HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

December 18, 2013

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

The HMA Weekly Roundup will not be published for the next two weeks. We will resume weekly publishing on Wednesday, January 8, 2014. HMA and the Weekly Roundup team wish all our readers a happy and safe holidays.

IN FOCUS

PUERTO RICO ISSUES RFI FOR MEDICAID MANAGED CARE, TARGETING PROCUREMENT IN EARLY 2014

This week, our *In Focus* section comes to us from Juan Montanez of HMA's Washington, DC office and provides an update on recent developments of a potential Medicaid managed care procurement in the territory in early 2014. Even as the local legislature and Governor García Padilla's administration continue to explore options for transforming the Commonwealth's health care system, the Health Insurance Administration--better known by its Spanish acronym, ASES--and the Department of Health are working on changes to the Government Health Insurance Plan (GHIP). This program, known informally in Puerto Rico as *MI Salud*, is the government-run medical assistance program that incorporates Medicaid and CHIP federal funds and serves more than 1.6 million Commonwealth residents.

RFI Issued

On December 6, 2013 ASES published a Request for Information (RFI) soliciting input from health care organizations and insurers in the lead up to a Request for Proposals (RFP). According to the RFI, the RFP may be issued as early as next January.

In the RFI, ASES has communicated the Government's intentions regarding changes in the design of *MI Salud*:

- **The Government "seeks to return to risk-based MCOs."** It is not yet clear whether this means that only traditional health insurance companies will be able to bid on this RFP. That noted, given the island's history of large physician groups managing financial risk through sub-capitated arrangements and Governor García Padilla's health care platform, which called for the development of "regional integrated delivery systems," it is possible that the *MI Salud* program will be opened up to organizations other than traditional insurers.
- **The Government seeks to "incorporate behavioral health and physical health services into one contract."** This is a major change in the design of the program, which will inevitably result in a different mix of contracts.
- **The Government intends to "have more than one health plan in each region."** For purposes of managing the program and awarding contracts for behavioral and physical health services, the GHIP divides Puerto Rico into eight geographic regions and a ninth "virtual region," which covers foster children and victims of domestic violence. Historically, only one physical health MCO and one behavioral health organization (BHO) have been selected to offer services in each region. As a U.S. territory with capped annual Medicaid federal funding, Puerto Rico is not required to adhere to the Medicaid provider freedom-of-choice provisions of the Social Security Act. That notwithstanding, CMS has been encouraging Puerto Rico to build in choice of plans within each GHIP region. Were this proposed change to be implemented, it would be another significant departure from the current program design.

Responses to the RFI are due Wednesday December 18, 2013. In the RFI, ASES posted a tentative procurement schedule (below), which is aggressive although not inconsistent with previous GHIP procurement cycles.

Event/Milestone	Date
Issue RFP	January 2014
Select Finalists (for Contract Negotiation)	March 2014
Conduct Readiness Review	April/May 2014
Implementation	July 2014

HMA Medicaid Roundup

California

HMA Roundup—Alana Ketchel

Covered CA Plans Include 80% of State Physicians. On December 11, 2013, Covered California officials clarified that 80% of the state's practicing physicians and 360 hospitals are available through the Exchange's health plans. This came after reports focused on the plans' narrow provider networks, raising concerns about access. Peter Lee, Covered California's CEO, stated there are contingency plans to require health plans to expand their networks if needed. The two largest commercial plans in the state have 63,000 and 72,000 physicians in their networks compared to Covered California's 58,000. Read more.

96% of Covered CA Enrollment in Four Private Plans. The LA Times featured an article about Anthem Blue Cross' early market share leadership in private plan enrollment on the Covered California Exchange, with 30% of the private plan enrollees through November 2013. Blue Shield came in with 27% share, Kaiser Permanente boasted a 24%share, and Health Net featured a 16% share. Seven other Exchange offered plans shared 4% market share. Read more.

California Granted More Time to Reduce Prison Population. In June 2013, federal judges ordered the California government to release 8% of the prison population by 2014. The deadline to release the prisoners has already been extended, but on December 11, 2013, judges added more time for California to negotiate a solution and, if negotiations fail, California will have until April 18, 2014 to meet prisoner population targets. Read more.

Covered CA Enrollment Jumps in December but Still Few Latinos. In figures released December 12, 2013, Covered California reported that more than 156,000 people enrolled in health plans as of December 7. Almost 50,000 Californians signed up in the first week of December alone. Medi-Cal applicants rose to 179,000. Concern remains, however, regarding the low participation rate among the Latino population. Spanish speakers comprised just 5% of enrollees in October and November, far below the expected 29% rate, which reflects the state's demographic composition. Read more.

Pending Medicare Legislation Could Impact Reimbursement Rates in Some CA Counties. A December 14, 2013 article published by the Press Democrat highlights that prospective changes in Medicare's Sustainable Growth Rate (SGR) formula—to be taken up by Congress in early 2014—may increase Medicare reimbursement to providers in high population counties in California. Counties usually designated by Medicare as rural, including Sacramento, San Diego, and Sonoma Counties, will be redefined as urban under the new agreement, increasing physician reimbursement

by at least 6% in the affected areas. Elizabeth McNeill, head of government relations for the California Medical Association, said that there is unprecedented bi-partisan agreement on the SGR bill. Read more.

DHCS Updates Duals Enrollment Strategy for LA County. On December 9, 2013, the California Department of Health Care Services (DHCS) released an updated draft enrollment strategy for Los Angeles County under the Cal MediConnect dual-eligibles care coordination pilot. DHCS estimates that 288,399 Medicare and Medi-Cal beneficiaries are eligible for passive enrollment into a Cal MediConnect health plan in LA County, although the CMS agreement has an enrollment cap of 200,000. The updated timetable calls for voluntary enrollment in Cal MediConnect to be allowed from April 2014 to June 2014. Cal MediConnect plans will not be allowed to receive passive enrollment if they fail readiness reviews or have a CMS Low Performing Icon (LPI). Under the current draft proposal, Health Net would be eligible to receive passive enrollment as soon as July 1, 2014. If LA Care does not have an LPI designation on its 2015 CMS star rating, passive enrollment could begin as soon as December 1, 2014. Dual-eligibles currently enrolled in a Medi-Cal managed care plan by HealthNet or LA Care would be enrolled in a Cal MediConnect product from the same carrier on July 1, 2014. Read more.

Insurance Card Critical to Tapping Non-Emergency Care. In a December 16, 2013 article, Kaiser Health News highlighted the myriad problems from online enrollment in health plans offered on California's Exchange to actual effective coverage. With various enrollment glitches, handoffs of data from the Exchange to insurers, confirmation packets to consumers, and bills that must be paid by January 6, 2014, there are various opportunities for delays that might prevent enrollees from receiving an insurance card to use for non-emergency care in the new year. While some 60,000 invoices by insurance companies, few premiums have actually been paid to date. Read more.

Colorado

HMA Roundup—Joan Henneberry

Colorado Private Health Plan Enrollment Now Approaching Low-End Target for December. Connect for Health Colorado confirmed that enrollments in private plans available on the state's Exchange have reached 23,009 as of December 14, 2013, creeping closer to the low-end 36,900 target for the month established before the October 1, 2013 launch of the Exchange. More than 13,000 of those enrollees had completed applications in the first half of the month. As of December 14, 2013, nearly 50,000 Coloradans had been enrolled in the newly expanded Medicaid program in just two weeks, up from the 64,290 figure at the end of November. Read more.

District of Columbia

DC Options Charter School Investigated for Potential Medicaid Fraud. A December 16, 2013 Washington Post article focused on a federal investigation into potential Medicaid fraud by former leaders of the DC Options Public Charter School. Among the concerns are inflated Medicaid payments for school bus usage and exaggerated characterizations of the needs of its disabled students. On December 16, 2013, the DC Public Charter School Board voted to take steps to close Options. Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

AHCA Challenges Health News Florida Story about "Bumpy" Transition to Managed Long-Term Care. On December 11, 2013, Health News Florida published an article about a study conducted by Georgetown University Health Policy Institute that cited a high level of auto-assignments of long-term care beneficiaries. The study noted cumbersome enrollment, inadequate care plan notifications, and the potential for case managers to stop being advocates for frail and elderly patients. On December 12, 2013, the Florida Agency for Health Care Administration (AHCA) issued a press release that claimed the article "omits facts about recipient choice (and) responsibility in the long-term care program." AHCA noted it had implemented an extensive choice counseling system and that auto-assignments accounted for multiple relevant factors, including existing Medicare Special Needs Plan (SNP) or Medicare Advantage plan relationships and provider relationships. Read more.

Georgia

HMA Roundup – Mark Trail

Georgia Exchange Participation Remains Low. On December 11, 2013, Georgia Health News published an article that highlighted a quintupling in Georgia enrollees in health plans available on the Exchange—from 1,390 at the end of October 2013 to 6,859 by the end of November 2013. However, the 6,859 figure represents just 3.4% of the Administration's original target of 204,000 enrollees by the end of March 2014. The Department of Community Health has cited administrative burdens with manually processing beneficiary information from the federal healthcare.gov portal. HHS has reported that 61,443 Georgians had completed health plan applications, up from 28,642 at the end of October, potentially covering as many as 122,543 people. Read more.

Hawaii

Hawaii Health Director Dies in Plane Crash. On December 11, 2013, Hawaii's Health Director Loretta Fuddy died in a small plane crash off Kalaupapa. There were eight survivors. Fuddy had been appointed to her position in 2011 by Gov. Neil Abercrombie. Read more.

Illinois

Illinois Health Connect contract awarded to incumbent Automated Health Systems. Illinois Health Connect, the state's Medicaid Primary Care Case Management program, announced intent to award a new contract to the incumbent vendor, Automated Health Systems, on Thursday, December 12, 2013. Under the contract, Automated Health Systems will continue primary care provider (PCP) enrollment in Illinois Health Connect, as well as enrollment assistance in the newly formed Care Coordination Entities (CCEs) and the Accountable Care Entities (ACEs) currently being procured. The 2 year contract begins January 1, 2014, and has an option for up to 3 extension years.

Illinois Duals Demonstration contracts signed, network review underway. At the Illinois Department of Healthcare and Family Services (HFS) December 17, 2013 Medicaid Advisory Committee (MAC) meeting, HFS announced that contracts has been signed with the 8 health plans in the state's dual eligibles demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI). The state is currently reviewed network adequacy and stated that not all plans may be operating in all of the MMAI demonstration counties on the date of implementation if networks are deemed inadequate. The MMAI is set to begin voluntary enrollment coverage on February 1, 2014, with passive enrollment to begin on May 1, 2014.

Governor Quinn agrees to shift Medicaid eligibility work to state employees, MAXIMUS to continue in supporting role. On December 17, 2013, Governor Pat Quinn agreed to a negotiated agreement with the AFSCME union regarding the union's suit on the state's outsourcing of eligibility and enrollment verification to MAXIMUS. The agreement allows MAXIMUS to continue providing software, call center services, and a mailroom through June 2015, but the state will now be responsible for hiring as many as 500 new employees to handle additional workload. The state hired MAXIMUS in 2012 to conduct the eligibility and enrollment verification process in response to legislation mandating a review of the Medicaid rolls and disenrollment of ineligible enrollees. MAXIMUS has been providing eligibility recommendations to state employee case workers, who have then made final eligibility determinations. Read more.

Indiana

HMA Roundup—Cathy Rudd

Fiscal Intermediary RFP Issued for Consumer Directed Aged and Disabled Program. On December 11, 2013, Indiana's Family and Social Services Administration Division of Aging issued an RFP for fiscal intermediary services for its consumer directed program available through the aged and disabled waiver. Indiana seeks a single organization to provide cost-effective and accessible payroll and tax services to the A&D waiver participants. The Division of Aging authorizes attendant care services up to 40 hours per week and participants hire, manage, and dismiss personal care attendants. The pre-proposal conference is slated for December 19, 2013, questions are due on December 20, 2013, and proposals are due on January 24, 2014. The awarded contract will be for two years and two one-year extensions possible for a total of four years. The incumbent is PCG Public Partnerships. The current contract is for five and a half years for a total of $1.5 million. Read more.

Pence to Meet with Sebelius in February on Healthy Indiana Plan. Last week, Governor Mike Pence announced that he plans to meet with Health and Human Services (HHS) Secretary Kathleen Sebelius in February 2014 during a National Governors Association meeting to discuss the state's proposal to use the Healthy Indiana Plan (HIP) as the vehicle for Medicaid expansion. Sebelius offered flexibility to work with Indiana in helping to make HIP compliant with federal Medicaid rules but specified that the current HIP rules are not acceptable as they stand. Indiana will have to submit a request by June 30 to extend HIP beyond 2014 but will have to adapt current rules that otherwise requires co-pays of some of the poorest Hoosiers and imposes enrollment caps. Read more.

Iowa

Iowa Accepts HHS Adaptations to Iowa Health and Wellness Plan. On December 12, 2013, Iowa Governor Terry Branstad agreed to expand the state's Medicaid program using the Iowa Health and Wellness Plan. A compromise between the state and the HHS allows the state to charge modest premiums to beneficiaries earning more than 100% of the federal poverty line (up to 133%). Branstad joined Arkansas with an approved alternative expansion approach, rather than merely expanding eligibility for the traditional Medicaid program. Read more.

Maryland

Governor O'Malley Announces Maryland Exchange Changes and Delayed Deadlines for Enrollment. On December 16, 2013, Governor Martin O'Malley and Lieutenant Governor Anthony Brown announced steps to boost Exchange enrollment. The Maryland Exchange brought in Optum/QSSI to improve website performance. In addition, O'Malley appointed IT Department Secretary Isabel FitzGerald to lead the IT effort for the Exchange, following nine successful fixes to major issues within the website. CareFirst has agreed to extend the enrollment deadline from December 23, 2013 to December 27, 2013 and the payment deadline to January 15, 2014, which would still allow for effective coverage as of January 1, 2014. The state has undertaken discussions with other insurance carriers, as well. Read more.

O'Malley Acknowledges Exchange Difficulties and Projects Online Fixes to be Largely Complete in December. On December 12, 2013, Governor Martin O'Malley and Lieutenant Governor admitted that Maryland's Exchange had experienced a rocky start but was set to complete most technological fixes within December 2013. O'Malley reiterated a goal of signing up 260,000 Marylanders for health plans by the end of March 2014, nearly 150,000 of whom would be in private plans offered on the Exchange. As of December 7, 2013, 16,000 residents had signed up for Medicaid coverage and 5,200 for private plans. Once the state's Exchange site is fixed, Maryland will undertake an aggressive marketing campaign to goose enrollment. Read more.

Massachusetts

HMA Roundup—Rob Buchanan

Health Connector to Undertake Manual Steps to Process Applications. Last week, state regulators at a Health Connector Board meeting directed the blame for poor enrollment figures at CGI, the primary IT vendor for the Exchange. Massachusetts had nearly 97,000 accounts created on the Exchange as of December 10, 2013, but just 1,993 plans had been formally selected (albeit up from 800 as of the end of October 2013). Health Connector officials plan to use a standalone tool to assess eligibility for coverage and issue letters informing applicants of their plan options and subsidy estimates. Read more.

Minnesota

MNsure Executive Director Steps Down Amid Rollout Troubles and Vacation Controversy. On December 17, 2013, April Todd-Malmlov stepped down from her position as executive director of MNsure, Minnesota's Exchange. Following headlines about disappointing enrollment levels, technical glitches, and an international vacation scheduled in the midst of the Exchange's launch, Todd-Malmlov had been under significant criticism. Scott Leitz was named interim CEO of the Exchange

while the board conducts a national search for a permanent chief executive. Todd-Malmlov had spearheaded Exchange efforts since early 2011, following work as the state's health economist and positions with UnitedHealth Group. The state had enrolled 4,478 residents in private health plans, which represents 6.7% of the Obama Administration's target of 67,000. Read more.

New Hampshire

Medicaid Enhancement Tax Under Fire. On December 15, 2013, the Concord Monitor wrote about the future of New Hampshire's Medicaid Enhancement Tax (MET), which is currently the subject of two lawsuits and various bills in the legislature. The state relies on this hospital tax, which generates Federal matching funds, for nearly $146 million over a budget biennium. However, reforms contemplated in legislation would adjust the tax to reduce diversionary uses of the funds. Lawsuits assert that the MET unconstitutionally targets hospitals but not other providers for performing the same services. Read more.

Medicaid Managed Care Transition Proceeding Smoothly So Far. A December 16, 2013 AP article notes that New Hampshire officials appear pleased with the first few weeks of transitioning the state's Medicaid beneficiaries to a managed care program. The December 1, 2013 launch has yielded call center volumes and problem resolutions in line with expectations, although pharmacy claims appear to be an initial trouble spot. Read more.

NH Health Exchange Advisory Board Offers Update. At a December 12, 2013 Health Exchange Advisory Board meeting, insurance carriers noted improvements in the functions of the federal healthcare.gov exchange website, although Anthem Blue Cross Blue Shield of New Hampshire noted that it would be another week before the recent technical improvements would allow the company to tally the number of state residents who have applied or purchased plans on the Exchange. According to federal data, while 8,763 applications covering as many as 17,234 people, had been filed by New Hampshire residents at the end of November 2013, only 1,569 had enrolled in plans. Another 1,200 applications were due to be transferred from the federal Exchange to the state Medicaid office. Read more.

Minuteman Health Aims to Join NH Exchange in 2015. On December 13, 2013, the Boston Business Journal featured a story on Minuteman Health, a Massachusetts not-for-profit cooperative plan launched in partnership by Tufts and Vanguard/Tenet. The health plan launched in Massachusetts in October and hopes to expand as an Exchange-offered plan in New Hampshire in 2015, pending insurance licensure and an adequate provider network. In addition, Harvard Pilgrim confirmed that it hopes to join Minuteman and Anthem BCBS of NH as health plan carriers in the state. Read more.

New York

HMA Roundup—Denise Soffel

New York Health Exchange Enrollment. New York State reports it has enrolled 134,622 people in its health insurance exchange, a 33 percent increase over last week's report. Of those who have enrolled through New York's exchange, 95,196 have signed up for a private health insurance plan while 39,426 have enrolled in Medicaid.

Care Management for All – Nursing Home Carve-In. The nursing home benefit is being carved into the Medicaid managed care benefit effective March 2014. Originally scheduled for October 2013, the carve-in has been delayed twice as the Department of Health worked with stakeholders to develop the policy and implementation plan. Beginning with 8 downstate counties (NYC, Nassau, Suffolk and Westchester) all eligible recipients over age 21 in need of custodial care will be required to enroll in a Medicaid managed care plan or an MLTC. The need for long stay custodial placement will no longer trigger disenrollment from Medicaid managed care. Mandatory enrollment will expand to the rest of the state in September 2014. Beneficiaries currently in a skilled nursing facility will not be required to enroll in a plan; they will remain in the fee-for-service system. Six months after the mandatory program begins, individuals permanently placed in a nursing home will have the option of joining a Medicaid managed care plan on a voluntary basis.

Policies being developed reflect state and federal priorities regarding Olmsted and the goal of placement in the most integrated, least restrictive setting, and also emphasize person-centeredness and patient engagement in the care planning process. Members will not be subject to a lock-in provision; they can change plans at any time they choose in order to obtain access to a nursing home that is not part of their plan's network.

The state is encouraging plans to develop alternate payment arrangements with nursing home providers. Under New York's duals demonstration, Fully Integrated Dual Advantage (FIDA) plans will be required to enter alternate payment arrangements, including sub-capitation, bundled payments and shared savings. The state is committed to managed care plans sharing both risk and reward with the providers in their networks. This requirement will not be imposed on managed care plans in the mainstream program for at least the first two years, to allow providers to begin preparing for risk arrangements.

Waiver Amendment Request. State Medicaid Director Jason Helgerson reported that after a meeting with CMS earlier this week, he thinks they are "rather close to approval" on NYS's waiver amendment request for a Delivery System Reform Incentive Payment (DSRIP) Plan. The state posted its draft submission on the MRT website and is seeking comments on the draft through January 15. The plan is specifically designed to reduce avoidable hospital use by 25 percent statewide within five years. New York was ranked last in the country in its rate of avoidable hospitalization according to the Commonwealth Fund State Scorecard. The plan is intended to downsize unneeded inpatient capacity, transform hospital delivery, and provide funding to community-based providers to expand their capacity. The plan specifically encourages hospitals to reach out to community partners in developing projects. The proposed DSRIP plan identifies 25 programs that are divided into three focus areas, including:

- Hospital Transition, Public Hospital Innovation, Primary Care Expansion and Vital Access Providers;
- Long Term Care Transformation; and
- Public Health Innovation.

Projects would be selected through an RFP process. All projects will be evaluated against four performance measures: avoidable hospitalizations, cost savings, number of Medicaid beneficiaries affected, and the robustness of the evidence base supporting the intervention. Public hospitals will be eligible for about half the DSRIP funding, other safety net institutions (including long-term care, ambulatory care and behavioral health) will be eligible for the other half.

The state is hoping that CMS approval will come before the end of the year. The project timetable would have projects due the end of April, with decisions about fund allocation by June 1.

SUNY Downtown Votes to Convert LICH into a Residential Condos and Health Care Services. On December 17, 2013, SUNY Downstate Trustees approved the initiation of negotiations with the highest-scoring proposal for the Long Island College Hospital campus in Brooklyn, although the Executive Committee that met afterwards decided to table the decision. The proposal that had been selected was from Brooklyn-based developer Fortis Property Group and included healthcare services provided by ProHEALTH, a New York primary care and multi-specialty practice group already providing care in Brooklyn and other locations in New York. The proposed plan includes an array of primary care, specialty care, urgent care center, and office-based surgery as well as the development of a Community Foundation. SUNY currently has liabilities of nearly $500 million and monthly losses approaching $13 million. This will be a critical issue facing incoming New York City Mayor Bill de Blasio when he takes office and Kings County Supreme Court Justice Carolyn Demarest must still approve a deal.

Pennsylvania

HMA Roundup –Matt Roan

Medicaid Medical Home Bill Approved by House Committee. The House Health and Human Services Committee has approved a bill that would form a Patient Centered Medical Home Council in Pennsylvania to advise the Department of Public Welfare on policy options for implementing changes to the state's healthcare delivery system that would include primary care physician-led care teams. Representative Matt Baker (R) Chair of the Committee noted that 26 other state Medicaid programs have established Medical Home program, and that similar efforts in the state would complement more comprehensive reforms that are a part of the Governor's Healthy PA initiative and Pennsylvania's State Innovation Model (SIM) grant project with CMS. Read more.

UPMC Responds to Proposed Legislation with Attack Mailers Targeting State Representative. A proposed law co-sponsored by Representative Jim Christiana (R) and Rep. Dan Frankel (D), which would require integrated health systems which include both hospital systems and health plans to accept payment from all insurance carriers has drawn a unique response from UPMC. The proposed law addresses the ongoing conflict between UPMC and Highmark as both companies have threatened to shut members of competing health plans out of each organizations hospital systems. UPMC has sent a mailer to constituents of Representative Christiana claiming that the legislator has abandoned his conservative principles and is seeking to increase government interference in healthcare. UPMC officials deny that the mailer is politically motivated, claiming that they saw a need to educate residents about what they view as an inconsistency between his proposed legislation and his political philosophy. No mailers were sent to residents of Representative Frankel's (the Democratic co-sponsor of the bill) district. Read more.

Report Ranks PA High on Physician Supply, but Retention of New Docs is a Challenge. A report from the Association of American Medical Colleges has ranked Pennsylvania 10th among the states in the ratio of physicians to the general population. According to the study, Pennsylvania has 253 physicians engaged in patient care per 100,000 residents. Despite the strong supply of physicians, state policymak-

ers remain concerned about the availability of primary care, especially as residents have access to new health coverage options under the Affordable Care Act, and the Governor's Healthy PA initiative. Additionally, despite ranking fourth in the country in terms of medical school students, Pennsylvania ranks 37th in terms of retaining new doctors as recent medical school graduates relocate to other states, often to take advantage of more generous loan forgiveness programs. Read more.

Governor Corbett Resists Moving Kids from CHIP to Medicaid. Governor Corbett is continuing his push to retain low-income children in the state's CHIP program rather than shifting them to the state's Medicaid program despite indications from the federal government that moving children from families with incomes less than 133% of federal poverty level is required by law. It was announced last week that the Corbett Administration had come to an agreement with HHS to pursue a phased approach for the transition, ensuring that families would not experience disruption of care on January 1, 2014 which is when, under the ACA, states must implement the changeover. HHS agreed to grant extensions to this deadline provided that Pennsylvania submit a transition plan, but instead Governor Corbett has proposed that families have a choice to remain in CHIP or transition to Medicaid when their current CHIP coverage comes up for annual renewal. Nearly 50,000 CHIP recipients fall into the income categories to be transitioned. Advocates have noted that the Medicaid program offers more generous benefits for children but that access to providers is generally better in the CHIP program due to higher reimbursements. HHS has not responded to Corbett's proposal. Read more.

Tennessee

Tennessee Awards Three Incumbents Statewide Medicaid Managed Care Contracts. On December 16, 2013, the state of Tennessee completed its evaluations of proposals submitted for its TennCare statewide Medicaid managed care reprocurement. The three incumbent Medicaid managed care plans—UnitedHealthcare, BlueCare Tennessee, and AmeriGroup—were awarded contracts under the new contracts, outpacing rival bids by Aetna, Centene, and Cigna. Contracts are slated to be announced and signed on December 27, 2013, with the contract effective through December 2016, with up to eight one-year extensions. All Medicaid benefits—spanning physical health, behavioral health, and long-term services and supports (which includes care for the dual eligibles)—are covered under the TennCare contracts. All Medicaid managed care plans are required to offer D-SNPs (dual eligible Medicare Advantage Special Needs Plans) in every county of the state. Read more.

Texas

HMA Roundup—Dianne Longley and Linda Wertz

Texas Enrollment in Exchange Health Plans More than Quadruples in a Month. With last week's release of state-by-state enrollment information by the HHS, it was revealed that 14,038 Texans had selected a plan through November 2013 using the federally facilitated Exchange, second only to Florida. In addition, nearly 119,000 Texans had completed applications representing about 245,000 people but had not selected plans. The 14,038 figure more than quadrupled the 2,991 Texans who had selected a plan as of the end of October 2013 but still represented just 2.2 percent of the Obama Administration's original target for enrollments in qualified health plans in Texas. Read more.

Virginia

Virginia Announces Duals Awards to Three Plans. On December 9, 2013, Virginia's Department of Medical Assistance Services (DMAS) completed its evaluation of proposals for the Medicare-Medicaid Alignment Demonstration. The state announced its intention to award all regions—Central VA, Northern VA, Tidewater, Western/Charlottesville, and Roanoke—to Humana, Health Keepers, and VA Premier Health.

Washington

Washington Healthplanfinder Woes May Push Back Enrollment Deadline. In a December 15, 2013 article, the Seattle Times published an article highlighting the likelihood of a delayed enrollment deadline for Washington residents who continue to be stymied by technical glitches at the Healthplanfinder website. Over the weekend, officials at the Washington Health Benefit Exchange, which runs Healthplanfinder, cited ongoing dialogues with insurers about extending timelines for residents to submit applications and pay their premiums, while still qualifying for health coverage effective January 1, 2014. Exchange CEO Richard Onizuka expressed sympathy with individuals who have been frustrated by the system and will report back insurer responses to the deadline extension request. Read more.

Washington's Estate-Recovery Rules May Be Under Review. The Seattle Times featured an article on Washington State's estate recovery rules that may apply more broadly to deceased Medicaid beneficiaries to cover routine healthcare expenses, not just long-term care. On December 13, Governor Jay Inslee's office and the state Medicaid office aims to write an emergency rule that would limit estate recovery to long-term care and related medical expenses. While the state might forfeit about $3 million in potential revenues, Dr. Bob Crittenden—senior health advisor to Inslee—noted that the move would be the right thing to do given that Medicaid beneficiaries over 55 would be held to tougher expense recovery efforts than more affluent participants in the state's health exchange. Last month, Oregon officials removed the Medicaid estate-recovery provisions for routine expenses and removed the age provision, as well. Read more.

Wisconsin

Wisconsin Democrats Offer Legislation that Would Allow Counties to Accept Medicaid Expansion Funding. On December 10, 2013, the Journal Sentinel published an article focusing on the legislative initiative of Assembly Democrats to give counties the ability to tap enhanced Federal Medicaid matching funds the state had otherwise rejected. Eighteen counties have passed resolutions backing Medicaid expansion and State Rep. Melissa Sargent believes her legislation would improve local finances, while expanding Badgercare. However, Sargent acknowledges that her bill may go nowhere with Republican majorities in the legislature and Governor Scott Walker opposed to expansion. Read more.

National

HHS reports nearly 365,000 enrolled in qualified health plans through November. According to a new HHS report, 1.9 million have made it through the eligibility process but have not yet selected a plan. An additional 803,077 were determined or assessed eligible for Medicaid or the Children's Health Insurance Program (CHIP) in October and November by the Health Insurance Marketplace. Read more.

MACPAC recommends Medicaid benefit parity for pregnant women, 12-month continuous Medicaid eligibility. At last week's Medicaid and CHIP Payment and Access Commission (MACPAC) meeting, the commission unveiled a recommendation that states offer identical comprehensive benefits to women who are eligible for Medicaid due to a pregnancy as those available to women whose are Medicaid eligible as parents of dependent children. Under the Affordable Care Act, states are able to continue a category of eligibility for pregnant women, which includes limited pregnancy-related services only, even if they have opted to expand Medicaid. Read more. The commission also recommended that states be allowed to implement 12-month continuous eligibility for Medicaid to mitigate the negative impacts of Medicaid beneficiaries "churning" between Medicaid and Exchange eligibility. The proposed change would allow individuals on Medicaid to remain on the program throughout the year, even if their income fluctuates above Medicaid eligibility thresholds. The Congressional Budget Office estimates this programmatic change would cost between $50 billion and $250 billion in 2015, and less than $1 billion over five years.

Industry News

WellCare appoints New York plan president. WellCare announced on December 12, 2013 that it has permanently appointed John J. Burke as the state president of WellCare's Medicaid and Medicare Advantage operations in New York. Burke has served as the interim state president in New York since September 2013. Burke has been with WellCare since 2004. Prior to joining WellCare, Burke was vice president of network management for Healthfirst in New York and served on that company's board of directors from 1999 to 2001. Read more.

Centene announces agreement to acquire majority stake in Fidelis SecureCare of Michigan. Centene announced on December 18, 2013 that it has signed an agreement to acquire a majority stake in Michigan's Fidelis SecureCare, a deal expected to close in late 2014. According to Centene's press release, Fidelis SecureCare was recently selected by the Michigan Department of Community Health as one of six health plans to provide integrated healthcare services to members who are dually eligible for Medicare and Medicaid in Macomb and Wayne counties. The program is expected to serve approximately 90,000 of the dual-eligible beneficiaries in the state, with enrollment expected to commence in the fourth quarter of 2014. Read more.

Centene announces agreement to purchase majority interest in U.S. Medical Management, LLC. On December 12, 2013, Centene announced it will acquire a majority interest, approximately 68%, in Troy, Michigan's U.S. Medical Management, LLC, expected to close in early 2014. USMM provides a continuum of in-home services including primary care, health risk assessments, home health, hospice, podiatry, radiology, DME, lab, and pharmacy. Read more.

RFP Calendar

Date	State	Event	Beneficiaries
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 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 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	350,000	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	X	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	105,000	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	2/1/2014	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	Humana; Health Keepers; VA Premier Health
Vermont	Capitated	22,000	X	TBD	TBD Dec. 2013			1/1/2015	
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	7/1/2014	9/1/2014	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**	***11***			***8***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

‡ Capitated duals integration model for health homes population.

HMA News

HMA Supports CHC Efforts to Secure ACA Mental Health Services Funds

HHS recently announced it will soon make $50 million in Affordable Care Act mental health services funds available for community health centers (CHCs) to create and expand integrated behavioral health services. While details are yet to be released, HMA is prepared to support health centers take advantage of the mental health services funds.

HMA can help CHCs with a wide array of services, including:

- Creating and implementing a model of integrated care
- Adding behavioral health services at CHCs
- Hiring and training staff
- Providing tools to aid successful integration
- Assessing and redesigning existing services

To learn more, email:

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