HMA

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup
Trends in State Health Policy

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AUGUST 14, 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: HAWAII RFP TO CONSOLIDATE MEDICAID MANAGED CARE CONTRACTS

This week, our *In Focus* section reviews Hawaii's QUEST Integration (QI) program request for proposals (RFP). Hawaii operates several independent programs under the QUEST Medicaid umbrella. The QI program will consolidate these programs under Section 1115 Waiver authority into a single Medicaid managed care program serving all of Hawaii's Medicaid population. The state of Hawaii currently operates two separate Medicaid managed care programs – QUEST and QUEST Expanded Access (QExA) – served by five managed care plans. Included within these programs are several smaller Medicaid and non-Medicaid state-funded programs the beneficiaries of which will all be mandatorily enrolled in the plans awarded QI contracts under this RFP.

Target Population

The QI program will cover all Medicaid and state-funded non-Medicaid individuals under a unified contract with the awarded health plans. In total, this population exceeds 292,400 as of June 2013 enrollment data, presented in the table below.

Table 1 – Hawaii Medicaid QUEST, QExA, & Other Program Enrollment, June 2013

Program	Notes	Enrollment
QUEST		
1931	Parents/Families	87,993
QUEST		49,758
S-CHIP		28,890
QUEST-ACE	Limited coverage for adults <200% FPL	26,525
TANF		15,198
QUEST-Net	Limited coverage for previously eligible adults <300% FPL	11,833
1925 TMA	Transitional Medical Assistance	6,558
General Assistance		5,497
QUEST-SF	QUEST-State funded	5,055
Foster Care		5,020
QExA		
ABD		43,577
QExA Spend-down		2,415
Other		
QMB, SLMB, QDWI		4,091
Basic Health Hawaii		13

Source: State Monthly Enrollment Report.

The only individuals excluded from the QI program are those who are: Medicare Special Savings Program Members; enrolled in the State of Hawaii Organ and Transplant Program (SHOTT); retroactively eligible only; and those eligible under non-ABD medically needy spend-down.

RFP Requirements and Scoring Criteria

Interested health plans are required to bid to serve at least the island of Oahu and one other island. Oahu is by far the largest island, with nearly 180,000 QI eligible beneficiaries. Bidders may request to operate statewide as well. If fewer than two selected health plans apply to operate statewide, the state will allow an awarded plan to serve statewide even if they did not submit a statewide bid. If no plan chooses to change to statewide, then the state may issue another RFP. The following table details enrollment by island as of June 2013.

Table 2 – QI Eligible Beneficiaries by Island, June 2013

Island	Total Enrollment	% of Total
Oahu	179,227	61.3%
Hawaii	62,145	21.3%
Maui	30,951	10.6%
Kauai	16,072	5.5%
Molokai	3,305	1.1%
Lanai	723	0.2%
Total	**292,423**	

Source: State Monthly Enrollment Report.

The scoring criteria, detailed in Table 3 below, appear evenly balanced across all scoring categories, with none weighted heavily as compared to the others. However, each category has minimum scoring criteria that must be met to be eligible for a contract award. The experience and references category includes a narrative based on the bidder's experience in Hawaii. This experience narrative is, along with three other categories (detailed below), worth 90 points out of a minimum 112.5 points to pass the section; it could potentially give an advantage to incumbent health plans. The RFP also reiterates that Medicaid managed care experience in Hawaii is weighed higher than in other states.

Table 3 – QUEST Integration RFP Scoring Criteria

Evaluation Categories	Available Points	Min. Points
Experience and References	**150**	**112.5**
A. Narrative- experience in Hawaii B. Contract for Medicaid program clients C. Letters of recommendation D. Information about termination, non-renewal, etc.	90	
E. EQRO evaluations	20	
F. EPSDT measures	20	
G. HEDIS validation evaluations	20	
80.315 Provider Network and Services	**150**	**112.5**
80.315.1 Provider Network Narrative 80.315.2 Attachment: Required Providers 80.315.3 Attachment: Maps of Providers	100	

Evaluation Categories	Available Points	Min. Points
80.315.4 Availability of Providers Narrative 80.315.5 Provider Services Narrative	50	
80.320 Covered Benefits and Services	**150**	**112.5**
80.320.1 Covered Benefits and Services Narrative	30	
80.320.2 Long-Term Services and Supports (LTSS)	30	
80.320.3 Hospital readmission within thirty (30) days	30	
80.320.4 EPSDT Narrative	30	
80.320.5 Transition of Care Narrative	30	
80.325 Service Coordination System/Services	**150**	**112.5**
80.330 Member Services	**100**	**75**
80.330.1 General Member Services	40	
80.330.2 Toll-free Call Center and 24 Hour Nurse Line	30	
80.330.3 Member Grievance System	30	
80.335 QAPI/ Utilization Management	**150**	**112.5**
80.335.1 QAPI program	20	
80.335.2 General Provisions	20	
80.335.3 Value-Based Purchasing	30	
80.335.4 Performance Measures	20	
80.335.5 Disease Management	20	
80.340.1 UMP	20	
80.340.2 UMP and Authorization of Services	20	
80.345 Health Plan Administrative Requirements	**150**	**112.5**
80.345.1 Fraud and Abuse	30	
80.345.2 Narrative and Organization Charts	20	
80.345.3 Organization and Staffing Tables	20	
80.345.4 Reporting Requirements	20	
80.345.5 Encounter Data Reporting Requirements	20	
80.345.6 Information Technology	20	
80.345.7 Third Party Liability	20	
Total	**1,000**	**750**

Timeline

The QI RFP was released on August 5, with a notice of intent to propose due three weeks later, on August 26, 2013. The notice of intent is not required to bid on the RFP, but will be necessary to submit to receive updates and RFP amendments. Proposals are due on November 1, 2013; however, proposed capitation rates will not be released until the following week, on November 8, 2013. The state anticipates finalized capitation rates to be released on December 6, 2013, with contract awards following on January 6, 2014. The QUEST Integration program will launch with an enrollment effective date of January 1, 2015.

Table 4 – QUEST Integration RFP Timeline

Timeline	Date
RFP Released	August 5, 2013
Notice of Intent to Propose Due	August 26, 2013
Proposals Due	November 1, 2013
Issue Proposed Capitation Rates	November 8, 2013
Issue Final Capitation Rates	December 6, 2013
Contract Awards	January 6, 2014
Implementation	January 1, 2015

QUEST and QExA Incumbents

The QUEST program is currently served by five health plans. AlohaCare is a local not-for-profit provider organized health plan. Ohana Health Plan (WellCare) and United Healthcare are the two QExA plans and began serving the QUEST program in July 2012 under new contracts procured in 2011. Hawaii Medical Service Association (Blue Cross and Blue Shield of Hawaii) is currently the largest health plan, with more than 50 percent of QUEST enrollment.

Table 5 – QUEST & QExA Enrollment by Health Plan, June 2013

Health Plan	QUEST Enrollment	QExA Enrollment	Total Enrollment
HMSA (BCBS of Hawaii)	130,918		130,918
AlohaCare (Local)	69,690		69,690
Ohana Health Plan (WellCare)	9,581	24,572	34,153
United Healthcare	8,892	21,364	30,256
Kaiser Permanente	23,167		23,167
Total Enrollment	**242,248**	**45,936**	**288,184**

Source: State Monthly Enrollment Report.

HMA Medicaid Roundup

Arkansas

HMA Roundup

Arkansas Files 1115 Waiver for "Private Option." On August 6, 2013, Arkansas sent CMS its 1115 waiver request to use Medicaid expansion funds for premium assistance on exchange plans. Initially, "private option" beneficiaries would include (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or incarcerated and (2) parents between the ages of 19 and 65 with incomes between 17 and 138% FPL who are not enrolled in Medicare or incarcerated. Eventually, the state aims to revise the waiver to include parents with incomes below 17 percent of poverty level and children. Dual eligible are not included in the waiver request. The waiver application now must go through a 30 day comment period and a 15 day review period, meaning CMS approval can come no earlier than late September 2013. The Beebe Administration hopes to secure approval by October 1, when enrollment in the exchange is to begin. Meanwhile, a group called Arkansans Against Big Government is collecting signatures to place a 2014 ballot measure before voters to repeal the state's Medicaid expansion legislation.

California

HMA Roundup—Jennifer Kent

Pediatric Dental Benefits Recommendation Ordered by Exchange. On Thursday, August 8, 2013, the Covered California board ordered its staff to draft a recommendation by year-end to make embedded pediatric dental benefits available no later than 2015. Advocates had lobbied the board to require embedded dental benefits for 2014 because of their concerns regarding separate out-of-pocket costs and overall affordability. Exchange staff acknowledged that they had not adequately understood the complications surrounding the pediatric dental benefit and the various mechanisms of structuring it, but indicated there is no way to change the current product offerings for 2014 because of the system changes required and the feedback from the plans indicating their inability to embed a dental benefit at this late a date. Based on the concerns regarding affordability for low-income families purchasing stand-alone dental products, the staff recommended that the benefit not be a mandatory purchase for 2014.

Court Rules that Public School Staff Can Inject Insulin. In a ruling on August 12, 2013, the California Supreme Court ruled that qualified public school staff would be permitted to inject diabetic students with insulin. The American Nurses Association had argued that only school nurses were properly trained to administer injections. The American Diabetes Association successfully argued that there were insufficient public school nurses to safely ensure diabetic children with access to necessary care. The ANA threatened to appeal to the US Supreme Court.

Quality Ratings Not Included in Exchange Enrollment System. Last week, Covered California announced that it was dropping plans to post insurance company quality ratings in the online enrollment system because they do not reflect many of the new plans and networks that are being offered for the first time. The decision was met with dismay from highly-rated insurers and advocates who argue that health plan decisions hinge on more factors than price. Peter Lee, executive director of the exchange, notes that the ratings are outdated, at nearly 3 years old, and plans and networks have changed significantly since then. The exchange vowed to evaluate options to collect performance data and establish its own report card. Kaiser, Sharp, and Western Health Advantage urged that the exchange reconsider its decision and use the label "not yet rated" for newer plans, rather than removing all quality scores from consideration.

Colorado

HMA Roundup—Joan Henneberry

Colorado Hospital Association and United Healthcare Reduce Readmissions. On August 1, 2013, the Colorado Hospital Association (CHA) and United Healthcare announced nearly $3 million in savings and a significant reduction in avoidable readmissions as part of the Reducing Hospital Readmissions& Safe Transitions Collaborative. United had funded a $1.1 million grant to the CHA to help the 19 participating hospitals institute plans to coordinate post-hospitalization care in 2011. "Same cause" readmissions within 30 days dropped from 9.8 percent to 5.18 percent at the participating hospitals. "All cause" readmissions fell from 14.94 percent to 8.45 percent during their first year of participation. Key elements of the initiative included ensuring follow-up tests and provider appointments scheduled prior to discharge, confirmation of medication plans, and follow-up phone calls with patients.

Colorado Exchange Reporting Medicaid Data-Sharing Issues. The IT project manager for Connect for Health Colorado, the state exchange, reported to the board of directors that the exchange is not yet getting necessary, accurate data from the state Medicaid agency systems. The exchange is prepared to switch to contingency plans on September 15, 2013 if needed. The challenge seems to be the accuracy of Medicaid eligibility estimates. The exchange board also heard from the Division of Insurance which approved 242 plans from 13 carriers to be sold in the exchange marketplace beginning October 1, 2013. Ninety-two of the plans are targeted at small employers and 150 designed for individuals. Only two plans will be available in the "platinum" category, with 13 in the catastrophic category. Most of the plans will cover 60-80 percent of the costs of care.

Connecticut

In the news

"Thousands Of Connecticut Nursing Home Beds Empty As State Rebalances Care" Connecticut has seen its nursing home occupancy rate fall from third-highest in the nation to tenth, driven at least partially by the state's "money follows the person" program, which is transitioning Medicaid nursing home patients to home and community based settings. (CTWatchdog.com)

Florida

HMA Roundup – Gary Crayton and Elaine Peters

AHCA provides guidance for Medicare Advantage plans covering dual eligibles. Last week, the Agency for Health Care Administration posted a notice related to the Medicaid Managed Medical Assistance (MMA) program. Dual eligibles that are already enrolled in a Medicare Advantage plan that already offers the full set of MMA benefits would not be required to enroll in Medicaid MMA plans as the Medicare Advantage plan would be considered a fully liable third party responsible for the provision of MMA services. To coordinate enrollment activities and avoid duplication of costs, the agency is requesting letters of interest by August 30, 2013 from Medicare Advantage organizations to determine if they are fully liable third parties for MMA services.

Florida Economists Predict Budget Surplus. Last week, state economists predicted that Florida should enjoy steady economic growth that would drive tax collections up by 3.4 percent over the next year and 4.4 percent the following year. As a result, the state should have a $2 billion budget surplus that could be deployed for expanding programs or cutting taxes. The Federal sequester, however, may have represented about a 25 basis point drag on economic growth in the state.

Managed Long Term Care Transition Proceeding in Central Florida. With the August 1, 2013 transitions of 9,000 long-term care beneficiaries to managed Medicaid long-term care plans, Central Florida has been on the leading edge of change in the state's long-term care system. The transition appears to be proceeding without major problems, so far. In Central Florida, AHCA has contracted with four plans — American Eldercare, Coventry Health Plan, Sunshine State Health Plan and UnitedHealthcare of Florida. The managed long-term transition is slated to be complete on March 1, 2014. A primary goal of this transition is to encourage home and community-based services as an alternative to institutionalized care, which will eventually require electronic verification systems to track time spent with beneficiaries.

Florida Hospital Association Touts Readmissions Progress. On August 13, 2013, the Florida Hospital Association released a report that quality initiatives have significantly improved readmissions rates for participating hospitals in the state. Readmissions have dropped 15 percent, while surgical complications have fallen 14.5 percent over the first five years. Better coordination of care, collaboration among hospitals, and improved communication have been key factors in driving down readmissions.

Georgia

HMA Roundup – Mark Trail

DCH Announces BCBS as State Health Benefit Plan Vendor. On August 9, 2013, the Department of Community Health announced that Blue Cross Blue Shield of Georgia would take over administration and medical management responsibilities of the state's $3 billion State Health Benefit Plan, replacing Cigna and United Healthcare effective January 1, 2014. Express Scripts will oversee the pharmacy benefits, while Healthways will be responsible for wellness benefits. A Fulton County judge declined to suspend the contract award in a lawsuit filed by United Healthcare over the bidding process. The chief of

the SHBP estimates that the new plan could save the state $200 million annually. DCH will seek out an additional insurer for a metro Atlanta regional vendor contract.

Georgia Tax Collections Up in July. On August 12, 2013, Georgia announced its net tax collections for July grew 6.7 percent over the prior year's period at $1.41 billion. Individual tax receipts were up 8.6 percent, while net sales & use tax collections for July 2013 fell 6.6 percent, corporate income tax collections dropped 21.8 percent, and motor vehicle tag and title fees nearly quadrupled due to new tax legislation, House Bill 266, which became effective as of March 1.

Hawaii

HMA Roundup

Health Exchange Awards $6.7 Million to 34 Community Organizations. Last week, the Hawaii Health Connector awarded $6.7 million in grants to 34 community organizations to hire 191 marketplace assisters in educating the public about new health plan options available as of January 1, 2014.

Idaho

HMA Roundup

Idaho Exchange to Be Operated by Federal Government in 2014. Following a delayed vote by the Idaho legislature on March 28, 2013 to approve a state-run exchange, it was determined last week that the state had insufficient time to create one in time to meet an impending October 1 operating deadline. Idaho signed a contract with Public Consulting Group to put a customized Idaho "skin" to its section of the federal-run exchange. The state intends to post informational pages about the Idaho exchange, which should be state-run for 2015. Idaho's exchange has been awarded a $20.3 million federal startup grant and may apply for additional funds in the future.

Illinois

HMA Roundup – Andrew Fairgrieve

Chicago's Medical Home Network Joins Medicaid Care Coordination Initiative. The Illinois Department of Healthcare & Family Services (HFS) announced on Tuesday, August 13, 2012, that the Medical Home Network (MHN) has joined the state's Care Coordination Innovations Project (CCIP). Under the CCIP, HFS is expanding care coordination, through managed care and other community and provider-organized care entities, to at least 50 percent of the Medicaid population by 2015. MHN is a delivery network, serving 170,000 Medicaid beneficiaries on Chicago's south and southwest sides that virtually links 12 hospitals and 110 primary care sites, known as medical homes, through an IT infrastructure known as MHNConnect, which provides real-time connectivity between medical homes, hospitals, and other care providers.

Safety Net Hospital Grants to Fund Capital Construction. On Thursday, August 8, 2013, Governor Pat Quinn announced $47 million in state grants to fifteen Cook County hospitals to underwrite capital construction in safety-net hospitals.

Indiana

HMA Roundup—Cathy Rudd

Incumbent Vendor Chosen for Medicaid Fee-for-Service Prior Authorization and UM. On August 9, 2013, the Indiana Department of Administration announced that Advantage Health Solutions—an incumbent vendor competing with four other vendors—was selected to enter into contract negotiations for the $12.8 million Medicaid prior authorization and utilization management function on behalf of the Indiana Family & Social Services Administration, Office of Medicaid Policy and Planning.

Public Opportunities for Input on Medicaid Managed Care for ABD Population. The House Enrolled Act 1328 requires a report from the Indiana Family and Social Services Administration (FSSA) on three approaches to Medicaid managed care for the blind, aged, and disabled Medicaid population: risk-based capitated managed care; managed fee-for-service; and home and community based services management program. The FSSA ABD Task Force will host three public opportunities for stakeholders (August 15 and 16) and interested parties (August 19) to provide input into the process. A report will be delivered to the legislative Health Finance Committee by December 15, 2013.

Iowa

HMA Roundup

Wellmark Foresees Problems with the State's Exchange. On Wednesday, August 7, 2013, John Forsyth, chairman of Wellmark Blue Cross and Blue Shield, predicted that the state's health exchange would experience difficulties, at least initially. The state's dominant provider of individual and small group health plans decided not to participate in the Iowa health exchange in 2014 because the government is far behind its own deadlines in establishing the exchanges. Although Governor Terry Branstad personally requested Wellmark to participate, the insurer determined to stand aside until 2015. Meanwhile, Governor Branstad believes that the exchange would feature at least two plan options across the state despite Aetna's recent decision to pull out of various other state exchanges. Aetna's Coventry unit is one of two carriers that applied to offer has yet to sign a contract with the state.

Maryland

HMA Roundup

New Health Quality Director Named. On August 7, 2013, the Maryland Department of Health and Mental Hygiene (DHMH) Secretary Dr. Joshua Sharfstein announced the appointment of Dr. Tricia Tomsko Nay as the Executive Director of the Office of Health Care Quality (OHCQ). The OHCQ is responsible for monitoring the quality of care at 14,000 health facilities and programs in Maryland. Dr. Nay joined OHCQ as medical director in 2008 and served as acting executive director since January 2013. Dr. Nay is a fellow of the American Academy of Family Practice, the American Academy of Hospice and Palliative Medicine, and the American Institute for Healthcare Quality. She previously served as a Deputy Medical Examiner in Montgomery County.

Massachusetts

HMA Roundup—Tom Dehner and Rob Buchanan

Beth Israel to Absorb Jordan Health Systems. Last week, Beth Israel Deaconess Medical Center (BIDMC) and Jordan Health Systems Inc. (JHSI) announced an agreement that would result in Beth Israel becoming JHSI's corporate parent. The state's Public Health Council must approve the plan and the Massachusetts Health Policy Commission will conduct a "cost and market impact review." Assuming state and federal approvals, the hospitals will work to expand the number of primary care physicians and specialists in the Plymouth area to enable patients to stay closer to home for outpatient treatment. The agreement will likely lead to Harvard Medical School faculty appointments for certain JHSI physicians, collaborative health care quality initiatives, and shared electronic medical records to foster coordination of care.

New Hampshire

HMA Roundup

Harvard Pilgrim to Offer NH Exchange Plan in 2015. On Friday, August 9, 2013, Harvard Pilgrim Health Care indicated its intention to offer health exchange plans in New Hampshire in 2015. For 2014, only Anthem Blue Cross and Blue Shield will participate on the state's exchange.

New York

HMA Roundup—Denise Soffel

Court Delays NYC Health Insurance RFP Effort. Mayor Michael Bloomberg has consistently pushed for changes to the city's health insurance plans to boost cost-sharing and slow the rate of healthcare cost growth. On Friday, August 9, 2013, the Municipal Labor Committee, a coalition of unions, filed obtained a temporary restraining order stalling the city's effort to seek bids for its health insurance plan. The mayor hopes to save $400 million a year on the city's $6 billion healthcare costs.

Medicaid Enrollment and Spending. New York State's Medicaid enrollment reached 5,295,204 in May 2013, an increase of 42,500, or 0.8 percent, since the beginning of the fiscal year April 1. Enrollment in the fee-for-service program declined by 1.2 percent as the state continues to implement its Care Management for All strategy. Medicaid spending under the SFY 2014 global cap through May 2014 is $5 million or 0.2 percent under the target. The state is anticipating Medicaid rate adjustments resulting in price increases of up to $490 million this fiscal year. Details, including spending by region, can be found in the monthly Global Spending Cap report available **here.**

NYS and CMS Still Working on Clarifications on Year-Old Waiver Application. CMS weighed in on the impasse between the feds and New York State, which filed a Medicaid waiver request in August 2012. Such waiver requests are complicated, and CMS has never set a deadline for granting states' requests. The agency "has been collaborating with New York on their waiver proposal to improve their Medicaid program," said a spokesman.

North Carolina

HMA Roundup

NC DHHS to Quintuple Office of Internal Audit. On August 7, 2013, the North Carolina Department of Health and Human Services announced the expansion of its Office of Internal Audit from eight to 40 to increase efficiency and accountability. Health and Human Services Secretary Aldona Wos said that staffing for the Office of Internal Audit has not kept up with growth in the $18 billion department. Recently, the state's Medicaid program had $485 million in unexpected shortfalls due to forecasting and other errors.

Ohio

HMA Roundup

Aetna Withdraws from Ohio Exchange. Last week, Aetna told the state of Ohio that it was withdrawing its individual exchange filing in Ohio for 2014, but would continue with its Coventry individual product on the exchange. Aetna intends to continue with its individual product outside the exchange market.

Oregon

HMA Roundup

Oregon Exchange Unavailable to Enroll Online by October 1. As one of the 14 states building its own health exchange, Oregon has hit a snafu that will delay the opening of its online marketplace until later in October, at the earliest. Last week, Cover Oregon officials said the exchange could begin enrolling beneficiaries starting on October 1, but only through an agent or community partner, not online. Approximately 1,000 agents and 800 community partners have been trained to navigate people through the site. However, due to concerns about systems capabilities and capacity, the exchange will limit access to the site for two to four weeks while they fix flaws before making the online marketplace fully accessible to the general public. Cover Oregon appears to be operating with a $16 million shortfall following a "misprojection" of remaining funds under a $59 million Federal grant.

Pennsylvania

HMA Roundup – Matt Roan

Court Rules Providers Were Overcharged by State for Medical Malpractice Fund. On Monday, August 12, 2013, the Commonwealth Court ruled 6-1 in favor of healthcare providers who accused Pennsylvania of overcharging them for a medical malpractice insurance fund, when the fund had significant unspent balance from prior years. The excess balance was transferred into a general fund that did not help providers receive affordable liability insurance.

Tennessee

HMA Roundup

Governor Haslam Unclear on TennCare Expansion. Facing an end-of-summer deadline to determine Medicaid expansion in his state, Tennessee Governor Bill Haslam indicated last week that he remains unclear about a potential TennCare expansion using a premium assistance approach. Haslam said that he would like to avoid the potential for cutting TennCare rolls once the full 100% Federal subsidy was reduced in the future. Haslam plans to visit Washington DC to get further clarity from the Federal Health and Human Services Department on the state's options and prospects.

Texas

HMA Roundup—Dianne Longley and Linda Wertz

HHS Secretary Offers Openness to "Uniquely Texan" Medicaid Expansion. On Thursday, August 8, 2013, HHS Secretary Kathleen Sebelius announced openness to a "uniquely Texan" option to expand Medicaid eligibility in the state. Various proposals to tailor an expansion that would be acceptable to Governor Rick Perry and various legislators ultimately failed during the most recent legislative session.

Texas Refuses to Enforce ACA Health Insurance Reforms. Texas is one of six states that have informed the Federal Government that it will not enforce provisions and regulations of the Affordable Care Act. As a result, CMS must step in to fill the role of reviewing insurance forms and responding to consumer complaints. A spokesman for the Texas Department of Insurance stated that the agency cannot enforce regulations not embedded in state law. Texas was not required to respond to a federal request for information about its insurance plans by July 31.

Vermont

HMA Roundup

Vermont First in Nation to Finalize Premiums and Choices for Health Exchange. On August 7, 2013, Vermont's House health care committee members got a briefing on the state's progress in meeting health reform requirements. Vermont Health Connect's web site is live, offering residents the chance to compare up to 18 plans—including premiums and networks—and determine eligibility for additional financial assistance. Governor Peter Shumlin proudly declared Vermont as the first state to "finalize both its premiums and its choices for its health insurance marketplace."

Washington

HMA Roundup

Washington Announces Qualified Health Homes Plans. On August 9, 2013, the Washington State Health Care Authority announced "apparently successful" applicants for the designation as Qualified Health Homes. For Coverage Area 1 (Clallam, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, and Thurston Counties), both Coordinated Care Corporation and Molina Healthcare of Washington, Inc. were named. Provisional designation was offered to Community Health Plan of Washington, United Behavioral Health, and UnitedHealthcare of Washington, Inc., assuming that each submits a satisfactory corrective action plan and implementation timeline. For Coverage Area 2 (Island, San Juan, Skagit, and Whatcom Counties), provisional designation was offered to Community Health Plan of Washington, Coordinated Care Corporation, Molina Healthcare of Washington, Inc., Northwest Regional Council, and UnitedHealthcare of Washington, Inc., assuming that each submits a satisfactory corrective action plan and implementation timeline. For Coverage Area 6 (Adams, Chelan, Douglas, Ferry, Grant, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, and Whitman Counties), only Molina Healthcare of Washington, Inc. was named an apparently successful applicant. Provisional designation was offered to Community Choice Healthcare Network, Community Health Plan of Washington, Coordinated Care Corporation, and UnitedHealthcare of Washington, Inc., assuming that each submits a satisfactory corrective action plan and timeline. Services should begin on or around October 1, 2013.

Washington Exchange to Lack Chatting Feature Initially. While other states grapple with difficulties in implementing their exchanges, Washington has generally been ahead of its peers in meeting deadlines and benchmarks. Unfortunately, it appears that Healthplanfinder will open in October without an originally planned chat feature, which might limit consumers' ability to get help with enrollment and for brokers to be paid for their services. Exchange officials plan to include the feature upon the release of the next version.

Lack of Exchange Plan Choices Assailed by Critics. When Washington approved four companies to offer individual health plans on the state's exchange, it rejected five other applicants, raising concerns about consumer options from various corporate, political, and advocacy corners. Three of the rejected companies had been approved to deliver Medicaid plans, but will be unable to offer bridge coverage to beneficiaries whose incomes may temporarily exceed Medicaid eligibility thresholds. State Insurance Commissioner Mike Kreidler determined that some plans were unable to develop sufficient provider networks or comply with other regulations.

Wisconsin

HMA Roundup

Wisconsin Requests Federal Approval to Change BadgerCare Plus Income Eligibility. On August 9, 2013, Wisconsin's Department of Health Services requested CMS approval to narrow income eligibility thresholds for the state's BadgerCare Plus Medicaid program. The state's budget calls for the cutoff to be 100 percent of the Federal Poverty Level, down from the current 200 percent. In addition, the budget would eliminate BadgerCare Plus Core, for childless adults. Governor Scott Walker envisions that those beneficiaries who would be dropped from BadgerCare Plus Core to be eligible either for the full BadgerCare Plus program or for federal premium subsidies on the state's health exchange.

Wisconsin Submits Revised Duals Demonstration MOU to CMS. On August 12, 2013, Wisconsin's Department of Health Services (DHS) submitted their proposed memorandum of understanding (MOU) on the dual eligible integration demonstration to CMS for approval. The MOU proposed deviates from the framework of the financial alignment demonstration MOU template provided by CMS. In a letter accompanying the proposed MOU, DHS asked for approval of the MOU by March 1, 2014, indicating that they would otherwise withdraw from the demonstration.

In the news

"UnitedHealthcare, Humana eventually may enter Wisconsin exchange" Although it was revealed that United and Humana will not participate in Wisconsin's exchange in 2014, both companies will continue to consider participation in coming years. Additionally, Milwaukee, Wisconsin-based Assurant Health announced that it will begin offering plans on the exchange in 2015. (Milwaukee Business Journal)

National

HMA Roundup

State Tax Revenues Show 13 Straight Quarters of Growth, says Rockefeller Institute. According to the Rockefeller Institute of Government's most recent State Revenue Report, state tax revenues for the first quarter of 2013 were up 8.6 percent from the year prior, largely due to higher income growth. However, the report notes that strong growth in income tax revenues was not evenly distributed across all states, with California significantly driving up the national growth rate. Additionally, the report notes that overall state tax collections have rebounded above the levels reported in early 2008, prior to the economic downturn, in 39 states.

HHS Awards for ACA Navigators Anticipated August 15. Community-based organizations in 34 states are awaiting the announcement of $54 million in funding for Navigators from the Department of Health and Human Services (HHS), expected to be announced August 15. Additionally, the Center for Consumer Information and Insurance Oversight (CCIIO) is anticipating awarding an additional $30 million contract for in-person enrollment assisters in certain states.

Some Insurers to Get One-Year Grace Period on Out-of-Pocket Cost Limits. Department of Labor administrators confirmed this week that the Affordable Care Act's limit on individual out-of-pocket costs would be delayed until 2015 for many group health plans. Enrollees in certain health plans will see higher limits or no limits at all for 2014. Under the rule limiting out-of-pocket costs, individual expenses were not to exceed $6,350 per year, while costs for a family were to be capped at $12,700.

INDUSTRY NEWS

Magellan to Increase Ownership in AlphaCare of New York. Magellan Health Services has entered into an agreement to invest in AlphaCare of New York, taking a 65 percent ownership stake in the company. AlphaCare is a recently licensed Medicaid managed long term care (MLTC) plan and Medicare plan in New York State. AlphaCare operates a Medicaid MLTC Plan in Bronx, Kings, New York, Queens, and Westchester Counties and Medicare Plans in Bronx, Kings, New York, and Queens Counties. It began enrolling members in August. In addition, AlphaCare applied to participate in the New York Fully Integrated Duals Advantage (FIDA) Demonstration Program, a capitated dual eligible financial alignment model, in Bronx, Kings, New York, and Queens Counties and was selected to participate in all four counties.

Independence Blue Cross Requests Approval to Change Corporate Structure. On Thursday, August 8, 2013, Independence Blue Cross filed a request with the Pennsylvania Insurance Department to change its corporate structure, although it would remain a non-profit tax-paying entity. The redesign envisions a non-profit corporate parent holding company, as well as a for-profit holding company, beneath it, carrying the AmeriHealth name. The AmeriHealth holding company would include existing subsidiaries and affiliates, simplifying the organization's financial reporting and transparency. IBC and its affiliates and subsidiaries span 22 states and the District of Columbia, serving more than 7 million beneficiaries.

Allina and BCBS of MN Partner on New Insurance Plan. On August 6, 2013, Blue Cross Blue Shield of Minnesota and the Allina Integrated Medical Network of Allina Health announced a partnership that will deliver a new kind of health plan to the Twin Cities: BluePrint by Blue Cross and Allina Health. The plan aims at collaborative care management, increased patient engagement, and a more customer-friendly approach to individualized care. The plan will be available for individuals and employers in the 11-county Twin Cities metropolitan area on the state's MNsure health exchange. Premiums should be lower than more open choice PPO plans because patients are limited to Allina hospitals, clinics and the 53 independent physician groups in its network. Core to this plan's focus will be preventive care for individuals with chronic conditions and more active ongoing care management.

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	Implementation	22,700
November 1, 2013	Florida LTC (Regions 1,2,10)	Implementation	13,700
November 1, 2013	Hawaii	Proposals Due	292,000
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
January 6, 2014	Hawaii	Contract Awards	292,000
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
January 1, 2015	Hawaii	Implementation	292,000

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	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model					
California	Capitated	456,000	X	3/1/2012	4/4/2012	X	1/1/2014	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
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	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714					TBD	
Idaho	Capitated	22,548	June 2013	TBD	August 2013	7/25/2013	4/1/2014	Blue Cross of Idaho; Regence
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	X	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
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	Aetna; CareSource; Centene; Molina; UnitedHealth
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	Humana; VA Premier; WellPoint/Amerigroup
Vermont	Capitated	22,000	10/1/2013	TBD	TBD	7/15/2013	9/1/2014	
Washington	MMFS Capitated	115,000	X X	5/15/2013	6/6/2013	MFFS Only	7/1/2013 1/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
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

"Review of State Approaches to Medicaid Expansion"
Virginia General Assembly Medicaid Innovation and Reform Commission

Vern Smith - Presenter
August 19, 2013
Richmond, Virginia

Vern Smith, Managing Principal at HMA, will join Cynthia B. Jones, Director of the Department of Medical Assistance Services, and Darin J. Gordon, Director of TennCare, to explain state approaches to Medicaid expansion. States to be highlighted include Michigan, Arkansas, Indiana and/or Ohio, and Tennessee. The session will also look at Medicaid managed care and dual eligible demonstration projects.

"Accountable Care: How PCAs and HCCNs Can Drive Quality and Data Usage at the Local Level"
National Association of Community Health Centers 2013 Community Health Institute

Art Jones – Panelist
August 26, 2013
Chicago, Illinois

While the concept of Accountable Care Organizations was created by CMS, managed care organizations have taken this strategy and adapted it to meet their core business objectives. PCAs and HCCNs are uniquely positioned to play a pivotal role in building state and local infrastructures to support these new business ventures.

This session will provide an overview of the United Healthcare ACO strategy and its translation to an actual Accountable Care "Platform" at the local level and how the health center movement needs to respond by reinventing operations and partnership strategies to succeed.