HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 13, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Kartik Raju
Email

THIS WEEK

IN FOCUS

INDIANA RELEASES MEDICAID ABD RFP

This week our *In Focus* section reviews the request for proposals (RFP) issued by Indiana's Family & Social Services Administration (FSSA) to implement risk-based managed care for the aged, blind, and disabled (ABD) Medicaid population. The program, to be known as Hoosier Care Connect, is set to launch in April, 2015. The RFP indicates that interested bidders must have submitted a response to the ABD request for information (RFI) earlier this year to be eligible to respond to the RFP. At this time, FSSA has not made public a list of RFI respondents.

Target Population

Hoosier Care Connect will enroll Medicaid ABD beneficiaries who are not dual eligible and do not have an institutional level of care in a managed care organization (MCO). FSSA estimates approximately 84,000 Medicaid ABD beneficiaries will enroll in the first year of the program. Individuals receiving or transitioning to any of the following services will be excluded or disenrolled from Hoosier Care Connect:

- Long-term institutional care
- Hospice in an institutional setting
- Psychiatric treatment in a state hospital
- Psychiatric residential treatment facility (PRTF) services
- Intermediate care facilities for individuals with intellectual disabilities (ICF/IID)
- Home and community-based services (HCBS) waivers

The RFP lays out projected monthly enrollment and capitation rates for the target Hoosier Care Connect population, summarized in the table below. More than three-fourths of anticipated enrollment will be disabled adults, with estimated annual spending of more than $865 million. In total, the Hoosier Care Connect program is estimated to enroll around 85,000 beneficiaries, with an average per-member-per-month capitation of nearly $985, and annual spending of around $1 billion.

Hoosier Care Connect Population	Monthly Enrollment (Projected)	CY 2015 PMPM	Annual Spending (Capitation)
Disabled Adult (21+)	66,600	$1,083.14	$865,645,488
Disabled Children (under 21)	17,500	$653.18	$137,167,800
Disabled (Dual Eligible)	1,000	$229.95	$2,759,400
Total Hoosier Care Connect	**85,100**	**$984.70**	**$1,005,572,688**

Source: RFP.

Service Carve-Outs

The following services will be carved-out of the capitation rates under Hoosier Care Connect, although MCOs will be expected to provide coordination around the delivery of these services:

- Community-based behavioral health services provided under the Medicaid Rehabilitation Option (MRO)
- 1915(i) State Plan Home and Community-Based Services provided under the Behavioral and Primary Healthcare Coordination (BPHC), Adult Mental Health and Habilitation (AMHH), and Children's Mental Health Wraparound (CMHW) programs
- Individualized Family Services Plan (IFSP) services under FSSA FirstSteps program
- Individualized Education Plan (IEP) Services provided by schools

Hoosier Care Connect Contract Provisions

Capitation Risk Adjustment. PMPM capitation rates will be risk-adjusted based on the relative morbidity of a MCO's enrolled members to the statewide population.

Incentive Payment Withhold. In the first contract year, 1.5 percent of the capitation rate will be withheld with the opportunity to be earned back by meeting specified measures and outcomes. The percentage withhold will increase in subsequent contract year.

Medical Loss Ratio (MLR) Requirement. The RFP states that Hoosier Care Connect MCOs will be held to a MLR of 87 percent in year one, 88 percent in year two, and 90 percent in year three. The state will be able to recoup capitation payments in excess of the MLR requirement on an annual basis.

Health Insurance Provider Fee (HIPF) Reimbursement. The Affordable Care Act's HIPF will be retroactively reimbursed through adjustment to capitation rates, based on annual HIPF documentation submitted by MCOs to the state.

RFP Timeline and Contract Award Information

FSSA will be responding to questions on the RFP and capitation rates this week and the following week. Proposals are due to FSSA on September 12, 2014, with contract award recommendations tentatively scheduled for November 20, 2014. Hoosier Care Connect is scheduled to begin operations on April 1, 2015.

Timeline	Date
FSSA Responses to Written Questions/RFP Amendments	August 15, 2014
FSSA Responses to Written Questions on Capitation Rates	August 21, 2014
Proposals Due	September 12, 2014
Award Recommendation	November 20, 2014
Implementation	April 1, 2015

The state intends to award contracts to one or more MCOs, with an initial contract term of four years and two optional extension years.

Evaluation Criteria

The Hoosier Care Connect RFP evaluation criteria places significant weight on whether the bidder qualifies as an Indiana company (10 percent), on minority and women business subcontractor commitments (20 percent), and on veteran business subcontractor commitments (5 percent).

Evaluation Criteria	Points
Adherence to mandatory requirements	Pass/Fail
Management assessment/quality (Business and technical proposal)	60
Indiana economic impact	5
Buy Indiana (bidder qualifies as an Indiana company)	10
Minority (10) and Women Business (10) Subcontractor Commitment	20
Indiana Veteran Business Enterprise Subcontractor Commitment	5
Total (Before Bonus)	**100**
Minority and Women Business Subcontractor Commitment Bonus	2
Indiana Veteran Business Enterprise Subcontractor Commitment Bonus	1
Total Possible Points	**103**

Current Managed Care Market

Enrollment in the state's three managed care programs – Hoosier Healthwise, Care Select, and the Healthy Indiana Plan (HIP) – are detailed in the table below.

Health Plans (Hoosier Healthwise, Care Select, Healthy Indiana Plan)	July 2014 Enrollment	Percent
MDWise	305,345	40%
Anthem (WellPoint	241,593	32%
MHS (Centene)	196,249	26%
Advantage	16,078	2%
Total Enrollment	**759,265**	

Link to RFP Website

http://www.in.gov/idoa/proc/bids/rfp-15-001/

HMA Medicaid Roundup

California

HMA Roundup – Alana Ketchel

California Children's Services Planning. On August 12, 2014 the Department of Health Care Services announced that it is in the planning stages of improving the California Children's Services (CCS) program and will begin a stakeholder engagement process to support the 1115 Bridge to Reform Waiver Renewal. The first meeting is scheduled to be held in September. Read more

State to Add Autism Therapy as Medi-Cal Benefit. According to an August 6, 2014 report from *California Healthline*, officials from the Department of Health Care Services (DHCS) stated that applied behavior analysis (ABA therapy) is a covered Medi-Cal benefit. Officials plan to submit a state plan amendment by September 30th to begin the process to make autism therapy an official benefit for those under age 21. The policy would be retroactive to July 1. DHCS plans to hold a stakeholder meeting August 29th to discuss the policy. Read more

Department of Public Health Opens Data Portal. The California Department of Public Health announced on August 8, 2014 that the state launched an Open Data Portal, providing datasets available to public use. The expectation is that users will access the aggregated data to gather information and develop mobile apps addressing important public health issues. Per the Department, "the portal offers access to standardized data that can be easily retrieved, downloaded, sorted, searched, analyzed, redistributed, and re-used by individuals, business, researchers, journalists, developers, and government to process, trend, and innovate using a single data table or combinations of data tables." Read more

Florida

Medicaid Expansion Debate to Factor in Florida Governor's Race. On August 9, 2014, the *Tallahassee Democrat* reported on the role of the Medicaid expansion debate in the upcoming gubernatorial election between Charlie Crist and currently Governor Rick Scott. Crist, formerly governor himself, has stated that one of the first things he would do if elected is call a special session to expand Medicaid. Governor Scott, meanwhile, has backed away from some supportive comments of expansion, stating that he could only support it if the federal government paid the full cost going forward. Read more

Georgia

Federal Data Shows Georgia's Significant Woodwork Effect. On August 12, 2014, *Georgia Health News* reported on federal enrollment figures showing a 16 percent increase in Medicaid and PeachCare enrollment since October 2013, the highest of any state that did not expand Medicaid. Georgia officials state that the increase in enrollment is much lower, at just 5.6 percent, but have not had the opportunity to fully study the federal data. According to the article, Georgia was known to have a large number of individuals eligible for Medcaid and PeachCare prior to the ACA that had not enrolled. Read more

Indiana

State Officials meet with Potawatomi Tribe to discuss Indiana's Medicaid Waiver. On August 9, 2014, the *Indy Star* reported that Indiana State Officials met with the Pokagon Band of the Potawatomi Indians to discuss the Healthy Indiana Plan 2.0. The Pokagon Band submitted a letter to the state on August 4, 2014 supporting the expansion of Medicaid access to adults, but proposed that Native Americans be carved out of the plan, as other states have already done. Now that the state has satisfied the consultation request, The Department of Health and Human Services (HHS) is now able to begin the official review and public comment period for the HIP 2.0. Read more

Kansas

$10.7 million in unallowable Medicaid reimbursements claimed by Kansas. On August 11, 2014, *Kansas Health Institute* reported that from July 1, 2009 through June 30, 2010 Kansas improperly billed Medicaid $10.75 million for school-based health services. The Department of Health and Human Services, Office of Inspector General, is recommending that Kansas refund the unallowable reimbursement received to the federal government. Read more

Massachusetts

Massachusetts Exchange Contractor hCentive Inc. to be Ready for Open Enrollment. On August 8, 2014, the *Wall Street Journal* reported that Massachusetts' Exchange officials have determined that the Exchange system enrollment developed by hCentive, Inc. will be ready in time for the November 15 open period. Massachusetts hired hCentive to run the Exchange, but was also pursuing the option of using the Federal Marketplace portal if hCentive's was not ready. In June 2014, the state ended its contract with CGI Group, who developed the Exchange system used in last year's open enrollment period. Read more

BMC's HealthNet Plan and Partners' Neighborhood Health Plan Appeal to State on Cost Pressures. On August 7, 2014, the *Boston Business Journal* reported that both Boston Medical Center's HealthNet Plan and Partners Healthcare's Medicaid business are looking to the state as their financial pressures from Medicaid services continue to grow. BMC cites cost pressures from Sovaldi, as well as lower membership levels and higher acuity, as drivers of their financial losses. Read more

Michigan

Medicaid Expansion to Benefit Michigan Corrections Budget. On August 11, 2014, *The Detroit News* reported that the Michigan Department of Corrections could save as much as $19 million in health care costs as a result of the Medicaid expansion. Under the expansion, certain inmates and parolees can receive mental health, substance abuse, and other health care services through Medicaid, rather than through Corrections health providers. Read more

New Jersey

HMA Roundup – Karen Brodsky (*Email Karen*)

Division of Disability Services revises proposal deadline for Fiscal Intermediary/Counseling Services RFP. As reported in the HMA Weekly Roundup on July 2, 2014, the state's Department of the Treasury, Division of Purchase and Property released a Request for Proposals (RFP, T-2949, Solicitation #: 15-X-23219) on June 23, 2014 on behalf of the Department of Human Services, for use by the Division of Disability Services (DDS), Division of Aging Services (DoAS) and Division of Developmental Disabilities (DDD). This is a reprocurement for participant direction services of the T-2240 Third Party Services: Fiscal and Support Services, Cash and Counseling Program and T-1876 Third Party Services: DHSS, Senior Initiatives term contracts, due to expire on December 31, 2014. Due to the volume of questions received during the Question and Answer Period, the proposal opening date for RFP 2015-X-23219 – Fiscal Intermediary and Counseling Services has been postponed and rescheduled. Proposals were originally due by 2:00 p.m. on August 12, 2014 and are now due by 2:00 p.m. on September 2, 2014. Complete information on this RFP is available on the Department of the Treasury, Division of Purchase and Property website here.

New York

HMA Roundup – Denise Soffel

DSRIP Design Grants Awarded. The state announced $21.5 million in Design Grant awards. Awards were made to 43 emerging PPSs, including 19 in New York City. Grant amounts ranged from $369,000 to $1 million. The funds are meant to cover expenses related to conducting a community health needs assessment and other planning activities. The NYC Health and Hospitals Corporation, which operates the public hospital system in NYC, received a total of $2 million for its seven design grant applications. The State University system, which operates three sites, received a total of $1 million. In total, 27 percent of the funds went to public hospitals while 73 percent went to other safety net providers. Thirty-six percent of the awards went to emerging PPSs in New York City, including $5 million to PPSs proposed for Brooklyn. The individual awards can be seen on the DSRIP website. In an effort to encourage consolidation among emerging PPSs, last week the state announced that regions served by a single PPS would be awarded bonus points in the scoring of their applications, which will lead to higher valuation and therefore higher incentive payments. DSRIP applications are due December 16.

DSRIP Dashboards. In partnership with Salient, the Department of Health (DOH) has developed a number of DSRIP dashboards that generate data and analysis to be used to assist with planning, community needs assessment, and application development for the DSRIP initiative. They can be found on the DSRIP web site. The dashboards present Medicaid utilization and enrollment data made available by DOH. The data will be updated monthly to present the most current information for service, beginning with data from 2011 through present. Data can be filtered by region, county, or zip code; provider type; managed care plan; diagnosis; and age. They can generate comparisons between a given geography and state-wide performance, as well as utilization behavior over time.

Oregon

Exchange Contractor Oracle Files Breach-of-Contract Suit. On August 8, 2014, *AP/Yahoo News* reported that Oracle Corp. has filed a breach-of-contract suit against the state of Oregon's Cover Oregon health insurance Exchange. The suit seeks $23 million in payments, plus interest and other damages. Cover Oregon has blamed Oracle for the failed Exchange launch, while Oracle contends the state was responsible. Oregon Governor John Kitzhaber has called for the state to sue Oracle to recover some of the $134 million it paid to the contractor. Read more

Pennsylvania

HMA Roundup – Matt Roan

Hospitals say Medicaid Expansion will Help Address Financial Woes. Pennsylvania hospitals facing financial difficulties are highlighting Medicaid expansion as a means to improve their budget difficulties. According to the Meadville Tribune, community hospital cutbacks and staffing reductions have led to the loss of almost 700 health care jobs in the last eight months as hospitals struggle with uncompensated care costs in the absence of Medicaid expansion in PA. A spokesperson for the Hospital and Health System Association of Pennsylvania said that the cost of care for the uninsured has increased by more than 53% in the last five years, and accounted for over $1B in state fiscal year 2011-2012. Pennsylvania is one of 24 states that have not moved forward with Medicaid expansion. Governor Corbett has submitted an alternative approach to healthcare expansion called Healthy PA to the U.S. Department of Health and Human Services. The plan is still under review by federal officials who are meeting regularly with state officials to negotiate the details. Read more

Geisinger Launches "ProvenWellness Neighborhood" Initiative. Geisinger Health System has announced the implementation of a pilot program in Scranton, PA aided at eliminating barriers to healthcare for vulnerable residents. As reported in the Times Tribune, the pilot, funded through a grant from the Harry and Jeanette Weinberg Foundation, will provide staff who will identify patient needs and connect them to appropriate services, including transportation to medical appointments and health coaching. The program, dubbed "ProvenWellness Neighborhood," is expected to serve at least 1,000 Medicaid, Medicare, and uninsured residents this year, and may expand to serving up to 17,000 in year two. Read more

UnitedHealthcare to Enter PA Federally Facilitated Marketplace. United Healthcare announced last week that it will be entering the Federally Facilitated Marketplace in Pennsylvania next year with plans to serve members in Philadelphia and Pittsburgh. The entry into Pennsylvania is part of a broader strategy of United who, according to CEO Stephen Hemsley, will expand its exchange participation to at least 24 states nationally. In the first year of ACA implementation United offered plans in only four states. Read more

PA Department of Public Welfare Announces Public Meetings on Home and Community-Based Service Changes. The Pennsylvania Department of Public Welfare has announced a series of public meetings across the Commonwealth focused on changes to the state's Home and Community-Based Medicaid Waiver programs that are the result of a new Federal regulation which went into effect in March, 2014. Among the key changes are new requirements around person-centered plans of care and the definition of care settings that qualify as being home or community-based. The Department has also announced that it will be releasing a draft version of its HCBS Transition Plan on August 15th, a document that the federal regulation requires states with Medicaid HCBS waivers to create. Read more

Rhode Island

Hospital Charity Care Drops under Medicaid Expansion. On August 8, 2014, *Rhode Island Public Radio* reported that Rhode Island's hospitals have seen a nearly 18 percent decrease in the amount of charity care they must provide since the state expanded Medicaid at the beginning of the year. Read more

South Carolina

Transfer of Federal Marketplace Applications lead to Backlog for South Carolina Medicaid Agency. On August 11, 2014, *The State* reported that South Carolina's Medicaid agency is in the midst of processing a backlog of approximately 15,000 applications, transferred to the agency from the federal online marketplace. The federal government began transferring 38,000 applications to the SC Medicaid agency in mid-February, with an estimated 5,000 to 6,000 still awaiting transfer. Six temporary employees have been hired to help with paperwork and eligibility determinations; the agency believes the backlog will be eliminated within a couple of weeks. Read more

Texas

Texas in Dispute with Contractor Regarding Authorization of Orthodontic Services. On August 11, 2014, *The Texas Tribune* reported that a federal audit of the Texas Medicaid Programs dental claims revealed that between 2003 and 2010, Medicaid payments for orthodontic services grew by more than 3,000 percent. Federal auditors are saying that the state agency failed to oversee that the contractor, Texas Medicaid and Healthcare Partnership (TMHP), properly used Medicaid guidelines to determine the medical necessity of orthodontic claims. The Texas Health and Human Services Commission has since terminated their contract with TMHP and has filed a lawsuit against its parent company, Xerox. Read more

National

Medicaid Enrollment Increases 7 Million under ACA. In HHS' updated June 2014 Medicaid and CHIP enrollment report, a reported 7.2 million new participants have gained coverage under the two programs. The report indicates that states with expanded Medicaid program have seen enrollment increases of 18.5 percent, while non-expansion states have increased only 4 percent. An estimated 5.7 million low-income individuals remain uninsured in the 24 non-expanding states. Read more

Provider-Owned Medicaid MCOs Show Profitability. An August 11, 2014 article in *Healthcare Payer News* suggests that provider-owned Medicaid managed care organizations are showing profitability in states where traditional MCOs are struggling. Furthermore, the article suggests that provider-owned MCOs may be well positioned to take advantage of state changes to their Medicaid programs. While overall, provider-owned and traditional MCOs were just as likely to be profitable, the article highlights states where provider-owned MCOs were the only ones to turn a profit. The article cites examples of provider-owned success stories in Massachusetts, New Mexico, Pennsylvania, and Wisconsin. Read more

Health Insurance Exchange premiums expected to rise by an average of 7.5 percent. On August 11, 2014, *The Hill* reported that, on average, customers across the nation using the Health Insurance Exchange will see a 7.5 percent increase in their premiums. Health Research Institute (HRI) at PricewaterhouseCoopers compiled the data that found most premium increases coming in short of the dire projections expected in the second year of the ACA. Premium are both increasing and decreasing in many areas, the highest increase is in Nevada where Time Insurance Co. has proposed a rise of 36 percent with the biggest decrease in Arizona where a 23 percent rate drop has been proposed. The second ACA enrollment period is set to begin on November 15, 2014. Read more

Industry Research

Urban Institute/RWJ Reports on Impact of Forgoing Medicaid Expansion. In a report published this month, the Urban Institute analyses the economic impact across the 24 states that have not expanded Medicaid. The report states that these 24 states will leave 6.7 million residents uninsured as of 2016. Additionally, states are missing out on $423.6 million in federal Medicaid funding over the ten-year period of 2013-2022, which could impact economic activity and job growth. Meanwhile, hospitals in these 24 states will lose out on $167.8 billion in Medicaid funding meant to offset cuts to Medicare and Medicaid reimbursements. Link to Report

Industry News

Molina Healthcare to Acquire First Coast Advantage's Florida Medicaid Contract. On August 8, 2014, Molina Healthcare announced that is has reached an agreement with First Coast Advantage to assume the company's Medicaid contract in Region 4 of the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance (MMA) Program. Region 4 includes Baker, Clay, Duval, Flagler, Nassau, St. Johns, and Volusia counties. Molina currently holds contracts in other regions for both traditional and managed long-term care. The deal will require the approval of Florida's Agency for Health Care Administration. Read more

WellPoint Announces Will Change Name to Anthem, Inc; Amerigroup Name to Remain. On August 13, 2014, WellPoint announced plans to change its corporate name to Anthem, Inc. President and CEO Joseph Swedish states that the firm is best known by the Anthem name. Pending approval of shareholders, the change is expected to take place by the end of 2014. Read more

It was reported by *Health News Florida*, however, that the name change will not impact WellPoint's Amerigroup line of business. WellPoint acquired Amerigroup in 2013. Read more

Fidelis SeniorCare Names President and CEO. It was reported on August 13, 2014, by HeraldOnline.com, that Fidelis SeniorCare has appointed Alec Cunningham as the company's new President and CEO. Fidelis' founder and former CEO, Sam Willcoxon, will remain with the company as Chairman. Cunningham previously served as the CEO of WellCare. Read more

MAXIMUS Reports Third Quarter Financial Results. On August 7, 2014, MAXIMUS reported financial results for the nine months ending June 30, 2014, announcing a 40 percent year-over-year increase in their health services segment, accounting for more than $300 million in revenue. MAXIMUS CEO Richard A. Montoni states that the firm "continue[s] to see governments looking to partners, like MAXIMUS, to help them manage complex social benefit programs. These efforts are creating increased demand for our services over the long-term." Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
August 11, 2014	Puerto Rico	Proposals Due	1,600,000
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
September 10, 2014	Washington Foster Care	Proposals due	23,000
September 12, 2014	Indiana ABD	Proposals Due	85,000
September 26, 2014	Louisiana	Proposals Due	900,000
October 9, 2014	Arizona (Behavioral)	Proposals Due	23,000
October 24, 2014	Louisiana	Proposals Due	900,000
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	Washington Foster Care	Implementation	23,000
January 1, 2015	Texas Duals	Implementation	168,000
January 1, 2015	New York Duals	Implementation	178,000
January, 2015	Georgia	RFP Release	1,250,000
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.*

‡ Capitated duals integration model for health homes population.

HMA NEWS

HMA/Kaiser Brief Profiles Newer Programs in Medicaid Health Homes

Link to Issue Brief

HMA Managing Principal Mike Nardone and Kaiser's Julia Paradise authored the recently released issue brief, "Medicaid Health Homes: A Profile of Newer Programs" for the Kaiser Commission on Medicaid and the Uninsured (KCMU).

The Affordable Care Act (ACA) established a new state option in the Medicaid program to implement "health homes" for individuals with chronic conditions, giving states a new tool to develop models of care designed to improve care coordination and reduce costs for high-need populations. In August 2012, the KCMU issued a brief examining the first six health home programs. This update profiles health home programs in the nine states that have taken up the option in the intervening two years – Alabama, Idaho, Maine, Maryland, Ohio, South Dakota, Washington, Wisconsin, and Vermont.

States have implemented health home programs in a variety of ways, reflecting different targeting priorities, underlying delivery and payment systems, and visions of delivery system reform, as well as other state-level factors. This issue brief identified both themes and diversity in the more recent health home programs in a number areas, including geographic scope, target population, health home providers, payment, fee for service versus managed care, and HIT.