HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 25, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

FLORIDA LOW-INCOME POOL (LIP) UPDATE

This week, our *In Focus* section reviews the background and current status of Florida's Low-Income Pool (LIP), a more than $2.1 billion funding mechanism to provide additional funding to the state's hospitals. Federal approval for the LIP program expires on June 30, 2015, and the Centers for Medicare & Medicaid Services (CMS) has informed Florida's Agency for Health Care Administration that LIP will not be approved to continue in its current form. While negotiations between AHCA and CMS on the future of LIP continue, the Florida Senate has put forward a proposed redesign of the LIP program. The Florida House, however, has not put forward a LIP proposal at this time pending resolution of outstanding issues between CMS and the Agency. In this week's update, we provide background on LIP and look at the Senate's proposed changes.

LIP Background

The LIP program was approved on October 19, 2005, as a part of Florida's Medicaid Reform 1115 Waiver and was established by the state effective July 1, 2006. The purpose of LIP is to ensure continued government support of health care services to the uninsured, underinsured, and Medicaid populations, as the Florida Medicaid program changed such that the majority of members are served by managed care plans. The LIP consists of a capped annual funding allotment, which may be used for health care expenditures such as medical care costs or premiums incurred by the state, hospitals, clinics, or other provider types for uncompensated medical care, as well as for augmenting Medicaid funds. Local governments, such as counties, hospital taxing districts, and other state agencies provide funding for the nonfederal share of LIP program which had traditionally been $1 billion. Payments through LIP are made quarterly to hospitals and other providers directly by the state and are outside of fee-for-service (FFS) or managed care capitation payments.

On November 27, 2013, the Agency submitted an amendment seeking federal authority to extend Florida’s Managed Medical Assistance (MMA) Waiver for the period July 1, 2014, to June 30, 2017. The waiver is designed to implement a new Statewide Medicaid Managed Care (SMMC) delivery system without increasing costs and to continue the LIP program. The MMA program provides primary and acute medical care for certain populations through high-quality, competitively selected managed care organizations (MCOs).

On April 11, 2014, CMS approved the MMA Waiver extension request for the three-year period July 1, 2014, to June 30, 2017. However, Florida's LIP funding was extended for only one year from July 1, 2014, through June 30, 2015. During this one-year extension, CMS authorized LIP funding to provide stability for providers during the transition to SMMC. Expenditures for uncompensated care costs and other allowable expenditures are to be verified through cost reports.

The LIP program funding was increased to $2.167 billion in FY 2014-15 and consists of the following three existing funding streams:

- $1 billion - LIP Program
- $963 million - Hospital Self-Funded Rate Exemptions and Adjustments
- $204 million - Medical School Supplemental Payments

In negotiations between CMS and the Agency, several major issues have been identified that CMS wants addressed for future years. LIP 6, which is described below, is believed to be the biggest point of concern for CMS in the negotiation process. To address this issue and to improve the LIP or an alternative program, the Senate has developed its own proposal which is described below.

Senate LIP Proposal

The Senate’s proposal for LIP holds the total LIP funding at the current level of $2.167 billion in FY 2014-15, but restructures and redistributes funding across the multiple LIP and LIP related components. Most notably:

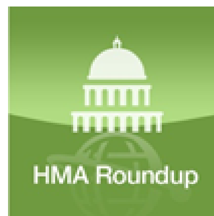
- Continues $116 million support for rural hospitals, trauma centers, primary care services, specialty pediatric hospitals, and safety-net hospitals, along with a special aspect of incenting quality (known as Special LIP).

- Continues support for other provider access systems at $117 million and medical schools at $204.5 million.
- Provides for a return on investment to local governments and hospital authorities that provide intergovernmental transfers (IGTs) that serve as the state match for the LIP program (LIP 4). This increases LIP 4 by $485.6 million.
- Provides $233.7 million (LIP 7) for additional payments to hospitals that are classified as essential community providers, Regional Perinatal Intensive Care Centers (RPICC), statutory teaching hospitals and trauma centers.
- Reduces current funding of $963.2 million to $244.4 million (LIP 6) for specific payments to identified hospitals outside of the Medicaid rate structure. (The reduction in LIP 6 funds the increases in LIP 4 and LIP 7).
- Redirects $202.9 million into base funding for DRG hospital inpatient rates (outside of LIP).
- Requests an amendment to certain Medicaid calculations so that intergovernmental (IGT) donors are not penalized for transferring those funds to the Medicaid program.

Looking Ahead – Legislative Action and CMS Approval

As noted previously, the Florida House has opted to wait for resolution between AHCA and CMS, at least around the general parameters and funding levels approved for LIP going forward, before putting forward a proposal of their own. This is consistent with what the House initially did at this point last year.

The Florida legislative session concludes at the end of April. If there is not an agreement by CMS and AHCA on LIP by mid-April, the Senate and House may not be able to come to an agreement on LIP prior to the end of session. The Legislature might address this by making an appropriation for LIP or an alternative program and requiring approval by the Legislative Budget Commission after session to expend these funds or calling a special session of the Legislature to address LIP.



HMA
MEDICAID
ROUNDUP

California

HMA Roundup – Warren Lyons (Email Warren)

Several Potential Buyers for Daughters of Charity Hospitals. On March 23, 2015, *San Jose Mercury News* reported that Daughters of Charity Health System indicated that several potential buyers have expressed interest in the hospitals, including Alecto Healthcare Services, Hospital Corporation of America, and Blue Wolf Capital. Prime Healthcare Services recently abandoned an $843 million bid because of strict required conditions, including keeping four of the six hospitals open as acute care hospitals for 10 years. Read More

Blue Shield of California's Tax Exempt Status Revoked. On March 18, 2015, *Los Angeles Times* reported that the California Franchise Tax Board revoked Blue Shield of California's tax-exempt status. The audit which led to the decision came after criticism over Blue Shield's rate hikes, executive pay, and a surplus of $4.2 billion. The insurer may now owe tens of millions of dollars in state taxes each year and is being ordered to file tax returns back to 2013. Michael Johnson, who recently resigned as public policy director at Blue Shield of California, said the company was acting too much like its for-profit competitors. He is launching a public campaign calling on Blue Shield of California to transition into a for-profit company and return billions of dollars to the public. Read More

Over Half of Denti-Cal Kids Do Not Receive Regular Dental Care, Providers Dropping. On March 17, 2015, *California Healthline* reported that according to a state auditor report, more than half of children covered through Denti-Cal are not receiving regular dental care while the number of providers is dropping. A joint legislative hearing will discuss the report that included the following findings:

- Less than 50 percent of Denti-Cal children received dental services
- 5 counties with at least 2,000 Denti-Cal children had no providers
- 11 counties had no providers who were accepting new Denti-Cal patients
- Oversight of the program by Department of Health Care Services is inadequate Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Colorado HealthOP's Surge on Insurance Exchange Carries Red Flag. An aggressive price cut by Colorado's nonprofit health insurance cooperative this

year led to its capturing the biggest market share of the state exchange, but analysts warn the move carries financial risk. A similar co-op serving Iowa and Nebraska was shut down by regulators in January after heavy losses, and the Colorado HealthOP's losses were even greater when compared to its remaining funds, according to one analysis report. Colorado HealthOP, one of 23 CO-OPs nationwide, reduced premiums on its middle-tier, or Silver, plans by an average of 10 percent. Its customer count shot up from about 14,200 in late 2014 to about 75,000 this enrollment period. Read More

Colorado Biosimilars Bill Awaits Governor's Signature. Colorado's biosimilars bill letting pharmacists provide patients with generic drugs in place of name-brand biotech medicines now needs only a governor's signature to become law. The bill changes state law to give pharmacists the ability to substitute cheaper generic biosimilars for the prescribed name brand in cases where the U.S. Food and Drug Administration has declared the drugs interchangeable. The pharmacist will also have to notify the patient and the prescribing physician of the switch. The state House of Representatives passed the bill with only one "no" vote on Tuesday, and it heads on to John Hickenlooper's desk. Read More

Connecticut

$63 Million Medicaid Reimbursement Claim Denial Caused by Growing Budget Deficit. On March 20, 2015, *CBS Connecticut* reported that Connecticut was denied $63 million in Medicaid reimbursements by CMS because of a growing budget deficit. A report released by Governor Dannel Malloy's budget office predicts the state will have a $133 million deficit for fiscal year ending June 30. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Requests 1115 Waiver Amendment for Immediate Managed Care Enrollment upon Eligibility Determination. The Agency for Health Care Administration will host two public meetings to solicit public input on an upcoming amendment request for Florida's 1115 Managed Medical Assistance (MMA) Waiver. The State is requesting this amendment to remove the 30-day period between eligibility determination and managed care plan enrollments and to amend the auto-assignment criteria. The MMA Waiver amendment meetings are scheduled on Wednesday, April 1, 2015 in Tampa, FL and Tuesday, April 14, 2015 in Tallahassee, FL. Read More

Third Senate Panel Approves Medicaid Expansion Proposal. On March 25, 2015, the Miami Herald reported that a third Senate panel has endorsed the Senate's proposed Medicaid expansion alternative (SB 7044), which would require monthly premiums for expansion enrollees. The Senate Appropriations Committee's approval of the bill sets it up for a vote on the Senate floor. Health Policy Chairman Representative Aaron Bean acknowledged that the bill still had "a long way to go," especially given the House's refusal to consider the proposal. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Senate Committee Budget Proposal Awards $19.5 Million Medicaid Pay Raise for Doctors. On March 18, 2015, *Georgia Health News* reported that the Senate Appropriations Committee passed a budget proposal awarding a Medicaid pay raise of $5.9 million to ob-gyns and $13.6 million to pediatricians, internists, and family medicine physicians. The Senate will still need to approve the plan. The House's proposed budget awards a $4.6 million pay raise. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

House Passes Governor-Backed Bill to Remedy FY 2015 Budget Shortfall. On March 24, 2015, the *State Journal-Register* reported that the Illinois House passed a bill (HB317) with the backing of Republican Governor Bruce Rauner to remedy the state's $1.6 billion shortfall in the current fiscal year. The bill includes a 2.25 percent cut to the annual appropriation across many department budgets, including the Department of Healthcare and Family Services (HFS), which administers the Medicaid program. The 2.25 percent cut will impact Medicaid providers, including the state's MCOs, provided it passes both chambers and is signed by the Governor. Due to the fact that an annualized 2.25 percent cut is proposed for the last quarter of the fiscal year, the impact over to providers and MCOs is a significantly more substantial reduction to reimbursements within the 4th quarter of FY 2015. The FY 2016 budget will continue to be negotiated throughout the spring legislative session and the HMA Weekly Roundup will be able to provide more details regarding the reductions, as well as updates regarding ACEs and CCEs, next week. Read More

Land of Lincoln Health Grabs 12 Percent Market Share on Get Covered Illinois. On March 25, 2015, Crain's Chicago Business reported that Land of Lincoln Health, the state's CO-OP insurer offered on the state's Get Covered Illinois Exchange, enrolled about 42,000 of 350,000 total consumers who selected a qualified health plan for plan year 2015. This 12 percent market share is up from just 2 percent in 2014. Land of Lincoln also has enrolled an additional 5,000 small businesses and 1,600 large businesses so far. The article cites up to 30 percent decreases in premiums for 2015 and larger provider network agreements with the increase in enrollment. Read More

Iowa

Senate Votes to Establish Committee to Oversee Medicaid Managed Care. On March 19, 2015, *WCF Courier* reported that as the state's $4.2 billion Medicaid program is moving to managed care, the Senate has voted to establish a committee to oversee the transformation. Read More

Kansas

Medicaid Waiver Waiting Lists Could Cost State Over $100 Million A Year. On March 19, 2015, *Kansas Health Institute* reported that home and community-based services for Kansans with disabilities on Medicaid waiver waiting lists can

end up costing the state over $100 million per year. The costs can double if the federal government requires full funding. Kansas Department of Health and Environment Secretary Susan Mosier warned legislator of these potential costs. The Kansas Hospital Association, one of the leading groups lobbying for expansion, said the hospitals are willing to talk about how to cover the state's share of the costs, even if this includes eliminating the waiting lists. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Proposed Rule Would Increase Nursing Delegation Activities in New Jersey. The Division of Consumer Affairs, State Board of Nursing issued a proposed set of rule changes that would permit practical nurses, certified homemaker-home health aides (CHHAs), and unlicensed assistive persons to do some tasks now performed exclusively by registered professional nurses. These changes pertain to N.J.A.C. 13:37-6, which sets forth rules governing the delegation of nursing tasks. According to *NJ Spotlight*, which reported on the proposal on March 16, 2015, "The rule change would allow health aides to do any task that is within a nurse's scope of practice and that can be done with little risk to patients and without the need for nursing judgment, as long as the nurse can teach the aide how to do it and is comfortable that the aide is competent to do it. The focus is on patients with chronic conditions receiving long-term care, and includes giving medications orally or through injections, and helping with eye drops, catheters, and enemas." The state conducted a nursing delegation pilot program with 19 home health agencies between 2008 and 2011 that was considered a success. Deputy Human Services Commissioner Lowell Arye reported at a gathering of state officials with AARP on March 13, 2015, that the lack of delegation has contributed in part to nursing home admissions that were otherwise avoidable. A copy of the proposed rule changes and form to submit public comments until April 3, 2015 can be found here.

New Jersey Issues Request for Interest (RFI) for a Behavioral Health Home Learning Collaborative. New Jersey has procured the services of The National Council for Behavioral Healthcare (The National Council) to facilitate a Behavioral Health Home Learning Community (BHH-LC). The BHH-LC will build behavioral health home capacity in Atlantic, Cape May, and Monmouth Counties. Behavioral health agencies licensed through the Department of Human Services (DHS) as mental health provider agencies qualify to participate in the BHH-LC and become state-certified BHH providers. At least 80 percent of a provider agency's current consumers must reside in Atlantic, Cape May, and/or Monmouth County.

Participants in the BHH-LC will develop a behavioral health home implementation plan that will be reviewed and assessed by the DHS Division of Mental Health and Addiction Services (DMHAS). If the plan is approved, the provider will become eligible to provide behavioral health home services and apply for state startup funds, if available. To qualify for startup funds, agencies will be required to complete an application and will have two years in which to achieve certification as a Health Home by a nationally recognized and state-approved accrediting body.

New Jersey's behavioral health homes will be administered jointly by DMHAS and the Division of Medical Assistance and Health Services (DMAHS).

Behavioral health treatment will be reimbursed by the current mechanisms. The consumer's physical health claims will continue to be paid and managed by one of the state's Medicaid Managed Care Organizations. Interested providers were invited to respond to a Request for Information by March 24, 2015. Agencies selected for participation will receive notification by April 7, 2015, and the first BHH-LC will become operational on May 11, 2015. To date behavioral health homes have begun in Bergen and Mercer counties. Read more.

Medicaid Agency and Medicaid Fraud Division Release an RFP for a Third Party Liability Recovery Services vendor. On March 23, 2015, New Jersey's Department of Treasury, Division of Purchase and Property issued an RFP (Solicitation No. 2015-X-23249) on behalf of the Medicaid Fraud Division (MFD) of the Office of the State Comptroller (OSC) and the Division of Medical Assistance and Health Services (DMAHS) of the Department of Human Services (DHS) DHS for a third party liability recovery services contractor. The purpose of the RFP is to solicit proposals for the identification of third-party liability (TPL) and the maximization of cost avoidance and recoveries of Medicaid payments. Questions about the RFP are being accepted until 5 p.m. on April 6, 2015. Proposals will be accepted up until 2 p.m. on April 28, 2015. The current contract extension is held by Health Management Systems, Inc. (HMS), a publicly traded company that offers cost containment solutions to government and commercial healthcare programs. HMS's contract expires on April 30, 2015, or when a new contract has been awarded, whichever transpires first. Read more.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York State Department of Health Extends DSRIP Implementation Plan Deadline to May 1. The New York State Department of Health announced that the deadline for submitting DSRIP Implementation Plans will be extended to May 1 due to the postponement of the final valuation from March 27 to after the NYS Legislature approves the budget.

Health Home Development Fund. CMS approved a state plan amendment defining the use of the Health Home Development Fund, a component of the New York State 1115 Medicaid Waiver that was finalized in April 2014. The state's health home program coordinates care for high-need, high-cost populations and is seen as a critical part of implementing the "Care Management for All" component of the Medicaid Redesign Team Action Plan. Ensuring the long-term stability and success of health homes requires significant resources, particularly around the need to establish HIT linkages between health homes, care managers and other network partners, critical to the communication and sharing of care management information.

The Health Home Development Fund is designed to improve performance of the health homes, with particular emphasis on outreach. Three areas have been identified for Development Fund focus: outreach to individuals eligible for Health and Recovery Plans (HARPs, the Medicaid managed care product developed for individuals with serious mental illness); alignment with the Performing Provider Systems created in response to DSRIP; and expanding health home services for children. The SPA approved spending of $190.6 million over three years, which will be distributed in the form of a PMPM rate add-on.

The amount of the add-on will be determined by dividing the total funding amount available by the number of claims submitted by health homes for outreach and engagement activities. The money is front-loaded, with $80 million available for activities from August 2015 to March 2015; $66.7 million for activities from April 2015 to December 2015; and $43.9 million for activities during 2016.

The use of funds is limited to outreach and engagement functions. The state has identified four areas of potential spending:

- Member engagement and health home promotion, which includes targeting for outreach, communication strategies, forums, development of low-literacy materials, and community engagement.
- Workforce training and retraining, which includes educating care management staff to provide services to a more diverse population, particularly to those with behavioral health issues; training on assessment tools and integrated care planning; cultural competence; and the use of HIT.
- HIT and clinical connectivity, which includes electronic interfaces and network development; tablets and other hardware for frontline workers; technical assistance; and the development of billing systems to facilitate health home payments to downstream providers.
- Joint governance technical assistance, meant to help the health home build a cohesive network and engage in readiness for making the transition to becoming an ACO.

North Carolina

Bill to Transition Control of State-Run Substance Abuse Centers to Local Mental Health Agencies Moves Forward. On March 19, 2015, *North Carolina Health News* reported that the House Health Committee approved HB 119, moving it to the appropriations committee. The bill gives local mental health agencies control over the three state-run abuse centers, significantly changing their funding and management. Additionally, the bill would create a data system to track long-term outcomes of patients. For fiscal year 2013-14, the state spent $46 million to treat 3,875 individuals who were referred by mental health managed care organizations. MCOs, however, do not cover any patient costs, and thus have no incentive to restrict referrals. The bill would encourage MCOs to invest in cheaper alternatives, such as facility-based crisis centers. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Budget Hearings in Ohio's House Finance Subcommittee May Conclude This Week. The House Finance Subcommittee is said to be wrapping up its budget hearings this week. Testimony has covered a broad scope of topics and with several topics dominating, including the Governor's proposal that by July 2019, the state will no longer accept claims submitted by Independent Providers of waiver services unless the individual they work for is on a self-directed waiver option and changes to Ohio's long term care system, including for individuals

with developmental disabilities, as well as changes for state-operated developmental centers and sheltered workshops.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Medicaid Expansion: Key Events and Milestones. Pennsylvania recently added a website with information related to the transition from the Healthy PA Demonstration Waiver to a traditional Medicaid expansion. In addition to a detailed timeline covering the schedules for consumers and managed care plans, the site includes links to client notices and other information about the transition from the alternate waiver program championed by former Pennsylvania governor Tom Corbett to the expansion of the existing Medicaid managed care program, HealthChoices, as promised during the campaign by newly elected Governor Tom Wolf. The site reports that the transition of all consumers who were enrolled in Healthy PA will be complete by September 1, 2015, and the Healthy PA waiver will be terminated by September 30, 2015. http://www.healthchoicespa.com/ Read More

CMS Provides Funds for PA Health Information Exchange. Pennsylvania eHealth Partnership Authority granted $11.8 million in funds to assist both ambulatory practices and hospitals in bridging their systems to the Pennsylvania Patient & Provider Network. The funding for the program was offered via grant by CMS and the application for funding HIE expansion will continue from March 19, 2015, to April 3, 2015. Health Information Organizations (HIOs) in Pennsylvania are encouraged to apply for the funding in order to assist ambulatory practices and hospitals that take part in the Medicaid EHR Incentive Program. The application is available here. Read More

Competitors Collaborate to Make HIE Work. In the greater Philadelphia area, health organizations are taking a historic opportunity for a major metropolitan experiment with HealthShare Exchange of Southeastern Pennsylvania (HSX). HSX is bringing together a membership of more than 50 hospitals, medical practices, clinics and insurers, which includes two Medicaid Managed Care Organizations, to share patient health records and claims data — and make it all accessible to inpatient, outpatient and clinic settings at the point of care. A test of the HSX's success will be how well it serves the region's payers and providers as they work in accountable care — such as the Delaware Valley ACO, serving 32,000 Medicare beneficiaries already. Read More

iCount Project to Target Pittsburgh's Repeat Health Care Patients. The project to spur innovative models for tackling Pittsburgh's "super-utilizer" dilemma, called iCount, calls on the about 1,000 behavioral health and social service agencies in the greater Pittsburgh region to consider teaming with a primary care provider to become one of three to five "community clusters" in iCount's three-year pilot program. The clusters will focus on the "golden three weeks" following a hospitalization by making daily patient contact and ensuring patients get the wraparound services they need—from transportation to child care to help in understanding medication regimens. Each cluster of up to 15 agencies, centered on a health care provider, will target a geographic area and a high-risk medical need, such as congestive heart failure or diabetes. Pennsylvania's roughly 84,000 super-utilizers rack up about $760 million annually in Medicare and Medicaid costs for inpatient hospital stays, data from

the Pennsylvania Health care Cost Containment Council show. That means 3 percent of hospitalized patients contribute to about 15 percent of the state's federally subsidized hospital bills. Read More

UPMC Makes Strategic Investment in Health Fidelity to Develop Technologies that Advance Value-Based Healthcare. Health Fidelity, a company that develops innovative technologies for the value-based healthcare era, today announced that UPMC has made a significant investment in the company. UPMC identified the value of using a comprehensive risk-adjustment solution for Medicare Advantage, Medicare ACO, and Health Insurance Exchange programs and then partnered in 2014 with Health Fidelity to complete development of this technology that significantly enhances operational efficiency and compliance management. Read More

Tennessee

Medicaid Expansion Receives Positive Recommendation in Senate Subcommittee. On March 24, 2015, *timesfreepress.com* reported that a Senate subcommittee positively recommended Governor Bill Haslam's expansion proposal. It needs one more vote to advance out of the full committee. Under the proposal, hospitals will cover $74 million of state costs. The original proposal was rejected in the Senate in February, in a 7 to 4 vote. Read More

Texas

Baylor Scott & White and Tenet to Partner on Five North Texas Hospitals. On March 23, 2015, Tenet Healthcare Corporation and Baylor Scott & White Health announced a definitive agreement to partner on providing care through five North Star hospitals, in Rockwall, Collin, and Dallas counties. Baylor Scott & White Health is the largest not-for-profit healthcare system in Texas, merged in 2013 from the Baylor Health Care System and Scott & White Healthcare. Read More

House Uses $102 Million of ACA Money to Help Pay for Medicaid Bill. On March 25, 2015, *The Texas Tribune* reported that the House Appropriations Committee voted to used Affordable Care Act money to help pay for the state's $338 million Medicaid bill – a total of $102 million. The money came from a federal reimbursement called the Integrated Eligibility and Enrollment program, designed with the assumption that the state would expand Medicaid. According to Rep. Sylvester Turner, when the money was presented, he says "no one indicated that it had anything to do with the ACA." Read More

National

House Republicans Target Medicaid to Offset Cost of Medicare Doc Hike. On March 24, 2015, *The Washington Post* reported that to offset a $140 billion part of the cost of higher payments to Medicare doctors, House Republicans decided to deepen budget savings in Medicaid. The Medicare fee legislation has a total cost of $210 billion over 10 years. Read More

Medicaid Expansion Lowers Hospital Uninsured Costs by $7.4 Billion. On March 23, 2015, *Reuters* reported that in 2014, the cost of caring for the uninsured in hospitals fell by $7.4 billion as a result of Medicaid expansion, according to a

report by the U.S. Department of Health and Human Services. Estimated uncompensated care costs in 2014 were $27.3 billion, down from $34.7 billion in 2013. Expansion states saw a reduction of $5 billion, while non-expansion states still saw a $2.4 billion drop. Read More

Representative Paul Ryan Urges Lawmakers Not to Set Up the Exchange, Wait for Republican Alternative. On March 20, 2015, *The Wall Street Journal* reported that Representative Paul Ryan urged legislators to not set up a Health Insurance Exchange and instead to consider an alternative health care proposal that would be introduced by June 20 by the congressional Republicans. The GOP legislation would "allow states to strip some of the health law's requirements that insurance plans must provide certain minimum benefits and a requirement that insurers sell to all customers equally regardless of their medical history." Read More

Long Term Care Cutting Life Insurer Profits, Earnings Drop 11 Percent. On March 25, 2015, *Philly.com* reported that life insurer profits have dropped 11 percent in the last quarter due to the rising costs of long term care. Life-insurance analyst Vincent Lui said insurers actually lose money on long term care policies, resulting in a major increase in prices. Average premiums in the last year have risen almost 9 percent. Four of the five largest providers have either stopped selling new policies or scaled back their business. However, elderly patients do not have many options other than private insurance; Medicare does not cover most nursing-home stays. Read More

Expansion States Diagnose New Diabetes Cases. On March 23, 2015, *The New York Times* reported that states that have expanded Medicaid saw an increase of diabetes cases, suggesting that the ACA's Medicaid expansion may help thousands begin treatment. The study, conducted by Quest Diagnostics, analyzed laboratory test results from 50 states and found that states that expanded Medicaid had diabetes diagnoses rise 23 percent to 18,020 in the second quarter of 2014 from 14,625 a year previously. Non-expansion states saw an increase of only 0.4 percent. Read More

States to Lower Health Care Costs by Focusing on Poverty. On March 22, 2015, *The New York Times* reported that numerous patients afflicted with poverty, homelessness, mental illness, addiction, or past trauma use emergency rooms for avoidable reasons, greatly increasing costs. As a result, states are trying to better manage these "super utilizers" through various initiatives. The Center for Health Care Strategies has identified 26 states. Additionally, the federal government is also helping through its $10 billion Innovation Center. The goal of these programs is to fix the patients' problems before they becomes expensive medical issues. Read More

Industry News

J.H. Whitney Acquires Pediatric Services Holding Corp. On March 23, 2015, *PE HUB* reported that J.H. Whitney Capital Partners, a middle-market private equity firm, acquired Pediatric Services Holding Corp, the parent company of PSA Healthcare, a provider of home care services for medically fragile individuals. Financial terms of the transaction were not disclosed. Read More

Tenet Enters Deal Combining Short-Stay Surgery and Imaging Assets with United Surgical Partners. On March 23, 2015, *The Wall Street Journal* reported that Tenet Healthcare announced a joint venture with Welsh Carson Anderson & Stowe, combining United Surgical Partners International Inc.'s short-stay (ambulatory) surgery centers and imaging facilities. Tenet will own 50.1 percent of the operation and will be able to purchase the remainder over five years. The deal is expected to create the biggest ambulatory-surgery provider in the U.S. USPI is valued at $5 billion. Read More

UPMC to Acquire Family Hospice and Palliative Care. The University of Pittsburgh Medical Center will acquire Family Hospice and Palliative Care, Pennsylvania's largest not-for-profit hospice provider. Additionally, UPMC made an undisclosed investment in Health Fidelity, a technology company that UPMC previously used for a risk adjustment solution last year. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
March 26, 2015	Iowa	Amended RFP Release	550,000
March 27, 2015	Mississippi CHIP	Proposals Due	50,300
March, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
April 15, 2015	Florida Healthy Kids	Contract Awards	185,000
April 24, 2015	Mississippi CHIP	Contract Awards	50,300
April, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 8, 2015	Iowa	Proposals Due	550,000
May 14, 2015	Georgia	Proposals Due	1,300,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
August, 2015	Michigan	Contract Awards	1,500,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,500,000
January 1, 2016	Iowa	Implementation	550,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	178,000	Application			8/26/2013	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500					*Cancelled Capitated Financial Alignment Model*		
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Update

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

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

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

HMA NEWS

Webinar Replay: Culturally Responsive Health Care and CLAS Standards

On March 12, 2015, HMA Information Services hosted the webinar, "Do the Right Thing: Culturally Responsive Health Care and the Federally Mandated CLAS Standards." During this webinar, HMA Principal Dr. Jeff Ring makes the case for culturally responsive health care and illustrates how to make culturally responsive health care work for patients and the organizations serving them. A replay of the webinar broadcast and the slides presented are available here.

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