HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 4, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

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IN FOCUS

TEXAS PROVIDES UPDATES ON MANAGED CARE INITIATIVES

This week, our *In Focus* section reviews the updates on Medicaid managed care initiatives provided to the Texas House Committee on Human Services on March 24, 2014, by the leadership of the state's Health and Human Services Commission (HHSC), the state's Medicaid agency, and the Department of Aging and Disability Services (DADS). HHSC and DADS provided a status update on the Administration's progress with the implementation of SB 7, which included expanding both the services included and the service areas for STAR+PLUS, the state's managed care program for the aged, blind, and disabled population. Additionally, HHSC and DADS provided an update on the state's dual eligible financial alignment demonstration and the STAR Kids RFP.

SB 7 included several expansions of managed care set to take place over the next 6 years, including expansion of the STAR+PLUS program into the Medicaid Rural Services Areas (MRSAs) of the state, the carve- in of nursing facility services to the STAR+PLUS managed care benefit, and integrating acute care for adults with intellectual and developmental disabilities (IDD) into STAR+PLUS. HHSC and DADS presented the following timeline for these initiatives:

Managed Care Initiative	Estimated Population	Implementation Timing
STAR+PLUS Rural Expansion	80,000	September 1, 2014
IDD Carve-In (Statewide)	TBD	September 1, 2014
Dual Eligible Financial Alignment Demonstration	132,600	January 1, 2015
Nursing Facility Services Carve-In (Statewide)	56,800	March 1, 2015
STAR Health (Foster Care) - Reprocurement	32,000	September 1, 2015
STAR Kids	200,000	September 1, 2016

STAR+PLUS MRSA Expansion

The STAR+PLUS rural expansion was procured under an RFP in late 2012 and HHSC awarded contracts to five MCOs across the three MRSAs, encompassing approximately 80,000 eligible beneficiaries. MRSA – West Texas will be served by Amerigroup and Superior Health Plan (Centene). MRSA – Northeast Texas will be served by Cigna-Healthspring and UnitedHealthcare. MRSA – Central Texas will be served by Superior Health Plan and UnitedHealthcare. As detailed in the calendar above, the MRSA expansion is set to begin on September 1, 2014 for all three MRSAs.

IDD Acute Care Services Carve-In

Also on September 1, 2014, certain individuals with intellectual and developmental disabilities will begin transitioning into the STAR+PLUS program for acute care services only. Those included are:

- Individuals receiving services in community-based intermediate care facilities for Individuals with Intellectual Disabilities or related conditions (ICF-IDDs); and
- Individuals enrolled in certain DADS 1915(c) waiver programs, including Home and Community-based Services (HCS), Community Living Assistance and Support Services (CLASS), Texas Home Living (TxHmL) and Deaf Blind Multiple Disabilities (DBMD).

Additionally, children and young adults under age 21 receiving supplemental security income (SSI) or SSI-related benefits may voluntarily enroll into STAR+PLUS. Individuals in state supported living centers, and dual eligibles enrolled in certain DADS waivers or residing in an ICF are excluded from the carve-in.

In response to SB 7, HHSC has applied for Community First Choice (CFC) approval from CMS to deliver attendant and habilitative services to the IDD population with a 6 percent enhancement in federal funding rates.

Finally, HHSC and DADS will develop IDD pilot programs with private providers of IDD services under a capitated model to be implemented no later than September 1, 2016. Participating providers will be required to coordinate ICF and waiver services and must work with MCOs to coordinate delivery of acute care services. Participation in the pilot by persons with IDD will be voluntary, and results will be used to develop recommendations to the Legislature regarding the program, including potential changes to STAR+PLUS.

Nursing Facility Services Carve-In

Originally scheduled for late 2014, it was announced last month that the carve-in of the nursing facility services benefit to the STAR+PLUS program would be delayed until March 1, 2015. Statewide, there are approximately 56,800 nursing facility residents who will be transitioned into the STAR+PLUS program. Children and young adults under age 21 will be excluded from the carve-in, while adults age 21 and older will be mandatorily enrolled. Under this expansion, the STAR+PLUS health plans will be financially responsible for managing institutional care services under an integrated model.

Dual Eligible Demonstration Update and Membership Projections

The March 24 presentation indicates that HHSC will enter into three-way contracts with CMS and current STAR+PLUS health plans in six counties of the state - Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant. The current STAR+PLUS health plans eligible to participate in the demonstration, pending CMS approval, are Amerigroup, Health Spring, Molina, Superior (Centene), and UnitedHealthcare. The total dual eligible populations across these six counties is around 132,600. As in other CMS Financial Alignment dual demonstration states, duals will be able to opt out of participation. Dual eligibles in these six counties are currently receiving Medicaid managed long-term supports and services (MLTSS), excluding nursing facility services, through one of these five health plans under the STAR+PLUS program. The duals demonstration is set to begin on January 1, 2015, pending approval by CMS and the execution of a memoranda of understanding (MOU) with CMS and three-way contract approval and readiness review of the health plans.

Current STAR+PLUS enrollment by health plan, as of November 2013, for the duals demonstration counties is presented below.

Current STAR+PLUS	Total Enrolled	Amerigroup	Centene	HealthSpring	Molina	United
Tarrant County	33,837	27,293		6,544		
Dallas County	58,550		25,733		32,817	
Harris County	102,356	44,525			13,391	44,440
Hidalgo County	73,753		38,450	18,238	17,065	
Bexar County	48,959	9,873	30,458		8,628	
El Paso County	24,717	12,936			11,781	
Total	**342,172**	**94,627**	**94,641**	**24,782**	**83,682**	**44,440**

Below, we detail enrollment scenarios by health plan if dual eligible demonstration enrollment were apportioned across the health plans based on their current STAR+PLUS market share in each of the six demonstration counties.

Duals Demonstration	Total Dual Eligibles	Amerigroup	Centene	HealthSpring	Molina	United
Tarrant County	11,522	*9,294*		*2,228*		
Dallas County	21,142		*9,292*		*11,850*	
Harris County	38,402	*16,705*			*5,024*	*16,673*
Hidalgo County	23,556		*12,281*	*5,825*	*5,450*	
Bexar County	21,352	*4,306*	*13,283*		*3,763*	
El Paso County	16,634	*8,706*			*7,928*	
Total	**132,608**	**39,010**	**34,856**	**8,053**	**34,016**	**16,673**

STAR Kids RFP

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

accept proposals through late October 2014. Children with SSI in foster care will continue to receive services through the STAR Health program, for which a reprocurement RFP is scheduled to be released on April 8, 2014.

At a meeting of the STAR Kids Advisory Committee on March 26, 2014, HHSC reviewed the draft RFP and invited comments and suggestions from committee members and public attendees. A lengthy discussion focused on provider networks and the challenges parents encounter when trying to locate in-network physicians who will accept new children with complex health needs. HHSC indicated that network adequacy will be a signifiant area of evaluation as part of the review process, and that MCOs are required to develop robust networks with the wide range of specialty providers this population requires. Other areas of recommended changes in the RFP included reduction of administrative requirements for providers, clarifying care coordinator responisibilities and minimum visit requirements to ensure enrollees are not forced to participate in certain activities, and revisions to the appeals process to provide more protection and quicker resolution for enrolleees. Written comments on the draft RFP are due no later than April 18, 2014.

Additional information on Texas' managed care expansions can be found at the following state websites:

Link to HHSC/DADS Presentation:
http://www.hhsc.state.tx.us/news/presentations/2014/Managed-Care-Initiatives.pdf
Link to HHSC Managed Care Initiatives website:
http://www.hhsc.state.tx.us/medicaid/mmc.shtml

HMA Medicaid Roundup

Arizona

Magellan Health Services Disputes Mercy Maricopa Mental Health Contract. On March 28, 2014, *Arizona Central* reported that Representative David Stevens attempted to get the state Legislature to nullify a $3 billion mental health contract with Mercy Maricopa Integrated Care on the grounds that the contract is illegal. Stevens spoke on behalf of Magellan Health Services, which held the contract since 2007 and lost it to Mercy Maricopa last year. While the House has rejected the amendment, Stevens and Magellan lobbyists will now advocate their case in the Senate. Read more

California

HMA Roundup – Alana Ketchel

Medi-Cal Providers Not Yet Receiving Pay Boost Required by the ACA. On March 31, 2014, the *California Health Report* reported that providers serving Medi-Cal recipients are still not receiving the increased reimbursements promised under the Affordable Care Act (ACA). California has one of the lowest Medicaid reimbursement rates in the nation. But as of January 2013, the ACA temporarily permitted doctors who treat Medi-Cal patients to be reimbursed at the Medicare rate, which is significantly higher. The state Department of Health Care Services and the Medi-Cal managed care plans the department contracts with have been slow to compensate California doctors, dissuading many primary care doctors from taking on more Medi-Cal patients. Read more

Adult Day Centers Struggling, But Financial Reprieves Have Proven Useful. On March 31, 2014, *California Healthline* reported on the precarious viability of Community Based Adult Services (CBAS) programs. Significant cuts to Medicaid reimbursements have jeopardized CBAS centers around the state, forcing many to close and limiting access to much-needed senior care. Recently, some of these CBAS centers have received a financial reprieve from the Department of Health Care Services and health insurers, which have agreed to reverse or offset, respectively, the cost of reimbursement reductions. Read more

Central Valley Facing Physician Shortage. The *Central Valley Business Times* reported on March 24, 2014 about a California HealthCare Foundation report on physician supply in California. The report found that California's physician supply increased significantly from 1993 to 2013, more than double the rate of population growth. However, certain regions did not meet the recommended physician-to-patient ratio, including San Joaquin Valley and the Inland Empire region. The report states that the Affordable Care Act coverage expansion will increase demand for physicians while the supply will shrink as more California doctors approach retirement. Read more

Covered California Enrollees To Receive $2 Billion in Subsidies. *HealthyCal* reported on March 27, 2014 that forty percent of Californians eligible for an Exchange insurance subsidy enrolled in Covered California by March 1, 2014. This translates to over two billion dollars in tax credits over the next year, according to a brief by the Kaiser Family Foundation. California's rate of enrollment is among the highest in the nation. Read more

Covered California Experiences Enrollment Surge in Last Week, Offers Extension. A March 28, 2014 *LA Times* article reports that approximately 80,000 Californians selected a Covered California health plan during the last week of open enrollment and 150,000 others created an account and began the process to shop for health insurance on the website. To accommodate those who are having trouble enrolling by March 31, 2014 due to technical challenges, the exchange is extending the deadline to April 15, 2014 to complete online enrollment. Read more

Colorado

HMA Roundup – Joan Henneberry

Marketplace Enrollment Update. Connect for Health Colorado announced that the last minute surge in enrollments resulted in 118,628 individuals signing up for health insurance. Over 12,000 signed up in the last week of the open enrollment period. That is in addition to 160,000 newly eligible Medicaid clients.

Colorado Health Foundation Issues Annual Health Report Card Grades. The Colorado Health Foundation, which funded $86 million in programs to improve the health of Coloradans in 2012, issued its eighth annual Health Report Card on the state's performance April 2, 2014 and found considerable room for improvement. It called for increased emphasis on physical education for school children; intensifying outreach to uninsured Coloradans, particularly those between 19 and 34, to get them enrolled in health insurance; and expanding access to integrated mental, behavioral and physical health care.

Florida

HMA Roundup – Elaine Peters and Gary Crayton

House and Senate Appropriations Committees Pass FY 2014-2015 Budgets. This week, the House and Senate Appropriations Committees passed their respective FY 2014-2015 budgets off the floor. With regards to Medicaid, both budgets:

- Fully fund the estimated 3.7 million Medicaid beneficiaries
- Make no Medicaid provider rate reductions or eligibility reductions or eliminations
- Fully fund the estimated 270,000 children in the KidCare program
- Continue the $1 billion Low Income Pool (LIP) program contingent on reauthorization of the 1115 Waiver
- Require that rates for nursing facilities and ICF/DDs be set once a year on July 1 (currently set twice a year)
- Provide increased slots for Long Term Care (LTC) Waiver
    - House budget – 1,280 slots
    - Senate budget – 1,100 slots
- Provide increased slots of 1,260 for the Developmentally Disabled (DD) Waiver

- Provide a Private Duty Nursing Services provider rate increase for Licensed Practical Nurses (LPN)
  - House budget - 10% LPN rate increase
  - Senate budget - 20% LPN rate increase
- Include a rate increase of 3.5% for Prescribed Pediatric Extended Care (PPEC)

The budgets will now be reviewed by Conference Committees to resolve any differences.

Scott Administration Meets with CMS to Discuss LIP Funding in Health Care Budget. On April 1, 2014, *Political Fix Florida* reported on budget negotiations this week between Governor Rick Scott and federal regulators to address the state's Low Income Pool (LIP) fund. The state waiver for LIP is currently capped at $1 billion, but that limit can be amended by CMS for the upcoming fiscal year. With no clear indication of what federal officials will decide about the waiver and with final budget negotiations looming, the Florida Agency for Health Care Administration budget writers are struggling to determine funding for LIP and related programs. Read more

Senator Nelson Proposes Using Local Match to Finance Medicaid Expansion. On March 27, 2014, *Health News Florida* reported that Senator Bill Nelson is promoting an idea that could allow for Medicaid expansion in Florida. In a letter to CMS Chief Marilyn Tavenner, Nelson explains that Florida could use federal funds to cover 1.2 million low-income residents, while using funds from local area hospitals to pay for any state cost relating to Medicaid expansion after full federal funding expires, thus removing the burden of financing Medicaid from other state agencies. Read more

Illinois

HMA Roundup – Andrew Fairgrieve

Initial Duals Demonstration, City of Chicago ICP Enrollments Publicized. Illinois' Department of Healthcare and Family Services (HFS) published March 2014 enrollment numbers, the first month to capture voluntary dual eligible demonstration enrollments and mandatory enrollment into the state's non-dual Medicaid managed care program for the aged, blind and disabled (ABD). In its first month, the state's dual eligible demonstration, known as the Medicare-Medicaid Alignment Initiative (MMAI), has voluntarily enrolled a total of 192 dual eligible beneficiaries in both Greater Chicago and Central Illinois. Combined dual eligibles across the two regions is estimated at around 111,000.

Greater Chicago - MMAI (Duals)	March 2014 Enrollment	% Total
BCBS of Illinois	73	50.0%
Humana	24	16.4%
IlliniCare (Centene)	24	16.4%
Aetna Better Health	14	9.6%
Cigna HealthSpring	6	4.1%
Meridian Health Plan	5	3.4%
Total - Greater Chicago	**146**	
Central Illinois - MMAI (Duals)	**March 2014 Enrollment**	**% Total**
Health Alliance	43	93.5%
Molina Healthcare	3	6.5%
Total - Central Illinois	**46**	

In its first month of expansion enrollment for the City of Chicago, the state's mandatory managed care program for non-dual ABD, known as the Integrated Care Program (ICP), has enrolled nearly 2,400 of an estimated 69,000 eligible non-dual ABDs in the City of Chicago, the final region to implement in the state's ICP expansion, which began in mid-2013.

City of Chicago - Integrated Care Program	March 2014 Enrollment	% Total
IlliniCare (Centene)	1,118	47.2%
Aetna Better Health	912	38.5%
Community Care Alliance of Illinois (CCAI)	158	6.7%
BCBS of Illinois	125	5.3%
Meridian Health Plan	47	2.0%
Humana	8	0.3%
Cigna HealthSpring	2	0.1%
Total	**2,370**	

Cook County Awards CountyCare Management Contract to Centene's IlliniCare. On March 29, 2014, the *Chicago Tribune* reported that the Cook County Health and Hospitals System (CCHHS) has received approval by its Board for a $1.8 billion contract with IlliniCare Health Plan Inc. (Centene) to run the day-to-day operations of its Medicaid managed care initiative, CountyCare. CountyCare was established under a Medicaid early expansion waiver from CMS in 2013. IlliniCare will run CountyCare starting on July 1, 2014 and the county will manage health services provided through the program. Read more

Louisiana

DHH Works to Improve Dental Care Access for Medicaid and LaCHIP Recipients. On March 29, 2014, the *Monroe News Star* reported that the Louisiana Department of Health and Hospitals (DHH) is planning to provide dental coverage to Medicaid and CHIP recipients through managed care beginning July 1, 2014. Clinicians have raised concerns that a poor transition to managed care or delayed or low reimbursements may dissuade dentists from accepting Medicaid patients. Because of the statewide shortage of dental providers, this could significantly limit access to dental services critical to maintaining good health. To address these concerns and improve dental health outcomes, the DHH is considering hiring a dental benefits program manager to improve coordination of access to care. Read more

Maine

House Gives Initial Approval to Expand MaineCare Family Planning Services Coverage. On March 26, 2014, the *Bangor Daily News* reported that the Maine House has approved a bill that would expand MaineCare coverage to provide preventive and family planning services to women who make up to 200 percent of the federal poverty level. Starting October 31, 2014, these women would gain coverage for cancer screening, annual exams, birth control, sexual health education, counseling and prevention, and testing and treatment for sexually transmitted diseases. Bill sponsor Representative Jane Pringle says that other states that have expanded such services to all women have seen significant returns on investment. Read more

Third Medicaid Expansion Bill Presented to Governor LePage. On March 28, 2014, the *Associated Press* reported that the Maine Legislature has sent a Medicaid expansion bill to the desk of Governor Paul LePage, where it will almost certainly be vetoed. While the bill was approved in both legislative chambers in March, it did not receive the two-thirds support needed to override the governor's veto. Governor LePage, who vetoed two expansion bills last session, continues to argue that Medicaid expansion will be too expensive and will further burden the Medicaid system. Read more

Maryland

Maryland Exchange Board Votes to Replace System with Connecticut's. On April 1, 2014, the *Washington Post* reported that Maryland's Exchange board has voted to replace the state's troubled health insurance Exchange with technology from Connecticut's successful state-based Exchange. The board has hired Deloitte to carry out the transition and estimates the change will cost $40 to $50 million. Of the states that have reported significant technical issues with their state-based exchanges, Maryland is the first to replace their system. Secretary of information technology Isabel FitzGerald told board members that the exchange should have the Connecticut marketplace's core functions before the start of the next enrollment period on November 15. Read more

Lawmakers Seek to Increase Pay to Workers Who Care for Developmentally Disabled. On March 26, 2014, the *Washington Post* reported on the Maryland Senate's progress in advancing an amended version of Governor Martin O'Malley's minimum wage bill. O'Malley's bill will raise minimum wage statewide, but Senator Thomas Middleton and a leading advocate for the disabled community say that the bill should also raise Medicaid reimbursements to workers who care for the developmentally disabled in community-based programs. The governor's office is still in discussions with lawmakers about the best way to provide this raise. Read more

Michigan

HMA Roundup – Esther Reagan

Healthy Michigan Medicaid Expansion Program Officially Opens for Enrollment. On April 1, 2014, the *Detroit Free Press* reported that the Healthy Michigan Medicaid expansion plan has officially begun. The program will expand health care coverage to 470,000 previously uninsured low-income Michigan residents. Of the states participating in Medicaid expansion under the Affordable Care Act, Michigan is the only one to delay expansion until now. Healthy Michigan is the only expansion program that provides incentives for healthy behaviors and encourages cost-sharing among beneficiaries. Read more

Mississippi

Less than Half of Mississippi Primary Care Physicians Willing to See New Medicaid Recipients. On March 29, 2014, the *Clarion Ledger* reported that less than half of Mississippi's primary care physicians are willing to see new Medicaid patients due to low reimbursement rates and administrative burdens. This contrasts with the nation as a whole, where more than two thirds of doctors are willing to see new Medicaid beneficiaries. Read more

New York

HMA Roundup – Denise Soffel

New York State Legislature Approves FY 2015 Budget. The New York State legislature approved the fiscal year 2015 state budget on March 31, 2014, the last day of the 2014 fiscal year. The final budget largely reflects the Executive proposal. One item that arose late in negotiations was a measure that will no longer hold consumers financially responsible for surprise, uninsured medical costs. These costs can arise when a consumer goes to a hospital for a procedure by a doctor who is covered by their healthcare provider, but end up with another doctor or specialist who is not covered. The new legislation removes the consumer from billing disputes between out-of-network doctors and health insurers.

The budget also included language that provides a role for the legislature in decisions about how the state will allocate the $8 billion in Medicaid waiver funds over the next five years. The budget creates an advisory council to recommend facilities for funding, with members appointed by both houses of the legislature in addition to the Commissioner of Health.

The Medicaid global cap, which limits the growth in Medicaid spending to the rate of health care inflation, was extended for an additional year, through March 31, 2016. The budget includes a shared savings program under the global cap. If savings are generated under the cap, at least 50 percent of those savings will be shared with Medicaid providers.

The budget includes authorization to establish a Basic Health Program beginning in January 2015. A program that would have allowed private equity pilot demonstrations, allowing business corporations to own or operate hospitals to assist in health care restructuring, was not included in the final budget. Regional Health Improvement Collaboratives, proposed by the Governor as a way to convene community stakeholders to identify and address health challenges, were not included in the enacted budget.

Update on "New York State of Health" Exchange Enrollment. New York State of Health, the New York health exchange, reports that at the close of the open enrollment period 865,487 individuals have enrolled for coverage through the exchange. Over 120,000 individuals signed up during the last week of open enrollment. Among those who have completed their application, 52 percent have been found eligible for Medicaid. Most of the Medicaid enrollment was driven by individuals who had been eligible for coverage prior to the ACA Medicaid expansion in January 2014, as New York estimated that the newly eligible individuals, single adults and childless couples with income between 100 and 138 percent of the federal poverty level, numbered 77,000 individuals.

Following the lead of the federal exchange, NYSOH will allow anyone who began an application but was unable to complete the process additional time to complete their enrollment. Applicants have until April 15 to complete the enrollment. Self-attestation that you began the process is sufficient to obtain the extension.

Medicaid Nursing Home Benefit Transition to Managed Care Delayed. New York is delaying the transition of the nursing home benefit to Medicaid managed care, originally scheduled for April 1, 2014, to July 1, 2014. Finalizing the start date is contingent on CMS approval of the transition plan. A number of issues remain unresolved, including NAMI payments, the personal needs allowance, co-insurance and cost-sharing and Medicaid processing. All enrollment of nursing home residents

will be done by MAXIMUS, working collaboratively with nursing homes to visit eligible Medicaid beneficiaries to review enrollment options.

New York Department of Health Issues Balancing Incentive Program RFA. The Department of Health released an RFA for the Balancing Incentive Program Innovation Fund. New York received $598.7 million in BIP funds in March of 2013, and has allocated approximately $45 million to date. The current RFA will distribute an additional $45 million. Awards are limited to not-for-profit agencies, government entities and consumer advocacy groups; for-profit entities are not eligible. Projects must increase access to non-institutional long term services and supports; must be targeted to Medicaid beneficiaries; and must be a Medicaid-allowable expense. Applications are due on May 7, 2014.

New York State Innovation Challenge. New York State has created a Health Innovation Challenge to create technology-driven tools that will facilitate reviewing information on health care quality, charges and costs for medical procedures provided at NYS hospitals. The challenge offers three prizes ($15,000, $3,500, $1,500) for the best ideas, as judged by an independent panel. The competition, entitled *"Healthy Connections = Healthy Communities,"* is meant to encourage the development of web-, mobile-, or desktop-based applications that allow consumers, employers, researchers and purchasers to easily explore data on inpatient procedures across the state. Raw data are available on numerous sites, including New York's Health Data NY as well as from Medicare. Data solutions must "present the quality, cost and efficiency data in a format that is easy to interpret." Submissions are due July 24. Read more

New Health and Hospitals Corporation Leadership Introduced. The NYC Health and Hospitals Corporation, the city's public hospital system, experienced a change in leadership this week. Dr. Ramanathan Raju began his tenure as President and CEO of the system. HHC, which has an operating budget of $6.9 billion, forecasts a deficit of $428 million in the current fiscal year. The previous President, Alan Aviles, served 12 years, the longest tenure of any HHC president since the public benefit corporation was established in 1969.

North Carolina

Lawmakers Begin Estimating Potential Medicaid Budget Shortfall This Year. On March 27, 2014, *North Carolina Health News* reported that the state's Medicaid program will be over budget by anywhere from $68 million to $131 million this year. The Department of Health and Human Services, state budget office and the legislature's fiscal staff offered these estimates to the department's oversight committee this week, but noted that they need to analyze more data in order to make more accurate predictions before the end of the fiscal year in June. Read more

Oregon

Cover Oregon Board to Decide Whether to Fix Website or Adopt Federal Exchange. On March 25, 2014, the Cover Oregon health exchange board told the Legislative Oversight Committee it will decide in two weeks whether to adopt the federal insurance exchange website or hire a new contractor to fix the existing site. The state has ceased work with Oracle, the company hired to build the website, after poor management and technical glitches significantly impacted enrollment. The board reconvenes on April 10, 2014. Read more

Pennsylvania

HMA Roundup – Matt Roan

Pennsylvania Welfare Secretary Provides Update on Healthy PA Waiver. Bev MacKereth, Secretary of the Pennsylvania Department of Public Welfare (DPW) provided an update on the status of the Governor's Healthy PA proposal to the Medical Assistance Advisory Committee last week. The proposal is currently under review by the Centers for Medicaid and Medicare Services (CMS). Highlights from the Secretary's update included:

- The Governor has agreed to modify the proposed requirements around work search activities, converting the proposed requirement to a voluntary, one-year pilot where instead of losing Medicaid eligibility for failure to engage in work-search activities, recipients would receive incentives for engaging in work search. The Secretary indicated that this remains an area of discussion with CMS despite this modification.
- Many have raised concerns that the proposed plan does not cover podiatry, optometry, and chiropractic. The Secretary clarified that DPW is leaving it up to the plans who will deliver services under Healthy PA as to whether or not they will cover these services.
- The Secretary reported that in order to make the changes proposed in Healthy PA, DPW will need to execute several State Plan Amendments. She also reported that while DPW is making changes to the State Plan, it will want to include several updates that are unrelated to Healthy PA, but that will correct items in the state plan that are out of date. Stakeholders on the MAAC expressed concern that DPW has not been transparent about the planned changes, and stressed the need for stakeholder engagement around any proposed changes to the State Plan.

Western PA Hospital Profits are Up; Future Outlook Uncertain. On March 29, *Trib Total Media* reported that pending ACA changes have resulted in financial uncertainty in some Western Pennsylvania hospitals. In the last six months of 2013, profits were up at many of these hospitals, but hospital administrators are concerned about the financial outlook for 2014. According to an analysis of financial reports conducted by the Pittsburgh Tribune-Review, higher revenue helped to drive operating income up at eight hospital systems representing 33 facilities in the region. As an example, Butler Health reported a 7 percent increase in revenue as compared to the same period in 2012, leading to an operating profit of approximately $2.5M as compared to a loss of approximately $600,000 experienced in 2012. The positive revenue trend is not expected to continue as hospital finances are projected to be impacted by several aspects of healthcare reform in 2014. Among the impacting factors are decreasing Medicare reimbursements, the lack of Medicaid expansion in PA, and the fact that newly covered populations through the ACA are enrolled largely in plans with high deductibles and copays which hospitals sometimes have trouble collecting from patients. Read more

Pennsylvania Hospitals Cut Jobs in Response to Lower Reimbursements. According to statistics from the Pennsylvania Department of Labor and Industry, and a survey conducted by the Hospital and Healthsystem Association of Pennsylvania (HAP), looming changes associated with health care reform and a generally sluggish economy has led Pennsylvania hospitals to eliminate 3,900 jobs in the past year. According to HAP's survey:

- 67 percent of the 104 hospitals that responded said they have instituted hiring freezes or plan to.
- 51 percent of the hospitals said they have, or are considering, canceling or delaying renovation or building projects.
- 49 percent have laid off workers or are considering doing so.
- 41 percent have, or are examining, cutting certain health-care services.

Medicare reimbursement reductions are a driving factor of reduced hiring and capital investment, according to HAP. For the period of 2013 through the end of 2014, Pennsylvania hospitals will see their Medicare payments reduced by approximately $800M. Read more

Tennessee

Governor Continues Medicaid Expansion Talks Amid Resistance in Legislature. On March 29, 2014, the *Memphis Daily News* discussed continuing debate over the prospect of Medicaid expansion in Tennessee. Governor Bill Haslam is continuing talks with federal officials to reach a possible Medicaid expansion deal, but he faces significant resistance from the Republicans in both legislative chambers, who have indicated they want Tennessee to have as little to do with the ACA as possible. Read more

Utah

Governor Herbert Aims to Strike Deal with Feds to Expand Medicaid in Utah. On March 29, 2014, the *Washington Post* reported that Governor Gary Herbert hopes to have a Utah Medicaid expansion deal in place with the Obama administration by this summer. Herbert is asking the federal government for a three-year block grant to cover about 110,000 low-income Utah residents with private insurance. It is unclear whether the state Legislature, which was reluctant to expand Medicaid this session, will support Herbert if he successfully reaches a deal with the Obama administration. Read more

Virginia

Medicaid Application Backlog Prompts Expansion Debate. On March 30, 2014, the *Richmond Times-Dispatch* reported that the backlog of 42,000 Medicaid applications in Virginia has prompted political debate over the decision to expand Medicaid under the Affordable Care Act. State officials say that the backlog is due to glitches in the federal marketplace and has nothing to do with the rationale of expanding Medicaid, but expansion opponents say the backlog is proof the state is not equipped to add up to 400,000 low-income Virginians to Medicaid. Read more

West Virginia

West Virginia Seeing Nearly Double Projected Medicaid Expansion Enrollment. On April 1, 2014, the *Wheeling News-Register* reported that West Virginia nearly doubled the projected number of residents to sign up for health care under Medicaid expansion on the final day of open enrollment. By March 31, 2014, 104,820 people had signed up, or 41,820 higher than the federal projection. Jeremiah Samples of the Department of Health and Human Services said the state accomplished this enrollment by identifying potential participants using information on existing food stamps and Medicaid applications. Read more

National

Exchange Enrollments Top 7 Million in Late Enrollment Push, Opponents Continue to Question Enrollment Figures. On April 1, 2014, *The New York Times* reported that despite the Obama administration's news that nearly 7.1 million Americans have signed up for health insurance coverage through the Exchanges, Affordable Care Act critics continue to note that the Obama administration has not yet released information on how many of these enrollees have actually paid premiums, or how many were already insured before ACA open enrollment. Read more

Doc Fix Bill Delays ACA Medicaid Cuts Until Fiscal Year 2016. On March 26, 2014, the *Washington Post* reported that a new "doc fix" legislation aimed at avoiding a sharp drop-off in Medicare payments also includes a one-year delay of scheduled Medicaid cuts to hospitals serving low-income patients. These Disproportionate Share Hospitals (DSHs) receive Medicaid funds for providing uncompensated care, but this compensation was set to be cut starting in fiscal year 2014 and extending through 2022. However, the Supreme Court's decision to make Medicaid expansion voluntary has resulted in a higher uninsured population than ACA drafters originally anticipated and thus higher-than-expected levels of uncompensated care. The "doc-fix" will push back DSH cuts until the start of fiscal year 2016. Read more

"Private Option" for Medicaid Expansion Cuts Several Potentially Important Benefits. On March 27, 2014, *Stateline* discussed the potential consequences of "private option" state Medicaid expansion plans on the efficacy of Medicaid expansion. Medicaid coverage includes "wraparound benefits" such as regular screenings, diagnosis of various conditions in children and young adults, and free transportation to doctors' offices; but private insurers typically do not offer these kinds of services. Low-income patients with private insurance coverage may not have access to the unique benefits of Medicaid and may therefore have delayed care and lower quality health outcomes. Read more

HHS Report Indicates CMS System for Sharing Information About Terminated Providers Needs Improvement. On March 27, 2014, *Reuters* reported that the Medicaid and CHIP Information Sharing System does not adequately gather or communicate information about providers that bill for fraudulent claims. The federal data-sharing system was established to prevent health care providers banned from one state's Medicaid program from billing another state's program. According to a U.S. Department of Health and Human Services Inspector General, the system contains no records from 17 states or Washington, D.C. of banned providers nearly two years after it went live. The report also states that CMS made no effort to require states to report banned providers, and that state reports were often unreliable or incomplete. Read more

Hospitals Continue to Face Pressure to Engage in Mergers & Acquisitions. On March 27, 2014, *Fierce Health Finance* reported on the growing trend of hospital mergers and acquisitions nationwide. According to data from Irving Levin Associates, there were "267 healthcare-related transactions during the third quarter of 2013, an increase of 16 percent from the second quarter of the year and a 20 percent jump from the third quarter of 2012." Some of the most significant pressures prompting mergers and acquisitions are geographic isolation, limited or inconsistent funding streams, and unfunded mandates such as ICD-10, which require financial investments many facilities cannot foot on their own. Read more

INDUSTRY NEWS

LHC Group Completes Acquisition of Deaconess HomeCare and Elk Valley Health Services. LHC Group, a publicly traded home health, hospice, and post-acute services, announced on April 1, 2014, that it has completed the acquisition of Deaconess HomeCare and Elk Valley Health Services from BioScrip. The previously announced transaction includes 120 counties for home health, 33 counties for hospice, and 95 counties for community-based services in the states of Mississippi, Tennessee, Kentucky and Illinois. Read more

Cigna CEO Announces Estimated Exchange Enrollment Levels. At April 1, 2014's Reuters Health Summit, Cigna CEO David Cordani announced that the company's qualified health plans offered on the Exchanges had enrolled between 75,000 and 100,000 beneficiaries across five states in which Cigna is operating. Cordani said Cigna it will evaluate its new customers before making a decision on expansion beyond the current five states – Arizona, Colorado, Florida, Tennessee, and Texas – in 2015. Read more

RFP Calendar

Date	State	Event	Beneficiaries
April 4, 2014	Delaware	Proposals Due	200,000
April 8, 2014	Texas STAR Health (Foster Care)	RFP Release	32,000
April 11, 2014	Puerto Rico	Contract Awards	1,600,000
May 1, 2014	Virginia Duals	Passive enrollment begins	79,000
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
May 1, 2014	Texas NorthSTAR (Behavioral)	Proposals Due	840,000
May 12,2014	Rhode Island (Duals)	Proposals due	28,000
Late May, 2014	Indiana ABD	RFP Release	50,000
June 1, 2014	Illinois Duals	Passive enrollment begins	111,000
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 6, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
June 12, 2014	Delaware	Contract awards	200,000
July 1, 2014	Puerto Rico	Implementation	1,600,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Passive enrollment begins	68,000
July 1, 2014	Michigan Duals	Implementation	70,000
July 1, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
Mid-July 2014	Texas STAR Kids	RFP Released	200,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
Late October 2014	Texas STAR Kids	Proposals Due	200,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Vermont Duals	Implementation	22,000
January 1, 2015	Texas Duals	Implementation	132,000
January 1, 2015	Ohio Duals	Passive enrollment begins	115,000
January 1, 2015	Washington Duals	Passive enrollment begins	48,500
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013		4/1/2014	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714						TBD	
Idaho		22,548	Not pursuing Financial Alignment Model						
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri	MFFS‡	6,380					10/1/2012		
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	5/12/2014	9/1/2014			4/1/2015	
South Carolina	Capitated	68,000	X			10/25/2013	7/1/2014	1/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	132,600						1/1/2015	Amerigroup, Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013		5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	10/1/2014	1/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 6 MFFS**	**1.3M Capitated 520K FFS**	***12***			***9***			

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

‡ Capitated duals integration model for health homes population.

HMA News

HMA Webinar to provide "Insights for Pennsylvania Stakeholders on Innovations in Long-Term Care"

HMA's national consulting team has extensive experience and wide-ranging expertise in the long-term care world. As Pennsylvania explores the best approach for achieving the right level of care, at the right time, in the most appropriate setting for its disabled and elderly populations, this HMA Webinar will offer insights on innovations being implemented across the country and potential implications for Pennsylvania. Hear directly from a panel of our experts during a free webinar on Friday, April 4. Register.

HMA to Host Seminar on Care Transformation in Chicago – April 11, 2014

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

HMA Upcoming Appearances

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

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