HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 15, 2015

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

THIS WEEK

IN FOCUS

KENTUCKY ISSUES MEDICAID MANAGED CARE REQUEST FOR PROPOSALS (RFP)

This week, our *In Focus* section reviews the Request for Proposals (RFP) issued by the Commonwealth of Kentucky's Cabinet for Health and Family Services (CHFS) to rebid the existing Medicaid managed care contracts set to expire on June 30, 2015. As of January 2015, more than 1.08 million Kentucky Medicaid members were enrolled in one of five managed care organizations (MCOs). The RFP incorporates a number of contractual changes to improve contract oversight and administration, including changes proposed by advocates and other stakeholders. Compared to similar RFPs in other states, however, the Kentucky RFP has several unusual features. First, the timeline for responses is very short, with proposals due on May 5, 2015, just over three weeks after the RFP release

date. Second, there are significantly different proposal requirements for incumbent versus non-incumbent bidders. Finally, little information is provided on how proposals will be scored, particularly in light of the differing requirements for incumbent and non-incumbent bidders.

Current Medicaid MCO Market Overview

Covered Population. Five MCOs currently provide services to nearly 1.1 million members across most eligibility categories, including the Medicaid expansion population, dual eligibles, aged, blind, and disabled (ABD), and foster care populations. Individuals excluded from MCO enrollment include those residing in a nursing facility for more than 30 days, certain Medicaid waiver consumers, individuals residing in an ICF/MR, and those receiving coverage through the Breast or Cervical Cancer Treatment Program. There are no proposed changes to MCO eligibility under the RFP.

MCO Market Share. As of January 2015, WellCare had the largest market share with more than 413,000 members representing 38 percent of total Kentucky MCO enrollees. Aetna had the second highest enrollment, at more than 291,000 members (26.8 percent). Passport Health Plan, the only local, non-publicly traded MCO, was the third largest plan overall, with close to 229,000 covered lives (21 percent). Humana and Anthem each served less than 100,000 members, with market shares of 8.9 percent and 5.2 percent, respectively.

	Region								All Regions	All Regions
Medicaid MCO	1	2	3	4	5	6	7	8	Total	Mkt. Share
WellCare	23,599	36,078	31,465	58,151	77,892	30,157	41,101	114,830	413,273	38.0%
Coventry (Aetna)	17,022	34,863	25,083	52,386	64,975	28,440	19,728	48,957	291,454	26.8%
Passport	3,693	5,852	175,498	10,499	14,754	5,170	3,818	9,312	228,596	21.0%
Humana	3,948	6,188	37,694	10,288	16,921	5,268	5,186	11,343	96,836	8.9%
Anthem	3,884	6,063	0	10,303	16,358	5,179	4,834	10,318	56,939	5.2%
Total MCO Enrollment	**52,146**	**89,044**	**269,740**	**141,627**	**190,900**	**74,214**	**74,667**	**194,760**	**1,087,098**	
Fee-For-Service (FFS)	6,510	10,724	26,272	18,528	19,583	7,026	8,462	21,802	118,907	
Total Medicaid	**58,656**	**99,768**	**296,012**	**160,155**	**210,483**	**81,240**	**83,129**	**216,562**	**1,206,005**	

Source: CHFS Enrollment Data, January 2015

Medicaid MCO Spending and PMPM Rates. Bidders must agree to accept the per member per month (PMPM) rates specified in Attachment H to the RFP. PMPM rates are included for all eligibility categories, age groupings, and regions and are presented both with and without the health insurance provider fee (HIPF) adjustment. Based on average PMPM rates described in the RFP, HMA estimates the total value of the RFP at more than $6 billion in annualized spending, assuming Medicaid enrollment growth continues in 2015, pushing MCO enrollment above 1.1 million average members.

RFP Requirements, Contract Awards, Timeline

The RFP requires incumbent health plans to respond only to Part A, which requires a transmittal letter, disclosure of any violations, and any required affidavits. Incumbent bidders must also agree to the revised MCO contract (detailed below) and submit the completed contract signature page.

Non-incumbent bidders must respond to the Part A requirements but also prepare a proposal for Part B that requires information on the bidder's organization, experience in serving Medicaid managed care populations, administration and staffing, regulatory compliance, vendor references, and financial plan, including a five-year financial pro forma and a narrative financial plan.

The RFP does not specify the number of contract awards CHFS intends to make. All bidders will be scored on their responsiveness to Part A, while non-incumbent bidders will be evaluated on a pass/fail basis with regard to Part B. There is no additional detail on the scoring of proposals available at this time. The RFP also does not specify how many plans are eligible for contract awards.

As indicated on the RFP timeline below, bidder questions are due by 12:00 noon ET on April 17th, with responses to be posted the following Friday, April 24th. Proposals are due to CHFS on May 5, 2015, with an anticipated implementation date of July 1, 2015. The initial contract term is for one year, expiring June 30, 2016, with four optional one-year extensions, taking the potential life of the contract through June of 2020.

RFP Event	Date
RFP Released	Friday, April 10, 2015
Bidder Questions Due (12:00 ET)	Friday, April 17, 2015
Question Responses Posted	Friday, April 24, 2015
Proposals Due	Tuesday, May 05, 2015
Anticipated Implementation Date	Wednesday, July 01, 2015

Changes to MCO Contracts

According to CHFS Secretary Audrey Tayse Haynes, the RFP modifies and standardizes the Medicaid MCO contracts to "appropriately address concerns expressed by advocates and healthcare providers". A summary of the changes follows.

Standardization of contracts for all MCOs and requiring all contracts to be statewide. Currently four of the five MCOs serve all eight regions of the state, with Anthem the only plan not serving Region 3, which was bid and implemented separately in 2013.

Establishment of target medical loss ratios (MLRs) for both the Medicaid expansion (ACA) and non-expansion (non-ACA) populations, as follows:

- The target MLR for the ACA population will be set at 87 percent. Actual MLRs more than 5 percent above or below the target MLR will be subject to risk corridor adjustments. For MLRs below 82 percent, the MCO will refund 80 percent of the difference between the actual and target MLR. For MLRs above 92 percent, the state will make an adjustment payment to the MCO equal to 80 percent of difference between actual and target MLR.
- The target MLR for the non-ACA population will be set at 85 percent. For actual MLRs below 85 percent, MCOs will refund 80 percent of the difference between target and actual MLR. There is no adjustment for actual MLRs above the target. Beginning January 1, 2017, upon the expiration of 100 percent federal funds for the Medicaid expansion, the ACA population will be included in the 85 percent target MLR calculation and adjustments.

Health outcomes incentive pools will be established based on HEDIS measures. Initially, 1 percent of capitation rates will be withheld, to be earned back for meeting established HEDIS score outcomes. In each subsequent year, the withhold amount will be increased by 0.25 percent, with an overall cap on withholding at 2 percent.

Additional contract changes outlined in the RFP include:

- Changes to the medical necessity determination process, including adoption of national standards on what constitutes medical necessity
- Expanded performance requirements regarding the pharmacy benefit
- Adoption of common forms to initiate prior-authorization and grievance and appeals processes applicable to all MCOs (begins January 1, 2016)
- Adoption of a common form to file claims
- Requirement for provider credentialing to follow National Committee for Quality Assurance (NCQA) standards
- Requirement for insurer assessments if applicable
- New minimum provider access standards for behavioral health services
- Requirement to develop alternatives to non-emergent emergency room utilization
- Requirement for on-line provider network updates within 10 days of a change
- Recognition of persons with Severe Mental Illness (SMI) as persons with special needs
- Increased penalties for non-conformance with Contract requirements.

Link to RFP Documents

The RFP documents are available through Kentucky's Vendor Self Service System (Linked here). The RFP number is 1500000283.

HMA Medicaid Roundup

Alaska

Gov. Walker Urges Expansion as Legislators Try to Cut Costs of Current Medicaid Program. On April 13, 2015, *Alaska Dispatch News* reported that Governor Bill Walker may veto a bill that would reduce spending in the state's Medicaid program without expanding it. While Republican lawmakers object to expanding the program, Governor Walker's administration is asserting that expansion will save the state millions of dollars. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

California Bills Address State's Mental Health System. On April 13, 2015, *Los Angeles Times* reported that lawmakers are trying to address the inconsistency of policies and approaches in the state's involuntary treatment system through the following bills:

- AB 59: Would streamline process for implementing Laura's Law, which allows for court-ordered outpatient treatment for people with severe mental illness
- AB 1193: Would require counties to implement Laura's Law unless county supervisors vote to opt out and extend the current January 2017 sunset date of Laura's Law to 2022
- AB 1194: Would require authorities to consider a person's history in deciding whether to take them onto custody on a forced 72-hour psychiatric hold
- AB 1300: Would make changes to standardize the 72-hour hold process and ease the transfer of psychiatric patients. Read More

LA County Officials Propose Over $100 Million For Jail Reform. On April 13th, *Los Angeles Times* reported that Los Angeles administrators released a $26.9 billion budget for the fiscal year beginning July 1, 2015. Officials plan to spend over $100 million on jail reform, including reducing abuse, improving treatment of mentally ill inmates, and diverting others with mental health issues from going to jail. A total of $75 million was allocated for jail change and $45.3 million for change in the jail mental health system. The budget also adds an extra $10 million to diversion programs for mentally ill defendants. Read More

Covered California Proposes Cap on Specialty Prescription Drug Costs for 2016. On April 14, 2015, *California Healthline* reported that officials are proposing

a specialty prescription cost cap for consumers purchasing 2016 plans. The proposal will prevent consumers from paying over $500 per prescription; silver plans will have a cap at $200, platinum at $300, bronze at $500, and gold at $500. The Board of Directors will vote later this week. Read More

Fresno County to Provide Specialty Medical Care for Undocumented Immigrants. On April 7, 2015, *The Fresno Bee* reported that Fresno County Supervisors voted to provide specialty medical care for undocumented immigrants and the poor. By deferring repayment of road funds, $5.6 million made available for specialty health care. The county has been negotiating the plan with the Community Regional Medical Center and specialty providers for over 18 months. Read More

Connecticut

Lawmakers Consider Changes to Medicaid Audits. On April 14, 2015, *The CT Mirror* reported that, as a result of provider complaints regarding Medicaid audits which they say penalize providers for honest errors with financial costs dramatically higher than the size of the error, legislators are considering making changes. The Human Services Committee passed a bill that would change the rules for audits, restricting the way DSS can calculate projected overpayments in cases of clerical errors and limiting the amount of money the department can seek for these errors. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Uncertainty Continues around LIP Funding Negotiations with CMS, Medicaid Expansion. On April 15, 2015, *Health News Florida* reported that a letter from CMS to Florida officials on April 14 suggested a link between approval of a new LIP funding model and the state's decision to expand Medicaid. The Florida Senate has proposed a revised LIP model. Approval of a redesigned LIP program appears to have stalled in recent weeks. The Senate also contends that LIP and Medicaid expansion, through an alternative private insurance model (FHIX), are linked, while the House has rejected this claim. Uncertainty on LIP funding and the Medicaid expansion could hamper any likelihood of the House and Senate resolving a budget before the May 1, 2015 deadline. Meanwhile, on April 15, 2015, Florida's Medicaid Director, Justin Senior, sent a letter in response to CMS indicating that they would file a formal amendment to the 1115 waiver that will renew LIP for two years and address other concerns. Read More

House Speaker Predicts Need for Special Session, Senate President Looks to Resolve on Time. On April 15, 2015, the *Orlando Sentinel* reported that House Speaker Steve Crisafulli indicated it is likely the House and Senate will require a special session to resolve the budget, with disagreement on Medicaid expansion and the LIP program looming large in the resolution process. Read More. Meanwhile, the *Miami Herald* reported that Senate President Andy Gardiner had a conversation with Rick Scott and indicated a desire to resolve the budget on time, with a package of tax cuts "on the shelf." Read More

Senate Panel Confirms Secretary Dudek. On April 15, 2015, the *Miami Herald* reported that the Senate Ethics and Elections Committee voted 8-1 to approve

Agency for Health Care Administration Secretary Elizabeth Dudek to remain in her position. However, the vote was preceded by more than an hour of reportedly tough questioning around resolution of the health care budget, including CMS negotiations on LIP and the Medicaid expansion. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia DCH Announces ABD Managed Care Plans on Hold. On April 14, 2015, Georgia Health News reported that Georgia's Department of Community Health (DCH) has announced that it will not proceed at this time with a plan to procure Medicaid managed care organizations to serve the state's elderly and disabled Medicaid population (ABD). According to the report, the decision was made after the General Assembly removed $12 million in state funding for the program from Governor Deal's FY 2016 budget. The state previously issued a RFP for the ABD population, but cancelled it due to bids coming in over budget. There are an estimated 450,000 ABD Medicaid beneficiaries in Georgia. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Governor's Proposed Mental Health Cuts Criticized. On April 10, 2015, the *Chicago Tribune/Kaiser Health News* reported on claims from critics that Governor Bruce Rauner's proposed cuts to mental health services could end up costing the state significantly more. Governor Rauner's budget would cut around $82 million from the Department of Human Services' Division of Mental Health (a 15 percent overall cut), with an estimated $54.4 million in discontinued services and $27.6 million in reduced services. Critics of the plan argue that cuts to community-based and other programs will result in increased costs in hospitalizations and inpatient mental health care. A study conducted by Thresholds, a provider of health care, housing, and other resources to individuals with mental illnesses, found that cuts to mental health services in Illinois from 2009 through 2012 drove a 19 percent increase in psychiatric and substance-abuse hospitalizations and around $18 million more in spending than would have occurred in community-based programs. Read More

Smaller Chicago-Area Hospitals Warn of Closures under Governor's Budget. On April 13, 2015, the *Chicago Sun Times* reported that a group of Chicago-area hospitals outlined the potential impact of Governor Bruce Rauner's proposed budget to legislators. Under the Governor's budget proposal, hospitals would see an approximately $800 million annual impact to reimbursement and other funding streams. Leaders from several Safety Net hospitals (those with more than 50 percent of their patients on Medicaid) warned legislators that if these cuts were to be implemented, many smaller hospitals would likely be forced to close. Read More

Illinois Medicaid Advisory Committee to Meet Friday, April 17. The Illinois Medicaid Advisory Committee (MAC) will meet on Friday, April 17, in both Chicago and Springfield at 10:00 AM Central Time. The posted meeting agenda includes discussion of legislative and budget updates, as well as new committee

appointments. HMA will provide a summary of the MAC meeting in next week's *Weekly Roundup*. Read More

Iowa

Iowa to Release Amended RFP, Provide Deadline Extension. In a notice dated April 15, 2015, the Iowa Department of Human Services announced that it will soon be publishing updates to the statewide Medicaid managed care RFP, including an updated rate data book, capitation rates, and a second amendment to the RFP. Additionally, the notice indicates that a short extension to the submission timeframe will be provided. The current deadline for proposals is May 8, 2015.

Michigan

Henry Ford Health System Reports Positive Margin for 2014. On April 14, 2015, *Modern Healthcare* reported that Detroit-area Henry Ford Health System reported a positive margin of 0.6 percent for 2014, after a negative margin of -0.3 percent in 2013. The system cited a decrease in inpatient admissions, while increasing ambulatory and other lines of business, as a driver of the financial turnaround. Meanwhile, the health plan owned by Henry Ford, Health Alliance Plan, saw a net loss of more than $1.6 million. Health Alliance Plan offers Exchange and non-Exchange commercial plans, as well as operates in the state's Medicaid managed care program. Read More

Montana

Legislature Backs Medicaid Expansion. On April 11, 2015, *Politico* reported that the Montana Legislature passed a Medicaid expansion by a final vote of 54-42 marking the first occasion this year where a Republican-dominated legislature is agreeing to expand coverage under the health care law. Read More

Nebraska

Legislature Defeats Third Attempt at Medicaid Expansion. On April 8, 2015, *The State* reported that Nebraska lawmakers voted down a Medicaid expansion by a vote of 28-16, delaying it for the rest of the year. This was the third expansion bill to be proposed in the state. The Governor said expansion would be an expensive burden for the state. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

The Division of Medical Assistance and Health Services (DMAHS) held a quarterly meeting of the Medical Assistance Advisory Council (MAAC) on April 13, 2015. The following updates and presentations were presented.

Annual Transportation Study Results. The DMAHS, Office of Customer Service presented the results from an annual review of its transportation contract with LogistiCare to the Medical Assistance Advisory Council (MAAC). The annual review was conducted by IPRO, an external quality review

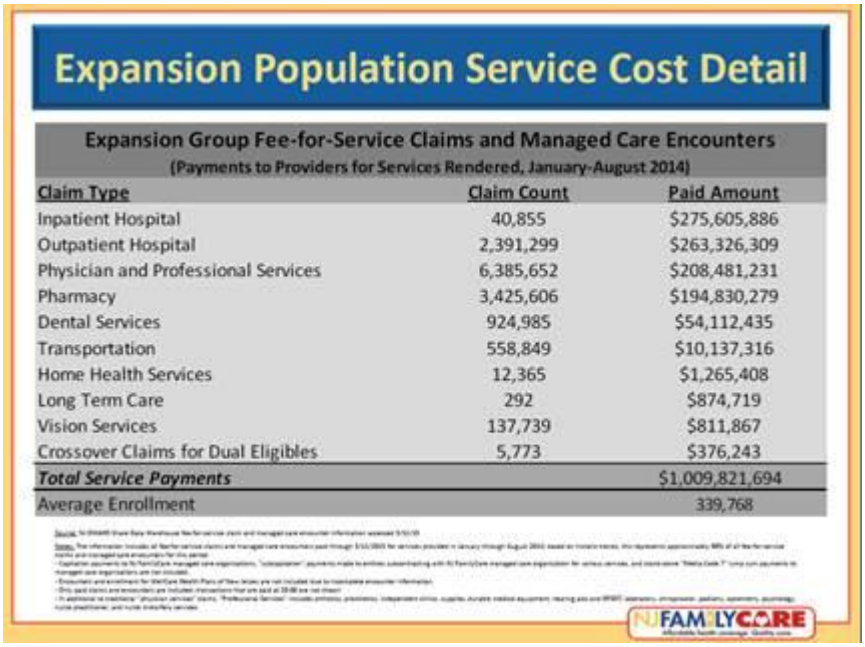
organization. The study included a review of utilization, satisfaction and trip performance between July 2012 and June 2013. Over 4.5 million trips were conducted in the study year of which about 55 percent were attributed to livery services. Ninety percent of riders expressed satisfaction with their pick-up times. Close to 100 percent of riders believed their driver drove safely and treated them with courtesy and respect. Other findings are available in a Power Point presentation on the DMAHS website beginning on slide 17.

Supports Program Update. Elizabeth Shea, Assistant Commissioner of the NJ Division of Developmental Disabilities (DDD) provided an update on the Supports Program, a Medicaid waiver program through which adults with intellectual and developmental disabilities who live in a non-licensed setting can access Division-funded services. This is a major DDD initiative under the 1115 Comprehensive Medicaid Waiver and in its second phase of implementation. The update included the following highlights:

- DDD launched a New Jersey Comprehensive Assessment Tool in November 2014.
- A Standardized Service Plan called the Individualized Service Plan is being rolled out.
- Over 50 agencies have been trained to provide care management services. Individuals can select their care managers from this pool of provider agencies.
- Final standardized fee-for-service reimbursement rates will be introduced on July 1, 2015.
- DDD began a certification process for day habilitation providers.
- DDD is working with DMAHS on substantive amendments to the standard terms and conditions of the waiver to add two new eligibility categories that will give more individuals access to the Supports Program.

Additional information about the Supports Program may be found on the DDD web site.

NJ FamilyCare Expansion Enrollment Update. DMAHS Director, Valerie Harr, reported that New Jersey Medicaid experienced an increase of over 420,000 enrollees as of March 2015, a 32.7 percent increase since December 2013, bringing the state's total Medicaid enrollment to over 1.7 million beneficiaries. This enrollment represents 19 percent of the state's population. Ninety-two percent of all Medicaid enrollees are enrolled in a managed care organization. DMAHS examined claims records for the new expansion eligibility group between January and August 2014 and determined that these individuals are accessing benefits. Service cost detail is presented below.



Expansion Population Service Cost Detail

Expansion Group Fee-for-Service Claims and Managed Care Encounters
(Payments to Providers for Services Rendered, January-August 2014)

Claim Type	Claim Count	Paid Amount
Inpatient Hospital	40,855	$275,605,886
Outpatient Hospital	2,391,299	$263,326,309
Physician and Professional Services	6,385,652	$208,481,231
Pharmacy	3,425,606	$194,830,279
Dental Services	924,985	$54,112,435
Transportation	558,849	$10,137,316
Home Health Services	12,365	$1,265,408
Long Term Care	292	$874,719
Vision Services	137,739	$811,867
Crossover Claims for Dual Eligibles	5,773	$376,243
Total Service Payments		$1,009,821,694
Average Enrollment		339,768

NJFAMILYCARE

Most of New Jersey's County Welfare Agencies experienced backlogs in processing expansion enrollment applications with between 9,000 and 12,000 applications delayed more than 45 days. DMAHS has extended its contract with Xerox, the state's enrollment broker, to process backlogged applications and expects to clear the backlog by the end of May 2015. Details about the Expansion update are available in the MAAC meeting Power Point presentation beginning on slide 49.

Medicaid ACO Program Update. Director Harr reported that DMAHS reviewed Medicaid ACO application submissions and sent requests for additional information to the ACO applicants in December 2014. The ACOs responded to the questions in February 2015, and DMAHS replied with a few more questions, with particular interest in the ACOs' physician participation estimates. DMAHS is collaborating with the New Jersey Health Care Quality Institute (NJHCQI) to resolve the questions about ACO provider network sufficiency. DMAHS expects to certify the ACOs within the next few weeks with a full launch of the Medicaid ACO demonstration by summer 2015.

DMAHS announces plans to contract with an Interim Managing Entity (IME) to manage addiction services. Roxanne Kennedy, the DMAHS contact for Managed Behavioral Health, provided an update on the state's interim steps towards the management of mental health and addiction services to improve access to substance use care. IME managed services will be provided by agencies that are licensed by the Department of Human Services, contracted with the Division of Mental Health and Addiction Services (DMHAS), and enrolled as Medicaid providers in NJFamilyCare.

DHS will contract with Rutgers University Behavioral Health Care (UBHC) to manage state, block grant and NJ FamilyCare IME services beginning July 1, 2015 under a fee-for service arrangement. UBHC was selected due to its experience as a state clinical academic entity, years of experience managing care, sophisticated technology infrastructure, knowledge of state resources, and ease of procurement with another state entity. UBHC will handle addiction service authorizations and the state will continue to handle provider reimbursements

through its fiscal agent. In January 2016 the state will add the Community Support Services program for mental health services to those services to be authorized by UBHC. A breakdown of IME service management is below:

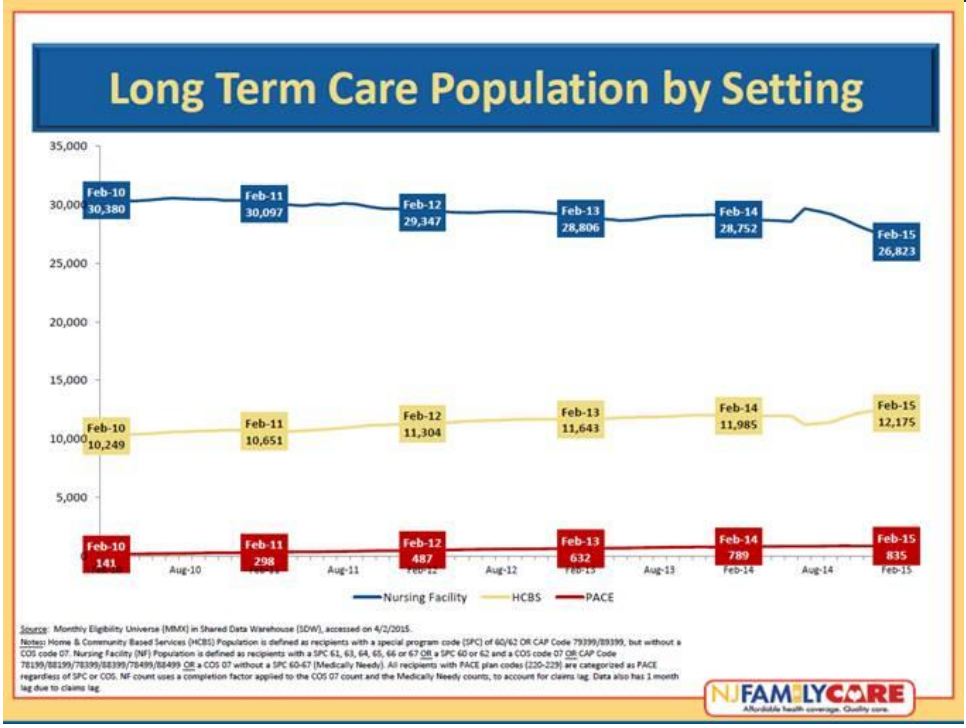
Scope- Covered Initiatives

MANAGED BY THE IME	NOT MANAGED BY THE IME
NJ FamilyCare (Medicaid)	Child Welfare/Department of Children and Families programs
Driving Under the Influence (DUII)	County funds
Medication Assisted Treatment Initiative (MATI)	Department of Corrections Mutual Agreement Program (DOC-MAP)
South Jersey Initiative (SJI)	Drug Court/Administrative Office of the Courts
Substance Abuse Prevention and Treatment Block Grant	Prevention services
	Recovery and Rebuilding Initiative (RRI)
	Screening, Brief Intervention, Referral to Treatment (SBIRT)
	State Parole Board Mutual Agreement Program (SPB- MAP)
	Substance Abuse Initiative (SAI)/Division of Family Development

Source: NJ Division of Mental Health and Addiction Services, Behavioral Health Providers meeting, March 2015

An Addictions Professional Advisory Committee is in place to provide input to the UBHC arrangement. Ms. Kennedy indicated that DMAHS continues to develop the RFP for an Administrative Services Organization (ASO) contract for the management of behavioral health services and that the IME arrangement is a first step in that direction. Read more.

Managed Long Term Services and Supports Update. Lowell Arye, DHS Deputy Commissioner provided the MAAC with an update about the MLTSS implementation, which began in July 2014. Close to 40,000 individuals on Medicaid are currently receiving long term care of which about 35 percent are in MLTSS, and the remaining receive their long term care benefits through Medicaid fee-for-service. The non-MLTSS group are primarily individuals who were residing in a nursing facility or enrolled in a PACE program at the time of the implementation and were excluded from the mandatory MLTSS transition. The state experienced an overall decrease in its nursing facility population of 1,500 since June 2014. Currently 32.7 percent of MLTSS enrollees use home and community based services (HCBS).



HCBS services now represent 46 percent of the state's spending on long term services and supports, an increase of about 7.5 percent from December 2013. This increase represents an improvement in the state's efforts to shift the balance of long term care services from institutional to home and community based settings. Read more, beginning on slide 62.

New York

HMA Roundup – Denise Soffel (Email Denise)

Behavioral Health Carve-In Delayed Again. While the timeline posted on the Department of Health website have not yet been revised, representatives from the Office of Mental Health confirmed that the behavioral health carve-in will again be delayed. At a meeting hosted by New York Association of Psychiatric Rehabilitation Services, state officials indicated that CMS has not yet approved rates, and so the timeline for implementation has been pushed back. The start date for behavioral health being carved into the managed care benefit, and the start-up of the Health and Recovery Plan (HARP) product in NYC, currently scheduled for July 1, 2015, will be delayed slightly, with the actual start date yet to be determined. The start date for the rest of the state will be no earlier than April 2016. At a recent meeting of the Medicaid Redesign Team Behavioral Health Work Group the state had indicated that the RFQ to qualify Medicaid managed care plans for plans outside NYC was to be released imminently, with a rest-of-state start date of October, 2015. That time frame has been pushed out an additional six months. This delay will allow more time for OMH, OASAS, and DOH to prepare managed care organizations, finalize terms and conditions with CMS, and educate providers and consumers about the change in service delivery and access. OMH went on to say that implementation of managed behavioral healthcare for children, currently slated for January 2016, will not begin until 2017. The official start date will be announced as the state finalizes development of that process.

North Carolina

Federal Regulators Give Preliminary Certification of Medicaid Payment System. On April 13, 2015, *Winston-Salem Journal* reported that the state's controversial Medicaid claim payment system, NCTracks, was given preliminary certification approval by federal health regulators. NCTracks was launched in July 2013 and cost $484 million. It handles roughly 97,000 providers statewide. Back in 2013, an audit found that DHHS officials failed to fully test the system prior to implementation. Since then, the system has had a history of inefficiencies, including struggling to provide timely reimbursements. Providers have complained about slow payments, denied claims, and poor customer service. Read More

State Audit Finds Medicaid Program Accumulated $350 Million in Liabilities. On April 13, 2015, *The News & Observer* reported that a North Carolina audit of the Medicaid program found $350 million in accumulated liabilities, as of June 30, 2014. The audit comes as legislators negotiate the future of Medicaid. The state's program has an annual budget of $14 billion, 65 percent of which is paid by the federal government. Read More

Northwest Community Care And Partnership Community Care Forming an Alliance. On April 9, 2015, *Winston-Salem Journal* reported that Northwest and Partnership, two affiliates of the Community Care network, are forming an alliance effective July 1. The alliance will affect 10 counties in North Carolina. Northwest and Partnership will continue to operate independently but will have a strategic management team and a new governance authority. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

House Revisions to the Proposed Budget Would Strip the Ability of the State's Medicaid Director to Determine Eligibility. The Ohio House has finished reviewing the budget introduced by Governor John Kasich in early February. The predominately GOP House now has its own plan for how to move forward in the upcoming biennium. The House Finance Chairman indicated the revisions cut about $775 million from the Governor's version. Highlights of changes include removing authority for the State Medicaid Director to determine eligibility, instead requiring legislative approval to make changes. It also directs the Department of Medicaid to request permission from federal authorities to allow Ohio to implement Health Savings Accounts. The House bill does not make changes to the State's existing Medicaid expansion. It does remove many of the Governor's tax provisions. His proposals drew broad concern from business groups and state representatives. They disliked the proposed increases on business taxes, oil and gas severance taxes and cigarette taxes along with his sales tax increase. The House version removes major tax changes and creates a commission to review proposed increases. The House would also separate into another bill Kasich's proposal to create a more comprehensive approach to public assistance, like food stamps, childcare support, and housing and cash assistance.

Ohio to Adopt New Network Transparency Standards. A recent article in the Columbus Dispatch reports that Lt Gov. Mary Taylor, who heads the State's Department of Insurance, has signaled that her Department will be issuing

regulations that require insurance directories to include up to date information about providers and require that documents complying with the new regulations be provided upon request. Read More

Governor Kasich Says Expansion Will Continue Into Second Year. On April 10, 2015, *The Blade* reported that Governor Kasich stated that he believes authority for the Medicaid expansion will continue into the next year without the need to resort to a budgetary panel. Some lawmakers, however, do not believe the final budget will include it. Instead, they believe the expansion will be moved into a separate bill for debate. Kasich said he would allow a floor vote on expansion, confident it would still pass. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Move to Traditional Medicaid Expansion on Track in Pennsylvania. The Pennsylvania Health Law Project has issued their March 2015 newsletter focused on Medicaid, including a Medicaid Enrollment Update. Governor Wolf's aggressive timeframe for ending his predecessor's alternative expansion (Healthy PA) and launching a traditional Medicaid expansion appears to be on track and will officially begin April 27th. As a reminder, the transition will be done in phases and will (1) undo the Healthy PA benefit package reforms (Healthy/low risk; Healthy Plus/high risk; and Private Coverage Option) and instead enact a single benefit package for adult recipients, and (2) gradually wind down the "Private Coverage Option" managed care system. Read More

Jen Burnett leaving CMS to Join Wolf Administration as Deputy Secretary of Long Term Living. After four years at the Disabled and Elderly Health Programs Group (DEHPG) at CMS, Jen Burnett is leaving to accept an opportunity with Governor Wolf's administration in Pennsylvania, where she has been appointed to be the Deputy Secretary of Long Term Living in the Department of Human Services. Burnett previously worked in the Pennsylvania DHS under the Governor Rendell Administration.

Despite Many Addiction Treatment Specialists, State Faces Rising Demand. The ACA's extension of insurance to more people — and its mandate that all plans cover treatment for drug and alcohol addiction, as well as the expansion of Medicaid in many states — is dramatically increasing the number of people able to afford medical treatment for their drug or alcohol addiction. The number of specialists available to treat patients in Pennsylvania, however, has not kept pace. With 56 treatment specialists for every 1,000 people suffering from addiction, Pennsylvania ranks fourth in the nation but still struggles to meet the demand for treatment. A challenge not evident in Pennsylvania's high ranking is that private practices often do not accept Medicaid, leaving the burden of the increased workload on practices that do. According to Jeff Zornitsky, director of strategic initiatives with health care consulting firm Advocates for Human Potential, Inc. "While there's a lot of attention given to shortages and labor force adequacy in the medical professions, there is very, very little attention given to behavioral health." Read More

PA Health Information Exchange Grants $11.8 Million to HIOs. On April 13, the Pennsylvania eHealth Partnership Authority announced the availability of $11.8 million for connecting hospitals and ambulatory practices to the Authority's Pennsylvania Patient & Provider Network (P3N), which is

essentially the state's health information exchange. These funds were provided through a grant from the Centers for Medicare & Medicaid Services (CMS). The P3N facilitates electronic health information exchange throughout the entire state by connecting medical providers to health information organizations. These health information organizations are then bridged to the P3N. The application period to receive these grants began on April 13th and will run until 5:00 PM EDT on April 17th. These grants are afforded to health information organizations in Pennsylvania that would like to connect both ambulatory clinics and hospitals taking part in the Medicare and Medicaid EHR Incentive Programs. Read More

Battle Over Unionizing Home Health Aides Heats Up. On April 9, 2015, *The Wall Street Journal* reported that groups are trying to block an executive order by Governor Tom Wolf, which could allow home health aides hired by consumers to join a union. The Pennsylvania Homecare Association and United Cerebral Palsy of Pennsylvania filed a lawsuit arguing the order violates state labor law. Groups say that family members will be allowed to join a union, but under state law, workers of domestic service are excluded from unionizing. Read More

South Carolina

Senate to Propose New Expansion Plan for Working Poor. On April 13, 2015, *The State* reported that a bipartisan group of senators will propose a plan to insure 194,000 low-income uninsured people whose primary source of provider services is the emergency room. Governor Nikki Haley said she will fight the Senate to prevent expansion. Read More

Texas

Texas Medical Board Votes to Restrict Telemedicine. On April 10, 2015, *The New York Times* reported that the Texas Medical Board voted to limit telemedicine practices in the state. While other states are loosening restrictions and requiring insurers to pay for it in the face of doctor shortages and pressure to increase convenient care, Texas is doing the opposite. Industry representatives have warned the state this will reduce access to medical care while demand continues to increase. The ruling passed by the Texas Medical Board states that "questions and answers exchanged through email, electronic text, or chat or telephonic evaluation of or consultation with a patient" are inadequate to establish a doctor-patient relationship, which is required to give a diagnosis or prescribe drugs in the state. Read More

Tennessee

House Approves $450 Million Hospital Fee to Draw Down Federal Money. On April 13, 2015, *Idaho Statesman* reported that the Tennessee House approved an annual $450 million assessment on Tennessee hospitals by a vote of 90-2 in order to draw down $826 million in federal money. Under Governor Bill Haslam's Insure Tennessee expansion proposal, however, hospitals would only contributed $74 million to draw down $2.8 billion in federal funds. Haslam's expansion proposal was killed twice before. Read More

National

OIG to Investigate Generic Drug Price Increase Effect on Medicaid. On April 14, 2015, the *Wall Street Journal* reported that the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS) will conduct a review of generic drug price increase and the impact this has had on the Medicaid drug rebate program. The announcement comes in response to a letter sent to OIG by Senator Bernie Sanders and Representative Elijah Cummings. Both legislators have also introduced bills in their respective chambers to require generic pharmaceutical manufacturers to pay additional rebates to state Medicaid programs for drugs with prices rising faster than the rate of inflation, as is currently required for brand-name manufacturers. The lawmakers cite a CBO estimate that extending the rebates to generics could save $500 million over the next decade. Read More

CMS Announces Navigator Grant Opportunity. On April 15, 2015, CMS announced the opening of a round of funding to support Navigators in federally facilitated and state partnership Marketplaces. Successful applicants will be awarded three year projects, with up to $67 million available in the first year of the award. The funding opportunity is open to eligible individuals, as well as private and public entities, applying to serve as Navigators. Previously awarded Navigator entities may apply for this round of funding, and applications are due by June 15, 2015. To access the funding opportunity announcement, visit: http://www.grants.gov, and search for CFDA # 93.332.

New Medicaid Enrollees Significantly Increased Prescription Drug Use in 2014. On April 14, 2015, *The New York Times* reported that according to an IMS Institute for Healthcare Informatics report, new Medicaid enrollees in 2014 significantly increased prescription drug use, while private commercial coverage drug use dropped. Medicaid patients in expansion states filled 25.4 percent more prescriptions than in the previous year before expansion. Medicaid patients in non-expansion states saw an increase of only 2.8 percent. The total spending on prescription drugs across the United States rose by 13.1 percent to $373.9 billion. Read More

Price of Gilead's Sovaldi Hep C Pill Limiting Medicaid Patient Access. On April 8, 2015, *The Wall Street Journal* reported that Gilead's Sovaldi Hepatitis C therapy, which costs $84,000, or $1,000 per pill, is leaving many low-income patients untreated. The price has sparked an outcry from insurers, Congress, and others. A WSJ analysis found that state Medicaid programs spent $1.33 billion on hepatitis C medication. There is great disparity, however, between the states and patient access to Sovaldi varied widely. Texas, for instance, refused to pay for Sovaldi in the first nine months of the year, according to the data. A Texas spokesperson said it spent nothing on the medication in the fourth quarter as well. Read More

Industry News

KPMG to Acquire Beacon Partners. On April 12, 2015, *the Wall Street Journal* reported that KPMG LLP will acquire Beacon Partners Inc., a Massachusetts-based provider of management consulting services to hospitals, physician groups, and other health care providers. Financial terms were not disclosed. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
April 24, 2015	Mississippi CHIP	Contract Awards	50,300
April 27, 2015	Florida Healthy Kids	Contract Awards	185,000
Spring, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Spring, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 5, 2015	Kentucky	Proposals Due	1,100,000
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	Kentucky	Implementation	1,100,000
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 (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
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 (Centene), 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	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
California	39,731	42,473	44,804	48,976	51,527	58,945	122,908	123,079	124,239
Illinois	37,248	48,114	46,870	49,060	49,253	57,967	63,731	64,199	62,067
Massachusetts	18,836	18,067	17,739	17,465	18,104	17,918	17,867	17,763	17,797
New York							17	406	539
Ohio							68,262	66,892	65,657
South Carolina								83	1,205
Texas									20
Virginia	11,169	11,983	21,958	28,642	29,648	27,701	27,527	26,877	26,250
Total Duals Demo Enrollment	**106,984**	**120,637**	**131,371**	**144,143**	**148,532**	**162,531**	**300,312**	**299,299**	**297,774**

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

HMA News

Chris Armijo to Speak at Minority Health Community Forum

April 16. Denver, Colorado

HMA Community Strategies Senior Associate Chris Armijo will speak at the "Prevention is Power: Taking Action for Health Equity" community forum and discussion, hosted by the Colorado Office of Health Equity.

HMA's Accountable Care Institute Releases Paper on Health Care Providers and Value-Based Reimbursement

To access this document, as well as other ACI resources, please click here.

HMA's Accountable Care Institute (ACI) released a paper this week for health care providers on the topic of value-based reimbursement. Movement of patients into managed care is a significant part of health care transformation currently underway in the United States. Managed Care Organizations are increasingly offering value-based payment models as a way to help the provider community achieve high-quality care, cost containment, and patient satisfaction. This paper serves as a starting point for health care providers who are exploring value-based payment models. It is designed to help providers understand the reimbursement continuum, potential risks and rewards, and the flow of money.

HMA's Deborah Gracey is the primary author on the paper, with contributions from HMA's Art Jones, MD, Margaret Kirkegaard, MD, and Meghan Kirkpatrick.