HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

IN FOCUS: CMS TARGETING MEDICAID "SUPER-UTILIZERS"

HMA ROUNDUP: INDIVIDUAL EXCHANGE PLANS ANNOUNCED IN CONNECTICUT, DELAWARE, GEORGIA, HAWAII, IDAHO, MAINE, MARYLAND, NEW HAMPSHIRE, VIRGINIA, WASHINGTON, WISCONSIN; CALIFORNIA ANNOUNCES SHOP PLANS; NEW YORK INDICATES DUAL ELIGIBLE DEMONSTRATION MOU IMMINENT; RHODE ISLAND UPDATES DUAL ELIGIBLE ROLLOUT SCHEDULE

INDUSTRY NEWS: AETNA SITS OUT INSURANCE EXCHANGES IN MARYLAND, CONNECTICUT AND GEORGIA; CATAMARAN TO ACQUIRE WISCONSIN PBM; NEW YORK CITY TO RE-BID EMPLOYEES' HEALTH PLAN CONTRACT

AUGUST 7, 2013

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IN FOCUS: CMS TARGETING MEDICAID "SUPER-UTILIZERS"

This week, our *In Focus* section reviews a CMS Center for Medicaid & CHIP Services (CMCS) informational bulletin from Director Cindy Mann which details the key policy issues in developing programs to target Medicaid "super-utilizers." The bulletin notes that just 5 percent of Medicaid enrollees account for 54 percent of all Medicaid spending. "Super-utilizers" are those Medicaid beneficiaries who accumulate large numbers of emergency visits and hospital admissions which might have been prevented through a combination of coordinated care, preventative care, and care in the most appropriate settings. The bulletin, dated July 24, 2013, is based on interviews with ten super-utilizer programs and provides high level policy issues and detailed case studies from the programs.

Key Policy Decisions for Medicaid Super-Utilizer Programs

The following is an outline of the key questions to be answered and policy and programmatic design issues to be addressed as states and providers approach the topic of targeting super-utilizers. The CMCS information bulletin provides much greater detail on each of these points.

Should we pursue a super-utilizer program in our state?

- Identify the super-utilizer population
- Identify factors driving high utilization in this population
- Assess feasibility of eliminating unnecessary utilization
- Estimate cost and savings associated with the program
- Identify infrastructure investments needed, such as web-based provider portals with patient data, real-time utilization data, and decision support tools

What payers are involved?

Partnerships with Medicare and commercial insurers may incentivize greater provider participation than Medicaid-only programs. However, multiple payers may present data challenges, particularly for states without an all-payer claims database.

Who provides the services and what is their relationship to primary care providers?

A key question in designing a super-utilizer program is how it will work with primary care providers (PCPs). Programs can work in partnership with PCPs to enhance their capacity to care for the super-utilizer population, for example:

- Embedded centralized case managers within the primary care practice;
- Community-based organization care managers who support multiple primary care practices; or
- Community-based care teams who visit super-utilizer patients in home and community-based settings.

Alternatively, programs may look to transfer super-utilizer patients from primary care into specialized care settings to provide more comprehensive management of services. Examples of this approach include short-term interventions in a specialized super-utilizer clinic and permanent ambulatory intensive care units.

What is the targeting strategy?

A program must determine how super-utilizer patients will be identified for intervention. CMCS found many approaches for this in the 10 programs evaluated, including:

- Targeting based on high observed-to-expected costs;
- Targeting specific patterns of care;
- Targeting very high levels of utilization;
- Targeting based on referrals and follow-up investigation;
- Excluding candidate clients with medical conditions associated with high but non-preventable costs;
- Targeting by presence of risk factors associated with high, preventable costs; and
- Targeting by community.

What services are provided?

CMCS has found that the most effective super-utilizer programs are those that excel in matching services to the needs of their patients. Services in the 10 programs reviewed include care coordination, in-person medical care, in-person behavioral care, assistance with social needs, and health coaching. Most significantly, CMCS found that traditional care management approaches relying primarily on historical claims data have had limited success. Access to real-time data is an essential piece of a program's success, as it allows for care manager engagement with patients while still at the hospital or ED.

How is the program funded?

As noted in the bulletin, the way in which care team organizations are paid can create powerful incentives, and should be considered carefully. Existing programs use a variety of funding mechanisms:

- Medicaid fixed per-member-per-month (PMPM) case management payments (North Carolina, Vermont)
- Multi-payer case management payments, including Medicare, Medicaid health home, FQHC, and PMPM commercial insurance payments (Maine)
- Per-episode of care payment for program services (Spectrum Health – Michigan)
- PMPM payments to managed care organizations (Hennepin Health – Minnesota)
- Shared savings for total cost of care, whereby state enters into partial-risk arrangement with the care team (Minnesota)

Medicaid Super-Utilizer Program Case Studies

The CMCS informational bulletin includes several case studies on the programs reviewed:

- Oregon: CareOregon Community Care Program
- North Carolina: Community Care of North Carolina Priority Patients Program and Transitional Care Program
- Minnesota: Hennepin Health and Hennepin County Medical Center Coordinated Care Clinic
- Maine: Maine Community Care Teams
- Michigan: Spectrum Health Center for Integrative Medicine
- Vermont: Vermont Chronic Care Initiative

HMA Medicaid Roundup

Alabama

HMA Roundup

Gov. Bentley Signs Prescription Drug Abuse Laws. On Monday, August 5, 2013, Gov. Robert Bentley signed into law three bills designed to reduce the abuse of prescription drugs in Alabama. House Bill 150 clarifies language for the Board of Medical Examiners to regulate the use of a monitoring program for individuals who receive controlled substances and the medical professionals who prescribed them. The Medicaid Agency can access the database to review prescription drug use by people enrolled in Medicaid. House Bill 151 grants the Board of Medical Examiners subpoena power to investigate pain management clinics. Pain management clinics must have a licensed physician as a medical director and must acquire registration from the board. House Bill 152 institutes criminal penalties for patients who deceptively conceal from physicians that they had received the same or similar prescription drugs from other physicians during a concurrent period of time.

Arkansas

HMA Roundup

Legislative Committee Approves of Health Exchange Enrollment Funding. On Thursday, August 1, 2013, the Arkansas House Subcommittee on Performance Evaluation and Expenditure Review approved of $383,624 to pay for 21 meetings to educate Arkansans about the state's health exchange, as well as 10 guides working for the state Minority Health Commission to enroll beneficiaries in plans. The federal government has issued about $17 million in grants to the state Insurance Department to fund nearly 500 guides, employed by various Arkansas organizations, to help the public understand health plan options under the Affordable Care Act.

California

HMA Roundup—Jennifer Kent

Third Phase of Healthy Families Transition Goes Into Effect. As of August 1, 2013, California has begun its third phase of the transition of Healthy Families children to Medi-Cal managed care plans. According to the Department of Health Care Services, in the first two phases, nearly all of the 615,000 affected children retained their health plans (99 percent). About 94 percent of children had to switch primary care physicians. However, unlike the first two phases which involved children covered by insurers that also had Medi-Cal plans or subcontracted with Medi-Cal plans, Phase 3 may be more challenging as it covers about 110,000 children in plans that do not have Medi-Cal plans or subcontracts. Phase four will involve about 35,000 children in areas that do not have Medi-Cal plans.

Small Business Health Insurance Rates Released. On Thursday, August 1, 2013, Covered California unveiled health plan options and rates for small businesses under the Small Business Health Options Program (SHOP). The following carriers will offer plans on the small business exchange: Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, Sharp Health Plan, and Western Health Advantage. According to Covered California, premiums in the state's most populous counties should be lower than current rates for similar coverage.

Hospital Association Still Pushing for Reversal of Medi-Cal Rate Cuts. With the end of the California legislature's summer recess, the California Hospital Association is calling on lawmakers to reverse Medi-Cal rate cuts. A nearly 10 percent rate cut—retroactive to 2011—looms over healthcare providers and creates the threat of safety net providers shutting down. Duane Dauner, the CEO of the CHA, points to the reversal of cuts as the "great unfinished business" of the legislative session.

Nurse Practitioner Bill Fails in Assembly. On Tuesday, August 6, 2013, a bill (SB 491) granting nurse practitioners more autonomy was rejected 6-3 in an Assembly committee after four Democrats decided not to vote. On the other hand, SB 493, which would expand pharmacists' roles, passed unanimously 12-0 in the Assembly Business, Professions and Consumer Protection Committee and will be reconsidered next week when SB 492—related to the expanded role of optometrists—is scheduled for a hearing.

Colorado

HMA Roundup—Joan Henneberry

Insurance Officials Delay Release of Health Exchange Rates. On July 31, 2013, the state's Division of Insurance announced it would miss its original August 1 target date to release rates for the state's health exchange. Regulators need about two more weeks to fully review the 750 plans from 17 insurers. The state will review the proposals to ensure compliance with the ACA's requirements and actuaries will evaluate the feasibility of rates. The state should finish work on the insurance rates this week and get the data to Connect For Health Colorado, the state's exchange. Rates should be released to the public about a week later. A spokeswoman for Connect For Health Colorado said in a statement that the delay would not affect the exchange.

State to Hold Hearing on Medicaid Dental Benefits. On August 9, 2013, the Dental Benefits Collaborative kick-off meeting will be held to allow stakeholders and the public to offer input on the recently added adult dental benefit signed into law by Governor John Hickenlooper in May. The Department of Healthcare Policy and Financing requests feedback on plan designs, delivery models, costs, and client experience. The call will be held 1-3 PM Mountain Time at 877-820-7831 (passcode 423066).

Connecticut

HMA Roundup

Insurance Department Releases Exchange Plan Rates; Aetna Withdraws. On Monday, August 5, 2013, the state's Insurance Department released all of the approved monthly rates for plans on Access Health CT, the Connecticut health exchange. ConnectiCare Benefits featured the lowest base rates for each of the tiers, on average. Aetna withdrew from the exchange, expressing disagreement with the assumptions underlying the rate approval process. Aetna's withdrawal follows ConnectiCare Benefits' withdrawal from the SHOP exchange.

In the news

"My Place CT – Connecticut's Plan For Long-Term Care" Kaiser Health News speaks with Dawn Lambert, project director for Connecticut State Department of Social Services' Money Follows the Person Program, regarding My Place CT, the state's information hub for Medicaid long term care services. (Kaiser Health News)

Delaware

HMA Roundup

State Launches State Health Exchange Site. In late July, Delaware unveiled the state's health insurance marketplace web site, Choose Health Delaware (choosehealthde.com). In addition, the state has hired four community-based organizations, Brandywine Women's Health Associates, Christiana Care, the Delmarva Foundation, and Westside Family Healthcare, to help beneficiaries in the enrollment process. Highmark Blue Cross Blue Shield, Coventry Health and Life Insurance, and Coventry Health Care of Delaware will offer exchange plans, although rates will not be released until early September.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida KidCare Grew Sixth Straight Year. On August 6, 2013, Florida KidCare announced the addition of 62,500 more children to the Florida KidCare program, marking the sixth consecutive year of growth. In July 2007, the total number of children covered under the program was less than 1.4 million, but the figure stands now at about 2.1 million. According to the Center for Children and Families at Georgetown University, Florida is one of the three best states in reducing the number of uninsured children. Florida's rate dropped to 11.9 percent, down from 16.7 percent three years ago.

Florida Revenue Estimates Raised for 2014-2015 Fiscal Year. On Tuesday, August 6, 2013, state economists raised their estimates for general revenue collections for the 2014-2015 fiscal year by $62.5 million to $28.9 billion. The boost is largely attributable to a boost in projected carryover funds from the current fiscal year. Gov. Rick Scott has consistently pointed to a strong state economy, which has helped reduce total state debt by $3.5 billion over three years, along with the payoff of a $3.5 billion IOU to the federal government for unemployment benefits payments.

Medicaid Prepaid Dental Health Plan Update. On August 6, 2013, the Florida Agency for Health Care Administration released an update on the Prepaid Dental Health Plan Program (PDHP) which, in December 2012, was expanded from Miami-Dade County pilot to a statewide program. The two prepaid dental health plan networks have more dentists in every region of the state (2,700 unduplicated) than the fee-for-service program (2,000), as of June 2013. As of July 1, 2013, all eligible children covered under Medicaid were enrolled in one of the two prepaid dental plans, DentaQuest or MCNA Dental. The state intends to broaden dental services for children in conjunction with the Statewide Medicaid Managed Care program.

Advocates Push CMS to Help Avoid Medicaid Disenrollment of Low Income Workers. On Wednesday, July 31, 2013, KidsWell Florida—a coalition of advocacy groups—wrote to CMS to take steps to preserve the Medicaid eligibility of working parents who will otherwise lose their health coverage at the start of 2014. According to Kids Well Florida, there are 45,000 low-income working parents who would only retain their Medicaid coverage if they stopped working, due largely to the Florida legislature's refusal to expand the Medicaid program in conformance with the Affordable Care Act's original income thresholds.

Gov. Scott Approves Controversial Disclosure Form. On Tuesday, August 6, 2013, Gov. Rick Scott, Attorney General Pam Bondi, Agriculture Commissioner Adam Putnam and Chief Financial Officer Jeff Atwater signed off on newly required state disclosure forms that ostensibly attempt to identify the costs of implementing the Affordable Care Act as part of insurance premiums. Republicans argue that the form offers the insured greater transparency, while Democrats decry the new requirement as a political maneuver designed to raise opposition to the ACA. Advocates are particularly irked by the absence of premium subsidies as part of the disclosure.

Georgia

HMA Roundup – Mark Trail

Insurance Commissioner Approves Rates for Exchange; Aetna Withdraws. On Thursday, August 1, 2013, Georgia Insurance Commissioner Ralph Hudgens approved rates for health plans on the state's exchange. Previously, Hudgens had requested an extension of the deadline to review plan rates, but did not receive a response. Hudgens said that actuaries found that rates from plans offered by six of seven insurers were reasonable, while Alliant's rates were reduced by ten percent. Hudgens highlighted potential rate increases of up to 198 percent, although he acknowledged that figure as a worst-case scenario for a particular category of beneficiaries with one insurer, rather than a representative statistic. Furthermore, the increases do not account for subsidies to qualified beneficiaries. However, Aetna announced that it would withdraw both Coventry and Aetna plans from the exchange, leaving just five insurers with exchange offerings.

Hawaii

HMA Roundup

Hawaii Health Connector Features Two Insurers. The Hawaii Health Connector will have just two insurers: Hawaii Medical Service Association and Kaiser Permanente Hawaii. The state's health exchange notes that no other carriers submitted plans to the state, with University Health Alliance and Hawaii Medical Assurance Association declining to participate. HMSA executives have ominously warned of "rate shock" due to an expected increase in health care utilization and additional fees to operate the state's exchange. In a state-by-state report released on Wednesday, July 31, 2013, the Obama Administration estimates that 92 percent of Hawaii's residents who already have insurance will have more health plan choices.

Idaho

HMA Roundup

Idaho Health Plans Revealed; Premiums to Be Announced in September. Recently, the Idaho Department of Insurance announced that the state's health exchange will feature 79 individual health plans from 5 issuers: PacificSource Health, Blue Cross of Idaho, SelectHealth, Altius Health, and Bridgespan Health (a subsidiary of Regence Blue Shield). In addition, the SHOP exchange will feature 55 plans from 3 companies: Blue Cross of Idaho, PacificSource, and SelectHealth. Plan premiums are expected to be released in September.

Indiana

HMA Roundup—Cathy Rudd

Report Taps Indiana as a Potential Big Winner from Medicaid Expansion. According to an Urban Institute report released on Wednesday, July 31, 2013, Indiana would be among the biggest beneficiaries from Medicaid expansion, with the number of uninsured Hoosiers dropping from 17 percent of the non-elderly population to about 8 percent. That 55 percent reduction in the uninsured rate would be eighth biggest improvement among the 50 states. The state continues its negotiations with HHS Secretary Kathleen Sebelius to gain approval to extend the Healthy Indiana Plan beyond the end of this year.

Louisiana

HMA Roundup

CNSI Lawsuit Stayed by State District Court. On Wednesday, July 31, 2013, State District Judge Tim Kelley granted a six-month stay in a civil suit brought by Client Services Network Inc. after the state attorney general declared the case could interfere with an ongoing criminal investigation. CNSI's $200 million MMIS contract with the state was cancelled in March after allegations of improper interventions by former Secretary of Health and Hospitals Bruce Greenstein on behalf of CNSI, his former employer. CNSI believes that the state will spend up to $75 million more over three years with another vendor, as well as $5 million more on a new bidding process.

Maine

HMA Roundup

Maine Releases Rates for Health Exchange Plans. On Wednesday, July 31, 2013, Maine's Bureau of Insurance released hundreds of pages of documents filed by Anthem and Maine Community Health Options, the two carriers deemed to sell plans on the state's health exchange. On Saturday, August 3, 2013, the Bureau issued side-by-side comparisons of rates for individuals across different tiers of plans and for different age groups, by region. Maine Community Health Options will maintain the same premiums, regardless of smoking status, while Anthem charges 30 percent more to smokers. All Maine Community Health Options plans have networks that span the entire state, while Anthem has narrow network options that may exclude providers in certain areas.

In the news

"Thousands of Mainers set to lose Medicaid coverage" More than 25,000 Maine residents on Medicaid could lose their coverage at the end of this year due to a combination of budget cuts to MaineCare, the state's Medicaid program, and the decision not to expand Medicaid on January 1, 2014. Those set to lose coverage include roughly 15,000 low-income parents and more than 10,000 low-income childless adults. (Boston Globe)

Maryland

HMA Roundup

Baltimore City Government Drops Coverage for Non-Filers of Eiligibility Forms. In an effort to reduce healthcare spending on ineligible dependents or those with redundant coverage, as of July 1, 2013, the city of Baltimore dropped more than 1,600 spouses, children and others from city health care benefits coverage when forms proving eligibility were not submitted. The city estimates nearly $6.5 million in annual savings from this effort, although unions, advocates, and the affected parties are up in arms about the purge. The city has undertaken negotiations with those workers who mailed back forms and attempted compliance, but not with workers who ignored the process.

Aetna Withdraws from Maryland Exchange. Following an announcement of significantly lower approved rates by the Maryland Insurance Commissioner last week, Aetna announced its withdrawal from participating in the Maryland Exchange. The announcement includes proposed plans from Coventry, which is now part of Aetna. Aetna's decision came shortly after withdrawing from participating in Georgia's. There are seven carriers remaining in the Maryland exchange.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Atrius Health Not Required to Pay Back Medicare for Losses. On July 31, 2013, Atrius Health, a pioneer accountable care organization in Massachusetts, revealed that its losses were small enough not to require any payments to the Medicare program, contrary to prior press reports.

Kaiser Report Indicates 23 Massachusetts Hospitals to Pay Larger Readmissions Penalties. In an August 2 analysis released by Kaiser Health News, 23 Massachusetts hospitals are on the hook to pay larger readmissions penalties to the federal government. Observers note that these penalties often hit safety net hospitals hardest, as they disproportionately tend to the poorest and most complex patients.

New Hampshire

HMA Roundup

Anthem Qualified as Only NH Health Exchange Plan. On Wednesday, July 31, 2013, New Hampshire's Insurance Department revealed that only one insurer was qualified by the state to participate in its health exchange: Anthem Blue Cross Blue Shield. This status is not particularly different from the current individual market, where one carrier has 90 percent of the market share.

NH Commission Evaluating Arkansas and Iowa Expansion Models. The New Hampshire Commission charged with evaluating Medicaid expansion is evaluating the premium assistance models pursued by Arkansas and Iowa. According to analysts, the Arkansas "wraparound benefits" approach is expected to meet HHS approval more quickly because the Iowa proposal includes a $20 monthly premium to participants. The commission faces an October 15 deadline for a recommendation on whether or not to expand the Medicaid program, as well as an approach. If some adapted Medicaid expansion is proposed, the state would likely require a special legislative session and a rapid CMS approval on a likely waiver application.

New Jersey

HMA Roundup

United Healthcare Cited in Audit for Insufficient Efforts to Combat Fraud and Waste. On July 31, 2013, the New Jersey Comptroller's Office issued a report critical of United Healthcare for not having enough investigators to combat fraud and waste, as well as insufficient training of its existing investigators. Fraud recoveries of just $800,000 annually represent just 0.1 percent of the company's annual Medicaid revenues in the state. United representatives agreed to implement recommendations for rooting out fraud and waste. The state has audits underway with Amerigroup and Healthfirst, having already completed an audit with Horizon NJ Health.

New York

HMA Roundup – Denise Soffel

Agreement with Department of Justice Regarding Care of Adult Home Residents: The Justice Department, along with plaintiff adult home residents, entered into a comprehensive settlement agreement with the state of New York under the Americans with Disabilities Act (ADA). The settlement agreement ends a 10-year lawsuit over the availability of appropriate housing options for 4,000 people with mental illness living in adult home facilities in New York City. Under the settlement agreement, New York will offer supported housing to people with mental illness currently residing in adult homes. The Supreme Court made clear in the Olmstead decision that people with disabilities have a civil right under the ADA to receive services in the most integrated setting appropriate to their needs. The state worked cooperatively with the Justice Department and private plaintiffs to negotiate a settlement that resolves the allegations that the New York mental health service system violates the ADA by relying on large, institutional adult homes instead of supported housing units that are scattered throughout the community.

Over the next five years, New York will provide scattered-site supported housing to at least 2,000, and potentially more than 4,000, adult home residents. This includes 1,050 units already being developed and operated by community providers in Brooklyn and Queens, plus additional units to be promulgated by OMH for development in Staten Island and the Bronx within two years. The agreement leaves open the possibility for additional housing development as needed. It stipulates that within the next four years, at least 2,500 individuals must be assessed by Health Homes or Managed Long Term Care plans (MLTCs). Health Homes and MLTCPs will work with housing providers to help coordinate and transition individuals from adult homes to supported housing in the community. New York has also committed to providing people moving to supported housing with the community-based services and supports that will allow them to thrive in the community. The agreement also will ensure that adult home residents have the information they need to make an informed choice about where to live. If they choose to move to supported housing, they will participate in a person-centered, transition planning process. An independent reviewer with extensive experience in mental health systems will monitor the state's compliance with the agreement.

Duals Integration Demonstration Proposal MOU: New York reported that they are close to finalizing the MOU with CMS for the duals integration demonstration, which will create FIDA plans. Two issues remain unresolved: the appeals and grievance process, and the savings percentages. The state has indicated they want an appeals and grievance process that is completely integrated and consumer-friendly. They expect resolution of these issues within a week, at which point CMS and the state will jointly begin readiness review. The state has identified 25 plans that have been selected and will undergo readiness review, including 24 MLTC plans and one DISCO (Developmental Disabilities Individual Support and Care Coordination Organization), Partners Health Plan.

Basic Health Plan: As part of this year's budget Governor Cuomo established a work group that is charged with reviewing the state's options for establishing a Basic Health Plan under the ACA. The work group, which includes consumer advocates, legislators, providers and health plans, is to report back to the Governor in November 2013. At the

first meeting of the group there was a strong sense that NYS should pursue a Basic Health Plan, although many details remain to be resolved.

House Committee Investigating Potential Cuomo Interference in Medicaid Audit. In a letter issued August 4, 2013, the US House Oversight and Government Reform Committee reported that it is investigating any potential interference by Gov. Andrew Cuomo's office in an extensive Office of the Medicaid Inspector General audit of the Visiting Nurse Service of New York. In 2011, initial estimates of overpayments for 2003 and 2004 totaled $153 million, but were subsequently revised downward to $68 million. State officials indicate that the initial estimates had been based on small samples.

NYC Bidding Out City Health Plan Contract. On Friday, August 2, 2013, Mayor Michael Bloomberg said that New York City would put the city's $6.3 billion health care contract out to bid. According to the mayor, the incumbent plan, EmblemHealth, has opted not to seek a rate increase for the next fiscal year. Bloomberg notes that 95 percent of the city's workers pay no premiums. The Administration is consulting with the Municipal Labor Committee of city unions to develop an RFP for the contract.

Ohio

HMA Roundup

Ohio Insurance Department Claims 2014 Individual Premiums to Grow 41 Percent. On Thursday, August 1, 2013, Ohio released health exchange premiums, with critics and supporters of the Affordable Care Act using the release as ammunition. The Ohio Department of Insurance reviewed 200 plans that will be offered on the exchange and found that the average monthly premium for individual plans will rise 41 percent from $236.29 in 2013 to $332.58 in 2014. For the small group market, monthly premiums are expected to grow by 18 percent from the 2013 average of $341.03 to $401.99 in 2014. Lt. Gov. Mary Taylor criticized the ACA for limiting plan choices and driving up the cost of healthcare. House Speaker Boehner used the release as fodder to decry the ACA. ACA supporters criticized the analysis, which ignores tax subsidies, because it does not account for the average out-of-pocket expenses that individuals will experience. Moreover, ACA supporters note that including platinum and gold plans in the analysis reflects an "apples and oranges" statistic, which will not reflect the weighting of participation in bronze and silver plans.

Oregon

In the news

"State of Oregon Expands Health Plan Care Coordination Program" As of July 1, 2013, Oregon expanded care coordination services through the Oregon Health Plan Care Coordination (OHPCC) program, administered by APS Healthcare, Inc., to more than 26,000 dual eligible beneficiaries. The program now serves more than 70,000 Medicaid beneficiaries in Oregon, providing care coordination services for high acuity patients. APS Healthcare was acquired by Universal American in late 2012. (Universal American Press Release)

Pennsylvania

HMA Roundup –Matt Roan

Bill Introduced to allow Pharmacists to Administer Vaccines. A bill has been introduced in the PA House of Representatives which would allow Vaccination-Certified Pharmacists administer a wider array of vaccines to children between the ages of 7 and 17. Current law allows certified pharmacists to administer vaccines to adults ages 18 and older. The proposed law is meant to provide easier access to vaccination for parents who have had difficulty obtaining required shots for their children to enter school. Last year the PA Department of Health began implementing mandatory vaccination for school entry including a requirement for the pertussis vaccine. The effective date of the vaccination mandate has been delayed twice due to the large number of children who remain unvaccinated and who would be prevented from school attendance if the mandate was enforced. Physician groups are opposing the legislation to broaden the scope of practice of pharmacists contending that the risk of adverse reactions to vaccines are best managed in a physician's office.

Children's Hospital of Philadelphia Seeks International Growth. The Children's Hospital of Philadelphia (CHOP), the nation's leading children's hospital, has been working to expand its operations beyond the Philadelphia region. A deal to open a clinic in San Antonio, TX was de-railed last week when Vanguard Health Systems, a partner in the San Antonio project, was sold to Tenet Healthcare Corp. Tenet runs St. Christopher's Hospital for Children, a Philadelphia-based CHOP competitor. Despite this setback, CHOP continues to assess expansion possibilities in the New York City metro area, and internationally. CHOP has been in talks with state-owned asset management company in Beijing, China to open a 300 bed Women and Children's hospital. Additionally, CHOP has been consulting with a women and children's hospital in Saudi Arabia. Dr. Steven Altschuler, CEO of CHOP reports that international ventures and service to international patients in Philadelphia have become more profitable than domestic business. CHOP's international business is approaching $100M annually.

Eight Insurers Express Interest in the PA Health Exchange. The PA Insurance Department reported last week that eight health insurance companies and their subsidiary plans have expressed interest in selling policies on Pennsylvania's health exchange: Independence Blue Cross, Highmark, Capital Blue Cross, Blue Cross Blue Shield of NE Pennsylvania, Aetna, UPMC, Geisinger, and Coventry Health Care. Insurance industry analysts are reporting that the interest expressed by major insurers in the state is a good indicator that competitive pressures will result in more affordable insurance premiums for Pennsylvanians on the exchange.

Rhode Island

HMA Roundup

Rhode Island EOHHS Updates Duals Demonstration Timeline. The Rhode Island Executive Office of Health and Human Services provided an updated timeline for the planned roll-out of its dual eligible demonstration initiative. Details in the table below.

Enrollment Effective Date	Population Included
11/1/2013	½ of Nursing home residents ½ of MME that were previously enrolled in RIte Care, RIte Share, Rhody Health Partners (RHP) or Connect Care Choice (CCC) Current RHP and CCC members (Medicaid only) with LTSS Current CCC members (Medicaid only) without LTSS
12/1/2013	½ of Nursing home residents ½ of MME that were previously enrolled in RIte Care, RIte Share, RHP or CCC
2/1/2014	1/3 of MMEs with LTSS 1/3 of MMEs without LTSS
3/1/2014	1/3 of MMEs with LTSS 1/3 of MMEs without LTSS
4/1/2014	1/3 of MMEs with LTSS 1/3 of MMEs without LTSS MME clients on the DD waiver MME clients with SPMI (severe mental illness) SPMI/DD clients who are nursing home residents (both MME and Medicaid only)

South Carolina

HMA Roundup

State Approves Patient-Centered Medical Homes Pilot to Curb Health Costs. On Monday, August 5, 2013, the Public Employee Benefit Authority offered preliminary approval to institute a one-year pilot program in Charleston to offer access to patient-centered medical homes which would include case managers, lower deductibles, and incentives for healthier behavior.

Insurance Department Claims Premiums to Rise 50 to 70 Percent in 2014. On Friday, August 2, 2013, the SC Department of Insurance estimated that individual health insurance rates would rise 50 to 70 percent in 2014, while small group premiums would increase 10 to 20 percent. Insurance Department Director Ray Farmer acknowledged that increases could be higher or lower based on the product chosen, age, smoking status, and other factors. Farmer said the Department of Insurance is actively working with all carriers seeking CMS approval of the rates. Four companies submitted plans for the exchange: Blue Choice Health Plan, BlueCross BlueShield of South Carolina, Consumers' Choice Health Plan and Coventry Health Care of the Carolinas. Another eight companies have filed plans to offer individual plans outside of the federal exchange. Tax subsidies were not factored into the premium increase announcement.

Healthcare Budget and Legislative Items to Watch. The South Carolina Department of Health and Humans Services closed out its 2012-2013 fiscal year approximately $200 million under budget. As part of the Healthy Outcomes Initiative, all hospitals are slated to receive a 3% rate increase, although managed care rate changes are as yet unclear. Although the state has not used the full Disproportionate Share (DSH) allotment for the last two years, for FY 2013-14, it appears that South Carolina will use the full allotment of $474.5 million. Participation by hospitals in the Healthy Outcomes Initiative will be required to receive a full share of the DSH allotment. Nursing homes were designated for a rate increase of $16.9 million overall ($5 million from state funds).

Gov. Nikki Haley's veto of certificate of need (CON) funding was sustained by the legislature. The upcoming legislative session is likely to involve Medicaid expansion discussions, the authorization of electronic monitoring in long term care facilities, and a potential mandate for coverage of telemedicine services.

Vermont

HMA Roundup

New Deputy Commissioner in the Department of Mental Health. On Thursday, August 1, 2013, Vermont officials announced the appointment of Frank Reed to the position of deputy commissioner of the Department of Mental Health. Mr. Reed has worked at the department for 14 years, most recently as the interim deputy and commissioner. Mr. Reed is a licensed clinical social worker, who has served as president of the Vermont Chapter of the National Association of Social Workers.

Virginia

HMA Roundup

Virginia Unveils 15 Health Exchange Plans. On Wednesday, July 31, 2013, the Bureau of Insurance approved 15 health plans to be offered on the state's health exchange: 9 in the individual market and 6 in the small group market. In addition, there will be 21 standalone plans for pediatric dental care: 8 in the individual market and 13 in the small business market. Rates will not be released until the Federal Government determines which insurers will be approved to offer plans.

Washington

HMA Roundup—Doug Porter

Washington Insurance Department Approves Exchange Plans. On Thursday, August 1, 2013, Washington Insurance Commissioner Mike Kreidler announced that he's approved 31 plans from Bridgespan, Group Health Cooperative, Life Wise, and Premera Blue Cross to be offered on the state's health exchange. The Washington Health Benefit Exchange must offer final approval, which is expected later this month. Only Lifewise will offer plans in all 39 counties. Premera will sell in all counties but Clark. The approved rates are 1.8 percent lower than proposed by the plans, but vary based on age, home county, smoking habits, and choice of plan.

CMCS Cites Problems with Regional Support Network Bidding Process. In recent correspondences, CMS has raised concerns with the process Washington state uses to purchase mental health services from counties under its 1915(b) waiver. Over the last two decades, the state has contracted with one or more counties to serve as Regional Support Networks (RSNs), maintaining a close relationship between mental health providers and local institutions. However, CMS believes that these contracts appear to be intergovernmental arrangements which are not competitively bid, and violate procurement requirements. CMS has identified two options for the state to remedy the situation: (1) openly procure behavioral health services and require the RSNs to compete on the same basis as any commercial entity or (2) change the payment methodology to a cost-plus fee-for-service arrangement under a non-risk contract. CMS has suggested that the state should have a corrective plan in place within 90 days of the early July correspondence and should institute changes in state practices to conform to federal requirements. The state's assistant attorney general and outside counsel are reviewing CMS' position.

Wisconsin

HMA Roundup

Wisconsin Reveals Health Exchange Plans. On Tuesday, August 6, 2013, the Office of the Commissioner of Insurance revealed that 13 health insurers have filed to participate in the state's individual health exchange, while 9 have filed to participate in the Small Business Health Option (SHOP) exchange. Two of the state's largest health insurers, UnitedHealthcare and Humana, have opted not to participate in either. Rates were not released at this time. The individual health plan applicants are Common Ground Healthcare Cooperative, Compcare Health Services Insurance Corp. (Anthem Blue Cross and Blue Shield in Wisconsin), Dean Health Plan Inc., Group Health Cooperative of South Central Wisconsin, Gundersen Health Plan Inc., Health Tradition Health Plan, Medica Health Plans of Wisconsin, MercyCare HMO Inc., Molina Healthcare of Wisconsin Inc., Physicians Plus Insurance Corp., Security Health Plan of Wisconsin Inc., Unity Health Plans Insurance Corp., and Arise (WPS Health Plan Inc.)

The employer plan applicants are Common Ground Healthcare Cooperative, Group Health Cooperative of South Central Wisconsin, Gundersen Health Plan, Inc., Health Tradition Health Plan, Medica Insurance Company, MercyCare HMO, MercyCare Insurance Co., Security Health Plan of Wisconsin Inc., and Arise (WPS Health Plan Inc.).

National

HMA Roundup

CMS' Tavenner Asserts Exchanges Will Be Ready, Rejects Claims ACA Harming Workers. Centers for Medicaid & Medicaid Services (CMS) Director Marilyn Tavenner, responding to questions during a congressional hearing, declared that the health insurance exchanges, or marketplaces, will be open for enrollment on October 1. Tavenner's assertions back up HHS Secretary Kathleen Sebelius' claims that the agency is on target to launch the exchanges on October 1. Additionally, Tavenner rejected claims from republican lawmakers who have asserted that the Affordable Care Act is causing employees to lose hours or benefits due to changes in policies that impact their employers.

SGR Repeal-and-Replace Measure Passed Out of House Committee. Last week, the House Energy and Commerce Committee voted unanimously to approve a bill to repeal the Medicare Sustainable Growth Rate (SGR). Under the bill, Medicare physician reimbursements would grow 0.5 percent annually over five years. After that, Medicare would convert to an enhanced fee-for-service system based on certain quality measures.

INDUSTRY NEWS

Catamaran Corp. to Acquire Restat LLC. Catamaran has agreed to acquire Restat, a Milwaukee, Wisconsin-based pharmacy benefit manager (PBM) for nearly $410 million. Catamaran expects the deal to be finalized in the fourth quarter of this year.

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 9, 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	X	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	August 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**	***9***			***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 Jack Meyer Discusses ACA Implementation on Texas Public Radio

Managing Principal Jack Meyer recently talked with Texas Public Radio about the Affordable Care Act as the Oct. 1 deadline for several aspects of the law quickly approaches. The interview is available to stream on Texas Public Radio's website here.