HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 9, 2013

RFP Calendar

Dual Eligibles Calendar

HMA News

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IN FOCUS

HIGHLIGHTS FROM KAISER/HMA 50-STATE MEDICAID DIRECTOR SURVEY

This week, our *In Focus* section reviews highlights and shares key takeaways from the Kaiser Commission on Medicaid and the Uninsured's (KCMU) new report, ***Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014***, released on Monday, October 7, 2013. The report, published annually, was prepared by Vernon K. Smith, Ph.D., Kathleen Gifford, and Eileen Ellis from HMA, and by Robin Rudowitz and Laura Snyder from the Kaiser Commission on Medicaid and the Uninsured. HMA's Jenna Walls and Dennis Roberts also contributed to the report.

The findings in this report are drawn from the 13th consecutive year of the KCMU and HMA budget survey of Medicaid officials in all 50 states and the District of Columbia. This survey reports on trends in Medicaid spending, enrollment, and policy initiatives for FY 2013 and FY 2014. The report describes policy changes in reimbursement, eligibility, benefits, delivery systems, and long-term care and includes detailed appendices with state-by-state information, and a more in depth look through four state-specific case studies of Medicaid budget and policy decisions in Arizona, Florida, Kentucky, and Washington. Links to the executive summary and full report are provided below:

Link to Executive Summary (PDF)

Link to Full Report (PDF)

Report Summary Points

- Nearly all states are developing and implementing payment and delivery system reforms designed to improve quality, manage costs, and better balance the delivery of long-term services and supports across institutional and community-based settings.
- Implementation of the Affordable Care Act (ACA) will result in major changes to Medicaid eligibility and enrollment, regardless of a state's decision to move forward with Medicaid expansion.

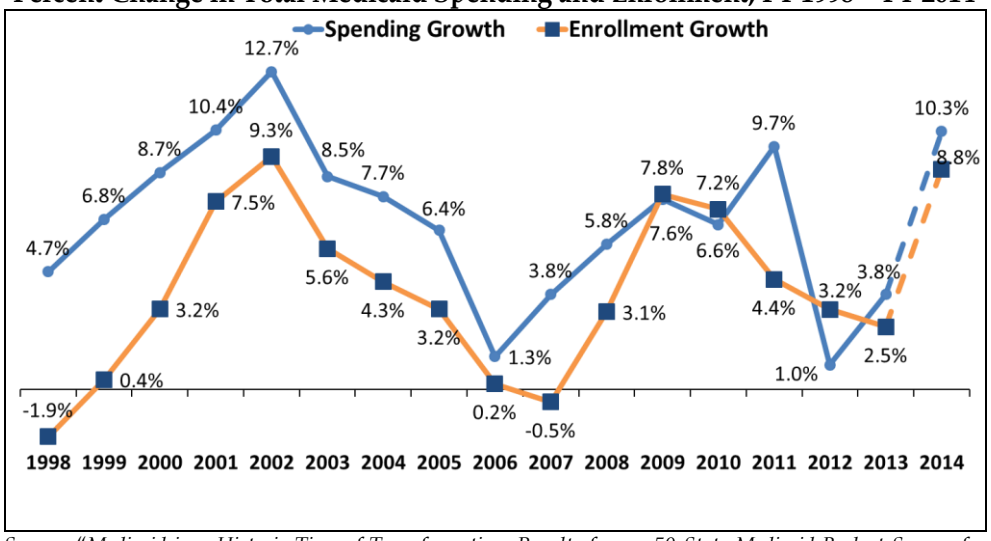
- Economic improvement in states drove modest growth in Medicaid spending and enrollment in FY 2013. In FY 2014, states are anticipating an increase in both enrollment and spending and higher levels of enrollment and total spending growth in states moving forward with the Medicaid expansion.
- Economic improvement has allowed states to restore previous cuts to Medicaid benefits and eligibility as well as improve provider payment rates. However, states are still adopting policies to control costs and enhance program integrity.
- As the report's title indicates, FY 2014 will be a transformative year for Medicaid programs across the U.S.

Key Report Highlights

Medicaid Spending and Enrollment Growth Rates

- FY 2012 total Medicaid spending increased at one of the lowest annual rates on record, on average by 1.0 percent across all states. In FY 2013, spending growth edged up to 3.8 percent across all states, while Medicaid enrollment growth fell to its lowest rate since FY 2007, at just 2.5 percent.
- FY 2014 state budget appropriations are projecting significant growth in both spending and enrollment, with anticipated growth in enrollment of 8.8 percent and growth in spending of 10.5 percent across all states.

Percent Change in Total Medicaid Spending and Enrollment, FY 1998 – FY 2014



Source: "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014" Kaiser Commission on Medicaid and the Uninsured. October 2013.

- In the 25 states moving forward with Medicaid expansion at this time, enrollment growth is projected at 11.8 percent and spending growth at 13.0 percent.
- In the remaining 26 states not moving forward with Medicaid expansion at this time, enrollment growth is projected at 5.3 percent and spending growth at 6.8 percent.

Medicaid Eligibility and Enrollment Changes Coming

- The ACA requires states to coordinate enrollment between Medicaid and the new health insurance Marketplaces. In 23 states, the Marketplace will conduct an initial assessment of Medicaid eligibility and allow Medicaid to

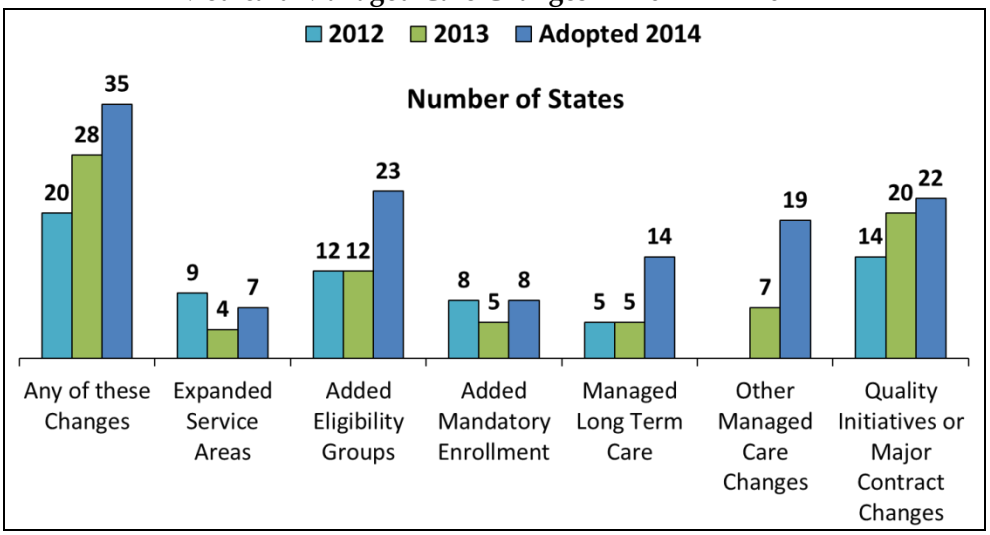
make a final eligibility determination. In 12 states, the Marketplace will make final Medicaid eligibility determinations.

- In FY 2014, all states will transition to a uniform income standard under the ACA, as well as changes to CHIP eligibility and new application, enrollment, and renewal processes.
- Beyond these requirements, 29 states are implementing eligibility expansions: 25 states expanding Medicaid, 4 states increasing or eliminating income or assets for long-term care, and 2 states expanding family planning.
- Additionally, 38 states are implementing application and renewal simplifications: 31 states extending renewals set for Q1 of 2014; 15 states implementing early adoption of the modified adjusted gross income (MAGI) eligibility standard; 7 states enrolling individuals based on SNAP eligibility; 4 states enrolling parents based on children's income eligibility; and 3 states implementing 12-month continuous eligibility.

Payment and Delivery System Reforms

- Medicaid managed care is a significant area of change in both fiscal years. In FY 2013, four states expanded the geographic coverage of managed care, and seven states are planning geographic expansions in FY 2014. Additionally:
    - 23 states are planning eligibility group expansions, up from 12 in FY 2013;
    - 8 states are adding mandatory enrollment, up from 5 states in FY 2013;
    - 14 states are implementing or expanding their managed long-term supports and services (LTSS) programs, up from 5 states in FY 2013; and
    - 22 states are implementing quality initiatives or other major contract changes in their managed care programs.

Medicaid Managed Care Changes FY 2012 – FY 2014



Source: "Medicaid in a Historic Time of Transformation: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2013 and 2014" Kaiser Commission on Medicaid and the Uninsured. October 2013.

- Many states are taking advantage of the health homes model created by the ACA, with 21 states undertaking Medicaid health homes initiatives in FY 2014, up from just 6 states in FY 2013.
- In addition to the 14 states planning to integrate care for dual eligibles through the financial alignment demonstrations, seven states indicated that they are implementing other dual eligible coordination initiatives in FY 2013 and FY 2014. Three states plan to expand their Program of All-Inclusive Care for the Elderly (PACE) programs serving dual eligibles.

Reimbursement Changes

Expiration of enhanced funding through the American Recovery and Reinvestment Act of 2009 (ARRA) extensive Medicaid reimbursement cuts to providers in FY 2012. In FY 2013 and anticipated for FY 2014, the number of states making reductions to provider rates is decreasing, while the number of states improving provider payment rates is increasing in four major categories of provider reimbursement. In FY 2014:

- 19 states are increasing inpatient hospital rates (up from 13 in FY 2013), while 31 states are reducing rates (down from 38 in FY 2013);
- 14 states are increasing physician rates (up from 6 in FY 2013), while 5 states are decreasing rates (up from 3 in FY 2013);
- 25 states are increasing MCO rates (up from 23 in FY 2013), while only 2 states are reducing MCO rates (down from 7 in FY 2013); and
- 38 states are increasing nursing home rates (up from 34 in FY 2013), while 12 states are reducing rates (down from 17 in FY 2013).

Looking Ahead: Perspectives of Medicaid Directors

When asked to identify the top issues and challenges for FY 2014 and beyond, Medicaid directors listed the following:

- The biggest challenges facing Medicaid programs are related to the ACA, particularly the changes in eligibility systems and policies and the coordination with health insurance Marketplaces.
- Medicaid directors are also challenged by the development and implementation of significant payment and delivery system reforms, including the integration of care for dual eligible individuals and greater attention to long-term care.
- Additionally, Medicaid directors reported being challenged by the continued focus on Medicaid costs and state budgets.
- Finally, Medicaid directors identified challenges with limited resources in staffing and funding, as well as the need for subject matter expertise in IT, Medicaid policy, and managed care.

HMA MEDICAID ROUNDUP

Alaska

HMA Roundup

Democrats Push for Medicaid Study; Gov. Parnell Still Undecided. Over the last year, Gov. Sean Parnell has resisted expanding Medicaid and remains uncertain about whether or not to include expansion in his budget proposal, due December 15. A consulting firm evaluated the costs of Medicaid expansion in a study delivered to the Department of Health and Social Services last April, but neither the department nor the governor has disclosed the findings. On October 4, 2013, Democratic state senators sent a letter to Gov. Parnell to make the study public, only to be rebuffed by Health Commissioner William Streur on the grounds of "deliberative process."

Arizona

HMA Roundup

Gov. Brewer Pushes for Dismissal of Lawsuit by Medicaid Expansion Opponents. On October 2, 2013, attorneys for Gov. Jan Brewer argued that there are no legal grounds for the Arizona lawmakers, who failed to prevent Medicaid expansion, to sue over a legislative loss, as there was no injury or harm incurred by the element being challenged: a provider tax. The Goldwater Institute argues that the passage of Medicaid expansion failed to meet the two-thirds majority threshold required for a tax increase and included an unconstitutional ceding of authority to the executive branch. Gov. Brewer has asked the court to dismiss the case.

Arkansas

HMA Roundup

Arkansans Encouraged by New Insurance Options. Within 48 hours of the launch of the Arkansas Health Insurance Marketplace, more 36,000 people visited the Arkansas Health Connector web site, with nearly half clicking the "Enroll Now" button. In September, the Department of Human Services reached out to 132,000 households of participants in various DHS programs to determine if they would seek coverage under the private option. Already, DHS received more than 55,400 affirmations, an "incredible response to a single letter", according to DHS Director John Selig.

California

HMA Roundup

Covered California Activates Doctor Search Feature Online. Following headlines around the country of glitches on health exchange websites, Covered California officials announced a critical fix to its site. As of October 7, 2013, consumers have been able to search for their health care providers before deciding on a health plan. That missing feature did not affect Kaiser's plan, which was a comprehensive provider network, but most other plans' narrower networks were limited in providing in-network provider information.

Provider Rates Being Cut, Even as Exchange Enrolls New Members. In a curious bit of timing, while California is in the process of adding nearly a million new lives to Medi-Cal, the state is implementing provider cuts to what are already some of the lowest rates in the nation. The phase-in of the 10 percent cuts in Medi-Cal rates to various providers has begun, although primary care physicians will see a slight increase and skilled nursing facilities attached to hospitals will avoid the cuts.

California State University System Promoting Exchange to Students. In the wake of a recent Kaiser Family Foundation poll that indicated 70 percent of respondents did not understand how the ACA affected them personally, the state of California has launched an advertising campaign and a concerted outreach campaign to boost public awareness. The California State University system boasts a diverse 437,000 student base. State officials estimate that up to 40 percent of the students are uninsured, with the vast majority making income less than four times the federal poverty level. As such, there is a major opportunity for these students to enroll in health plans offered on the state's exchange, with subsidies to pay for the insurance. Politico reports that the $1.25 million grant from the state's exchange has funded a concerted outreach effort.

Covered California Statistics Strong, Despite Initial Inaccuracies. According to the Los Angeles Times, while Covered California touted 5 million hits on its website on the first day of open enrollment, it turns out that the correct figures was about 645,000 hits. The misstatement by officials on the first day was an "internal miscommunication" relating to page views, rather than unique users, according to Peter Lee, executive director of Covered California. However, on October 8, Lee announced that 16,311 households completed health plan applications. Another 27,305 had created accounts with partially completed applications. Almost a million individuals had visited coveredca.com in the first week, while 59,000 calls were placed at two of the state's three call centers. Waiting times were cut from 30 minutes on the first day to 4 minutes by Friday and 30 seconds on Saturday.

Pharmacist Scope of Practice Bill Signed into Law. On October 1, 2013, Gov. Jerry Brown signed into law a bill (SB 493) that allows pharmacists to initiate certain prescriptions, consult with patients, and offer clinical advice. The law becomes effective January 1, 2014.

Long-Term Care Ombudsman Law Signed by Brown. On October 3, 2013, Gov. Jerry Brown signed into law a bill (SB 609) that bolsters the Office of the State Long-Term Care Ombudsman by increasing penalties for providers that interfere with investigations conducted by the office. The legislation was prompted by some cases of workers at long-term care facilities blocking ombudsman representatives from having private access to residents. The law becomes effective January 1, 2014.

Physical Therapy Bill Signed into Law. On October 7, 2013, Gov. Jerry Brown signed into law a bill (AB 1000) that allows patients to receive physical therapy without obtaining a physician's referral. The change in practice allows patients to see physical therapists for 12 visits or 45 days before requiring a physician's examination. Physicians are also allowed, under the new law, to establish their own physical therapy practices and refer patients to them. Some independent physical therapists complained about the law, because insurance companies and Workers Compensation plans will not pay for physical therapy without a physician's referral.

Colorado

HMA Roundup—Joan Henneberry

Colorado Authorizes Medicaid Billing for LARC Devices. This past week, Colorado became the second state (following South Carolina) to alter the way that Long Acting Reversible Contraceptive (LARC) devices, such as IUDs and implants, were reimbursed immediately postpartum. Previously, LARC could not be billed in a bundled labor and delivery payment, dissuading providers from prescribing them to new mothers despite ample research supporting the practice and demand for the devices. As of October 1, 2013, Medicaid providers can now bill for both the device and for the placement of long acting reversible contraceptive devices outside a global labor and delivery payment. Spacing births between pregnancies through the use of family planning and contraception is linked to reduced premature births and improved birth outcomes. Program data suggest policies guaranteeing adequate reimbursement to providers may lead to higher rates of LARC usage among patients, better health outcomes, and significant savings to Colorado Medicaid. Health Management Associates was involved in the research related to this policy and payment change.

State Supreme Court Agrees to Review Nurse Anesthetist Case. On October 7, 2013, the Colorado Supreme Court agreed to decide whether certified registered nurse anesthetists (CRNAs) will be allowed to administer anesthesia without physician supervision. In 2010, Governor Bill Ritter interpreted state law to permit the practice for Medicare patients. Two Colorado health societies sued to overturn the decision only to have the Denver District Court and Colorado Court of Appeals uphold the executive's decision. The state Supreme Court will evaluate whether the Court of Appeals erred in its upholding of the governor's decision.

Delaware

HMA Roundup

Delaware Legislators Consider Cutting Medicaid Spending. On October 3, 2013, State Medicaid Director Stephen Groff met with Delaware's Joint Finance Committee to discuss some of the primary cost drivers in the $700 million health program. Groff noted that the 100 percent federal subsidy for the newly expanded Medicaid population through 2016 and 90 percent federal funding longer term means that the expansion should not overly strain the state's budget. Overall, the federal share of Medicaid spending will grow from 55 percent to 77 percent. Groff noted that a shift from a fee-for-service payment system to an outcomes-based shared savings system could lower Medicaid spending.

District of Columbia

HMA Roundup

Government Shutdown Puts Medicaid Payments on Hold. With the federal government shutdown now in its second week, the District of Columbia's Medicaid managed care and provider payments have been placed on hold. Unlike states, whose Medicaid funding remains unaffected, the District is directly impacted because its federal operating funds have been cut off during the shutdown. While claims and capitated payments may be accrued, the cash flow impacts may become increasingly difficult for safety net providers to absorb the longer the shutdown continues.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida Corrections Health Vendors Have Faced Many Lawsuits. The BrowardBulldog.org published findings from its public records requests that indicate numerous lawsuits against the two vendors chosen by the state to administer healthcare for its North and Central Florida prison populations. Corizon has faced some 660 malpractice lawsuits over the last five years, nationwide, while Wexford Health Sources has faced more than 1,000 malpractice claims including suits, notices of intent to sue, and complaint letters.

Sebelius Encourages Medicaid Expansion in Visit with Tampa Navigators. On October 8, 2013, HHS Secretary Kathleen Sebelius visited with University of South Florida navigators, who received the largest grant in the state to help educate and enroll Florida residents in health plans. Sebelius acknowledged problems with the federal backbone for the state exchanges, due in part to the overwhelming use of the site nationwide. However, she would not quantify the number of consumers who have successfully enrolled, committing only to the monthly release of statistics. Sebelius reiterated her call for the state to expand its Medicaid program, pointing to nearly $51 billion in federal funds that will be left on the table over the next decade.

State Senate Takes Up Assisted Living Oversight Legislation. After passing assisted living (AL) oversight legislation that ultimately died in the House, Florida state senators have again taken up the cause to pass legislation that would tighten regulations, specify responsibilities for delivering mental health services to AL residents, clarify Ombudsman duties, and outline Agency for Health Care Administration licensing processes. Senator Eleanor Sobel, chair of the Children Families and Elder Affairs Committee, indicated said she may have a House sponsor for legislation. Senators called on the Agency for Health Care Administration to be more proactive in shutting down and prosecuting unlicensed providers.

AHCA Enhances Consumer Site to Support LTC Transition. On October 7, 2013, the Agency for Health Care Administration announced two key enhancements to its FloridaHealthFinder.gov website. The first improvement focuses on assisted living facilities, their services, license types, inspection reports, and facility search functions. The second improvement is the addition of a hub to explore nursing home options including decision support tools, inspection ratings, "Gold Seal" designated facilities, and "watch list" facilities. With the transition to managed long-term care, the AHCA has engaged in multiple educational sessions in English

and Spanish to ensure a seamless transition for all stakeholders.

The Long-Term Care Program will be live in all regions by March 2014. More information is available at http:/ahca.myflorida.com/SMMC.

AHCA Schedules Public Hearings on Medicaid Managed Care Waiver Extension. Florida operates Medicaid managed care under two federal waivers: the 1115 Managed Medical Assistance (MMA) Waiver and the 1915(b) Medicaid Managed Care Waiver. The 1115 waiver is effective through June 30, 2014 and the AHCA is seeking approval for a three year extension through June 30, 2017. In accordance with the federal requirement to hold public meetings 30 days prior to submitting a final waiver extension request, the Agency has scheduled three public meetings in Tampa, Miami, and Tallahassee for October 8, 9, and 11, respectively, to gather public input. The schedule is posted below.

Schedule of Public Meetings				
Location Address	**Date**	**Time**	**FAR Notice**	**Agenda/ Presentation**
Tampa Egypt Shriners 4050 Dana Shores Drive Tampa, FL 33634	October 8, 2013	1:00p.m. – 3:30p.m.	To be posted	To be posted
Miami Florida International University (FIU) Kovens Center 3000 N.E. 151 Street North Miami, FL 33181-3000	October 9, 2013	1:00p.m. – 3:30p.m.	To be posted	To be posted
Tallahassee Agency for Health Care Administration 2727 Mahan Drive, Building 3, 1st Floor Conference Room A Tallahassee, FL 32308	October 11, 2013	1:00p.m. – 3:30p.m.	To be posted	To be posted

Georgia

HMA Roundup – Mark Trail

State ABD RFP May Be Pushed to End of October. Sources indicate that the Georgia Medicaid managed care RFP for the Aged, Blind, and Disabled (ABD) population may be delayed until the end of October 2013. It remains unclear if this delay will affect the implementation date.

Conservative Georgia District Hails the Shutdown. The New York Times recently profiled Rep. Tom Graves, a Republican representing the 14th Congressional District of Georgia, as one of the key figures behind the government shutdown, given his sponsorship of the "Defund Obamacare Act." In contrast to many public opinion polls criticizing the GOP for its insistence on tying the ACA to continuing budget resolutions, many voters in this district praise the resoluteness of Graves and Republicans, who are characterized as willing to compromise.

Georgia Tax Collections Up 5.8 Percent Year-to-Date. This past week, Gov. Nathan Deal announced that Georgia's net tax collections for the month of September rose 8.3 percent over the comparable year ago period to $1.72 billion. Year-to-date, the $4.48 billion in net tax collections have grown 5.8 percent over the comparable year ago period.

Illinois

HMA Roundup – Andrew Fairgrieve and Erika Wicks

Dual Eligible Enrollment Delayed One Month. Illinois' Department of Healthcare and Family Services (HFS) announced on Tuesday, October 8, that enrollment in the state's dual eligible financial alignment demonstration would be delayed by one month, with voluntary enrollment set to begin February 1, 2014, followed by passive enrollment beginning May 1, 2014. The state's duals demonstration, known as the Medicare-Medicaid Alignment Initiative, or MMAI, is targeting more than 130,000 dual eligibles in the Chicago and Central Illinois regions.

Medicaid-Only ABD Managed Care Expansion Underway. Illinois' expansion of its Integrated Care Program (ICP) is underway into five new regions. The ICP launched in suburban Chicago in 2011, with Aetna and IlliniCare (Centene) as the two MCOs serving the Medicaid-only aged, blind, and disabled (ABD) population. As part of a broader managed care initiative, HFS is expanding the ICP into Rockford, Central Illinois, Metro East, and Quad Cities regions this year and into the City of Chicago in early 2014. As of September 2013, more than 3,100 have been enrolled in the Rockford region with Aetna, Centene, and Community Care Alliance of Illinois. Nearly 1,700 enrollees have enrolled in Meridian Health Plan, Molina, or Health Alliance in Central Illinois, and just over 160 beneficiaries have enrolled in either Meridian or Molina in the Metro East region. Enrollment notices have been sent to eligible individuals in the Quad Cities region.

Complex Children Care Coordination Awards Announced. Illinois HFS has announced three awards to care coordination entities (CCEs) to serve the Medicaid complex children population. The three CCEs awarded are La Rabida Children's Hospital in Chicago, Lurie Children's Hospital of Chicago, and OSF Healthcare System in Peoria. CCEs are provider-based networks organized to provide care coordination alternatives to capitated managed care.

Community Care Alliance of Illinois Approved as Medicare Advantage Plan. Community Care Alliance of Illinois (CCAI), a subsidiary of local not-for-profit Medicaid managed care organization Family Health Network, has received approval to operate a Medicare Advantage plan in Illinois. CCAI was awarded a contract to serve as a Managed Care Community Network (MCCN) in Rockford and the Chicago area. CCAI has already enrolled more than 1,200 Medicaid-only seniors and persons with disabilities in the Rockford area under the state's Integrated Care Program expansion. CCAI was the lone unsuccessful bidder in the state's dual eligible financial alignment demonstration procurement.

Indiana

HMA Roundup—Cathy Rudd

Indiana Attorney General Sues IRS over Employer Mandate Regulations. On October 8, 2013, Indiana Attorney General Greg Zoeller sued the IRS on behalf of 15 school districts for allegedly overstepping its authority in imposing "employer mandate" regulations on state and local governments under the Affordable Care Act. The lawsuit contends the IRS is improperly treating Indiana as a taxable entity under the Affordable Care Act with regulations that impose financial penalties on state and local governments including school districts. It further contends those penalties cannot be applied to government employers in states like Indiana that did not create their own state health care exchanges.

Kansas

HMA Roundup

KanCare Critiques Offered to Legislative Committee. On October 7, 2013, the Joint Committee on Home and Community Based Services and KanCare Oversight heard positive testimony from state officials and health plans as well as complaints from healthcare providers and consumers. Shawn Sullivan, director of the Kansas Department of Aging and Disability Services, noted that some home care clients' authorized hours are being cut reflecting that some basic housekeeping tasks should be performed by able-bodied family members, consistent with long-standing policy. Complaints were reported by hospitals and providers that KanCare has created more bureaucracy, delayed payments, inaccurate reimbursements, and denials of necessary care. On Jan. 1, 2014, KanCare will begin to administer home- and community-based services for the developmentally disabled.

Maine

HMA Roundup

$19 Million Cut from Riverview Psychiatric Center. On October 3, 2013, the federal government cut $19 million in funding from the Riverview Psychiatric Center in Augusta (representing half the hospital's operating budget) following a critical CMS review citing overcrowding, the use correctional officers, and improper staff cost allocations. Maine's Department of Health and Human Services Commissioner Mary Mayhew appealed the decision and the Department is investigating options to deliver services without federal funds.

MaineCare NEMT Provider Told to Improve Performance. On September 30, 2013, Maine's Medicaid Director Stefanie Nadeau wrote Coordinated Transportation Solutions—a provider of non-emergency transportation services—to complain about poor performance and require a corrective action plan by October 7, 2013. CTS took over the program for parts of Maine on August 1, and since that time the Medicaid agency has received numerous complaints about missed rides, inadequate transportation provider coverage, and poor customer service. While the state requires 90 percent of calls to be answered by a live representative in 60 seconds or less, the call abandonment rate has been between 15 and 58 percent with average wait times of 3 to 24 minutes. Significant measurable improvements are required by December 1, 2013, or the agency may impose sanctions.

Maryland

HMA Roundup

Maryland Health Exchange Performance Stats Show High Interest and Few Enrollments. On October 7, 2013, Maryland Health Connection released a report outlining its first week's performance. While 174,000 unique visitors checked in with 10,500 calls and 13,500 new accounts, just 326 residents successfully enrolled in plans. The website faced technical difficulties on its first day with various error messages and frozen screens, but the exchange has added server capacity and plans a software upgrade and nightly technical fixes.

Massachusetts

HMA Roundup

Massachusetts Promotes Price Transparency for Healthcare Consumers. Effective October 1, 2013, a new state law went into effect requiring health insurers to be able to tell consumers the cost of healthcare procedures, in advance, in order to promote comparison shopping and more educated healthcare utilization. Insurers are concerned that the law holds health plans responsible if their estimates are wrong. Blue Cross now offers a cost estimator for PPO members, but will only offer binding estimates for members who complete a form or register on a toll-free line. Hospitals are on the hook to provide similar cost information beginning January 1, 2014.

Michigan

HMA Roundup—Esther Reagan

Duals Demonstration Bidders and Regions. Health Management Associates has obtained information about the current state of the Michigan's duals demonstration program from the state Department of Technology, Management, & Budget. Below we present the bidders by region. Region 7 encompasses Wayne County; Region 9 covers Macomb County; Region 4 represents the eight-county region in SW Michigan; and Region 1 is the Upper Peninsula. Readiness reviews are anticipated to begin in November 2013 and implementation is currently planned for July 1, 2014.

Bidder	Region 7	Region 9	Region 4	Region 1
AmeriHealth	X	X		
CoventryCares	X	X	X	
Fidelis Secure Care	X	X		
McLaren	X	X		
Meridian	X	X	X	
Midwest	X	X		
Molina	X	X		
ProCare	X	X		
United	X	X		
Upper Peninsula Health Plan				X

Minnesota

HMA Roundup

CieloStar's Private Health Exchange Benefits from ACA. The Star Tribune profiled CieloStar, a Minnesota firm that has been building private health exchanges that have benefited from the Affordable Care Act. The company believes it will double in size in 2014 due in part to agreements with chambers of commerce, which could usher in thousands of new enrollees.

MNsure Faced with Technical Challenges. Following the glitches of week one, Minnesota's exchange appears to be facing different technical difficulties in week two that have impeded account registrations. Despite these challenges, on October 7, 2013, the site logged 4,300 unique visitors and, 6,000 people have created MNsure accounts in the last week, including 163 employer accounts. The exchange plans will release more data on October 16 about the types of plans being chosen and more comprehensive usage statistics.

Mississippi

HMA Roundup

Mississippi Democrats to Raise Medicaid Expansion in Next Session. A Reuter's article highlights the unique situation of Mississippi with regard to health reform. The state is among the 25 that opted not to expand Medicaid and routinely ranks near the bottom of many public health measures. However, Governor Phil Bryant rejected Medicaid expansion on the basis that additional administrative costs would have been too high, thus turning down some $426 million in Federal funds that would have otherwise flowed into the state. House Minority Leader Bobby Moak said that "the healthcare act was written for Mississippi", but the politicians decided to turn it down. With a decline in disproportionate share payments, the state's hospitals are in a precarious financial situation, which might actually be the issue that changes Governor Bryant's mind, according to some advocates. Democrats have announced they intend to press the Medicaid expansion issue again in the next session.

New Hampshire

HMA Roundup

Medicaid Special Panel Votes 8-1 to Authorize Expansion in a Special Session. On Tuesday, October 8, 2013, a special panel voted 8-1 to recommend the Legislature meet in a special session to authorize the expansion of the state's Medicaid program, effective January 1, 2014, subject to CMS approval. A key stipulation is that for the working poor, the state would pay to keep them on their employer's private plans, if that is more cost-effective than using the Medicaid program. Most panelists also require the Legislature to reauthorize the program should the Federal Government reduce its projected funding levels in the future. The panel must make its final recommendations to the Legislature by October 15.

Legislator Considering Applying Enterprise Tax to Not-for-Profit Hospitals. Last week, the Concord Monitor reported that Representative David Hess is evaluating a proposal to apply the state's business enterprise tax to not-for-profit hospitals, partly due to the generous compensation packages of hospital executives. By mid-November, Hess has to determine whether or not to file his draft bill, which would tax the pay of not-for-profit hospital executives.

New York

HMA Roundup—Denise Soffel

More than 40,000 New Yorkers Sign Up for Marketplace Plans in One Week. On October 8, 2013, the New York State Department of Health announced that more than 40,000 New Yorkers signed up for insurance on the state's health insurance marketplace, surpassing that of any other state. Following reports of 30 million hits in the first few days, NY State of Health has improved its web site and added server capacity to handle the volume of inquiries.

Medicaid Eligibility Changes. New York State's Department of Health has posted an administrative directive (ADM) on its web site that sets forth changes in Medicaid eligibility as a result of the ACA. The administrative directive, which is written for county commissioners of social service, where administrative responsibility for Medicaid enrollment is currently housed, includes four topics:

- Expanded Medicaid coverage under the ACA
- MAGI budgeting
- Benchmark Medicaid benefits
- New Medicaid enrollment procedures through the health benefit exchange, NY State of Health

New York's state-operated marketplace went live on October 1, and is accepting Medicaid applications as well as enrollment in coverage offered through the exchange. The ADM can be found here.

Coverage through the Marketplace May Limit Access to Select Hospitals. A report on WNYC radio highlights the fact that not all hospitals are part of the new insurance plans being offered through the New York health insurance marketplace. Eleven plans are offering a product through the exchange in New York City, and their networks vary substantially. The two highest ranked hospitals in NYC (according to the US News and World Report rankings), New York-Presbyterian University Hospital, and the NYU Langone Medical Center, have both only contracted to join the network of two plans (although not the same plans). In an effort to keep insurance rates competitive, health plans are aggressively negotiating with providers, and offering rates that are sometimes below Medicaid rates. The result is narrow provider networks, with potential access concerns for consumers purchasing coverage through the exchange.

Mental Health Restructuring Continues. The Behavioral Health work group of the Medicaid Redesign Team met to continue their work on restructuring the behavioral health benefits within the Medicaid program. State officials provided an update on their conversations with CMS regarding program design. As previously reported, the state has decided to delay implementation of the program for nine months, establishing Health and Recovery Plans (HARPs) in New York City effective January 2015, and throughout the rest of the state effective July 2015. HARPs are being designed as a product line to be offered by mainstream Medicaid managed care plans currently participating in the program. HARP enrollment will be open to Medicaid beneficiaries with serious mental illness and/or substance use disorders, based on a pattern of high utilization/high cost.

As initially designed, anyone enrolled in a HARP was to be offered a comprehensive benefit package that not only included all physical health services and enhanced behavioral health services and care management, but also a list of services currently only available through waiver programs, referred to as "1915 (i) services." The list of 1915 (i) services includes the following: rehabilitation, habilitation, crisis intervention, educational support services, other support services, individual employment support services, peer supports, and self-directed services.

Everyone in a HARP will receive care management through a health home. Care management will be in the hands of providers. Plans are responsible for overseeing the care management plan to assure appropriateness and the avoidance of conflict. After extensive discussions with CMS the state has determined that eligibility for 1915 (i) services will not be automatic for all HARP members. Instead, individuals will undergo a functional assessment using the InterRAI suite of assessment tools, which will determine individual care needs. The state is operating within the financial constraints of the Medicaid program, and does not have the resources to offer significant new benefits to all HARP-eligible members. While the state is committed to reinvesting savings from behavioral health interventions back into the behavioral health delivery system, those savings will not be available on day one. The state is exploring options for start-up funding for 1915 (i) services, including money from the Balancing Incentives Program (BIP) or through a waiver amendment establishing a Delivery System Reform Incentive Payment (DSRIP) program in New York.

Members of the work group expressed concern that without sufficient up-front investment in HARPs the plans will not be able to provide the services that will ultimately generate savings. State officials appreciated that concern, but argued that the Medicaid global cap limits their ability to enhance the HARP premium. The state has developed utilization and cost data for HARP-eligible beneficiaries, between 140,000 and 180,000 people statewide; a new data book will be available soon. The data indicate that half of current spending on the eligible population comes from in-patient detox and rehab, creating an enormous opportunity for savings. The average statewide PMPM is $2,500, higher in NYC and lower in the rest of the state.

The state plans to release a Request for Information in the coming weeks. They are seeking input from stakeholders that will help shape the Request for Qualifications for the HARP, which they expect to release in February. The state is mindful of the tension between revenue protection for providers and plan interest in innovative payment models. In an effort to minimize disruption of care patterns and help assure a smooth transition, the state is proposing a requirement that HARPs contract with all Office of Mental Health and Office of Alcoholism and Substance Abuse Services licensed or certified providers that currently serve 5 or more of their members. The contract period would be for 2 years, at the current fee-for-service reimbursement rates.

North Carolina

HMA Roundup

NC Lawmakers Demanded Quick Fix to NCTracks Problems. On Tuesday, October 8, 2013, North Carolina state lawmakers demanded solutions to the myriad complaints about the new Medicaid billing system, known as NCTracks. Officials from the Department of Health and Human Services officials and Computer Sciences Corporation (CSC) acknowledged problems, but pointed to improvements in claims and customer service. However, providers reported delayed and denied claims, cash flow impacts, and extensive wait times with customer support.

Ohio

HMA Roundup

Kasich May Push for Medicaid Expansion via Executive Order. According to some highly placed politicians and observers, Ohio may finally move past its fits-and-starts and go forward with a Medicaid expansion. The Controlling Board, a legislative spending oversight panel with one gubernatorial appointee and six legislative appointees, may grant Governor John Kasich the authority to spend Federal funds to cover an expanded Medicaid population. Politico quotes Representative Tracy Maxwell Heard, the Democratic leader of the Ohio House, as saying that "all players are ready," while Senate President Keith Faber speculates that the Governor could pursue expansion by executive order, then seek Controlling Board approval of the funding.

Oklahoma

HMA Roundup

Oklahoma Sues to Block Exchange Subsidies. The Los Angeles Times reports that Oklahoma Attorney General Scott Pruitt has initiated a lawsuit to avoid implementing the full provisions of the ACA in his state on the premise that the law's wording precludes residents of states that do not run their own exchanges from tapping tax subsidies to purchase coverage.

Oregon

HMA Roundup

Dental Plans Negotiating with CCOs to Meet November 1 Deadline. Oregon's coordinated care organizations (CCOs) are pushing to introduce dental coverage by January 1, 2014, in line with the Medicaid expansion. To meet this deadline, CCOs are pushing dental plans to lock into an agreement soon in order to submit binding letters of intent with the Oregon Health Authority by November 1, 2013.

Oregon Exchange Web Site Not Fully Functional Until Month End. On October 7, 2013, Cover Oregon officials confirmed that the exchange's site will not be fully functional until the end of the month. In its first week, the exchange handled 230,000 unique visitors and 7,300 phone calls, but the system is not currently able to accurately assess eligibility for subsidies, so the exchange has delayed online enrollment until those issues are resolved. In the meantime, insurance agents and navigators can manually enroll consumers.

Pennsylvania

HMA Roundup – Matt Roan

Pennsylvania Officials Gauge Impact of Federal Shutdown on State Operations. Pennsylvania Officials in charge of health and human services are combing through the state's finances to identify likely impacts due to the Federal shutdown. While no human services programs have been immediately impacted, there are several funding streams that will dry up if the impasse in Washington persists for several more weeks. Among the programs that officials are concerned about are Food Stamps, cash assistance, home heating assistance, the Women Infants and Children (WIC) nutritional program, and social services for people with developmental and intellectual disabilities.

UPMC defends Non-Profit Status. UPMC has begun to file a series of reports to Allegheny County in defense of the tax exempt status of much of its property. In the lengthy documents, UPMC cites charity care, write-offs of bad debt and operational deficits to prove that they are not driven by profit. UPMC also points to the fact that no employee's compensation is impacted by the organizations financial performance. City and County officials have been challenging the tax exempt status of UPMC which owns 200 tax free parcels in Allegheny County, making it the county's largest private landholder.

Allentown Family Finds Security In Healthcare Sharing Ministry. Faith-based cost sharing programs for healthcare are on the rise as the individual mandate of the ACA is nearing implementation. Members of the non-profit cost sharing programs are exempt from the mandate even though their program does not count as insurance, and is not regulated by the state. For the Williams family in Emmaus, PA the cost sharing program is good enough for them. After joining Samaritan Ministries Healthcare Cost Sharing Program, Mrs. Williams became pregnant, received a full course of prenatal treatment and delivered her son via a cesarean section. Total out of pocket expenses for the pregnancy were $300. Critics of such plans say that they are not all they are cracked up to be, since they are not regulated as insurance they are not subject to capital reserve requirements, and as a result may not cover the most costly catastrophic care needs. Most cost sharing plans have a cap on reimbursement, and make no legal guarantees of coverage.

NLRB Charges UPMC with Harassing Workers. According to the Pittsburgh Business Times, the National Labor Relations Board has cited UPMC (University of Pittsburgh Medical Center) for harassing and firing four workers for their union-organizing efforts as part of 19 charges of unfair labor practices. UPMC has next week to respond to the complaints with a hearing scheduled for Dec. 16.

South Carolina

HMA Roundup

South Carolina Medicaid Debuts Online Application. On October 1, 2013, South Carolina's Medicaid program introduced the debut of its online application. More than 770 people submitted applications at the S.C. Department of Health and Human Services' Healthy Connections website in the first week alone. This represented the first phase of the state's upgraded Medicaid eligibility system. Even without expanding eligibility for Medicaid, Medicaid Director Tony Keck expects enrollment will grow by about 170,000 in 2014, likely due to the "woodwork effect."

Tennessee

HMA Roundup

Tennessee Issues TennCare RFP. On October 8, 2013, the State of Tennessee issued an amended RFP for TennCare managed care contracts with three vendors. All three contractors will provide managed care services, by region, in all three regions of the State. The Middle Tennessee region is scheduled to have implementation of services effective January 1, 2015. In no case will these implementation dates be earlier than January 1, 2015 or later than January 1, 2016. These services include physical health services, behavioral health services, and long term services and supports; establishing and managing a provider network including credentialing and contracting with providers; utilization management; quality management; member services; financial management; claims management; and maintaining sufficient information systems.

Texas

HMA Roundup – Dianne Longley and Linda Wertz

Texas Releases NEMT Draft RFP. The Texas Health and Human Services Commission (HHSC) released a draft RFP for Nonemergency Medical Transportation Services (NEMT). Responses to the draft RFP will inform the development of a final RFP, tentatively scheduled to be released November 2, 2013. The final RFP will procure Medical Transportation Organizations (MTOs) to create a statewide Medicaid transportation network. Draft RFP responses are due October 17, 2013. The Draft RFP and other documents are available here.

Vermont

HMA Roundup

Vermont Medicaid 1115 Waiver Extended. Vermont Health Access was granted a three-year extension of its existing 1115 Waiver, through the end of 2016. Under the Waiver, Vermont accepts a total cap on Medicaid spending, but will be able to provide greater flexibilities in administering their Medicaid program, including making available millions of dollars in premium assistance for Vermont residents purchasing insurance through the new Marketplace.

Virginia

HMA Roundup

Former Missouri Medicaid Director Appointed to Department of Health. Former Missouri Medicaid Director Ian McCaslin has been appointed to serve as the director of Family Health Services in the Virginia Department of Health, effective October 25. McCaslin unexpectedly left his position as Missouri Medicaid Director in May 2013. Both McCaslin and Missouri Governor Jay Nixon declined to comment on his departure.

Medicaid Expansion Debates Continues in Virginia. The vice chairman of a legislative panel exploring both Medicaid reforms and Medicaid expansion in Virginia was quoted in an internal memo that it could take months to years to determine whether Medicaid expansion would merit action. However, a democratic member of the panel said progress is underway to potentially expand Medicaid in the next year.

Washington

HMA Roundup

Marketplace Enrollment Report Shows Medicaid Woodwork Impact. As of Monday, October 7, Washington's insurance Marketplace, the Washington Health Benefit Exchange, had enrolled nearly 9,500 applicants. Of these, nearly 2,600 were found to be immediately eligible for, and were enrolled in, Medicaid. Close to 6,000 will be eligible for Medicaid on January 1, 2014. As of October 7, only a little over 900 individuals had been enrolled in a qualified health plan (QHP). However, an additional 10,500 QHP enrollments were pending submittal of first payment. Of the first week of enrollment, which totals roughly 20,000 including the pending QHP enrollments, approximately 30 percent will be newly eligible for Medicaid, while 13 percent were already eligible for Medicaid.

Seattle Children's Hospital Sues Insurance Commissioner over Marketplace Networks. Seattle Children's has filed a suit against Washington's Office of the Insurance Commissioner on the grounds that their exclusion from six of the eight insurers on the state's Marketplace will negatively impact patient care.

West Virginia

HMA Roundup

West Virginia Medicaid Expansion Enrollment Underway. Prior to the launch of the federal insurance Marketplace enrollment website for West Virginians, the state began sending auto-enrollment notices to individuals who will become eligible for Medicaid on January 1, 2014. So far, nearly 50,000 individuals have responded and been enrolled for coverage that begins next year. Additionally, the state is operating a Medicaid enrollment site, known as West Virginia inRoads, which nearly 2,000 individuals have used to enroll in the Medicaid expansion.

National

HMA Roundup

CMS Revises DSH Rule While Providers Push for Two-Year Delay. CMS issued an interim final rule modifying last month's proposed rule on disproportionate share hospital (DSH) payments. Last month, CMS announced final rulemaking on DSH reductions prescribed under the Affordable Care Act, which will cut $500 million from the program in FY 2014 and $600 million in FY 2015. The interim rule addresses cost-reporting that spans multiple fiscal years and ensures Indian Health Service hospitals are properly factored in DSH calculation. Comments will be accepted on the interim rule through November 29, 2013. Meanwhile, the American Hospital Association and other provider advocates are continuing to push for a two-year delay in the Medicare and Medicaid DSH reductions.

Health Insurance Marketplaces Open, But Enrollment Unknown. Health insurance carriers selling plans on the Marketplaces, which launched last week, are reporting that enrollment data has not yet been made available to them. Kaiser Health News is reporting that around 37,000 people have applied for insurance through eight state-based marketplaces. Kentucky has reported 7,000 completed applications in the first two days of enrollment, while Hawaii and Connecticut each reported 1,200 and 1,000, respectively. Other states are reporting to Kaiser and to insurers that information on enrollment figures will not be released until the end of October or later.

CMS Staff Dedicated to Waivers and State Plans are All Furloughed. According to the National Association of Medicaid Directors, key work between the states and CMS has been delayed or deferred due to the government shutdown. According to NAMD's Executive Director Matt Salo, CMS officials responsible for the work of "approving/amending waivers and state plans have all been furloughed", affecting such items as modified Medicaid expansions, dual eligible projects, pilots, and other state plan modifications.

INDUSTRY NEWS

"Dr. Greg Buchert, MD, [formerly of HMA] was appointed the chief executive officer and plan president of California Health & Wellness, Centene's California subsidiary"

Centene's California Health & Wellness Announces Greg Buchert, MD, as CEO and Plan President. On October 3, 2013, Dr. Greg Buchert, MD, was appointed the chief executive officer and plan president of California Health & Wellness, Centene's California subsidiary. Dr. Buchert most recently worked as a Principal Consultant at Health Management Associates, and previously served as the COO of CalOptima. Dr. Buchert received a MD from Tulane University School of Medicine, a MPH from Tulane University of Public Health, and a BA from Tufts University. California Health & Wellness was recently awarded Medi-Cal managed care contracts in Imperial County and 18 Northern California counties.

WellCare Names Arizona, California, Hawaii Region President. WellCare Health Plans has announced that Chrissie Cooper has rejoined the company as the region president for Arizona, California, and Hawaii. Cooper initially joined WellCare in 2006 and most recently served as president of WellCare`s Florida and Hawaii Division from December 2009 to March 2013. Prior to joining WellCare, she held several leadership positions at PacifiCare Health Systems, and she received both her bachelor`s and master`s degrees from the University of Arizona.

UC Irvine Health and MemorialCare agree to affiliation. The UC Board of Regents approved an affiliation between the two Southern California hospital systems that allows each to remain independent. The partnership will open new primary care health centers to serve communities in need of greater health care services. UC Irvine Medical Center is a 412-bed hospital and serves as the primary teaching hospital for the UC Irvine School of Medicine. MemorialCare is a nonprofit health system with six hospitals and 3,000 affiliated physicians.

Pennsylvania's Keystone First and Jefferson Health System Form Shared Savings Agreement. AmeriHealth Caritas' Keystone First Medicaid managed care plan has reached a shared savings agreement with Jefferson Health System's network of hospitals, health centers, and physicians. Under the agreement, Jefferson's providers will receive a share of all savings generated through

Keystone First's PerformPlus value-based incentive program.

Jordan and HealthCare Innovations Private Services Announce Business Combination. Jordan Health Services, which provides home health services to patients throughout the state of Texas, and Healthcare Innovations Private Services, the largest provider of Medicaid home health services in the state of Oklahoma, announced on October 3, 2013 that they have combined their organizations. Together, the companies each day will fulfill the personal care, case management, skilled nursing, pediatric, and hospice needs of approximately 22,000 patients in Texas and Oklahoma through 61 locations across both states.

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Wisconsin MLTC (Select Regions)	Contract awards	10,000
November 1, 2013	Rhode Island MLTC	Implementation	22,700
November 1, 2013	Florida LTC (Regions 2,10)	Implementation	11,935
November 1, 2013	Hawaii	Proposals Due	292,000
November 21, 2013	Tennessee	Proposals Due	1,200,000
December 1, 2013	New Hampshire	Implementation	130,000
December 1, 2013	Florida LTC (Region 11)	Implementation	17,257
December 30, 2013	Delaware	RFP Release	200,000
"Early 2014"	North Carolina	RFP Release	TBD
January 1, 2014	Massachusetts CarePlus (ACA)	Implementation	305,000
January 1, 2014	Massachusetts Duals	Implementation	115,000
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 6, 2014	Hawaii	Contract Awards	292,000
February 1, 2014	Illinois Duals	Implementation	136,000
February 1, 2014	Florida LTC (Regions 5,6)	Implementation	19,538
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
April 1, 2014	California Duals	Implementation	456,000
April 1, 2014	Ohio Duals	Implementation	115,000
April 1, 2014	Idaho Duals	Implementation	17,700
May 1, 2014	Washington Duals	Implementation	48,500
June 30, 2014	Delaware	Contract awards	200,000
July 1, 2014	South Carolina Duals	Implementation	68,000
July 1, 2014	New York Duals	Implementation	178,000
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
January 1, 2015	Tennessee	Implementation	1,200,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

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	3/27/2013	4/1/2014	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	2/22/2013	2/1/2014	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		4/1/2014	Blue Cross of Idaho
Massachusetts	Capitated	109,636	X	8/20/2012	11/5/2012	8/22/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	70,000	X	9/10/2013	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	178,000				8/26/2013	7/1/2014	
North Carolina	MFFS	222,151					TBD	
Ohio	Capitated	114,000	X	5/25/2012	Scoring: 6/28/12	12/11/2012	4/1/2014	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258					TBD	
Oregon		68,000	Not pursuing Financial Alignment Model					
Rhode Island	Capitated	28,000	X	3/27/2013	August 2013		11/1/2013*	Neighborhood Health Plan of RI
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	5/21/2013	1/1/2014	Humana; VA Premier; WellPoint/Amerigroup
Vermont	Capitated	22,000	10/1/2013	TBD	TBD		9/1/2014	
Washington	MMFS Capitated	115,000	X X	5/15/2013	6/6/2013	MFFS Only	MFFS: 7/1; 10/1/2013 Capitated: 5/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model				
Totals	**14 Capitated 6 MFFS**	**1.5M Capitated 485K FFS**	***9***			***7***		

** 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 Joan Henneberry to Talk about ACA on Studio 12 October 9

HMA Principal Joan Henneberry will appear on PBS/Colorado Public Television, Channel 12's live show Studio 12 at 7 p.m. Mountain Time October 9, 2013. The show will explore the Affordable Care Act (ACA) and the government shut down. Joan will explain various aspects of the Affordable Care Act, how it impacts the public, and various ACA preparations taking place in Colorado. Also joining the live round table discussion will be Professor Norman Provizer, political science professor at Metro State University of Denver.

"State Innovation Models: Early Experiences and Challenges of an Initiative to Advance Broad Health System Reform."

Sharon Silow-Carroll, Author

JoAnn Lamphere, Author

In September 2013, the Commonwealth Fund released a report authored by Sharon Silow-Carroll and JoAnn Lamphere of Health Management Associates that reviewed the new models of care delivery and payment in states participating in the State Innovation Models (SIM) Initiative. (Link to Report)

"Health Behind Bars: What Obamacare Means for Courts, Prison, Jails, and the Justice-Involved (And How to Report the Story)"

Center on Media, Crime, and Justice

Donna Strugar-Fritsch, Panelist

October 21-22, 2013

New York, New York

"Health Insurance Exchanges"

American Institute of CPAs Healthcare Industry Conference

Barbara Markham Smith, Presenter

November 15, 2013

New Orleans, Louisiana

"Where Payor Meets Provider: Managing in a World of Managed Care"

HCap Conference sponsored by: Lincoln Healthcare Group

Greg Nersessian, Panelist

December 5, 2013

Washington, DC