HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

UPDATE: IRS ISSUES FINAL RULE ON HEALTH INSURANCE PROVIDER FEE MEDICAID MANAGED LONG TERM CARE PREMIUM IMPACT

As an update to our November 13, 2013 *In Focus*, in which we reviewed the potential impact of the Health Insurance Provider Fee (HIPF) on Medicaid managed care plans, the Internal Revenue Service (IRS) published a final rule on November 26, 2013, which clarified the impact on the HIPF of Medicaid managed long term care programs (available here). The final rule addressed questions from commenters regarding the inclusion of Medicaid-covered benefits for long term care, nursing home care, and home and community based services (HCBS). In the November 26 rule, the IRS indicated that to the extent that Medicaid managed care plans can separately identify

premiums received for long term care, those amounts would be excluded from the calculation of net premiums written under the HIPF assessment. The practical effect of this guidance is that for dual eligible demonstration programs, assuming that the long term care premiums are determined to be "separately identified," the majority of Medicaid revenue would not be subject to the tax. As such, based on the calculations we described in our analysis, we would refine our estimate of the net margin impact for Medicare-Medicaid Plans (MMP) to be in the 0.7% to 1.0% range versus the range we had previously calculated of 0.7% to 1.8%. The actual impact of the tax would largely be determined by the Medicare Advantage penetration for dual eligibles in the counties participating in the demonstrations.

INDIANA TASKFORCE PUBLISHES DRAFT OF MEDICAID ABD MANAGED CARE OPTIONS

This week, our *In Focus* section reviews draft managed care options for the aged, blind, and disabled (ABD) Medicaid population, published in late November by the ABD Taskforce convened by the Indiana Family and Social Service Administration (FSSA). The FSSA was charged by the Indiana legislature under House Enrolled Act 1328 to evaluate and respond to questions regarding options for managed care for the ABD populations, although the draft report does not provide recommendations on which option to pursue. The report cites the importance of addressing ABD expenditures which account for nearly 70 percent of Indiana's Medicaid expenditures in FY 2012, and are anticipated to grow by roughly $908 million by 2025. The FSSA draft report provides background, pros and cons, and savings or cost estimates related to the three major options – risk-based managed care, managed fee-for-service (FFS), and HCBS management. Within each major option, the report analyzes the impact of four different ABD population exclusions: institutional populations, individuals with intellectual and developmental disabilities (IDD), dual eligibles, and individuals under age 21. A final report from the FSSA ABD Taskforce is due to the legislature by December 15, 2013.

Link to FSSA ABD Taskforce Draft Report (November 21, 2013):
http://www.in.gov/fssa/files/ABD_Draft_Report_11.23.13_.pdf

Link to FFS ABD Taskforce Website:
http://www.in.gov/fssa/4828.htm

Draft Report: ABD Managed Care Options

The FSSA ABD Taskforce reviewed the three model options across a set of core principles, as follows:

- Potential to improve quality outcomes and consistency of care across the delivery system;
- Enrollee choice, protections, and access;
- Potential to coordinate care across the delivery system and care continuum;
- Flexible person centered care; and
- Transition planning, contract oversight, and implementation issues.

The RBMC and Managed FFS models were the only two options to meet all of the core principles. Additionally, the Taskforce reviewed the three model options for the potential to ensure enrollee access to timely, efficient, and high quality care through a set of contract provision options. The RBMC model was the only option to meet all of the contract provision options. Full detail on the core principles and contracting options are provided in the FSSA ABD Taskforce draft report.

In the following three sections, we walk through the high level savings and cost analysis the taskforce provides on the three major options. These cost and savings estimates were provided by the state's in-house actuary and represent achievable savings or net new costs over three to five years. The draft report's conclusions are somewhat surprising given that managed care transitions typically yield cost savings, yet most of the scenarios detailed below yield net cost increases to the state (negative savings numbers in the tables). The report provides some explanation of these estimated outcomes, which we breakdown following the three options.

Option 1: Risk-Based Managed Care (RBMC) for ABD Population

Under the RBMC model, the state would contract with managed care organizations (MCOs) to serve the ABD population or subsets of the ABD population as detailed in the different options and savings/cost estimates below. The RBMC option includes analysis of a managed care carve-out of the Medicaid Rehabilitation Option (MRO) services only. MRO services are currently administered exclusively through Community Mental Health Centers (CMHCs) and are funded through an arrangement that does not require state matching funds.

Option 1: Risk Based Managed Care - Net Savings/New Costs Achievable in 3 to 5 years

RBMC Options	Estimated Enrollment	Net State Savings/ (Net New Costs) ($ millions)	%
No Population Exclusions	**171,200**	**($49.6)**	**-3.8%**
Institutional Population Excluded	139,300	($15.4)	-2.0%
IDD Population Excluded	161,200	($36.7)	-3.2%
Under-21 Population Excluded	151,300	($43.1)	-3.7%
Dual Eligibles Excluded	75,000	$4.2	0.7%
MRO Carve-Out	171,200	($45.6)	-3.6%

Option 2: Managed Fee-For-Service (FFS) for ABD Population

Under a managed FFS model, the state would contract with a vendor organization or community-based networks of providers to provide similar care management services as would be provided under the RBMC model. However, there would not be financial risk to the managed FFS provider aside from performance outcomes and savings targets.

Option 2: Managed FFS - Net Savings/New Costs Achievable in 3 to 5 years

Managed FFS Options	Estimated Enrollment	Net State Savings/ (Net New Costs) ($ millions)	%
No Population Exclusions	**171,200**	**($0.8)**	**-0.1%**
Institutional Population Excluded	139,300	($0.1)	0.0%
IDD Population Excluded	161,200	$0.1	0.0%
Under-21 Population Excluded	151,300	$0.7	0.1%
Dual Eligibles Excluded	75,000	$9.9	1.6%

Option 3: Home and Community Based Services (HCBS) Management Program

Under the third option, HCBS management, the state would contract with area agencies on aging (AAAs) or other community-based care coordination organizations to provide needed home and community based services to keep the ABD population out of an institutional setting whenever possible. Unlike the RBMC and Managed FFS models, this model would focus only on HCBS and long-term supports and services. The draft report does not attribute any state savings or new costs to the HCBS management approach.

Summary of Options and Explanation of Net New Cost Estimates

In the RBMC option, most scenarios yield significant new costs to the state, while the Managed FFS option may yield limited new state costs under certain scenarios. The draft report outlines some of the key factors driving these estimates.

- The ACA's health insurer fee is assumed to drive a 2.5% increase in administrative costs for RBMC health plans. Savings on claims would have to exceed the fee increase to yield net savings under an ABD managed care transition.
- Savings achieved through transition of dual eligibles to RBMC would be shared with Medicare, reducing net savings to the state.
- Fixed administrative costs under the RBMC model would be on top of higher per-member per-month (PMPM) rates for the non-dual ABD population.
- For most HCBS waiver populations, the majority of costs are waiver services. The report indicates that no claims cost savings were estimated to be attainable for waiver services, as "under the current delivery system, these services are already managed through strategies such as case management, budget caps and service authorizations through budget allocation processes."
- Previous attempts by the state to reduce utilization through service limits have been met with legal challenges.
- State waiver programs already exist to divert individuals away from institutionalization and into home and community based care settings when possible, reducing the potential for savings from deinstitutionalization.

The report additionally notes that the RBMC option could have significant impacts on the state's assessment programs for hospitals, nursing homes, and intermediate care facilities for the intellectually disabled (ICF/IDs), which provide additional funding to the state Medicaid program as well as enhanced provider reimbursement rates. This could generate opposition from the provider community to a RBMC approach to the ABD population.

HMA Medicaid Roundup

Alaska

Alaska Medicaid Committee and HHS Commissioner Evaluating State's Most Critical Health Needs. Just on the heels of Gov. Sean Parnell rejecting Medicaid expansion, Health and Human Services Commissioner Bill Streur said that a Medicaid committee and his department are analyzing the most critical health needs of the state and how best to address those issues. On December 3, 2013, at a House Finance Committee hearing, Streur indicated that some form of expanded healthcare might be included in the governor's supplemental budget in January 2014. Furthermore, Streur acknowledged the federal government's flexibility in permitting state adaptations to qualify for enhanced federal matches. A spokesperson for Parnell indicated that he was looking forward to recommendations from the Medicaid Reform Advisory Group. Read more.

California

Medi-Cal Enrollment Leads the Nation. Last week, the Department of Health Care Services reported that 143,608 people had been deemed eligible for Medi-Cal coverage (through November 20) upon completing applications with the state's exchange, *Covered California*. State health officials projected that one million to two million new beneficiaries would enroll in Medi-Cal under the ACA's expanded eligibility, which would include the transfer of 600,000 Low Income Health Program beneficiaries in 2014. Read more.

Covered California Unveils SHOP Marketplace. Following the federal government's announcement of a one year delay for online small business enrollment in health plans, California's progress with its own state-run exchange stood out in contrast. On December 2, 2013, Covered California launched its Small Business Health Options (SHOP) marketplace to offer employers with 50 or fewer employees online enrollment in health plans on the exchange. Users can access online quotes, submit applications, and initiate open enrollment for employees at *coveredca.com*. In addition, the SHOP marketplace brings online enrollment functions to the Certified Insurance Agent community. Participating health carriers on the SHOP exchange include Blue Shield of California, Chinese Community Health Plan, Health Net, Kaiser Permanente, Sharp Health Plan and Western Health Advantage. Read more.

Medi-Cal Long Term Care Spending to Reach $12.4 Billion by 2023. A recent UC-Berkeley study projects that long-term care spending by Medi-Cal should nearly double in a decade, from $6.6 billion in 2013 to $12.4 billion in 2023. California will have 44 percent more seniors over that time frame, from 4.8 million to 6.9 million, with more than two-thirds requiring long-term care services. The growth in spending is driven by longer life expectancies, poorer health among Baby Boomers, and

inadequate care infrastructure for seniors. With as much as 90 percent of long-term care provided uncompensated by family caregivers, there are concerns about the health of the caregivers, worker productivity, and increased absenteeism. Read more.

Colorado

HMA Roundup—Joan Henneberry

Connect for Health Colorado Enrolls 10,000 in Private Plans and 64,000 in Medicaid. On December 2, 2013, Connect for Health Colorado announced new enrollment figures through November 30, 2013. Nearly 10,000 people (9,980) enrolled to purchase private policies through the exchange, including almost 600 in a single day last week. November private plan enrollments of 6,816 more than doubled the prior month's 3,164. The Medicaid agency showed growth in enrollment from 47,000 in mid-November to over 64,000 by the end of the month. Customers must purchase health insurance by Dec. 15 in order for their coverage to start on Jan. 1. The federal government has extended that deadline to Dec. 23 and Connect for Health CEO Patty Fontneau said that the exchange is discussing a similar extension with Colorado carriers as well. People who do not buy health insurance by March 31, 2014 will face federal tax penalties that start low and increase every year. Read more.

Accountable Care Collaborative Shows Progress in Reducing Readmissions and $27 Million in Incentive Payments. Last month, the Department of Health Care Policy and Financing released a progress report on Regional Care Coordination Organizations to manage services and provide medical homes for the Medicaid population. In its second full year of operations, the Accountable Care Collaborative (ACC) covered 47% of the Medicaid enrollees, or 352,236 individuals. For state fiscal year 2010-2013, the state reported $44 million in gross savings, and $6 million in costs avoided. Below, we offer some key findings

- 15-20% reduction for hospital readmissions and 25% reduction in high cost imaging services relative to a comparison population prior to program implementation;
- 22% reduction in hospital admissions among ACC members with COPD who have been enrolled in the program six months or more, compared to those not enrolled;
- Lower rates of exacerbated chronic health conditions such as hypertension (5%) and diabetes (9%) relative to clients not enrolled in the ACC Program
- Slightly slower growth in emergency room utilization by ACC enrollees (1.9 percent vs. 2.8 percent for non-ACC enrollees)

Primary care practices received $489,000 in incentive payments and Regional Care Collaborative Organizations (RCCOs) received $689,000 of that in incentive payments for achieving lower hospital readmissions and emergency room usage. Read more.

Connecticut

Legislative Committee Considers Bill Easing For-Profit Hospital Acquisitions of Physician Practices. On December 3, 2013, the Connecticut legislature's Labor and Public Employees Committee heard testimony from hospital executives and union leaders to consider the advantages and disadvantages of for-profit hospitals in light of the for-profit joint venture between Tenet and Waterbury Hospital in Bristol, Connecticut. The catalyst was a bill that would ease the way for private for-profit hospitals to acquire physician practices from not-for-profit hospitals. With ongoing negotiations between Tenet and Waterbury Hospital, the committee wants to determine if for-profits hurt quality care to maximize returns to shareholders. Union officials pointed to Tenet's history of fines, settlements, and investigations over the last decade, while Tenet noted that those actions were taken prior to the new management team taking over. Darlene Stromstad, president and CEO of Waterbury Hospital, reiterated Tenet's point that economies of scale would help the hospital invest in improved equipment and deliver better services. Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

AHCA Submits 3-Year MMA Waiver Extension to CMS. On November 27, 2013, the Agency for Health Care Administration submitted an 1115 waiver request to CMS to extend the statewide Medicaid Managed Care program from July 1, 2014 through June 30, 2017. The state has not requested any changes to the MMA program during the waiver period. Read more.

AHCA Requests CMS Approval for Expansion of Low Income Pool Program. In the November 27, 2013 MMA waiver extension document, AHCA also included a proposal to redesign the Low Income Pool (LIP) program as a "System Access and Transformation Incentive Fund" at $4.5 billion annually (up from $1 billion). The state would expect to collect additional funds through voluntary contributions from counties, public hospitals, and special taxing districts, which would trigger additional matching federal funds. The mix of "transformation awards" would expand from 15 percent in year one to 40 percent by year three.

AHCA Finalizes 2013-2014 Medicaid Plan Rates. Last month, the AHCA provided final rates for HMOs, capitated Provider Service Networks (PSNs), and Prepaid Dental (PDHP) programs. The rates excluded HIV/AIDS for reform and specialty plans, which will be forthcoming in December. Overall, the rates grew 2.4 percent over the prior year, although normalized growth was 0.7 percent, excluding the effect of 2013 DRG hospital rate changes.

Incoming Speaker Opposes Medicaid Expansion. In a Health News Florida article, the next Florida House Speaker—State Rep. Steve Crisafulli—was profiled as consistently opposed to Medicaid expansion as the current Speaker, Will Weatherford. Crisafulli believes that the Medicaid program is already too big and that Florida should develop its own plan for expanding health coverage. Read more.

Gov. Scott's Support for Medicaid Expansion is Muted. Politico recently discussed the controversial decision by Florida Gov. Rick Scott to support Medicaid expansion early in 2013 and his subsequent retrenchment from the issue. Although the state could tap into as much as $51 billion in additional federal funds for Medicaid expansion over the next decade, Scott's early support faded against loud opposition to ex-

pansion within the state House GOP ranks. Arizona Gov. Jan Brewer and Ohio Gov. John Kasich both bucked Medicaid expansion critics within the Republican Party and muscled through expansion through the use of political capital and executive decision making. However, following a successful push to get Florida Senate approval for expansion, Scott's appeals met with immovable opposition from House Speaker Will Weatherford. Read more.

Georgia

HMA Roundup – Mark Trail

DCH Releases Integrated Eligibility System RFP. On November 27, 2013, the Department of Community Health (DCH) released a request for proposals (RFP) to replace various public assistance eligibility systems with a single integrated eligibility system (IES). The RFP requires a system that is compliant with ACA and CMS requirements, while aligning the needs of DCH; the Departments of Public Health, Human Services, Early Care and Learning; the Georgia Technology Authority (GTA), and other partners. The closing date for the proposals is January 15, 2014 and an offerors conference will be held on December 11, 2013. Notice of intent to award is expected by early May 2014. The contract award would allow the state up to six fiscal years of renewals. Read more.

Most Georgia Counties are Dependent on Rural Hospitals. A WALB.com article focuses on the challenges faced by rural hospitals facing the prospect of closing due to reimbursement pressures and increasing costs. Most of the state's counties rely on the 63 rural-based hospitals. Given the state's refusal to pursue Medicaid expansion along with cuts in disproportionate share (DSH) payments, Georgia's critical access hospitals and FQHCs are feeling the squeeze in delivering care to some two million rural Georgians. Read more.

Grady Health System's Mental Health Program at Risk. Last week, Georgia Health News published a feature on the dicey financial challenges of Grady Health System's mental health program. With the Atlanta-based safety net provider facing some $100 million in funding cuts, mental health programs—which lose $6 million annually—are among the areas subject to elimination. CEO John Haupert notes that Grady is the second largest provider of mental health services in the state, behind only the prison system, but a combination of Medicaid funding cuts, DSH payment cuts, and Fulton County proposed cuts could cause the slicing of services. Various constituencies fear that the elimination of Grady's mental health programs would result in more people on the streets, more crime, and longer waiting lists for behavioral health services around Atlanta. Read more.

Hawaii

Hawaii Health Connector Executive Director to Resign on December 6. On November 22, 2013, Hawaii Health Connector Executive Director Coral Andrews said she will resign effective December 6, 2013. The role will be filled by Tom Matsuda, the state's ACA implementation manager, on an interim basis. The exchange's board of directors has begun an official search for a permanent leader of the marketplace. Andrews had previously served as vice president of the Healthcare Association of Hawaii. Read more.

Indiana

HMA Roundup—Cathy Rudd

Indiana Still Waits for Federal Approval of "Personal Responsibility" in Medicaid. Last week, a Gannett article explored the waiting game Indiana is playing in gaining federal approval of proposed increases in "personal responsibility" under the Healthy Indiana Plan. Gov. Mike Pence has explicitly tied any Medicaid expansion to one modeled on the state's Healthy Indiana Plan, which limits the amount of care that participants may receive and requires cost sharing on the first $1,100 of care. While federal law limits premiums on individuals making less than 150 percent of Federal poverty level income, the state aims to clarify that required contributions to an account cannot be considered a premium but a co-pay that is permissible under federal statutes. Read more.

Iowa

Gov. Branstad Optimistic About Federal Approval of Waiver. On December 3, 2013, Governor Terry Branstad expressed hope for federal approval for the state's Iowa Health and Wellness Plan under a Medicaid waiver in the "very near future." Branstad noted the bipartisan nature of the agreement, the progress in signing people up, and the relatively glitch-free web site. Gov. Branstad acknowledged prior federal concerns about monthly premiums, but they could be waived if individuals meet certain health goals or demonstrate hardship. Already, more than 50,000 Iowans have signed up for the program and another 4,199 have applied for health coverage through the state. Read more.

Maine

ACA Advisory Committee Avoids Pushing Medicaid Expansion, Despite Majority Approval of the Concept. In a December 2, 2013 meeting, the Maine Health Exchange Advisory Committee avoided recommendations related to Medicaid expansion, although all but one member of the panel support taking the 100 percent federal funding for expansion. Gordon Smith, executive VP of the Maine Medical Association, expressed concerns that stepping into such controversies would hurt committee efforts on other issues. Some committee members are pushing for more data from CMS, the Maine Department of Health and Human Services, and the Maine Bureau of Insurance to determine who is applying for subsidies and how many Maine residents are ineligible for subsidies but disqualified from Medicaid. The committee will likely support actions to simplify enrolling for coverage. Read more.

Maryland

Maryland State Medical Society Notes Greater Interest in Accepting Medicaid Patients. According to a member survey conducted by the MedChi, the Maryland State Medical Society, 46 percent of doctors are considering accepting Medicaid reimbursement. Among those who already accept Medicaid, some 57 percent plan to increase the number of Medicaid patients they see. With the temporary increase in payments to physicians under Medicaid, more physicians appear interested in engaging with Medicaid patients. Read more.

Massachusetts

HMA Roundup—Rob Buchanan

Health Policy Commission to Review Partners-South Shore Deal. Last month, the Massachusetts Health Policy Commission voted unanimously to commence a cost and market impact review of Partners Health Care's proposed acquisition of Harbor Medical Associates, as part of the larger examination of Partners' acquisition of South Shore Hospital in Weymouth. The physician alignment is a major component of the hospital merger, so both transactions will be examined together on cost, quality, access to care, and competitiveness. The preliminary review is due by year end, which will trigger a comment period by the respective hospitals, before a final vote is taken in January 2014. A negative review by the commission would be expected to affect the evaluation of other state and federal officials, who are empowered to block the deals. Read more.

Study Indicates Mandated Behavioral Health Screening is Working to Secure Necessary Treatments. In a recent study published in Pediatrics magazine, new enrollments in MassHealth (the state Medicaid program) indicate that mandatory behavioral health screening in the state has identified large numbers of children with problems that would not otherwise have been treated. Newly identified children are more likely to be from historically undertreated groups, reflecting the benefits of screening for engagement and re-engagement in mental health services. These newly identified children were younger, more likely to be Asian, and less likely to be male, white and in foster care. Read more.

Former CMS Head Promotes Exploring Single Payer. Dr. Donald Berwick, former CMS head and gubernatorial candidate, recommends exploring a "single-payer" system as part of his healthcare platform. He wrote that "it is time to explore seriously the possibility of a single payer system in Massachusetts" to address the complexities and "hassles" of the current system. He notes that Vermont is already evaluating a statewide single payer system. In addition, Berwick's platform emphasizes pursuing mental health services and substance abuse treatment as a central and integrated part of healthcare system. Read more.

Michigan

HMA Roundup—Esther Reagan

Updates on Integrated Care for Dual Eligibles. The most recent edition HMA's *Michigan Update* discusses the state of the proposed integrated care demonstration for dual eligibles in four regions of the state. The state is currently finalizing a Memorandum of Understanding (MOU) with CMS, working with CMS to develop the Medicare and Medicaid capitation rates for the ICOs and PIHPs, and preparing necessary waiver documents in order to implement the demonstration. In early November, the state released results of the analysis of submitted proposals from the July RFP for ICOs. The table below identifies the successful bidders by region, with their rank ordering on the basis of total score. Each of the tentatively awarded ICOs will need to successfully complete a readiness review. Approximately 105,000 duals are targeted for this demonstration; the totals by region appear in the table below.

Dual Eligible Demonstration Integrated Care Organization Bidders by Region

Bidder Name	Region 1	Region 4	Region 7	Region 9
Estimated Total of Duals Targeted for Demonstration	**9,000**	**21,000**	**58,000**	**17,000**
Amerihealth Michigan, Inc.			Rank 4	Rank 4
CoventryCares of MI, Inc.		Rank 1	Rank 3	Rank 3
Fidelis Secure Care of MI, Inc.			Rank 6	Rank 6
McLaren Health Plan, Inc.			Bid	Bid
Meridian Health Plan of MI		Rank 2	Bid	Bid
Midwest Health Plan			Rank 5	Rank 5
Molina Healthcare of MI			Rank 2	Rank 2
ProCare Health Plan			Bid	Bid
UnitedHealthcare Comm. Plan, Inc.			Rank 1	Rank 1
Upper Peninsula Health Plan, LLC	Rank 1			

Note: *Region 1 is the Upper Peninsula. Region 4 is the eight-county region in southwest Michigan (Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph and Van Buren). Region 7 is Wayne County and Region 9 is Macomb County.*

The health plans identified as "Bid" in the table submitted proposals but were not ranked among the top six plans chosen tentatively for awards: McLaren Health Plan, Inc., Meridian Health Plan of Michigan and Pro Care Health Plan, Inc. Meridian and Pro Care have submitted protests but the results of the state's review of the protests have not been made available to date.

On November 22, 2013, Michigan Department of Community Health (DCH) staff held the first in a series of implementation meetings with the potential ICO contractors to discuss next steps in the procurement process. Highlights of implementation details include:

- **Readiness reviews will be conducted by NORC at the University of Chicago**, an organization contracted for this purpose, and the process will commence as soon as the MOU is finalized, which is expected to be in the near future. NORC is performing the readiness reviews in all states and the review will consist of a desk review and a site visit. Michigan's implementation plan may result in some portion of the reviews being performed on a staggered basis.
- **DCH is developing a state level consumer advisory council** to assure stakeholder participation in the demonstration implementation process. As discussed in the two regional stakeholder forums, DCH will provide training to consumer members of the ICO governing body to assure their informed participation.
- **Medicaid rates are being developed with the assistance of Milliman**. Draft rates are expected to be available by late January 2014. CMS is calculating the savings amount for both Medicaid and Medicare.
- **DCH expects to provide training for the potential ICO contractors** on a number of topics including self-determination and person-centered planning. Training may also be provided on care coordination, the Care Bridge, the beneficiary appeals processes for both Medicare and Medicaid, and features of the state's data warehouse.

- **DCH plans to work with both the ICOs and the Prepaid Inpatient Health Plans (PIHPs)** on developing a statewide definition of mild to moderate behavioral health needs and expects to develop a common framework for the contracts between ICOs and PIHPs to cover data sharing, bi-directional reporting and the Medicare payment flow.
- **DCH indicates that individuals receiving hospice care will not be included in the demonstration.** This is a change from what was stated in the RFP, which had indicated the individuals could be enrolled but hospice care carved out.

Link to Michigan Update

Medicaid Expansion to Help Inmates. A November 30, 2013 Washington Post-Kaiser Health News article highlights how Medicaid expansion in the state will help both inmates and former detainees obtain necessary healthcare, which may reduce recidivism. Since 1997, some Medicaid funds have been allocated to cover specialized hospital care for 24 hours or more outside the prison system for inmates who had been covered by Medicaid before incarceration. Michigan received $8 million in matching funds for that purpose in the most recent fiscal year, but that figure could grow to as much as $20 million in 2014. Michigan has used state funds to cover healthcare for released prisoners for about a decade and has seen a nearly 16 percent drop in its prison population over the last five years. Recidivism among released prisoners with special needs — has been cut from 50 percent in 1998 to 22.5 percent in 2012. Read more.

Missouri

New Medicaid Director Named. On November 22, 2013, Gov. Jay Nixon named Dr. Joe Parks as Missouri's next Medicaid Director, effective December 16, 2013. Dr. Parks is currently the chief medical officer for Missouri's Department of Mental Health. The Medicaid position had been open since the May 2013 departure of Ian McCaslin. Dr. Parks will step down from his positions as Director of the Missouri Institute of Mental Health (University of Missouri-St. Louis) and as President of the Medical Director's Council of the National Association of State Mental Health Program Directors. Read more.

New Hampshire

New Hampshire Transition to Medicaid Managed Care Going Well. On December 3, 2013, DHHS Commissioner Nicholas Toumpas said that the first few days of the state's Medicaid managed care program had gone smoothly. About 104,000 of the state's 130,000 Medicaid beneficiaries had been transferred to managed care plans. Read more.

New York

HMA Roundup—Denise Soffel

MLTC Phase 4 Underway. Phase 4 of the mandatory Medicaid managed long-term care program began on December 1, 2013, including the "urban upstate" counties: Albany, Onondaga (Syracuse), Monroe (Rochester) and Erie (Buffalo). The state expects a total of about 5,000 individuals enrolling in those four counties. Subsequent phases are not scheduled, but will not occur before April 2014, as CMS requires the

state to give 90 days' notice before beginning implementation of the mandatory program in a new county. The biggest issue affecting the timing of the roll-out is counties demonstrating adequate provider network capacity. It is still the state's goal to implement the mandatory program state-wide.

New York State of Health Enrollment Updates. NY State of Health announced that as of December 1, the Exchange has accepted 284,440 completed applications, and 91,103 New Yorkers have enrolled in plans on the Exchange. The state will post weekly enrollment numbers on the Exchange website. The rates for the health plans on NYSOH represent a 53 percent reduction compared to the previous year's rates in the individual market. In addition to this cost-savings, it is estimated that nearly three-quarters of individual enrollees will qualify for financial assistance.

Vital Access/Safety Net Provider Program Awards. Governor Cuomo announced $46 million in awards to 37 organizations across the state to support projects that will improve community care, particularly for fragile, elderly and low-income populations. The VAP program was established by the Medicaid Redesign Team to achieve defined financial, operational, and quality improvement goals related to integration or reconfiguration of services offered by a facility. Specific examples include:

- Expand access to ambulatory services through additional needed services or added hours of operations;
- Open urgent care centers to help reduce use of emergency rooms;
- Improve quality through reduced adverse events thus also reducing overall costs;
- Expand services in rural areas through additional primary and specialty care services;
- Establish care coordination between providers and levels of health care service delivery; and
- Provide more effective services that meet the needs of the community.

Read more.

Memorial Sloan-Kettering Added as In-Network Provider on Several Exchange Plans. Crain's New York reports that several health plans offered on the New York State of Health will include Memorial Sloan-Kettering within their networks. The hospital had already been a network provider for Oscar Health Insurance and Health Republic Insurance of New York, which uses the MagnaCare network of providers (that includes Memorial Sloan-Kettering). In addition, the hospital is in negotiations with other plans available on the exchange. Read more.

Oklahoma

Governor Warns of $60 Million Medicaid Shortfall. On December 2, 2013, Gov. Mary Fallin warned that the Medicaid program would need to make up for $60 million in lower federal matching funds due to the state's increase in per capita income. In addition, she warned that more funding will be necessary to pay for growth in Medicaid enrollment associated with the "woodwork effect" or "welcome mat effect" of currently eligible Oklahomans. Tax collections have trailed earlier projections and prior year levels, so the legislature may need to act on special funding measures. Read more.

Oregon

Cover Oregon Does Not Expect Online Enrollment Before March 31. At a recent legislative hearing, Cover Oregon Executive Director Rocky King told legislators that the Exchange would plan to do a full manual system until March 31, 2014, the end of the open enrollment period. The Exchange is telling residents to use the web site to compare plans and then file paper applications. While Oracle—the state's IT contractor—aims to enable online enrollment for community partners and agents (and eventually the general public), King is not convinced that it will happen. In addition, the Exchange is withholding 5 percent of the payments due to Oracle given the contractor's performance on the contract. Read more.

Pennsylvania

HMA Roundup –Matt Roan

PA Blues Plans extend "Special Care" Coverage Options. The PA Insurance Department has encouraged health plans to continue coverage for customers who had received terminations related to the implementation of the Affordable Care Act. The four Pennsylvania Blue Cross Blue Shield plans have responded with announcements that it will extend coverage through its "Special Care" programs to allow consumers more time to shop for alternative plans on the Health Insurance Exchange. Special Care is a program offered by Blues Plans that offers bare bones coverage at a low price for consumers who don't qualify for Medicaid. These policies do not meet the Essential Health Benefits required of all insurance plans under the ACA. Statements from the Blues plans suggest that consumers should be able to find more comprehensive coverage through the Exchange at a lower cost when Federal subsidies are taken into account. At least two of the plans, Highmark and Independence Blue Cross, have indicated that they will be requesting Insurance Department approval for premium increases for their Special Care plans effective January 1, 2014. Read more.

Governor Corbett Highlights State Alzheimer's Planning Efforts. During a visit to a nursing facility in Allentown, PA, Governor Corbett touted the work of an advisory group formed earlier in the year to develop a statewide Alzheimer's management plan. The Governor reported that an estimated 280,000 Pennsylvanians have Alzheimer's and that a comprehensive plan is needed to ensure adequate services to this vulnerable population. The Planning Committee is expected to deliver its report to the Governor in February of 2014. Read more.

Fiscal Year to Date State Revenue Collections Continue to Beat Projections. PA Department of Revenue reporting continues to show that collections are slightly above projections. For the month of November, the Commonwealth collected $1.7B in General Fund revenue, beating estimates by about $800,000. Fiscal Year to Date collections are up by about $42.6 million or 0.4% above projections. While Personal Income Tax and Sales Tax collections lagged slightly below estimates, corporate taxes, inheritance taxes, and realty transfer taxes all beat projections.

Aetna and PinnacleHealth System Announce Accountable Care Agreement. Aetna has announced a new partnership with PinnacleHealth System in central PA to implement an accountable care model. Beginning in April of 2014, Aetna will offer fully insured and self-insured health plans that leverage PinnacleHealth's community-based service delivery system. Under the agreement the new products will be co-

branded and PinnacleHealth has agreed to meet certain quality and cost outcomes for enrolled members. Read more.

Rhode Island

Report Raises Questions About Self-Financing Capability of HealthSource RI. Last month, the Rhode Island Public Expenditure Council (RIPEC) issued a report, *"HealthSource RI: Status Updates,"* evaluating results and future prospects for the state's Exchange. While premiums on the Exchange are among the lowest in the New England region, deductibles are among the highest. Given that the Exchange had been created by executive order, it is still incumbent on the state to write the entity into law for revenue purposes. With federal funding for the Exchange drying up in 2015, all forms of self-sustaining funding mechanisms must be considered, including premium surcharges. Read more.

South Dakota

Governor Will Not Rule Out Expansion of Medicaid. In a speech on December 3, 2013, South Dakota Gov. Dennis Daugaard reiterated his opposition to expanding Medicaid, but would not rule it out in the future. He indicated interest in broadening health coverage for tens of thousands of South Dakotans by other means. Democrats were heartened by the slight opening for potential Medicaid expansion. Read more.

Texas

HHS Commissioner Questions CMS Temporary Process for Transferring Medicaid Applications. On December 3, 2013, Texas Health and Human Services Commissioner Kyle Janek questioned the temporary process set up by CMS to transfer Medicaid applications from the federal health insurance marketplace. Janek raised concerns about the accuracy of information being sent, additional workloads on the state, and a general lack of testing. Janek found the spreadsheets sent by CMS to be error-ridden, according to Janek. Moreover, Janek was unclear about how the federal government would communicate errors to the affected individuals. Read more.

Texas Issues NEMT RFP. On November 25, 2013, the Texas Health and Human Services Commission issued a Request for Proposal (# 529-15-0002) for Nonemergency Medical Transportation Services, with a due date of January 15, 2014. The sole point of contact for the proposal is Robert Hall within the procurement and contracting services division of HHSC. Read more.

Vermont

Vermont Health Connect Security Lapse Reports Sent to Governor and Attorney General. A November 30, 2013 Associated Press article reported on three security lapse reports sent to Vermont's governor and attorney general regarding a mid-October security lapse on the Vermont Health Connect website. Mark Larson—commissioner of the Department of Vermont Health Access—notified CMS, and state officials following a data breach on October 17, 2013, but failed to mention the incident at a legislative hearing on November 5, 2013. Larson and Shumlin characterized the incident as too insignificant to mention. At the hearing, Larson said, "We

have found no situation where somebody's private information has been breached.'' However, AP reporting of the incident on November 22, 2013 triggered a firestorm of criticism about Larson's veracity. Read more.

Additional Funds Sought for Medicaid, Emergency Housing, and Corrections. On December 2, 2013, the Department of Children and Families requested a tripling of funds for emergency housing to provide temporary shelter for the homeless. House Appropriations Committee Chair Martha Heath questioned why a state with such low unemployment would have a sudden spike in housing assistance requirements. In addition, the Shumlin Administration is seeking $7 million more in Medicaid funding due to increasing caseloads. The Department of Corrections has requested another $1.5 million in funding to transfer inmates to out-of-state prisons to free space for pre-trial detainees. Read more.

Washington

HMA Roundup – Doug Porter

Washington State MOU Signed for Dual Eligible Demonstration. Last month, Washington State's Medicaid program and CMS signed a memorandum of understanding that will launch a duals demonstration in Snohomish and King Counties. The Department of Social and Health Services and the Health Care Authority have collaborated with county officials to design the model, which will institute a shared savings program. The project will integrate medical, behavioral, and long-term care to align benefits for the medically complex. Regence BlueShield and United Healthcare are the two successful health plan bidders. Read more.

Wyoming

Wyoming Governor Rejects Medicaid Expansion. On November 29, 2013, Wyoming Gov. Matt Mead rejected Medicaid expansion due to the multiple glitches and problems associated with the Affordable Care Act. Mead characterized the ACA as having eliminated more people from existing insurance plans than successfully enrolling the uninsured. Democratic Senate Minority Leader Chris Rothfuss bemoaned the state's opportunity cost of $750 million in additional federal funding over seven years. Read more.

National

Administration Announces Major Healthcare.gov Fixes, But Delays Federal SHOP Marketplace to 2015. Coming off the Thanksgiving holiday break, the Obama administration announced significant repairs to the Healthcare.gov enrollment website and a renewed publicity push to get people to enroll. The repairs appear to have had some success, as Politico reported on December 4 that around 29,000 people were able to enroll through the website on Sunday, December 1 and Monday, December 2 alone. The two-day total accounts for roughly 20 percent of all enrollments since October 1. However, the administration also announced that the federal Small Business Health Options Program (SHOP) Exchange would be delayed until the 2015 enrollment period.

Marketplaces Driving Medicaid Enrollment Increase as Some Warn of Doctor Shortages. Preliminary data released by HHS on December 3, 2013, shows a nearly 15 percent increase in Medicaid enrollment applications in the month of October, likely driven by the push for coverage expansion through the state and federal health insurance Marketplaces. (Read more.) Meanwhile, the New York Times reported on November 28, 2013 that expanded Medicaid programs could exacerbate doctor shortages and access issues for Medicaid patients, particularly when the enhance primary care payments rates under the ACA expire. Read more.

Industry Research

Managed Medicaid 2013: New Growth, New Challenges. A new report from Corporate Research Group (CRG) provides statistical data on Medicaid plan financial performance, membership, and utilization data among both for-profit and not-for-profit entities. It also takes a close look at the pipeline for managed Medicaid conversions, the fate of the dual demonstration, and the outlook for expansion under the Affordable Care Act. For more information, please visit: http://www.corporateresearchgroup.com

Industry News

United CEO Discusses Health Reform Impact. United Healthcare CEO Stephen Hemsley indicated in comments at the company's investor conference that 2014 annual earnings will be "profoundly impacted" by the Affordable Care Act (ACA). Hemsley cited the payment of as much as $1.9 billion in new taxes and fees, as well as rate reductions to Medicare Advantage plans as driving the impact. United, which is largely absent from the health insurance Marketplaces in 2014, will not see the impact of increased individual market business as a result of the Marketplaces, but is well positioned to receive significant newly eligible Medicaid enrollment in its Medicaid managed care business. Read more.

WellCare Approved to Expand South Carolina Medicaid Business. On November 26, 2013, the South Carolina Department of Health and Human Services (SCDHHS) approved WellCare to expand into six additional counties in the state, beginning January 1, 2014. WellCare will serve the Medicaid managed care population in all but one county across the state. In addition, Carolina Medical Homes membership is expected to shift to WellCare on January 1, 2014. Read more.

Kindred Healthcare Completes Acquisition of Senior Home Care. On December 2, 2013, Kindred Healthcare announced it had completed the acquisition of Senior Home Care, Inc. for $95 million. Senior Home Care was one of the largest home health providers in Florida and Louisiana, with 47 locations and annual revenue of roughly $143 million. Read more.

Towers Watson Acquires Liazon, Targets Private Health Benefit Exchange Expansion. Towers Watson announced on November 22, 2013, that it has acquired Liazon Corporation, which operates an online benefit marketplace for employers and employees. The acquisition is viewed as strengthening Towers Watson's existing OneExchange private health benefit exchange offerings. Read more.

RFP Calendar

Date	State	Event	Beneficiaries
December 1, 2013	New Hampshire	Implementation	130,000
December 1, 2013	Florida LTC (Region 11)	Implementation	17,257
December 16, 2013	Tennessee	Contract Awards	1,200,000
December 30, 2013	Delaware	RFP Release	200,000
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	Virginia Duals	Implementation	79,000
January 1, 2014	Texas Duals	Implementation	214,400
January 22, 2014	Texas NorthSTAR (Behavioral)	RFP Release	406,000
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
April 17, 2014	Texas NorthSTAR (Behavioral)	Proposals due	406,000
May 1, 2014	Washington Duals	Implementation	48,500
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 30, 2014	Delaware	Contract awards	200,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
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
July 7, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	406,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
January 1, 2015	Vermont Duals	Implementation	22,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	406,000

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	Opt- in Enrollment Date	Passive Enrollment 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	5/1/2014	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			TBD	Blue Cross of Idaho
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	70,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
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	9/1/2014	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	60 days prior to passive	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	X			10/25/2013		7/1/2014	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013		5/1/2014	
Vermont	Capitated	22,000	10/1/2013	TBD	TBD Dec. 2013			1/1/20115	
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013		5/1/2014	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**13 Capitated 6 MFFS**	**1.5M Capitated 485K FFS**	***9***			***8***			

** 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

"Clinical Management Apps: Creating Partnerships Between Providers and Patients"
The Commonwealth Fund

Sharon Silow-Carroll, Author
Barbara Markham Smith, Author

The market for health applications, or apps, on mobile devices is growing rapidly, with over 40,000 currently in use. One type of app technology—clinical management apps—enable patients and providers to work together to manage chronic conditions, particularly diabetes and asthma. Challenges to broader adoption of apps include the lack of objective research to evaluate outcomes, uncertainty about how to pay for and encourage the use of cost-effective apps, and the absence of a regulatory framework that standardizes development to ensure performance. If this infrastructure is developed, apps may serve as a catalyst to stimulate the transformation of health care generally and target low-income populations to expand access to care and help reduce health disparities. Link to Report.

"Stewards of Affordable Housing for the Future - Health and Wellness Outcomes Measurement"
Presented to Stewards of Affordable Housing for the Future

Mike Nardone, Author
Matt Roan, Author
Linda Trowbridge, Author

Over the past year, SAHF has engaged HMA to assist in developing a common set of health and wellness outcome measures as well as to provide an overview of the current healthcare landscape and advise on potential financing strategies for engaging the healthcare system to support housing as a vehicle to improve health outcomes. This is part of a broader effort, SAHF and its members are undertaking to gather, aggregate and apply outcome measures across five topics areas to determine the impact and cost implications of the resident services they provide. This spring, HMA finalized a report highlighting the effort to date. View the full report here.

"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