HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Jim Kumpel, CFA
Email

Andrew Fairgrieve
Email

THIS WEEK

IN FOCUS

CMS PROPOSED INSURANCE EXCHANGE RULES FOR 2015 REVIEWED

This week, our *In Focus* section comes to us from HMA Senior Consultant Donna Laverdiere in our San Francisco office. Donna provides an overview of last week's proposed federal rules on the Exchanges and insurance market standards that would take effect in 2015.

On March 14, 2014, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule entitled *Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond.* This proposed rule includes provisions on a number of different issues including insurance market standards, Marketplace requirements, and provisions related to the premium stabilization programs. Some provisions of the proposed rule are adjustments to and expansions of existing requirements like standards for Navigators and Qualified Health Plans (QHPs), while others set forth new standards on which CMS had yet to regulate, in areas including quality reporting and QHP issuer oversight. Major provisions of the proposed rule include:

Changes to opt-out provisions for self-funded, non-federal governmental plans: The proposed rule codifies in regulation the requirement that self-funded, non-federal governmental plans can no longer opt out of requirements related to limitations on preexisting condition exclusion periods, requirements for special enrollment periods, and prohibitions on health status discrimination. The proposed rule also requires that opt-out elections be submitted in an electronic format and further clarifies that plan sponsors of self-funded, non-federal governmental plans offering coverage subject to a collectively bargained agreement ratified before March 23, 2010 can continue to be exempt from all seven of the original opt-out elections until the expiration of the last plan year subject to the agreement.

Statutory exceptions to guaranteed availability and renewability: The proposed rule codifies statutory exceptions to the guaranteed availability and renewability requirements in regulation, for example that enrollment in QHPs is restricted to citizens and lawful residents. The proposed rule also clarifies that only Federal law can create exceptions to the guaranteed availability and renewability requirements.

Product discontinuation and renewal: The proposed rule would allow issuers to make changes to existing plans due to ACA requirements within certain specified criteria without those changes constituting withdrawals that would result in product terminations for existing enrollees.

Review of rate increases: The proposed rule clarifies that CMS will review rate increases for existing products that an issuer withdrew and attempted to file as new products in order to avoid rate review provisions. CMS will utilize the same criteria in place under the guaranteed renewability standards to determine whether a plan is substantially different from the plan that was previously filed and withdrawn.

Requirements related to fixed indemnity coverage in the individual market: The proposed rule changes the requirements related to excepted benefits to allow fixed indemnity coverage to be considered an excepted benefit if: it is sold only to individuals who have minimum essential coverage, there is no coordination of benefits under any health coverage, the benefits are paid in a fixed dollar amount, and a notice is displayed in plan materials that the coverage is not minimum essential coverage.

Risk adjustment, reinsurance, and risk corridors: The rule proposes a revision to the allocation of reinsurance collections due to sequestration and the possibility that reinsurance collections may fall short of estimates, such that contributions are allocated first to the reinsurance pool and administrative expenses and second to the U.S. Treasury. The rule also proposes to increase the limits on allowable administrative costs to 22 percent and profits to 5 percent in the risk corridors calculation, and that the medical loss ratio (MLR) calculation not take into account any additional payments resulting from these adjustments.

Penalties for consumer assistance entities: The proposed rule would allow CMS to exert certain oversight authority over Navigators and other assisters and impose civil money penalties due to violation of federal requirements, for example encouraging consumers to enroll in particular QHPs. The rule also specifies certain state laws related to assisters that might prevent the application of the ACA, like requiring Navigators to be agents or brokers, and sets forth some additional requirements related to assisters.

Penalties for providing false information to the Marketplace: The rule proposes imposing civil money penalties in cases of the deliberate provision of false information to a Marketplace, for example providing false information on a coverage application.

Verification of employer-sponsored coverage: CMS indicates that it will no longer pursue an electronic means for verifying employer-sponsored coverage on behalf of a state-based Marketplace.

Eligibility for exemption from the shared responsibility payment: HHS will no longer provide the option for a state-based Marketplace to adopt an eligibility determination made by HHS for an exemption from the shared responsibility payment for applications submitted on or after November 15, 2014.

SHOP provisions: The rule proposes a one year transition policy under which a SHOP would be permitted to choose not to implement the employee choice model in 2015 under certain circumstances. The rule also proposes to align the employer election period in the SHOP with the later open enrollment start date for the individual Marketplace in 2014, which was shifted from October 15, 2014 to November 15, 2014 in the 2015 Payment Notice.

Quality provisions: The proposed rule sets forth parameters for the Quality Rating System (QRS), which would be implemented and displayed on Marketplace websites beginning in 2016. The QRS would utilize a five-star scale similar to Medicare Advantage and Prescription Drug Plan ratings. The rule also proposes that Marketplaces will display the results of the Enrollee Satisfaction Survey required by the ACA to consumers beginning in 2016. In addition, the rule proposes issuer quality data reporting requirements to support the QRS.

Prescription drug benefits: The rule considers amending the existing formulary exceptions standards to require that these processes can be expedited when necessary in certain circumstances, such as when an enrollee is suffering from a serious health condition.

Indexing of cost-sharing limits: The rule proposes that in calculating annual limitations on cost-sharing and deductibles in the small group market, these calculations will be rounded down to the nearest $50 increment.

QHP issuer oversight provisions: The proposed rule sets forth enforcement remedies and oversight mechanisms related to QHPs operating in the Federally-facilitated Marketplace.

Medical loss ratio reporting and rebate requirements: Because of the delay of the ICD-10 conversion to October 1, 2014, issuers can claim ICD-10 conversion costs as quality improvement activities under the MLR for 2014. The rule clarifies that data reported under the MLR in states with merged individual and small group markets must be aggregated. The proposed rule also allows issuers who offered transitional coverage to increase their incurred claims and expenses for quality improvement activities to account for the additional burden associated with offering this coverage. The proposed rule also clarifies how issuers should handle distribution of de minimus rebate amounts.

HMA Medicaid Roundup

Alabama

Alabama Medicaid Agency Picks Navigant to Provide RCO Implementation Support. On March 20, 2014, the Alabama Medicaid Agency announced that it will award Navigant Healthcare a contract worth an estimated $12 million to provide Regional Care Organization (RCO) Implementation Support for the next two years. Last year, the state's legislature passed a bill calling for the state to be divided into regions in which community-led networks would coordinate the health care of Medicaid recipients. Navigant will help each region transition to this new regional treatment model. Read more

California

HMA Roundup – Alana Ketchel

CMS Approves Waiver Amendment for California to Begin Coverage Under Coordinated Care Initiative, DHCS Amends Timeline. On March 19th, 2014, CMS approved an amendment to California's 1115 Waiver (Bridge to Reform), authorizing the Department of Health Care Services (DHCS) to implement the Coordinated Care Initiative (CCI) starting after April 1, 2014. The CCI mandates managed care enrollment for dual eligibles and makes changes to long-term services and supports. The amendment also allowed for the operation of the Program for All-Inclusive Care for the Elderly (PACE) in Humboldt County alongside the Humboldt County Operated Health System (COHS). Read more

On March 25, 2014, the California Department of Health Care Services announced the following changes to the Coordinated Care Initiative timeline and strategy to minimize beneficiary confusion:

- Cal MediConnect and Managed Medi-Cal Long-Term Services and Supports (MLTSS) enrollment will be aligned so that beneficiaries will not transition to MLTSS ahead of passive enrollment into Cal MediConnect.
- The Medi-Cal fee-for-service (FFS) population will transition to MLTSS starting in August 2014 rather than July – this allows more time for review of 90 day beneficiary notices.
- Enrollment in Alameda and Orange counties will start no sooner than January 2015 to better ensure plan readiness. Read more

Many Eligible Homeless Not Enrolling in Medi-Cal. On March 19th, 2014, *HealthyCal* reported that many homeless individuals in California are not taking advantage of becoming Medi-Cal eligible under Medicaid expansion. They are instead continuing to seek care at free clinics. The article suggested that the homeless population may not be aware of the option to enroll in Medi-Cal or are unable to provide the needed paperwork. It is estimated that over half of California's homeless population is eligible for Medi-Cal. Read more

Covered California Exchange Enrollment Challenges Remain for Certain Populations. On March 20, 2014, the *Los Angeles Times* reported that nearly half of those that called California's health insurance Exchange in February and March were not able to get through and hung up. While California remains a nationwide leader for Exchange enrollment and the Exchange website has seen many improvements since it went live, less than 5 percent of calls are answered within 30 seconds, enrollment among Latinos and African Americans remains low, and 40 percent of Exchange customers surveyed have found the enrollment process to be difficult. Read more

New Assembly Bills Would Change Charity Care Regulations. On March 20, 2014, *California Healthline* reported that the California Assembly has introduced two bills (AB 1952 and AB503) that would require non-profit hospitals to spend 5 percent of their revenue on charity care, as well as create uniform community benefits requirements. The bills aim to strengthen charity care requirements for non-profit acute care facilities that benefit from tax-exempt status. According to a March 20, 2014 report by *Payers and Providers*, the California Hospital Association opposes the bills. Read more

Governor Signs Continuity of Care Bill. On March 24, 2014, the *Sacramento Business Journal* reported that Governor Jerry Brown has approved a bill that guarantees continuity of care for patients whose insurance was cancelled due to non-compliance with Affordable Care Act standards. Starting March 20, the day the bill was signed, patients with ongoing health conditions can continue to receive treatment from their current provider even if the provider is not in the new plan's network. Read more

Medical Malpractice Cap Increase Could Be On November Ballot. On March 24, 2014, *Reuters* reported that consumer advocates have enough signatures to propose raising a state cap on medical malpractice awards to $1.1 million on the November ballot. The current cap is $250,000 and is not indexed to inflation. The measure would also require random drug testing of doctors. Read more

Connecticut

State Legislators Discuss Changes Permitting Hospital Conversions to For-Profit. On March 21, 2014, the *CT Mirror* reported that state legislators are weighing the benefits and costs of changing state law to allow conversion of non-profit hospitals to for-profit status. The consideration comes as several non-profit facilities around the state facing financial difficulties are being approached by for-profit chains for potential acquisition deals. Read more

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Florida House and Senate Release Budget Bills. On March 21, 2014, the *Florida Current* reported on the details of the House and Senate budgets for fiscal 2015. Both chambers' budget bills include much of Governor Rick Scott's budget recommendations, including increased funds for education and health and human services, at least $500 million in tax and fee cuts, no raises for most state workers and full funding for the state transportation work plan. Read more

Senator Bill Nelson Working with Feds to Expand Medicaid in Florida. On March 19, 2014, the *Florida Current* reported that Senator Bill Nelson is working with CMS officials in Washington to find a way for Florida to accept $51 billion in federal funds for Medicaid expansion. The state Legislature has refused to use federal funds for Medicaid expansion, but Nelson hopes he can find a way for the federal government to get the money to the state anyway. Nelson said he hopes to be able to discuss the details of his efforts in a couple of weeks. Read more

Florida Lawmakers Not Discussing Medicaid Expansion. On March 24, 2014, the *Tampa Bay Times* reported that the Florida Legislature is hesitant to restart discussions on Medicaid expansion in this year's legislative sessions. Republican lawmakers argue that discussion is pointless unless the state is granted more flexibility in spending of the $51 billion the federal government has allocated for Medicaid expansion in Florida. Read more

House Panel Approves Telemedicine Bill. On March 24, 2014, a House panel approved a bill aimed at increasing the use of telemedicine in Florida. Opponents of the bill have raised concerns about how the state will hold out-of-state physicians accountable for care they provide via telemedicine. However, co-sponsor Travis Cummings expects to propose an amendment that will address this issue. Supporters of the bill saw it will help lower healthcare costs and provide broader access to care. The Senate is also considering a telemedicine bill. Read more

Georgia

HMA Roundup – Mark Trail

General Assembly Budget's Healthcare Provisions for FY 2015. The Georgia General Assembly completed their 2014 Session on March 20, 2014. The Session was generally uncontentious this year, in as much as all Members in both chambers must seek reelection this year. The SFY 2015 Budget passed with only minor changes from the Governor's original budget proposal. There were no rate or benefit cuts included in the final appropriations bill. While not inclusive of all changes, the following represents the most significant changes affecting Medicaid and PeachCare for Kids (CHIP):

- Increased funds to account for ACA related expenses
    - $3.4 million for MMIS changes
    - $136 million from increased enrollment from 'woodwork effect'
    - $84.9 million from move to 12 month eligibility
    - $93.8 million resulting from the premium tax
- Increased funds to cover program cost growth (mainly ABD, and some CHIP reduction) by $120 million

- Increased provider rates:
    - 5 percent for community living homes and personal care service providers in the Community Care Service Program (CCSP) and Service Options Using Resources in a Community Environment program (SOURCE) waivers - $1.7 million
    - Raise nursing home fair market rental values to the 2012 cost report - $40 million
- Decreased cost by:
    - Accelerating hospital cost settlements – ($13.5 million)
    - Use PARIS system when checking eligibility – ($10.4 million)
    - Projected savings from the ABD Care Management program ($12.4 million)
- The budget also authorized the DCH to continue its family planning using an 1115 waiver
- Provided for 25 additional ICWP waiver slots (for the TBI and significantly physically disabled)

Other healthcare related Legislation considered during the Session included:

- Two bills passed containing language first to prohibit ACA Medicaid without specific authorization from the Legislature; and another prohibiting use of any funds by a state entity to advocate for expansion of Medicaid or otherwise attempt to influence citizens for the same. (HB-990 & HB-943).
- The 'medical marijuana' bills failed to pass (HB-885 & SB-291).
- The bill attempting to privatize the foster care delivery system was Tabled (HB-913); while another was modified to create a pilot program for the same (SB-350), which did pass.
- SB-397 attempted to mandate coverage of certain treatment of autism spectrum disorder, but failed to pass.
- SB 349 passed granting the Department of BHDD expanded powers to enforce contacts with the Community Service Boards, other public entities, and other private providers; including authority to enforce performance based contracts which may include financial incentives or consequences based on the results achieved by a contractor as measured by output, quality, or outcome measures.

Governor Announces Reforms to Improve Rural Healthcare Access. On March 19, 2014, the office of Governor Nathan Deal announced three new proposals to improve rural access to healthcare. The Governor states that recent closures of rural healthcare facilities across the state are "not only bad for health care access but also for the local economies." The reforms will permit rural hospitals in danger of closing to offer fewer services, which would increase their financial stability and prevent them from shutting down. To increase communication between hospitals and the state, Deal is designating an employee from within the Department of Community Health to serve as a point person for rural hospitals. Read more

WellCare Expands Dental and Vision Services for Medicaid Recipients. On March 20, 2014, WellCare Health Plans, Inc. announced that it has expanded its dental and vision benefits to include preventative care for all adult (21 and older) Medicaid members in Georgia. Emergency dental services and procedures to evaluate and diagnose eye disease continue to be covered benefits for adults. WellCare of Georgia members under 21 will continue to receive preventative vision and dental benefits. Read more

Hawaii

Federal Government Rejects Hawaii Health Connector's Spending Request. On March 21, 2014, the *Washington Times* reported that the federal government has denied the Hawaii Health Connector Exchange's request to spend its $205 million in federal funds more slowly. Exchange officials asked for the time extension because significant technical difficulties with the exchange have impeded spending on the exchange and enrollment in the state. Under current agreements with the federal government, most of the funds have to be spent by the end of 2014. Read more

Illinois

Governor Quinn Executive Budget Proposal for FY 2015 includes more than $3 billion for Medicaid managed care. On March 26, 2014, Governor Pat Quinn unveiled his executive budget proposal recommendation for fiscal year 2015. The Department of Healthcare and Family Services (HFS) budget, which includes the Medicaid program, projects that by the end of FY 2015, more than 71 percent of Medicaid beneficiaries will be enrolled in coordinated care, which includes traditional Medicaid MCOs, managed care community networks (MCCNs), and newly awarded provider-led Accountable Care Entities (ACEs), along with specialized care coordination entities (CCEs) for children and adults with complex care needs. It is estimated that only 16.4 percent of Medicaid beneficiaries will be enrolled in coordinated care at the end of FY 2014. Governor Quinn's budget proposes estimated medical assistance payments to Medicaid MCOs of more than $3.06 billion in FY 2015, more than four times the estimated $738.1 million to be spent in FY 2014. Overall HFS spending is set to increase less than one percent over FY 2014 in the Governor's proposal. Read more

Indiana

General Assembly Does Not Extend Nursing Facility Moratorium Provisions. The Indiana General Assembly adjourned on March 13, 2014 without passing an extension to the current moratorium on Medicaid nursing home beds that will expire on June 30, 2014. The Family and Social Services Administration reported that the moratorium on Medicaid certified beds resulted in a decline of over 500 beds statewide in the five years that it was in effect and that the statewide occupancy rate is currently just over 80%. According to three nursing facility associations that supported an extension (the Indiana Health Care Association, LeadingAge Indiana and Hoosier Owners & Providers for the Elderly) 44 states limit nursing home beds through a moratorium, a Certificate of Need process or a combination of both approaches as a cost containment measure to prevent escalating Medicaid costs. Read more

Louisiana

Court Rules CNSI May Review Records Related to Contract Cancellation. On March 23, 2014, the *Daily Reporter* reported that Governor Bobby Jindal's administration must give former contractor Client Network Services, Inc. (CNSI) records related to the cancellation of its $200 million MMIS contract. CNSI filed a wrongful termination suit against the state last year, arguing that the documents will show the company had done nothing wrong. Read more

Nebraska

Medicaid Expansion Bill Fails in Cloture Vote. On March 19, 2014, the *Washington Post* reported that Nebraska's latest Medicaid expansion bill has been defeated in a cloture vote this week. The bill, sponsored by Senator Kathy Campbell, offered an alternative to ACA Medicaid expansion aimed at attracting Republican legislators who opposed expansion. The bill would have used federal dollars to purchase private insurance plans to cover 54,000 poor Nebraskans and was projected to provide the state with $2.3 billion in additional funds over the next six years. Read more

Nevada

Nevada Extends Enrollment Deadline Due to Problems With Exchange Enrollment. On March 24, 2014, the *Daily Caller* reported that Nevada's Silver State Health Insurance Exchange has extended its deadline enrollment. The state will offer a 60-day extension for up to 300,000 residents who tried to sign up for exchange coverage, but failed due to technical glitches with the state's exchange. The extension was prompted, in part, by low enrollment figures in the state. Nevada and Maryland are currently the only states that have decided to extend their enrollment deadlines past the federally-imposed enrollment deadline of March 31, 2014. Read more

New Hampshire

New Hampshire House Passes Medicaid Expansion Bill. On March 25, 2014, the *Concord Monitor* reported that New Hampshire's House has voted to expand Medicaid programs to an estimated 50,000 low-income adults using federal subsidies provided under the Affordable Care Act. The vote sends the bill to the Governor Maggie Hassan, who has already expressed interest in signing the bill into law. The bill would use federal funds to subsidize private insurance coverage for the 50,000 uninsured rather than enrolling them in traditional Medicaid. Read more

Medicaid Managed Care "Prior Authorization" Process Proves Challenging for Recipients. On March 20, 2014, *New Hampshire Public Radio* reported on the challenges associated with the state's Medicaid managed care transition. Officials decided to transition traditional Medicaid coverage to private insurance companies over 100 days ago in hopes of saving the state $15 million per year. One of the most challenging elements is the prior authorization process, which requires individuals to provide documentation of their need for specific treatments or medications before receiving coverage. Read more

New Jersey

HMA Roundup – Karen Brodsky

Multiple Efforts to Enroll the Uninsured in Marketplace Health Plans before March 31. There are multiple efforts underway this week to enroll the uninsured into marketplace health plans. State Senator Nia H. Gill partnered with Montclair State University on March 24 to kick off 'Enrollment Week' on the university campus. New Jersey for Enroll America, the state chapter of a national nonprofit, is working with 12 State legislators to distribute enrollment information to their constituents by email and through their district offices. The New Jersey Hospital Association, through a grant from New Jersey Health Initiatives (NJHI), a local funding arm of the Robert Wood Johnson Foundation (RWJF), hired 25 former U.S. servicemen and women and trained them to assist consumers who are exploring new insurance options under the Affordable Care Act. They are providing enrollment assistance in hospitals and community sites across the state. The New Jersey Primary Care Association's Outreach and Enrollment Network has been running a Listserv for all New Jersey FQHC Certified Application Counselors, including volunteers, staff and supervisors involved with outreach and enrollment efforts. Enrollments are being done by 20 FQHCs throughout the state.

DMHAS RFP Issued for Involuntary Outpatient Commitment Programs (IOC). On March 17, 2014, Lynn Kovich, Assistant Commissioner of the Division of Mental Health and Addiction Services (DMHAS) released an RFP to increase access to treatment and support services for those ordered committed to treatment in the community. DMHAS seeks proposals to provide an IOC program in the following 15 counties: Atlantic, Bergen, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Passaic, Salem, Somerset and Sussex. Applicants may submit proposals to provide IOC in one or more counties. Successful applicants will provide a comprehensive outpatient service, coordination and referral system that addresses the needs of individuals committed to outpatient treatment. The population to be served are adults, 18 years of age or older who have serious and persistent mental illness and who have been committed or presented for commitment to involuntary outpatient treatment within the identified county or counties. Annualized funding of up to $4.5 million is available through this RFP to competitively award IOC programs that serve a total of up to fifteen counties with up to $300,000 available per county. DMHAS expects that the providers of these services will generate income from third party entities such as Medicaid and private insurance. Read more

New Mexico

New Mexico Exchange Officials Consider Extending Open Enrollment Period. On March 21, 2014, the *Santa Fe New Mexican* reported that the New Mexico Health Insurance Exchange has expressed interest in extending the deadline for which uninsured residents can sign up for health insurance coverage. The state has experienced lower than expected enrollment and Exchange officials worry that many residents will remain uninsured unless the enrollment deadline is extended beyond the federally-imposed deadline of March 31. Board Chairman Dr. J.R. Damron said he wants to first confirm that the federal government will not deny New Mexicans subsidies or tax benefits if they enroll after the federal deadline. Exchange officials are currently in discussion with CMS over who has the authority to extend open enrollment. Read more

New York

HMA Roundup – Denise Soffel

Exchange Enrollment Activity. New York's health insurance Exchange, NY State of Health, has enrolled a total of 717,207 people, an increase of more than 50,000 enrollees in the last week. This includes 342,895 (48 percent) who signed up for private insurance and 374,312 (52 percent) who qualified for Medicaid. Of those who have enrolled, 70 percent had no insurance at the time they applied for coverage. Reducing the number of uninsured in NYS by 500,000 people translates into a decline in the rate of uninsured from 11.7 percent of the population to 9.2 percent. Read more

Department of Health Issues Balancing Incentive Program RFA. The New York State Department of Health has issued a Request for Applications (RFA) for the Balancing Incentive Program (BIP). The statewide BIP RFA provides for up to $45 million in Innovation Fund Grants to mitigate barriers to community-based care in all regions of the state for Medicaid beneficiaries with long term care needs. Read more

Behavioral Health Carve-In RFQ Released. The state released its request for qualifications (RFQ) for the behavioral health carve-in, which is scheduled for New York City on January 1, 2015, and for the rest of the state on July 1, 2015. All Medicaid managed care plans must respond to the RFQ, demonstrating their capacity to provide comprehensive behavioral health services, either independently or in partnership with a behavioral health organization. The state has indicated that if a plan does not initially meet the state's qualifications, they will be allowed to resubmit their proposal in a partnership. The RFQ outlines stringent performance standards, including demonstrated success in implementing complex behavioral health programs, experience with waiver services and peer support, experience coordinating non-Medicaid-funded care including local, state and federal grant programs, cultural competence, experience and demonstrated success in implementing behavioral health-medical integration as evidenced by documented improvements in clinical and financial outcomes. Plans will also have to articulate leadership goals that "support a partnership among plan providers, government, members and advocates," and "embrace a vision of a system that is person-centered, recovery-oriented, integrated, and outcomes-driven."

The RFQ also lays out requirements for becoming a Health and Recovery Plan (HARP), a managed care product that will be offered to individuals with serious mental illness or substance use disorder. Any Medicaid managed care plan in the state is eligible to apply to become a HARP, but HARP services must be offered in every county that the plan does business. The three HIV Special Needs Plans that operate in NYC are also eligible to apply as a HARP. In addition to comprehensive physical and behavioral health services, HARPS will provide a range of 1915(i) home and community-based services, including rehabilitation and habilitation, peer supports, respite, family support, employment support, education support and support for self-directed care. HCBS services will be reimbursed on a fee-for-service basis for the first two years of HARP operation. The state indicates that 148,000 Medicaid beneficiaries currently meet HARP eligibility criteria; the preliminary premium for HARPs is $2,674 per member per month.

Applications for New York City managed care plans are due on June 6, 2014. Conditional designation will occur throughout the summer, and readiness review will be conducted in September and October. This timeline will recur 6 months later for the rest of the state, although the RFQ may be revised in response to NYC experience. Read more

Budget Negotiations Nearing a Conclusion with Two Health Issues to Be Addressed. The state legislature is close to finalizing budget negotiations, but two health issues remain unresolved to date. The Senate's one-house budget defunds the state's health exchange, removing $53 million, on the grounds that the executive order that established the exchange indicates that it will be self-sustaining and will not rely on tax revenue funding. Given the universally acknowledged success of the NY exchange, it is unlikely that the Governor and the Assembly will go along with the Senate's proposal. Both the Senate and Assembly want more say about how the state spends Medicaid waiver funds. The Cuomo administration has indicated that the $8 billion waiver the federal government approved in February will in part be used to help financially distressed hospitals, particularly in Brooklyn. Legislators from outside New York City argue that hospitals across the state are struggling, and they would like more say about where and how waiver funds are allocated.

Nursing Home Carve-In Transition Awaits Federal Approval. New York has not yet received federal approval to begin the transition of nursing home populations and benefits into Medicaid managed care. The state had hoped to begin the transition on April 1. In response to consumer concerns, the state clarified that health plans will not be permitted to enter nursing homes for marketing purposes; eligible beneficiaries will be contacted by the state's enrollment broker, MAXIMUS, and provided assistance in plan selection. Plans will be required to contract with multiple facilities to allow for consumer choice, ranging from as many as eight nursing homes in the most populous counties to a minimum of two in smaller and rural areas. The state is encouraging plans to negotiate alternative payment arrangements with providers rather than fee-for-service arrangements, but is not requiring shared savings.

Audit Reveals Medicaid Program Spends Billions on Veterans. On March 20, 2014, the *Journal News* reported that veterans in New York seeking health insurance have been incorrectly placed in the state's Medicaid program, rather than in federal programs managed through veterans' affairs agencies. State Comptroller Thomas DiNapoli believes these mistakes may be the result of poor administrative coordination between the state Health Department and local social-services departments. According to an audit launched by DiNapoli, New York's Medicaid program reimbursed health care providers $3.5 billion for medical services provided to 70,000 veterans during a five-year period. Read more

Authorities Reach Settlement with MVP Health Care Over Mental Health Claims. On March 20, 2014, *Newsday* reported that MVP Health Care agreed to reform its handling of behavioral health claims, cover residential treatment and charge its lower primary care co-payment for outpatient mental health and addiction treatment. The insurer, which covers more than 500,000 people in upstate New York, has established a system by which residents can resubmit mental health-related claims that were previously denied. The attorney general's Health Care Bureau discovered that MVP has denied nearly 40,000 claims for mental health treatment over the past three years. Read more

Ohio

Ohio Medicaid Applicants Top 180,000. On March 25, 2014, the Governor's Office of Health Transformation announced that, as of March 10, 180,000 Ohioans had submitted applications for Medicaid coverage through Ohio's new online eligibility system. Of those applications, 141,000 (78 percent) have already been resolved, with 115,000 individuals enrolled in Medicaid and 26,000 determined ineligible. 54,000 of these new enrollees are "newly eligible" as a result of ACA Medicaid expansion. Read more

Oregon

Governor Kitzhaber Announces Reforms After Unfavorable Cover Oregon Exchange Report. On March 20, 2014, the *Oregonian* reported that Governor John Kitzhaber has announced a major changing of management for the state's Exchange, known as Cover Oregon, following the release of a highly unfavorable third-party review of the Exchange. Kitzhaber announced that there would be a major overhaul of both the Cover Oregon and the Oregon Health Authority management structures. He also stated that there will be a comprehensive inventory and assessment of state information-technology projects and contracting practices related to Cover Oregon. Read more

Pennsylvania

HMA Roundup – Matt Roan

Democratic Gubernatorial Candidates Plan to Scrap Healthy PA if Elected. On March 24, 2014, *Public Opinion Pennsylvania* reported that Democratic gubernatorial candidates in the running to challenge Governor Tom Corbett this fall would take efforts to undo the "Healthy PA" alternative Medicaid expansion plan if elected. Opponents of Healthy PA argue that the program will be more expensive than Medicaid expansion under the federal healthcare law, and that Healthy PA may involve narrower provider networks and fewer benefits for recipients. Read more

Glitch in Federal Marketplace Could Discourage Enrollments. On March 20, 2014, the *Philadelphia Inquirer* confirmed a glitch in the Federal Health Insurance Marketplace which could discourage thousands of individuals eligible for subsidies from applying for healthcare coverage. The article estimates that approximately 70,000 people across all of the states on the Federal Marketplace are impacted by the glitch, including approximately 5,000 people in Pennsylvania. After news of the glitch broke, CMS responded promptly, updating the simulator with the correct 2013 guidelines overnight, the error impacted the system for approximately 35 days. Now, advocates are working to encourage applicants whose incomes are close to the 100 percent thresholds to re-visit the site to attempt enrollment. Read more

Duke LifePoint to Acquire Conemaugh Health System. On March 15, 2014**,** North Carolina-based Duke LifePoint, a joint venture of the Duke University Health System and LifePoint hospitals, announced plans to acquire Pennsylvania-based Conemaugh Health system, a network of three hospitals, physician practices and outpatient services facilities. Conemaugh, unlike many health systems seeking consolidation with larger systems, has been doing well financially and has stated that the sale to Duke LifePoint is about improving services rather than achieving a financial turnaround. Read more

South Carolina

Hospitals Report Varying Success Enrolling the Uninsured in Medicaid Expansion Alternative. On March 23, 2014, the *Post and Courier* reported that enrollment through South Carolina's alternative Medicaid expansion plan has resulted in varying degrees of success. The "Healthy Outcomes Plan" aims to insure patients with chronic conditions who have used the emergency room at least five times. Hospital staff is largely responsible for enrolling these patients in the Healthy Outcomes Plan, but many cite that difficulties reaching this target population have made enrollment extremely challenging. Read more

South Dakota

Prisons Implement E-Care to Reduce Inmate Transfer Costs for Emergency Room Visits. On March 24, 2014, the *Argus Leader* reported that a new telemedicine emergency system has reduced the number of emergency room visits by prisoners and has saved the corrections system around $150,000 in transfer costs. The system, which was implemented in April 2012, connects cameras at four state prison clinics to Avera's e-hub in Sioux Falls so that Avera providers can help triage patients. Over the past two years, the e-hub has saved about two inmate hospital visits per week. Read more

Texas

HMA Roundup – Dianne Longley and Linda Wertz

Texas Dual Eligible Demonstration Details Confirmed. In a presentation to the Texas House Committee on Human Services, dated March 24, 2014, the Health and Human Services Commission (HHSC) provided an update on state Medicaid managed care initiatives, including the dual eligible demonstration. The presentation indicates that HHSC will enter into three-way contracts with CMS and STAR+PLUS health plans in six counties - Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant. The current STAR+PLUS health plans eligible to participate in the demonstration, pending approval, are Amerigroup, Health Spring, Molina, Superior (Centene), and United. The current dual eligible populations across these six counties is around 132,600 and, as in other demonstration states, duals will be able to opt out of participation. Dual eligibles in these six counties are currently receiving Medicaid managed long-term supports and services (MLTSS), excluding nursing facility services, through one of these five health plans under the STAR+PLUS program.

Texas HHSC Releases Draft STAR Kids Medicaid Managed Care RFP. On March 19, 2014, Texas HHSC released a draft request for proposal for establishment of the STAR Kids Medicaid managed care program for children and young adults with disabilities. The program targets improved care access, quality, and continuity of care. The program also aims to improve provider collaboration and integration of different services. The final RFP will be released in July 2014, and HHSC will accept proposals through late October 2014. Read more

Virginia

McAuliffe Proposes Two-Year Pilot Program for Medicaid Expansion. On March 25, 2014, the *Virginian Pilot* reported on disagreement between Governor Terry McAuliffe and the state's House over whether Medicaid expansion should be included in the state's budget. During a special session called this week in hopes of reaching a budget deal, McAuliffe proposed including a two-year Medicaid expansion pilot program in the state budget. The Republican-dominated House Appropriations Committee rejected the proposal, arguing that Medicaid expansion is not a sustainable program in the long run. The Senate has not yet responded to McAuliffe's proposed adjustments to the budget. Read more

Washington

Initiative to Curb Unnecessary ER Spending Saves $34 Million in 2013. On March 20, 2014, the *Seattle Times* reported that an initiative undertaken by the state Medicaid program and a coalition of doctors and hospitals helped cut nearly $34 million in unnecessary emergency room visits last year. The plan included connecting hospital emergency departments across the state so doctors can check if a patient is making multiple ER visits, getting duplicate tests, or seeking drugs for a chronic condition that could be better controlled in a primary care setting. The plan also included educational programs to train emergency physicians how to help patients connect with primary care doctors in their communities. Read more

National

Obama Administration Grants Open Enrollment Extension Days Before Deadline. On March 25, 2014, the *Washington Post* reported that the Obama administration will extend the open enrollment deadline for Americans unable to enroll in health plans through the federal insurance Marketplace by March 31. Consumers who have begun to apply for coverage on HealthCare.gov, but who do not finish by March 31, will have until mid-April to ask for an extension, which would make them eligible for a "special enrollment period." Read more

Federal Exchange Continues to Delay Medicaid and CHIP Application Process. On March 25, 2014, *CQ Healthbeat* reported that over 400,000 Americans who qualify for Medicaid or CHIP are still waiting for their applications to be sent from the federal insurance Exchange website to states for processing due to technical problems with the exchange. Hundreds of thousands more applications that have already been sent to states are frozen as officials sift through duplicate applications and try to fix errors. Read more

Changing Dynamic Predicted in Medicaid Expansion Debate. On March 21, 2014, the *National Journal* predicted that more states resisting Medicaid expansion will soon start to change their view in order to take advantage of generous federal funding. There have been several signs across the nation, in the form of legislative discussions and public protests, indicating that the dynamic between opponents and proponents of Medicaid expansion is starting to shift towards expanding coverage. Read more

Exchange Navigators Role to Continue Beyond March 31. On March 24, 2014, *BenefitsPro* reported on the future role of exchange navigators, certified application counselors and other exchange helpers after the open enrollment period ends on March 31. The Centers for Medicare and Medicaid explain that these 30,000 workers will continue to maintain many of their existing responsibilities after the open enrollment period, including helping new enrollees understand their benefits. These staff members will also continue to help small business owners and individuals who qualify for the "special enrollment period" to apply for insurance coverage. Read more

Industry News

Molina Healthcare Filing Outlines Status of State Reimbursement for HIPF. On March 24, 2014, an SEC 8-K filing by Molina Healthcare provides an update on the status of its efforts to obtain full reimbursement of the Affordable Care Act's health insurance providers fee (HIPF), including a gross-up payment for the associated tax effects. The company's guidance assumes the ACA fee and related tax effects will be fully reimbursed in all states, including expected first quarter 2014 revenue recognition in Wisconsin and Washington. The timing of revenue recognition in other states remains uncertain. Read more

WellPoint Raises 2014 Financial Outlook. On March 20, 2014, WellPoint raised its full year 2014 earnings outlook. The company now expects full year 2014 net income to be greater than $8.20 per share, up from at least $8.00 per share. The increased earnings outlook is driven by membership growth and enhanced revenues and margins. Read more

Aetna Names Brubaker President of Pennsylvania, West Virginia, and Delaware Operations. On March 18, 2014, the *Philadelphia Business Journal* reported that Aetna has named Laurie Brubaker as the President of its operations in Pennsylvania, Delaware and West Virginia. Ms. Brubaker previously served as the Chief Culture Officer at Aetna, and previously held positions with Blue Cross Blue Shield Plans in Pennsylvania and New Jersey. Read more

IMS Health IPO May Value Company At Up to Nearly $7 Billion. On March 24, 2014, *Reuters* reported that healthcare information company IMS Health Holdings expects to price its initial public offering at $18 to $21 per share, valuing the company at up to $6.97 billion. IMS said it would sell 52 million shares in the offering, with the rest being offered by shareholders. Read more

Omnicare Inc. Names New CEO. On March 25, 2014, the *Cincinnati Business Courier* reported that Omnicare will gain a new CEO at the end of this year. Current CEO John Workman is set to retire and will be succeeded by now-COO Nitin Sahney. As COO, Sahney has been responsible for the strategic and operational leadership of all business operations, including the Long-Term Care and Specialty Care groups. Read more

RFP Calendar

Date	State	Event	Beneficiaries
April 1, 2014	Maryland (Behavioral)	Proposals Due	250,000
April 1, 2014	California Duals	Passive enrollment begins	456,000
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
May 1, 2014	Texas NorthSTAR (Behavioral)	Proposals Due	840,000
May 12,2014	Rhode Island (Duals)	Proposals due	28,000
Late May, 2014	Indiana ABD	RFP Release	50,000
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 1, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
Mid-July 2014	Texas STAR Kids	RFP Released	200,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
Late October 2014	Texas STAR Kids	Proposals Due	200,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Vermont Duals	Implementation	22,000
January 1, 2015	Texas Duals	Implementation	132,000
January 1, 2015	Ohio Duals	Passive enrollment begins	115,000
January 1, 2015	Washington Duals	Passive enrollment begins	48,500
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
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	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

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				2/28/2014		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	4/1/2014	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		22,548	Not pursuing Financial Alignment Model						
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	5/12/2014	9/1/2014			4/1/2015	
South Carolina	Capitated	68,000	X			10/25/2013	7/1/2014	1/1/2015	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	132,600						1/1/2015	Amerigroup, Health Spring, Molina, Superior, United
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	**11 Capitated 6 MFFS**	**1.3M 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 to Host Seminar on Care Transformation in Chicago – April 11, 2014

HMA's Accountable Care Institute is offering a one-day seminar on exploring the transformation from volume-based care to value-based care. The seminar will be held on ***April 11 from 8:30am–4:00pm*** at ***Mt. Sinai Hospital in Chicago, Illinois***. The seminar is ideal for provider organizations, FQHCs, clinicians, and community-based social service partners seeking to transform care and develop accountable care structures. The event is free, but space is limited, and will be on a first-come, first-served basis. For more information and to register, please visit: **Care Transformation Seminar Registration**

HMA Prepared to Assist Providers with Medicare BPCI Opportunity

CMS recently announced a limited-time open application period for additional participants to be considered for the Medicare Bundled Payments for Care Improvement (BPCI) initiative. The BPCI is an exciting and innovative opportunity for hospitals, post-acute care providers, and physician group practices to earn upside savings under episodic Medicare payment bundles. The BPCI open application period is an unexpected opportunity that is unlikely to occur again for three years. Eligible providers must apply for entry by April 18, 2014.

HMA Principal Stacy Mitchell and Senior Consultant Mike Fazio are an experienced bundled payments team with expertise in the BPCI program. Stacy and Mike successfully helped clients enter the program for BPCI's initial launch on January 1, 2014. They are ready to put their experience and expertise to work for clients to help navigate the challenges and opportunities that come with this innovative opportunity.

To learn more about how HMA can help take advantage of this BPCI opportunity, please contact Stacy Mitchell (717) 836-7760, smitchell@healthmanagement.com or Mike Fazio (617) 720-7800, mfazio@healthmanagement.com.

HMA Upcoming Appearances

"Transforming Medicaid: What it means for States and Your Audience"
Association of Health Care Journalists – Health Journalism 2014
Joan Henneberry – Presenter
March 29, 2014
Denver, Colorado

"HIT: Creating Connectivity between Jails and Communities"
Health Reform and Criminal Justice: Building Connectivity Conference
Capri Dye – Panelist
April 4, 2014
Wilmington, Delaware

"Integrating Primary Care with Behavioral Health in Rural Settings"
2014 Alaska Rural Health Conference
Gina Lasky – Co-presenter
April 22, 2014
Anchorage, Alaska

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