HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 12, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Jim Kumpel, CFA
Email

Andrew Fairgrieve
Email

THIS WEEK

IN FOCUS

TEXAS ISSUES DRAFT RFP FOR STAR HEALTH PROGRAM

This week, our *In Focus* section reviews the draft request for proposals (RFP) issued by Texas' Health and Human Services Commission (HHSC) for the STAR Health program, which services children and young adults who are currently in or formerly were in the foster care system. STAR Health currently serves around 32,000 children and young adults under a single managed care contract with Centene's Superior Health Plan. HHSC published a draft RFP on February 7, 2014, and comments will be accepted through February 20, 2014. HHSC's draft RFP timeline indicates the state is targeting a RFP release in early April 2014 with an implementation date of September 2015.

Target Population

The draft RFP placed particular importance on the integration of physical and behavioral health needs of the foster care and former foster care population. STAR Health eligible individuals include the following:

- Children and young adults in Department of Family and Protective Services (DFPS) conservatorship;
- Adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement;
- Adults aged 18 through the month of their 21st birthday who are participating in the Former Foster Care Children (FFCC) program or are participating in the Medicaid for Transitioning Foster Care Youth (MTFCY) Program due to ineligibility for the FFCC program; and
- Adults aged 21 through the month of their 23rd birthday who are participating in the Former Foster Care for Higher Education (FFCHE) Program due to ineligibility for the FFCC program.

Supporting documents indicate that during fiscal year 2012, a total of 49,356 children and young adults were eligible for STAR Health at some point during the year. As of October 2013, 31,260 were enrolled in Centene's Superior Health Plan. This discrepancy likely results from the number of individuals cycling out of eligibility due to age or other eligibility criteria.

RFP Timing and Contract Term

Per the draft RFP timeline, comments will be accepted until February 20, 2014. Based on these comments, a final RFP will be released on April 8, 2014, with a vendor conference and question and answer period to follow. Proposals are due on June 6, 2014 with a contract award announcement date to be determined. Implementation is set for September 1, 2015. These dates are subject to change in the final RFP.

Milestone	Date
Draft RFP Released	February 7, 2014
Draft RFP Comments Due	February 20, 2014
RFP Released	**April 8, 2014**
Vendor Conference	April 17, 2014
Respondent Questions Due	April 25, 2014
Letters Claiming Mandatory Contract Status Due (see note below)	May 1, 2014
HHSC Posts Responses to Respondent Questions	May 9, 2014
Proposals Due	**June 6, 2014**
Contract Awards	**TBD**
Implementation	**September 1, 2015**

The initial contract term will be dependent on the date the contract is made effective. Per the draft RFP, the initial term will extend through August 31, 2018. The state may extend the contract for any additional duration with a maximum contract term of 8 years.

Texas Mandatory Contracting Rule

In the timeline above, the due date for letters from health plans claiming mandatory contract status are due on May 1, 2014. Under Texas Government Code, health plans are eligible to automatically receive a managed care contract in their region if the health plan is wholly owned and operated by a hospital district in that region, or is operated

by a nonprofit corporation working under contract with a hospital district in that region to serve the safety net population. Eligible health plans must submit a response to the RFP and meet all of the same terms and conditions as other bidders. Source: Link to TX Government Code 533.004

Contract Awards and Market Opportunity

The draft RFP does not appear to suggest a number of likely contract awards. Although the STAR Health program is currently served statewide by Superior Health Plan, the draft RFP would indicate that bidders may offer to serve more limited geographic areas, which would necessitate multiple awards.

STAR Health per-member-per-month (PMPM) capitation rates for FY 2014 were roughly $813, up 5.4 percent from the previous year. Based on a PMPM of $850 and average monthly enrollment of 32,000, the estimated size of the total STAR Health population is $326.4 million annually.

Link to RFP Documents

Link to Draft RFP Announcement

Link to Draft RFP

Link to Draft RFP Procurement Library

HMA Medicaid Roundup

Alaska

Alaska's Backpayments Accumulate Following MMIS Upgrade. In a February 4, 2014 article, the *Alaska Dispatch* highlights the challenges in processing claims and generating on-time payments since the October 2013 "go-live" of its Medicaid Management Information System (MMIS) upgrade. The $32 million system replaced a 26-year old system, with 90 percent of the funding underwritten by the federal government. However, the Department of Health and Social Services acknowledged in a February 4, 2014 hearing that the system has been plagued with connectivity, programming, and claims processing glitches that have led to accumulating back payments that threaten the cash flows of smaller healthcare providers. In response, Alaska has begun offering providers advance payments ($118 million to date) to alleviate those cash flow concerns. Read more.

Arizona

Medicaid Expansion Lawsuit Dismissed by County Judge. On February 8, 2014, Maricopa County Superior Court Judge Katherine Cooper dismissed a lawsuit that had challenged the legality of a hospital assessment that was tied to the state's Medicaid expansion plan passed in 2013. Cooper deemed that the plaintiffs did not have the right to sue and represented a group within the legislature who lost a vote over H.B. 2010. The Goldwater Institute, which filed the suit on behalf of 36 GOP legislators and three citizens, promised to appeal the decision. Cooper noted that hospitals chose not to sue and would have been the only potentially damaged party with standing to sue. Read more.

Arkansas

Arkansas Model for Medicaid Expansion at Risk. A February 6, 2014 *Associated Press* article highlights the challenging legislative path ahead for the widely followed Arkansas approach to Medicaid expansion, using Federal matching funds for premium assistance to enable the expansion population to buy plans in the health insurance Marketplace. Though approved by the legislature in 2013, the reauthorization of the program is threatened by the loss of two Senate supporters—one through a GOP electoral win for a vacated seat and a reversal by a previous GOP supporter. So far, more than 83,000 Arkansans have enrolled in plans under the Arkansas model, and Governor Mike Beebe has aggressively emphasized that the state could lose more than $915 million in matching funds, hospitals could be endangered by reductions in disproportionate share payments, and health insurers could pull out of the market if reauthorization is not approved. Read more.

California

HMA Roundup—Alana Ketchel

Medi-Cal Pharmacy Cuts Take Effect. On February 7, 2014, a 10 percent decrease in Medi-Cal payments for certain prescription drugs took effect. KQED's "California Report" reported the concerns of some pharmacists and advocates that the cut would lead pharmacies to stop carrying certain drugs to avoid a loss, leaving patients without access to expensive medications. In response, the state created a list of 2,600 drugs that are exempt from the decrease in payment, but pharmacies will have to pay Medi-Cal for the remainder of the drugs dating back to June 2011 when the cuts became law. Read more.

Duals Demonstration Schedule Altered. On February 4, 2014, state representatives announced a new schedule for enrolling dual-eligible beneficiaries into managed care plans, under Cal MediConnect. San Mateo County will begin passive enrollment of beneficiaries at the originally scheduled date of April 1. However, in the other six counties participating in the demonstration, April enrollment will be solely voluntary. In LA County, passive enrollment will not start before July. Riverside, San Bernadino and San Diego counties are delayed until May 1 at the earliest. CalOptima and LA Care will not be allowed to passively enroll beneficiaries until at least January 2015 due to problems with performance. Read more.

California-based National Rural ACO Aims for Savings Across Three States. On February 7, 2014, *California Healthline* reported on the National Rural Accountable Care Organization (NRACO), which aims to improve care for rural residents in California, Indiana, and Michigan. The Medicare Shared Savings Program requires that ACOs serve a minimum of 5,000 patients. The National Rural ACO hopes to achieve that scale by networking rural hospitals across three states. NRACO's nine rural founding provider groups are Margaret Mary Community Hospital in Batesville, IN; Memorial Hospital in Logansport, IN; Alcona Health Centers in Lincoln, MI; McKenzie Health System in Sandusky, MI; Mammoth Hospital in Mammoth Lakes, CA; Northern Inyo Hospital in Bishop, CA; Southern Inyo Healthcare District in Lone Pine, CA; Ridgecrest Regional Hospital in Ridgecrest, CA; and John C. Fremont Healthcare District in Mariposa, CA. Read more.

Covered California Removes Physician Directories and Hires More Staff. On February 6, 2014, Covered California announced it would remove its combined provider directory until errors were resolved. According to a *New York Times* report, errors included inaccurate listings of language proficiencies, specialty designations, and insurance plan participation. The exchange has pointed consumers to individual plan directories to seek provider information until further notice. The exchange also attempted to address concerns regarding wait times for service and gaps in enrollment. On February 10, 2014, Covered California announced it would add 350 service center representatives by the end of March, among other improvements to outreach and enrollment processes. Read more.

L.A. Care Health Plan CEO to Step Down in January 2015. On February 7, 2014, L.A. Care Health Plan announced that its CEO, Howard A. Kahn, would leave the managed care organization in January 2015. L.A. Care enrolled 8,053 LA County residents on the state's exchange through December 31, 2013, reflecting 6 percent market share in the region. Kahn had previously been an executive at Cigna, Aetna, and the Health Plan of San Mateo. Read more.

Connecticut

Connecticut to Expand Scope of Nurse Practitioners. On February 7, 2014, a proposal (S.B. 36) by Governor Daniel Malloy to permit nurse practitioners to treat patients and prescribe medications independent of physicians was referred to the General Assembly's Joint Committee on Public Health. Currently, state law requires advanced practice registered nurses (APRNs) to collaborate with a licensed physician. The proposal would allow APRNs to practice alone after three years of collaborative work with a licensed physician. Last year, a similar measure was added as an amendment to another bill but was never taken up for a vote. The Connecticut State Medical Society is alarmed by the proposal, citing concerns about patient safety, training, and education. Public Health Commissioner, Dr. Jewel Mullen, noted that a review committee consisting of many healthcare stakeholders did not find that health safety would be impaired by the changes. The American Association of Nurse Practitioners highlights that seventeen states and Washington, D.C. allow nurse practitioners to treat patients independently and prescribe drugs. Read more.

Malloy's Budget Healthcare Initiatives Reviewed. In a February 6, 2014 article, the *Connecticut Mirror* focused on healthcare initiatives in Governor Malloy's proposed budget. The Katie Beckett waiver would receive $1.5 million in additional funding for the care of children with significant disabilities, expanding the program from 200 to 300 children in FY 2014-15. The Connecticut Home Care Program for Adults with Disabilities, serving 50 people with degenerative neurological conditions, would be doubled to 100 slots at a cost of $1.2 million in the next fiscal year and $1.6 million annually in future years. Malloy proposes to maintain the primary care physician payment increases at a cost of $15.1 million during the next fiscal year and $36.2 million per year subsequently. Regarding inmate health, Malloy proposes $4.3 million for a state-funded medical assistance program to provide care in the community to those in halfway houses. The state seeks between $40 million and $60 million in federal funds to implement the State Healthcare Innovation Plan but would initially allocate $3.3 million in state funds to push the project along. The budget would provide $4.25 million for mental health services, including $1.75 million for residential, transitional and other services for high-risk groups, including young adults; $2.2 million to help those with mental illness live in the community; and $250,000 for an anti-stigma campaign. The Department of Children and Families would receive $2 million in funding to expand community-based services for children and adolescents with complex behavioral needs. Read more.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Telemedicine Legislation Considered. On February 10, 2014, the *Miami Herald* examined efforts by some in the Florida legislature to reimburse telemedicine visits on par with in-person visits. Many Florida hospitals already provide these consultation services for overseas soldiers and contractors, which are usually covered out-of-pocket or through grants. The Senate Health Policy Committee held hearings to consider standards, reimbursement parity, and licensing issues. Senator Eleanor Sobel expressed the need to ensure that out-of-state healthcare providers are licensed in Florida. Read more.

Florida Medical Association Sidesteps Medicaid Expansion Position. On February 10, 2014, *Health News Florida* reported that the Florida Medical Association's Board of Governors sent a resolution supporting Medicaid expansion to committee, effectively tabling the issue. Dr. Aaron Elkin, sponsor of the resolution, expressed disappointment at the "politics involved," but vowed to form a coalition of groups to advocate for expansion in Florida. While the Texas Medical Association is actively advocating for the state to expand coverage, the Florida Medical Association remains neutral. Read more.

Managed Long Term Care Advancing in Florida. On February 11, 2014, *Kaiser Health News* focused on Florida's statewide rollout of managed long term care for its expanding senior population. While some beneficiaries may be able to move out of nursing homes into community settings, other individuals may have complex conditions that require around-the-clock oversight, potentially undermining the cost advantages of non-institutional care. To ease the transition for nursing homes, Florida is guaranteeing that reimbursements will not be cut in the first year, nursing homes could opt into all health plan networks in the first year, and an appeals system would ensure patients and families have a voice in care decisions. The article notes that while seven other states—Kansas, Delaware, Minnesota, Tennessee, Hawaii, New Mexico, and Arizona—also have statewide managed long term care efforts, Florida's program is the largest mandatory program. Read more.

Nova Southeastern and HCA Florida Hospital Plans Resubmitted. The *Sun Sentinel* noted that, on February 3, 2014, HCA Florida resubmitted an application with the Agency for Health Care Administration to build a teaching hospital on the Nova Southeastern University Davie campus. Just two months ago, the agency denied a similar request following letters of opposition from other Broward County hospitals. HCA spokesperson, Nicole Baxter-Miller, expressed optimism that the company will succeed in its proposal, which could spawn a 31-acre "Academical Village" complex to replace a strip mall. Read more.

Florida Moves Foster Kids into Managed Care. A February 11, 2014 *Kaiser Health News* article highlights the efforts of Florida and other states to coordinate the healthcare needs of foster kids using specialized managed care plans. Starting in May 2014, Florida will have a special Medicaid plan for an estimated 31,600 Florida children in the welfare system. Centene's Florida subsidiary, Sunshine Health, will manage the state's Child Welfare Specialty Plan for about $1.1 billion over five years. Sunshine Health will aim to integrate physical and behavioral health, dental and other services, and discretionary items to address both health and social needs. Read more.

Georgia

HMA Roundup – Mark Trail

Georgia House Appopriations Committee Approves FY15 Budget. On February 11, 2014, the Georgia House Appropriations Committee offered unanimous approval to a $20.8 billion budget for fiscal 2015, sending the budget to the full House. Some highlights related to Medicaid and PeachCare are reflected below:

Aged Blind and Disabled (ABD)

- Added funds to provide a 5 percent rate increase for Community Living Homes (ALS) and Personal Care Assistance (PSS) in the Community Care Services Program (CCSP)/SOURCE waiver
- Decreased state funds due to savings from the use of PARIS (an eligibility comparison to other states), eliminating duplicative enrollments

- Reduced state funds from increased hospital cost settlements
- Decreased state funds from the patient centered outcome incentives and DM programs

Low Income Medicaid (LIM)

- Reduced the increase for program growth
- Decreased state funds due to savings from the use of PARIS eliminating duplicative enrollments
- Included funds for the P4HB (Family Planning Waiver)
- Reduced state funds from increased drug rebates
- Reduced state funds from transfer of tobacco funds for the Georgia Center for Oncology
- Reduced state funds from increased hospital cost settlements

PeachCare

- Decreased state funds due to savings from the use of PARIS
- Reduced state funds from increased hospital cost settlements

Georgia GOP Evaluating Hospital "Bailout" Absent Medicaid Expansion. On February 9, 2014, the Associated Press profiled Georgia, Mississippi, and South Carolina—states that rejected Medicaid expansion—for their efforts to financially support hospitals that are losing disproportionate share payments. In Georgia, Atlanta's Grady Memorial Hospital, a safety net hospital, expects reductions of $141 million in federal funds, particularly given the hospital's patient mix consisting of 60 percent of either uninsured or Medicaid patients. Georgia State Representative Terry England is evaluating options that would pay tens of millions of dollars to hospitals. Governor Deal's budget officials project that the state's share of expanding Medicaid could be $2.8 billion over the next decade, but Georgia Budget and Policy Institute estimates that the net costs would be about $35 million annually after accounting for new taxes that offset costs. South Carolina has focused on raising Medicaid payments to rural hospitals from 60 percent of an uninsured patient's bill to 100 percent. Read more.

Georgia Community Boards May Have New Oversight. On February 8, 2014, *Georgia Health News* highlighted a bill that would update regulations on the 26 community service boards (CSBs) that offer services to 175,000 residents with behavioral health problems or developmental disabilities. The bill follows a September report on financial irregularities at Gateway Behavioral Health Services, whose CEO was fired. As a result, the Department of Behavioral Health and Developmental Disabilities (DBHDD) took over operation of Gateway last year. Senate Bill 349, sponsored by Senator Charlie Bethel, would mandate that CSBs have public or elected officials on their governing boards; allow contractual incentives and penalties; institute conflict-of-interest rules; require state approval of CSB subsidiaries; and prohibit lawsuits by a CSB against the state. The Georgia Association of Community Service Boards offered its support of the legislation. Read more.

Illinois

Illinois Unveils 1115 Waiver Proposal. Governor Pat Quinn's office announced on February 12, 2014 that the state had posted its 1115 waiver proposal, known as *"The Path To Transformation,"* which would allow the state to obtain $5.2 billion in federal funds over five years to reform the state's Medicaid delivery system. The waiver is organized around four "pathways to health":

- Transformation and modernization of the delivery system to create patient-centered health homes;
- Improving the overall health of the population through a focus on prevention, primary care and wellness;
- Building a 21st Century healthcare workforce; and
- Rebuilding and expanding the state's home and community-based infrastructure, especially for those with complex health and behavioral health needs.

Additionally, the 1115 waiver looks to incentivize delivery system reform and encourage stable housing for Medicaid beneficiaries. Governor Quinn's press release indicates the state intends to submit its request to CMS on March 12, 2014. Public hearings on the 1115 waiver will be held in Springfield, Illinois this week and Chicago next week. Link to Governor's Press Release. / Link to 1115 Waiver Webpage.

Maryland

Maryland Health Exchange Options Explored. On February 10, 2014, Maryland's Secretary of Health and Mental Hygiene, Joshua Sharfstein, told an oversight committee for the Maryland exchange that the ongoing system defects have necessitated substantial manual work and reliance on call centers. The state is evaluating alternatives for the next enrollment period, which begins November 15, 2014, including walking away from the state's current system. Compared to original estimates that Maryland would enroll 150,000 to 180,000 residents in private plans by March 31, 2014, the actual figures through February 7, 2014 stood at 29,059. Maryland awarded its primary contractor a $193 million five-year contract to build the exchange's system, but the defects in core software have prevented real-time status updates for applications. The state is evaluating the overhaul of its system, leveraging the Federal government's infrastructure, tapping other states' systems, or joining a consortium. Read more.

Massachusetts

HMA Roundup—Rob Buchanan

Governor Patrick Hires New Health Connector Management and Vendor. On February 6, 2014, Governor Deval Patrick announced new management to oversee the Massachuesetts Health Connector website development and a new technology partner to fix lingering problems. A detailed report from MITRE noted numerous failings by its current technology partner, as well as by state managers overseeing the project. To oversee the project, Patrick named Sarah Iselin, currently on leave from her position as chief strategy officer at Blue Cross Blue Shield of Massachusetts. Optum was chosen to address the backlog of people waiting for new coverage, much as it stepped into a similar role with the federal government's Healthcare.gov challenges. The Healthcare

Connector Board voted to approve a contract with Optum through April 30, 2014, which will be capped at $9.8 million for the first 30 days. Read more.

Michigan

HMA Roundup – Esther Reagan

Fiscal Year (FY) 2014-2015 Executive Recommendation. On February 5th Michigan Governor Rick Snyder made public his proposed Fiscal Year (FY) 2014-2015 Executive Budget Recommendation. The Governor's Recommendation totals $52.4 billion across all State Departments. Of this total, $10.1 billion is State General Fund, which represents an increase of nearly $650 million (6.8 percent) over the current year level of State General Fund spending. The Recommendation includes $11.9 billion in State School Aid funding. Major highlights of the Governor's Recommendation include:

- An increase in State School Aid expenditures of $322.0 million, $150.0 million of which would be used to increase the K-12 foundation allowance;
- An additional $65.0 million in funding for Early Childhood Education;
- Additional funding for State Higher Education ($80.3 million);
- An increase in Revenue Sharing payments to local governments of $19.4 million; and
- A proposal to provide to the City of Detroit $350.0 million over 20 years ($17.5 million per annum).

The Recommendation expands eligibility for the State's Homestead Property Tax Credit by increasing the homestead property tax credit's income limit and the size of the tax credit.

Proposed Michigan Department of Community Health Appropriation. Governor Snyder's proposed $17.4 billion Gross / $2.9 billion State General Fund appropriation for the Michigan Department of Community Health (MDCH) funds several expansions of existing health coverage and assistance programs. This represents a 7 percent increase ($191.4 million) in State General Fund spending in MDCH. Detailed below are major changes included in Governor Snyder's Recommendation for MDCH.

Medicaid. The FY 2014-15 Recommendation assumes $15.3 billion Gross / $2.3 billion General Fund to support Michigan's Medicaid program. The Recommendation proposes additional spending on several fairly significant program expansions.

- **Caseload, Utilization and Inflation:** The Recommendation projects a one percent growth in the Medicaid program caseload. The budget funds moderate cost growth in Medicaid physical and behavioral health care and the MIChild program. **($150.9 million Gross / $42.4 million General Fund)**
- **Medicaid Managed Care Rate Adjustment:** The Recommendation adjusts capitation rates paid to Medicaid HMOs for physical health care and to Prepaid Inpatient Health Plans (PIHPs) for behavioral health services to meet federal "actuarial soundness" requirements. The budget assumes a 2.5 percent increase for Medicaid HMOs and a 1.5 percent increase for PIHPs. **($121.9 million Gross / $42.0 million General Fund)**
- **Elimination of Rural Hospital Payment:** The FY 2013-14 MDCH budget included $35.6 million in Medicaid funding for a targeted payment to specified rural hospitals. Funding for this effort is not included in the Governor's Recommendation for FY 2014-15. **(-$35.6 million Gross / -$12.0 million General Fund)**

- **Graduate Medical Education (GME) Funding:** The Recommendation continues the baseline level of funding for GME at $158 million but does not repeat a "one time" appropriation of $4.3 million that was part of the FY 2013-14 appropriation.
- **Special Indigent Care Payments:** The Recommendation removes this $95.7 million line item (federal and local funds only) due to elimination of DSH payments based on Indigent Care Agreements.
- **Healthy Michigan Plan Savings Assumption:** The Recommendation assumes an average enrollment of 401,000 in the Healthy Michigan Plan for FY 2014-15. The proposed budget annualizes program savings in non-Medicaid behavioral health care service costs associated with implementation of the Medicaid expansion. **($16.0 million General Fund)**
- **ACA Primary Care Rate Increase:** Medicaid primary care services have been reimbursed at Medicare rates for calendar 2013 and 2014, with the rate enhancement supported with 100 percent federal funds. The 100 percent funding ends as of January 1, 2015. The Recommendation provides $26.0 million in General Fund dollars to support Medicaid primary care reimbursement at levels that include 50 percent of the difference between Medicaid and Medicare rates. **($75.4 million Gross / $26.0 million General Fund)**
- **Expansion of Healthy Kids Dental:** The Recommendation funds expansion of the State's Healthy Kids Dental program (that provides enhanced reimbursement for Medicaid children's dental services) to Macomb and Kalamazoo Counties. With the addition of these two counties, the Healthy Kids Dental program would be available in 80 of the state's 83 counties. **($15.7 million Gross / $5.4 million General Fund)**
- **MI Choice Expansion:** The Recommendation provides funding for an additional 1,250 individuals through the State's home and community-based services (HCBS) waiver program for the elderly and disabled. **($26.2 million Gross / $9.0 million General Fund)**

Mental Health

- **Mental Health Commission Report:** The Recommendation provides funding for implementation of the recommendations included in the Governor's Mental Health Commission report released this past month. **($10.6 million Gross / $10.6 million General Fund)**
- **Mental Health Jail Diversion:** The Recommendation also provides resources for an initiative to support strategies to prevent incarceration of individuals with serious mental illness or developmental disabilities. Funded strategies would include in-jail mental health treatment, crisis intervention teams and data collection.

Public Health and Other Services

- **Home Delivered Meals:** The Recommendation provides an additional $5.0 million for home-delivered meals and other in-home services provided through Michigan's Area Agencies on Aging. **($5.0 million Gross / $5.0 million General Fund)**

The Executive Recommendation will now be reviewed and discussed by both houses of the Michigan Legislature as the appropriation process begins in earnest.

Minnesota

Disability Funding Changes Creates Uncertainty. In a February 6, 2014 online article, *Minnesota Public Radio* focuses on changes in the way the state directs funding for community-based services for people with disabilities. The prior county-based systems created inconsistencies in rate-setting, occasionally leading to non-compliance with Federal regulations, resulting in a CMS mandate to shift to a statewide system. The January 1, 2014 debut of the new rate-setting tool has caused advocates and providers to fear inevitable cuts in payments and services, which could drive smaller providers out of business. Read more.

Missouri

Missouri Aims to Address Wait List for Developmentally Disabled. In a February 8, 2014 article, the *Associated Press* explores a proposal by Governor Jay Nixon to chip away at a nearly 1,400 person wait list to provide in-home services to the developmentally disabled. Nixon proposes spending $24 million in Medicaid funds to cover 970 people. Read more.

Nevada

Nevada Lowers Exchange Enrollment Targets. On February 6, 2014, Jon Hager, director of Nevada's Health Insurance Exchange, lowered the state's goal of enrolling 118,000 people in private plans to 50,000 by the end of March 2014. According to the *Las Vegas Sun*, Hager pinned the blame on technology glitches and has held back payments on its $75 million contract. Currently, there are 15,000 Nevadans who have enrolled and paid premiums. Read more.

New Hampshire

Bipartisan Deal to Expand Medicaid in New Hampshire. On February 6, 2014, state Senate leaders announced a bipartisan agreement to expand Medicaid in the state to pay for private insurance for 49,000 uninsured residents. Governor Maggie Hassan touted the agreement in her state-of-the-state speech shortly thereafter. The plan will require three federal waivers, will sunset after three years without 100 percent federal funding (subject to legislation to continue the program), and would apply the federal funding to premium assistance for private plans. If CMS approvals to implement the program are not obtained, the program would end on June 30, 2015. Read more.

New Hampshire Hospitals Challenge Medicaid Enhancement Tax. On February 10, 2014, lawyers for Catholic Medical Center, St. Joseph Hospital, and Exeter Hospital asked a judge to declare the Medicaid Enhancement Tax unconstitutional for not applying the tax to other providers who perform the same services. The state Department of Revenue Administration (DRA) responded that the legal challenge is a reaction to a reduction in disproportionate share payments. Last year, all New Hampshire hospitals paid $181 million in Medicaid Enhancement taxes. A ruling is expected in 60 days. Read more.

New Jersey

HMA Roundup—Karen Brodsky

Local Conference Planned on Accountable Care Organizations and Healthcare Delivery System Reform. On February 28, 2014, *NJ Spotlight* will hold a conference to explore the ways that primary healthcare providers, hospitals, and clinics are planning to meet the challenges of the existing and costly healthcare delivery system with a new delivery model, accountable care organizations (ACO). This two-session conference will review the differences between possible approaches, what works and what doesn't, with a keynote address by Dr. Jeffrey Brenner, medical director of Cooper Health System's Urban Health Institute and the executive director of the Camden Coalition of Healthcare Providers. It will run from 8:30 am – 2:00 pm at the RWJ Hamilton Center for Health & Wellness in Mercerville, New Jersey. For more information and to register: Link to Conference Information.

New York

HMA Roundup—Denise Soffel

DSRIP Update. New York has submitted a revised plan for its Delivery System Reform Incentive Payment (DSRIP) plan, and reports active negotiations with CMS. The $7.3 billion plan is focused on reducing avoidable hospitalization use (emergency department visits, readmissions, and admissions for potentially avoidable conditions). The state emphasized that projects must be built on community collaborations and that even the most integrated delivery system in New York does not have the capacity to meet the DSRIP goals. The network of community-based providers and services included in a DSRIP collaboration must be financially rewarded for contributions to the project through the distribution of incentive payments. The revised submission can be found on the Medicaid Redesign Team website. Read more.

NY State Exchange Enrollment Tops 412,000. On February 10, 2014, the New York State of Health announced that 412,221 New Yorkers have enrolled in health plans through the exchange, including 31,000 people in the past week alone. The mix of enrollees was 251,306 in private plans and 160,915 in Medicaid. About 697,000 residents have completed applications, but have not yet enrolled. Donna Frescatore, executive director of the exchange, noted that two-thirds of enrollees had been uninsured at the time of their application. The exchange call center has responded to more than 558,000 calls from New Yorkers since October. Read more.

Oregon

Basic Health Plan Study Approved. On February 5, 2014, the Oregon House Health Committee approved H.B. 4109 and referred the legislation to the Ways and Means Committee. The bill would require the Oregon Health Authority to study a "Basic Health Plan," a state-run health plan for working-class Oregonians who do not qualify for Medicaid. State Representative Brian Clem hopes the plan could provide a means for the working poor to pay $50 or less a month in premiums. Read more.

DOJ Criticizes Oregon's Community-Based Mental Health Progress. In a February 5, 2014 article, *StateofReform.com* noted a January 2014 report from the U.S. Department of Justice (DOJ), which found Oregon to have made limited progress in reducing the institutionalization of mental health patients in the state. In a 2012 settlement, the state had agreed to boost its community mental health programs to conform with the

Olmstead Act. The DOJ cited an inadequate supply of supportive services, such as housing and employment, deemed the state's mental health services as inadequately distributed throughout the state, and found that the services are not necessarily evidence-based. In 2013, the Oregon Legislature expanded funding for community mental health programs by $40 millionand added another $20 million in September. Oregon Health Authority Acting Director Tina Edlund noted that those funding measures were not necessarily reflected in the DOJ report. Read more.

Oregon Collaborative to Improve Behavioral and Physical Health Integration. Last week, the Patient-Centered Primary Care Home Institute announced a collaborative of 15 to 25 practices in order to identify ways to better integrate behavioral and physical health, particularly in mental health and substance abuse clinics. Oregon's coordinated care organizations (CCOs) and primary care homes have emphasized this integration, in part, because patients with severe mental illnesses and substance abuse problems tend to leave physical health conditions untreated, resulting in more frequent use of emergency rooms. The collaborative will run through February 2015. Read more.

Pennsylvania

HMA Roundup –Matt Roan

Budget Secretary Questioned on Proposed Medicaid Payment Delays. In the first of several legislative hearings on Governor Tom Corbett's proposed budget for SFY 14-15, on February 10, 2014, Budget Secretary Charles Zogby responded to lawmakers' questions on the Governor's plan to save money in the upcoming budget year by delaying Medicaid managed care payments by one month. The tactic of rolling Medicaid managed care plan payments into a future budget year has been used in the past to free up cash flow for other budget priorities. The Governor's budget assumes that the delay will result in an additional $390M in available funds for SFY 14-15. The Medicaid managed care payment delay is one of several one-time revenue sources that the proposed budget relies on to be balanced. Corbett administration officials have responded to criticism of the tactics by pointing out that similar budget fixes were routinely employed by former Governor Ed Rendell, a Democrat. Read more.

Medicaid Payments to Schools Delayed. School districts across the Commonwealth are complaining about reductions to and delays of Medicaid payments that support health-related services rendered to special needs students. School districts receive roughly $100 million per year in Medicaid funds through a program known as ACCESS meant to offset expenses for services to special needs students including one on one school nursing, medication administration, and special transportation accommodations. School officials anticipated a reduction in reimbursement due to a 2012 federal audit which found that some of the billed services were not Medicaid reimbursable. The audit resulted in new program rules which reduced reimbursement, but districts now face further challenges with late payments as the state has transitioned management of ACCESS claims to a new vendor. School districts have complained that reporting requirements are burdensome and that school officials have not been adequately trained on what is required to have claims paid. Additionally, new state requirements that claims include a letter of denial from the students health insurer have caused difficulty. School districts are required to submit a denial letter for each claim even though virtually all insurers deny coverage for the services schools are providing. Rather than submitting each claim to insurers first, school districts want to be able to submit blanket denial letters from insurers to meet the requirement. Read more.

Healthy PA Waiver to be Submitted by March 2014. In February 7, 2014 interview, Governor Tom Corbett announced that his administration plans to submit its waiver application for Medicaid reforms and coverage expansion under Healthy PA to CMS by the end of the month. The Governor said he expected a quick approval of the plan by federal officials, with whom the state has engaged in ongoing discussions as the plan was developed. The Governor reported that he expects that approval will be received prior to the State Budget being enacted in July 2014. Changes in the plan including implementation of new coverage options for low income uninsured Pennsylvanians would be implemented in January of 2015. Read more.

Legislature Passes a Bill Providing Income Exemptions for Low Cost Drug Plan for Seniors. Last week, the Pennsylvania House and Senate both unanimously passed a bill that would provide additional income disregards in determining eligibility for the Commonwealth's low cost drug plan for seniors known as PACE and PACENet. The bill would exempt Social Security Cost of Living Adjustments as well as Social Security income used to pay Medicare Part-B premiums from the income calculation for the program. The bill is currently on the Governor's desk awaiting signature. Read more.

South Carolina

South Carolina Seeks Additional Funds for Dental, Weight-Loss, and Health Screenings. On February 5, 2014, South Carolina's Medicaid Director Tony Keck presented a budget to a state House Ways and Means panel, which included $15.3 million from state taxes ($52 million overall, including federal funds) for preventative dental services for adults, weight loss programs for obese adults, and health screenings. Read more.

Vermont

Vermont Calls Off Eligibility RFP. On February 4, 2014, *Vermont Digger* reported that the state canceled its request for proposal (RFP) for an integrated eligibility project on January 24, 2014, when the Agency of Human Services found CGI was the only bidder. The revised eligibility RFP is expected in March 2014. Read more.

Virginia

Governor McAuliffe Calls for Medicaid Expansion. On February 5, 2014, Governor Terry McAuliffe called for a bipartisan compromise to expand Medicaid in the commonwealth, for the sake of the uninsured and the economy. House Speaker William J. Howell said that Medicaid expansion would not happen in this legislative session and a Medicaid reform commission was still doing work on improving the program. Read more.

Virginia Senate Republicans Offer Medicaid Alternative. On February 6, 2014, Virginia Senate Republicans unveiled "Marketplace Virginia" to bring more healthcare coverage to the working poor and expanded funding for hospitals, using a private option model. The concept relies on recovering $1.7 billion annually in state taxes used for the Affordable Care Act. House Speaker William Howell rebuffed the proposal as "Obamacare" by another name. Read more.

Virginia Senate Passes Mental Health Bill. On February 10, 2014, the Virginia Senate unanimously (38-0) approved S.B. 260, which would establish a 24-hour limit on involuntary emergency custody orders. The House gave preliminary approval to a

different measure, which would increase the limit to eight hours. Both chambers would create an online database to identify available beds in public and private facilities, as well as a "bed of last resort" within a state hospital. Read more.

Washington

HMA Roundup—Doug Porter

Washington Basic Health Plan May Be Revived. Washington State's innovative Basic Health Plan broke ground in 1987 by helping childless adults gain access to subsidized health benefits. With the Affordable Care Act, it would appear that this state-sponsored program is not necessary in states that have accepted Medicaid expansion. However, on February 5, 2014, the Health Care and Wellness Committee passed (by a vote of 9 to 8) H.B. 2594, which would direct the Health Care Authority to develop a "blueprint that establishes a federal Basic Health Program and submit it to the Centers for Medicare and Medicaid Services." Read more.

Washington Physicians Push for Higher Medicaid Rates, Telemedicine. On February 10, 2014, Washington state doctors lobbied for legislation that would preserve higher Medicaid payments for primary care services. In addition, physicians pushed for legislation that would pay for telemedicine services equal to in-person encounters. Read more.

National

HHS Reports 3.3 Million Enrolled in Exchange Plans as of February. On February 12, 2014, the Department of Health and Human Services' (HHS') released its monthly report on exchange enrollments, highlighting that 3.3 million individuals have enrolled in qualified health plans through the exchanges. Of these, 1.36 million enrolled through state-run exchanges, with 1.94 million enrolling through the Federal enrollment portal. Twenty-five percent of the enrollees (more than 800,000) are between the ages of 18 and 34. Additionally, the report notes that 62 percent of enrollees have selected Silver tiered plans, with 19 percent selecting Bronze, 12 percent selecting Gold, 7 percent selecting Platinum, and just 1 percent of enrollees selecting a Catastrophic plan. Finally, the report notes that 82 percent of the individuals who have selected health plans are eligible for financial assistance through the advance premium tax credit. Read more.

Administration Announces Partial Delay in Employer Mandate. On February 10, 2014, the Obama Administration announced a partial delay of the mandate that employers provide insurance to their employees. Beginning January 1, 2015, employers with 100 or more employees must comply with the coverage mandate. This had been previously delayed from a planned 2014 implementation. However, businesses with 50 to 99 employees will have one more year, until January 1, 2016, to comply with the mandate. Read more.

***Stateline* Update on Dual Eligible Financial Alignment Demonstrations.** Pew Charitable Trusts' *Stateline* this week takes a look at the progress and implementation of the 11 states pursuing federal dual eligible financial alignment demonstrations, as well as the handful of states looking at managed fee-for-service options. The writeup addresses the size and scope of the demonstrations as well as key issues and concerns about the demonstrations. Read more.

Industry News

Molina Healthcare Reports Year-End Results. On February 10, 2014, Molina Healthcare reported 2013 results, with full-year revenues of $6.6 billion, up 11 percent from 2012, and total membership of 1.9 million, up 7.5 percent from 2012. On the earnings conference call, Molina executives noted that January 2014 enrollment was up roughly 200,000 members due to expansion into South Carolina and increased Medicaid enrollments in other states. Molina did not release enrollment information for Exchange plans, but noted significant enrollment increases in California, Ohio, New Mexico, and Wisconsin. Read more.

Health Net Reports Year-End Results. On February 11, 2014, Health Net reported 2013 results, with full year revenues of $11.1 billion, down 2.1 percent from 2012. Total Western Region enrollment of 2.4 million members dropped 4.1 percent from the prior year period. The company made major investments to prepare for both the Affordable Care Act and the California Coordinated Care Initiative. The company offered 2014 EPS guidance of at least $3.00 on a 30 percent increase in revenues driven by 600,000 new members. Read more

Aetna Reports Year-End Results. On February 6, 2014, Aetna reported 2013 results, with full-year revenues of $47.3 billion, up 29 percent from 2012, medical membership of 22.2 million, up 22 percent from 2012. The company expects its Medicare Advantage membership to grow by 110,000 by the end of first quarter 2014. The company's Medicare business had a medical loss ratio of 87.9 percent, up from 85.6 percent in the prior year period, while the Medicaid business had a medical loss ratio of 84.7 percent, down from 87.3 percent in the prior year period. Read more

WellCare Health Plans Reports Year-End Results. On February 12, 2014, WellCare Health Plans reported 2013 results, with full-year premium revenues of $9.4 billion, up 29 percent from 2012, driven by a 59 percent segment increase in Medicare Advantage revenues and a 27 percent segment increase in Medicaid premium revenues. Medicaid segment membership of 1.8 million advanced 11 percent from the prior year period. The company estimated a net income impact of $1.17 to $1.26 per share in 2014, due to health insurer fees. In addition, the company projected that 2014 capital expenditures could grow as much as 50 percent over the prior year. Read more

Cigna, Others Weigh in on Exchange Plan Profitability. Cigna announced this week that it expects to post a loss on its Exchange business for 2014, citing low enrollment and older-than-anticipated enrollees. Cigna's announcement follows guidance from Humana and Aetna anticipating negative margins for 2014. Health Care Service Corporation, the parent company of Blue Cross and Blue Shield plans, is anticipating smaller margins, but could not yet determine if they would post a loss on Exchange business lines. Meanwhile, WellPoint is one of the few insurers projected a profit, announcing earlier this year and anticipated profit of 3 to 5 percent on their Exchange business. Read more.

AmeriHealth Caritas CEO Announces Retirement. Michael Rashid has announced his retirement as president and CEO of AmeriHealth Caritas as of March 31, 2014. Rashid has been with AmeriHealth since 1994 and CEO since 2010. Paul Tufano, currently the executive vice president at Independence Blue Cross and chairman of AmeriHealth Caritas, will be appointed CEO upon Rashid's departure. Anne Morrissey, chief operating officer at AmeriHealth Caritas, will also become president of the company. Read more.

RFP CALENDAR

Date	State	Event	Beneficiaries
TBD, Early 2014	Texas NorthSTAR (Behavioral)	RFP Release	406,000
February 27, 2014	Georgia ABD	Proposals Due	320,000
March 1, 2014	Florida LTC (Regions 1,3,4)	Implementation	18,971
March 21, 2014	Puerto Rico	Proposals Due	1,600,000
April 1, 2014	California Duals	Passive enrollment begins	456,000
April 1, 2014	Ohio Duals	Passive enrollment begins	115,000
April 4, 2014	Delaware	Proposals Due	200,000
April 8, 2014	Texas STAR Health (Foster Care)	RFP Release	32,000
April 11, 2014	Puerto Rico	Contract Awards	1,600,000
May 1, 2014	Virginia Duals	Passive enrollment begins	79,000
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
June 1, 2014	Illinois Duals	Passive enrollment begins	136,000
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 6, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
June 12, 2014	Delaware	Contract awards	200,000
July 1, 2014	Puerto Rico	Implementation	1,600,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Passive enrollment begins	68,000
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	New York Duals	Passive enrollment begins	178,000
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Washington Duals	Passive enrollment begins	48,500
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	406,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000

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 (CareMore)
Colorado	MFFS	62,982						7/1/2014	
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	3/1/2014	6/1/2014	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	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	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			TBD	
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		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	10/1/2014	1/1/2015	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	**12 Capitated 6 MFFS**	**1.2M Capitated 520K FFS**	***12***			***9***			

** 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 Prepares Chart Book for the New York State Health Foundation: *"Health Care Costs and Spending in New York State"*

Prepared by HMA's:
Diana Rodin, M.P.H.
Jack Meyer, Ph.D.

A New York State Health Foundation-funded chart book released this month, "*Health Care Costs and Spending in New York State,*" pulls together a compendium of information on health care costs, spending, and payments based on existing State and national research. Prepared by Health Management Associates, the slides in this online chart book synthesize a wide range of data into an easy-to-use resource that covers the impact of rising costs, drivers of spending growth, variations in spending, and the relationship between quality of care and spending. It illustrates trends over time, highlights regional variations within the State, and contrasts New York with the nation and other states. Link to Report.

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