HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 18, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

THIS WEEK

- IN FOCUS: TEXAS HEALTH PLANS CITE SAVINGS, QUALITY IMPROVEMENTS UNDER MANAGED CARE
- 16.4 MILLION INSURED SINCE ACA IMPLEMENTATION
- CALIFORNIA MEDICAID DRAFT WAIVER RENEWAL PROPOSAL RELEASED
- ALASKA GOVERNOR PROPOSES NEW MEDICAID EXPANSION BILL
- HIP 2.0 MEDICAID EXPANSION INCREASES NUMBER OF PROVIDERS
- DETAILS EMERGE RELATED TO VALUE BASED MEDICAID PAYMENTS IN NEW YORK
- OHIO GOVERNOR PROPOSES PREMIUMS FOR MEDICAID RECIPIENTS
- MAGELLAN TO ACQUIRE 4D PHARMACY MANAGEMENT SYSTEMS

IN FOCUS

TEXAS HEALTH PLANS CITE SAVINGS, QUALITY IMPROVEMENTS UNDER MANAGED CARE

This week, our *In Focus* section reviews two reports made available by the Texas Association of Health Plans (TAHP) that found improvements to access and quality of care as well as cost savings under the state's Medicaid managed care programs. The reports, prepared for TAHP by Milliman and Sellers Dorsey, focus on the STAR and STAR+PLUS programs, including pharmacy and dental benefit carve-ins. The STAR program is a traditional Medicaid managed care program focusing on the children and families populations, while STAR+PLUS provides managed care to the aged, blind & disabled (ABD) populations, including dual eligibles and individuals receiving long-term supports and services (LTSS). The reports found an estimated $3.8 billion in savings from FY 2010 through FY 2015, as compared to estimated fee-for-service costs, and double-digit percentage reductions in hospital admissions for a number of conditions, including asthma, diabetes, and GI infections.

Texas STAR and STAR+PLUS Cost Impact

Over state fiscal years (FY) 2010 through 2015, the STAR and STAR+PLUS programs are estimated to have saved $3.79 billion, or 7.9 percent versus estimated fee-for-service (FFS) costs for the same population and time period. **Table 1**, below, summarizes the estimated cost impact of STAR and STAR+PLUS from FY 2010 through FY 2015. The STAR program accounted for the bulk of savings, more than $2.1 billion, with the dental carve-in (occurred in FY 2012) accounting for more than $1.5 billion in savings. The STAR+PLUS program saw estimated savings of $327 million (10.8 percent) in pharmacy expenditures and $172 million (3.5 percent) in LTSS expenditures. However, savings in STAR+PLUS were offset by increases in estimated costs in acute non-inpatient services ($114 million, 3.7 percent) and acute inpatient services ($219 million, 16 percent). The cost impact reports that capitation rates for the inpatient acute services rose significantly for FY 2014 due to increased claims cost under FFS and in initial years of the carve-in. It cannot be determined if this increase would also have occurred in a continued FFS model.

Table 1 – MCO vs FFS Cost Impact, FY 2010 – FY 2015 ($M)

Program/Service	FY15 Avg. Members	FY10-FY15 Avg. Members	FY10-FY15 MCO Costs	FY10-FY15 Est. FFS Costs	FY10-FY15 Cost Impact	FY10-FY15 Impact %
STAR Programs Overall	**2,170,424**	**1,739,611**	**$28,091**	**$30,197**	**-$2,106**	**-7.0%**
STAR Pharmacy[1]	3,136,415	2,720,216	$3,757	$3,797	-$40	-1.1%
STAR Medical	2,170,424	1,739,611	$24,334	$26,400	-$2,066	-7.8%
STAR+PLUS Overall	**199,040**	**185,879**	**$12,198**	**$12,364**	**-$166**	**-1.3%**
STAR+PLUS Pharmacy[1]	193,214	186,370	$2,705	$3,032	-$327	-10.8%
STAR+PLUS LTSS	199,040	185,879	$4,705	$4,877	-$172	-3.5%
STAR+PLUS Acute (Non-IP)	96,711	89,222	$3,196	$3,082	$114	3.7%
STAR+PLUS Acute (IP)[1]	193,214	185,830	$1,592	$1,373	$219	16.0%
Medicaid Dental[1]	**2,844,287**	**2,862,926**	**$3,823**	**$5,342**	**-$1,519**	**-28.4%**
Total Cost Impact			**$44,112**	**$47,903**	**-$3,791**	**-7.9%**

Source: Milliman, February 17, 2015. [1]Benefits carved-in FY 2012.

As seen in Table 2 below, savings patterns versus FFS continue in trended projections for FY 2016 through FY 2018, with another $3.3 billion in estimated savings for the next three years, equal to an 8.7 percent reduction in costs. In the coming years, the report projects slightly less savings in the STAR program on a percentage basis, while STAR+PLUS savings are anticipated to grow, due to savings in the acute non-inpatient services category.

Table 2 – MCO vs FFS Cost Impact, FY 2016 – FY 2018, Projected ($M)

Program/Service	FY16-FY18 Avg. Members	FY16-FY18 MCO Costs	FY16-FY18 Est. FFS Costs	FY16-FY18 Cost Impact	FY16-FY18 Impact %
STAR Programs Overall	**2,593,729**	**$21,480**	**$22,937**	**-$1,457**	**-6.4%**
STAR Pharmacy[1]		$4,926	$4,978	-$52	-1.0%
STAR Medical		$16,554	$17,959	-$1,405	-7.8%
STAR+PLUS Overall	**210,709**	**$9,450**	**$9,831**	**-$381**	**-3.9%**
STAR+PLUS Pharmacy[1]		$3,028	$3,394	-$366	-10.8%
STAR+PLUS LTSS		$2,923	$3,031	-$108	-3.6%
STAR+PLUS Acute (Non-IP)		$1,729	$1,880	-$151	-8.0%
STAR+PLUS Acute (IP)[1]		$1,770	$1,526	$244	16.0%
Medicaid Dental[1]		**$3,723**	**$5,202**	**-$1,479**	**-28.4%**
Total Cost Impact		**$34,653**	**$37,970**	**-$3,317**	**-8.7%**

Source: Milliman, February 17, 2015. [1]Benefits carved-in FY 2012.

Access and Quality Improvements under Managed Care

A second report commissioned by TAHP found improvements in access to care and quality outcomes under the expansion of managed care. Highlights of these findings include:

- An average of 93 percent of child/adolescent members had a primary care provider (PCP), with 90 percent that visited their PCP in the past year.
- Performance expectations surpassed on well-child visits and immunizations.
- The wait list for home and community based services (HCBS) waivers reduced.
- Reductions in hospitalizations for the following conditions from 2009 to 2011:
    - Asthma – 22 percent reduction in hospitalizations
    - Diabetes – 26 percent decrease in short-term complication rates per 100,000 (31 percent in STAR+PLUS, 45 percent for STAR Health)
    - Gastroenteritis – 37 percent decrease in hospitalizations
    - Bacterial pneumonia – 19 percent decrease (STAR+PLUS).

Additionally, the report found a decrease in overall member complaints, even as enrollment in STAR and STAR+PLUS rose significantly. Looking ahead, the report provides the following recommendations for Medicaid managed care in Texas:

- Alignment of the regulatory environment and federal and state Medicaid policies to support key principles of managed care;
- Further service integration will reduce Medicaid costs and increase quality, especially when all services for an individual are managed under a single health plan;
- Collaborative and transparent rate-setting process between the MCOs and Texas Health and Human Services Commission (HHSC);
- Reductions in administrative complexity, wherever possible; and
- Allowing the MCOs the ability to continue to innovate, including paying for and providing services in different ways, including the use of broader cost savings to address particular populations like "superutilizers" or homeless individuals.

Links to TAHP Reports

Links to both the Milliman and Sellers Dorsey reports, as well as a TAHP overview of Medicaid managed care in Texas, are available here.

HMA Medicaid Roundup

Alaska

Gov. Walker Proposes New Medicaid Expansion Bill. On March 17, 2015, *KTUU* reported that after a subcommittee process removed expansion from his budget, Governor Bill Walker presented a formal Medicaid expansion bill. The bill would accept $146 million in federal funds and affect approximately 42,000 eligible Alaskans. Walker stated that the state could save $6 million to $8 million annually with expansion. Read More

House Rejects Medicaid Expansion. On March 12, 2015, *Fairbanks Daily News-Miner* reported that the House ruled against a budget amendment to expand Medicaid. The amendment would have accepted $145 million in federal funds. The House stated it wants to see expansion proposed in a bill rather than in the budget in order for it to receive a full legislative process. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

California Medicaid Draft Waiver Renewal Proposal Released. The California Department of Health Care Services released its long awaited draft Section 1115 Waiver proposal, named Medi-Cal 2020, for public comment on its web site. The waiver renewal would affect the California Medi-Cal program beginning October 1, 2015. One innovation is a proposed Federal/State Shared Savings formula to fund new Waiver initiatives using California's share of total savings totaling $15-20 billion. Read More

Study Shows Need to Re-Focus Safety Net. On March 12, 2015, *Health Access California* released a report showing the impacts of the ACA on safety-net programs. Some of the findings include:

- Counties continue to be dramatically different in how they care for the medically indigent.
- Forty-three counties serve residents at twice the federal poverty level; six counties have income limits below that; nine counties have income levels above that.
- Only ten counties provide services beyond emergency care to the undocumented.
- Counties with broad eligibility requirements are seeing strong continued need for their safety-net programs, with tens of thousands people enrolled in some counties.

- Counties with restrictive eligibility requirements, especially those that exclude the undocumented, are finding few if anyone left in their indigent care programs.
- While some counties adjusted benefits, most counties generally did not change eligibility for their programs in the last two years, opting for a "wait and see" approach. Read More

Medi-Cal Termination Data Unavailable. On March 16, 2015, *California Healthline* reported that DHCS could not provide the number and percentage of Medi-Cal renewals or terminations. State officials are currently handling a million renewals a month. Cathy Senderling-McDonald, deputy executive director for the County Welfare Directors Association of California, said the state is most likely pulling data for 2014 now. She stated that with so many moving pieces, it is more important to get good data than to see everything now. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

House, Senate Budget Disagreement over Federal Funding and Expansion. On March 15, 2015, *The Florida Times-Union* reported that the Senate is incorporating Medicaid expansion into its budget proposal. However, Florida House representatives have been blocking expansion for the last two years and instead hope to get $2 billion to continue funding the state's Low Income Pool program. Expansion would bring approximately $50 billion in the next 10 years. The House's top leaders stated they will not be considering the Senate's Medicaid expansion plan. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Nursing Home Rate Increases Back in Budget. On March 16, 2015, *WTOC* reported that Governor Nathan Deal added rate increases for nursing homes in his budget after they were previously stalled by the regulating agency a few months back. The House approved the $27 million increase. The Senate will issue its statement later this week. Read More

Indiana

House Approves Three Year Moratorium on Nursing Home Construction. On March 17, 2015, *Indianapolis Business Journal* reported that the House approved 52-40 a proposal for a moratorium on nursing home construction until June 2018. House Committee Chairman Tim Brown said thousands of unused nursing home beds are costing the state millions annually. According to an Indiana Family and Social Services Administration report, additional proposed nursing homes could increase Medicaid costs by $24 million each year. Furthermore, moratorium supporters say that there is a desire to shift from nursing homes to assisted living centers. Read More

HIP 2.0 Medicaid Expansion Increases Number of Providers and Physicians. On March 17, 2015, Indiana announced that the expansion of the Healthy

Indiana Plan and other Medicaid programs have led to a significant increase of primary-care physicians. The Indiana Health Coverage Programs provider network added 939 providers and 335 physicians since the waiver approval on January 27. Anthem increased its primary care providers by 11 percent, MDwise 26 percent, and Managed Health Services 20 percent. Indiana's expanded Medicaid program pays providers reimbursement rates similar to that of Medicare. Additionally, the state increased traditional Medicaid rates by 25 percent. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Health Connector May Reduce Plan Options By One Third. On March 12, 2015, *The Boston Globe* reported that the Massachusetts Health Connector had 126 different plan options in the most recent enrollment period. Senior Manager of External Affairs and Plan Management, Sarah Bushold, said the Connector plans to reduce this by a third by limiting the number of plans each insurer can offer to 14. There are currently 11 insurers on the exchange. Read More

Feds Object to Risk Adjustment Compromise Proposed Earlier This Month. On March 17, 2015, *The Boston Globe* reported that federal officials at CMS have objected to Massachusetts' proposed phase-in of risk adjustment payments for the state's insurers. The risk-adjustment payments could shift more than $100 million from smaller insurers to the state's largest health plan, Blue Cross Blue Shield of Massachusetts, due to their higher enrollment of sicker patients. State officials had proposed earlier this month to phase-in the risk adjustments, requiring only 50 percent of the payments to be made this year. Read More

Governor Baker Announces Two Health Connector Board Appointments. On March 12, 2015, *MassLive* reported that Governor Charlie Baker has announced appointments to fill two of the four vacant Health Connector board positions. Governor Baker has appointed Mark Gaunya, co-owner of an insurance brokerage company and past president of the Massachusetts Association of Health Underwriters, and Rina Vertes, the president of an actuarial consulting business and former CFO at Minuteman Health. The two seats filled are reserved under state law for an insurance broker and a health actuary. Read More

Missouri

Governor Nixon's Expansion Bill May Not Go Anywhere. On March 15, 2015, *St. Louis Public Radio* reported that lawmakers do not believe Governor Nixon's Medicaid Expansion bill will go anywhere. House Speaker John Diehl said the proposal reminds him of previous attempts made by the Governor. Diehl stated if the Governor was serious about it, he would create an actual plan, not just "press availability." Senate Majority Floor Leader Ron Richard also said if expansion was serious, the Senate would have started talking about it months ago. Read More

Missouri Medicaid Focuses on Consumer Wellness Incentives. On March 15, 2015, *St. Louis Post-Dispatch* reported that the Medicaid contracts awarded to Aetna, Centene, and WellCare this month focused on patient wellness incentives, which reward exercise, healthy eating, and regular doctor visits. This

was in response to Missouri's request for companies to participate in Medicaid Reform and Transformation and asked them to offer "incentives to members in order to promote responsible behavior and encourage efficient use of health care services." Read More

House Passes FY 2016 State Budget. On March 12, 2015, *St. Louis Public Radio* reported that the Missouri House has passed the Fiscal Year 2016 state budget plan. The 13 bills were passed three weeks early to immediately override any potential vetoes from Governor Jay Nixon rather than waiting for September's veto session. The health budget has a House recommendation of $1.256 billion and a Governor's amended recommendation of $1.249 billion. Read More

Governor Nixon to Propose Expansion Bill with Work Requirements. On March 12, 2015, *Kaiser Health News* reported that Governor Jay Nixon will support a Medicaid expansion proposal with work requirements, where Medicaid recipients would be required to work or pay more for coverage. The recipients will be referred to career centers to help them find work. The proposal would expand eligibility to cover an additional 300,000 people. State Republicans have resisted Medicaid expansion in fear of long term costs. Medicaid is already one of the state's largest expenditures, costing approximately $8 billion annually. Read More

Nebraska

Health and Human Services Committee Advances Medicaid Redesign Bill. On March 11, 2015, *KIOS* reported that Medicaid Redesign Act will progress to the floor for debate after the Health and Human Services Committee voted 5-2 on the bill. The bill is expected to face opposition from the governor and lawmakers. Three previous attempts to expand Medicaid in the state have failed. Read More

New Hampshire

Medicaid Expansion May End in 2016. On March 15, 2015, *New Hampshire Union Leader* reported that a House committee has voted to let Medicaid expansion expire at the end of 2016, removing it from Governor Maggie Hassan's budget proposal that expands it through 2017. Governor Hassan said she will continue to work with legislators to try to keep the program alive. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Budget Update. With the new fiscal year beginning on April 1, New York is in the throes of budget negotiations. Both the Democrat-controlled Assembly and the Republican-controlled Senate have passed their one-house budget bills, and they include several points of contention with the Executive proposed budget. Some of the areas of disagreement that are related to health care spending are:

- Implementation of a Basic Health Program, proposed by the Governor and supported by the Assembly, is opposed by the Senate due to uncertainty about funding for lawful immigrants over the long term.

The Senate budget does not include funding for the BHP and repeals the state's authority to establish the program.

- New regulation of retail health clinics and urgent care sites was proposed by the Governor. The Assembly accepted the proposals regarding urgent care but rejected the proposals regarding retail sites; the Senate did the opposite.
- Prescriber prevail rules, which were eliminated by the Governor due to concerns about inappropriate prescribing, were reinstated for Medicaid by the Assembly, and expanded to include all payors by the Senate.
- A number of pharmacy rebate and prior authorization changes proposed by the governor were rejected by both chambers of the legislature.
- An increase in managed care co-pays was included in the Governor's 30-day amendments due to a federal requirement that managed care co-pays be comparable to co-pays in the fee-for-service system. The Assembly rejected the increase; the Senate accepted it.
- The Governor proposed a surcharge on private health insurance plans as a way of generating funding to operate New York State of Health, the NY exchange marketplace. The Assembly amended the proposal to say that insurance plans could not shift the cost of the assessment to consumers; the Senate does not include any mechanism for funding the exchange.
- The Governor's budget includes a provision that would allow Performing Provider Systems under DSRIP to negotiate value-based payment arrangements with insurers, something that is required under the federal terms and conditions of the DSRIP waiver. Both the Assembly and the Senate rejected the provision.
- Private equity demonstration projects that would allow a limited number of pilots for private equity to invest in restructuring of hospitals were proposed by the Governor for the third year in a row. The Assembly rejected the proposal while the Senate increased the number of pilots from five to ten.

Behavioral Health Transition. As part of Care Management for All, New York is planning to carve all behavioral health services into the Medicaid managed care benefit. In addition, they are creating a new managed care product for individuals with serious mental illness and/or substance use disorder, called Health and Recovery Plans (HARPs). The carve-in is scheduled to begin in New York City in July 2015.

The Department of Health continues weekly phone conversations with CMS to finalize the special terms and conditions that will guide the carve-in of all behavioral health services into the Medicaid managed care benefit, as well as the implementation of HARPs. Rates have not yet been finalized. MAXIMUS, the NYS enrollment broker, will be distributing enrollment information to approximately 60,000 beneficiaries who have been identified as meeting HARP eligibility criteria, based on diagnosis and utilization history. They will be passively enrolled into the HARP operated by the Medicaid managed care plan in which they are currently enrolled, and offered the ability to opt out of enrollment.

As a HARP member, enrollees will be eligible for a number of HCBS services that are not offered within the mainstream plans. These services are intended to address the complexity of social service and recovery needs of individuals with serious mental illness. Payment for HCBS services will be outside the capitation rate for two years. In an effort to control utilization of HCBS services DoH has proposed imposing per person dollar caps on utilization of $7,500 or $15,000 per person, depending on individual beneficiary characteristics.

The state has posted a list of agencies that have been designated to provide HCBS to HARP beneficiaries, including contact information for the agencies, the counties where they provide services, and the HCBS services for which they have been approved (Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, Habilitation/Residential Support Services, Family Support and Training, Mobile Crisis Intervention, Short-term Crisis Respite, Intensive Crisis Respite, Pre-vocational Services, Transitional Employment, Intensive Supported Employment, Ongoing Supported Employment, Education Support Services, Empowerment Services - Peer Supports, and Non-Medical Transportation). The list can be found on the OMH website.

While the behavioral health transition for NYC has begun, the timetable for transitioning behavioral health for the rest of the state has not been finalized. The tentative time-frame would have a Request for Qualifications out before the end of this month, with submissions from health plans due mid-June and start-up in October.

Value Based Payment for NYS's Medicaid Program. As part of NY's DSRIP program the state must develop a plan for comprehensive payment reform, moving from fee-for-service to value-based purchasing. Payment reform is meant to ensure long-term sustainability of DSRIP investments. As part of the terms and conditions negotiated with CMS, NYS must submit a roadmap for comprehensive payment reform by April 1, 2015. This roadmap, which is being developed in concert with a large stakeholder group, is meant to describe how contracts with Medicaid managed care plans will be amended to achieve the DSRIP year 5 goal of 90 percent of payments from plans to providers being based on value-based payment methodologies.

The state released its third draft of the roadmap earlier in March. The draft can be found on the MRT website. The state is accepting public comment on the draft through March 30, 2015.

NYS does not foresee a single path towards payment reform. Rather, it aims to give managed care plans, DSRIP performing provider systems (PPSs) and providers a menu of options, allowing them to select those that fit their strategy, local context and ability to manage innovative payment models. Among the options described:

- Total care for the total population – a global capitation arrangement between a managed care plan and a PPS that includes all expenditures for all members attributed to that PPS.
- Integrated primary care – a contract between a managed care plan and a patient-centered medical home within the PPS to reimburse the PCMH based on the savings and quality outcomes they have achieved. This model focuses on savings due to reduced avoidable hospital use, particularly for conditions where well-managed primary care has been shown to reduce hospital use (i.e., behavioral health, diabetes, asthma).

- Episodic bundles of care – a contract between a managed care plan and a PPS or group of providers for patient-focused bundles of care (such as for maternity care, stroke or depression) that includes inpatient and outpatient care, diagnostic testing and treatment within a single payment. Bundled payments may also be considered for managing chronic conditions, with a full-year-of-care bundle that includes all condition-related costs.
- Total care for special needs populations – an approach for some specific high-cost populations whose comorbidity or disability require highly specific and costly care needs, for whom NYS has already developed a population-specific managed care approach and payment. This includes the multi-morbid disabled (the MLTC/FIDA-eligible population), those with serious behavioral health conditions (the HARP-eligible population), and those with developmental disability (the DISCO-eligible population).
- Fee-for-Service for preventive care – purely preventive activities such as immunizations and evidence-based health screenings will remain reimbursed on a fee-for-service basis to encourage their use.

Managed care plans and PPSs are free to create combinations of value-based payment arrangements. Plans can also contract directly with provider groups within a PPS using any of the strategies identified. Finally, plans and PPSs can identify various levels of risk assumption on the part of the PPS and/or provider, shifting to greater levels of assumed risk over time. Level 1 value based payments include upside shared savings, level 2 includes both upside and downside risk sharing, with both upside and downside shared risk being mediated by quality outcomes, and level 3 representing global capitation.

A statewide goal of 80-90% of total managed care plan-PPS/provider payments (in terms of total dollars) will have to be captured in at least Level 1 value based payments by the end of year 5.

The state recognizes that providers throughout the State are at varying levels of readiness to begin transitioning to value-based payments. As such, the State will evaluate progress into value-based payment in three distinct categories:

- Leading PPSs/Groups of Providers: These providers are ready, willing and able to enter into value-based payments arrangements, likely building upon current experience in value-based payments arrangements with payers.
- Learning Providers: These providers are willing to enter into value-based payments arrangements, but may require more time and additional technical assistance to be fully prepared to enter into agreements with payers.
- IAAF Providers: Providers who receive Interim Access Assurance Fund (IAAF) support will be allowed to undergo the required significant restructuring before value-based payments steps will need to be made.

Mental Health Parity. NYS Attorney General Eric Schneiderman announced a settlement with Rochester-based Excellus Health Plan, requiring the health insurer to cover residential treatment for behavioral health conditions and reform its procedures for evaluating behavioral health treatment claims. The settlement also requires Excellus to provide notice of a new appeal right to 3,300

members whose requests for inpatient substance use disorder rehabilitation and eating disorder residential treatment Excellus denied from 2011 through 2014. The estimated value of Excellus's denial of these individuals' requests is up to $9 million.

Excellus, which is part of the Blue Cross Blue Shield Association, has 1.5 million members and is upstate New York's largest health plan. An investigation by the AG found that Excellus denied inpatient substance use disorder rehabilitation recovery services seven times as often as inpatient medical services. The settlement with Excellus follows settlements with Cigna, MVP Health Care, and EmblemHealth and ValueOptions, the behavioral health vendor for MVP and Emblem, earlier this year.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Nursing Homes Could Receive $84 Million Increase in Medicaid Payments. On March 15, 2015, *The Columbus Dispatch* reported that Ohio nursing homes that meet five new quality measures could receive an $84 million increase in Medicaid payments under Governor John Kasich's plan. The five measures dealing with staffing levels; consistent assignment of nursing aides; rate of pressure ulcers among residents; rate of antipsychotic drug use among residents; and rate of avoidable hospital admissions would replace the current measures in place. However, nursing home advocates believe homes will end up losing money because of the unrealistic standards. Executive director of the Ohio Health Care Association Pete Van Runkle stated nursing homes will only be able to meet 10 percent to 15 percent of the new measures. Read More

Governor Kasich Proposes Premiums for Medicaid Recipients. On March 14, 2015, *Sandusky Register* reported that Governor John Kasich is proposing $20 premiums for some Medicaid recipients. Wendy Patton, Senior Projects Director for Policy Matters Ohio, stated that even modest fees can prevent people obtaining health care. However, a spokesman for the state's Medicaid program said the premiums would only affect a small portion of recipients – adults over 100 percent of the state poverty level. The proposal could save the state $1.6 million in 2016 and $3.2 million in 2017. Read More

Dual Doctors Fight Against Governor's Plan to Cut Rates. On March 13, 2015, *The Columbus Dispatch* reported that Governor John Kasich is planning to increase primary care doctor Medicaid rates by $156 million over the next two years by cutting the rates of doctors serving dual eligible patients and cutting funds for physician training. The Ohio State Medical Association is urging lawmakers to reject the budget plan as an estimated 183,000 dual members could be affected. Some House Representatives also worry that the plan will cut access to care. Read More

Ohio Submits HCBS Transition Plan to Federal Government. After months of work and statewide formal public comment period, Ohio has revised its HCBS Transition Plan. The Plan, submitted to CMS mid-March, reflects adjustments to the draft by adding clarity and adjusting the approach to specific settings. A copy of the submitted Plan can be found posted at the Office of Health Transformation website. Read More

Phasing Out Independent Home Care Providers. Under the Governor's proposed budget new independent providers would not be allowed to bill Medicaid for home care services beginning in July 2016, though those whose certifications have not expired would be allowed to continue until July 2019. The Ohio House subcommittee hearing the budget bill has heard testimony from both advocates and individuals who use independent providers. Read More

The Ohio Association of County Boards is seeking feedback – The Ohio Association of County Boards is seeking feedback from families, individuals and providers on the Governor's proposal to phase out independent providers by 2019. Specifically, they want to hear from individuals who receive services on a DD waiver and their families about why the initiative is good or bad for Ohio's developmental disability service delivery system. A link to their letter is available here. Read More

Pennsylvania

HMA Roundup – Matt McGeorge (Email Matt)

Attorney General Talks Medicaid Fraud at Budget Hearing. Attorney General Kathleen Kane submitted a $97.5 million budget request for her office to support increase in fraud investigation staff for Medicaid expansion oversight. The AG states that Medicaid fraud is out of control. Kane told lawmakers she needs a 5.7 percent budget increase to hire 18 fraud investigators to handle Medicaid expansion to as many as 600,000 people under the ACA. Read More

PA DHS Receives $12.88 Million Federal Grant to Support Families. Governor Wolf and the Department of Human Services announced that Pennsylvania received a $12.88 Million Federal Grant from the U.S. Department of Health and Human Services for Maternal, Infant, and Early Childhood Home Visiting (MIECHV). The grant, through the ACA, supports families by connecting parents to PCPs, dentists, insurers and increasing the number of children who are immunized. One program Pennsylvania will support is Healthy Families America which has demonstrated success in decreasing the number of low birth weight babies. Read More

Washington

Washington Exchange Needs Additional $125 Million Funding. On March 12, 2015, *Fox News* reported that the state is falling behind its goal of sign-ups by over 50,000. The exchange has enrolled 160,000 thus far. The deadline has been extended but the exchange needs an additional $125 million in funding from the state Legislature. Most of the money would be used for advertising. Read More

West Virginia

West Virginia Medicaid to Integrate Behavioral Health Into Managed Care By July 2015. West Virginia Medicaid is preparing to integrate specialty behavioral health services into managed care for non-disabled beneficiaries by July 2015. Currently specialty behavioral health services for all Medicaid beneficiaries are reimbursed on a fee-for-service basis. Read More

National

16.4 Million Insured Since ACA Implementation. On March 16, 2015, *Kaiser Health News* reported that since the Affordable Care Act was enacted five years ago, 16.4 million non-elderly people have gained coverage. Of these, 2.3 million were young adults aged 18 to 26. Since 2012, the number of uninsured has dropped to 13.2 percent from 20.3 percent. The largest drop was seen among Latinos – from 41.8 percent to 29.5 percent. Read More

Hospitals Hope to Weaken Readmission Penalty. The American Hospital Association and other hospital lobbyists are fighting to weaken readmission penalties, specifically for hospitals who serve many disadvantaged, low income patients. This population sees more intensive levels of care and higher rates of admissions. AHA is hoping to get a "doc fix" bill to replace a payment patch. Additionally, AHA and allies are trying to increase support for companion bills addressing readmission policy. They believe the penalties are unfair for rural hospitals. Senator Joe Manchin III proposed a bill to take into account patients' socioeconomic status when calculating readmission policies. The Medicare Payment Advisory Commission suggested using peer grouping to adjust penalties for such hospitals.

GOP Lawmakers in Non-Expansion States Would Possibly Support if Hospitals Pay Price. On March 17, 2015, *Governing* reported that in the majority of the 22 states who have not expanded Medicaid, governors and legislators are looking to hospitals and providers, the biggest proponents of expansion, to cover any of the costs associated with expanding Medicaid. Most of these remaining states are under Republican control. In 2013, Arizona agreed to a deal to expand Medicaid with hospitals picking up costs. Indiana also had hospitals partially fund expansion along with a cigarette tax revenue. However, disagreements over costs are making it difficult in other states. Although hospitals have seen a 30 percent drop in uninsured patients, they will face billions of dollars in cuts next year. Read More

Industry News

Summit Announces Partnership with Flexpoint Ford. On March 12, 2015, Summit Behavioral Healthcare, a Georgia-based provider of addiction treatment and behavioral health services, announced a partnership with Flexpoint Ford, a private equity firm dedicated to the financial services and healthcare sectors. Flexpoint currently manages $1 billion in committed capital. Through the partnership, Summit hopes to accelerate its growth in current and new markets in the United States. Read More

Magellan to Acquire 4D Pharmacy Management Systems. On March 18, 2015, Magellan Health, an Arizona based healthcare management company, announced that it entered into an agreement to acquire 4D Pharmacy Management Systems, a Michigan based full-service pharmacy benefit manager. The transaction has a base price of $55 million cash, with an additional $30 million based on future milestones. The deal is set to close second quarter of 2015. Read More

MaineHealth Issues $85,105,000 Series 2014 Bonds. On March 18, 2015, CainBrothers announced that MaineHealth issued $85,105,000 Series 2014 fixed rate revenue bonds "to finance an operating room expansion project, finance the construction and equipping of a new medical office building, refinance $42.76 million of outstanding debt and to finance swap termination payments associated with the refunded bonds." Maine will pay an approximate interest rate of 4.25 percent for an average life of over 21 years. 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 4, 2015	Georgia	Proposals Due	1,300,000
May 8, 2015	Iowa	Proposals Due	550,000
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

HMA to Co-Sponsor NQF Annual Conference

HMA is a co-sponsor of the 2015 National Quality Forum (NQF) Annual Conference, "Tackling Costs: The Quality Solution," taking place in Washington, DC, on March 23 and 24. For more information on the conference agenda and speakers: NQF Annual Conference 2015

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.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Olympia, Washington; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC. http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.