HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 30, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

- IN FOCUS: HRSA ISSUES PROPOSED 340B "MEGA GUIDANCE"
- NEBRASKA, SOUTH DAKOTA CONSIDERING MEDICAID EXPANSIONS
- UTAHACCESS+ MEDICAID EXPANSION PLAN UNVEILED
- MASSACHUSETTS DUALS DEMO TO RECEIVE ADDITIONAL FUNDING
- NEW YORK DEVELOPS MLTC WHITE PAPER
- NEW YORK HEALTH COOPERATIVE SHUTTING DOWN
- UNIVERA COMMUNITY HEALTH (NY) ACQUIRED BY THE MONROE PLAN
- RHODE ISLAND MEDICAID DIRECTOR GIFFORD STEPPING DOWN
- HEALTHCARE INDUSTRY BRACES FOR EXPANSION OF CODES ON OCT. 1
- CORIZON HEALTH APPOINTS WITTY AS CEO
- AETNA WELCOMES LOVEMAN, JELINEK TO EXECUTIVE TEAM

IN FOCUS

HRSA ISSUES PROPOSED 340B DRUG PRICING PROGRAM "MEGA GUIDANCE"

This week, our *In Focus* section comes to us from HMA Managing Principal Donna Strugar-Fritsch and Research Assistant Melissa Sanchez. Donna and Melissa provide a review of the proposed guidance issued by the Health Resources and Services Administration (HRSA) on the 340B Drug Pricing Program.

On August 28, 2015, HRSA issued its proposed 340B omnibus guidance which modifies the 340B Drug Pricing Program established by Congress in 1992 and expanded under the Affordable Care Act. Significantly, the guidance offers new policies which build on the many elements of the program already being enforced by HRSA. Changes to the program come in response to questions raised by other government agencies, including the Government Accountability Office, and pharmaceutical industry stakeholders. The major focus of the guidance is on program eligibility and the clarification of which individuals are eligible for prescriptions through the 340B program.

The proposed guidance comes on the footsteps of a previously proposed but unissued rule for the program which was not made public following legal challenges brought against HRSA, which challenged HRSA's authority to issue certain rules for the 340B program. In 2013, HRSA issued a regulation on the use of orphan drugs (drugs with limited distribution or low volume) for non-orphan purposes. Pharmaceutical Research and Manufacturers of America (PhRMA) sued, challenging HRSA's scope in issuing the regulation. In May 2014, the court ruled in PhRMA's favor, vacating HRSA's regulation and ruling that the 340B statute did not grant HRSA authority to issue regulations on the orphan drug exemption. The legal action has placed a considerable damper on HRSA's perceived authority to issue regulations on anything not specifically named in the original 340B statute. HRSA currently believes it can issue regulations on 340B ceiling prices, civil monetary penalties, and dispute resolutions processes. HRSA action on other topics is limited to guidance.

The proposed guidance stands to impact almost all elements of the 340B program, including the scope of allowable 340B purchases, program compliance and reporting requirements, covered entity audits, and coordination between Medicaid, other payers, and program participants. What follows is a brief overview of the 340B program and the major changes outlined in the released guidance as they relate to covered entities. Comments on the proposed guidance are due to the agency by October 27, 2015.

Overview

The 340B Drug Pricing Program requires drug manufacturers who participate in the Medicaid Rebate Program to provide significant discounts to covered entities for certain outpatient medications. Since the expansion of the program under the Affordable Care Act, the program has seen a stark rise in the number of hospital organizations (a hospital and all of its eligible affiliated sites) which alone grew from 1,365 in 2010 and to 2,140 in 2014. The Government Accountability Office (GAO) estimates that 40 percent of hospitals are eligible for the program, and nearly one-third of all hospitals now participate.

HRSA estimates the program saved providers $3.8 billion in drug costs in 2013. Covered entities can purchase 340B drugs for all eligible patients, including patients with Medicare or private insurance. Covered entities can generate revenue by capitalizing on their savings through the program, which allows them to retain reimbursements for the drugs that exceed the discounted prices they pay for the medications under the program. They can also reduce their costs for medications provided at low or no costs to low-income patients.

Covered Entities and Populations

The initial 340B Drug Pricing Program aimed to include certain types of clinics or public hospitals that receive federal grants from the Department of Health and Human Services and included federally qualified health centers, Rule 330 grantees, and Ryan White grantees who continue to be eligible to enroll in the program as covered entities. Covered entitles now also include disproportionate share (DSH) hospitals, critical access hospitals (CAHs), rural referral centers, sole community hospitals, children's hospitals, and freestanding cancer hospitals. The latter two types of covered entities were added by the Affordable Care Act. Participation in the 340B program as a nonprofit hospital is contingent on a recognized affiliation between an eligible hospital or clinic and the state or local government. Each type of eligible hospital except for CAHs must provide

care to a minimum number of patients who are Medicaid and low-income Medicare, which is calculated as a minimum DSH adjustment percentage.

HRSA has previously outlined three criteria for who is an eligible patient, but these criteria have been criticized for allowing for varying interpretations by covered entities, which might employ the program either too broadly or too narrowly. Under the previously issued guidance eligible patients must:

- have an established relationship with the covered entity, such that the covered entity maintains records of the individual's health care; and
- receive health care services from a health care professional who is either employed by the covered entity or provides health care under contractual or other arrangements (e.g., referral for consultation) such that responsibility for the care provided remains with the covered entity; and
- receive a health care service or range of services from the covered entity which is consistent with the service or range of services for which grant funding or Federally-qualified health center look-alike status has been provided to the entity. (DSH are exempt from this requirement)

Highlights from the Proposed Guidance

The proposed guidance seeks to address ambiguity in the definition of covered entitles and individuals by increasing the number of conditions for patient eligibility from three to six criteria. In addition to the three existing criteria, it proposes that eligible patients must:

- be classified as outpatient when the drug is ordered or prescribed;
- receive care from a provider who is directly employed by the covered entity or an independent contractor for which the covered entity is authorized to bill;
- receive service that is consistent with a covered entity's scope of grant, project or contract, as is applicable.

These new criteria also proscribe the entities that can benefit from the 340B program by affiliation with a covered entity. Under the new guidance, for instance, an individual would not be considered a 340B provider's patient if his or her care was provided by another organization that "has an affiliation arrangement with the covered entity, even if the covered entity has access to the affiliated organization's records."

The combination of patient definition and covered entity affiliation proposed in the guidance would considerably narrow the scope of prescriptions covered by the program. Hospitals and clinic-based covered entitles such as federally qualified health centers (FQHC) and FQHC Look-a-Likes, Tribal/Urban Indian Health Centers, Ryan White HIV/AIDS Program Grantees, Title X Family Planning Clinics, and Sexually Transmitted Disease Clinics anticipate concerns with access because of provisions within the proposed guidance that proscribe the use of 340B drugs for patients referred to private practice specialty care or an outside provider by a covered entity. Referrals for specialty care by federally funded covered entities are common and made necessary by a lack of specialist providers employed at these types of clinical settings. Limitations on the fulfillment of prescriptions written by referred-to outside providers for 340B medications could significantly impact patient access to much needed medication prescribed by specialists.

One section of the proposed guidance makes strides towards facilitating patient access to otherwise limited specialty care through endorsement of prescriptions made during telehealth or telemedicine encounters.

Although not mentioned explicitly, the guidance appears to prevent 340B use for drugs prescribed in connection with services furnished at hospital clinics located in correctional facilities. For these drugs to be eligible, such clinics would need to appear on a reimbursable line of the hospital's Medicare cost report and be registered as child sites. Because services provided to incarcerated individuals are not covered by Medicare, such clinics are generally unable to be listed on a reimbursable line.

New guidelines for eligibility also limit the inclusion of entities whose relationship to a patient is the provision of care that encompasses only the infusion of a drug or dispensing of a drug. This new limitation is an attempt to limit the use of 340B program drugs to cover prescriptions made to employees of covered entities, which has become a concerning trend among certain participant entities.

The proposed guidance offers a definition of "covered outpatient drugs" that:

- Makes drugs covered as part of a Medicaid bundled rate ineligible for 340B pricing.
- Outlines new technical changes to the registration and oversight of contract pharmacies by covered entities.
- Finds covered entities responsible for the prevention of duplicate discounts on medications for Medicaid managed care organizations.

The Affordable Care Act included Medicaid MCO drugs in the Medicaid rebate program but did not specify how states should address the interface between 340B and Medicaid managed care to avoid duplicate discounts. In response to subsequent confusion in the field, the HRSA guidance proposes that covered entities determine whether to carve in or carve out Medicaid managed care drugs. A covered entity may treat 340B drugs the same or differently for Medicaid fee-for-service and managed care patients and can even treat 340B drugs differently among Medicaid MCOs. The guidance makes an appeal for stakeholder input on this proposed change.

HRSA makes few to no changes to current policies around its process for auditing covered entities and will continue to allow covered entities to challenge audit findings and require those requested to do so to submit a corrective action plan to the agency. Notably, the new proposed guidance states that HRSA cannot remove a 340B covered entity that is found to be noncompliant from the program if it can demonstrate that it is currently compliant with the program's regulations. Processes for manufacturer audits of covered entities remain unchanged under the new guidance, but the proposed changes now also include guidance for the audit of drug manufacturers and their contractors.

Throughout the guidance, HRSA offers opportunities for response and makes explicit call for additional comment from stakeholders on certain issues. The mega-guidance is significant to covered entities and their affiliates, and these entities should consider a thoughtful response during the comment period through the end of October.

Link to Guidance, Related Documents

https://federalregister.gov/a/2015-21246

HMA Medicaid Roundup

California

HMA Roundup – Don Novo (Email Don)

Mitch Katz, Current Head of the Department of Health Services, to Lead L.A. County's Consolidated Healthcare Agency. On September 29, 2015, *Los Angeles Times* reported that county supervisors appear prepared to place Mitch Katz at the top of a new agency that will consolidate the Department of Health Services with separate county mental health and public health operations. The new agency will account for nearly a third of the county's $27 billion budget. Katz is the current head of the Department of Health Services. He has been praised for turning around massive budget deficits in the hospital system and smoothing out the transition to the Affordable Care Act. Opponents of the new agency say the demands of medical care and the political clout of the hospital system would take priority over mental health, substance abuse treatment, and public health programs such as disease prevention initiatives. Read More

Wide Health Care Cost Gap between Northern, Southern California. On September 27, 2015, *The Sacramento Bee* reported that in California, there is a large gap in health care costs between the North and the South. A health care comparison tool unveiled by state officials and *Consumer Reports* magazine shows great disparities in prices for health care, including common procedures, surgeries, and insurance costs, with costs being higher in the North. The geographic divide has been noted for several years but recent developments in transparency have emphasized it. Experts believe the difference in costs is a result of the lack of competition in Northern California, which is dominated by larger hospital chains, while the South consists of many smaller hospital alliances and independent doctor groups. Read More

Contra Costa Approves Health Program for Residents who are Undocumented. On September 22, 2015, *KQED* identified Contra Costa County as the 47th county in California to approve a program providing preventive, non-emergency care to undocumented adults. The county's one-year, $1 million pilot program could launch as early as November and would give participants access to immunizations, mental health care, and other services. KQED's "State of Health." Read More

Audit Report Finds Inadequate Oversight of School Health Program. On September 22, 2015, *California Healthline* reported that a recent state audit finds that the California Department of Health Care Services has failed to adequately oversee and manage a program that reimburses school districts for some of the cost of referring students to the state's Medicaid program. Nearly one in six

school districts has dropped out of the program, the audit finds. *EdSource*, California State Auditor report. Read More

Proposal Calls for Tax Increases to Fund Healthcare and Education. A group led by the California Hospital Association and Service Employees International Union-United Healthcare Workers West proposed a ballot initiative to expand and make permanent the state's income tax increases. The funding would be used to help fund education and health care programs. *Sacramento Bee*'s "Capitol Alert," *AP/Sacramento Bee*. Read More

California Community Health Centers' Telehealth Programs Face Barriers. On September 21, 2015 *California Healthline* reported that a new report by the Center for Connected Health Policy finds that California community health centers with telehealth services face several barriers — such as complex billing and reimbursement rules and difficulty tracking visits — to making their programs financially sustainable. *Healthcare Informatics*, CCHP report. Read More

Connecticut

Governor Malloy to Cut $63 Million to Hospital Medicaid Payments. On September 21, 2015, *Becker's Hospital Review* reported that Governor Dannel Malloy will cut $63 million to hospital Medicaid payments, as part of a plan to trim $102 million from the state budget. Jennifer Jackson, Connecticut Hospital Association CEO, stated the cuts will hurt patients and put a "tremendous additional strain" on healthcare providers. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Governor Scott Proposes Hospital Transparency as Requirement for Funding. On September 30, 2015, *Health News Florida* reported that Governor Rock Scott released a proposal requiring hospitals to post the prices and average payments received for products and services on their websites. He stated that for hospitals to receive funding, tax-payers should know what the money is spent on. Scott also called for patients to be able to pursue complaints of hospital price gouging with law-enforcement and regulatory agencies. The Florida Hospital Association called the accusations of price gouging as "mean-spirited accusations that are completely unfounded." Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Memorial Health to Pursue Partnership with North Carolina's Novant Health Hospital System. On September 23, 2015, *Georgia Health News* reported that Memorial Health announced it will pursue a partnership with Novant Health. Officials said they are unsure if the partnership would be a merger or a looser arrangement. Memorial Health operates Memorial University Medical Center, a 604-bed hospital in Savannah. It has been working with North Carolina-based Novant Health since 2012 in a shared services agreement. This agreement has saved Memorial $8 million in costs. Read More

Kansas

Via Christi Health: Hospital Providers Losing Revenue Without Medicaid Expansion. On September 23, 2015, *Salina Post* reported that Jeff Korsmo, CEO of Via Christi Health, issued a statement to Governor Sam Brownback and legislative leaders urging them to expand Medicaid. He stated that healthcare providers are struggling financially from lack of expansion. Via Christi has lost nearly $28 million in revenues in the last two years and is already $3.3 million below budget projections two months into the new fiscal year. Via Christi will manage costs by focusing on hiring critical clinical staff, moving employees in low-volume areas to other positions that serve more patients, reducing the number of management positions, and halting discretionary spending for travel, education, and meetings. According to the Kansas Hospital Association, Kansas hospitals stand to lose approximately $132 million in 2016 without expansion. Read More

Massachusetts

One Care to Receive Additional Funding Over Next Two Years; Fallon Health to Exit Program. On September 24, 2015, *Worcester Business Journal Online* reported that One Care, a pilot run by MassHealth that provides care management to approximately 17,000 disabled residents will update its rates. A total of $47.6 million in state and federal funding over the next two years will be used to pay "more accurate" rates. The program has lost over $54 million since its launch in 2013 through March of 2015. Fallon Health will withdraw at the end of September. Fallon's One Care plan lost $12.9 million over the first 18 months of the program. The One Care demonstration is due to expire after 2016; however, MassHealth has requested a two-year extension through 2018. Read More

Minnesota

Judge Approves State Plan For Disability Reform. On September 29, 2015, *StarTribune* reported that U.S. District Judge Donovan Frank approved a state plan to reform disability services. The plan creates state and local initiatives help people with disabilities move into jobs and housing in the community, while reducing Minnesota's long-standing dependence on segregated settings, such as group homes and sheltered workshops. This will allow hundreds of Minnesotans with disabilities to gain access to better jobs, housing, and medical care. It will also accelerate the move of people from state institutions and reduce the use of restraints and seclusion there. The plan took three years to write and underwent multiple revisions. Read More

Unpaid Care Costs Fall 6 Percent at Hospitals. On September 29, 2015, *StarTribune* reported that the cost of unpaid care at state hospitals fell six percent last year, according to a report released by Minnesota Department of Health. Based on financial data for 126 out of 133 hospitals in the state, uncompensated care costs fell from $313.8 million in 2013 to $294.1 million in 2014. The drop in costs coincides with the expansion of health insurance coverage under the ACA. This was the largest drop in cost in the last 20 years. Read More

Nebraska

Lawmakers Considering Medicaid Expansion Options. On September 27, 2015, *The Washington Times* reported that a coalition of state lawmakers is looking at options to expand Medicaid. They are reaching out to Chambers of Commerce and hospital groups for evidence of the potential impact on business from expansion. The group is led by Senator John McCollister. McCollister stated that he saw the possible benefits of expansion after reviewing a study from the University of Nebraska that predicted the state would realize at least $1 billion in economic benefits. Opponents say expansion is too costly and would not help the economy. Read More

New Hampshire

MCO Contracts Amended to Enroll Individuals with Developmental Disabilities, Timing Remains Unknown. On September 30, 2015, OpenMinds reported that New Hampshire has amended its Medicaid MCO contracts to prepare to transition individuals with intellectual and developmental disabilities (I/DD) into managed care at a yet-to-be-determined date. Other contract amendments were included in addition to the I/DD provision. Beginning October 1, 2015, MCOs will utilize their own preferred drug lists. Beginning January 1, 2016, MCOs will assume responsibility for the Choices for Independence (CFI) waiver services, with nursing home services to be added July 1, 2016. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Health Care Quality Institute (NJHCQI) to hold Annual Medicaid Payment Reform Summit. On October 9, 2015, NJHCQI will hold its fourth annual Medicaid Payment Report Summit at the Holiday Inn Express Princeton Southeast in Plainsboro. The Summit will feature innovations in New Jersey Medicaid and population health, integration of behavioral health care, Medicaid and national innovations in complex care, and innovations in data and technology to support Medicaid beneficiaries and communities. NJHCQI is conducting this Summit with support from the Nicholson Foundation. The agenda and registration may be accessed here.

New York

HMA Roundup – Denise Soffel (Email Denise)

The Future of Managed Long Term Care and the Fully Integrated Duals Advantage (FIDA) Program. The Department of Health and the Center for Medicare and Medicaid Services co-hosted a forum on the future of Managed Long Term Care and the Fully Integrated Duals Advantage (FIDA) program. Both NYS and CMS acknowledged that implementation of FIDA has been disappointing, noting that if enrollment does not increase, the future of the program is in question. The forum was the beginning of a stakeholder process to revisit MLTC and FIDA, and to solicit feedback on how the programs can be strengthened, including strategies for how to grow FIDA enrollment.

The state has developed a draft white paper on the future of managed long term care as part of the Care Management for All strategy that outlines proposed changes to the current MLTC program, focusing on better alignment with other state initiatives and priorities. As the roll-out of mandatory managed long term care (affecting duals requiring more than 120 days of community-based long term care) reaches completion state-wide, the state is now exploring how DSRIP and a move toward value-based payment can build on the state's experience with managed long-term care.

The white paper proposes a new program, MLTC Plus, focused on strengthening relationships between individuals enrolled in MLTCs and their primary care physicians. MLTC Plus would incorporate a three-pronged approach: integrating new services into the MLTC benefit, adding primary care and behavioral health; establishing quality incentives and bonus payments for primary care providers that encourage care coordination; and strengthening care transitions from hospital to community. These three components, enhancing MLTC plans' ability to strengthen relationships between members and their primary care providers, would help reduce avoidable hospitalizations and readmissions. The state envisions selecting a small number of MLTCs to pilot an MLTC Plus approach.

As part of the FDIA discussion the state presented some explanations for the low FIDA enrollment. They indicated that participants who chose to opt out were afraid they would lose their current physician; they did not see any benefit to joining FIDA; and they were extremely cautious about making any changes in their health care coverage. They also noted that outreach and education to providers was insufficient, and provider resistance has been a major problem. Finally, they noted that providers see the Interdisciplinary Team (IDT) model required by FIDA as particularly onerous. The state proposes changes in several areas that would increase flexibility in program design. Several changes to the IDT process were proposed: making it optional; and providing financial incentives to plans, to providers, and/or to consumers for participating in the IDT process. A CMS representative noted that among the duals demonstration projects across the country, New York's is the most ambitious. The state is proposing easing the marketing guidelines so plans can customize their marketing approach. The state is proposing allowing FIDA plans to enroll consumers directly rather than sending them to the state enrollment broker, MAXIMUS. In order to incent plans to enroll individuals into integrated products, the state is proposing that enrollment into partial capitation products be frozen until at least 25 percent of a plan's members are enrolled in a fully integrated plan, whether FIDA, Medicaid Advantage Plus or PACE. The state is also contemplating expanding enrollment to the dual population not yet in need of long term services. Finally, the state is proposing enhancements to the FIDA benefit package, including the HCBS services that will be available through the HARP product, and an over-the-counter drug card.

NYS has not yet posted the White Paper on its web site, although it will undertake a public review and comment period. HMA can share the White Paper upon request.

Delivery System Reform Incentive Program Update. NYS Medicaid Director Jason Helgerson has recorded a new DSRIP White Board, providing a status report on DSRIP implementation. He discusses four points:

- New York's DSRIP program has moved beyond planning into implementation. All 25 Performing Provider Systems submitted implementation plans that are undergoing review. Helgerson stated that the plans are very strong, although some remediation steps are being identified.
- One aspect of the DSRIP program, as outlined in the Roadmap for Medicaid Payment Reform, is a move toward value based payment. DSRIP commits the state to 80 – 90 percent of all Medicaid payments going out through some type of value-based arrangement over the 5 years of the program. Recognizing that some providers have more experience with value based payments, and are better prepared for a different payment model, the state is looking for providers who are interested in participating in pilot programs as early adopters of its value based payment models.
- In recognition that implementation of specific DSRIP projects continue to evolve, PPSs will be able to add additional providers to their PPS networks late in October. NYS expects that PPSs will be allowed to add to their provider networks periodically over the 5-year DSRIP program.
- The terms and conditions of the DSRIP program require a midpoint assessment, which will give PPSs and the state an opportunity for some mid-course adjustment. The state has proposed to CMS that the assessment, originally planned for year 3, be moved up to July 2016, so any structural changes identified can be implemented before the beginning of year 3, when incentive payments begin to be tied to outcome rather than process measures.

Essential Plan. New York is implementing a provision of the Affordable Care Act known as the Basic Health Program. Several consumer advocacy groups presented a webinar that shared program details of what will be called the Essential Plan. The webinar slides can be found on the Health Care for All New York website. Eligibility for the Essential Plan includes individuals with incomes above the Medicaid level, up to 200 percent FPL. This includes a group of parents between 138 and 150 percent FPL that had been covered under New York's Medicaid expansion program, Family Health Plus, but were not included in the ACA Medicaid expansion, who had been enrolled in qualified health plans through the exchange, with a state wrap-around that provided Medicaid-equivalent coverage and cost-sharing. Lawfully present non-citizens are eligible for the Essential Plan, as are immigrants currently covered by New York's Medicaid program as a result of a lawsuit establishing eligibility for state-only funded Medicaid for certain immigrants ("Aliessa immigrants").The Essential Plan will provide the same benefits as qualified health plans, with the option to purchase dental and vision plans. Aliessa immigrants were moved from Medicaid to the Essential Plan in April 2015; other eligible individuals will enroll during open enrollment for coverage beginning in January 2016. The Essential Plan will have rolling enrollment; it will not be restricted to open enrollment or special enrollment periods.

New York Health Cooperative Shutting Down. Health Republic Insurance of New York, the nation's largest co-op, has been told to wind down its business. The health plan covers over 200,000 New Yorkers. Coverage under Health Republic will be terminated at the end of the calendar year, and its members will have to select other health plans during the open enrollment period beginning

November 1. According to a report in *Capital New York*, federal and state regulators made the decision to shut the plan given its likelihood of becoming insolvent. It is the fourth co-op to close since the ACA was implemented. Health Republic offered one of the lowest premiums of any insurer on the exchange, and attracted roughly 20 percent of the New York market.

DSRIP Learning Symposium. The Department of Health hosted the first annual Learning Symposium for Performing Provider Systems participating in NY's DSRIP program. The 2-day symposium included sessions on integrated delivery systems, provider and consumer engagement, value-based purchasing, behavioral health/clinical integration, care transitions, and primary care. Slides from all the presentations can be found on the DSRIP website.

Medicaid Managed Care Advisory Review Panel. The Medicaid Managed Care Advisory Review Panel, the oversight body for New York's Medicaid managed care program, met on September 24. Plan updates:

- The Department of Health has approved a new Medicaid managed care plan effective August 1, 2015. Crystal Run operates a health center in the Hudson Valley region, and has a large provider network. They will be offering both Medicaid and QHP plans.
- MVP and Hudson Health Plan continue to merge operations. All Medicaid managed care enrollees will be migrating from Hudson Health Plan to MVP as of January 2016.
- Univera Community Health, a Medicaid managed care plan operating in the western part of the state, has been acquired by the Monroe Plan, an IPA headquartered in Rochester. The plan will now operate under the name YourCare. At the same time, the Monroe Plan ended its contract for management services with Excellus, Excellus retains contracts with Monroe Plan providers; it has brought the management functions in-house.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio Has a New Commission on Infant Mortality: Ohio's infant mortality rate is among the worst in the nation, 23 percent higher than the national average according to the Department of Public Health as reported by *Cleveland.com.* In response, Ohio Lawmakers have created the Infant Mortality Commission to review the effectiveness of programs aimed at reducing the number of babies dying before their first birthday. Senator Shannon Jones, a Springboro Republican leads the panel, which is focusing on the disparities between black and white infant death rates. Overall, Ohio's infant mortality rate dropped to 7.4 deaths per 1,000 live births from 7.6 in 2012. The rate for white babies fell to 6.0 from 6.4, while the rate for black babies went from 13.9 to 13.8. Ohio's Medicaid expansion has helped increase access to health care and the recently passed budget included $13.4 million annually for managed care plans to enhance local efforts in areas with high rates of infant mortality. The ODH 2014 infant mortality data will be released in the fall. Read More

About Half of Adults Who Got Medicaid through Ohio's Medicaid Expansion are Working. According to the *Dayton Daily News*, citing a recently released study by Families USA, 50.5 percent of adults covered by the Medicaid

expansion work in occupations such as sales, food service, office and administrative support. Read More

Preliminary Data Released by Ohio Department of Health Shows Fentanyl Significantly Contributes to Rise in Drug Overdose Deaths. Fentanyl is a lethal opiate, 30 to 50 times more potent than heroin. In 2014, there were 502 fentanyl related drug overdose deaths in Ohio, compared to 84 deaths involving fentanyl in 2013. Overall, drug overdose deaths in Ohio increased from 2,110 in 2013 to 2,482 in 2014, according to preliminary data released by the Ohio Department of Health. ODH released the data seven months sooner than in past years (ahead of most states) to help the state and local governments and communities better understand the challenge. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania's monthly MAAC Meeting Held September 24, 2015. The Pennsylvania Department of Human Services hosted the monthly meeting of the Medical Assistance Advisory Committee last week. Below are summaries of the specific office updates. Relevant handouts can be found here.

Office of Medical Assistance Programs Update. Laurie Rock, Acting Bureau Director for the Bureau of Managed Care Operations, gave an overview of the RFP status for the HealthChoices program. The RFP included the following targets for Managed Care Plans for percent of the medical portion of the capitation of the payment of the plan expected to be paid out in value based purchasing arrangements: Year 1 - 7.5 percent; Year 2 - 15 percent; Year 3 - 30 percent. Rock noted that the bureau added a new pay for performance initiative – integrated care plan program – which encourages further collaboration between physical and behavioral health plans. She noted that requirements were strengthened for prenatal and maternal and the RFP includes requirements for plans to manage over 50% of their patients with face to face contact. The RFP was issued on Sept 16 and the deadline for comment submissions is October 16. A pre-proposal conference is scheduled for October 20. Answers to RFP questions will be posted on October 26 and bids are due by November 17 at 2 pm.

Office of Mental Health and Substance Abuse Services Update. Dennis Marion, Deputy Secretary for OMHSAS provided an update on Certified Community Behavioral Health Clinics (CCBHC) grant status. He stated that Pennsylvania's application was accepted and the department was cautiously optimistic they would get into the CCBHC pool of states.

Office of Long Term Living Update. Jen Burnett, Deputy Secretary for OLTL, provided an update on the Managed Long-Term Services and Supports concept paper. She said the Community HealthChoices concept paper takes into consideration the feedback on the discussion document and invited stakeholders to review the paper and provide feedback by October 16. Burnett emphasized that feedback received will be used to finalize the program design for the RFP that will be issues in November 2015. The program is going to focus on adults over the age of 21 in need of long term services and supports funded by the Medicaid program regardless of whether they receive those services in a home and community based setting or in a nursing facility. The main goals of Community HealthChoices including the following:

- Enhance opportunities for community based living;
- Strengthen coordination of long-term services and supports (LTSS) and other types of health care, including all Medicare and Medicaid services for dual eligible individuals;
- Ensure quality and accountability;
- Advance program innovation particularly with regard to employment goals;
- Increase efficiency and effectiveness through the use of technology.

UnitedHealthcare will enter Western Pa.'s market for Medicare Advantage plans. The nation's largest health insurer will make Medicare Advantage plans widely available to Western Pennsylvania seniors for the first time this fall, adding an option for thousands of people caught in the middle of the bitter feud between UPMC and Highmark Inc. United likely will include UPMC and Allegheny Health Network hospitals and doctors in its network, experts said. The plans will give another option to seniors trying to navigate a shifting market as Highmark, which owns the Allegheny Health Network hospital system, competes with UPMC Health Plan, which was founded by the area's dominant hospital system. United joins national insurers Aetna and Humana in competing for a share of a market dominated by Highmark and UPMC. Read More

Rhode Island

Medicaid Director Deidre Gifford Stepping Down. On September 28, 2015, *WPRI* reported that Deidre Gifford will step down as Medicaid Director to pursue opportunities in Washington, D.C. Gifford plans to stay until late October to ensure a smooth transition. The state is currently looking for a new person to fill the role. Medicaid accounts for approximately one-third of the state's budget — over $2 billion a year. Read More

South Dakota

Governor Dennis Daugaard Proposed Medicaid Expansion Plan. On September 28, 2015, *The Washington Post* reported that Governor Dennis Daugaard is meeting with Health and Human Services Secretary Sylvia Burwell to discuss his proposed plan to expand Medicaid. The proposal is still in the early stages and is estimated to cost the state between $30 million and $33 million starting in 2020. The proposal pays for the state's share of the expansion in part by expanding access to services that are fully funded by the federal government, with the goal of freeing up enough state funding to pay for the addition of more residents to the Medicaid program. The state is also asking for a change in the classification of some services to have them fully paid for by the federal government. Read More

Utah

UtahAccess+ Medicaid Expansion Plan Unveiled to Lawmakers. On September 29, 2015, *KSL.com* reported that the new Medicaid expansion plan, HealthAccess+, was unveiled in closed Republican caucuses in the House and Senate. The plan was proposed by Governor Gary Herbert and Republican legislative leaders, and is similar to the Healthy Utah plan that passed the Senate but failed in the House during the 2015 Legislature. HealthAccess+ would bring

$450 million in federal funds to Utahns. Hospitals, doctors, and other provider groups will be taxed starting in 2017 to raise $35 million. For hospitals, this could initially cost $4.5 million, while doctors would each pay $800. The state would contribute over $19 million. The public and health care providers will get an opportunity to comment at next week's Health Reform Task Force meeting. Read More

Vermont

Spike in Medicaid Costs Strain Budget. On September 23, 2015, *VPR* reported that there has been an unexpected spike in Medicaid costs since the start of the new fiscal year, which began less than three months ago. Analysts predict Medicaid costs may come in more than $60 million over budget in 2016. Furthermore, the increases may double the state budget gap in the fiscal year 2017 budget. The causes for the high Medicaid costs include higher utilization and the arrival of a new expensive drug to treat cystic fibrosis. Read More

National

Healthcare Industry Braces for Expansion of Codes on Oct. 1. On September 27, 2015, *The Wall Street Journal* reported that on October 1, 2015, the nation's healthcare system will switch to a new set of codes. The massive expansion that will change paperwork, insurance, and monitoring, is expected to create disruptions among providers. For doctors, the number of diagnostic codes will increase from 14,000 to 70,000. For hospitals, the number of procedure codes will expand from 4,000 to 72,000. Experts predict claim denials may double as providers and payers get used to the new set of codes. Read More

Correctional Facilities Enforcing Medical Copayments and Other Fees on Inmates. On September 29, 2015, *Kaiser Health News* reported that an analysis by the Brennan Center for Criminal Justice found that 35 states authorize copayments and other fees for medical services at state prisons or county jails. Furthermore, a study by the center found that inmate copayments range from a few dollars to as much as $100 for medical care. The practice is part of a larger trend of charging inmates for various prison services, including room and board, phone calls, and internet use. These fees may deter prisoners from making requests for care and from seeking necessary care for chronic conditions or treatment of communicable diseases that easily spread through crowded prisons. Read More

INDUSTRY NEWS

Blue Cross Blue Shield Association Announces Healthcare Database, BCBS Axis. On September 24, 2015, *FierceHealthPayer* reported that the Blue Cross Blue Shield Association announced a healthcare quality and cost information database, BCBS Axis. Axis will include information for 2.3 billion procedures each year from 96 percent of all hospitals in the country and 92 percent of doctors. BCBSA calls it the "largest database in the healthcare industry," with information from every zip code in the country. Axis will de-identify data to protect BCBS customers. Read More

Corizon Health Appoints Karey Witty as CEO. On September 23, 2015, Corizon Health announced that Karey Witty has been appointed as the company's CEO, effective November 2, 2015. Former CEO, Woodrow A. Meyers Jr., will become the Vice Chair of the Board of Directors and serve as a consultant to the company. Read More

Aetna Announces Two-Senior Level Leadership Additions. On September 30, 2015, Aetna announced that Gary Loveman, Ph.D. will join as executive vice president, and president of the Healthagen health services organization, which includes Aetna's Consumer Business. Additionally, Rock Jelinek will join as executive vice president for the Aetna-Humana integration, and Aetna's enterprise strategy. Both Loveman and Jelinek will join Aetna's Executive Committee, the company's senior-most leadership team. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
October 1, 2015	Florida Healthy Kids	Implementation	185,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October, 2015	Indiana	RFP Release	900,000
November 16, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
November 17, 2015	Pennsylvania HealthChoices	Proposals Due	1,700,000
December 31, 2015	Indiana	Proposals Due	900,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 15, 2016	Pennsylvania MLTSS/Duals	Proposals Due	450,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	450,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	450,000

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; Cigna-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 (*exiting demo*); 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	30,000	X	5/12/2014	9/1/2014	7/30/2015	12/1/2015	2/1/2016	Neighborhood INTEGRITY
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	4/1/2016	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), Cigna-HealthSpring, 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***			***12***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active demonstration enrollment.

State	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
California	122,908	123,079	124,239	122,520	122,798	122,846	120,452	116,470
Illinois	63,731	64,199	60,684	58,338	55,672	52,763	52,170	51,631
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705	17,671	17,518
Michigan					9,216	14,867	28,171	35,102
New York	17	406	539	6,660	7,215	5,031	7,122	9,062
Ohio	68,262	66,892	65,657	63,625	63,446	62,958	61,871	62,418
South Carolina		83	1,205	1,398	1,366	1,317	1,388	1,380
Texas			58	15,335	27,589	37,805	44,931	56,423
Virginia	27,333	26,877	27,765	27,349	30,877	29,970	29,507	29,200
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,262**	**363,283**	**379,204**

HMA NEWS

New this week on the HMA Information Services website:

- **West Virginia** Medicaid managed care enrollment up 85 percent, as of Sep-15 Data
- North Carolina lawmakers tentatively agree to shift to Medicaid managed care, Sep-15
- Public documents including the **Massachusetts** Senior Care Options responses and the **Georgia** GA Families and GA Families 360 CMO RFP, proposals, and protests
- Plus upcoming webinars on *Emerging Tools and Technology for Consumer Engagement in Health Care* and *Risk-Ready Primary Care: The Next Wave in Practice Transformation for a Value-Based Future*

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA's Edwards Co-authors Health Affairs MLTSS Policy Brief

HMA Principal Barbara Edwards is co-author of the *Health Affairs* health policy brief "Rebalancing Medicaid Long-Term Services and Supports." The brief examines Medicaid's support of more flexible community-based long-term services and supports, including what's at issue, the current debate and what's next. Read More

HMA Webinar Replays Available:

- ***"A Step-by-Step Guide to Integrating Behavioral Health into the Primary Care Setting" –*** Link to Replay
- ***"21st Century LTSS – A Roadmap" –*** Link to Replay

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