HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 12, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

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- EXCHANGE ENROLLMENTS REACH 4.2 MILLION, ACCORDING TO HHS
- INDIANA EXPECTED TO ISSUE MEDICAID ABD RFP IN MAY
- NEW HAMPSHIRE SENATE APPROVES MEDICAID EXPANSION
- NEW JERSEY MLTSS TO CARVE-OUT EXISTING NURSING FACILITY RESIDENTS
- PENNSYLVANIA GOVERNOR OFFERS MODIFICATION TO HEALTHY PA JOB SEARCH REQUIREMENTS
- HMA UPCOMING APPEARANCES BY: GREG NERSESSIAN, BROOKE EHRENPREIS, JOAN HENNEBERRY, AND CAPRI DYE

IN FOCUS

STATE BUDGETARY ADJUSTMENTS FOR HEALTH INSURANCE PROVIDER FEE REVIEWED

This week, our *In Focus* section comes to us from HMA Senior Consultant, David Fosdick (Lansing, Michigan). David provides an overview of state budgetary actions that have been announced to adjust for the Health Insurance Provider Fee (HIPF). The HMA Weekly Roundup previously reviewed the HIPF in our November 13, 2013 Weekly Roundup (link) and provided an update based on IRS comments on the HIPF in our December 4, 2013 Weekly Roundup (link).

State Budgetary Adjustments to Account for Health Insurance Providers Fee

Coverage expansions authorized through the Affordable Care Act (ACA) are partially funded through the Health Insurance Providers Fee, a non-deductible excise tax applied to the premium revenue of eligible health insurers. Tax filings are due September 30, 2014 and states that make use of commercial Medicaid managed care organizations (MCO) will need to adjust capitation rates to account for tax liability associated with their enrollees.

Appropriately, budgeting for this fee through the state appropriations process will be complicated by several issues, specifically:

- **The fee will not apply to all Medicaid managed care organizations:** The ACA fully exempts non-profit carriers that receive more than 80 percent of their revenue from public health coverage programs and those with less than $25.0 million in net written premium revenue.
- **Liability will vary between carriers and be difficult to project:** The Health Insurance Providers Fee is not set at a fixed rate; the ACA established revenue targets for the fee program ($8.0 billion in 2014), and each carrier's liability is calculated by determining the product of the carrier's share of taxable premium revenue and the revenue target.
- **Revenue from rate adjustments for the Health Insurance Providers Fee will be subject to the federal corporate income tax:** Any increase in reimbursement to Medicaid MCOs must also include funding for the recipient carrier's increased federal corporate income tax liability.

A review of initial Fiscal Year (FY) 2015 budget documents suggest that most states with large Medicaid managed care programs have made explicit adjustments in their Medicaid appropriation to account for this fee. Provided below is a summary of proposed adjustments in reimbursement to Medicaid MCOs to account for the Health Insurance Providers Fee in selected states. Please note that in many instances the reported figures are an initial recommendation from the Governor; the final allocation to MCOs may be adjusted in the months ahead as more information about the scale of MCO tax liability becomes available.

STATE	ACTION	LINK / PAGE
California	The Governor's FY 2014-2015 recommendation for the Department of Health Care Services appropriates $54.6 million for health insurance providers' tax liability in FY 2013-14 and FY 2014-15.	LINK Page 17
Florida	The current year appropriation (FY 2013-14) allocated $39.8 million to account for Medicaid managed care organization liability through the Health Insurance Providers Fee. The February, 2014 State of Florida Social Services Estimating Conference projects likely expenditure of $100.0 million to account for the HIPF.	
Georgia	House Bill 744, the FY 2015 appropriation for the State of Georgia, provides $77.8 million to care management organizations (CMOs) in the state Medicaid program, and $12.7 million to CMOs contracted with the state's PeachCare program to account for the Health Insurance Providers Fee.	LINK Item 17.8.13 & 17.9.7 Page 26
Louisiana	The FY 2015 Governor's recommendation provides a $31.3 million base adjustment in reimbursement for the Bayou Health program to reflect caseload and ACA-related costs, including the Health Insurance Providers Tax. An additional $3.1 million is recommended for the Louisiana Behavioral Health Plan for compliance with the tax.	LINK Page 124

STATE	ACTION	LINK / PAGE
Maryland	The Governor's budget provides $265.7 million to reflect a positive 6.8 percent adjustment in rates provided to contracted Medicaid managed care organizations. Budget detail notes that 2.0 percent of this increase (roughly $78.1 million) is necessary to account for the Health Insurance Providers Fee.	LINK Page 22
Michigan	The state's contracted actuary accounted for the impact of the Health Insurance Provider's Fee in its calculation of necessary adjustments in health plan reimbursement to meet federal Medicaid "actuarial soundness" requirements. The impact of the fee, along with projected changes in member utilization, was built into a projected 2.5 percent increase in Medicaid capitation rates. This figure was included in the Governor's recommendation for FY 2014-15.	LINK Item 47 Page 28
New Jersey	The Governor's proposed FY 2015 appropriation provides $39.2 million to fund managed care plan liability through the Health Insurance Providers Fee.	LINK Page 102
New York	The state's actuary has adjusted Medicaid capitation rates 1.5 percent to reflect contracted Medicaid MCOs liability through the Health Insurance Providers Fee, and an additional 1.0 percent to account for additional federal tax liability associated with this adjustment.	
Ohio	In its projection of baseline Medicaid expenditures used to generate the FY 2014 and FY 2015 Biennial budget, The Ohio Legislative Service Commission projected an increase in Medicaid managed care expenditure of 1.1 percent in FY 2014 and 1.5 percent in 2015 to account for the HIPF.	LINK Page 52
Pennsylvania	The Governor's Executive Budget recommended a positive adjustment in Medicaid MCO reimbursement of $139.3 million to account for tax liability through the Health Insurance Providers Fee.	LINK Item 2.B Page 134
Tennessee	The enacted FY 2014 appropriation provided $351.0 million in additional funding to the state's TennCare program to account for new costs associated with the ACA, including new "woodwork" enrollees in the program and coverage and financing mandates (including the Health Insurance Providers Fee). The recommended FY 2015 budget annualizes this figure with an additional $220.1 million in funding.	2014: LINK Page B-159 2015: LINK Page B-138
Washington	The Governor's proposed budget for the FY 2013-15 biennium provided $39.4 million to account for the Health Insurance Providers Fee.	

STATE	ACTION	LINK / PAGE
Wisconsin	The Governor's biennial budget for FY 2014-2015 assumed increased Medicaid program costs associated with the ACA, including the Health Insurance Providers Tax, and provided $91.9 million in FY 2014 and $192.1 million in FY 2015.	LINK Item 2 Page 12

HMA Medicaid Roundup

Arkansas

Arkansas "Private Option" Waivers Face Deadline. On March 5, 2014, The *Washington Post* discussed the multiple adaptations that must take place to ensure the long-term viability of Arkansas' "private option" for Medicaid expansion. After surviving a defunding attempt this week, the state faces a September 15 deadline to request federal approval for the establishment of health savings accounts, expanded co-pays, and limits on Medicaid-funded non-emergency transportation. Medicaid Director Andy Allison and his department are currently working on the waivers that will have to be submitted for the changes. Legislation that passed last week mandates the end of the private option program should the federal government deny the state's waiver request by February 1, 2015. Read more

California

Court Rejects Pharmacy Appeal for Higher Reimbursements from Managed Care Health Plans. A California appeals court rejected an appeal from pharmacies that would have required managed care health plans to consider the cost of obtaining prescription drugs when determining their Medi-Cal reimbursement rates. Pharmacies in several Northern California counties stated "they were losing money because the plan's rates were less than their costs for obtaining the drugs." The court ruled that regulators can address access to quality without considering providers' costs. Read more

Health Workers Union Advocating for Cost Control in California. On March 5, 2014, *Kaiser Health News* reported that United Health Care Workers West (SEIU-UHW) is seeking to place two measures on the November ballot to lower health care costs. The first would cap what hospitals can charge above the actual cost of services to 25 percent. The union also seeks to limit non-profit hospital CEO salaries to $450,000 annually. According to the article, 17 Democratic lawmakers have endorsed the ballot measures. Read more

Medi-Cal Cuts a Challenge for PACE Programs. On March 3, 2014, *California Healthline* reported on an Assembly hearing in Sacramento focused on California's Program of All-Inclusive Care for the Elderly (PACE). PACE is one of California's models for its Coordinated Care Initiative for dual-eligible individuals, yet advocates say PACE centers are struggling to maintain the same level of service with declining Medi-Cal reimbursements. Medi-Cal reimbursement rates were most recently cut by 10 percent for most providers. Read more

State Senator Sues Covered California. On March 4, 2014, State Senator Ted Gaines filed a suit against Covered California for overstepping its authority in denying

enrollees the ability to keep their existing health plans. In November 2013, Covered California's board voted not to grant an extension for health plan policies that were not in compliance Affordable Care Act minimum coverage requirements, despite tacit federal approval of a temporary extension of such plans. Gaines is currently running for state insurance commissioner. Read more

LA Care Deemed Ready for Duals Demonstration. LA Care will be allowed to accept enrollees into the dual-eligible demonstration after it passed a readiness review on March 5, 2014. The demonstration is set to launch in LA County in July. LA Care will still not be able to passively enroll participants at that time, due to its low Medicare Star ratings, but will be permitted to accept dual-eligibles who choose to enroll in its managed care plan. Read more

Many California Exchange Enrollees Have Not Paid First Premium. On March 10, 2014, *California Healthline* reported that about 15 percent of Californians who have enrolled in Covered California health plans, as of January 31, 2014, had not yet paid their first month's premiums. Premiums must be paid by the open enrollment deadline of March 31, 2014. Read more

Colorado

HMA Roundup – Joan Henneberry

Exchange CEO Warns of Budget Shortfalls. In spite of dire warnings by Patty Fontneau, CEO of Connect for Health Colorado, the board refused to hike user fees to meet operating expenses. Fontneau requested a 21 percent increase in user fees, and said that without the increase she will have to cut spending. Staff also reported new, reduced projected enrollments for 2014 with the new number being 152,000 for both 2014 and 2015. At one time the exchange expected to enroll as many as 204,000 Coloradans but current numbers are at 90,000 enrollees.

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Key Florida Committee Chairs Do Not Support Medicaid Expansion Under ACA. On March 11, 2014, *Health News Florida* reported that House Select Committee Chairman, Representative Richard Corcoran, and Health Policy Committee Chairman, Senator Aaron Bean, oppose Medicaid expansion in Florida. Both prefer a state-based, alternative plan called Florida Health Choices, which offers narrow specialty discount plans. Read more

Halifax Health to Pay $85 Million in Whistleblower Suit Settlement. On March 10, 2014, the *Daytona Beach News-Journal* reported that Halifax Health must pay the U.S. Department of Justice $85 million within 10 days as part of a settlement agreement filed Monday in federal court. In 2009, the hospital's Director of Physician Services, Elin Baklid-Kunz, filed a whistleblower suit against Halifax alleging illegal contracts with doctors and overbilling. Per the settlement, Halifax will operate under a corporate-integrity agreement for five years to ensure ethical practices. Halifax has admitted it violated the Stark Law, but denies that its doctors performed unnecessary procedures or that it submitted fraudulent claims. Read more

Florida House and Senate Committees Pass Telemedicine Measures. On March 5, 2014, the Florida Senate Health Policy Committee voted 7-2 to approve SPB 7028, a measure that would establish telemedicine guidelines. On March 3, 2014, the House

select committee had passed its own telemedicine bill (HB 751), which appears to have lighter regulatory oversight. The Senate bill would limit the definition of telemedicine providers to physicians, which prompted outcries from nursing groups who argued that their roles would be severely limited by the Senate's legislation. Read more

Georgia

HMA Roundup – Mark Trail

Thousands in Georgia Awaiting Medicaid Eligibility Determination. On March 5, 2014, *The Atlantic Journal Constitution* reported that thousands of low-income Georgians remain without health coverage due to disconnect between federal and state information systems. State officials explain that the federal government has not provided sufficient information for them to accurately determine Medicaid eligibility of many Georgians. Read more

Georgia House and Senate Health Budget Differences to Be Resolved by March 20. On March 6, 2014, the Georgia House Budget and Research Office released a document outlining the differences between the budgets proposed by the House and Senate for fiscal 2015. Several of the budgetary differences presented in this document relate to Medicaid funding, including funding for community health administration and program support, coverage for the aged, blind and disabled, and savings from the revision of supplemental drug rebates. House and Senate budgetary differences in these areas must be resolved in conference committee before the legislative session ends on March 20. Read more

Hawaii

Lawmakers Propose Fee for Private Insurers Not Participating in the Hawaii Health Connector. On March 11, 2014, the *Hawaii Reporter* featured efforts by lawmakers to impose a fee on private insurers not participating in the Hawaii Health Connector health insurance exchange. The proposal calls for a fee of at least two percent of premiums to subsidize the exchange and encourage insurer participation. Read more

Indiana

HMA Roundup – Catherine Rudd

Indiana to Issue ABD RFP in May. This week, HMA confirmed with state Medicaid officials that Indiana plans to issue an aged, blind, and disabled (ABD) managed care RFP in late May 2014. Under the RFP, dual eligibles, long-term services and support, and Medicaid Rehabilitation Option (MRO) services would be carved out. The ABD contracts would cover approximately 50,000 enrollees.

Kansas

Proposal for Mandated Autism Insurance Coverage Debuted. On March 9, 2014, the *Kansas City Star* reported on the latest efforts to mandate insurance coverage for children with autism in Kansas. Kansas is one of 17 states that does not require private insurance coverage for autism, even though it is required for the state employee health plan. Representative John Rubin recently negotiated a deal with insurance companies that would extend autism coverage to about 250 children starting in 2015. Opponents of Rubin's autism coverage bill suggest that the bill does not provide enough coverage

and that most of Kansas' 8,400 autistic children will not receive any benefits from it. Read more

Maine

Maine Considers Further Limiting Medicaid Coverage for Opiate Addiction Therapy. On March 7, 2014, the *Maine Public Broadcasting Network* discussed efforts within Maine's legislature to create additional limitations on Medicaid coverage for opiate addiction treatment. Currently, the state has a two-year cap on Medicaid coverage for methadone and Suboxone, the two most efficacious medications for treating opiate addictions. The Legislature's Appropriations Committee is now considering a six-month cap on treatment coverage. Read more

Massachusetts

HMA Roundup – Rob Buchanan

Massachusetts Chipping Away at Insurance Application Backlog. On March 7, 2014, Sarah Iselin, Governor Deval Patrick's special assistant, said that the state was making progress addressing the backlog of paper applications that required processing. Last week, some 17,000 applications had data entered into the system, with 5,000 requiring follow-up. An additional 43,000 backlogged paper applications still need to be screened and processed. In addition, the state is considering an additional extended deadline request to the federal government. Officials are also considering adapting technology from a functioning state-run insurance exchange for use in Massachusetts. Read more

Boston Medical Center to Merge Campuses. On March 6, 2014, *Becker's Hospital Review* profiled plans by Boston Medical Center (BMC) to consolidate its two campuses in a three-year, $270 million construction and renovation project. While the Boston City Hospital and University Hospital campuses have been part of BMC since a 1996 merger, increased integration of the hospitals' departments and facilities through this project could save the organization $25 million annually through process efficiencies. Read more

Mississippi

Mississippi Medicaid Coordinated Access Network RFP Awards Posted. Contract awards have been formally posted to Mississippi's Medicaid procurement website for the Mississippi Coordinated Access Network (MississippiCAN) RFP. Contracts were awarded to Centene's Magnolia Health Plan and United Healthcare. Centene and United were the incumbent plans and the only two bidders listed on the award notice. Centene had previously announced they had been awarded a contract in a press release earlier this year. Link to Notice.

New Hampshire

New Hampshire Senate Votes for Medicaid Expansion Plan. On March 6, 2014, the New Hampshire Senate voted 18-5 to expand health coverage to 50,000 low-income adults via private health insurance using enhanced federal Medicaid funding. Under the bill, the program would end in 2016 when the federal government's required contribution drops below 100 percent, unless it is reauthorized. The bill will now move to the House, which has passed similar legislation. Read more

New Jersey

HMA Roundup – Karen Brodsky

Managed Long-Term Services and Supports Implementation Will Keep Nursing Facility Residents in Medicaid Fee-for-Service. Following Governor Chris Christie's budget address on February 25, 2014, New Jersey's Division of Medical Assistance and Health Services (DMAHS) notified its Medicaid managed care organizations (MCO) that the SFY15 budget will not enroll existing nursing facility residents into managed care, as previously planned under the state's Comprehensive Medicaid Waiver. As a result, approximately 27,000 nursing facility residents will remain under Medicaid fee-for-service. Beginning July 1, 2014, the MCOs will become responsible for all new nursing facility residents, as well as for home and community services for the waiver populations currently enrolled in managed care. Language that details this change will be included in the final budget book to be released this spring.

Obama Administration's Three-Year Extension for Insurance Plans Without ACA Minimum Coverage Requirements Has Minimal Impact in New Jersey. On March 7, 2014, NJ Spotlight reported that insurance plans not in compliance with ACA guidelines have now been extended through 2017. Governor Christie had said in November that New Jersey insurers could decide if they wanted to continue offering these transitional plans, although most declined to do so. Wardell Sanders, President and CEO of the New Jersey Association of Health Plans, explained that insurers had little time to implement an extension of these policies and that they did not believe extending non-compliant plans would be in the best interest of their customers. AmeriHealth, Horizon Blue Cross Blue Shield NJ, and Health Republic of New Jersey are in the healthcare marketplace and will only sell and renew compliant plans. United Healthcare's Oxford Health Plans will give its 100,000 members the option to renew their current plans for one year. Read more

Marketplace enrollment in New Jersey. The Department of Health and Human Services, ASPE Issue Brief on the Health Insurance Marketplace enrollment as of March 1, 2014, reports that 187,231 New Jersey residents were determined to be eligible to enroll in a Marketplace plan and of those, 74,370 have selected one. This represents a 36 percent increase from last month or 19,565 additional residents who have selected a plan from one month ago. Of the applicants, 123,092 New Jersey residents were found eligible for Medicaid or CHIP, a 17.5 percent increase from last month or an additional 18,403 residents. This month's report shows that 59% of New Jersey Marketplace applicants qualify for financial assistance. The cumulative number of individuals that have selected a Marketplace plan between October 1, 2013 and March 1, 2014 nationally is 4.2 million, up from 3.3 million last month. More information can be found in the ASPE Issue Brief released March 11, 2014. Read more.

New Jersey Division of Developmental Disabilities Releases RFP on the Prevention of Developmental Disabilities. On March 5, 2014 the New Jersey Division of Developmental Disabilities (DDD) issued an RFP seeking bidders to propose statewide projects and special projects aimed at reducing the incidence of developmental disabilities in New Jersey. Contracts of up to $125,000 per year may be available for statewide programs, and grants of up to $40,000 per year are expected to be available for special projects. Interested applicants may submit questions to the DDD or the Office for the Prevention of Developmental Disabilities (OPDD) until March 17, 2014. Responses to questions will be posted on the Department of Human Services website by March 20, 2014. Proposals should be submitted to Jonathan Sabin, Director, OPDD, DDD by April 24, 2014. Read more

New Jersey Department of Health Releases FY 2015 Grant Program Opportunities. This week, the Department of Health released a Directory of Grant Programs which provides a comprehensive listing of grant funds available from the Department. These grant funds will become available during the period of July 1, 2014 through June 30, 2015. Grants are available in the following 13 categories: 1) HIV/AIDS, STD and TB Services; 2) Cancer Control and Tobacco Prevention; 3) Chronic Disease and Prevention; 4) Commission on Brain Injury Research; 5) Commission on Spinal Cord Research; 6) Epidemiology, Environmental, and Occupational Health Services; 7) Clinical Autism Programs; 8) Maternal, Child and Community Health Services; 9) Minority and Multicultural Health; 10) Primary Care Services; 11) Public Health Infrastructure Preparedness and Emergency Response; 12) Special Child and Early Intervention Health Services; 13) Supplemental Nutrition Services for Women, Infants and Children (WIC). Read more

New York

HMA Roundup – Denise Soffel

New York State of Health Proposing Changes in Network Requirements. In a February 26, 2014 presentation, New York state health officials discussed the possibility of requiring health plans participating on the state exchange to include an out-of-network benefit in 2015. This move is supported by consumer advocates as well as by specialist physicians, but is opposed by the health plans currently participating in the exchange. The current lack of out-of-network benefits for individuals obtaining coverage through the exchange had been criticized on the grounds of consumer choice, but the state had previously argued that provider network requirements were robust. The insurance industry argues that closed networks enable lower premiums and that out-of-network benefits could boost premiums by as much as 30 percent. Read more

Exchange Enrollment Nears 600,000. The New York State of Health announced that, as of March 11, 2014, 908,595 New Yorkers have completed their applications, and 590,639 have enrolled for coverage since the launch of the New York State of Health on October 1, 2013. Over 70 percent of New Yorkers who have enrolled to date had been uninsured at the time of application. The new enrollees consist of 299,836 in private plans and 290,803 in Medicaid. Read more

Managed Long-Term Care Programs Reviewed by New York Times. On March 6, 2014, the *New York Times* discussed nationwide efforts to curb soaring Medicaid costs. At least 26 states are establishing programs to institute managed long-term care plans to save on institutional care and expand home and community-based alternatives. However, some argue that these alternative long-term care plans have rigid rules related to treatments offered, per-patient spending, and needs assessment tools, often resulting in the denial of services routinely covered under traditional fee-for-service Medicaid. Read more

HHS Report Cites New York's Excessive Medicaid Rates for Disabled Residents. On March 12, 2014, the *Wall Street Journal* highlighted a report from the HHS inspector general that called New York's Medicaid reimbursement rates for disabled residents "excessive." The report notes that the state's Medicaid rates were more than double those of privately operated residences offering the same services. The federal government, which pays half of New York's Medicaid costs, paid $320 million more than actual care costs in 2010. New York State has implemented a new payment approach retroactive to April 1, 2013. Read more

Nevada

Problematic State Insurance Exchange May Jeopardize Enrollment Goal. On March 10, 2014, the *Reno Gazette-Journal* reported on Nevada's progress in enrolling residents for health insurance coverage using the Nevada Health Link marketplace. Because of technical problems with the website, the Health Insurance Exchange Board is considering an extension of the enrollment deadline for people who have had trouble signing into the marketplace. The current deadline to sign up and pay for a qualified health plan is March 31, and the state's enrollment figures fall short of the recently-lowered target of 50,000. Read more

Pennsylvania

HMA Roundup – Matt Roan

Governor Corbett Offers Modification to Healthy PA Job Search Requirements. Last week, Governor Tom Corbett announced a modification to the Healthy PA waiver submitted to the Department of Health and Human Services last month. The Governor proposes to remove provisions of the waiver that would tie Medicaid eligibility to completion of approved job search activities, and replace them with a one year pilot program called "Encouraging Employment," which will use incentives to motivate unemployed and underemployed enrollees to search for better employment opportunities. Many healthcare advocates have identified the work search requirements within the waiver application to be problematic, and there is doubt as to whether CMS will be able to approve a plan that ties Medicaid eligibility to work search activities. Read more

PA Unemployment Rate Drops Below National Average. On March 7, 2014, the Pennsylvania Department of Labor and Industry reported January 2014 employment statistics which show a 0.4 percent drop in the unemployment rate across the Commonwealth. The report also shows that, for the first time since January 2009, total employment in Pennsylvania exceeded 6 million. The state's unemployment rate of 6.4 percent came in lower than the national unemployment rate which stands at 6.6 percent. Read more

Proposed Legislation Would Improve Monitoring for Prescription Drug Abuse. On March 10, 2014, the *Times Tribune* featured a story profiling efforts to create a statewide prescription drug monitoring database in legislation being considered by the Senate Health and Welfare committee. The issue of prescription drug abuse in Pennsylvania has been in the spotlight recently, and received particular attention during legislative appropriations committee hearings with State Attorney General Kathleen Kane. The bill, sponsored by Representative Matt Baker, was introduced in October and would create a statewide database to track and monitor the names of individuals filling prescriptions for controlled substances, the prescribing provider, the pharmacist or other dispenser, and the source of payment. The tool is meant to help state officials identify potential patterns of drug abuse or inappropriate prescribing patterns. Read more

Philadelphia Area Hospitals Facing Financial Challenges. On March 8, 2014, the Philadelphia Inquirer reported on the financial difficulties at Philadelphia-area hospitals and health systems. Crozer-Keystone Health System, Temple University Health System, Einstein Health Network, and Holy Redeemer Health System have all reported operating losses associated with overall declines in admissions and payer mixes heavily reliant on Medicaid. The decline in admissions was attributed to the

overall push to deliver more services in outpatient settings, as well as recent Medicare rules that penalize re-admissions within 30 days of discharge. Read more

Tennessee

Senate Votes to Require Legislative Approval to Expand TennCare. On March 6, 2014, the Tennessee Senate voted to require Governor Bill Haslam to get lawmakers' permission before expanding TennCare, the state's Medicaid program. Haslam stated that he has no objection to the measure, as he had already planned on seeking legislative approval for any expansion effort. Read more

Utah

Utah House and Senate Disagree On Medicaid Expansion. On March 10, 2014, the *Deseret News* reported on continued disagreement in the Utah House and Senate regarding Medicaid expansion. Earlier this week, the Senate passed a partial Medicaid expansion plan that would allow Governor Gary Herbert to seek a block grant from the federal government to roll out his "Healthy Utah" private insurance plan, with legislative oversight. However, House Speaker Becky Lockhart declared that the bill would not be considered for floor debate before the legislative session ends on March 13, 2014. Read more

Wisconsin

Senate Passes Bill to Reform Milwaukee County Mental Health Care. On March 11, 2014, the Wisconsin Senate unanimously approved a bill to put a board of medical professionals—rather than politicians—in charge of Milwaukee County's mental health system. The bill also requires the state to conduct an audit of the county's Mental Health Complex by December 1. The legislation aims to improve the quality of care in the county's mental health facilities, which had been criticized for negligence and abuse of patients. The bill will now move to the Assembly, where it is expected to pass. Read more

National

ASPE Releases Latest Marketplace Open Enrollment Figures. On March 11, 2014, the HHS Office of The Assistant Secretary for Planning and Evaluation issued its latest update on national enrollment on state-run and federally facilitated exchanges. As of March 1, 4.2 million Americans had selected a marketplace plan, with 942,800 new enrollees in the month of February (compared to 1.1 million in January). Of that monthly figure, 681,500 were enrolled in the Federally Facilitated Marketplaces. Nearly two thirds of enrollees (63 percent) selected a mid-level "Silver" marketplace plan. A quarter of the enrollees are between the ages of 18 and 34 years old. In addition, 4.4 million Americans were notified of their eligibility for Medicaid or CHIP by the Marketplace. Read more

CMS Issues Basic Health Program Rules. On March 7, 2014, the Centers for Medicare and Medicaid Services released a rule and a payment bulletin establishing the basic health program, an affordable alternative to marketplace coverage for low-income people. The program is scheduled to start on January 1, 2015 and would provide subsidized health insurance plans to individuals and families with incomes between

138 percent and 200 percent of the federal poverty level. The new plans will have to follow Medicaid or marketplace rules on the types of medical providers the networks would include, as well as the number, mix, and geographic distribution of providers. The basic health program could offer more manageable out-of-pocket costs for people compared to those of a marketplace plan. Read more

Health Insurance Regulator Gary Cohen to Resign. On March 6, 2014, *Bloomberg* reported that Gary Cohen will resign from his position as director of the Center for Consumer Information and Insurance Oversight (part of CMS) at the end of the month. Cohen's agency devises the regulations for ACA insurance exchanges, monitors insurer premiums, and enforces consumer protections under the health law. Cohen will be temporarily succeeded by Mandy Cohen, a medical doctor who manages consumer assistance for the agency. Read more

Medicaid Enrollment Figures Questioned by Several Republican-Led States. On March 4, 2014, *Modern Healthcare* reported that state officials are in disagreement over Medicaid enrollment figures reported by the Obama administration and others. The Obama administration reports that 8.9 million Americans had been determined eligible for Medicaid through Medicaid agencies and state exchanges, with another 1.2 million deemed eligible through the federal enrollment portal. However, officials in Republican-led states, which largely have rejected Medicaid expansion, cite considerably lower Medicaid enrollment figures in their states. Read more

Federal Government Focuses on Quality of Care in Nursing Homes. On March 7, 2014, *Kaiser Health News* reported on growing federal efforts to strengthen inspections of nursing homes. A report released last week by the HHS Inspector General estimates that a third of nursing home residents suffered harm due to substandard care, resulting in more hospitalizations and larger Medicare bills. The Inspector General and the Centers for Medicare and Medicaid are collaborating to identify the red flags of poor care, unrelated to natural disease progressions. Read more

Insurance Providers Running Actuarial Studies to Estimate Cost of ACA. On March 7, 2014, *Kaiser Health News* reported that several insurance companies have hired Wakely Consulting Group to provide early estimates of the costs and revenues of new exchange enrollees. These estimates will help insurers assess the overall health of their policyholders, the validity of their 2014 insurance plan pricing, and how they should price insurance plans in the future. To address insurer concerns about confidentiality, Wakely will not be sharing its findings with the federal government. Read more

Prisoners Gaining Coverage Through Medicaid Expansion. On March 9, 2014, The *New York Times* profiled the national effort to enroll inmates in health insurance under the Affordable Care Act. Medicaid expansion under the law, which allows states to extend coverage to single and childless adults, applies to a significant portion of the prison population. States currently spend billions of dollars annually on prison healthcare, much of which can be shifted to the federal government as prisoners enroll in Medicaid. Several state officials are also calling for the coordination of care for prisoners upon release to reduce recidivism and lower overall costs. Read more

Health Index Highlights Drop in Uninsured. On March 10, 2014, the *Washington Post* discussed the Gallup-Healthways Well-Being Index, which indicates that 15.9 percent of U.S. adults are insured thus far in 2014, down from 17.1 percent in the last quarter of 2013. This translates to 3 million more Americans acquiring insurance coverage so far in 2014. Almost every major demographic group increased its number of insured individuals, although progress for Hispanics has been more limited. Read more

Business Community Divided about the Benefits of Medicaid Expansion. On March 10, 2014, *Kaiser Health News* discussed disagreement within the business community over the benefits of Medicaid expansion. Business groups that support expansion argue that doing so could help save safety net hospitals and allow hospitals to lower costs to employers; however, many smaller employers and other organizations remain on the sidelines or opposed. Read more

Industry News

County Villa Health Services Files for Bankruptcy. On March 5, 2014, *The Wall Street Journal* reported that California nursing home operator Country Villa Health Services has filed for Chapter 11 bankruptcy protection. Chief Executive Officer Stephen Reissman says that the company's legal issues, including seven class-action suits, precipitated cash flow shortfalls, sparking the filing. The company's 19 nursing homes and assisted living centers cared for 1,711 patients and residents (reflecting a 90 percent occupancy rate) and employed 2,113 people as of last month. Read more

MAXIMUS Contact Centers Receive Honors from BenchmarkPortal. On March 6, 2014, MAXIMUS announced that four contact centers in Massachusetts, Texas, and Georgia were recognized as "Certified Centers of Excellence" by BenchmarkPortal. The centers were assessed based on their operational efficiency, service-level standards, customer satisfaction, and employee training. Read more

Tenet Announces Partnership with Yale. On March 6, 2014, Tenet Healthcare announced a partnership with Yale New Haven Health System to create a health care delivery network in Connecticut, with further plans to grow in the greater northeast region. The partnership aims to leverage economies of scale, build a clinically integrated delivery platform with local physicians, and establish innovative value-based contracts with employers and payers. There are letters of intent to acquire Waterbury Hospital, Bristol Hospital, and Eastern Connecticut Health Network, subject to receipt of regulatory approvals and definitive agreements.

Imperial Capital to Target Health IT and Health Services Companies. On March 12, 2014, *MedCity News* reported that Toronto-based private equity firm Imperial Capital recently closed its fifth fund, with plans to deploy some of the $295 million raised to invest in middle-market healthcare companies in the U.S. and Canada. In particular, the fund is interested in health IT and healthcare service businesses with limited reimbursement risks. Read more

RFP Calendar

Date	State	Event	Beneficiaries
March 21, 2014	Puerto Rico	Proposals Due	1,600,000
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
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	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	3/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714						TBD	
Idaho		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	3/27/2013	August 2013			TBD	
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	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013		5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	10/1/2014	1/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 6 MFFS**	**1.2M Capitated 520K FFS**	***12***			***9***			

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

‡ Capitated duals integration model for health homes population.

HMA Upcoming Appearances

"State of the Healthcare Services Market"
McDermott Will & Emory:
2014 Healthcare Services Private Equity Symposium
Greg Nersessian – Panelist
March 13, 2014
Miami, Florida

"The Health of Healthcare in the U.S."
California Capital Summit Breakfast
Brooke Ehrenpreis – Moderator
March 21, 2014
Los Angeles, CA

"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