HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 29, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

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- HMA UPCOMING WEBINAR: *"A HEALTHCARE WIN FOR VETERANS AND STATES: STRATEGIES FOR ENHANCING VETERANS' BENEFITS BY FACILITATING ACCESS TO THE V.A. SYSTEM"*

IN FOCUS

HHS OIG RECOMMENDATIONS ON MEDICAID MCO ACCESS STANDARDS

This week our *In Focus* section reviews the Department of Health and Human Services (HHS) Office of Inspector General (OIG) report, *State Standards for Access to Care in Medicaid Managed Care*, published September 8, 2014. The OIG surveyed 33 states providing risk-based Medicaid managed care at the request of Congress and reported on existing standards for access to care, as well as recommendations for future regulations on access standards for Medicaid Managed Care Organizations (MCOs). Additionally, our *In Focus* section reviews comments from the Centers for Medicare & Medicaid Services (CMS) and from the National Association of Medicaid Directors (NAMD) in response to the OIG report. Since the publication of the report, *Modern Healthcare* reported

on October 28, 2014, that CMS officials are reporting they are on track to issue "sweeping" new regulations on access standards in January 2015.

Link to Report: ***State Standards for Access to Care in Medicaid Managed Care***

OIG Survey Findings – Existing Access Standards

OIG conducted a survey of 33 states in the first half of 2013 on existing measures of access to care, how states monitor compliance, and what corrective actions and oversight systems and processes are in place. Summarized below are these findings. For more detailed findings and state-specific standards, refer to the report and appendices in the link above.

State standards for access to care vary widely and are often not specific to certain types of providers or geographic areas of the State. The three most common types of access standards are (1) standards that limit the distance or amount of time enrollees should have to travel to see a provider; (2) standards that require appointments to be provided within a certain timeframe; and (3) standards that require a minimum number of providers in relation to the number of enrollees.

- Thirty-two states limit the distance or time enrollees should have to travel to see a provider.
- Thirty-one states require that appointments be provided within a certain timeframe.
- Twenty states require a minimum number of providers based on the number of enrollees.
- Twenty-two states have other standards for access to care, such as in-office wait time (11 states), access to multilingual care (6 states), 24-hour telephone access to providers (6 states), and other access-related performance standards.

States have different strategies to assess compliance with access standards, but do not commonly use direct tests. The OIG reports that most states do not often use direct tests to assess whether MCOs are in compliance with access standards. The report notes that "direct tests commonly include telephone calls to providers that either assess compliance with a specific standard, such as wait times for appointments, or assess the accuracy of provider information, such as whether a provider is participating in a plan as a contracted provider.

- All states rely on reports from managed care plans, but reports vary widely across the states surveyed.
- States also use external quality review organizations to assess compliance, but these reviews often to not include direct tests of compliance.
- Eight states reported conducting their own direct tests of plan compliance.

Most States did not identify any violations of access standards over a 5-year period; States that found the most violations conducted direct tests of compliance.

- Eleven of the 33 States with risk-based managed care plans identified at least one violation of their access standards between the time period of January 1, 2008 to January 1, 2013.

- Just 3 States—Ohio, New York, and Georgia—identified more than three-quarters of all violations. In these 3 States, the State or its external quality review organization (EQRO) conducted direct tests of plan compliance, including making calls to providers.

Most states that identified violations relied on the use of corrective action plans to address deficiencies six states imposed sanctions.

- The 11 states that identified violations most commonly relied on the use of corrective action plans (CAPs) to address them. States either issue CAPs to plans or approve CAPs developed by plans.
- Six of the 11 states that identified violations reported imposing sanctions in response to violations, including issuing monetary penalties and blocking new enrollees from signing up with plans.

OIG Recommendations to CMS

In response to OIG's survey results and findings, the OIG report outlines four recommendations to CMS:

1. **Strengthen oversight of state standards and ensure that states develop standards for key providers.** OIG recommends that CMS issue guidance to strengthen state standards on access, as well as require states to develop standards for a core set of providers important to the Medicaid MCO population, including primary care, pediatricians, obstetricians, and other high-demand specialists. Additionally, CMS should work with states to ensure access standards address differences between urban and rural areas.
2. **Strengthen oversight of states' methods to assess plan compliance and ensure that all states conduct direct tests of access standards**. OIG recommends that CMS should require all states or their EQROs to conduct direct tests to assess MCO compliance with access standards.
3. **Improve states' efforts to identify and address violations of access standards.** OIG recommends that CMS should work with states to improve identification and addressing of violations of access standards. Additionally, CMS should use information it has begun to collect to track violations and ensure states address them appropriately.
4. **Provide technical assistance and share effective practices.** OIG recommends that CMS provide technical assistance to states as well as share effective practices with all states to improve access for Medicaid managed care enrollees.

CMS Response to OIG Recommendations

In a response to the OIG, CMS Administrator Marilyn Tavenner concurred with the four recommendations made in the report, noting that some of the recommendations are already in practice to some degree. Additionally, the response indicates that CMS believes states should still retain flexibility in determining which compliance actions should be applied. As noted in the introductory paragraph, *Modern Healthcare* is reporting that CMS will likely issue guidance in January 2015 on access standards for Medicaid MCOs.

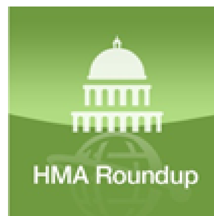
NAMD Response to OIG Recommendations

In a letter dated October 17, 2014, the National Associated of Medicaid Directors (NAMD) responded to the OIG recommendations with the suggestion that CMS and OIG should not consider a lack of uniformity among states as a failure to fulfill their obligation to beneficiaries regarding access in Medicaid managed care programs. NAMD argues that the OIG survey was narrowly focused on access standards and does not take into account the broader context and interplay between state Medicaid administrations and contracted Medicaid MCOs. For example, NAMD states that Medicaid programs have dedicated staff in regular communication with MCOs regarding access and utlization issues and conduct a variety of processes that effectively prevent, identiy, and resolve access challenges for beneficiaries. Additionally, NAMD contends that access must be considered in the broader context of Medicaid within the health care marketplace, balancing access along with assurances of economy, efficiency, and appropriate utilization. Finally, NAMD presents the broader shifts in Medicaid programs occuring since the OIG survey, including Medicaid expansions, increased enrollments in non-expansion states, and Medicaid reforms, such as telemedicine. NAMD states that CMS should make expectations clear on the access standards-setting process and allow states the leeway to create standards most suited for their populations and policy goals.

Link to NAMD Response Letter

States Included in OIG Survey

The 33 states inlcuded in the OIG access standards survey were: Arizona, California, Colorado, Delaware, DC, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, West Virginia, and Wisconsin.



HMA MEDICAID ROUNDUP

California

HMA Roundup – Alana Ketchel (Email Alana)

Seniors, Disabled Moving to Medicaid Managed Care in Rural Counties. On October 28, 2014, the *California Healthline* reported that the state will be shifting a vulnerable group of Medi-Cal beneficiaries into managed care on December 1. About 20,000 seniors and persons with disabilities in 28 rural counties will move from Medi-Cal fee-for-service to managed care plans. The rural expansion started about a year ago with non-disabled adults and children. Read more

CalOptima Duals Enrollment Freeze Lifted. On October 27, 2014, the *Orange County Register* reported that CalOptima will again be able to enroll beneficiaries into its Dual Eligible Special Needs Plan, called OneCare, starting November 1. The plan was previously under an enrollment freeze after a CMS audit revealed serious threats to patients' health and safety. CalOptima is the sole plan participating in the duals demonstration program in Orange County. Read more

DHCS Penalizes Hospitals for Provider Preventable Conditions. On October 24, 2014, *KPCC* reported that the Department of Health Care Services has penalized at least 85 hospitals for errors committed while treating Medi-Cal patients. Between July 2013 and August 2014, 145 hospitals reported "provider preventable conditions," which are defined as instances in which a patient suffers harm due to a medical error. So far, the state has withheld nearly $1 million in Medi-Cal payments to hospitals that reported such errors. Read more

State Lays Out Plan for Senate on Drug Medi-Cal . On October 24, 2014, the *California Healthline* reported that the state reviewed its plan for the Drug Medi-Cal Program at a Senate hearing last week. California has been negotiating with CMS to get a federal waiver from a restriction on residential care facilities and is reportedly close to securing support. State officials believe this federal waiver is necessary to ensure an adequate supply of residential beds to care for those with substance use disorders. The state is holding a stakeholder meeting on November 3, after which the state will submit the waiver request to CMS. Read more

Exchange Renewal Notices May Confuse Some Families in Medi-Cal. On October 20, 2014, the *California Healthline* reported that state officials are concerned that families who are partially enrolled in a Covered California plan and Medi-Cal may be misled about Covered California renewal notices. There is an estimated 20 percent overlap in which parents are Covered California enrollees and their children are eligible for Medi-Cal. When those parents receive renewal notices from Covered California, they may incorrectly assume their children's Medi-Cal eligibility has also been renewed. The Department of

Health Care Services says it is making efforts to clarify that there is a separate county process for Medi-Cal renewal. Read more

Clinics Seeing Increased Demand from ACA. On October 19, 2014, the *Los Angeles Daily News/CHCF Center for Health Reporting* reported that California's community clinics and health centers are experiencing rising demand since implementation of the Affordable Care Act. In 2013, clinics saw approximately 3.4 million California residents, up from 2.5 million in 2008. Some clinics have extended hours to meet the increase in usage. Demand is expected to increase as Covered California enrollment enters its second year. Read more

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Exchange Customers May Pay More for Insurance Next Year. On October 27, 2014, the *Denver Business Journal* reported that subsidies for plans purchased through the Connect For Health Colorado exchange will be reduced in 2015. Subsidies for residents buying marketplace plans will drop significantly, and exchange customers may have to increase their personal contributions by more than 75 percent per month if they want to keep their current plans. Twenty carriers are planning to offer policies on the exchange next year, and premiums are expected to rise by less than two percent. Because of increased price competition amongst carriers in the exchange, consumers will have the opportunity to seek cheaper options for coverage. Read more

Florida

HMA Roundup – Gary Crayton and Elaine Peters (Email Gary/Elaine)

AHCA Asks Judge to Review New Evidence Refuting Lawsuit Which Deemed Children's Health Care Inadequate. On October 29, 2014, *Flagler Live* reported that the Agency for Health Care Administration (AHCA) filed court documents asking federal judge Adalberto Jordan to consider new evidence in a 2005 case filed by the Florida Pediatric Society focusing on the adequacy of care provided to children on Medicaid. AHCA and the Department of Health explain that the Medicaid program has undergone significant changes since the case was filed. Chief among these changes is the new requirement that nearly all Medicaid beneficiaries enroll in HMOs or other types of managed care plans to ensure adequate coordination of their care. Now that the new managed care system is in full swing, AHCA aims to present new evidence demonstrating improvements to child health care quality and access. Read more

Kansas

Former Executive Alleges Misconduct by KanCare Contractor Sunflower State Health Plan. On October 28, 2014, the *Topeka Capital-Journal* reported that a former Sunflower State Health Plan employee filed a wrongful-termination suit alleging retaliation from management after she objected to unethical practices put in place to improve company revenue. Sunflower State Health Plan, a subsidiary of Centene, was one of three for-profit managed care organizations selected to operate KanCare. Former Sunflower executive Jacqueline Leary claims that Centene closed automatic assignment avenues for all physicians

working at hospitals with negotiated rates above 100 percent of the standard payment for Kansas Medicaid providers. Leary also alleges the company moved about 7,500 Medicaid members to physicians employed by entities that were being paid the standard reimbursement. Read more

Louisiana

Department of Health and Hospitals Recommends Five Bayou Health Plans. On October 24, 2014, the Louisiana Department of Health and Hospitals (DHH) announced the recommendation of five managed care organizations to administer the next contract period for Bayou Health. All of these health plans will operate statewide. The following plans were recommended by DHH:

- Aetna Better Health of Louisiana (new entrant)
- Amerigroup Louisiana, Inc. (current paid incumbent)
- AmeriHealth Caritas Louisiana (current paid incumbent)
- Louisiana Healthcare Connections (current paid incumbent)
- UnitedHealthcare Community Plan (current shared savings incumbent)

The health plans were selected through a competitive procurement process and the release of an RFP this summer. The health plans' proposals collectively include dozens of added benefits and services for beneficiaries, including certain vision and dental benefits for adults not covered under legacy Medicaid, coverage of certain vaccines for adults, weight management programs, 24-hour nurse support lines, physician home visits for postpartum care, and incentives to complete wellness screenings and other preventive care. The RFP proposals even include added benefits for providers, including financial incentives for meeting certain quality and outcome metrics. DHH released a comprehensive score summary showing the criteria by which the plans were evaluated.

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

400,000 Residents Must Re-Apply for Health Connector Insurance Plan Coverage Due to Last Year's Botched Online Systems Launch. On October 27, 2014, the *Herald News* reported that nearly 400,000 Massachusetts residents currently enrolled in Massachusetts Health Connector insurance plans will need to fill out a new application during the upcoming open enrollment period or risk losing their coverage. According to Health Connector executive director Jean Yang, these consumers need to re-apply because of a failed online systems launch last year, which resulted in 300,000 residents being put on temporary MassHealth and another 90,000 in the Commonwealth Care program. While the next open enrollment period ends on February 15, most people will need to sign up well before that date in order to avoid experiencing a coverage gap. Read more

Gary Gottieb to Step Down as CEO of Partners HealthCare. On October 25, 2015, the *Boston Globe* reported that Gary Gottlieb will step down as Chief Executive Officer for Partners HealthCare effective July 2015. The Partners HealthCare network comprises ten hospitals and employs over 6,000 physicians. Gottlieb's departure comes as the company faces a decision by the Superior

Court on their pending deal to take over three hospitals in the Boston area. Insurers, competitors and consumer advocates have criticized the deal, arguing that Partners already has too much power in the area and charges too much for its services. Gottlieb is leaving his position to take on the position of chief executive at Partners in Health, a Boston-based nonprofit. Read more

Nevada

Reno Providers Overwhelmed by Care Needs of New Medicaid Enrollees. On October 28, 2014, *Kaiser Health News* reported that pent-up demand for services amongst new Medicaid enrollees in Reno are causing long wait times for doctors' appointments. Medicaid enrollment in the state grew by nearly 300,000 people since September 2013; enrollment in Reno alone grew from 50,000 to 90,000 during that period. Reno providers report that they are struggling to keep up with care for new enrollees, many who have multiple chronic conditions. The providers also report that low Medicaid reimbursement rates dissuade them from accepting new Medicaid patients, further exacerbating care access issues. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Managed Long Term Services and Supports (MLTSS) Service Dictionary is Available on the Medicaid Website. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has uploaded a copy of the MLTSS Service Dictionary to its website. The Service Dictionary identifies all of the services that are available to an individual who meets the clinical, functional and financial eligibility requirements for a nursing facility level of care, and who therefore qualifies for MLTSS. In addition to the definitions for each service, the MLTSS Service Dictionary lists service limitations, provider specifications, billing codes, HIPAA compliant code, unit of service, licensing entity, accrediting entities (when applicable), regulation cites and taxonomy code for each MLTSS service. Read more

New Jersey Drug Utilization Review Board (DURB) Annual Report Released for Public Comment. The New Jersey DURB has released its annual report, which covers the July 1, 2012 – June 30, 2013 period. The NJ DURB is responsible for reviewing and recommending specific processes for prospective and retrospective components of the drug utilization review process intended to improve medication utilization and the quality of care under the Medicaid program. Among the DURB findings were the use of short-acting opiods, oral diabetic medications and HIV pre-exposure prophylaxis, outcomes of clinical interventions, and a review of the drug utilization protocols of the state's contracted Medicaid managed care organizations. A complete copy of the annual report can be found here. Comments may be submitted up until December 19, 2014 to:

Margaret Rose
Attn: SFY 2013 DURB Report
Division of Medical Assistance and Health Services
Office of Legal and Regulatory Affairs
P.O. Box 712, Trenton, NJ 08625-0712

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New Mexico

Behavioral Healthcare Provider Sues State Over Medicaid Payment Freeze. On October 24, 2014, the *Las Cruces Sun-News* reported that the Southwest Counseling Center has filed a lawsuit against the New Mexico Human Services Department (HSD) for allegedly violating its due process rights when it indefinitely suspended Medicaid payments in June 2013 without a hearing. The state froze Medicaid funding for Southwest and 14 other behavioral health providers last year as it investigated potential cases of over-billing and fraud; without Medicaid money the facility was forced to stop offering services. Southwest claims that HSD was unable to find “credible allegations of fraud” after auditing the facility. Southwest also accuses HSD of violating open records laws by hiding records related to the allegations against the facility. Read more

New York

BlueCross BlueShield Reverses Decision to Exit Medicaid and Child Health Plus Programs. On October 22, 2014, the *Buffalo News* reported that BlueCross BlueShield of Western New York has reversed its decision to exit the Medicaid and Child Health Plus managed care programs. This reversal means that the 53,000 New York Medicaid and Child Health Plus clients on the plan will not have to switch their coverage to another insurer this year. BlueCross BlueShield reported in July that it would leave the programs effective October 31 because of steep financial losses. The insurer changed its mind because it is in discussions with another company to administer its Medicaid managed care program. For now, the company is not accepting new members in the programs. Read more

LeadingAge and The Hospice and Palliative Care Association of NY Announce Affiliation. On October 28, 2014, LeadingAge New York and The Hospice and Palliative Care Association of New York announced an affiliation agreement. The affiliation marks the companies’ efforts to increase service offerings to their patients. At no additional cost, members of each association will now be able to access the combined service offerings of both associations; these services include advocacy; educational programing; member rates for audios, events and conferences; data analytics; technical assistance related to state and federal legislative and regulatory issues; and competitive pricing on contracts through Value First, which is LeadingAge’s group purchasing organization. The associations also aim to co-develop an analytical tool that will allow hospice palliative care providers to benchmark themselves against others. Read more

NYC Department Health and Mental Hygiene and Technology Vendor Accused of Medicaid Fraud Scheme. On October 27, 2014, the *New York Times* reported that federal authorities have accused officials from the New York City Department of Health and Mental Hygiene of a five-year effort to defraud Medicaid by exploiting loopholes in the Medicaid computer billing system. The office of U.S. attorney Preet Bharara argues that city officials and their Medicaid billing system contractor, Computer Sciences Corporation, devised false diagnostic codes and other schemes to collect reimbursements for tens of

thousands of false claims between 2008 and 2012. The lawsuit follows a whistle-blowers complaint filed in 2012; the lawsuit demands triple damages and penalties, but does not specify how much it seeks in restitution. Read more

Phelps Memorial Hospital CEO Resigns. On October 27, 2014, the *River Journal* reported that Phelps Memorial Hospital CEO Keith F. Safian will resign effective November 30, 2014. Safian is credited with helping turn Phelps into one of the most profitable community hospitals in the Hudson Valley region over his 25-year tenure. His resignation comes as the hospital reaches an affiliation agreement with North Short LIJ-Health System. To ensure a smooth transition into the new affiliation, the Hospital Board has selected Daniel Blum, Senior VP since 2009, to succeed Safian as the next President. Read more

State Holds Conference for Capital Projects Funding Applicants. On October 24, 2014, *Crain's Healthpulse* reported that the state is making available $1.2 billion for capital restructuring. When CMS approved the state's Medicaid waiver that created the DSRIP program, it stated that none of the funding could go towards capital projects; but the state raised its own funds and is now holding a conference for applicants for that funding. The conference will take place on November 21 from 1PM to 4PM in Albany. The meeting will be webcast here.

Pennsylvania

HMA Roundup – Matt Roan (Email Matt)

Healthy PA Implementation to Coincide with the Termination of SelectPlan for Women. On October 24, 2014, the *Pittsburgh Post-Gazette* reported that as part of the roll-out of the Governor's alternative to Medicaid Expansion known as Healthy PA, the Corbett Administration has announced that it will be terminating a program that provides family planning services to low income women known as SelectPlan for Women. SelectPlan is a limited benefit Medicaid program that offers family planning, breast and cervical cancer screening and other women's health services to women between the ages of 18 and 44 with incomes less than 214 percent of FPL. Current Select Plan enrollees with incomes above 138 percent of FPL are already eligible for subsidized coverage through the health insurance marketplace that would cover these services. With the implementation of Healthy PA, women with incomes less than 138 percent of FPL will be eligible for coverage through the new Private Coverage Option or traditional Medicaid programs which also cover women's health services. Some women's health advocates are concerned that with the termination of Select Plan, enrollees will have to proactively apply for coverage under Healthy PA. The Department of Public Welfare has not announced any plans to automatically enroll SelectPlan members into Healthy PA coverage, but a Department spokesperson has said that the Administration is committed to ensuring that women will not experience a gap in coverage. Read more

Gubernatorial Candidate Tom Wolf Promises Welfare Changes. On October 25, 2014, the *Philadelphia Inquirer* reported that Democratic Gubernatorial Candidate Tom Wolf has announced planned changes to key welfare programs that have been cut during the first term of incumbent Governor Tom Corbett. With the General Election looming next week, Wolf announced that he plans to eliminate an asset test for the Supplemental Nutritional Assistance Program (SNAP) and to restore General Assistance cash benefits for poor and disabled

adults not eligible for federal cash assistance programs. Governor Corbett implemented the asset test for SNAP which bars non-elderly, non-disabled applicants with more than $5,500 in assets from collecting food stamps as a mechanism to fight fraud and abuse. Anti-Hunger advocates have contended that the number of SNAP recipients with that level of assets is very small, and that the state is spending more money administering the requirement than it is saving by not offering benefits. They also contend that the requirement has placed an undue burden on all applicants to the SNAP program. General Assistance cash benefits available to extremely poor adults and the disabled who do not qualify for Temporary Assistance for Needy Families (TANF) were also eliminated by Corbett. Wolf has announced that he plans to restore these benefits to improve the financial stability of these vulnerable populations. Wolf currently holds a double digit lead in the polls over the incumbent Governor Corbett. Read more

South Carolina

Medicaid to Offer Preventive Dental Benefits to Adults Starting December 1. On October 24, 2014, the *State* reported that South Carolina Medicaid will begin providing preventive dental benefits to nearly 300,000 adult beneficiaries starting on December 1. This is the first time preventive dental services will be covered for Medicaid adults in the state. Eligible beneficiaries will be able to get cleanings, fillings and extractions, with a $750 per year maximum benefit. The state Medicaid agency anticipates spending $35 million in 2015 and $40 million in 2016 to provide the benefit. The agency stated that they confirmed that dentists are willing to take on more patients before it launched the new benefit. Read more

Texas

HMA Roundup – Dianne Longley and Lisa Duchon (Email Dianne/Lisa)

Gubernatorial Candidates Divided on Medicaid Expansion in Texas. On October 28, 2014, *ABC/KSAT* reported that the upcoming gubernatorial election could determine whether Texas will expand its Medicaid program to cover more uninsured residents. Texas is one of 22 states that opted not to expand Medicaid under the ACA. Gubernatorial candidate Gary Abbott told *KSAT* that if elected, he would apply for a federal block grant to design a state-specific Medicaid expansion alternative for Texas. Candidate Wendy Davis supports expansion, citing that it will bring $100 billion in tax dollars into the state and generate 300,000 new jobs. Read more

Legislator Calls for Investigation of State Actuary's Falsified Work. On October 24, 2014, the *Austin American-Statesman* reported that State Rep. Richard Peña Raymond has asked the Office of Inspector General to review all Medicaid fraud cases handled by Brad Nelson, an actuary who recently admitted to falsifying data on at least one of the cases. Raymond is a member of the Sunset Commission, which earlier this month blamed the Office of Inspector General for mishandling the Medicaid cases and actuarial work (see the October 8 edition of the HMA Roundup for more). Human Services Commission spokeswoman Linda Edwards Gockel said that the agency is now reviewing 15 pending fraud investigations that Nelson had worked on, which may have been tainted with inaccuracies. Read more

HHSC Outlines Cost Containment Efforts. This month, the Texas Health and Human Services Commission (HHSC) released its Legislative Appropriations Request: Fiscal Years 2016-2017 and Consolidated Budget, Fiscal Years 2016-2017 (the Texas legislature only meets biennially). Within the consolidated budget, HHSC reported on 25 cost containment efforts for the current biennium, 2014-2015, noting that the agency has identified $438 million in General Revenue savings, or approximately 109 percent of the $400 million target that was set in what is referred to as HHSC Rider 51 of the 2014-2015 General Appropriations Act.

HHSC noted that significant reforms fall into these broad categories: managed care expansions, appropriate utilization of services, vendor drug program improvements, improved birth outcomes, quality-based payments, appropriate reimbursement, and reduction of fraud, waste and abuse. A sampling of some of the cost-containment initiatives that have met, exceeded or fallen short of targeted savings are listed below. Note that estimated cost reductions due to vendor drug improvements and improved birth outcomes, however, have yet to be determined; the targeted reduction amounts for these initiatives were $37.4 million and $45.2 million, respectively.

	Medicaid Cost-Containment Initiatives	Target ($M)	Current Estimate ($M)
Meet Cost-Containment Target	Implement payment reform and quality-based payment adjustments in fee-for-service and in managed care premiums	$25.90	$25.50
	Implement statewide monitoring of community care and home health through electronic visit verification in Medicaid fee-for-service and managed care	$27.10	$27.10
Exceed Cost-Containment Target	Continue to adjust outpatient Medicaid payments to a fee schedule that is a prospective payment system and that maximizes bundling of outpatient services, including hospital imaging rates	$48.40	$60.50
	Strengthen prior authorization requirements	$62.00	$117.40
	Increase fraud, waste, and abuse prevention and detection	$4.40	$14.00
Fall Short of Cost-Containment Target	Improve care coordination through a capitated managed care program for remaining fee-for-service populations	$16.50	$0.00
	Develop a more appropriate fee schedule for therapy services, requiring providers to submit the National Provider Identification (NPI) on each claim	$36.80	$24.20

HMA will continue to provide additional information in future *Weekly Roundup* issues on Medicaid budget developments in Texas.

Utah

Governor Herbert Strikes Deal with Feds on Healthy Utah Plan. On October 23, 2014, the *Salt Lake Tribune* reported that Governor Gary Herbert has reached a final agreement with the federal government on the Healthy Utah plan, his novel alternative to Medicaid expansion. The Healthy Utah Plan would help Utahns earning up to 138 percent of the federal poverty level who are not covered by Medicaid purchase private health insurance plans. The plan will bring $258 million in federal funds to the state. The governor expects to share details of the plan with legislators in mid-November, at which point there will be a 30-day public comment period. Read more

National

NAMD to Host Fall Conference in Washington, D.C Nov. 3-5. Link

MACPAC Holds Public Meeting in Washington, D.C. On October 30 and 31, 2014, the Medicaid and CHIP Payment and Access Commission (MACPAC) will hold a public meeting at the Ronald Reagan Building and International Trade Center in Washington, D.C. The morning session on October 30 will commence with a continued discussion about the future of CHIP, including a summary of recent analyses comparing cost sharing and benefits in CHIP to exchange coverage. The Commission will then review the finding of a September HHS Office of the Inspector General report on the CMS' oversight of managed care access standards. On October 31, the Commission will hear a summary of site visits to some of the states providing Medicaid long-term care services through managed care. The Commission will also review two HHS reports on efforts to improve quality of care for adults and children in Medicaid. A full agenda and meeting information is available here.

CMS Provides Extension of Higher Matching Funds. On October 29, 2014, the *CQ Healthbeat* reported that federal Medicaid officials will permanently pay 90 percent of the costs for technological upgrades to enrollment and eligibility systems. According to a letter from CMS on October 28 to the National Association of Medicaid Directors and the America Public Human Services Association, this funding was originally expected to drop to 50 percent of states' costs on January 1, 2016. CMS will also provide a three-year extension of a waiver option that allowed states to build integrated eligibility systems with human services programs, without having to make the human services programs cover part of the costs. These integrated systems can handle eligibility for Medicaid, as well as the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF).

States Ask Congress to Intervene on Drug Prices. On October 28, 2014, *AP*/the *St. Louis Post-Dispatch* reported that state Medicaid directors from the National Association of Medicaid Directors (NAMD) have urged action to address soaring prices for specialty drugs. In a letter to members of four Congressional committees, the NAMD members said that lawmakers should consider price controls on manufacturers or even federal assistance to states trying to pay for the new drugs. Without action, the Medicaid directors are concerned that state Medicaid programs will become financially insolvent or might have to further restrict access to certain medications. Read more

Insurers Limit Access to Pricey Hepatitis C Drugs. On October 28, 2014, *Kaiser Health News* reported that many Americans with hepatitis C are unable to access highly effective new treatments because they do not meet disease requirements set by insurers. Because of the high cost of the new drug regimens, which can cost upwards of $100,000 per patient, many public and private insurers have limited access to the treatments to patients with advanced liver disease. While patient advocates argue that granting access to the drugs represent an enormous public health opportunity, insurers reason that it is financially unsustainable to cover such expensive treatments for all infected individuals. Read more

States May Drop Pay Raises for Doctors. October 24, 2014, *Governing* reported that a federal initiative to increase Medicaid reimbursements to providers will likely cease in many states at the end of the year. The initiative, which began in January 2013, used $11 billion to boost reimbursements for primary care doctors and some specialists to Medicare levels in the hopes of encouraging doctors to take on Medicaid patients. The initiative ends in December, at which point states will have to use their own money to sustain the pay increases. While several states have indicated that they will continue pay increases (to at least some extent), others reported that they will likely drop the program, citing the lack of evidence that the program has in fact increased the number of participating doctors. Read more

INDUSTRY NEWS

Providence Service Corporation Completes Acquisition of Matrix Medical Network. On October 23, 2014, Providence Service Corporation announced that it has completed the acquisition of CCHN Group Holdings, Inc., an Arizona-based provider of in-home health assessment and care management services for a purchase price of $400 million, including $360 million in cash and $40 million in shares. Providence Service Corporation is a leader in human social services management, global employment services and non-emergency transportation. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
October 30, 2014	Texas STAR Kids	Proposals Due	175,000
October 31, 2014	Missouri	RFP Release	398,000
December 19, 2014	Missouri	Proposals Due	398,000
December, 2014	Georgia	RFP Release	1,250,000
January 1, 2015	Michigan Duals	Implementation	70,000
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
January 1, 2015	Texas Duals	Implementation	168,000
January 1, 2015	New York Duals	Implementation	178,000
January/February, 2015	Michigan	RFP Release	1,500,000
February 1, 2015	South Carolina Duals	Implementation	68,000
February 1, 2015	Louisiana	Implementation	900,000
March 2, 2015	Missouri	Contract Awards	398,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
July 1, 2015	Washington Duals	Implementation	48,500
July 1, 2015	Missouri	Implementation	398,000
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
January 1, 2016	Georgia	Implementation	1,250,000
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		9/1/2014	
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		62,714	Not pursuing Financial Alignment Model						
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	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	
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	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	168,000				5/23/2014	3/1/2015	4/1/2015	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	7/1/2015	9/1/2015 11/1/2015 1/1/2016	UnitedHealthcare
	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 5 MFFS**	**1.35M Capitated 513K FFS**	***12***			***11***			

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

HMA NEWS

HMA Upcoming Webinar: ***"A Healthcare Win for Veterans and States: Strategies for Enhancing Veterans' Benefits by Facilitating Access to the V.A. System"***

Wednesday, November 12, 2014
1:00 PM Eastern
Register Here

One state that has had tremendous success helping veterans take full advantage of their V.A. benefits is Washington. The state's Veterans Benefit Enhancement project is viewed as a model that could be expanded nationwide. Confirmed speakers Bill Allman, Veteran's Program Manager, Washington State Health Care Authority, and HMA's Doug Porter, Principal (Olympia, WA) will present on the following:

1. A case study of Washington's Veterans Benefit Enhancement project and the best practices that have made this initiative a success.
2. How other states have successfully helped veterans get the benefits they deserve through the V.A. and avoid the potential of financially crippling medical bills.
3. How prevalent it is for veterans and families to be eligible for V.A. benefits but not enrolled – and gain an understanding of the economic implications.
4. The type of outreach efforts that are most successful in helping veterans through the V.A. enrollment process.

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