HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 4, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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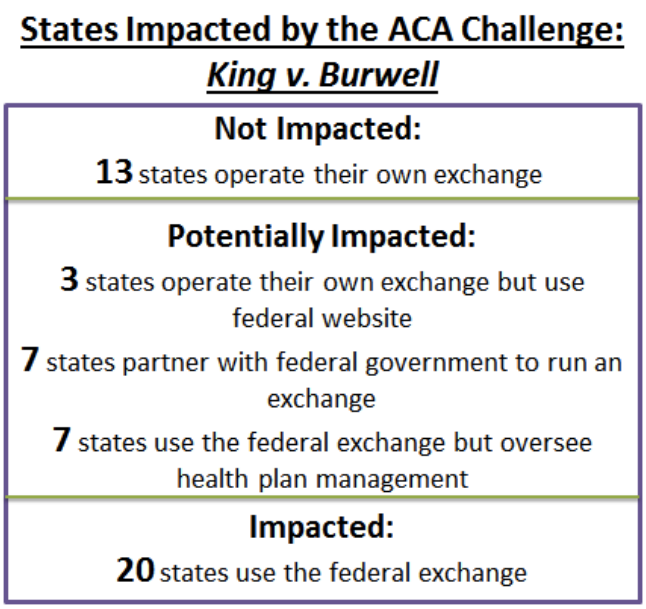
THIS WEEK

IN FOCUS

RESPONDING TO KING V. BURWELL: WHAT POLICY LEVERS CAN STATES "PULL" TO MAINTAIN COVERAGE IF THE SUPREME COURT SIDES WITH KING?

This week, our *In Focus* section reviews approaches states could consider in the event the Supreme Court eliminates federal marketplace subsidies for certain states. It was prepared by Claudine Swartz and Angelique Hrycko of Day Health Strategies (DHS) and Tom Dehner and Juan Montanez of HMA. DHS and HMA have collaborated on numerous marketplace planning and implementation projects.

All eyes are on the Supreme Court today as oral arguments in the *King v. Burwell* case begin. At issue is an IRS rule that authorizes financial subsidies to purchase health insurance offered through the federal marketplace. Unlike the first Affordable Care Act (ACA) challenge decided by the Court, which affected the entire country, *King v. Burwell* is expected to only affect a subset of states. The case does not involve the 13 states that operate their own exchange, but it does involve the 20 states that do not operate their own state marketplace and rely on the federal marketplace technology. This leaves gray area in which 14 states have some type of a partnership with the federal marketplace, and 3 states have an established exchange but use federal marketplace technology to operate it.



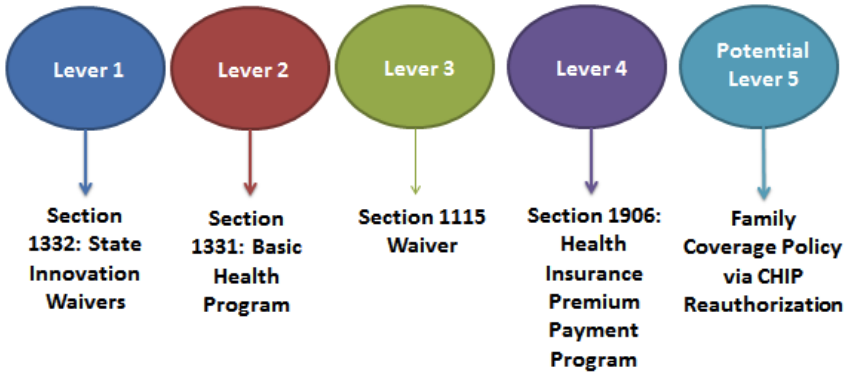
Predictions on a court ruling are in full swing. When it comes to the Supreme Court, we endorse the approach of Casey Stengel, who said "I never make predictions, especially about the future." In fact, the Supreme Court surprised nearly every analyst in 2012 when it used Congress's taxing authority to uphold the individual mandate, rather than the Commerce Clause. Moreover, while the case appears to simply be about whether federal subsidies are permissible outside of state-established exchanges, there is always the potential for a more complex or nuanced decision, particularly when the political and practical effects of the decision are as sweeping as they are in *King v. Burwell.*

Leaving predictions aside, it is clear that the potential disruption that could be caused by a lack of subsidized coverage in states using the federal marketplace is significant. A decision to disallow subsidies via the federal marketplace will disrupt coverage for millions of individuals who are currently receiving subsidies (estimates have ranged from 7-13 million), and may negatively influence the operation of state markets for other individual purchasers as well.

Impacted States Should Consider Key Coverage Levers

While the *King v. Burwell* outcome is uncertain, impacted states may begin contingency planning. States can use various levers to protect coverage for individuals that rely on premium subsidies through the federal marketplace. These levers resemble a calculator full of numbers from the federal code: Sections 1332, 1331, 1115, and 1906.

In the aftermath of *King v. Burwell*, there are policy levers states can "pull" to address resulting coverage gaps:



Lever #1: State Innovation Waivers

State Innovation Waivers have a few different names – Section 1332 Waivers, 2017 Waivers, and the Wyden Waiver – but they all reference the same flexibility: starting in 2017, states have the ability to create an alternative reform framework that results in ACA-comparable coverage levels at no higher cost. States may waive the obligation to operate a health insurance exchange, offer qualified health plans, ensure essential health benefits, provide cost sharing and premium tax credits, and enforce an individual and employer mandate. With federal approval, states could no longer be required to use an exchange – federal or state – to facilitate coverage, while still accessing subsidy funding. The Supreme Court could even look to State Innovation Waivers as a vehicle for states to maintain coverage for individuals that potentially lose subsidies via the federal marketplace. While the waiver submission and approval process is unknown today, this option conceivably provides states the ability to establish a framework to resolve all coverage gaps that may result from a Supreme Court decision, and address a wide range of other issues as well.

Lever #2: The Basic Health Program

While not as far reaching, states can also utilize the Basic Health Program (BHP) – Section 1331 – to provide coverage for individuals with incomes between 133-200 percent of the federal poverty level who are accessing subsidies via the federal marketplace. The BHP allows states to offer a coverage program for these individuals principally to minimize churn between Medicaid and exchange coverage. In order to fund a state-based BHP, a state receives 95 percent of the total premium subsidies that would otherwise be spent if coverage were accessed via an exchange.

The BHP is not likely a coverage solution for all individuals receiving subsidies via the federal marketplace because it does not address those with incomes above 200 percent of the federal poverty level. However, the approach prioritizes the lower-income group of those who could lose access to tax credits, a group that greatly benefits from subsidized coverage and desperately needs it. To date, Minnesota is the only state that has utilized the Basic Health Program, but it could be a tool used more widely in the future.

Lever #3: Section 1115 Waivers

The first two levers are new state tools authorized by the ACA. In contrast, a Section 1115 Waiver has long been used to provide states flexibility within their Medicaid programs and enable ongoing federal funding for state-specific approaches to Medicaid coverage, benefits or delivery systems. This includes using the Section 1115 Waiver to expand coverage for those ineligible for traditional Medicaid, as was the case when Massachusetts used the Section 1115 Waiver to achieve near universal coverage. Already, states have used Section 1115 Waivers to secure ACA flexibility, with numerous states requesting that Medicaid eligible individuals secure private coverage via a marketplace. In the wake of a Supreme Court decision, states will look to their Section 1115 Waiver authority to examine options to address a new coverage landscape.

Lever #4: Health Insurance Premium Payment Program

In addition to Section 1115 waivers, the Health Insurance Premium Payment Program (HIPP) – Section 1906 – is a well-utilized coverage tool. With HIPP, states may provide financial assistance to income-eligible individuals that select employer sponsored health insurance; in 2011, 24 states had HIPP Programs. This option allows Medicaid funding to be used for employer premiums, deductibles, and co-payments as long as employer coverage is deemed cost effective. While HIPP does not provide states with a complete coverage solution if federal marketplace subsidies are disallowed, it represents one approach that could serve as a piece of an overall solution.

Potential Lever #5: Expanding Family Coverage via CHIP Reauthorization

Last, we turn to a more speculative lever. Federal funding for the Children's Health Insurance Program (CHIP) expires in 2015. Alongside the reauthorization and funding debate will come the policy suggestion that it may be more efficient and cost effective to cover eligible children through the same health insurance plan as for their parents. While we don't know how, or whether, Congress will address this issue, the door is open for an innovative family coverage policy – particularly if the reauthorization debate is taking place in the context of a changed coverage landscape due to *King v. Burwell*.

Looking Ahead

Each lever described above varies in its reach and complexity. Some can be deployed in combination for a wider impact. In some instances, the levers are well-known and understood, while others represent new terrain.

For More Information…

If you have questions about the options mentioned here, or want more information about the possible ramifications of the Supreme Court decision, please contact Angelique Hrycko (angelique@dayhealthstrategies.com) at DHS or Tom Dehner (tdehner@healthmanagement.com) at HMA.

HMA Medicaid Roundup

Alaska

Republican Legislators to Strip Money Tied to Expansion from Budget. On February 26, 2015, *Alaska Dispatch News* reported that Republican House leaders will remove funding for Medicaid expansion from Governor Bill Walker's budget. Legislators want Walker to introduce a standalone expansion bill to receive a more thorough review. Walker's legislative director said the governor has no intentions in doing so and expansion will remain in the state's operating budget. Read More

Arizona

Judge to Decide Legality of Arizona's Medicaid Expansion Funding. On February 27, 2015, *The Desert Sun* reported that on July 10, 2015, Judge Katherine Cooper will hear a legal challenge to the main funding source for Arizona's expansion. Two months ago, the Supreme Court allowed a lawsuit challenging Governor Jan Brewer's expansion plan to proceed. The lawsuit was filed by 36 Republican lawmakers who claim the hospital money is a tax, which according to the state constitution would have needed a two-thirds vote in the Legislature to pass. Brewer says the funding is not a tax and that the legislature itself voted to not have a supreme majority. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

L.A. County Releases Report on Proposition 47 Impact. On February 25, 2015, the Los Angeles Times reported on the county's draft report on implementation of Proposition 47, which downgraded some drug and theft felonies to misdemeanors. According to the draft report, Proposition 47 is having a significant impact on the county's mental health system, as inmates with mental illnesses are released from state hospitals and into the county mental health system. The report also indicates that court-mandated drug and mental health treatment sign-ups are down more than 50 percent in the first three months of the program's implementation. Read More

Delaware

DHSS Lags in Reducing Medicaid Fraud, Abuse, and Waste. On February 25, 2015, *The Washington Post* reported that after planning to hire an outside contractor to reduce Medicaid fraud, abuse, and waste, the Delaware

Department of Health and Social Services (DHSS) missed the deadline to hire the contractor for a pilot program. DHSS does not agree that a contractor can save $26 million as proposed by co-chair Sen. Harris McDowell III. However, DHSS stated they are days away from finalizing a contract. The pilot program would cost $500,000. Representative Joseph Miro believes the department has been delayed because it fears the findings will cause bad publicity and embarrassment. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Gov. Rick Scott Will Not Fund Low Income Pool Program. On March 4, 2014, *The Miami Herald* reported that if the state and federal government do not reach an agreement, Governor Rick Scott will not allow the Low Income Pool program to be funded using state dollars. The $2 billion federal program reimburses hospitals for treating the poor and uninsured. CMS has recently stated that unless significant changes are made, it will not continue. Scott refuses to backfill the program using state money. He said, "Florida taxpayers fund our federal government and deserve to get a return on their investment." Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Budget Passes House. The FY 2016 Budget passed the House and is now in the Senate. Department of Community Health changes include:

- Elimination of $2 million for a "consulting contact" (17.1.6)
- Provides $250,000 for a FQHC startup (17.4.5)
- Provides $3 million for Rural Hospital Stabilization Committee's grants (17.4.6)
- Retains Task Force to study loss of DSH (17.6.2)
- Eliminates $70 million total funds for high cost Hep. C drugs (17.7.10)
    - Reportedly will be accounted for in next year's amended budget
- Eliminates $37 million total funds for the ABD Care Coordination vendor (17.7.11)
    - If this does not get restored in the Senate it is highly unlikely DCH will re-release of this RFP
- Provides $4 million for a 50 cent per hour rate increase for Personal Support Services in the ICWP (17.7.12)
- Provides $9 million total funds to increase select OBGYN codes to the 2014 Medicare rates (17.8.14)
- Provides $1.5 million total funds to increase fixed wing ambulance adult rates to the pediatric rates (17.8.15)
- Provides $4.7 million total funds to increase select primary care codes (17.8.16) Read More

DCH Announces Linda Wiant New Chief of Medicaid. On March 2, 2015, the Georgia Department of Community Health announced Linda Wiant as the new Chief of the Medical Assistance Plans Division, effective March 16, 2015. She currently serves as Pharmacy Director for DCH. Read More

Kansas

State Rejects Bill Giving Medicaid More Control of Mental Health Drugs. On February 25, 2015, *KAKE News* reported that the Senate rejected a bill that would have given the state's Medicaid program power to control prescriptions of mental health drugs with preferred drug lists. The vote against the bill was 25-15. Opponents said they were worried patients would not receive the drugs that they need. Supporters said the bill would help prevent patients from being over-medicated with strong drugs. The measure, initiated by Governor Brownback's administration, hoped to save the state $16 million a year in costs. Read More

Kentucky

Insurers Denying Hospitals Emergency-Room Payments. On March 2, 2015, *KYForward* reported that two hospitals told the Senate and the Welfare Committee that WellCare and CoventryCares are denying nearly half of payments for emergency-room services, paying the hospitals only $50, regardless of what was performed. The current policy in place is a "triage policy." It allows insurers to pay hospitals a flat, nonnegotiable $50 fee plus an $8 patient copayment if the visit was deemed a nonemergency. However, the Administrative Regulation Review Subcommittee found this policy did not follow federal standards. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Governor Baker to Close $1.5 Billion State Gap through MassHealth. On February 25, 2015, *WWLP.com* reported that the Massachusetts Taxpayers Foundation estimated the state needs to close a $1.5 billion budget gap. Governor Charlie Baker is planning tap into MassHealth to find the money. Baker also promised not to increase broad-based taxes. Read More

Health Connector Needs $20 Million in Renovations. On March 1, 2015, *The Boston Globe* reported that the Massachusetts Health Connector Board still needs $20 million this year in addition to the $254 million already allocated. The Health Connector's software will need further fixes next year to become fully functional. During this year's open enrollment, thousands of consumers reported software flaws and inadequate customer support. Read More

Governor Baker Removes Four from Connector Board. On February 25, 2015, *The Boston Globe* reported that Governor Charlie Baker removed Jonathan Gruber and three other members previously appointed by his predecessor from the Massachusetts Health Connector Board. A spokesman for Baker said the governor was not targeting any individual, but requested all four members step down. The move comes after controversy surrounding Gruber's comments around the passage of the Affordable Care Act. Replacements have not been announced. The next board meeting is scheduled for March 12. Read More

Insurers Report Operating Losses of Millions Due to Drug Costs and ACA. On February 27, 2015, *The Boston Globe* reported that the state's health plans were experiencing losses from high specialty drug costs and high costs associated with the rollout of exchanges. Blue Cross Blue Shield of MA reported an operating loss of $119 million. CFO Allen Maltz said taxes and fees went up

by $109 million. Harvard and Fallon reported operating losses of $18 million and $12 million, respectively. Read More

Minnesota

New Bill to Expand Telemedicine. On February 26, 2015, *StarTribune* reported that a new proposal may expand the reach of telemedicine. Under the bill, insurers will be required to pay for consultations the same way as in-person visits. Currently, some insurers do not cover telemedicine which is an issue for rural areas with a rapidly aging population and limited access to specialists. The bill would help those who cannot travel to urban areas to receive care in addition to cutting costs. Read More

Mississippi

Mississippi Telemedicine Program Ranks Top Seven in Nation. On February 26, 2015, *Politico* reported that Mississippi has emerged as a leader in telemedicine. One of the major reasons for this is the state's poor health and the largest shortage of doctors in the nation. A program to help the many residents without care began in 2003. Mississippi's Center for Telehealth now has remote connections with 165 locations. The center has 35 specialties and provides 8,000 telemedicine visits a month. As a result, small hospital costs dropped by 25 percent and admissions rose by 20 percent. Officials are hoping to expand telemedicine to schools next. Read More

Missouri

MO HealthNet Contract Awards Announced. On March 3, 2015 Missouri**'s** Office of Administration announced that Healthcare USA (Aetna), Home State Health Plan (Centene) and Missouri Care (WellCare) had been awarded contracts to serve the Central, Eastern and Western regions. We estimate the contracts will represent approximately $1 billion of annual Medicaid expenditures and are scheduled to start on July 1, 2015. The term of the contract is one year but may be extended for two additional years. For more information on this contract, please see our November 5, 2014 Roundup. Read More

House Bill to Expand Medicaid Telehealth. On February 28, 2015, *The Missourian* reported that a House bill seeks to change Medicaid reimbursement regulations for telehealth services. Currently, providers can be reimbursed only from approved originating sites and with an eligible health care provider present at the videoconference. The bill would add schools and MO HealthNet recipients' homes to the list of sites and add clinical social workers and health care providers practicing in rural health clinics to the list of eligible providers. Read More

Senator Silvey Hopes to Win Over Republicans with New Medicaid Expansion Plan. On February 25, 2015, *Bizjournals.com* reported that Senator Ryan Silvey introduced legislation SB418 that would accept federal money for Medicaid expansion through a block grant that would be placed in a trust fund. He believes he can get enough GOP lawmakers on his side to pass it. The plan takes after Wisconsin's strategy of expanding health coverage and opens the door for a complete overhaul of the state's Medicaid program. Read More

Nebraska

Senator Campbell Proposed Medicaid "Redesign" Bill. On February 26, 2015, *The Baltimore Sun* reported that after two failures to expand Medicaid, Senator Kathy Campbell proposed a "redesign" bill that provides flexibility for a state-specific design through a federal waiver. However, the bill is likely to face resistance from Governor Pete Ricketts as well as Republican lawmaker. Read More

New Jersey

Karen Brodsky (Email Karen)

New Jersey Experiences Steady Increase in Marketplace Enrollments. On February 23, 2015 *NJSpotlight* reported that the federal Marketplace open enrollment period ended with 252,792 New Jersey residents signed up before the deadline. This represents 40 percent of all state residents who were eligible to enroll, which is comparable to the enrollment rate of other federal Marketplace states at 41 percent. Most enrollees will qualify for federal tax credits to help with the cost of premium payments. As of January 2015, 83 percent of enrollees qualified for tax credits, which could be lost to New Jersey residents if the U.S. Supreme Court rules that the text of the ACA only allows for subsidies on state-run exchanges in the case of King v. Burwell, which will be decided in June or July of this year. Read more

Christie Administration Releases FY2016 Budget Summary - Department of Human Services Represents Largest Portion of Budget. On Tuesday, February 24, 2015, Governor Chris Christie delivered his Fiscal Year 2016 Budget Address to the Legislature in the Assembly Chambers at the Statehouse in Trenton. The total FY16 budget is $33.8 billion, a 3.1 percent increase from last year. The FY2016 Budget Summary was also released. The Department of Human Services (DHS) represents the largest portion of the annual budget at $18.69 billion, of which close to $11 billion will come from federal matching funds. Appropriations associated with DHS will include increases in the form of grants-in aid to:

Grants-In-Aid (millions) [1]	
Managed Long Term Services and Supports/Nursing Homes	$ 138.49
NJ FamilyCare/Disability Services Health Care Trend	$ 67.06
FY15/FY16 Developmental Disabilities Community Placements	$ 25.29
Affordable Care Act - NJ FamilyCare Health Insurance Providers Fee	$ 21.20
NJ FamilyCare Physician Reimbursement Increase	$ 15.00
FY15/FY16 Mental Health Olmstead Support Services	$ 8.26
Mental Health Involuntary Outpatient Commitment	$ 3.35
Community - Based Substance Use Disorder Treatment and Prevention	$ 2.31

[1] In general, appropriations for programs and services provided to the public on behalf of the State by a third party, or grants made directly to individuals based on assorted program eligibility criteria.

This issue of HMA's Roundup provides a few highlights from the New Jersey Department of Human Services budget summary. A complete review of the FY16 budget can be found in the FY2016 Budget Summary link above.

- ***NJ FamilyCare.*** The NJ FamilyCare program serves as the state's Medicaid program and Children's Health Insurance Program (CHIP), providing comprehensive health care coverage to almost 1.7 million residents at a projected $4.2 billion state share cost to the fiscal 2016 budget. NJ FamilyCare also serves parents previously funded with state dollars and now eligible for coverage with 100% federal funding through Medicaid expansion. An additional 390,000 uninsured individuals became covered through NJ FamilyCare as a result of Medicaid expansion. This contributed to an increase in the FY16 budget by $45 million in State and federal funds to raise reimbursement rates for certain primary and specialty care services, effective January 2016 to encourage more provider participation.
- ***Health Insurance Providers Fee.*** The Affordable Care Act (ACA) imposed a new national Health Insurance Providers Fee which requires health plans, including most Medicaid managed care organizations (MMCO) to pay. This is in effect, a federal tax, which NJ FamilyCare will reimburse to contracted MMCOs, and have a negative impact on the State budget. The Health Insurance Provider Fee is a source of considerable debate in the Medicaid and managed care industry. It is projected to cost the State $60.4 million, an increase of $21.2 million over the current year.
- ***Balancing Incentive Program (BIP).*** The State will also experience a budget increase related to the ACA in the replacement of federal matching funds associated with the Balancing Incentive Program (BIP). This temporary program is working to incentivize the use of home and community based services (HCBS) in place of institutional care. The Centers for Medicare and Medicaid Services (CMS) provided states with enhanced federal matching funds on HCBS services, including $50 million to New Jersey in FY15. The BIP program will end in early FY16 resulting in a returning to the standard federal matching rate for HCBS services, whereby the State will be required to replace $37.5 million in funding for those services.
- ***Charity Care.*** The 30 percent rise in Medicaid enrollment and addition of 250,000 individuals who have purchased health insurance from the federal Marketplace since January 2014 has led to a reduction in hospital claims for uncompensated care. The Charity Care budget stands at $502 million in federal and State support to cover these costs, and a $74 million reduction in the State funding for treating the uninsured.
- ***Managed Long Term Services and Supports.*** Additional resources have been included in the FY16 budget to support the transition of long term services and supports into Medicaid managed care, which began in July 2014.
- ***Mental Health and Addiction Services.*** The FY16 budget includes an additional $23 million to provide a single point of entry for individuals with drug addiction under a new management contract with Rutgers' University Behavioral Health Care. Funding will also increase by $8.5

million to pay for a Drug Court Program that treats individuals with substance use disorders who will receive treatment instead of a prison term. And $104.3 million is in the budget to continue efforts to provide home and community-based placements over psychiatric inpatient settings as an Olmstead initiative through the Division of Mental Health and Addiction Services.

- ***Developmental Disabilities.*** $51.5 million in state and federal funds will be available into FY16 to provide home and community based services and supports for individuals with developmental disabilities, and made possible by the closure of two developmental centers.

Replacement MMIS RFP Protest Period Extended. The New Jersey Department of the Treasury issued a special notice to extend the protest period for solicitation 2014-X-22996, Medicaid Management Information System (MMIS) from February 27, 2015 to March 13, 2015. The solicitation was originally issued on May 29, 2013 for the Division of Medical Assistance and Health Services to replace the MMIS, associated Medicaid professional services, and the MMIS Shared Data Warehouse. The current MMIS vendor is Molina Information Systems under a contract that was extended to May 31, 2016.

Prevention of Developmental Disabilities RFP Released. The Department of Human Services, Division of Developmental Disabilities (DDD) released a Request for Proposals (RFP) on February 25, 2015 to fund for-profit or non-profit organizations or governmental entities to conduct statewide and special projects that will assist DHS/DDD in reducing the incidence of intellectual and developmental disabilities in New Jersey. Projects can be focused on specific age groups (i.e., birth - 5, 6-10, teens, etc.), issues (fetal alcohol syndrome, lead poisoning, helmet use, etc.) or populations (pregnant women, newborns, etc.), or address the unique needs of populations and/or specific underserved regions throughout the State. Agencies are strongly encouraged to consider addressing the prevention of lead poisoning and/or fetal alcohol syndrome as the primary or secondary area of focus in their proposal. Contracts of up to $125,000 per year subject to State appropriation, may be available for statewide programs, and grants up to $50,000 per year subject to State appropriation, is expected to be available for special projects. Potential applicants are encouraged to submit questions to the OPDD at ddd.preventiondd@dhs.state.nj.us by 4:00 P.M. on March 12, 2015. Responses to submitted questions will be posted on the DHS website by March 17, 2015.

New York

HMA Roundup – Denise Soffel (Email Denise)

Delay in Implementation of Fully Integrated Duals Advantage. On Friday, February 27, 2015, the Department of Health announced a change in the implementation schedule for the Fully Integrated Duals Advantage program (FIDA), New York's duals demonstration. FIDA began enrollment in NYC and Nassau Counties in January 2015; Region II of the demonstration, including Suffolk and Westchester Counties, was scheduled for voluntary enrollment as of March 1 and passive enrollment as of July 1, 2015. CMS and the Department of Health are temporarily pausing the implementation of Region II (Suffolk and Westchester) due to network deficiencies. No opt-in enrollments will be accepted as CMS and DoH continue to review the adequacy of provider

networks in those counties. Crain's reports that DoH was receiving feedback that networks were far from robust. Provider education remains a major concern as many providers still lack adequate knowledge/awareness of FIDA.

Medicaid Managed Care Advisory Review Panel. The Medicaid Managed Care Advisory Review Panel met by teleconference on February 26. The MMCARP, an oversight panel established by the NYS legislature, is charged with reviewing the capacity of the Medicaid managed care program to meet the needs of all Medicaid beneficiaries. A Medicaid Managed Care Program Update included the following:

- A new plan has received approval to participate in the Medicaid Managed Care program. Crystal Run Healthcare, a large multi-specialty group practice headquartered in Middletown, NY, will begin providing services in Sullivan and Orange Counties beginning the spring of 2015. Crystal Run also operates an ACO and participates in the Medicare Shared Savings Program.
- School-based health centers will be carved into the Medicaid managed care benefit effective 7/1/2015.
- Expansion of health homes to include children is on target for implementation in January 2016.
- Health and Recovery Plans (HARPs) are a Medicaid managed care product designed to meet the needs of individuals with serious mental illness, HARPs are scheduled to begin enrollment in NYC effective July 1, 2015. The Department of Health, working with the Office of Mental Health and the Office of Alcohol and Substance Abuse Services, has identified 60,000 Medicaid beneficiaries in NYC who meet the HARP eligibility criteria. These individuals will be passively enrolled in the HARP that is operated by the Medicaid managed care plan in which they are currently enrolled; they will be informed of the enrollment and of their ability to opt out of the HARP, either to remain in a mainstream Medicaid managed care plan, or in a different HARP plan.
- The status of Health Now remains in limbo. They have not withdrawn from the Medicaid managed care program, although their enrollment has been frozen since they announced their intent to leave the Medicaid market effective October 2014. The Department of Health indicated that there has been no movement in negotiations regarding their on-going participation in the Medicaid program.

E-Prescribing Mandate. The NYS Assembly passed bill A.4274/S.2486 to delay the mandate requiring electronic prescribing of controlled substances by one year, to March 27, 2016. The delay is supported by the Medical Society of the State of NY due to concerns about provider readiness to meet the requirements of the law. The e-prescribing mandate was enacted into law in 2012 as part of the I-Stop (Internet System for Tracking Over-Prescribing) legislation. I-Stop requires that, effective March 2015, all prescriptions for controlled substances must be submitted electronically, in an effort to eliminate the problem of forged or stolen prescriptions. The bill was approved by the Senate last month, and now goes to the Governor's office.

Medicaid Computer System Contract. New York State announced its intent to award a $550 million, five-year contract to Xerox Corporation to build a system for the Medicaid program in May, 2014. The contract was approved by the

Attorney General, Eric Schneiderman, and sent to NYS Comptroller Tom DiNapoli for approval in December 2014. The contract is still awaiting approval, and NYS is now seeking to extend its contract with Computer Sciences Corporation to continue to run the Medicaid computer system in the interim. Bloomberg News reports that the length of the extension is still being negotiated, but the state had requested a 13-month extension, which CSC is willing to accommodate. CSC will continue to support the expansion of enrollment in Medicaid managed care, part of the Medicaid Redesign Team "Care Management for All" approach.

Health Plans Report Losses. Two health plans operating in the Western part of the state reported operating losses for 2014. As reported in the Buffalo News, HealthNow, part of BlueCross BlueShield of Western NY, reported an operating loss of $69.4 million on $2.4 billion in operating revenues. Excellus Blue Cross, part of Univera Healthcare, reported an operating loss of $55.3 million on revenue of $5.9 billion. Among the reasons given were a rise in the number of companies that self-insure, the ACA taxes, and inadequate reimbursement from public payors. Both plans have reduced their participation in the Medicaid managed care program due to financial losses. HealthNow announced its intention to withdraw from Medicaid managed care in July 2014, and although those plans have been on hold since October, the state has frozen their enrollment, leading to a decline in membership. Excellus withdrew from the Medicaid managed care market in a number of counties at the end of 2013. Excellus, which had been operating in 22 counties with a total of 220,000 members, reduced its operations to seven counties, serving about 130,000 Medicaid beneficiaries. Medicaid enrollment had bounced up again in recent months as a result of individuals newly enrolled in Medicaid as a result of the ACA. As of February 2015, Excellus had 176,000 Medicaid enrollees; HealthNow Medicaid enrollment was 36,000.

North Carolina

Physicians Face Retroactive Medicaid Reimbursement Cuts. On March 3, 2015, *North Carolina Health News* reported that the state's three percent Medicaid pay cut from last year's budget was enacted with cuts effective retroactively. Specialty physicians will see cuts retroactive to January 2014 and primary care physicians to January 2015. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Medicaid Spending and Enrollment. The Ohio Department of Medicaid reports that total Medicaid spending as of December was $327 million below estimate. Total Medicaid enrollment for January 2015 was reported to be 24,199 people below budget estimates according to its February 2015 Caseload Report. Enrollment in the expansion group was 125,457 above estimate, but more than offset by traditional enrollment, which was 149,656 below estimate. Medicaid anticipates enrollment will decrease beginning February 2015 as a result of restarting the federally required redetermination process. Read More

Nursing Home Reimbursement Changes and Stakeholder Concern. The Governor's new budget proposes a variety of changes for nursing homes, including increasing skilled nursing facility reimbursements by $84 million in Fiscal Year 2017 and rebasing the funding formula and other updates, tying reimbursement completely to quality performance, reducing reimbursement by $24 million for low acuity residents and removing the nursing facility formula from statute. The Executive Director of the Ohio Health Care Association, Peter Van Runkle, is raising concerns that the administration's proposal sets unrealistic standards and could result in a net loss for providers. Van Runkle is concerned that most providers would be unable to meet the new quality measures and could see funding decreases under the administration's proposal. He estimates that 30% of the quality measures would need to be met to break even and with that, in addition to the $24 million cut for low acuity, nursing homes would be left with $61 million.

***Columbus Dispatch* Reports 61,000 Could Lose Medicaid.** On February 27, 2015, *The Columbus Dispatch* reported that 61,000 people who have not verified their income could lose Medicaid coverage at the beginning of March. Those that are still eligible have 60 days to send in their information to receive retroactive coverage. About 25-30 percent of the renewal packets sent by the state came back undeliverable. Read More

Oregon

Judge Rules Oracle Must Extend Contract for the State's Medicaid Program. On February 25, 2015, *Bizjournals.com* reported that Oracle was ordered to continue providing IT services for the state's Medicaid program through February 28, 2016. Oracle's contract was ending at the end of February this year and the company did not wish to renew it. The state sued Oracle because thousands of people would be affected. Once the renewed contract ends, Oregon will implement the same system as in Kentucky, tailoring it to the state's needs. The project is set to complete by December 31, 2015. Read More

Pennsylvania

HMA Roundup – Matt McGeorge (Email Matt)

Pennsylvania Department of Human Services Provides Introduction on Medicaid Program Expansion. At the February 26th Medical Assistance Advisory Committee (MAAC), Secretary Ted Dallas and Executive Medicaid Director Leesa Allen provided an update on the Medical Assistance program's transition from Healthy PA to traditional Medicaid expansion. Below is an overview of the timeline presented at the meeting:

- Beginning in April or May 2015, individuals who were transitioned from General Assistance or SelectPlan for Women to a Healthy PA Private Coverage Option Plan (PCO) will be transitioned back to the HealthChoices system (the Pennsylvania Medicaid Managed Care Program)
- In April or May 2015 the Managed Care plans will be given more specific information about when plans will be considered only HealthChoices and no longer a Healthy PA PCO plan

- In August or September 2015 the Department will formally withdraw the Healthy PA waiver and hope to have finalized the transition in the Fall

Response from Department of Human Services on Lack of Substance Abuse Coverage with Healthy PA Plans. During the MAAC meeting, Mr. Dallas and Ms. Allen gave an update on how the Department has been addressing the transition of individuals who require substance abuse (SA) services but were assigned to a Healthy PA benefit package that does not cover those services. Approximately 8,500 cases were identified as needing to make the transition to the Healthy Plus benefit package in order to be eligible for SA services. County assistance offices are informing providers about who to bill and when the coverage will begin. The transition process only applies to individuals who were eligible for HealthChoices in 2014 and not those who are newly eligible to Medical Assistance.

Wolf Administration Investing in Public Health in Fiscal Year 2015-16 Proposed Budget. During his first budget address to a joint session of the Pennsylvania Legislature Governor Wolf announced funding priorities that will impact the Medicaid program as well as healthcare for all Pennsylvanians. The Governor noted that by moving to traditional Medicaid expansion the state General Fund costs will be reduced by $500 million in the upcoming fiscal year. The 2015 – 16 proposed budget also includes funding that is intended to reduce waiting lists for individuals with physical and intellectual disabilities ($45.9 million) and expand home and community based services ($31 million). In a press conference prior to the release of his budget, the Governor announced several key proposals related to long term care including the increase in HCBS waiver slots and the intent to phase in Medicaid managed long term care. Read More

The Department of Health's proposed budget includes a commitment of state funding to supplement the federal funding for the state innovation model plan that was approved by the Centers for Medicare and Medicaid Innovation Center. Other DOH funding commitments announced include: the development of a health registry related to Marcellus shale drilling, enhancing the Commonwealth's prescription drug monitoring program, reopening state health centers for screening, and case management services for STDs and HIV as well as disease investigations and immunization and adding to the mandatory panel screening requirements for newborns. Read More

Texas

Senate Asks Feds for Medicaid Flexibility. On March 2, 2015, *KXAN.com* reported that 20 Republican Senators asked President Obama for more Medicaid flexibility. Without it, they said, expansion is not worth discussing. Medicaid uses 30 percent of the state's budget and is increasing two and a half times faster than any other part of the government. Texas is looking for flexibility from the feds around copayments, work requirements, and expanded health saving accounts. Read More

Republican Lawmakers Expected to File Legislation for Higher Personal Attendant Wages. On March 3, 2015, the *Texas Tribune* reported that Republican lawmakers are expected to draft a bill increasing the wages of home care workers as requested by Governor Abbott in his proposed budget. Abbott had

asked Legislature to dedicate $105 million of the budget to raising wages by 5 percent. However, advocates say this is not enough, arguing the increase is only worth 37 cents an hour. Read More

Utah

House Agrees to Hear Governor Herbert's Medicaid Expansion Plan. On March 3, 2015, *Deseret News* reported that after refusing to hear Governor Gary Herbert's Healthy Utah Medicaid Expansion alternative, the House reversed their decision. This comes on the same day as a House counterproposal is introduced. House Speaker Greg Hughes released an apology for not allowing the committee to hear the proposal, which already passed the Senate. Read More

Wisconsin

Advocates Say Governor Walker's Cuts to Disabled Devastating. On March 1, 2015, *Twincities.com* reported that Governor Scott Walker's proposed budget will expand the Family Care program by 2017, but will end all other long term care programs. Advocates are alarmed at what the repercussions could be for the disabled. One program slated to be eliminated is the IRIS program, which serves 11,000 adults with long term care needs, as part of Walker's budget proposal to cut $14 million over the next two years. Read More

National

Safety-Net Hospitals In Large Non-Expansion States Had Good Performance. On March 4, 2015, *Kaiser Health News* reported that based on hospital financials from Florida, Texas, Georgia, Tennessee, South Carolina, Virginia and Kansas, safety-net hospitals had good performance in 2014; many did better than in 2013. However, the biggest challenge comes next year when Medicaid cuts start. Read More

King vs. Burwell Oral Arguments Completed. On March 4, 2015, *The New York Times* reported that the Supreme Court heard arguments in the King vs. Burwell case. The four liberal justices on the court supported the administration's argument for subsidies, while Chief Justice John G. Roberts said almost nothing. The court is expected to make their decision by late June. Read More

29 Percent of Foster Kids Miss Required Checkups. On March 2, 2015, *Kaiser Health News* reported that a Health and Human Services report found that 12 percent of foster kids never received an initial checkup and another 17 percent missed at least one required periodic assessment, based on medical records in New York, California, and Illinois from July 2011 to June 2012. Read More

ACA to Increase Medical Use by 4 Percent. On February 25, 2015, *philly.com* reported that according to a Commonwealth Fund study, the Affordable Care Act will increase primary care doctor visits by four percent nationally. This is roughly equivalent to an additional 70 visits a year per primary doctor. The study helps ease the worry that with the ACA, doctors will be unable to handle their patient load. Furthermore, there will be a two percent increase in emergency room visits and a three percent increase in outpatient hospital visits. The study assumes all states will expand Medicaid. Read More

Industry News

Acadia Acquires Quality Addiction Management. Acadia Healthcare, a provider of inpatient behavioral healthcare services, announced that it has acquired Quality Addiction Management, an operator of seven comprehensive treatment centers in Wisconsin. The transaction is valued at $53 million. Read More

Community Health Announces Divestitures in Alabama, Texas and South Carolina, Buyout of JV Partner in Oklahoma. Over March 2 and March 3, 2015, Community Health Systems, Inc. announced the divestiture of Riverview Regional Medical Center in Gadsden, Alabama, and Dallas Regional Medical Center in Mesquite, Texas to subsidiaries of Prime Healthcare Services, as well as Chesterfield General Hospital in Cheraw, South Carolina, and Marlboro Park Hospital in Bennettsville, South Carolina to M/C Healthcare LLC. Meanwhile, the company also announced the buyout of its partner and acquisition of full ownership of five hospitals in Oklahoma with nearly 220 combined beds. Read More

LHC Group Announces Home Health Joint Venture with Missouri Delta Medical Center. On March 2, 2015, LHC Group, a national provider of post-acute healthcare services, announced that it has entered into a home health joint venture with Missouri Delta Medical Center, a general medical and surgical hospital with 188 beds. The service area has a population of 150,000.

RFP Calendar

Date	State/Program	Event	Beneficiaries
March 26, 2015	Iowa	Amended RFP Release	550,000
March 27, 2015	Mississippi CHIP	Proposals Due	50,300
March, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
April 15, 2015	Florida Healthy Kids	Contract Awards	185,000
April 24, 2015	Mississippi CHIP	Contract Awards	50,300
April, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 4, 2015	Georgia	Proposals Due	1,300,000
May 8, 2015	Iowa	Proposals Due	550,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
August, 2015	Michigan	Contract Awards	1,500,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,500,000
January 1, 2016	Iowa	Implementation	550,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
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
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	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; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
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
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	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	178,000	Application			8/26/2013	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
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	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
California	17,846	39,731	42,473	44,804	48,976	51,527	58,945	122,908	123,079
Illinois	19,461	37,248	48,114	46,870	49,060	49,253	57,967	63,731	66,223
Massachusetts	13,409	18,836	18,067	17,739	17,465	18,104	17,918	17,867	17,763
New York								17	406
Ohio								68,262	66,892
South Carolina									83
Virginia		11,169	11,983	21,958	28,642	29,648	27,701	27,527	26,877
Total Duals Demo Enrollment	**50,716**	**106,984**	**120,637**	**131,371**	**144,143**	**148,532**	**162,531**	**300,312**	**301,323**

Source: State enrollment data and CMS enrollment data, compiled by HMA

HMA News

HMA Welcomes…

Stephen DePooter, Principal – Chicago, Illinois

Stephen comes to us most recently from the Illinois Department of Healthcare and Family Services (HFS) where he served as the Chief Information Officer for the last four years. In this role, Stephen had the responsibility for managing all technical aspects of the state Medicaid agency, including assisting with the implementation of the technology aspects of Medicaid Health Reform in Illinois. He led the Division of Information Services which supported the largest health care enrollment and claims processing systems in Illinois, as well as the state's child support system and the Enterprise Data Warehouse – processing over $20 billion in payments each year and servicing over three million Illinois citizens. Additional accomplishments in this role for Stephen include: implementing the first Microsoft Dynamics cloud-based case management system in IL for the Federal Money Follows the Person program (implemented within 12 weeks); leading the successful Integrated Eligibility System implementation; serving as the Program Manager for the Pharmacy Benefits Management System (SaaS), replacing a 30 year old COBOL legacy system; developing the most innovative Medicaid Management Information System implementation strategy in the country, gaining national acclaim and Federal approval; and creating the Bureau of Security within the IT division.

Prior to his work with DHFS, Stephen served as the Chief Information Officer for the Illinois Department of Veterans' Affairs for several years. Here he was responsible for all IT operations for the agency including network, hardware, and software. He consolidated six separate systems into one new centralized system to include all veteran information in a single database; implemented help desk ticketing system and internal process improvement measures; and served as the program sponsor and project manager of implementation of a clinical care planning system in four long term care facilities.

Additional roles in which Stephen has served includes: Systems Director, Applications with Memorial Health System in Springfield, IL; Corporate Security Administrator for Horace Mann Service Corporation; and Business Analyst for Emory Healthcare.

Stephen received both his Master of Liberal Arts degree and his Bachelor of Science degree from the University of Illinois at Urbana/Champaign. He also has a Certificate in IT Project Management from Georgia Institute of Technology, is a Certified Medicaid Professional II (MCMP-II), and has a Certificate in FISMA Risk Management. Stephen will be taking his exams for Project Management Professional (PMP) and Certified Information System Security Professional (CISSP) this spring/summer.

Steve O'Kane, Principal – Costa Mesa, California

Steve has been a healthcare consultant over the past year were he has provided his services to hospitals, healthcare centers, and non-profits in the areas of strategic planning, organizational development, and project management. Prior to this, Steve was the Chief Executive Officer for the Council of Community Clinics in San Diego, California for seven years. In this role, Steve was responsible for all operations of the Council of Community Clinics and its two

subsidiary organizations – Community Clinic Health Network and Council Connections. Some of his accomplishment in this role include: led the three companies through strategic and business planning; increased financial reserves by 150 percent over six years; evaluated and negotiated a Joint Venture for Council Connections that increased annual profitability by 200 percent; established relationships with the CEOs of the major California Foundations; and transformed the organization's culture to become an Employer of Choice.

Prior to his role with the Council of Community Clinics, Steve was the Vice President of Administrative Services for Alvarado Hospital. Here he was responsible for administering a large contract with the State of California that represented 20 percent of the hospital's patient days, strategic planning for the hospital's campus and associated Medical Office Buildings, and assisting physicians in developing practices.

Additional roles in which Steve has served includes: Interim Chief Operating Officer for Children's Hospital of Orange County; Vice President/Ambulatory and Support Services, Vice President/Regional Services, Vice President/Ambulatory and Clinical Services for Rady Children's Hospital; and Assistant Vice President at Children's Hospital of Central California.

Steve received both his Master of Business Administration degree as well as his Bachelor of Arts degree in Zoology from California State University – Fresno.

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