HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: MICHIGAN RELEASES DUAL ELIGIBLE DEMONSTRATION RFP

HMA ROUNDUP: MARYLAND ANNOUNCES REVISED HEALTH INSURANCE EXCHANGE RATES; IDAHO DISCLOSES DUAL ELIGIBLE DEMONSTRATION MCOS; SOUTH CAROLINA MOVES TO OPEN APPLICATION PROCESS FOR DUAL ELIGIBLE MCOS; MICHIGAN SENATE COMMITTEE UNANIMOUSLY APPROVES MEDICAID EXPANSION PLAN; CALIFORNIA SUBSTANCE ABUSE, NEW MEXICO BEHAVIORAL HEALTH PROVIDERS INVESTIGATED FOR FRAUD

INDUSTRY NEWS: MOLINA ACQUIRES SOUTH CAROLINA ASSETS OF COMMUNITY HEALTH SOLUTIONS; COMMUNITY HEALTH SYSTEMS ANNOUNCES MERGER AGREEMENT WITH HEALTH MANAGEMENT ASSOCIATES, A NAPLES, FLORIDA BASED HOSPITAL MANAGEMENT COMPANY UNAFFILIATED WITH OUR ORGANIZATION

JULY 31, 2013

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: MICHIGAN RELEASES DUAL ELIGIBLE DEMONSTRATION RFP

This week, our *In Focus* section reviews the request for proposal (RFP) released on July 26, 2013 for Michigan's dual eligible demonstration, known as the *Demonstration Program to Integrate Care for Persons Eligible for Medicare and Medicaid*. The RFP seeks to procure integrated care organizations (ICOs) to begin serving the dual eligible population in 4 regions in Michigan beginning July 1, 2014. Note that Michigan has not yet reached a memorandum of understanding (MOU) with CMS on the dual eligible initiative. We expect an MOU to be released relatively soon with more details on the program structure available then.

A link to the RFP on the state's procurement site is available here.

Target Population

Michigan is targeting roughly 90,000 duals out of more than 198,000 statewide in four regions. Excluded from the demonstration are:

- individuals under age 21
- those with commercial HMO coverage or Medicare Advantage through an employer
- the Medicaid MCO "special disenrollment" population
- individuals in a state psychiatric facility
- duals who are currently incarcerated
- persons without full Medicaid coverage
- persons with Additional Low Income Medicare Beneficiary/Qualified Individuals (ALMB/QI)

Dual eligibles enrolled in the state's MI CHOICE 1915(c) waiver or in a Program of All-Inclusive Care for the Elderly (PACE) plan may participate in the demonstration, but must first disenroll from their current program. The table below lists the four regions under the demonstration, which counties are included, and the number of plans the state intends to award for each region. Additionally, the table details the total number of duals and the number of duals currently enrolled in a MCO in each region.

Region	Counties	No. of Plans to be Awarded	No. of Duals	Duals in MCOs	% in MCOs
Region 1	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft	1*	8,786	891	10.1%
Region 4	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	2	18,183	3,014	16.6%
Region 7	Wayne	3-4	50,235	13,191	26.3%
Region 8	Macomb	2-3	12,270	3,137	25.6%
Demonstration Total			**89,474**	**20,233**	**22.6%**

Each of the four regions currently enrolls some duals in the state's Medicaid managed care plans, which also offer D-SNPs. The bulk of the targeted population is in the Detroit metro area, where currently roughly 25 percent of duals in each of the two regions are enrolled in a Medicaid MCO. Region 1, with close to 8,800 duals, is the Upper Peninsula of Michigan, which the state intends to be served by only one health plan, pending federal approval. Under a federal rural exemption, Medicaid-only and dual eligibles are currently served by Upper Peninsula Health Plan, and Michigan intends to extend this rural exemption to the dual eligible demonstration program.

Integrated Care

The RFP continues to maintain the direction set in Michigan's original proposal to CMS of having a separate contract for behavioral health and developmental disability services with the prepaid inpatient health plans (PIHPs) in each of the regions. ICOs are required to contract with the PIHP for provision of Medicare funded behavioral health services. Coordination between the ICO and the PIHP is to be supported by a formal contractual arrangement between the two and by an electronic care coordination platform to support the Care Bridge requirements of the RFP.

Demonstration Contract Highlights

Contract Term: Awarded ICOs will participate in the dual demonstration from July 1, 2014 through December 31, 2017 under three consecutive contract terms.

Performance Bonuses: A percentage of the ICO capitation rate, yet to be determined with CMS, will be withheld to be paid back to plans based on performance measures across quality of care, enrollee access and satisfaction, and administrative functions.

Risk Corridors: During year 1 of the demonstration, the following risk corridors will be applied to ICO profits and losses:

- Profit/loss of 0 – 4 percent: 100 percent to ICO;
- Profit/loss of 4.1 – 8 percent: 75 percent to ICO, 25 percent to Michigan/CMS;
- Profit/loss of 8.1 – 15 percent: 50 percent to ICO, 50 percent to Michigan/CMS;
- Profit/loss of 15 percent or more: 100 percent to ICO.

Timeline and Scoring Criteria

The following table lists the major milestones in the ICO procurement process. Michigan is working under a quick turnaround for RFP responses on the duals demonstration. Interested ICOs must submit responses by August 26, 2013; just one month after the RFP was issued.

Milestone	Date
RFP Issued	July 26, 2013
Questions Due	August 5, 2013
Responses Due	August 26, 2013
Begin Readiness Review	October 1, 2013
Implementation	July 1, 2014

ICOs must meet all minimum qualifications as part of the evaluation process. Network capacity is significant in the overall scoring and will be evaluated for each region an ICO bids to serve. The table below lists each of the scoring criteria categories and the points associated with each.

Scoring Criteria	Points	%
Minimum Bidder Qualifications	Y/N	
Bidder's Attestations	Y/N	
Administrative Capabilities *Care management, care coordination, and assessment; Performance management and quality assurance.*	985	18%
Key Capabilities *System requirements; Quality framework; Person-centered planning, self-determination, and enrollee protections; Vignettes.*	1,650	30%
State-Specific Network Capacity	1,890	34%
Medicare Model of Care Score	1,000	18%
Total Points Possible	**5,525**	

Current Medicaid and Duals Managed Care Market

Michigan is currently served by 13 Medicaid managed care plans, with all of them enrolling at least a small number of dual eligible beneficiaries. The four largest MCOs – Meridian, United, Molina, and McLaren – serve roughly two-thirds of the Medicaid market and dual eligibles market. All but two of the thirteen plans currently serve duals in at least one of the four demonstration regions. The table below lists each Medicaid health plan in Michigan, with total Medicaid enrollment, total dual eligible enrollment, and dual eligible enrollment in each of the four demonstration regions.

Health Plan	Total Medicaid	Total Duals	Duals by Demonstration Region	Region 1 U.P.	Region 4 SW Michigan	Region 7 Wayne	Region 9 Macomb
Meridian Health Plan of Michigan	295,031	6,299			1,208	808	412
UnitedHealthcare Community Plan	230,566	9,194			1,404	3,863	1,575
Molina Healthcare of Michigan	203,451	11,022			7	5,069	624
McLaren Health Plan	122,940	3,114			354		113
Midwest Health Plan	77,971	2,132				1,543	174
Priority Health Government Programs	68,813	2,064			28		
HealthPlus Partners	65,336	1,387					
Total Health Care	57,600	1,275				787	239
CoventryCares of MI	39,098	769			13	701	
Blue Cross Complete of Michigan	34,546	965				358	
Upper Peninsula Health Plan	29,666	891		891			
PHP Family Care	17,215	341					
Pro Care Health Plan	2,368	62				62	
Grand Total	**1,244,601**	**39,515**		**891**	**3,014**	**13,191**	**3,137**

HMA MEDICAID ROUNDUP

Arkansas

HMA Roundup

Community Health Centers Fear Funding Cuts Under DHS Waiver Proposal. On Thursday, July 25, 2013, representatives from community health centers told a joint meeting of House and Senate health committees that a proposed federal waiver drafted by the Department of Human Services would allow insurance companies to slash reimbursement rates below the current Prospective Payment System (PPS). This is a concern since these centers address underserved regions where rural Arkansans do not have ample access to care. DHS aims to submit its waiver applications by Aug. 2 with a Federal approval requested by October 1, when exchanges would begin enrollment.

California

HMA Roundup—Jennifer Kent

Movement to Remove Medical Malpractice Caps. A coalition backed by trial lawyers has undertaken a push to remove the $250,000 cap on pain and suffering damages in malpractice cases. On Thursday, July 25, 2013, the initiative was presented to the state attorney general's office for review, but would require 504,000 valid signatures from registered voters to qualify for the November 2014 ballot. Opponents of this effort include a coalition of physician, dental, and hospital groups who threatened to spend more than $50 million to defeat this measure, should it make the ballot.

Hospital Association Files Ballot Initiative to Ensure Provider Taxes Fund Hospitals. On Thursday, July 25, 2013, the California Hospital Association filed a ballot initiative to ensure that provider taxes imposed on hospitals are not diverted for other purposes. The Medi-Cal Funding and Accountability Act of 2014 would explicitly prevent the legislature and the executive branch from imposing a hospital provider tax unless the funds are used to pay for hospital care delivered to Medi-Cal patients. Supporters of the initiative maintain that since 2009, California has redirected a portion of provider tax-related funds money to the state's General Fund, thereby bypassing billions in potential Federal matching funds. About 800,000 qualified signatures will be needed to place the measure on the ballot.

In the news

"Investigation Finds Fraud Activity at Southern California Drug Clinics" A year-long investigation by CNN and the Center for Investigative Reporting (CIR) has revealed evidence of fraudulent billing by sixteen substance abuse treatment centers in Southern California. The clinics received a combined $94 million in Medicaid funding under the state's Drug Medi-Cal program. California DHCS Director Toby Douglas has indicated an investigation is underway statewide. (CaliforniaHealthline)

Connecticut

HMA Roundup

ConnectiCare Withdraws from Small Group Health Insurance Marketplace. On Friday, July 26, 2013, ConnectiCare Benefits withdrew its proposal to sell small-group health insurance on Connecticut's health exchange, although it will still offer individual plans (Access Health CT) on the exchange. There are now just three small group exchange carriers remaining: Anthem Blue Cross and Blue Shield, HealthyCT, and United Healthcare. Previously, HealthyCT had announced it was lowering proposed small group rates due to an expectation that participants would be healthier.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

AHCA Hosts Event to Launch Long-term Care Program. The Statewide Medicaid Managed Care Long-term Care Program is starting in Region 7 (Orange, Osceola, Seminole, and Brevard Counties) effective August 1, 2013. The Agency for Health Care Administration, Area 7 Medicaid office, is inviting nursing facility providers, hospice providers, assisted living providers, and aging network service providers in these four counties to participate in weekly provider-specific calls regarding the roll out of the Long-term Care program. Community stakeholders, partners and representatives from the seven designated health plans will participate in the event. In addition, choice counselors will staff booths and offer information and assistance with the program. Interested parties can call 1-888-670-3525 and may email questions to AHCACommunications@ahca.myflorida.com.

Deregulation Law Requires Health Insurers to Disclose ACA's Costs. A new health insurance deregulation law that passed at the end of the last session stipulates that health plans must send consumer notices that specify how much of the policy's cost is attributable to the Affordable Care Act. Consumer notices must adhere to a form that will be approved by the Governor and his Cabinet at a scheduled August 6 meeting. The current draft presented by the OIR would highlight what costs of the policy would be before health reform kicks in and how much of the costs of policies are associated with key features of the ACA. When Governor Scott signed the deregulation legislation into law, he noted that it does not apply to plans in effect before the ACA was passed in March 2010 and that state regulators would continue to review the rates of those plans. The Senate voted for the bill 25-6 and the House approved it 78-36.

Florida Insurance Officials Claim Individual Plan Premiums Will Spike 30-40 Percent. On Tuesday, July 30, 2013, the Florida Department of Insurance announced that health plans offered on the state's exchange would feature premium increases of 5 to 20 percent for small businesses and 30 to 40 percent for individuals. The state's deputy insurance commissioner, Wences Troncoso, attributes much of the increase to the guaranteed issue provision of the ACA that requires new policies to be sold to individuals, regardless of pre-existing conditions. Eleven companies have applied with insurance regulators to offer individual plans, while five companies have applied to offer small group plans. For two years, the state will not review rate filings for health plans, relying instead on Feder-

al oversight. In response, the Federal Health and Human Services Department noted that premiums in other states were lower than previously expected and that Florida's premiums should be affordable and accessible in a transparent marketplace.

House Speaker Will Weatherford Announced on July 31, 2013 the 2014 Committee Chairs and Vice Chairs. Few changes to the leaders of legislative committees in his chamber were made but he did make a switch in a key leadership position; Rep. Steve Crisafulli, already tapped as Weatherford's replacement as Speaker for 2014-2016, will be the House Majority Leader. Additionally, Rep. Jose Oliva was named chairman of the newly created Select Committee on Health Care Workforce Innovation. The panel will look at ways to increase the health care provider workforce to meet the state's needs. Rep. Cary Pigman was named vice chairman of the committee.

Georgia

HMA Roundup – Mark Trail

State Employees Health Plan Bidding Process to Change. On Thursday, July 25, 2013, Department of Community Health Commissioner Clyde Reese acknowledged that the process to select health vendors was "not properly inclusive" for the state employee's health plan. DCH's comments followed a United Healthcare protest that the bidding process locked out the insurer. The department will seek a "regional vendor" contract to supplement the statewide benefits contract award to Blue Cross and Blue Shield of Georgia. United and Cigna are the incumbents, with United boasting nearly 90 percent market share.

Georgia Seeks Delay to File Rates for Health Exchange. On Monday, July 29, 2013, Georgia's insurance commissioner, Ralf Hudgens, requested approval from HHS Secretary Kathleen Sebelius for a 30-day delay in filing premium rates. The seven insurers who applied to offer plans proposed rate hikes of up to 200 percent, in some cases, which Hudgens attributes to the ACA. Using hypothetical examples for different age groups in bronze plans available today as compared to those offered in January 2014, the agency identified rate increases that varied widely. For a 25 year old male, the range of increases would be 85 to 198 percent. For a 64 year old man, the increases would be 18 to 41 percent. For a 45 year old man, premiums would spike 40 to 120 percent. These examples, however, do not account for subsidies that many beneficiaries will qualify for under the ACA.

Idaho

HMA Roundup

Idaho Reveals Two Dual Eligible Demonstration Health Plans. Idaho disclosed the identities of the managed care organizations selected to participate in the state's planned dual eligible demonstration. The organizations are Blue Cross of Idaho and Regence Blue Shield of Idaho which is partnering with Amerihealth Caritas.

Indiana

HMA Roundup—Cathy Rudd

Indiana Insurance Commissioner Defends Rate Increase Announcement. In a July 30, 2013 op-ed piece, Indiana Insurance Commissioner Stephen Robertson defended a recent announcement that insurance premiums would rise 72 percent. Robertson responded to outcries from ACA supporters that the DOI was using misleading math by outlining the process taken to determine the increases. The DOI calculated PMPM (per member per month) average premiums for 2012, accounted for trend, and compared them to actual filings submitted to the DOI for 2014. Robertson points to the dramatic increases imposed on participants in the bronze and silver plans for younger and healthier Hoosiers, who will be expected to bear more cost-shifting from seniors and sicker residents. Robertson points to the ACA's requirements for more comprehensive (and pricier) health insurance than many individuals might otherwise choose. Robertson acknowledges tax subsidies may reduce the impact of out-of-pocket costs to individuals, but they do not change the underlying cost of the plans which will be borne by taxpayers.

Iowa

HMA Roundup

Iowa Health and Wellness Public Hearing Held on Monday. On Monday, July 29, 2013, the state held a public hearing in Des Moines related to the proposed Iowa Health and Wellness Plan, as part of the waiver process. The Health and Wellness plan is designed to provide coverage for beneficiaries under 138% of the FPL that are not currently eligible for Medicaid. The state is targeting an August 20 filing date for the waiver. Iowa Medicaid Director Jennifer Vermeer noted that some plan details are not finalized, but would include primary and emergency care, prescription drug coverage and dental care. Non-emergency transportation was not included in the legislation that passed in May, but may be part of the application for the waiver. Vermeer stressed that social service groups would be an important part of the enrollment and education process. Service delivery will be based on a Medical Home model.

Maryland

HMA Roundup

Maryland Insurance Commissioner Slashes Proposed Rates on Exchange Plans. On Friday, July 26, 2013, Maryland Insurance Commissioner Therese M. Goldsmith approved rates for nine insurance companies that had applied to sell individual health plans on the Maryland Health Connection (the state's exchange). Goldsmith reduced the premium rates proposed by every insurance carrier in the individual market, due to flawed data or inappropriate assumptions. The exchange will feature some of the lowest costs available among the states that have either approved or proposed rates. In some cases, proposed rates were slashed by as much as a third. While health advocates were pleased with the results, critics worried that such prices might not be sustainable. It is unknown how plans will respond to the approved rates as it concerns their participation in the exchange.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

One Care Program for Disabled Adults Scaled Back. Massachusetts has ratcheted back the scale of its "One Care" program that begins enrollment in October 2014. The dual eligibles demonstration project aimed to coordinate care for disabled low-income adults, but residents in five counties will be excluded because no insurer has applied to participate in Bristol, Berkshire, Barnstable, Dukes, and Nantucket. Boston Medical Center HealthNet, Neighborhood Health Plan, and Blue Cross Blue Shield of Massachusetts had won bids to participate, but dropped out of the program due to projected losses on inadequate rates, which did not account for personal care attendants or dental services.

Michigan

HMA Roundup—Esther Reagan

Senate Committee Approves Medicaid Expansion & Two Alternative Plans. On Wednesday, July 31, 2013, the Michigan State Senate Government Operations committee unanimously approved legislation that would expand Medicaid eligibility to hundreds of thousands of low-income Michigan residents. In addition, the panel approved of two "free market" alternative plans to Medicaid expansion. Previously, the House passed Medicaid expansion legislation (HB 4714), which the Senate bill would substitute with its own. The Senate will not be reconvened until August 27.

Minnesota

HMA Roundup

State Commerce and Health Departments Request Plans Unveil Rates Early. According to published reports, the Minnesota Commerce and Health Departments have requested that health plans participating on the state's health exchange, MNsure, unveil their rates on September 6, nearly a month before the October 1 launch date. The state's health plan trade association says that the request is being considered by the plans to offer consumers and small businesses more time to analyze and consider their options.

Mississippi

HMA Roundup

Mississippi Insurance Commissioner Looks to Run Small Business Exchange. On Friday, July 26, 2013, Mississippi Insurance Commissioner Mike Chaney filed a timeline with HHS to establish a small business exchange, also known as a SHOP exchange. Chaney believes the SHOP exchange can be operational by June 2014, assuming Federal approval. Three health insurers have indicated interest in offering plans on a SHOP exchange, but Chaney hopes to have as many as seven.

New Mexico

In the news

"Behavioral-health probe: A primer" The Santa Fe New Mexican offers a primer on the state's recent decision to defund 15 behavioral health care Medicaid providers over evidence of widespread fraud. (Santa Fe New Mexican)

New York

HMA Roundup—Denise Soffel

NY Health Department Still Pushing for Merger of Long Beach Medical Center. Following its closure during Hurricane Sandy in October 2012, the Long Beach Medical Center is embroiled in a battle with New York's Department of Health, which argues that it should merge with South Nassau Communities Hospital of Oceanside, with limited services remaining in Long Beach. The department notes that the hospital had been among the most financially distressed hospitals in the state and would have needed a business model change, regardless of the storm's effects. The LBMC Board has claimed openness to a merger, but believes the community requires an emergency department and associated clinical services. On Friday, July 26, 2013, hospital and department officials met to clarify their positions and broker some form of agreement.

In the news

"Program Compelling Outpatient Treatment for Mental Illness Is Working, Study Says" A study of New York's "Kendra's Law," which requires outpatient treatment for mental health patients who are not hospitalized, indicates the program is successful in reducing institutionalization and incarceration rates, while reducing Medicaid costs for the population by more than half. (New York Times)

North Carolina

HMA Roundup

NC Department of Insurance Approves Rates for Exchange Plans. On July 30, 2013, the North Carolina Department of Insurance announced it had completed timely reviews and approvals of health insurance rates for plans offered on the state's Health Insurance Marketplace. Rates for three insurers have been approved: Blue Cross and Blue Shield of North Carolina, Coventry, and FirstCarolinaCare, all of which will participate in the individual market. BCBSNC will participate in the small group market. NCDOI will not reveal rate details without the consent of the insurers.

Pennsylvania

HMA Roundup –Matt Roan

PA Department of Public Welfare Working on a Medicaid Expansion Plan. DPW Secretary Beverly Mackereth announced to the Medical Assistance Advisory Committee last week that the Administration is still reviewing its options for Medicaid expansion in PA. The Secretary stressed that conversations with CMS are ongoing, and that the Administrations focus is on ensuring that any expansion plan is affordable and sustainable from a state budget perspective. The Secretary said that her department is in the process of developing a proposal which she hopes will be ready for the Governor to review in the next month. One contentious issue related to expansion that the Secretary highlighted was the mandate to move certain children currently served in the state's CHIP program to the Medicaid rolls. The Secretary reported concerns that children may have to change primary care providers if their PCP does not participate in Medicaid.

Senator Casey Introduces Bill to Remedy "Observation" Issue. Sen. Bob Casey Jr. introduced a bill to address a growing issue impacting out-of-pocket expenses for Medicare beneficiaries. According to CMS rules, post-acute nursing home stays are only covered by Medicare if the patient has been admitted to the hospital for at least three consecutive days prior to their nursing home rehabilitation. Hospitals are increasingly using outpatient observation as a means to monitor patient status in the hospital rather than doing a formal admission. As a result patients who have been in the hospital for days may not meet the three day rule because of the lack of a formal admission. Medicare beneficiaries face significant out of pocket expenses for the subsequent nursing home stay which Medicare will not cover. The fix is being promoted by the PA chapter of the AARP, while hospitals have stressed that the use of the outpatient observation model is appropriate clinically and is not used to improve hospital financials.

PA Lottery Outsourcing Bid gets Another Extension. The bid to outsource operations of the PA Lottery was extended for the ninth time as Governor Corbett and Camelot Global Services LLC, the British firm selected to assume operations of the lottery, work to modify contract terms. The state Attorney General rejected the original contract on the basis of conflicts with the PA Constitution, and state gaming laws. Revenue from the lottery supports programs for PA Seniors including home and community based services. Camelot has promised increased revenues, while opponents of privatization point to record profits achieved by the current, state-run system.

West Penn Allegheny Health System Cuts Jobs in Wake of Highmark Takeover. West Penn Allegheny Health System has laid off 262 employees and has eliminated 200 vacant positions in an effort management has described as "right-sizing". WPAHS stressed that the majority of the positions eliminated did not relate to direct patient care.

South Carolina

HMA Roundup

State's Dual Eligibles MOU Negotiations Still Ongoing. On July 30, 2013, the South Carolina Dual Eligible Demonstration Workgroup held a meeting to provide stakeholders with an update on key operational changes related to the demonstration. Negotiations with CMS over the memorandum of understanding (MOU) are still ongoing, with a target for a signed agreement by the end of August 2013. The program is still on track for a July 1, 2014 implementation. Plan selection will not be a competitive process, but an open application process. The Department of Health and Human Services aims for non-binding letters of intent to be received by August 5, 2013.

Texas

HMA Roundup—Dianne Longley and Linda Wertz

Houston Ambulance Service Provider Enrollment Moratorium Announced. In a bid to reduce fraud, waste, and abuse, the Federal Health and Human Services Secretary, Kathleen Sebelius, announced a moratorium on the enrollment of Houston-area ambulance service providers. Based on data analysis and demonstrated cases alleging $9.5 million in fraudulent claims, CMS determined that ambulance transportation was not medically necessary for many patients. The Texas Legislature initiated its own efforts to crack down on such fraud in the most recent legislative session, with legislation signed into law by Gov. Rick Perry.

Vermont

HMA Roundup

Vermont Health Connect on Track for October Launch. On July 25, 2013, three Vermont state officials confirmed that the Vermont health exchange was on track for the October 1 launch. The state has been training navigators to assist beneficiaries to enroll in health plans. Final rates have been released and a subsidy calculator has been posted online to help individuals determine what their out-of-pocket expenses will be for the two insurance companies offering plans.

National

HMA Roundup

CBO Estimates Employer Mandate Delay Will Cost $12 Billion Over 10 Years. On July 30, 2013, the Congressional Budget Office and the Joint Committee on Taxation released a report that estimates the one-year delay in the employer mandate would result in an additional $12 billion of costs for the Affordable Care Act over the next decade. The primary culprit is the loss of $10 billion in penalty payments, with $3 billion in additional subsidies, offset somewhat by about $1 billion in additional taxes coming from slightly higher taxable compensation. It is now expected that this delay will result in 1 million fewer people to be enrolled in employment-based coverage in 2014. Republicans continue to question the Obama Administration's legal authority to unilaterally make this administrative change. CBO expects that looser procedures in verifying income will only nominally affect the number of enrollees in the exchanges since the IRS will be able to identify mistaken reported income when compared to tax returns at year-end.

Medicaid Managed Care Plans to Offer Plans on Exchanges. With the rollout of exchange plans, it is becoming clear that Medicaid managed care plans are increasingly participating as an economy option for non-Medicaid in such states as California, New Mexico, New York, Oregon and Washington. Observers note that the participation of these Medicaid managed-care insurers in exchanges enables continuity of care with an existing provider network, as a bridge for beneficiaries whose income would preclude Medicaid coverage. Providers express concerns that a more extensive membership base in Medicaid plans will ultimately depress payments to hospitals and physicians. Narrower networks may make membership enrollment more challenging, despite the generally lower premiums on the exchange.

Healthcare Cost Growth Slows to Historically Low Rate. On July 29, 2013, the Obama Administration released data that indicates personal spending on healthcare grew just 1.1 percent in the last 12 months for the period ending May 2013. This marks the lowest growth rate in 49 years.

INDUSTRY NEWS

Community Health Systems Purchases Naples-Based HMA. On Tuesday, July 30, 2013, Community Health Systems (CYH) and Naples-based Health Management Associates announced a definitive $7.6 billion merger agreement (including the assumption of about $3.7 billion in debt). **Naples-based Health Management Associates is a hospital management company that is not affiliated with our organization.** CYH will pay the equivalent of $13.78 per HMA share, consisting of $10.50 per share in cash plus 0.06942 of a share of CYH common stock for each HMA share. HMA shareholders would receive a Contingent Value Right (CVR) for each HMA share they own, worth up to an additional $1.00 per share, depending on the results of certain legal settlements. HMA noted that the total consideration amounted to 8.3 times trailing cash flow, greater than that paid in the Tenet-Vanguard deal announced last month. The deal is projected to close by the end of the first quarter of 2014.

Molina Purchases CHS South Carolina Assets. On Monday, July 29, 2013, Molina Healthcare announced an agreement to acquire certain assets of Community Health Solutions of America relating to its South Carolina Solutions (SCS) business. The deal positions Molina for growth in advance the new Medicaid managed care program in South Carolina. CHS will transfer to Molina Healthcare the Medical Homes Network (MHN) membership of CHS, excluding those in the Medically Complex Children's Waiver component of the MHN program. The transfer is contingent on Molina receiving an HMO license in the state, receiving an award of a full-risk Medicaid managed care contract, and the state's conversion of the MHN program to a full risk Medicaid managed care program, all of which should be satisfied by January 2014.

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
August 1, 2013	Florida LTC (Region 7)	Implementation	9,600
August 7, 2013	Massachusetts CarePlus (ACA)	Proposals Due	305,000
August, 2013	Wisconsin MLTC (Select Regions)	Contract awards	10,000
September 1, 2013	Idaho Behavioral	Implementation	200,000
September 1, 2013	Florida LTC (Regions 8,9)	Implementation	14,000
September 16, 2013	Florida acute care	Contract awards	2,800,000
September 20, 2013	Massachusetts CarePlus (ACA)	Contract Awards	305,000
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	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	Rhode Island Duals - Medicaid Only	Implementation	22,700
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	Massachusetts CarePlus (ACA)	Implementation	305,000
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	Ohio Duals	Implementation	115,000
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	7/26/2013	8/26/2013	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	4/1/2014
Oklahoma	MFFS	104,258					TBD
Oregon		68,000	Not pursuing Financial Alignment Model				
Rhode Island	Capitated	22,700	X	3/27/2013			11/1/2013*
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 NEWS

HMA's Jenna Walls authors report with AARP PPI and NASUAD on LTSS Trends. On July 16th, 2013, the AARP Public Policy Institute, National Association of States United for Aging and Disabilities (NASUAD) and Health Management Associates (HMA) released *At the Crossroads: Providing Long-Term Services and Supports at a Time of High Demand and Fiscal Constraint*. This new report highlights the challenges states face in delivering long-term services and supports (LTSS). While states begin implementing Affordable Care Act provisions that increase access to Medicaid home and community based services (HCBS), many states did not increase budgeting for non-Medicaid services such as senior centers, transportation, or caregiver supports. The report reflects findings from the third annual survey of LTSS systems across the United States, including the status of reforms and discernible trends, highlighting transformations and reforms underway, and trends across the country. **(Link to Report - PDF)**