HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 30, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

THIS WEEK

IN FOCUS

CMS OFFICE OF THE ACTUARY ISSUES MEDICAID FORECAST REPORT

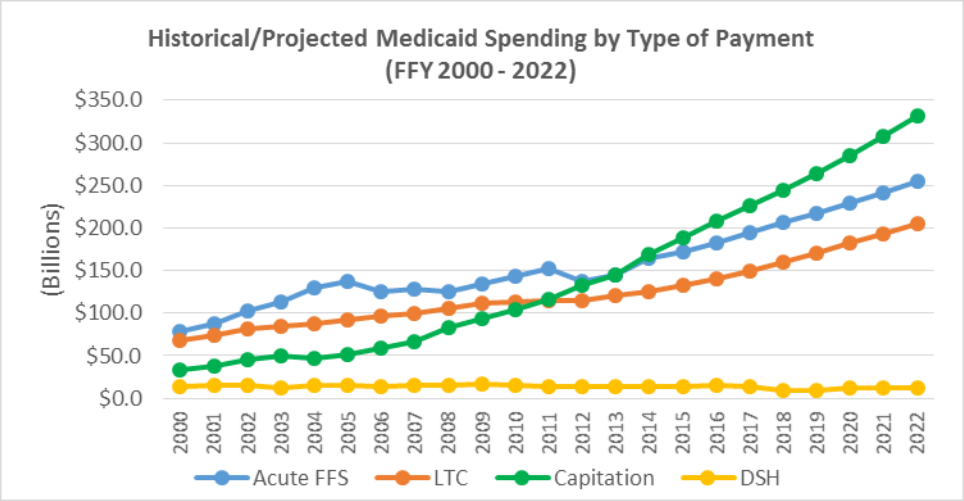
This week, our *In Focus* section reviews the *"2013 Actuarial Report on the Financial Outlook for Medicaid,"* published on April 25, 2014 by the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary. This is the fifth annual report issued by the Office of the Actuary and describes past and projected trends in spending and enrollment in the Medicaid program. Below, we summarize the key takeaways from the report, and later provide detail on some of the more relevant observations that can be made from the report as it relates to Medicaid enrollment and spending projections.

- Average Medicaid enrollment for Federal Fiscal Year (FFY) 2013 is estimated at 59.1 million, up just 0.7 percent from FFY 2012, the lowest rate of enrollment growth since FFY 2007.

- Medicaid enrollment is expected to grow by 3.3 percent annually and reach 80.9 million by 2022, while Medicaid spending is anticipated to grow by 7.1 percent annually and reach $853.6 billion by 2022.
- The Affordable Care Act will increase Medicaid spending by a total of $500 billion over the FFY 2013 to 2022 period, with nearly all of the increased spending ($496 billion) due to expanded eligibility. About 97 percent of the $500 billion is estimated to be paid by the federal government under enhanced matching rates.
- The report estimates 18.4 million new Medicaid enrollees under the expansion by FFY 2022.
- Capitated payments to Medicaid managed care organizations (MCOs) and other entities taking risk will shortly pass acute FFS and LTC as the dominant Medicaid spending outlay, and will continue to grow through FFY 2022.
- Medicaid spending for the aged and disabled populations will continue to represent the majority of Medicaid dollars, but will decline as a share of overall spending.

Medicaid Spending by Type of Payment

As mentioned above, the CMS Office of the Actuary estimates Medicaid capitation payments at $144.2 billion in FFY 2013. By FFY 2022, Medicaid capitation payments are estimated to more than double, to $332.2 billion annually. Meanwhile, long-term care (LTC) spending is expected to increase more than 71 percent, from $120.2 billion to $205.7 billion by FFY 2022. Acute fee-for-service (FFS) spending is expected to grow by more than 75 percent, from $144.6 billion to $254.2 billion over the same period.



Medicaid Enrollment and Spending by Category of Eligibility

The CMS Office of the Actuary projects Medicaid enrollment by category of eligibility, as well as per enrollee spending by category of eligibility. The table below details projected enrollment growth between FFY 2013 and 2022.

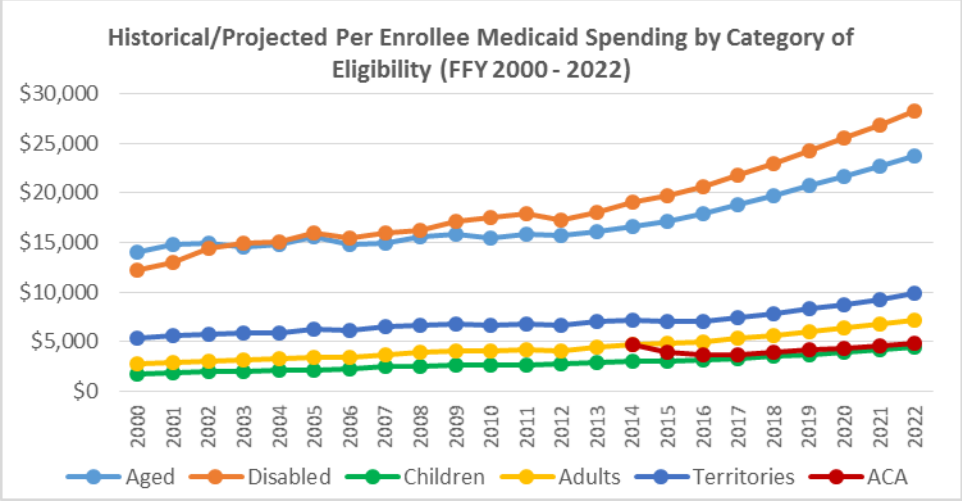
- The largest growth, in terms of pure enrollment, is unsurprisingly the ACA population, estimated to number 12.6 million by FFY 2022.
- The aged population is projected to grow by 32.7 percent, up to nearly 7 million by FFY 2022, while the disabled population is projected to grow by only 600,000 lives, just 6.2 percent.

- Children and adults (non-aged, non-disabled) populations are projected to increase by a combined 7.1 million, up 17 percent and 15.5 percent, respectively.

	Aged	Disabled	Children	Adults	Territories	ACA
2013	5.2m	9.7m	28.3m	14.8m	1.0m	0.0m
2014	5.4m	9.8m	29.5m	15.6m	1.0m	3.7m
2015	5.5m	9.8m	30.8m	16.2m	1.0m	7.9m
2016	5.7m	9.9m	31.8m	16.6m	1.0m	11.0m
2017	5.9m	10.0m	32.2m	16.8m	1.0m	12.0m
2018	6.0m	10.0m	32.4m	16.9m	1.0m	12.4m
2019	6.2m	10.1m	32.6m	16.9m	1.0m	12.5m
2020	6.4m	10.1m	32.8m	17.0m	1.0m	12.6m
2021	6.6m	10.2m	32.9m	17.0m	1.0m	12.6m
2022	6.9m	10.3m	33.1m	17.1m	1.0m	12.6m
Δ 2013-2022	**1.7m**	**0.6m**	**4.8m**	**2.3m**	**0.0m**	**12.6m**
% 2013-2022	***32.7%***	***6.2%***	***17.0%***	***15.5%***	***0.0%***	***NA***

Medicaid spending per enrollee by category of eligibility is detailed in the chart below, with aged and disabled per enrollee spending projected to continue to outpace other categories of eligibility.

- Per enrollee spending for aged Medicaid beneficiaries was estimated at roughly $16,100 annually (about $1,340 per-member-per-month (PMPM)) in FFY 2013. By FFY 2022, annual per enrollee spending will near $23,800 (about $1,980 PMPM), an increase of 47.2 percent over the period.
- Per enrollee spending for disabled Medicaid beneficiaries was estimated at roughly $18,100 annually (about $1,508 PMPM) in FFY 2013. By FFY 2022, annual per enrollee spending will top $28,300 (about $2,358 PMPM), an increase of 56.6 percent over the period.
- CMS Office of the Actuary projections for ACA newly eligible spending clearly show a presumed pent-up demand factor. FFY 2014 spending per enrollee of more than $4,600 is expected to drop to roughly $3,975 in FFY 2015, a decrease in per enrollee spending of more than 14 percent in one year.



Link to CMS Office of the Actuary report:
"2013 Actuarial Report on the Financial Outlook for Medicaid" (April 25, 2014)

HMA Medicaid Roundup

California

HMA Roundup – Alana Ketchel

Ballot Signatures Submitted for Medi-Cal Provider Fee Measure. On April 22, 2014, the *Sacramento Business Journal* reported that a group aiming to establish a stable Medi-Cal funding stream submitted 1.3 million signatures in support of a November ballot measure. The measure would establish the Medi-Cal Funding and Accountability Act of 2014, ensuring that the revenue from a current fee assessed on hospitals would be spent on Medi-Cal patients. Previously the state had diverted some of the dollars from the provider fee to the general fund. Read more

Assembly Committee Passes Increase in Medi-Cal Provider Rates. On April 25, 2014, the *California Healthline* reported that the California Assembly Committee on Health unanimously passed a measure to increase Medi-Cal primary care reimbursement rates to that of Medicare. The Committee also passed a companion bill to disregard the 10 percent cut in payments to Medi-Cal providers retroactive to 2011. The goal is to increase patients' access to Medi-Cal providers. The bills now proceed to the Assembly Committee on Appropriations. Read more

Errors in Medi-Cal Transition Leave Five Thousand in LA Uninsured. On April 24, 2014 the *California Healthline* reported on an error in the transition of 5,000 beneficiaries from Healthy Way L.A. to the Medi-Cal program. Apparently, identifying data from the Healthy Way L.A. system did not match the state's information for these individuals, preventing their transfer. The county has resolved approximately half of the cases thus far but the process is slow as it requires manual correction. If clinics have patients with urgent health needs, they should contact the county so the county can expedite the application processing. Read more

State Grants Funds to County Mental Health Programs. On April 24, 2014 the *Los Angeles Times* reported approval of $75 million in state grants going to 28 counties to bolster services for residents with severe mental illness. The funds will be used to add residential mental health and crisis "stabilization" beds, new workers in mobile teams, and vehicles. The funds constitute half of the dollars available under the Investment in Mental Health Wellness Act of 2013. Read more

California VA Overhauls Website to Connect Veterans to Benefits. On April 23, 2014, *Government Technology* reported on the California Department of Veterans Affairs' announcement of an update to its website and development of a new portal, myCalVet. The upgrades are intended to streamline veteran claims and loan processes and to support veterans in accessing tailored services and benefits. The government will use the site to collect ongoing information on veterans' needs to improve their offerings. Read more

Colorado

HMA Roundup – Joan Henneberry

Lawmakers Defend Brokers, Don't Want Exchange Selling Life, Car Insurance. On April 24, 2014, *Health News Colorado* reported that lawmakers voiced their disapproval of Connect for Health Colorado for considering selling other forms of insurance. Senator Ellen Roberts grilled exchange CEO Patty Fontneau during a legislative oversight committee hearing about whether she would consider selling other products. So far the exchange sells health and dental insurance and the board recently voted to add vision insurance. Exchange board members have been reluctant to divert from Connect for Health's mission to sell health insurance, but Fontneau will consider adding life insurance. Read more

District of Columbia

Specialty Hospital of Washington Might Be Forced Into Bankruptcy. On April 26, 2014, the Washington Post reported that two hospitals in Washington, D.C. may be forced to close by creditors who say the facilities owe them millions of dollars. Specialty Hospital of Washington operates two facilities in the District; they are the only facilities in the capitol dedicated to the long-term care needs of those suffering from complex conditions. The facilities have been accumulating millions of dollars in tax liens, court judgments and unpaid bills. While a spokeswoman for Specialty stated the company is not in bankruptcy, D.C. Department of Health Care Finance Director Wayne Turnage has developed plans to move Specialty's patients to other facilities if necessary. Read more

Florida

HMA Roundup – Elaine Peters and Gary Crayton

Update on FY 2014-15 Legislative Budget. The Budget Conference delivered their budget to lawmakers on Tuesday, April 29, 2014. The total budget is $77.1 billion of which 27.9 billion is General Revenue funds.

- The Medicaid services budget is $23.6 billion and fully funds an estimated 3.7 million Medicaid beneficiaries.
- The KidCare budget is $493.6 million and fully funds an estimated 269,778 KidCare children.

Highlights of the Medicaid budget include:

- **Low Income Pool** - $2.167 B for the following components: $1.0 b LIP program; $963m Hospital Self-Funded; $204m Medical School Supplemental Payments; and $500,000 to submit a report by January 15, 2005 on hospital financing as the state transitions to managed care
- **Developmentally Disabled Waiver** - $20.0 M to serve 1,260 critical needs individuals on the Medicaid waiver wait list
- **Long Term Care Waiver** - $12.6 M to serve individuals on the Medicaid LTC Waiver waitlist who have been classified as a priority score of five or higher
- **Personal Needs Allowance** - $35.4 M to increase the personal needs allowance from $35 to $105 per month for residents in ICF/DD and Nursing Homes

- **Program of All Inclusive Care for the Elderly (PACE)** – $13.0 M for an additional 600 PACE slots
- **Children's Medical Services Network (KidCare)** - $3.5 M total to adjust CMS Network capitation payments as a result of the transition to DRG payments to hospital providers
- **Private Duty Nursing Rate Increase** - $5.5 M for a rate increase for private duty nursing services provided by LPNs
- **Prescribed Pediatric Extended Care (PPEC) Rate Increase** - $4.0 M to increase the statewide PPEC rates
- **Therapy Services Rate Increase** - $10.0 M for a rate increase for occupational, physical and speech therapy services
- **Pediatrician Rate Increase** - $8.4 M for a Pediatrician rate increase, effective January 1, 2015
- **Advanced Data Analytics and Detection** - $5.0 M for the Public Benefits Integrity Data Analytics and Information Sharing Initiative to detect and deter fraud, waste, and abuse in Medicaid and other public benefit programs
- **FMMIS Evaluation/Procurement** - $3.6 M for activities related to development of a MMIS and procurement of new fiscal agent

Controversial "Tiering" Hospital Funding Model Delayed For at Least One Year. On April 23, 2014, the *Tampa Bay Times* reported that Florida's "tiering" law will not be implemented as planned this year. The law would have required counties that use local dollars to draw down more federal money for hospitals to begin sharing that money statewide. For hospitals currently receiving additional local dollars and Medicaid funds through this model, the law would mean a significant cut to their annual budgets. The Legislature's two health care budget chiefs, Rep. Matt Hudson and Sen. Denise Grimsley, agreed that the law should be delayed for at least a year. Read more

Lawmakers Divided on Future Operations of HCA Trauma Centers. On April 28, 2014, the *Miami Herald* reported that the Florida House and Senate are in disagreement on exactly how to allow three disputed trauma centers owned by Hospital Corporation of America to continue operating. The trauma centers came under fire by "safety net" hospitals for charging massive admissions fees to trauma patients. The Senate's version of the trauma center legislation includes language protecting the three trauma centers from legal action. It also includes a cap on trauma activation fees and establishes an advisory committee to make recommendations for approving new trauma centers. The House's version also includes language to protect the trauma centers, but it does not include an advisory council. Lawmakers are unsure if and how a compromise will be reached by the end of the Legislative session on May 2. Read more

Florida P&T Committee Adds Sovaldi to Medicaid Preferred Drug List. On April 29, 2014, *Health News Florida* reported that the Pharmaceutical & Therapeutics Committee has added Sovaldi, the enormously expensive new hepatitis C treatment, to the Medicaid preferred drug list. The decision comes amidst concerns from health plans that they will not be able to afford coverage for the drug, which costs around $84,000 per treatment. Read more

Georgia

HMA Roundup – Mark Trail and Kathy Ryland

DCH Approves Rule Revision That Will Improve Access to Rural Healthcare. On April 29, 2014, the Georgia Department of Community Health (DCH) Board met to consider final adoption of a revision to Rules and Regulations for Hospitals under its Healthcare Facility Regulation Division. The revision to Chapter 111-8-40 identifies and defines Rural Free Standing Emergency Departments, and is part of Governor Nathan Deal's initiative to improve access to rural healthcare in Georgia. Charles Owens, DCH's Director of Rural Health, has been named the point person for the initiative. Governor Deal also appointed a 15-person Rural Hospital Stabilization Committee tasked with helping rural hospitals deal with high cost issues.

The rule revisions state that any currently DCH-licensed rural hospital, or any previously licensed rural hospital where the license expired within the previous twelve months, may downgrade its scope of services to operate as a Rural Free Standing Emergency Department. In order to do this, the hospital must meet the following conditions:

- Must be located in a rural county and no more than 35 miles from a licensed general hospital
- Must be open 24 hours a day, seven days a week
- Must provide non-elective emergency treatment and procedures for periods less than 24 hours
- May provide elective, out-patient surgical treatment and procedures for periods less than 24 hours
- May provide basic obstetrics and gynecology treatment and procedures for periods less than 24 hours
- May provide elective endoscopy or other elective treatment and procedure which are not performed in an operating room

In addition, the Rural Free Standing Emergency Department shall:

- Make reasonable attempts to have a written patient referral and transfer agreement with a hospital within 35 miles
- Have its organization, scope and patient services availability approved by its governing body
- Have operational policies developed with participation by one or more licensed physicians
- Provide appropriate medical screening for, and stabilization of, an emergency medical condition without regard to the individual's ability to pay. If the Rural Free Standing Emergency Department cannot stabilize an individual, it shall transfer to another facility

The DCH Board unanimously approved the rule revision as written. After the revised rule is recorded by the Secretary of State, qualified facilities can apply to DCH's Healthcare Facility Regulation Division for this designation and will be given expedited consideration. Read more

Indiana

Caregivers for Elderly and Disabled Discuss Medicaid Cuts. On April 26, 2014, *AP/Modern Healthcare* reported that Indiana's low pay for personal care aides has resulting in frustration and stress amongst caregivers for the elderly and the disabled. Indiana's Medicaid funding has been cut for the past five years, and the state's pay for personal care aides has not kept up with inflation. In 2012, more than one third of caregivers in the state were receiving food stamps; turnover amongst caregivers is 50% on average nationally. Low pay and high-stress work are dissuading some caregivers from continuing their work, which could jeopardize the well-being of the expanding population of aging baby boomers and disabled. Read more

Kansas

Governor Brownback Proposes HCBS Waiting List Reduction. On April 25, 2014, the *Kansas Health Institute* reported that Governor Sam Brownback will ask the Kansas Legislature to approve spending an additional $2.6 million in state funds to help reduce the waiting lists for in-home, Medicaid services for the disabled. There are approximately 5,000 mentally- or physically disabled people on waiting lists for in-home services. If the funding request is approved, an estimated 209 additional people would receive the services. While advocates for the disabled are generally pleased that more people are being taken off the waitlists, many think Brownback should allocate additional money towards caring for the disabled so that waitlists can be further reduced and long-term care needs of the population can be addressed. Read more

State Reports to CMS on Brownback Medicaid Makeover. On April 28, 2014, the *Kansas Health Institute* reported that the state's three KanCare Medicaid contractors together lost about $110 million in their first year managing health care for the state's 380,000 Medicaid enrollees. However, each company received cash infusions from their parent companies to remain solvent. The information was included as part of a larger state document sent to CMS. Overall, the KanCare initiative exceeded the CMS requirement of "budget neutrality," meaning it did not cost the federal government any more than it did before the Brownback administration's Medicaid makeover. The program had several flaws, however, most notably its struggle to provide timely and accurate payments to providers. Read more

KDADS Secretary Reports Increased Aid for Disabled KanCare Beneficiaries. On April 29, 2014, the *Topeka Capital-Journal* reported that more disabled KanCare beneficiaries have reported increases in aid during the first year of Governor Sam Brownback's Medicaid managed care delivery system. According to Shawn Sullivan, secretary of the Kansas Department for Aging and Disability Services, 27.1 percent of Kansans enrolled in physical and developmental disability programs under KanCare have reported increases in services during 2013, while 14.1 percent have reported reductions in aid. Read more

Maine

Maine Awards New Contracts to Medicaid Transportation Brokers. On April 24, 2014, the Maine Department of Health and Human Services announced that it has awarded new contracts to three companies to do the work of matching clients with volunteer drivers and other agencies that transport MaineCare patients to and from their health care providers. According to the *Bangor Daily News,* Coordinated Transportations

Solutions (CTS) will lose its $28 million contract when it expires June 30, reportedly due to its unreliable service. The transition to a brokered system for delivering rides to health-related appointments for disabled Medicaid patients has been riddled with problems since it began last year, prompting the Legislature to be much more selective in granting contracts this year. Read more

Governor LePage Vetoes Bill to Fill $32 Million Budget Gap. On April 25, 2014, *AP*/the *Portland Press Herald* reported that Governor Paul LePage vetoed a bill that would close a $32 million gap in the state's budget next fiscal year and remove hundreds of developmentally disabled residents from waiting lists for certain Medicaid services, including home-based care. LePage argues that there is not enough funding to eliminate the waiting lists or keep struggling nursing homes open. Read more

Michigan

HMA Roundup – Eileen Ellis

Medicaid Expansion Enrollment. The Michigan Department of Community Health reported on April 28th that 158,654 individuals had been enrolled in Healthy Michigan since the beginning of April. State officials indicate that they expect to reach or surpass their goal of 175,000 enrollees by the end of April. Read more.

Medicaid HMO "Use Tax" and Health Insurance Claims Tax. Senator Roger Kahn, chairman of the Senate Appropriations Committee, has introduced two bills that would modify the revenue sources for Michigan's Medicaid program. SB 893 would reinstate Michigan's six percent "Use Tax" on services provided by Medicaid HMOs and the capitated mental health providers (Prepaid Inpatient Health Plans or PIHPs). SB 913 would reduce Michigan's Health Insurance Claims Assessment (HICA) from one percent of the value of health care services to 0.75 percent of the value of health care services.

The previous Medicaid HMO tax was replaced with the Use Tax in 2009 in response to the provision of the Deficit Reduction Act of 2005 which ended the "Medicaid managed care loophole" in the Medicaid provider tax statute. In 2011, as CMS began looking at the Use Tax and due to fears of new rules that could be issued barring the State from using this approach, Michigan enacted legislation that ended the Use Tax as of April 1, 2012 and implemented HICA as a replacement revenue source as of January 1, 2012.

To date the HICA has not generated the targeted level of revenues. In addition it appears that CMS is not adverse to the Use Tax on Medicaid managed care providers. The proposed legislation, by reinstating the Use Tax and reducing the level of HICA, would more than fill the deficit in HICA revenues and is supported by the Michigan Association of Health Plans. Read more

Missouri

Governor Nixon Proposes Medicaid Expansion Initiative for Small Businesses. On April 28, 2014, *AP*/*St. Louis Today* reported that Governor Jay Nixon's latest effort to expand Medicaid in Missouri. Nixon is proposing an initiative called "Missouri Health Works," which uses federal funds to subsidize private insurance costs for businesses with fewer than 150 employees. Nixon argues that currently, small businesses are "getting squeezed between sky-high health insurance costs and new requirements" under the federal health are law. Read more

New Jersey

HMA Roundup – Karen Brodsky

ACA's Medicaid Expansion Has Smaller Than Expected Impact on State Budget. On April 24, 2014, *NJ Spotlight* reported that ACA Medicaid expansion had a smaller than expected impact on the state's budget. While adults who became eligible for Medicaid as a result of the expansion are fully covered by the federal government, the publicity to enroll was expected to raise enrollments of uninsured individuals who already qualified for coverage under NJFamilyCare through the Children's Health Insurance Program (CHIP) and for Medicaid for parents or legal guardians eligible for Temporary Aid for Needy Families (TANF). The state covers part of the costs of CHIP and TANF enrollees. Aproximately 250,000 adults enrolled in Medicaid since January, but the state is required to cover part of the cost of benefits for only 10,152 people. "We budgeted for a certain number of people to come onto the Medicaid rolls and when that take-up for the woodwork didn't materialize," it contributed to the budget savings, State Human Services Commissioner Jennifer Velez said in an interview after testifying before the Senate Budget Committee earlier this month. The state expects to spend $87.6 million less than it budgeted for Medicaid in the current fiscal year as a result. Read more

NJProtect ends on April 30, 2014. On April 27, 2014, the *Record* reported that the federal high-risk pool called NJ Protect will end today. The New Jersey Department of Banking and Insurance (DOBI) began offering NJProtect in the summer of 2010 as a means to provide health insurance for people with pre-existing conditions who were uncovered for at least six months. Close to 3,000 people signed up for NJProtect, which was a product of the ACA, and offered by two carriers: AmeriHealth of New Jersey and Horizon Blue Cross and Blue Shield of NJ. It was scheduled to end on January 1, 2014 with the launch of the federal marketplace and the ACA rule that requires insurers to discontinue the pre-existing condition exclusion. But the deadline was extended a few times, when technical problems with the federal website made it difficult to enroll. According to DOBI, 103 people are still in the program and must sign up for other coverage, such as through the federal marketplace. If they obtain coverage in the marketplace before June 30, 2014, it will be retroactive to May 1, 2014. Read more

New York

HMA Roundup – Denise Soffel

1115 Medicaid Waiver and DSRIP. The Department of Health posted a Delivery System Reform Incentive Payment (DSRIP) Project Toolkit. The toolkit includes descriptions of the strategies and projects that were chosen by the state and approved by CMS for use by Performing Provider Systems to develop DSRIP plans. A Performing Provider System is a local partnership consisting of hospitals, health homes, skilled nursing facilities, FQHCs, behavioral health providers, home care agencies, and other stakeholders that come together to develop and implement a community strategy. The overall goal of DSRIP is to reduce avoidable hospital use by 25% through transforming the New York State health care delivery system. DSRIP will focus on the provision of high quality, integrated primary, specialty and behavioral health care in community-based settings with hospitals used primarily for emergency care and tertiary services. The Performing Provider Systems submitting an application for DSRIP must include at least 5 but no more than 10 projects chosen from three domains. Valuation of the DSRIP plan is driven in part by the project index score, which reflects the complexity of the project as well as its transformative impact.

- System Transformation Projects (37 – 56 points per project)
  - Creating integrated delivery systems
  - Implementing care coordination and transitional care programs
  - Connecting settings
- Clinical Improvement Projects (22 – 47 points per project)
  - Behavioral health
  - Cardiovascular health
  - Diabetes
  - Asthma
  - HIV/AIDS
  - Perinatal care
  - Palliative care
  - Renal care
- Population-Wide Projects (based on the NY Prevention Agenda) (15 - 24 points per project)
  - Promote mental health and prevent substance abuse
  - Prevent chronic disease
  - Prevent HIV and STDs
  - Promote healthy women, infants and children

The comment period for the draft Standard Terms and Conditions closed on April 29, but the state is still accepting comments on two attachments to the terms and conditions, where the protocols and mechanics of the waiver are described. The state has held a series of public meetings across the state to explain the DSRIP program and to respond to questions and comments. The Department of Health will be holding a Waiver Amendment/DSRIP Q&A operator-assisted conference call on Monday, May 5 from 1-3 PM, where they will provide a brief overview of DSRIP key principles. The primary purpose of the call will be to respond to questions from stakeholders. No pre-registration is required. Call-in information is listed below:

Dial-In: 888-892-6166

Conference ID: 36935496

Potential Performing Provider Systems must submit a non-binding letter of intent by May 15.

Medicaid Managed Care Program Update. The Medicaid Managed Care Advisory Review Panel held its quarterly meeting on April 24, 2014. Plan updates:

- Excellus has completed its withdrawal from the Medicaid managed care program in 14 of the 25 counties where it had been operating. Members were transferred to Fidelis, Today's Options (a plan offered by American Progressive Life & Health Insurance Company of New York, a member of the Universal American family of companies) and United Healthcare.
- United has expanded to an additional four counties as of January 2014. They are now operating in 33 counties plus the five boroughs of New York City.
- MVP Health Care continues to migrate its Medicaid managed care members to Hudson Health Plan, which it acquired last year.
- Fidelis has been approved to operate in two additional counties effective June. There is one remaining county where Fidelis has not established operations, Jefferson County.

Program updates:

- The transition of the nursing home benefit into Medicaid managed care has been delayed until at least June 1. The state is actively negotiating with CMS to resolve details around program roll-out. CMS is exploring ways to create incentives in the rates that would encourage managed care plans to transfer nursing home residents back into the community.
- School-based health centers are currently carved out of Medicaid managed care. As part of the Medicaid Redesign Team Care Management for All initiative, they were to be carved in effective October 2014. That transition has been delayed until July 2015.

Managed Long-Term Care and Fully Integrated Duals Advantage (FIDA). The duals integration demonstration program, FIDA, is on track to begin enrollment on October 1, 2014 for individuals opting into the program; passive enrollment will begin January 1, 2015. FIDA will be implemented in 8 downstate counties – New York City, Nassau, Suffolk and Westchester counties - where the majority of Medicaid beneficiaries reside. There is no lock-in for the FIDA program; participants can disenroll at any time. Virtually all individuals who are eligible for FIDA are already enrolled in a managed long-term care plan, and passive enrollment will be to that plan, so the state anticipates a smooth transition. All enrollments will be through the MAXIMUS, the NYS enrollment broker. MAXIMUS will also provide enrollment counseling and assistance. The state will also be contracting with a community-based organization to serve as a participant ombudsman for FIDA-enrolled individuals, providing independent and conflict-free assistance in navigating the delivery system and appealing adverse decisions.

Invitation and Requirements for Exchange Plan Participation for 2015. New York State of Health, the NY health exchange, released its invitation and requirements for insurer certification and recertification for participation in 2015. Application materials can be found on their website. Letters of interest are due on May 9, and the final participation submission is due June 1. The invitation maintains many of the 2014 conditions, including the requirement that insurers offer standardized plans at each metal tier, with the option of offering up to three non-standard plans. The Exchange had been under some pressure to require that all plans offer an out-of-network benefit. In light of new protections enacted in the state budget that protect consumers from surprise out-of-network bills, the Invitation encourages, but does not require, insurers to offer qualified health plans that cover out-of-network benefits. The invitation maintains the existing requirement that insurers offer health plans that cover out-of-network benefits in their exchange plans if they offer such plans in the outside market.

North Carolina

North Carolina DHHS Appoints New Medicaid Director. North Carolina's Department of Health and Human Services (DHHS) announced this week that it has appointed Dr. Robin Gary Cummings as the department's new Medicaid Director. Dr. Cummings joined DHHS in 2013 to lead the Office of Rural Health and Community Care. He replaces former Medicaid Director Carol Steckel, who resigned in October 2013. Read more

Oregon

Oregon to Abandon State Health Insurance Exchange. On April 25, 2014, the Los Angeles Times reported that Oregon health officials have voted unanimously to scrap the Cover Oregon health insurance exchange in favor of the federal exchange. The state-based exchange, built by technology vendor Oracle, experienced technical problems from its inception and did not succeed in enrolling a single private insurance customer online. Oregon's decision makes it the first state to abandon its own exchange in favor of the federal website. The state will switch to the federal exchange for the next enrollment period beginning in November. Read more

State May Scrap Another Oracle Project, Despite Its $71 Million Investment. On April 26, 2014, the *Oregonian* reported that an internal task force has recommended the state of Oregon shelve another Oracle-led project. Last week, the state Department of Human Services found the Oracle-led initiative to develop a system for low-income families to apply for food stamps and other benefits is still non-functional, months after its scheduled go-live date. To date, DHS has spent $71 million on the failed project. Read more

Pennsylvania

HMA Roundup – Matt Roan

House Republican Policy Committee Issues Report on Poverty Programs. The State House Republican Policy Committee has issued a report as a result of a statewide tour focused on evaluating solutions to poverty and improving anti-poverty programs. The report identifies 13 barriers that prevent people from moving out of poverty including: the breakdown of family support structures, lack of access to healthcare for the working poor, lack of affordable child care, difficulty moving past a criminal record, a poor economic environment, low financial literacy, lack of quality education, homelessness, substance abuse and mental health issues, transportation challenges, food insecurity and the benefits cliff (disincentives to earn more because benefits will be cut off). The report recommends better evaluation of anti-poverty programs and emphasizes that basic needs like food and shelter must be met before other issues can be addressed. While the report provides a framework for the Republican Caucus to address these issues, there are no specific legislative or policy initiatives outlined which would address the issues identified. Read more

Gubernatorial Candidate goes "All-In" on Obamacare Support. On April 23, 2014, *NPR* reported that Congresswoman Allyson Schwartz, a candidate in the Democratic primary for Governor, has launched a TV ad campaign focused on her support of healthcare reforms contained in the ACA. The ad touts the Congresswoman's role in crafting components of the ACA and criticizes incumbent Governor Tom Corbett for his failure to expand Medicaid as envisioned under the law. All four Democratic candidates in the race have expressed their support for Medicaid expansion, but national observers have noted that Schwartz's bold support for Obamacare sets her apart from other Democratic candidates who have distanced themselves from the polarizing law. In response to the ad, the Corbett campaign released a statement categorizing Schwartz as a far left liberal, and touting Corbett's alternative to Medicaid expansion known as Healthy PA. Schwartz, once considered the front runner for the Democratic nod, has fallen behind in the polling to businessman and former State Revenue Secretary Tom Wolf who has been blanketing the airwaves with his own campaign ads for the last several weeks. Read more

Poll Shows Pennsylvanians Increasingly Unhappy with Obamacare. On April 23, 2014, the *Morning Call* reported on results of a recent poll measuring satisfaction with the ACA across the state. According to a Muhlenberg College poll conducted after the end of the first ACA open enrollment period, there was an uptick in Pennsylvanians reporting that they are dissatisfied with the law. Those polled who stated that they were very or somewhat dissatisfied with the law rose from 44 percent a year ago to 47 percent in the most recent survey. The poll also found that those with coverage through employer sponsored plans or Medicare were more likely to report that the law had no impact on their coverage. In last year's poll only 23 percent reported that they were unaffected; in the more recent poll that number had increased to 48 percent. Overall satisfaction with healthcare services (apart from insurance coverage) has also decreased. Last year 39 percent reported being somewhat or very dissatisfied with healthcare services while this year the number dissatisfied increased to 47 percent. Read more

Rhode Island

Health Care Claims Database Introduced. On April 22, 2014, the *Brown Daily Herald* reported that the Rhode Island All-Payer Claims Database (APCD) will require all private and public health insurers and administrators in the state to submit eligibility and medical and pharmacy claims data beginning next month. The program wants to analyze claims data to look for patterns and statistical significance in order to develop strategies to cut health costs and improve quality of care. Twelve other states have already implemented APCD programs. Having large-scale data sets on physician care, outpatient treatment and malpractice will help the state develop policies for health insurance regulation and Medicaid. Read more

Rhode Island Medicaid to Cost $52 Million More Than Expected. On April 20, 2014, *WPRI News* reported Medicaid will cost state taxpayers $52 million more than previously projected during the current and upcoming state budget years. As of March 31, 64,590 people had enrolled; this is substantially higher than an estimate that only 28,000 would sign up by this September. The Legislature now must address the unexpected increase in spending as it crafts the budget for next year. Read more

Tennessee

Tennessee Enrolls Over 55,000 Into Medicaid Since October 2013. On April 28, 2014, the *Tennessean* reported that at least 55,000 state residents have enrolled into Medicaid (TennCare) since October, despite the fact that Tennessee has not expanded its Medicaid program. This figure does not include people who learned they qualified for TennCare in April during the federal governments' massive enrollment campaign. TennCare officials had originally estimated that 46,700 people would be added to Medicaid this state fiscal year, and an additional 53,200 in 2015. Read more

Vermont

Senate Panel Passes State Budget Including Increased Medicaid Reimbursements. On April 25, 2014, *VT Digger* reported that the General Fund spending plan recently passed by the Vermont Senate Appropriations Committee includes an amendment that increases Medicaid reimbursement rates for healthcare providers from 0.75 percent to 2 percent, on par with Governor Peter Shumlin's recommended budget increase. The amendment would cost the state roughly $4 million. Read more

Virginia

Medicaid Expansion Debate Continues As Budget Deadline Nears. On April 27, 2014, the *Richmond Times-Dispatch* reported that continuing disagreements amongst lawmakers on the prospect of expanding Medicaid in Virginia might lead lawmakers to postpone their deadline for the state budget. The Republican-controlled House, which opposes expansion, and the Democrat-controlled Senate, which supports it, have refused to advance on the other chamber's version of the budget, leaving the budgeting process for state-funded agencies in limbo. Both sides acknowledge that with the exception of Medicaid expansion, they could likely reach a deal on a spending plan within a week. The current deadline for finalizing the state's two-year budget is June 30. Read more

National

New Rule for Better Home Care Worker Wages Receives Mixed Reactions. On April 25, 2014, *Stateline* reported on the potential consequences of a new rule from the Obama administration that would provide better pay and working conditions to 2 million home care workers. Starting January 1, home care workers in 29 states will be eligible for the first time for the federal minimum wage of $7.25 an hour and overtime pay. Workers will also be compensated for time traveling to and from clients' homes. The U.S. Department of Labor estimates the rule will cost $6.8 million a year over a 10-year period, paid for by private businesses and state Medicaid programs. Several lawmakers and home care agencies warn that the plan might prompt care agencies to hike up prices to clients or limit their employees' hours to avoid paying overtime. Read more

Lack of Enrollee Information Makes it Difficult to Determine Next Year's Health Insurance Rates. On April 26, 2014, the *Washington Post* reported on the challenges facing actuaries and insurers trying to calculate next year's health insurance rates. Currently, little is known about the health status and medical needs of newly-enrolled beneficiaries. Without this information, insurers are finding it difficult to determine next year's cost, or to determine whether they should participate in the exchange next year. While several insurers agree that rates will increase in 2015, they also acknowledge that it is too early to confidently set next year's rates. Read more

States Enroll Former Foster Youth in Medicaid. On April 30, 2014, *Stateline* reported that 180,000 Americans recently released from foster care became eligible for Medicaid coverage on January 1. The ACA grants these individuals full Medicaid coverage until age 26 in the state where they lived when they left foster care. However, states have enrolled far fewer foster alumni for Medicaid than officials expected, largely because of lack of federal guidance and difficulty in located former foster children. Read more

Industry Research

Cain Brothers' House Call Replay: Psychiatric Hospitals. The second in a series of four Cain Brothers' House Calls on the Behavioral Health Sector focused on addiction and substance use. Panelists were asked to share their views on the following, among other topics:

- The role of psychiatric hospitals and where they fit, given the wide range of mental illnesses in our population and the many kinds of providers offering behavioral health services.
- The paths and processes by which patients find and are admitted to psychiatric hospital facilities and programs.
- How psychiatric hospital managers think about outcomes and define successes.
- Evolving care models and how psychiatric hospitals are integrating their services with other providers to expand the continuum of behavioral health care.
- Parity and reimbursement issues.
- The demand for acute care psychiatric beds and consolidation trends.
- Anticipated evolution over the next few years of psychiatric hospitals, their services, and their relationships with patients and other kinds of providers, given the changes in and needs of the market place.

The House Call was hosted by Cain Brothers' Managing Director Todd Rudsenske and included Don Dempsey from Marwood Group. Panelists included:

- Earl Reed, CEO, Springstone
- Jim Shaheen, CEO, Strategic Behavioral Health
- Richard Kresch, CEO, US Healthvest

A replay of the conference call, and information on upcoming Cain Brothers' House Calls, are available here.

Industry News

Hospital Operators Report Positive Impact From Health Care Reform. On April 25, 2014, *The Wall Street Journal* reported on the first quarter earnings reports from Universal Health Services (UHS) and LifePoint Hospitals Inc. (LPNT). Both operators reported that exchange enrollment and enrollment in Medicaid expansion have helped drive down self-pay patient admissions. Medicaid expansion was cited as especially significant. Both operators received gains on their shares after their earnings conferences, as did others in the industry, including HCA Holdings Inc. (HCA), Community Health Systems Inc. (CYH) and Tenet Healthcare Group (THC). Read more

WellPoint Reports Q1 2014 Financial Results. On April 30, 2014, WellPoint, Inc. reported its first quarter 2014 results in a live conference call. The company reported first quarter net income of $701.0 million, or $2.40 per share, including net gains of about $0.10 per share. Net income in the first quarter of 2013 was $885.2 million, or $2.89 per share, which included net investment losses of approximately $0.05 per share.

WellPoint Announces New Appointments. On April 30, 2014, WellPoint, Inc. announced that Thomas C. Zielinski has been named executive vice president and general counsel, effective June 2, 2014. Additionally, Peter Haytaian has been appointed executive vice president and president of the Company's Government Business Division. He will assume responsibility for all operations related to the Company's Medicaid and Medicare business segments, as well as National Government Services and the Federal Employee Program. He replaces Richard Zoretic, who announced he will retire on May 31, 2014. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	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 15, 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	111,000
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 6, 2014	New York Behavioral (NYC)	Proposals Due	NA
June 12, 2014	Delaware	Contract awards	200,000
June 13, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
June, 2014	Washington Foster Care	RFP Release	23,000
July 1, 2014	Puerto Rico	Implementation	1,600,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 7,2014	Rhode Island (Duals)	Proposals due	28,000
July 16, 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	South Carolina Duals	Passive enrollment begins	68,000
January 1, 2015	Texas Duals	Implementation	132,000
January 1, 2015	Michigan Duals	Implementation	70,000
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
January 1, 2015	New York Behavioral (NYC)	Implementation	NA
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	5/1/2014 7/1/2014 1/1/2015	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	4/3/2014	1/1/2015	4/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri		6,380	Not pursuing Financial Alignment Model						
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		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	53,600	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	3/1/2014	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***			***10***			

** 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 Welcomes Kathy Ryland, Principal – Atlanta, Georgia

Kathy comes to HMA most recently from WellCare of Georgia where she has served as the Chief Operations Officer for the Georgia Health Plan. In this role Kathy has been responsible for the overall operations of the GA Health Plan including strategic direction, administration for all existing programs, and the development of new programs. Additional responsibilities include leading and directing the overall improvement of operations such as provider contracting/relations, sales and marketing, medical management, regulatory compliance, and finance. Prior to becoming the COO for the GA Health Plan, Kathy was the VP of Regulatory Affairs and Operations where she ensured compliance with all statutory and contractual requirements.

Prior to her work with WellCare of GA, Kathy worked for Logisticare as the VP of Business Development. In this role, Kathy was responsible for the management of business development efforts in the state government sector to include initiating contacts, developing collaborative relationships, recommending business strategy, assessing competitor strengths, and oversight of the RFP response process. Kathy spent eight years of her career with the Division of Managed Care and Quality/Georgia Department of Community Health as the Division Chief. Here she was responsible for all functions relating to the administration of the GA Families and GA Better Health Care programs to include enrollment and eligibility, vendor management, as well as plan design and quality management. Some of her accomplishments in this role include – directed the procurement and implementation of the statewide Medicaid managed care program, Georgia Families, with over 900,000 enrolled members and three contracted care management organizations; successfully managed the statewide primary care case management program, Georgia Better Health Care, with over 800,000 lives and a network of over 4,200 primary care providers; and established a multi-disciplinary physician advisory committee which developed and implemented a multi-year statewide quality improvement initiative including physician report cards. Additional roles that Kathy has served includes VP, Managed Care (SRHS)/Executive Director (SCHN) for Southern Regional Health System and Southern Crescent Health Network, Inc.; Director of Managed Care for Southern Regional Medical Center; Senior Contracting Specialist for Cost Care, Inc.; and Senior Provider Relations Representative for CIGNA Health Plan of Georgia, Inc.

Kathy attended Chatham College and Troy State University. She is also the Founding President of the Georgia Society for Managed Care.

HMA Welcomes Chip Cantrell, Senior Consultant – Atlanta, Georgia

Chip comes to HMA most recently from Cognosante where he has worked as a Senior Consultant over the last four years. Prior to joining HMA, Chip served as the Executive Director for the Bureau of TennCare, Tennessee Member Service Center under Cognosante. In this role he has been responsible for the implementation and operation of the TN Health Connection, delivering eligibility services for the TennCare and CoverKids programs which has included directing the management and operation of a multi-modal call center, application processing, and document management services. Additional roles that Chip has served in at Cognosante include Project Manager for the Bureau of TennCare Independent Verification and Validation for Eligibility Determination System; Project Lead for the Georgia Department of Community Health

Integrated Eligibility System Request for Proposal Planning; Deputy Project Manager for the NJ Department of Human Services Division of Medical Assistance and Health Services Management Information System Replacement Planning; and Managed Care Project Manager for the Project Management Organization team for the State of GA Department of Community Health Medicaid Management System Design, Development, and Implementation.

Prior to joining Cognosante, Chip served as the Director of Marketing Communications for Logisticare and as a Product Director-Public Sector for OptumHealth. Chip worked for the Georgia Department of Community Health for over five years and served in various roles throughout his career there – Deputy Chief, Office of Managed Care and Quality as well as Project Coordinator, Office of IT. Additional roles that Chip has served includes Usability Specialist/Global IT Division for TRW; Director of Training and QA for Ziptone; and several positions during his 14 years with AT&T to include Operations Planning and Support Manager/Security Management and Training Instructor/Business Customer Care.

Chip received his Project Management Master's Certificate from Stevens Institute of Technology and has attended Farleigh Dickinson University and Clayton State College where he studied Sociology and Business Administration, respectively.

HMA Upcoming Appearances

"Medicaid Health Homes: Best Practices"
2014 Annual Conference
National Council of Community Behavioral Healthcare
Lynn Dierker – Presenter
Juan Montanez – Presenter
Alicia Smith – Presenter
May 5, 2014
Washington, D.C.