HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 16, 2013

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

TENNESSEE'S TENNCARE MANAGED CARE RFP

This week, our *In Focus* section reviews Tennessee's TennCare Medicaid managed care RFP, released on October 2, 2013. TennCare, the statewide Medicaid managed care program, currently serves around 1.2 million Medicaid beneficiaries in three regions. Below, we highlight key aspects of the RFP, including timing, scoring, and market opportunity, as well as review the incumbent managed care marketplace. Tennessee anticipates making awards to three managed care organizations, which will serve TennCare beneficiaries in all three regions statewide.

Dual Eligible Integration Requirements

Awarded MCOs will be responsible for coordinating all health care benefits for dual eligible beneficiaries in Tennessee, including those benefits covered under the TennCare CHOICES long term supports and service (LTSS) and the home and community based services (HCBS) program. With the state's intentions to make statewide MCO awards under this RFP, applicants must either currently operate a Dual Eligible Special Needs Plan (D-SNP) in every county or submit a detailed plan on how it will establish and operate a D-SNP in every county prior to implementation.

Managed Care Population & Spending

Tennessee's TennCare program has previously included most of the Medicaid and dual eligible population in the state, with excluded populations limited to the developmentally disabled, individuals enrolled in Programs of All-Inclusive Care for the Elderly (PACE), and partial dual eligibles who do not receive full Medicaid benefits.

According to the RFP data book, prepared by Aon Consulting, the TennCare rebid covers an average monthly enrollment from FY 2012 of 1.17 million beneficiaries across the three regions – East, Middle, and West. This enrollment estimate is in line with June 2013 TennCare enrollment data posted online, which reports 1.19 million beneficiaries.

Bidders are asked to submit a cost proposal for rate cells in all three regions within a range established by the data book. The table below summarizes the average blended per-member-per-month (PMPM) rate for each of the three regions and statewide based on the low end of the capitation range. Based on the TennCare data book, we estimate annual spending of $5.2 billion when using the low end of the capitation rate range, with an average statewide PMPM of roughly $368.

	Estimated Average Monthly Members (FY 2012)	Estimated Average PMPM (Min.)	Estimated Annual Capitation
East Region	415,511	$370.41	$1,846,904,076
Middle Region	403,007	$381.63	$1,845,573,697
West Region	357,456	$348.84	$1,496,329,263
Total Statewide	**1,175,974**	**$367.70**	**$5,188,807,036**

Source: HMA Analysis of Bureau of TennCare Data Book, October 2013.

RFP Evaluation and Awards

Tennessee intends to award three MCOs, each serving all three regions. The initial contract term will run from January 1, 2014 through December 31, 2016. Optional one-year contract extensions may be exercised by the state up to a maximum contract term of eight years. RFP responses will be evaluated out of 1,000 points spread across general requirements and technical, oral, and cost proposals, as detailed in the table below.

Scoring Section	Total Points	% of Total
General Qualifications and Experience	150	15%
Technical Qualifications, Experience, and Approach	500	50%
Oral Presentation	50	5%
Cost Proposal	300	30%
Total Points Possible	**1,000**	

Technical qualifications, experience, and approach make up 50 percent of the total scoring. The RFP indicates that incumbent MCOs will not be scored higher for having existing contracts with the state; however, the D-SNP requirement detailed above may pose an obstacle for some new bidders. The cost proposal, worth 30 percent, is based on how a bidder's proposed PMPM rates compare with the minimum rate range put forward in the data book and detailed above.

RFP Timeline

The TennCare RFP has a relatively short turn-around time, with responses due on November 21, 2013, roughly seven weeks after the RFP was released. The state intends to complete evaluation and have contracts signed by December 23, 2013. Implementation will begin on January 1, 2015 at the earliest and may be later in the East and West regions, to be determined by the state.

Timeline	Date
RFP Issued	October 2, 2013
Notice of Intent to Propose Deadline	October 8, 2013
State Q&A Responses Released	October 21, 2013
Proposals Due	November 21, 2013
State Evaluation Notice Published	December 16, 2013
Contract Signing	December 23, 2013
Implementation (earliest)	January 1, 2015

Incumbent Managed Care Market

TennCare is currently served by four managed care organizations across the three regions. United is the market leader, with just under half of statewide enrollment across all three regions.

TennCare MCO	East	Middle	West	Total
UnitedHealthcare	194,219	196,299	173,210	563,728
BlueCare	211,891		176,391	388,282
Amerigroup		197,148		197,148
TennCare Select				45,436
Total	**406,110**	**393,447**	**349,601**	**1,194,594**

Source: State Monthly Enrollment Data, June 2013.

Additional Information

Link to RFP

Link to Data Book

HMA Medicaid Roundup

Alaska

HMA Roundup

Senator Murkowski Seeks Weekly Updates on Alaska Exchange Enrollments. On October 14, 2013, Senator Lisa Murkowski sent a letter to HHS Secretary Kathleen Sebelius to request weekly updates from the department about enrollment attempts and successful enrollments on the Alaska exchange. Murkowski noted that the Government Accountability Office had warned in June that the exchanges would not be ready on time. Enroll Alaska confirmed that by the end of the second week of operations, no one from Alaska had successfully enrolled on the exchange, but the systems appeared to be operating better than in the first week.

Arizona

HMA Roundup

Arizona Medical Board Fires Executive Director. On October 12, 2013, following a critical report, The Arizona Medical Board voted 5-4 to fire its long-standing executive director, Lisa Wynn. Last week, a report issued by the Arizona Ombudsman-Citizens' Aide found a multitude of rules violations in credentialing physicians. Moreover, the report alleged Wynn and a former deputy director ordered staff to break state laws to hasten licensing of physicians. Wynn's representative argued that issues raised in the report were being addressed and that she was authorized to properly streamline an arcane system that was overly burdensome for physicians.

California

HMA Roundup

Governor Brown Vetoes Bill that Would Have Limited Generic Biotechnology Drugs. On October 12, 2013, Governor Jerry Brown vetoed S.B. 598, which would have allowed biosimilars to be substituted by pharmacists on the condition that the FDA assessed a biosimilar "interchangeable" with the branded product. Biotechnology companies promoted this legislation, but opponents—including health plans and consumer advocates—claimed the legislation represented a higher threshold that would inhibit the use of generic alternatives to branded biotech drugs. Governor Brown claimed that the Federal Government had not yet established its own standards.

Governor Brown Signs Home Care Licensing Law. On October 14, 2013, Governor Jerry Brown signed into law A.B. 1217, the Home Care Services Consumer Protection Act, which mandates home care agencies to become licensed in the state. The law also requires home care aides to be listed on the state's registry, which will indicate criminal background checks and "reputable character." The law will become effective January 1, 2016.

Governor Brown Signs Two Autism Bills. Last week, Governor Jerry Brown signed into law two bills related to autism and developmental disabilities. On October 9, 2013, Governor Brown signed into law S.B. 468 (the "Self Determination Program"), which allows families of people with autism and other developmental disabilities to craft a package of treatment services, rather than relying on plans generated by state-contracted regional centers. In addition, Governor Brown signed into law S.B. 126 (the "California Autism Insurance Mandate"), which requires the coverage of early autism treatment by private health plans. The program had been slated to expire in July 2014, but the new law extends the deadline to January 1, 2017.

Governor Brown Signs Hospital Bed Tax. On October 8, 2013, Governor Jerry Brown signed into law S.B. 239, which extends hospital bed taxes for three years through mid-2016, allowing the state to draw down more than $10.5 billion in federal Medicaid matching funds over that period. In addition, the legislation reversed a looming 10 percent cut in Medicaid payments to nursing homes operated by hospitals. Nonetheless, on October 9, 2013, the California Hospital Association filed a ballot initiative that would establish the percentage of hospital levies that would go to the state General Fund and how those funds would be spent. The intent of the initiative is to ensure that provider taxes are used only for the intended purpose, rather than for other budgetary items.

Colorado

HMA Roundup—Joan Henneberry

Connect for Health Web Site Statistics. The staff of Connect for Health Colorado reported to the board on October 14, data from the first week of open enrollment. Almost 163,000 people visited the website in week one, and 57% were first time visitors. Over 18,000 customer accounts were created and 226 plan enrollments were completed covering 305 lives. The call center was heavily utilized with a 5 minute wait time, and the average call time with a customer taking over 13 minutes. There are still reports of concern that because individuals coming to the exchange to buy insurance must first have a Medicaid denial, the wait time for that determination is interfering with the tax credit determination and shopping experience. Medicaid on-line determinations are reportedly taking about an hour – a major improvement from pre-ACA where they could take up to six weeks.

Connecticut

HMA Roundup

Access Health CT Reveals Price is the Biggest Complaint from Participants. Last week, Access Health CT COO Peter Van Loon revealed to a marketplace strategy committee that the single biggest complaint levied by participants has been the price of plans. Through the first ten days of operation, the exchange had processed 1,847

applications almost evenly split between Medicaid and private plan applicants.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida Announces Three Additional Medicaid Managed Care Awards. On October 10, 2013, the Agency for Health Care Administration announced three additional contracts as part of its Medicaid managed care system, supplementing September's contract awards to 10 managed care plans and five specialty plans. United Healthcare was awarded contracts in two regions, supplementing its prior two awards. Amerigroup was awarded with two new contracts, supplementing its two prior awards. Simply Healthcare was awarded with an MMA contract in region 11, supplementing its HIV/AIDS specialty plan offered in 10 regions. Coventry, Molina, and WellCare have all filed protests.

Statewide Medicaid Managed Care (SMMC)
Managed Medical Assistance(MMA) ITN
Recommended Awards - 9/23/13
And Additional Awards - 10/10/13 (green highlight)

		Region											
	Plan Name	1	2	3	4	5	6	7	8	9	10	11	TOTAL
	Standard Plans												
1	Amerigroup Florida, Inc.					X	X	X				X	4
2	Humana Medical Plan, Inc.	X					X			X	X	X	5
3	Preferred Medical Plan, Inc.											X	1
4	Sunshine State Health Plan, Inc.			X	X	X	X	X	X	X	X	X	9
5	UnitedHealthcare of Florida, Inc.			X	X			X				X	4
6	Wellcare/Staywell of Florida, Inc.		X	X		X	X	X	X			X	7
7	Better Health, LLC - PSN	X					X				X		3
8	Simply Healthcare Plans, Inc.											X	1
9	First Coast Advantage, LLC - PSN				X								1
10	Integral Health Plan, Inc. - PSN						X		X				2
11	Prestige Health Choice - PSN		X	X		X	X	X		X		X	7
	Total Standard Plans	2	2	4	3	4	7	5	3	3	3	8	44
	Specialty Plans												
1	AHF MCO of Florida, Inc. D.B.A. Positive Healthcare Florida HIV/AIDS Specialty Plan										X	X	2
2	Florida MHS, Inc. d/b/a Magellan Complete Care Serious Mental Illness Specialty Plan		X		X	X	X	X		X	X	X	8
3	Freedom Health, Inc. Cardiovascular Disease (CVD) Specialty Plan			X		X	X	X	X	X	X	X	8
3	Freedom Health, Inc. Chronic Obstructive Pulmonary Disease (COPD) Specialty Plan			X		X	X	X	X	X	X	X	8
3	Freedom Health, Inc. Congestive Heart Failure (CHF) Specialty Plan			X		X	X	X	X	X	X	X	8
3	Freedom Health, Inc. Diabetes Specialty Plan			X		X	X	X	X	X	X	X	8
4	Simply Healthcare Plans, Inc. d.b.a. Clear Health Alliance HIV/AIDS Specialty Plan	X	X	X		X	X	X	X	X	X	X	10
5	Sunshine State Health Plan, Inc. Child Welfare Specialty Plan	X	X	X	X	X	X	X	X	X	X	X	11
	Total Specialty Plans	**2**	**3**	**6**	**2**	**7**	**7**	**7**	**6**	**7**	**8**	**8**	**63**

Georgetown Researchers Warn that New Medicaid Managed Care Requires Careful Monitoring. Last week, two researchers from Georgetown University's Health Policy Institute released "Medicaid Managed Care in Florida: Federal Waiver Approval and Implementation." Since most of Florida's healthy Medicaid patients are already members of HMOs, the newly enrolled will tend to be more expensive and may be subject to cost-cutting efforts. As a result, the new mandatory Medicaid managed care rollout will require careful monitoring to ensure quality care, network adequacy, prescription drug availability, and medical loss ratio compliance.

Legislators May Maintain Dental Carve Out. Despite the rollout of Medicaid managed care, it is possible that the state will maintain a pediatric dental carve-out benefit. Rep. Jose Diaz introduced H.B. 27, which would preserve the Prepaid Dental

Health Plan for recipients under the age of 21. Specifically, the AHCA would be authorized to enter into contracts on prepaid or fixed fee prepaid dental health plans and seek federal waivers or amendments to the state's Medicaid plan. In the first half of 2013, DentaQuest was paid $47 million, while MCNA Dental was paid more than $55 million. In prior years, AHCA had supported the carve-out due to the more extensive state networks of dentists within the pre-paid plans. However, the AHCA currently does not support a carve-out.

Federal Shutdown Stops Nursing Home Inspections. The federal shutdown has impacted the Florida's nursing home inspections. Although essential state survey and certification activities, as well as emergency investigations involving immediate safety risks to an individual, routine visits for initial Medicare certification or recertification and complaint investigations have been impacted by the partial government shutdown.

Governor Scott's Chief of Staff Orders Agencies Not to "Backfill" Funding for Federal Programs. Last week, Governor Rick Scott's chief of staff, Adam Hollingsworth, issued a letter to various state agencies, ordering that no state funds be committed to keep federal programs afloat during the current shutdown. Some of the affected federal programs assist foster children, veterans, and schools.

Georgia

HMA Roundup – Mark Trail

Health Board Approves Medicaid ABD Care Coordination Proposal. On October 10, 2013, a Georgia health agency board offered initial approval to a proposal that would offer care coordination services for the aged, blind, and disabled (ABD) Medicaid population, who number about 450,000 and account for about 60 percent of total Medicaid spending. Enrollees would have access to a phone line that could connect patients to nurses, case managers, and providers. It is hoped that the services could generate $5 million to $10 million in annual savings by year two of the program. The Department of Community Health aims to choose a single vendor in an RFP process.

Medicaid and PeachCare for Kids Applications Added to Georgia's COMPASS Site. Recently, the Departments of Human Services and Community Health added applications for Medicaid and PeachCare for Kids to the state's COMPASS web site. The portal also features applications for Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Child Care and Parent Services (CAPS).

Georgia's State Health Benefit Plan Gets a New Chief. Effective October 1, 2013, Lurline Craig-Burke assumed the role of Chief of Georgia's State Health Benefit Plan (SHBP), a position she previously held a decade earlier. DCH Commissioner Clyde Reese III pointed to Craig-Burke's public and private sector health management experience. Craig-Burke most recently was a partner and Atlanta Office Business Leader for Mercer's Government Human Services Consulting Group. She was previously the founder and CEO of Precipice Strategies, senior vice president and state/local government national practice leader for Aon Corporation, and VP for Emory University System of Healthcare-Georgia 1st.

Hawaii

HMA Roundup

Hawaii Exchange to Re-Open by October 15. Officials from the Hawaii Health Connector recently apologized to state residents who have been unable to progress with enrollments. Coral Andrews, executive director of the exchange, reassured Hawaii's residents and businesses that the site would be operational by October 15, 2013 and that individual health plan information and rates would be available. Hawaii is one of five states that used CGI Group to build the exchange, but was the latest state-run exchange to launch.

Idaho

HMA Roundup

Idaho Exchange Fee Could Rise Up to 75 Percent. According to the Associated Press, Idaho's health exchange may need to raise its 1.5 percent assessment on each policy to 2.6 percent by 2016, according to emails sent by exchange finance chief Pat Kelly. The current assessment was set in June by Your Health Idaho exchange board of directors, well below the 3.5 percent fee charged on the federally facilitated exchanges. Kelly indicated in a September 5 email that the 1.5 percent fee may not be sustainable. In an AP interview, Executive Director Amy Dowd canceled Kelly's planned September 6 presentation since the exchange was not comfortable publishing a 2.6 percent figure at this point with limited data.

Illinois

HMA Roundup – Andrew Fairgrieve

On October 10, 2013, Illinois released a RFP to rebid the state's Primary Care Case management (PCCM) program, known as Illinois Health Connect. Illinois Health Connect is currently administered by Automated Health Systems. Illinois Health Connect enrolls roughly 1.7 million Medicaid beneficiaries statewide with a primary care doctor, although the program will see a reduction in enrollment in the latter part of 2014 and into 2015 as the state transitions to mandatory managed care in five regions. RFP responses are due on November 13, 2013.

Indiana

HMA Roundup—Cathy Rudd

Joseph Moser Appointed Indiana's New Medicaid Director. On October 10, 2013, the Indiana Family and Social Services Administration (FSSA) Secretary Debra Minott appointed Joseph William Moser as Indiana Medicaid Director, effective November 18. For the last five years, Moser served as director of government affairs and interim executive director for Medicaid Health Plans of America. Moser developed expertise on Medicaid reform and Medicaid managed care implementations.

Kentucky

HMA Roundup

Kynect Recognized as a Successful Exchange Model. In light of pervasive headlines critiquing the snafus and technical shortfalls of state and federally facilitated exchanges, Kentucky's Kynect exchange has been a standout for relatively smooth operations. Business Week noted that Governor Steve Beshear has taken a prominent role in jabbing at opponents to the Affordable Care Act for pouring time, money, and energy into overturning or defunding the law, even as the state's resident suffered from "horrendous" health statistics.

Maine

HMA Roundup

Behavioral Health Homes RFA. On October 11, 2013, Maine's Department of Health and Human Services has posted RFA for its Behavioral Health Home initiative. The BHH services will be provided by a behavioral health home organization (BHHO) that will work with a Health Home primary care practice to ensure comprehensive care management and care coordination services. BHHOs are licensed community mental health providers that meet various criteria outlined in the RFA. Separately, primary care practices will need to apply to deliver health home services in conjunction with the BHHOs. Applications must be submitted by November 22, 2013. Implementation of the BHH program is slated for January 2014.

Accountable Communities Initiative RFA. On October 11, 2013, Maine's Department of Health and Human Services posted a request for applications (RFA) for its MaineCare Accountable Communities Initiative. MaineCare aims to establish shared savings arrangements with providers that, together, will coordinate and deliver care to specified patients. Accountable Communities that succeed in reducing costs and meeting quality standards will share in savings in the model. The initiative will be offered statewide as a Medicaid State Plan option. The optional notice of intent / interest survey is due by November 15, 2013. The application is due December 9, 2013. Implementation is planned for May 1, 2014.

Maryland

HMA Roundup

Maryland Submits Plan to Overhaul Hospital Reimbursement. On October 11, 2013, Maryland's Department of Health and Mental Hygiene submitted to Federal officials a proposal that would allow the state to establish uniform rates for hospital charges, in contrast to individually negotiated rates between hospitals and health plans. Maryland would maintain this waiver so long as the growth in Medicare inpatient payment per admission is below the national average. This all-payer model would shift away from fee-for-service to global payments based on Medicare per beneficiary total hospital cost growth. All-payer per capital total hospital cost growth would be limited to 3.58 percent, in line with the state's average economic growth over the last decade. The Maryland Hospital Association, CareFirst BlueCross BlueShield, and consumer advocates voiced support for the proposal.

Montana

HMA Roundup

Montana MMIS Upgrade Delayed. Montana's Medicaid Management Information System (MMIS) upgrade has been beset by delays, forcing Xerox/ACS to seek an extension of deadlines. The state has negotiated a contract that will withhold payments until the program is up and running. Xerox recently completed MMIS upgrades in Alaska and New Hampshire and state officials appear sympathetic to Xerox' effort to address problems for a year-end completion.

Nebraska

HMA Roundup

Nebraska in Early Stages of Developing Managed LTSS Program. This past week, Nebraska Medicaid officials announced that the state was in the early stages of developing a statewide Medicaid managed care program for the delivery of long-term services and supports (MLTSS), effective July 2015. Long term services and supports would include skilled nursing care, Personal Assistance Service (PAS), home health services, and home and community-based waiver services such as Assisted Living; Home Care/Chore; Home-Delivered Meals; Personal Emergency Response Systems; and Respite Care. In addition, MLTSS would include physical and behavioral healthcare, dental care, and pharmacy benefits. Key goals associated with the program include the following:

- improve quality of life and health status through coordination of medical care, behavioral health care, and community-based services and supports
- promote choice and appropriate use of services (type, setting, and amount)
- increase client access to quality services and supports
- maintain fiscal prudence to sustain Nebraska Medicaid

New Hampshire

HMA Roundup

Panel Unanimously Approves Medicaid Expansion, Governor to Call Special Session. On Tuesday, October 15, a special panel voted unanimously to present a report to the New Hampshire legislature recommending they pass enabling legislation for the state to expand Medicaid to nearly 50,000 potential enrollees. Governor Maggie Hassan will call a special session of the legislature in November, with public hearings set for November 12 through 14, setting up a vote on expansion by November 21, 2013.

New York

HMA Roundup – Denise Soffel

Excellus BCBS Exiting Medicaid Managed Care Program. Excellus BlueCross BlueShield has notified doctors and other providers that it is exiting the Medicaid managed care and Family Health Plus programs given its projected losses of $100 million on those programs this year. Excellus plans to end its participation in the

programs on February 1, in Livingston, Ontario and Wayne counties, impacting 24,000 people. Effective March 1, 2014, Excellus would exit the programs in Monroe, Orleans and Yates counties, affecting about 85,000. The decision does not apply to Child Health Plus or Medicare offerings.

Governor Cuomo releases report on work of the Olmstead Cabinet. The Olmstead Cabinet was established by Executive Order in November 2012 and charged with reviewing New York's compliance with the Olmstead decision requiring that all state services and programs for people with disabilities must be provided in the most integrated setting appropriate to an individual's needs. The Cabinet was comprised of senior leadership across a number of state agencies: Budget; the Office for People with Developmental Disabilities; Health; Labor; Transportation; Mental Health; Alcoholism and Substance Abuse Services; Children and Family Services; Homes and Community Renewal; Temporary and Disability Assistance; Aging; and the Commission on Quality of Care and Advocacy for Persons with Disabilities.

The report reviews the current service provision arrangements for people with disabilities currently in segregated environments and identifies a series of actions that the state should pursue to move them into the community. The report looks at services for those with developmental disabilities, for individuals with serious mental illness, and for people in nursing homes. It reflects not only institutional care in settings such as nursing homes and adult homes, but also the issue of sheltered workshops, transportation, and the criminal justice system, and how they pertain to equal rights in community based settings.

The report describes changes that are being implemented in terms of assessment instruments and processes, and New York's move to more uniform assessment based on functional needs. The state is moving to coordinate the assessment process across the need for home care, developmental disability care, and community-based mental health. The new assessment tool, developed by interRAI, shares a common core of clinical items across programs. They are also working to integrate the assessment used by the State Office for the Aging to be able to identify opportunities for strategic investment in non-Medicaid services that might prevent the need for institutionalization.

Sandy Social Services Block Grant (SSBG) Funding. Governor Cuomo announced that $200 million has been awarded to more than 450 healthcare and human service providers and other community-based organizations following the impact of Superstorm Sandy. The federal Superstorm Sandy Social Services Block Grant is designed to cover unreimbursed expenses resulting from the storm, including social, health and mental health services for individuals, and for repair, renovation and rebuilding of health care facilities, mental hygiene facilities, child care facilities and other social services facilities. The state had initially submitted a request to CMS to amend its current Federal-State Health Reform Partnership (F-SHRP) Section 1115 waiver to finance a storm recovery grant program. The request for $427 million was intended to "provide emergency cash relief to assist numerous Medicaid providers that have been seriously impacted by Hurricane Sandy," and was seen as Phase 1 of a two-phased approach. Phase 2 would have focused on longer-term relief for implementation of a comprehensive restructuring plan.

Law on Hospital Closure Ruled Unconstitutional. A justice on the Brooklyn Supreme Court ruled that the law regulating the process for hospital closures is unconstitutional. The law requires the Department of Health to hold a public forum and report on the impact of a hospital's closure on the surrounding community's access to medical care prior to approving a closure. The justice ruled that the

language of the bill was too vague. Until the state legislature changes the law, no hospital in the state will be able to close. The decision came as a result of a lawsuit to stop efforts by SUNY Downstate to close Long Island College Hospital

North Carolina

HMA Roundup

***North Carolina Health News* Challenges Audit Response that Supports Managed Care Transition.** *North Carolina Health News*, an online healthcare news source in the state, has called into question findings of a response prepared to an audit of the Department of Health and Human Services. The audit response, overseen by former Medicaid Director Carol Steckel, made the strong case for a transition to risk-based managed care in North Carolina. *North Carolina Health News* is claiming that edits to the report prior to publishing made the Medicaid program appear worse off to make a stronger case for managed care.

Ohio

HMA Roundup

Ohio Pursues Medicaid Expansion Via Controlling Board, Rather than Legislation. On September 26, 2013, the Ohio Medicaid Director submitted a State Plan Amendment (SPA), seeking CMS approval to expand Medicaid coverage. On October 10, 2013, CMS approved the SPA. On October 11, 2013, the Ohio Medicaid Director submitted a request to the state's Controlling Board to authorize the spending of Federal (only) funds to expand Medicaid coverage. The Controlling Board approval on October 21, 2013 is the only action required to expand the Medicaid program. The seven member board consists of one gubernatorial appointee, two appointees made by Democratic leaders in the General Assembly, and four appointees made by Republican leaders in the General Assembly.

Pennsylvania

HMA Roundup –Matt Roan

DPW Offers Update on Long Term Care and Dual Eligibles Stakeholder Group. At a meeting of the Medical Assistance Advisory Committee's Subcommittee on Long Term Care Programs, The Department of Public Welfare provided an update on the convening of a Stakeholder Group to provide feedback on Long Term Care and Dual Eligible management initiatives. The stakeholder group is part of the Governor's Healthy PA plan and is expected to weigh in on options to improve management of Long Term Care benefits in PA. It is expected that the Group will look at Managed Long Term Care, and the potential for a Dual Eligible integration pilot. Appointments to the Stakeholder Group have not been finalized, appointments will be made by the end of this month, and then the Group will have one year to issue its report. In addition to DPW's stakeholder group, the PA Legislature has also established a Joint State Government Commission to research Long Term Care issues, the Commission has begun its work and is planning four regional informational meetings in the near future. The Commission's report is expected in June of 2014.

Pharmaceutical Monitoring System Raises Privacy Concerns. A bill introduced in the PA House of Representatives to establish the Pharmaceutical Accountability Monitoring System has some healthcare providers and advocates concerned about patient privacy. The bill, introduced by Rep. Matt Baker establishes a statewide database to track prescriptions of habit forming medication. The effort is part of Governor Corbett's wider healthcare reform initiatives known as Healthy PA and is focused on reducing prescription drug abuse. Providers are concerned about provisions of the program which would automatically report certain prescribing patterns to the Attorney General's office for possible investigation. Providers contend that certain specialties such as pain management clinics are appropriately prescribing these medications, but may be identified by the database as potential criminals. Providers are also worried that doctors will think twice about prescribing needed medications for fear of becoming the target of an investigation. Patient advocates have concerns about privacy protections, and are uncomfortable with the state knowing what drugs they are taking for conditions such as epilepsy.

Supreme Court Action on MCARE Fund Transfer. Legislative action in 2009 which moved $100M out of the Commonwealth's Medical Care Affordability and Reduction of Error fund (MCARE) has led to a court battle between provider associations and the state. The MCARE fund helps to cover the cost of Medical Malpractice for healthcare providers in the Commonwealth and is funded largely by assessments levied on providers. The Legislature amended the MCARE act in 2009 to shift $100M from the fund to the Commonwealth's General Fund. The Commonwealth contends that the money was a surplus and that shifting the funds for other government purposes was appropriate. Provider groups including the Hospital Association of PA and the PA Medical Society are arguing that the assessment formula provides that any surpluses be applied to the subsequent year's assessment formula. The PA Supreme Court has remanded the case back to the Commonwealth court for a ruling on whether the $100M represented a surplus that was available for other governmental purposes. In dissenting opinions, several Justices indicated that they believed the question of the surplus had been settled, and that the provider groups have demonstrated harm.

Virginia

HMA Roundup

Kaiser Permanente to Begin Serving Northern Virginia November 1. Beginning November 1, 2013 Kaiser Permanente will begin serving enrollees in the Northern Virginia region of Virginia's Medicaid managed care program, known as Medallion II. Kaiser will operate alongside WellPoint's Anthem Healthkeepers plan and INTotal Health, owned by Inova Health System.

Senate Finance Chair Pushing Medicaid Expansion Alternatives. Last week, Senator Walter A. Stosch, the Senate Finance Committee Chairman, indicated he wants Virginia to look at marketplace-based Medicaid expansion alternatives, such as those in Iowa and Arkansas. While Medicaid expansion advocates continue to push for traditional expansion, some have indicated that alternative expansion models should be brought to the table for evaluation.

National

HMA Roundup

State Marketplace Experiences Mixed, CO-OPs Concerned by Low Enrollment. Two weeks into the marketplace enrollment period, state experiences remain mixed. Some states, such as California, New York, and Washington are reporting surging enrollment as consumers continue to sign up through their online marketplace portals. Other states continue to face the technical glitches that marked the opening days of the enrollment period. Hawaii's marketplace portal finally launched on October 15, two weeks after its targeted launch date. Across the county, news reports out of states are a mixed bag of successes, technical glitches, and low, but generally rising enrollment numbers. However, the initial enrollment glitches pose a potential threat to CO-OP plans, as Kaiser Health News highlighted this week. CO-OPs, or consumer oriented and operated plans, are new health insurance carriers funded by federally awarded start-up loans. Low enrollment reports and technical barriers to enrollment are contributing to concerns about financial viability if the CO-OP plans do not meet enrollment targets over the next several months.

Industry News

Correctional Health Provider Corizon Parts Ways with CEO and President, Names New CEO. It was announced in the past week that Tennessee-based correctional health provider Corizon, a subsidiary of Valitas Health Services, parted ways with CEO Rich Hallworth and President Stuart Campbell on Wednesday, October 9, 2013. Woodrow Myers Jr., formerly the chief medical officer at WellPoint Inc., will join Corizon as its CEO, effective immediately.

AmeriHealth Caritas Announces D-SNP Plans in D.C., Louisiana. AmeriHealth Caritas announced on October 9, 2013, that it will offer Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) to dual eligible beneficiaries in the District of Columbia and three Louisiana parishes. Plans will begin accepting enrollment this month with an effective date of January 1, 2014.

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 financial alignment 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

"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