HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 27, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

THIS WEEK

IN FOCUS

CMS ISSUES LONG-AWAITED MEDICAID MANAGED CARE PROPOSED RULE

This week, our *In Focus* section reviews initial takeaways from the Medicaid managed care proposed rule (Link to PDF), issued on Tuesday, May 26, 2015, by the Centers for Medicare & Medicaid Services (CMS). The proposed rule, which had been anticipated over the last several months, addresses regulations regarding Medicaid managed care plans, including managed care organizations (MCOs), as well as other managed care entities such as PIHPs, PAHPs, and PCCM programs. The proposed rule seeks to align Medicaid managed care with

Qualified Health Plans (QHPs) available on the Marketplaces, as well as Medicare Advantage (MA) plans. Additionally, the proposed rule addresses medical loss ratios (MLRs), actuarial soundness and rate certification, quality measurement and delivery system reform initiatives, program integrity, and beneficiary protections, among other provisions.

While much of the 653 page document addresses minor policy changes or simply cleans up and clarifies regulatory language, there are several significant provisions of the proposed rule, which we review below.

Additionally, HMA will host a webinar on Thursday, May 28, 2015, at 3:00 pm Eastern time, to provide our first take on the proposed rule. Registration for the webinar and more information is available here. ***At the time of publication, registration for the webinar is full. A replay will be available on our website shortly after the completion of the call.***

Initial Key Takeaways from CMS Proposed Rule

The following are summaries of some of the key provisions of the CMS proposed rule. This should not be considered an exhaustive summary of the entire proposed rule. HMA will provide continued analysis of the proposed rule and its impact in the coming weeks.

- **MLR Provisions.** Under the proposed rule, CMS directs states to set capitation rates such that MCOs (or other capitated entities) would achieve a MLR of at least 85 percent under projected revenues and costs for the given rate year. Additionally, the rule suggests establishing a maximum MLR threshold in the rate-setting process, as well, but does not dictate a level. These MLR standards should be in place for contract years beginning after January 1, 2017. The proposed rule also sets out some standards for what is counted in the MLR calculation, addressing stop-loss and risk-corridor adjustments, as well as payments into Medicaid solvency funds that states may have in place.
- **Rate-Setting Provisions.** As a follow-on to the MLR provisions above, CMS is directing states to use annual MLR reporting from plans as a part of future rate development. In addition to historical and projected MLR input, rate development standards should include non-benefit costs and budget neutral risk-adjustment in the CMS-proposed six-step rate review and approval process. Additionally, the proposed rule expresses concern around the impact of capitation withholding on actuarial soundness, requiring that the portion withheld that is not "reasonably achievable" be excluded from determining rate soundness. CMS is also proposing a review of rates in addition to contracts, with a similar timeframe of 90 days prior to implementation. In general, the proposed rule seeks to promote actuarial soundness and transparency in the rate-setting process.
- **Marketing Provisions.** CMS proposes in this rule to clarify definitions around QHPs in regulations that prohibit marketing of a QHP to Medicaid members enrolled in a managed care plan owned by the same parent company. This proposed rule would loosen the restriction on a parent company marketing their QHP product to their Medicaid plan enrollees upon loss of Medicaid eligibility.

- **Network Adequacy and Beneficiary Information.** CMS has proposed network adequacy standards guidance for states, informed by and more closely aligned with QHP and MA standards. Included is the requirement of adoption of time and distance standards for primary care, OB-GYN, behavioral health, specialty, hospitals, pharmacy, pediatric dental, and other provider categories. However, CMS states that these standards are to be set by states and not be the federal government. The proposed rule also directs states to require managed care plans to include accurate provider directories and drug formularies on their websites.
- **Managed Care Quality Rating System.** Because of the similarities between the Medicaid and Marketplace populations, CMS proposes that states adopt quality rating systems that address the three indicators in the QHP quality rating system: clinical quality management, member experience, and plan efficiency, affordability, and management. CMS would allow for alternative models of quality rating, pending approval. Additionally, states may default to the MA five-star rating system for plans that serve only the dual eligible population. CMS is soliciting comments and input on this, with a target to implement within three to five years.
- **Standardization of Grievances and Appeals Processes.** The proposed rule directs states to standardize definitions, timing, and processes for handling of grievances and appeals for Medicaid managed care members. These standards are more closely aligned with MA and commercial insurance standards and also address the state fair hearing process and responsibilities for member notification.
- **Managed Long-Term Supports and Services (MLTSS).** Several sections of the proposed rule address MLTSS, largely because of the significant growth in MLTSS since the Medicaid managed care regulations were last updated in 2002. Primarily, CMS seeks to align managed care regulations with the ten principles of MLTSS programs issued to states as guidance in 2013 (HMA reviewed this guidance in our May 29, 2013 *Weekly Roundup*, available here).
- **Enrollment and Disenrollment.** The proposed rule cleans up regulatory language around passive and mandatory enrollment processes, as well as requires a member choice period of at least 14 days for plan selection. Additionally, the rule allows for MLTSS members to disenroll at any time, switching to another managed care plan or to fee-for-service, in the instance that a residential, institutional, or employment support provider is no longer in the member's plan's network and remaining in the current plan would impact the member's residence or employment status.
- **Update to IMD Exclusion.** The proposed rule would permit MCOs and PIHPs to receive a capitation payments for enrollees ages 21 to 64 residing in an institution for mental disease (IMD) for less than 15 days during the month. This signals a noted change to the federal IMD exclusion policy. Currently, federal regulations prohibit any federal reimbursement for services provided to an individual while in an IMD. To qualify for federal financial participation, the IMD must be a hospital providing psychiatric of substance use disorder (SUD) inpatient care, or a sub-acute facility providing psychiatric or SUD crisis residential services.

HMA Medicaid Roundup

Alabama

Medicaid Bill to Move ICN Long Term Care to Capitated System from Fee-For-Service. On May 20, 2015, *Birmingham Business Journal* reported that a bill introduced by Senate Majority Leader Greg Reed will move integrated care networks (ICNs) contracting with Medicaid to provide long term care services from fee-for-service to a capitated system. ICNs will exist alongside regional care organizations. Taxpayers may save $1.5 billion from the legislation. Read More

Medicaid Nursing Home Bill Clears Senate and House Health Committee. On May 24, 2015, *TimesDaily.com* reported that Senate Bill 431, under which Integrated Care Networks would provide nursing home or in-home care at a fixed rate per patient, will move on to the full House for a vote. Read More

Arizona

Analysis Finds Arizona Has Low Medicaid Spending on Long-Term Care. On May 23, 2015, *The Arizona Republic* reported that an analysis by Moody's Investors Services found Arizona kept Medicaid spending on long-term care below 4 percent. National spending averaged 6.5 percent a year from 1999 to 2009. Furthermore, Arizona's average cost increase of 2.3 percent was third lowest of the 50 states. Medicaid long-term care per capita spending was the lowest of all the states. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Covered California to Implement Price Caps on High-Cost Specialty Drugs. On May 21, 2015, *The Sacramento Bee* reported that all four board members of Covered California agreed to impose a $250 monthly cap on out-of-pocket prescription costs, effective 2016. Some may have the cap range from $150 to $500, depending on their plan. The new rules will spread costs of expensive specialty medicine over time. Prior to this, enrollees, for instance, could pay over $6,000 for the first bottle of Harvoni, a Hepatitis C drug. Read More

New Medi-Cal Director Discusses Doctor Shortages and Plans for Modernization. On May 24, 2015, *Los Angeles Times* conducted an interview with the new director of Medi-Cal, Jennifer Kent. Kent talked about her hopes to modernize Medi-Cal, moving it away from paper-based program and incorporating smartphone apps. She suggests providing coverage information

and pushing out notices through the app rather than sending a letter. Kent also stated, regarding shortages, that it is the managed care plan's responsibility to provide primary care physicians to Medi-Cal beneficiaries. She predicts Medi-Cal enrollment to stay in the low 12 millions for the next year. Read More

Connecticut

Senate Passes Health Care Bill to Increase Transparency and Establish System for Electronically Sharing Patient Records. On May 21, 2015, *The CT Mirror* reported that the Senate passed a major health care bill. The bill would create a statewide system to allow providers to share electronically patient records, increase transparency of the cost of care, rein in certain hospital billing practices, and reduce advantages that large health systems can gain through consolidation and size. However, the fate of the bill in the House is uncertain. Hospital officials and others in the industry oppose the bill. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Healthy Kids ITN Awards Announced. The Florida Healthy Kids Corporation (FHKC) announced, on May 21, 2015, the awards of the health benefits coverage ITN released on January 30, 2015. The FHKC rebid its existing managed care plan contracts for the Healthy Kids component of the Florida KidCare program across all 11 Regions of the state. Respondents were required to bid on the FHKC Title XXI subsidized population and the non-subsidized "full pay" population covering, more than 185,000 children ages 5 to 18 years of age, as of January 2015. Implementation is effective October 1, 2015. Following is a summary of the FHKC awards for the subsidized enrollment by Plan and Region. Regions have a choice of two plans with the exception of Region 11, which has a choice of three plans. All full-pay members will be enrolled in Sunshine Health Care Plan.

Summary of FHKC Awards for Subsidized Enrollees effective October 1, 2015

Region	Plan	Plan	Plan
1	Coventry	WellCare	
2	Coventry	WellCare	
3	Coventry	WellCare	
4	United	WellCare	
5	Coventry	WellCare	
6	Amerigroup	Coventry	
7	Amerigroup	Coventry	
8	Coventry	WellCare	
9	WellCare	Coventry	
10	Amerigroup	WellCare	
11	Amerigroup	Coventry	WellCare

Amerigroup (Anthem): 6, 7, 10, 11
Coventry (Aetna): 1-3, 5- 9, 11
United: 4
WellCare: 1-5, 8-11

CMS Makes Preliminary $1 Billion Offer for LIP Funding. On May 21, 2015, *Orlando Sentinel* reported that in a letter to state health regulators, CMS has given tentative approval for $1 billion in funding for LIP for FY2015-16 and $600 million for the following year. The state projects it will need an estimated $2.2 billion for the program the next fiscal year. Read More

House Budget and Health Debate Will Not Be Tied; Senate Proposes New Health Care Plan. On May 26, 2015, *Miami Herald* reported that Senate President Andy Gardiner said the House budget will be done during the special session beginning June but the health care debate will not be tied to the budget. The Senate has recently proposed a modified version of the Florida Health Insurance Affordability Exchange health care plan in an effort to resolve the budget impasse. The new proposal, FHIX 2.0, would have eligible patients wait until January for coverage. Patients would also have the option to stay on the federal exchange. The proposal still needs federal approval. Read More

Gov. Scott and House Reject Senate FHIX 2.0 Proposal. On May 27, 2015, *Health News Florida* reported that Governor Rick Scott and House GOP leaders immediately rejected a new Senate proposal - a modified version of the Florida Health Insurance Affordability Exchange. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Negotiates Over Settlement to Move People With Developmental Disabilities to Community Settings. On May 19, 2015, *WABE* reported that the state will not meet a June 30 deadline to move all people with a developmental disability from state-run psychiatric hospitals to community settings. The deadline is part of a 2010 settlement with the U.S. Justice Department. Almost 500 have been transferred, but roughly 268 people with disabilities remain in psychiatric hospitals. However, several deaths occurred after the people were placed into community settings. The state is now allowing transfers on a limited basis. Read More

Kansas

Bill That Proposes 3.5 Percent Fee on Health Insurance Policies on Marketplace Can be Used to Force Vote on Medicaid Expansion. On May 22, 2015, *Kansas Health Institute* reported that proposed Senate Bill 309 could be a vehicle for Medicaid expansion. The bill proposes that the state collect a 3.5 percent fee on policies sold on the federal online marketplace. According to a representative of the Kansas Office of Revisor of Statutes, because the bill references Medicaid, it may force a vote on expansion if it is amended. Medicaid expansion in this year's legislative session has been defeated by the conservative leadership of the House and Senate. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Proposal in House Budget Causes Fight Between Insurers, Consumer Advocates, and Steward Health Care System. On May 26, 2015, *The Boston Globe* reported that a proposal in the House budget that would allow hospitals and health systems to act as insurers in managing the care of Medicaid patients has spurred a fierce political fight. Steward Health Care System claims the proposal allows hospitals to adopt an accountable care organization model for Medicaid patients. However, consumer advocates and insurers say it goes farther than that. They believe the language of the proposal would allow health systems to take on risk the way insurance companies do but without following the same regulations and meeting the same requirements. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Additional DSRIP Funding Possible. Capital New York reports that an additional $1 billion has been added to New York's $6.4 billion DSRIP program. Performing Provider System valuation, which determines the amount of DSRIP funds available to each PPS, were shared with the PPSs on May 7, but the public announcement of those numbers, scheduled for May 8, was cancelled without explanation and has not yet been rescheduled. Capital New York indicates that several PPSs led by New York City hospitals were dissatisfied with the valuation they had received and threatened to withdraw from participating in the program. State Health Department officials refuse to comment on why the valuations have not been made public or whether additional funds have been identified.

The Essential Plan – New York's Basic Health Program. The New York State of Health Invitation and Requirements for Insurer Certification for 2016 includes details about participation in the Basic Health Program. Three variations on the BHP, which will be known as the Essential Plan, will be offered. Individuals with incomes greater than 138 percent of FPL but less than 200 percent of FPL will be eligible for the Standard BHP; those with incomes between 150 percent and 200 percent of FPL will be responsible for a $20 monthly premium. The benefits are based on the Essential Health Benefits benchmark plan offered through the Health Exchange. Plans may also offer an Essential Plan that includes coverage for adult dental and vision coverage. The Essential Plan is also available to individuals who are not eligible for Medicaid because of federal restrictions related to immigration status but who had been covered through New York's Medicaid program. In order to maintain coverage for legally present non-citizens who previously qualified for NY Medicaid benefits, the Essential Plan must include additional benefits, including non-prescription drugs, orthotic devices, orthopedic footwear, and vision and dental care. The Invitation can be found on the New York State of Health website.

North Carolina

Medicaid Director Robin Cummings to Step Down. On May 21, 2015, *Winston-Salem Journal* reported that Dr. Robin Cummings will step down from his position as the state Medicaid Director on June 5, 2015. Cummings became interim director in February 2014 and full-time director in April 2014. He will be replaced by Dave Richard, the state's top official for behavioral health, on June 1. Read More

Hospitals Executives Promote Medicaid Reform Plan to Lawmakers. On May 20, 2015, *North Carolina Health News* reported that state hospital executives talked to legislators to promote their plan for health reform. Hospitals have been experiencing Medicaid reimbursement cuts, increased assessments by the state government, and shrinking clout at the General Assembly. As a result, executives were hoping to convince lawmakers that they were ready to partner with the state to reform the system. The biggest issue hospitals focused on was their recent proposal to reform Medicaid by creating "provider-led entities" made up of doctor groups, hospitals, and other health care providers. The entities would get paid a set fee from the state for each Medicaid patient and in return would guarantee a level of quality and satisfaction for patients. Other executives spoke with lawmakers to preserve the state's certificate of need laws. Read More

DHHS Claims Group Home Money in House Budget; Providers Don't See it Written. On May 27, 2015, *North Carolina Health News* reported that the Department of Health and Human Services said there is money allocated for group homes within a recently passes House budget. Group home providers, however, are nervous because it is not written down. Funding set aside in the 2013 budget to tide group homes over has run dry. Homes are finding it a challenge to stay afloat. DHHS stated nothing can be done now. The 2013 bill prohibits more than $4 million to be spent on the homes. However, Dave Richard, deputy secretary of behavioral health and developmental disabilities, stated once the bill is no longer in effect, the department will "make things whole again." Read More

Ohio

Ohio Launches Behavioral Health System Redesign. On May 27, 2015, the Governor's Office of Health Transformation announced that a behavioral health system design team will work to improve care coordination and rebuild community behavioral health system capacity. The team seeks to modernize the Medicaid behavioral health benefit, develop new services for beneficiaries with intensive needs, and integrate behavioral health into Medicaid managed care. Read More

CareSource Launches Life Services Pilot. On May 21, 2015, *Dayton Business Journal* reported that CareSource launched CareSource Life Services this year. Life Services is a new business venture for the company that helps push members to full-time jobs and helps them begin to plan financially. The new enterprise will focus on people in their 20s to 40s, working part-time or in unskilled jobs. Life Services currently has 400 members and a 97 percent retention rate. CareSource hopes to grow it to 1,500 members. Read More

Puerto Rico

Low Medicaid and Medicare Reimbursement Rates Causing Health Care Crisis. On May 26, 2015, *The Washington Post* reported that low Medicaid and Medicare reimbursement rates may cause the collapse of the health-care system. Advocates say that nearly 400 of the 11,000 physicians leave each year. CMS is also expected to implement an 11 percent cut to Medicare Advantage reimbursements, which will cost the health-care system roughly $500 million. A federal grant for the Medicaid program will expire in two years as well. If it is not renewed, Puerto Rico will need to drastically cut Medicaid services or come up with $1.8 billion by 2018. Puerto Rico is already $73 billion in debt. Read More

Rhode Island

Neighborhood Health Plan Home-Care Program Predicts Medicaid Cost Savings of $2.7 Million. On May 26, 2015, *Providence Journal* reported that Neighborhood Health Plan identified 450 of its high utilizers and arranged for caregiver teams to visit the patients at their homes, reducing costly visits to the hospital. The program, called Health@Home, is proving to be successful; Neighborhood predicts savings of at least $2.7 million in the first year. Chief medical Office Dr. Francisco Trilla believes savings may even be double of that. Read More

Texas

HMA Roundup – Dianne Longley (Email Dianne)

Texas Medicaid Budget Decisions. As the Texas Legislature reaches the end of the regular biennial session on June 1st, the Senate and House have nearly reached agreement on the budget for fiscal years 2016-2017. Following conference committee decisions last week to resolve differences between the two budget proposals, both the House and Senate agreed on nearly all decisions of the conferees. However, upon final vote to adopt the conference committee report, an amendment in the House version has sent the budget proposal back into conference committee, but both the House and Senate expect the difference will be resolved shortly, ensuring the Legislature meets the deadline for final adoption and avoids a special legislative session.

Following is a summary of key conference committee funding decisions for the 2016-2017 two year budget, which begins September 1, 2015. The explanation of differences between the two proposals provides some context regarding how these funds will be used. Budget amounts include all funds (state and federal). Note, this table does not include all Medicaid decisions, but only those budget items that varied between the House and Senate. A final budget summary with additional detail will be provided next month, following final decisions and pending publication of the final budget documents, including riders.

Total Medicaid Funding: $51,542,795,108 [1]

Total CHIP Funding: $1,784,515,121 [2]

Conference Committee Decision Items[3]	House – All Funds Proposal	Senate – All Funds Proposal	Conference Decision	Explanation of difference in proposed budgets
Interest list: STAR+PLUS CBA	$2,539,592	$41,759,148	$31,319,361	House: funding for 100 STAR PLUS CBA slots. Senate: funding for 1,646 CBA slots. Both assume steady enrollment across biennium
Interest list: CLASS	$52,036,813	$28,508,403	$38,948,190	House: funding for 880 steady slots; Senate 564 steady slots.
Interest list: HCS	$108,766,559	$93,075,413	$93,075,413	House: funding for 2,134 steady slots: Senate 2,134 slots with one third enrolled in FY 2016 and remaining enrolled in FY 2017.
Promoting Independence STAR PLUS HCS	$70,716,652	$35,358,328	$70,716,652	House: funding for 1,045 steady slots; Senate would fund one half of agency request with 522 steady slots.
Maintain Claims Administrator Costs	$189,228,307	$0	$189,228,307	House proposal funds HHSC's request to increase funding for Medicaid claims administrator contract to include costs associated with implementation of electronic visit verification, management programs for key metrics, various change orders already in progress, potential future change order requests and other increases.
Community Attendant Care Wage Increases	$141,357,633	$88,893,285	$17,485,309 for rate enhancements; $88,893,285 for $8.00 per hour base wage	House proposed increase in base wage to $7.97 per hour and $30 million in GR for rate enhancement across community-based programs. Senate proposed increase in base wage to $8.00 per hour
Medicaid Staffing and Support		$2,960,090	$2,960,090	Senate funds HHSC's request for additional staff to support managed care expansions.

[1] Texas Legislative Budget Board, Issue Docket – Conference Committee on HB 1. Health and Human Services. May 19, 2015. Available at http://www.lbb.state.tx.us/Documents/Appropriations_Bills/84/Final/Article02_IssueDoc_05-20-2015_02_15_59_PM.pdf

[2] Ibid.

[3] Texas Legislative Budget Board, Medicaid Issue Docket, Conference Committee Decision Items, May 19, 2015. Available at http://www.lbb.state.tx.us/Documents/Appropriations_Bills/84/Final/Medicaid_Issue_Docket_05-19-2015_b.pdf

				Additional staff will allow expansion of UR functions, support plan management for new managed care program expansions and data analytics.
Rural Hospital Payments	$80,000,000		$58,073,966	House modifies methodology for reimbursement to rural hospitals for outpatient services. Reimbursement for general outpatient, non-emergent emergency department, imaging, and clinical laboratory services will be reimbursed at 100% of cost including inflation.
Additional Services for Persons with IDD		$46,114,579	$31,544,106	Senate includes funding to provide respite care and non-medical transportation to individuals with IDD
HCS Rate Increases			$15,824,906	
ICFs for IID Rate increases			$12,053,279	
Trauma Add-on for Hospitals			$93,066,820	
Funding for Safety Net Hospitals			$299,020,309	
Reduction: Cost containment rider		($869,570,428)	($869,570,428)	Senate included budget reductions through initiatives identified in cost-containment rider #51 (see below for more information).

The proposed budget also includes dozens of riders that enact additional provisions related to Medicaid and CHIP, as well as other Health and Human Services programs. Riders provide clarification, directions or legislative intent regarding specific provisions. In some cases, these line item appropriations are contingent on passage of additional legislation, or other contingencies imposed by the Legislature. Though not final, following are descriptions of a few of the Medicaid-related Riders.

- Requires HHSC to monitor implementation of behavioral health services integration into Medicaid managed care; managed care organizations that provide BH services through a contract with a third party shall be prioritized for monitoring oversight.
- Requires HHSC to evaluate the vendor drug program and new delivery models for cost-effectiveness, increased competition and improved health outcomes. Include efforts undertaken to make the current models more effective. Report due December 1, 2016.
- Contingent on funding, HHSC may establish a centralized internet portal through which providers may enroll in Medicaid. HHSC may also designate and share information with a centralized credentialing entity and coordinate with the MCOs to use the credentialing entity to collect and share information.

- HHSC shall evaluate data submitted to MCOs to determine usefulness of information or if additional data is needed to oversee contracts or evaluate effectiveness of Medicaid. HHSC shall develop a dashboard by October 1, 2016 that identifies Medicaid information to be used to oversee and compare performance of MCOs.
- HHSC shall submit a report to the Governor and Legislative Budget Board each time a new round of Network Access Improvement Program (NAIP) proposals are approved. Proposals shall include a list of participating public health related institutions, public hospitals and MCO partnerships, the anticipated amount paid to each MCO by HHSC and the anticipated amount paid to each HRI and public hospital by the MCO, and a summary of each partnership (including program methodology, targeted goals and performance metrics, and payment structure).
- No later than 45 calendar days prior to implementation of a change to premium rates for MCOs, HHSC shall submit the following to the LBB, the Governor and the State Auditor:
    - A schedule showing the original and revised rate, including information on the rate basis for the MCO reimbursements to providers;
    - A schedule and description of the rate-setting process for all rates listed; and
    - An estimate of the fiscal impact for each rate change.
- HHSC shall implement program policies to increase the utilization of long acting contraceptives by 10 percent annually. The commission shall develop provider education and training to promote utilization of the most effective forms of contraception, including vasectomy but excluding abortifacients or any other drug or device that terminates a pregnancy. Additionally, the Department of State Health Services, in collaboration with participating health care providers, shall implement program policies, as well as education and training, to promote their usage. HHSC shall ensure providers are reimbursed the cost of acquiring such devices.
- Medicaid appropriations include a reduction of $186,500,000 in General Revenue Funds and $249,349,498 in Federal Funds in fiscal year 2016 and $186,500,000 in General Revenue Funds and $247,220,930 in Federal Funds in fiscal year 2017, a biennial total of $373,000,000 in General Revenue Funds and $496,570,428 in Federal Funds. HHSC must develop a plan to achieve these reductions, which may include any or all of the following initiatives: (1) Continue strengthening and expanding prior authorization and utilization reviews, (2) Incentivize appropriate neonatal intensive care unit utilization and coding, (3) Fully implement dually eligible Medicare/Medicaid integrated care model and long term services and supports quality payment initiative, (4) Reform reimbursement methodology, policies, and utilization for acute care therapy services, (5) Maximize co-payments in Medicaid programs, (6) Increase fraud, waste, and abuse prevention and detection, (7)Explore changes to premium structure for managed care organizations and contracting tools to reduce costs and increase efficiency, (8) Renegotiate

more efficient contracts, (9) Develop a dynamic premium development process for managed care organizations that has an ongoing methodology for reducing inappropriate utilization, improving outcomes, reducing unnecessary spending, and increasing efficiency, (10) Implement fee-for-service payment changes and managed care premium adjustments that incentivize the most appropriate and effective use of services, (11) Improve birth outcomes, including improving access to information and payment reform, (12) Increase efficiencies in the vendor drug program, (13) Increase third party recoupments, (14) Create a pilot program on motor vehicle subrogation, and (15) Implement additional initiatives identified by HHSC. HHSC's plan for achieving these reductions must include reduction amounts by strategy and fiscal year and submitted in writing before December 1, 2015 to the Legislative Budget Board, the Governor, and the Comptroller of Public Accounts.

- HHSC shall conduct a thorough review of the agency's contract management and oversight function for Medicaid and CHIP managed care and fee-for-service contracts in order and make recommendations to improve their ability to identify anomalies in service utilization and their underlying cause. The review may be conducted by agency personnel or by an independent contractor (including under contract with the State Auditor's Office), but should be performed by reviewers who are not a part of agency contract administration or the Office of Inspector General. The review should consider the effectiveness and frequency of audits, the appropriateness of existing contract requirements including penalties, the availability of necessary data, the need for additional training and resources, and the adequacy of current prior authorization and utilization review functions. The agency shall report its findings and recommendations to the Legislature no later than September 1, 2016.

Wisconsin

Joint Finance Committee Approves Proposal to Raise Medicaid Premiums for Risky Behavior. On May 22, 2015, *Chicago Tribune* reported the Legislature's Joint Finance Committee approved Governor Scott Walker's proposal to increase Medicaid premiums for childless adults who engage in risky behavior. The change would affect approximately 157,000 beneficiaries. Walker is now requesting federal approval for the proposal. Read More

National

Major Health Insurers Seek Large Rate Boost for Exchange Plans. On May 21, 2015, *The Wall Street Journal* reported that major insurers are seeking rate boosts for Exchange plans. Health Care Service Corp. is asking for an increase of 51.6 percent for 2016 in New Mexico. BlueCross BlueShield of Tennessee requested an increase of 36.3 percent. CareFirst BlueCross BlueShield seeks a 30.4 percent increase. The insurers all cite high medical costs incurred by new enrollees. Insurance regulators can ask some insurers to scale back the rate increases if they cannot justify them. Read More

Industry News

Karen Ignagni Named President and CEO of EmblemHealth. Frank Branchini, Chairman and CEO, EmblemHealth, announced that Karen Ignagni has been selected to be the next President and CEO of EmblemHealth effective September 1, 2015. Mr. Branchini, who has served EmblemHealth and its predecessor GHI, as President/CEO for 30 years, will continue as the Chair of the Board of Directors. Ms. Ignagni joins EmblemHealth after more than 20 years with America's Health Insurance Plans ("AHIP") as President and CEO. EmblemHealth, Inc., formed through the merger of Group Health Incorporated (GHI) and HIP Health Plan of New York (HIP), provides health care coverage and administrative services to approximately 3.2 million people. This includes 231,000 Medicaid individuals enrolled in HIP, EmblemHealth's Medicaid managed care plan. The EmblemHealth press release can be found here.

CVS to Acquire Omnicare for $12.7 Billion. On May 21, 2015, CVS Health Corporation announced that it has entered into a definitive agreement to acquire Omnicare Inc. for $12.7 billion, including $2.3 billion in debt. Omnicare is a provider of pharmacy services to long term care facilities across 47 states. Read More

KEPRO Acquires APS Healthcare. On May 7, 2015, KEPRO Inc., announced that, in partnership with Consonance Capital Partners, it has acquired APS Healthcare from Universal American. Pennsylvania-based KEPRO is a quality improvement and care management organization offering solutions to reduce utilization of healthcare resources and optimize quality of care. APS Healthcare provides specialty healthcare solutions. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
June, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
June, 2015	Louisiana MLTSS - DD	RFP Release	15,000
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 3, 2015	Michigan	Proposals Due	1,600,000
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	1,600,000
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.*

HMA News

HMA Upcoming Appearance: Karen Brodsky to Present at 2015 State Health Research and Policy Interest Group Meeting

June 13, 2015
Minneapolis, Minnesota

HMA Principal Karen Brodsky, along with Angie Fertig (Medica Research Institute), Erin Taylor, and Sarah Gollust will be presenting State Health Access Reform Evaluation (SHARE findings) at the State Health Research and Policy Interest Group Meeting preceding the 2015 AcademyHealth Annual Research Meeting (ARM) on June 13, 2015. Read More

HMA Upcoming Webinar: *"New York State's Ambitious DSRIP Program: A Case Study"*

Thursday, May 28, 2015
1:00 PM Eastern
Register Here

New York has by far the most ambitious Delivery System Reform Incentive Payment (DSRIP) Program in the nation. The program has a clear focus on full health system transformation and payment reform. The state will invest $6.4 billion to incentivize collaboration among health care providers, social service providers, and community-based organizations to dramatically alter the way health care is delivered to Medicaid recipients. The primary goal: a 25% reduction in avoidable hospital use over five years. Getting there will require huge investments in community-based care, improvements in key quality metrics like hospital readmissions, and the continued shift from traditional fee-for-service payment models to value-based care.

During this webinar, you'll hear from Health Management Associates Principal Denise Soffel, PhD, who has been on the front lines helping New York plan, develop, and implement its DSRIP initiative.

HMA's Barbara Smith Delivers Commencement Address at University of Virginia School of Medicine Department of Public Health Sciences

HMA Principal Barbara Smith delivered the commencement address at the May 16, 2015, graduation ceremony for the University of Virginia School of Medicine Department of Public Health Sciences. Barbara's speech focused on the following points:

- The emphasis on population health management is fostering the erosion of the silos between public health and the traditional health system and requiring partnerships between the different health sectors that have not existed previously.
- Using public health strategies and methods and promoting collaboration between the public health community and the private sector is indispensable in achieving the goals of delivery system reform.
- The role of public health has never been more central to the dynamics of delivering care at the individual patient level

HMA WELCOMES…

Tom Murar, Principal – Lansing, Michigan

Tom comes to HMA most recently from Consumers Mutual Insurance of Michigan, where he served as the Chief Financial Officer for the past few years. In this role Tom directed the planning, organization, and implementation of overall procedures for financial reporting and administration, purchasing, risk management, cash management, and investments; directed and participated in management studies, providing financial analysis as required by the CEO and Board; was involved in the Qualified Health Plan process for Health Insurance Exchange products including plan design, financial modeling, coordination of actuarial work, filling and filing of templates and the DIFS approval process; directed large group underwriting activities, including group plan design, rate modeling and finalization, enrollment, billing, and collection processes; and coordinated with claims, health services and marketing/sales to ensure the financial integrity of the company.

Prior to his work with Consumers Mutual, Tom served as the Vice President of Medicare/Medicaid Solutions for Altegra Health (formerly Dynamic Commerce Applications). Here Tom was responsible for the sales cycle from identifying potential clients, through sales presentations, contractual negotiations, and implementation; investigating client issues/concerns to develop result-orientated solutions for their needs; assisting clients in developing and implementing operational programs needed to succeed in a risk-adjustment environment; and reviewing documents for clients related to the risk environment in which they were working.

Additional positions that Tom has served include Cape health Plan/Molina Healthcare of Michigan (Chief Financial Officer, Finance Director); Henry Ford Health System (Senior Financial Analyst); Mercy Health Plans (Senior Financial Analyst – HMO/PPO); and Health Alliance Plan (Financial Analyst).

Tom received his Master in Business Administration degree from the University of Notre Dame, graduating with Honors with a concentration in Finance and Marketing. He graduated Summa Cum Laude from the University of Detroit with a Bachelor of Science degree in Finance.