aligned with the changing delivery system. Historically, the Medicaid program rewarded institutional care at the expense of community-based care and primary and preventive services. The reimbursement system was designed to preserve provider capacity, and the regulatory system is siloed and contradictory. Helgerson said that the DSRIP program was an essential tool in redesigning the delivery system. He described it as seed capital for building a

delivery system based on performing provider systems. He noted that this is a high-risk strategy, as DSRIP funds come with strings attached, and will require underlying structural change in order to succeed. He also noted than no one has ever created a performing provider system on this scale. DSRIP creates the opportunity to fundamentally restructure health care delivery to achieve a different system, one that ensures long-term sustainability. He noted that 20 hospitals across the state have less than 15 days cash on hand, putting them at risk of closing within the year. The loss of these facilities, many of which are essential community providers, could create significant access to care problems.

As performing provider systems are established, care delivery will become more integrated. It is likely that integrated care will lead to further consolidation of the delivery system, which should lead to greater financial sustainability. Helgerson said that stand-alone providers are not the future of health care in New York, and solo practitioners should plan on forming/joining IPAs of community-based providers. As DSRIP is implemented, the state is committed to payment reform as well. The Department of Health has established a stakeholder process to explore payment reform options. The intent is that at the end of the 5-year DSRIP program, individual Performing Provider Systems will contract with managed care plans, including mainstream plans, managed long-term care plans, FIDA plans, HARPs and DISCOs, and will distribute payment to providers within the PPS on some value-based method.

Helgerson's presentation can be found on the UHF web site.

New York State of Health. As it prepares for a second enrollment period, the New York State of Health is improving efforts to reach New Yorkers with limited English proficiency. Working with consumer and immigrant health advocates to identify and resolve potential language barriers, the Department of Health is adding languages to the consumer assistance help line. The Exchange web site has been fully translated into Spanish, and a Spanish version of the health insurance application is being tested and will be ready for the enrollment period starting November 15. The state is working to have the applications translated into multiple languages, and to translate notices into Spanish and additional languages. While initial projections had indicated that as many as 36 percent of Exchange enrollees were non-English speakers, only 15 percent of enrollees during the first enrollment period indicated they preferred to communicate in a language other than English, leading the state to conclude that their outreach efforts in immigrant communities could be strengthened.

1199 Strike Averted. The League of Voluntary Hospitals and Homes of New York has reached a tentative agreement with 1199 SEIU, United Healthcare Workers East for a new contract. The League is an association of non-profit medical centers, hospitals, nursing homes and their affiliated facilities in the greater New York metropolitan area that acts as the bargaining agent for its members in labor contracts. The union, representing 70,000 health care workers, had threatened a one-day strike on July 31, the day after the current contract expires, and had given official 10-day notices for the strike.

The three-year "master contract" between leading hospitals in New York City and 1199 SEIU, originally set to expire July 15, was extended to July 30. Contentious issues included changes in how hospitals contribute to the National Benefit Fund and whether ambulatory care facilities would be union shops. Employers now contribute a percentage of an employee's salary to the benefit fund, which means that facilities paying higher wages, typically non-profits, are

subsidizing smaller, for-profits that pay their employees less. The new agreement provides a ceiling on how much each facility pays into the benefit fund. The second issue is related to the on-going shift to outpatient settings and the closing of hospitals (and the loss of unionized hospital jobs). The union wanted assurance that workers in community-based settings operated by League members are allowed to join the union and receive the same wages and benefits. While some hospital-operated free-standing sites are unionized, that is not universally the case. The League has agreed to allow workers the right to organize at new clinics.

HealthNow to Withdraw from Medicaid Managed Care Market in Western NY. On July 17, 2014, the *Buffalo News* reported that HealthNow, a Medicaid managed care plan administered by BlueCross BlueShield of Western New York, is withdrawing from the state's Medicaid managed care program effective October 31, 2014. The insurer cited losses in excess of $40 million over the past three years as the reason for its withdrawal from the market. The news means that 53,000 Medicaid managed care recipients in Erie, Chautauqua, Cattaraugus, Orleans, Wyoming and Allegany counties will have to move to another insurance provider by October 31. State and BlueCross BlueShield officials said they would work to make sure the transition goes smoothly. Read more

North Carolina

Senate Committee Approves Senate Medicaid Overhaul Bill. On July 17, 2014, *AP/The Republic* reported that a North Carolina Senate Committee has passed the Senate's Medicaid overhaul proposal, despite opposition from several medical organizations and Governor Pat McCrory, who prefer a House plan. The Senate proposal would shift Medicaid to a managed care model and would create a new state Department of Benefits to oversee Medicaid. Read more

Senate Medicaid Budget Proposal Could Cut Medicaid Eligibility for Thousands. On July 15, 2014, *North Carolina Health News* reported on the progress of the state Senate and House's Medicaid budget negotiations. To address cost concerns, the Senate has agreed to scrap their earlier proposal to cut eligibility for ABD beneficiaries. However, the Senate budget still disqualifies individuals for Medicaid because they qualify for other funding; the restriction would mean that at least 5,000 people living in assisted living facilities, group homes and adult care homes would lose their Medicaid. Read more

Pennsylvania

HMA Roundup – Matt Roan

Moody's Downgrades Pennsylvania's Bond Rating. On July 21, 2014, the *Patriot-News* reported that Moody's Investment Services has downgraded Pennsylvania's bond rating, citing a reliance on one-time revenue sources in the recently passed state budget, and the state's failure to address burgeoning pension obligations. Moody's noted that there is a "growing structural imbalance" within the state's finances. The Governor used the announcement to highlight the importance of solving the pension crisis. Earlier this month, the governor issued line item vetoes for budget lines that funded special projects within the legislative branch, while criticizing the General Assembly for their failure to pass a pension reform bill. Read more

Virginia

Commonwealth Coordinated Care Releases Latest Enrollment Numbers. This month, Commonwealth Coordinated Care (CCC) reported its June enrollment in the state of Virginia. Voluntary enrollment for CCC coverage began across the state in March 2014. CCC ended June with 2,514 individuals voluntarily enrolling in the program across five regions. Approximately 10,150 eligible beneficiaries have been automatically assigned to the CCC program in the Tidewater Region. There are also 15,423 individuals automatically assigned into CCC in the Central Virginia Region, with effective coverage beginning September 1, 2014. Automatic enrollment will take place in the Roanoke/Charlottesville Areas from September 1 to October 1, and in the Northern VA region from October 1 to November 1. Read more

Washington

Washington's Uninsured Rate Drops to 8.65 Percent. On July 17, 2014, *AP/Daily Herald* reported that the state's uninsured rate has dropped to 8.65 percent, according to estimates by the Office of the Insurance Commissioner. The department reported that 81,000 more residents gained insurance coverage by purchasing individual policies either through the Health Benefit Exchange or through an agent outside the exchange. The exchange also helped sign up nearly 350,000 people for Medicaid. The decrease in uninsured Washington residents mirrors the enrollment trend in more than two dozen other states that expanded Medicaid eligibility. Read more

Wisconsin

GAO Report Reveals Low Medicaid Reimbursement Rates in Wisconsin. On July 19, 2014, the *Milwaukee Journal Sentinel* reported on a recent report from the Government Accountability Office (GAO) which found that Medicaid payments for medical services in Wisconsin are 71 percent to 91 percent lower than private insurance rates on average. Low Medicaid reimbursement rates have led to a shortage of providers, particularly primary care physicians, in low-income neighborhoods around the state. It has also led to increased utilization of emergency room care. Read more

Sixty-One Percent of Residents Who Lost Medicaid Coverage Did Not Purchase Private Insurance Through the Exchange. On July 16, 2014, *AP/SF Gate* reported on statistics released by the Wisconsin Department of Health Services, which show that 38,000 people who lost their Medicaid coverage under stricter income requirements did not purchase private insurance through the online marketplace. Coverage ended for 63,000 residents in April after Governor Scott Walker decreased the income eligibility for Medicaid recipients in the state; 61 percent of these people did not purchase insurance through the exchange. While it is unclear if these residents obtained insurance through other family members or outside of the exchange, the numbers reinforce the concern that the marketplace is not a viable option for many low-income families who would have been covered if the state opted for Medicaid expansion. Read more

National

Courts Announce Conflicting Rulings on Subsidies for Federal Exchange Consumers. On July 22, 2014, *Kaiser Health News* reported on the conflicting decisions of two U.S. appeals courts about the legality of subsidies in the ACA. A three-judge panel for the U.S. Court of Appeals in Washington rules that subsidies may not be offered in the federal health exchange. The decision overturned a lower court ruling. Hours after the appeals court ruling, the Fourth Circuit Court of Appeals offered its own decision, which upholds the Obama administration's arguments that subsidies can be applied in the federal exchange. In *Halbig v. Burwell*, the plaintiff claims that a phrase in the ACA prohibits residents of states using federally-facilitated marketplaces from receiving subsidies for their health insurance coverage. Thirty-four states currently use federally-facilitated marketplaces. According to a July 17 report by the Urban Institute, prohibiting financial assistance in these marketplaces would make insurance options unaffordable for many consumers, 7.3 million of whom are estimated to receive federal subsidies in 2016. Losses would be as high as $4.8 billion in Florida and $5.6 billion in Texas. Read more

New Health Law Rules Could Widen Restricted Insurer Networks. On July 19, 2014, the *New York Times* reported on the Obama administration's efforts to address concerns of newly insured Americans that their ACA health plans have limited their choices of doctors and hospitals, leaving them with unexpected medical bills. Some insurers have tried to cut costs by excluding children's hospitals and academic medical centers; some specialists set quotas limiting the number of patients they will see from exchange plans, further limiting networks. Federal officials will analyze exchange plan networks and adapt standards similar to those used by the government to determine whether Medicare Advantage plans had enough doctors and hospitals in their networks. States are free to adopt additional standards of their own, which several states have already begun doing. Read more

HHS Exempts U.S. Territories from Several Major ACA Provisions in Effort to Maintain Healthy Insurance Market. On July 17, 2014, the *Washington Post* reported that the Obama administration has exempted U.S. territories from ACA market rules, including guaranteed coverage and mandated benefits. Officials in the territories, which include Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam and the Northern Mariana Islands, have warned that enforcing these requirements without requiring residents to get coverage or providing subsidies for coverage would destroy their insurance markets. The change occurred because the definition of "state" in the Public Health Service Act indicates that the ACA market rules do not apply to the territories. The Department of Health and Human Services said that group plans in the territories must still comply with other requirements in the law, like the ban on lifetime and annual limits, a ban on rescission and coverage of preventive benefits. Read more

ExpressScripts Releases Report on Potential Costs of Treating Medicaid Beneficiaries with Hepatitis C. On July 17, 2014, ExpressScripts released a report on the potential costs of treating Medicaid beneficiaries with Hepatitis C using the costly new drug Sovaldi. If the 750,000 Medicaid enrollees and prisoners infected with Hepatitis C nationwide receive a treatment regimen of Sovaldi and ribavirin, ExpressScripts projects states will spend more than $55.2 million on these treatments. California, Texas, Florida, New York and Illinois

have the highest total projected spend. Louisiana, Delaware, Mississippi, Oklahoma and Texas have the highest per capita projected spend, ranging from $200 to $294 per state resident. Read more

Narrow Network Health Plans Make Finding Specialist Difficult For Some Consumers. On July 16, 2014, *Kaiser Health News/Houston Public Media* reported that the new, narrow-network health insurance plans many Americans are purchasing through the ACA marketplaces have made it difficult for new beneficiaries to find specialists that will treat them. While narrow provider networks are not new, consumer advocates and providers worry that the trade-offs associated with having such a restricted plan will discourage new beneficiaries from keeping their coverage. Read more

Industry News

Ascension & Carondelet Health Network Sign Letter of Intent to Form a Partnership with Tenet Healthcare and Dignity Health. On July 22, 2014, Carondelet Health Network of Tucson, Arizona, and its parent company, Ascension, signed an exclusive, non-binding Letter of Intent with a subsidiary of Tenet Healthcare Corporation to create a joint venture with Dignity Health that would own and operate Carondelet. Under the proposed agreement, Tenet would be the majority provider in the joint venture with management responsibility for all operations of Carondelet's assets, including St. Joseph's and St. Mary's Hospitals in Tucson. Read more

Centene Corporation Reports Q2 2014 Results and Raises Guidance. On July 22, 2014, Centene Corporation announced its financial results for Q2 2014. The company delivered strong top and bottom line growth in the second quarter, reported premium and services revenues of $3.74 billion (representing 49 percent growth from Q2 2013) and an increase of 601,000 managed care members. The company also reported an operating cash flow of $159.4 million, or 3.3 times net earnings. Read more

CMS Awards Qualis Health Five-Year Contracts to Lead Quality Innovation Network for Idaho and Washington. On July 21, 2014, Qualis Health announced that it has been awarded five-year contracts by CMS to serve as the Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for the states of Idaho and Washington, effective July 18, 2014. Qualis will be tasked with improving healthcare value for 1.3 million Medicare beneficiaries in the two states, focusing on promoting effective preventing and treatment of chronic disease; making care safer by reducing harm cause in the delivery of care; promoting effective communication and coordination of care; and making care for affordable. The QIO program has achieved significant improvements in patient safety and quality and efficiency of care during current Qualis contracts covering the 2011-2014 period. Read more

UnitedHealthcare to Increase Participation in State Exchanges. On July 17, 2014, *Kaiser Health News* reported that UnitedHealthcare may sell individual policies through the exchanges in nearly half the states next year. On a conference call with investors this week, CEO Stephen Hemsley explained that the marketplaces look sustainable, and that there is now sufficient information on regulations, prices and consumer behavior for United to feel confident entering more markets. The insurer currently sells individual policies through federally-facilitated exchanges in only four states. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Indiana ABD	RFP Release	50,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
July 18, 2014	Texas STAR Kids	RFP Released	175,000
July 25, 2014	Washington Foster Care	RFP Release	23,000
July 28, 2014	Louisiana	RFP Release	900,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
August 11, 2014	Puerto Rico	Proposals Due	1,600,000
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
September 26, 2014	Louisiana	Proposals Due	900,000
October 9, 2014	Arizona (Behavioral)	Proposals Due	23,000
October 30, 2014	Texas STAR Kids	Proposals Due	175,000
January 1, 2015	Michigan Duals	Implementation	70,000
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
January 1, 2015	New York Behavioral (NYC)	Implementation	NA
January 1, 2015	Texas Duals	Implementation	168,000
January 1, 2015	New York Duals	Implementation	178,000
February 1, 2015	Washington Duals	Implementation	48,500
February 1, 2015	Louisiana	Implementation	900,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa		62,714	Not pursuing Financial Alignment Model						
Idaho		22,548	Not pursuing Financial Alignment Model						
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	1/1/2015	4/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri		6,380	Not pursuing Financial Alignment Model						
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X			10/25/2013	7/1/2014	1/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	168,000				5/23/2014	3/1/2015	4/1/2015	Amerigroup, Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013	3/1/2014	5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	2/1/2015	4/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 5 MFFS**	**1.35M Capitated 513K FFS**	***12***			***11***			

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

[1] Capitated duals integration model for health homes population.

HMA News

HMA's Work with Weiss Pediatric Care Featured in Tampa Bay Medical News

HMA is a leading partner and project manager in a joint Florida-Illinois Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant which has been working to transform pediatric practices into medical homes through the Florida Pediatric Medical Home Demonstration Project. Building off of the success of an initial medical home transformation collaborative in Florida, 13 new pediatric practices, including Weiss Pediatric Care, were selected and are engaged in this collaborative process to be trained and receive technical assistance in implementing medical home transformation in their own practices. In the June 2014 edition of *Tampa Bay Medical News*, Weiss Pediatric Care's progress as Sarasota County's first Pediatric Patient-Centered Medical Home is highlighted. Read more

HMA's JoAnn Lamphere Participates in National Association of Area Agencies on Aging (n4a) Annual Conference

HMA is helping community organizations, especially Area Agencies on Aging, build their business capabilities so they can effectively partner with managed care plans that are delivering managed long-term services and supports and services to dual populations under CMS' financial alignment demonstration. To that end, HMA serves as a sub-contractor to n4a (National Association of Area Agencies on Aging) as part of its U.S. Administration for Community Living grant. At the recent n4a 2014 Annual Conference and Tradeshow in Dallas, HMA's JoAnn Lamphere was part of the Pre-conference Intensive ACL Update: "Dual Financial Alignment, MLTSS and More" panel discussion. She also served as an expert participant in n4a's Managed Care Boot Camp.