HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 17, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

MEDICAID HEALTH PLANS OF AMERICA (MHPA) LETTER TO CMS REVIEWED

This week our *In Focus* section reviews a September 4, 2014, letter sent to Centers for Medicare & Medicaid Services (CMS) Director Cindy Mann, from the Medicaid Health Plans of America (MHPA), which represents more than 100 Medicaid managed care plans serving around 20 million full-risk Medicaid beneficiaries. The purpose of the letter is to provide recommendations to CMS for regulatory updates in the areas of:

- Rate-setting and actuarial soundness, including the health insurance providers fee (HIPF);

- Medical loss ratio (MLR) requirements;
- Upper payment limit (UPL) calculations;
- Enrollee rights and protections and marketing guidelines;
- Quality and program integrity; and
- Churn mitigation.

In the sections below, we review the key takeaways from the MHPA recommendations. The MHPA letter to CMS is available here.

Rate-Setting and Actuarial Soundness

Actuarially Sound Rates. MHPA requests that CMS adopt the definition of actuarial soundness established by the Actuarial Standards Board (ASB) in December 2013, which provides more robust definitions of revenue sources and costs to be included in actuarial rate-setting. Additionally, MHPA recommends that the definition of actuarially sound capitation rates explicitly includes both medical costs as well as the costs of doing business in the state.

Inclusion of HIPF, Other Taxes/Fees. MHPA requests that the definition of an actuarially sound payment include coverage of any costs that plans incur as a result of taxes and fees, such as the HIPF, that are not deductible for tax purposes.

Rate-Setting Review/Flexibility. MHPA offers several recommendations around rate-setting transparency and review, including a process for requesting additional review of actuarial soundness, and requiring an evaluation of rate reductions on access to care. Additionally, MHPA suggests that states and MCOs could be granted the flexibility to adjust capitation rates to reflect the entry of new, high cost products to the market, such as the hepatitis C drug, Sovaldi.

Medical Loss Ratio (MLR)

Argument against Standard Minimum MLR. The MHPA argues in the letter than due to the complexities and variation in Medicaid populations covered through risk-based managed care across states, a blanket federal minimum MLR would create operational challenges and threaten innovation in Medicaid managed care.

- MHPA suggests that a state with a managed long-term supports and services (MLTSS) program may require higher administrative costs to coordinate a wider variety and number of services. Different states have different patient mixes, while within states, certain MCOs may serve a specialized population not served by other MCOs in that state.
- Additionally, in instances where MCOs are responsible for managing pass-through payments to accountable care teams, administrative costs may be higher.
- MHPA also suggests that imposition of a separate MLR could deter MCOs from reimbursing providers at greater-than FFS rates, as well as reduce incentives for investing in programs that reduce unnecessary utilization and drive overall cost savings.

Upper Payment Limit (UPL)

Change in Hospital UPL Calculation. MHPA recommends that CMS revise federal regulations on the hospital UPL calculation to allow managed Medicaid days to be counted. MHPA argues that this would reduce barriers to states'

expansion of managed care and avoid lost funding for hospitals under a reduced UPL. Providers will likely support this recommendation given the critical importance of UPL payments in assuring both access and financial viability. Currently, supplemental payments under Medicaid managed care are limited to DSH and GME. Allowing for the inclusion of Medicaid managed care utilization within the UPL would provide states the flexibility to effectuate policy initiatives without undermining the impact of managed care models.

Enrollee Rights and Protections/Marketing

Adoption and Use of New Technologies. MHPA suggests that wherever possible, CMS should adopt appropriate rules for us of technology, such as cell phones and the internet, to engage beneficiaries.

Aligning Medicaid and QHP Marketing Regulations. MHPA argues that Medicaid MCO marketing regulations and those for qualified health plans (QHPs) on the Marketplaces should be aligned to eliminate the potential for an uneven playing field for Medicaid MCOs and traditional commercial insurers. Many Medicaid MCOs also offer QHP products and may be limited in marketing to potential QHP enrollees who may or may not be eligible for Medicaid.

Quality Measures

MHPA Recommendations on Quality Measures. The MHPA letter to CMS offers nearly a dozen recommendations on Medicaid MCO quality measures and quality programs going forward. We have highlighted some of the key recommendations below.

- Capitation rates should be actuarially sound before any performance incentives or bonus payments.
- In states with primary care case management (PCCM) or Medicaid accountable care organization (ACO) programs operating alongside Medicaid MCOs, all care coordination models should be measured on the same performance criteria.
- As with Medicare Advantage, new Medicaid MCOs or MCOs covering new populations/services should be noted as “too new” for measurement.

Medicaid “Churn” Mitigation

To limit the impact of Medicaid beneficiaries transitioning to and from commercial coverage, MHPA suggests the maintenance of non-emergency medical transportation (NEMT) and early periodic screening, diagnosis, and treatment (EPSDT) benefits under any coverage options. Additionally, MHPA suggests greater beneficiary education from CMS, as well as the facilitating of data sharing between Medicaid MCOs and QHPs.

HMA MEDICAID ROUNDUP

California

HMA Roundup – Alana Ketchel

Anthem Enters Joint Venture with Seven Hospital Groups to Create New HMO. On September 16, 2014, the *Los Angeles Times* reported that Anthem Blue Cross is collaborating with seven hospital groups in Los Angeles and Orange counties to create a health plan option for employers in Southern California. The new HMO plan, called Vivity Health, will be about 10 percent cheaper than Anthem's standard HMO. The partner hospitals in the venture include Cedars-Sinai Medical Center, the UCA Health System, MemorialCare Health System, Good Samaritan Hospital, Huntington Memorial Hospital, Torrance Memorial Medical Center and PIH Health. The plan also includes all of these institutions' affiliated physicians' offices, surgery centers, clinics and other outpatient facilities. The seven hospital partners and Anthem will share in any profits and losses from the joint venture. Read more

State Extends Autism Coverage for Medi-Cal Kids. On September 15, 2014, *Kaiser Health News* reported that thousands of kids from low-income families who have an autism spectrum disorder are now eligible for behavioral therapy as part of Medi-Cal's extension of autism benefits. California is among the first states to respond to the CMS rule that requires this therapy be covered as part of a "comprehensive array of preventive, diagnostic and treatment services" for low-income people 21 and under. Rates to providers have not yet been released, but the state plans to contain costs by using a managed care model. Read more

Covered California Begins 2015 Outreach Campaign. On September 15, 2014, Covered California announced it is launching its outreach efforts for 2015. The exchange aims to enroll 500,000 new people in this next phase of open enrollment. The campaign will also help existing enrollees renew. In addition to a new ad campaign, the exchange provided grants to community organizations to assist with outreach. Covered California's total investment in the outreach campaign totals $94 million. Read more

Medi-Cal Director Toby Douglas to Resign. On September 12, 2014, current Director of the Department of Health Care Services Toby Douglas announced in an email to stakeholders that he would retire at the end of the year. Douglas has served in this position since 2011; during his tenure, Medi-Cal began transitioning to a managed care model and added 3.5 million new beneficiaries. Douglas said he plans to seek out a new leadership position in health care. In a statement to state officials, California HHS Secretary Dooley wrote that she will soon begin the process of identifying a new DHCS Director.

LA County Installing Electronic Health Record. On September 11, 2014, the *California Healthline* reported that Los Angeles County is installing a county-wide electronic health record system, which would serve both public and private providers. The system, called the Online Real-time Centralized Health Information Database, or ORCHID, is being developed by Cerner. Beyond sharing information among the Department of Health Services' providers, the initiative will allow information sharing across the county Sheriff's Department, Probation Department and the Department of Mental Health. Patients will be identified and linked through a Master Patient Index. Read more

Kaiser Pays $4 Million for Violation of Mental Health Laws. On September 9, 2014, *Sacramento Bee* reported that Kaiser Permanente has agreed to pay a $4 million fine issued by the Department of Managed Health Care (DMHC) for violation of mental health laws. DMHC alleged that Kaiser inappropriately limited access to mental health appointments in a March 2013 report and did not adequately correct deficiencies. Kaiser dropped its appeal after a judge denied its request to keep documents from the scheduled trial confidential. Read more

Colorado

HMA Roundup – Joan Henneberry

Anthem Partners with Mountain Hospitals in Four Counties to Reduce Health Insurance Rates by 8 Percent. On September 12, 2014, *Health News Colorado* reported that Anthem Blue Cross and Blue Shield of Colorado will sell a new product for residents in four expensive resort communities, many of who currently pay some of the highest health insurance rates in the country. The new Anthem HMO will be called "Mountain Enhanced" and will cut rates for consumers by about 8 percent next year. As of now, the plan will be offered in Eagle, Summit, La Plata and Montezuma counties. Consumers who select Mountain Enhanced must agree to get their care locally, rather than driving to Denver or Grand Junction for care. Read more

Exchange Managers Prepare for Potential Issues that Could Slow Down Open Enrollment. On September 9, 2014, *Health News Colorado* reported that Colorado's health exchange managers are preparing for possible IT and sign-up complications resulting from employee turnover and exchange repairs. The exchange's Chief Financial Officer, Cammie Blais, is now leaving weeks after her former boss, CEO Patty Fontneau, stepped down. It also was reported that SeeChange, a health insurance carrier that only recently joined the exchange and co-op, is planning to leave the exchange ahead of the next open enrollment period. Finally, exchange managers are behind on repairing several application features, which could slow down applications in the next open enrollment cycle. Read more

Coalition for Homeless Opens New Health Care Facility in Denver. On September 9, 2014, the *Denver Post* reported that the Colorado Coalition for the Homeless has opened the Stout Street Health Center, a clinic that offers vision, dental and physical and mental health services to Denver's homeless. The facility will allow people (homeless or not) to get immediate care without having to make an appointment ahead of time. Coalition president John Parvensky calls the facility "the most advanced integration of mental and physical health care in the country for the homeless or anyone else." Read more

Connecticut

CTBHP Releases Behavioral Health Management RFI. On September 9, 2014, the Connecticut Departments of Social Services, Mental Health and Addiction Services and Children and Families released a Request for Information (RFI) seeking information about new techniques for behavioral health management. The Departments (collectively called the Connecticut Behavioral Health Partnership) are responsible for increasing access to behavioral health services and family-centered community-based services, while simultaneously decreasing unnecessary use of institutional services. The RFI aims to gather information on the innovative capabilities of behavioral health management vendors to design, implement and manage a behavioral health services system that improves member experience, improves member outcomes and manages expenditures for the Medicaid populations in the state. Responses are due by September 29, 2014. The Departments intend to issue an RFP in the near future and may use information from this RFI to inform the contents of the RFP. Read more

Florida

HMA Roundup – Elaine Peters

Univita Rules the Florida Medicaid Market – Is It Fair? On September 11, 2014, *Health News Florida* reported on Univita Health and its influence in the Florida Medicaid managed care market. Managed care plans have been contracting with Univita to manage their home-care and medical equipment businesses, even though Univita itself is a provider of home-care and equipment to the same health plans. Both the Florida Alliance for Home Care Services and the Florida Association of Medical Equipment Suppliers have complained to the state's Agency for Health Care Administration about Univita's potential conflict of interest in this matter. Read more

Georgia

DCH Suspends Nursing Home Rate Change. On September 11, 2014, *Georgia Health News* reported that Department of Community Health (DCH) Commissioner Clyde Reese has suspended a proposal that would give about 40 nursing homes rate increases from Medicaid. The rate change was designed to increase reimbursement to companies that bought Georgia nursing homes between January 1, 2012 and June 30, 2014, because of the costs that new owners bear in upgrading the facilities. While Reese finds the rate increase reasonable, he would like to extend the increase to a broader range of nursing homes. However, some members of the DCH Board had expressed skepticism about the rate change at an earlier board meeting. Read more

DCH Board Holds Monthly Meeting. On September 11, 2014, the Georgia Department of Community Health (DCH) Board held its bimonthly meeting. Commissioner Boyd gave a summary report of the Audit Committee's meeting prior, stating that CFO Tim Connell and his staff had given an update report on the progress of activities around the four findings and 10 management points from DCH's last audit. He stated that there were IT upgrades that had been made to facilitate more timely and accurate reporting.

Commissioner Clyde Reese then gave his report. He stated that the agency was working on a number of major procurements. His comments are summarized here:

- DCH continues to work with CMS around the cost savings aspect of the ABD Care Coordination RFP. No update on potential release for that.
- As timely credentialing has been an issue since the inception of the Georgia Families program, DCH is issuing a procurement for a single CVO which will perform the credentialing for all CMOs. He stated they hoped to release it in October, but that time could slip.
- DCH is re-procuring for a medical review contractor, as the current contract with GMCF is near its term.
- Commissioner Reese will be reviewing the RFP for the re-procurement of the Georgia Families CMOs "later this year." They hope to release the RFP in December 2014. No more specific date was given. He stated their goal was to select plans by July 1, 2015, leaving a year for implementation before July 1 2016.
- He stated that plans were underway for the State Health Benefit Plan Open Enrollment, which is scheduled for October 27, 2014 through November 14, 2014.
- There will be a special phone Board meeting later in September to consider provider fees for private hospitals.

Finally, Commissioner Reese stated that he was pulling the last item on the agenda, the Nursing Facility Services Rate Adjustment for Ownership Changes Public Notice, because DCH wanted to give it further study in order to form a more global approach. He stated that DCH wanted to be able to use more current cost reports that would more accurately reflect expenses incurred. Watch here

Indiana

Comment Period for HIP 2.0 Plan Drawing to a Close, Only Few Comments Posted So Far. On September 14, 2014, the *Times of Northwest Indiana* reported that Hoosiers wishing to comment on Governor Mike Pence's Healthy Indiana Plan (HIP) 2.0 Medicaid expansion alternative have until September 21 to do so. Only 15 comments have been submitted on the plan so far; these comments are evenly divided between people who support HIP 2.0 and people who believe the state should go with traditional ACA Medicaid expansion. Read more

Maine

Gubernatorial Candidate Mike Michaud Outlines His Ideas on Health Care in Maine. On September 15, 2014, the *Charlotte Observer* reported on Maine Gubernatorial hopeful Mike Michaud's ten-part health care plan, which includes taking advantage of telemedicine, supporting preventative care and improving substance abuse and mental health services. Michaud also supports expanding Medicaid to 70,000 Mainers and thinks the state should consider creating a state-based exchange marketplace, rather than using the federal website. Read more

Massachusetts

Connector Health Plan Rates for 2015 to Rise by 1.6 Percent on Average. On September 12, 2014, the *Boston Globe* reported the price of plans on the Massachusetts Health Connector will increase an average of 1.6 percent in 2015. That is less than the overall health care market statewide, in which premiums are going up an average of 3.1 percent. The Connector will offer plans from 11 health insurance companies when open enrollment begins on November 15. Read more

Health Connector Releases Enrollment Timeline in Preparation for November's Open Enrollment. On September 11, 2014, MassHealth/the Massachusetts Health Connector published a timeline for consumers who will be applying for health insurance coverage through the exchange for 2015. The timeline runs from October through January and includes instructions for consumers who have commercial health plans through the Connector, those who had Commonwealth Care plans last year that have been continued this year, and for those who have temporary coverage through MassHealth. An estimated 450,000 residents will be applying for 2015 coverage in the next open enrollment cycle. Read more

Minnesota

PreferredOne Pulls Out of MNsure Exchange. On September 16, 2014, the *Minneapolis/St. Paul Business Journal* reported that PreferredOne will stop offering plans on MNsure, the state's health insurance exchange. The insurer sites administrative and cost burdens as reasons for its decision. The news is significant to the MNsure exchange since PreferredOne offered the lowest-cost plans on the exchange this year. Consumers who signed up for PrefferedOne plans can renew their coverage for next year, though the insurer will be able to change premium prices for 2015. Read more

Nevada

Nevada Health Link Ends Search for New IT Vendor. On September 11, 2014, the *Las Vegas Review-Journal* reported that the board of the Silver State Health Insurance Exchange has voted to end the search for a company to replace its former IT vendor Xerox, which lost its contract in May following the exchange's rocky rollout. The board will instead permanently borrow enrollment and eligibility software from the federal HealthCare.gov system. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Five Community-Based Organizations Receive Federal Awards to Assist with ACA's Year 2 Open Enrollment Efforts. When federal Marketplace open enrollment begins on November 15, 2014, five New Jersey organizations will be ready to assist individuals navigate healthcare.gov with the help of $1.9 million in federal funding. The Center for Family Services; the Wendy Sykes-Oranges ACA Navigator Project; the Community Health Law Project in collaboration with the Employers Associaton of New Jersey; and The Family Resource

Network Inc. will benefit from funding to provide in-person assistance to facilitate health care access and enrollment. Read more.

Qualified Income Trusts to be Adopted in New Jersey. The State of New Jersey is planning to implement Qualified Income Trusts (QIT), previously referred to by the state and in the July 2, 2014 issue of the HMA Roundup as "Miller Trusts", for individuals who qualify for managed long term services and supports. Under a QIT, the individual's income is deposited into the trust after allowing for a small personal needs allowance and, if married, a monthly allowance for the applicant's spouse. The trust funds are then used to pay Medicare and Medicaid for part of the cost of their care, while at the same time, permitting Medicaid eligibility. The QIT may also be used to cover Medicare premiums and medical costs not covered by Medicare and Medicaid. Individuals who may use a QIT qualify for an institutional level of care, and can live in a nursing facility, assisted living facility or in their home. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) will soon post a QIT template and Frequently Asked Questions (FAQs) on its website that may be used by individuals who wish to establish a QIT. Read more.

New York

HMA Roundup – Denise Soffel

UnitedHealth Care Withdrawing from SHOP. UnitedHealth Care is pulling out of the state's SHOP, the small group health insurance market offered through the health exchange, affecting about 1,900 subscribers. The decision comes after the state's Department of Financial Services allowed the company only a 2.12 percent rate increase. United had asked for a 17.04 percent increase, according to the state.

New York Congressional Delegation Troubled by Medicaid Disallowances. In a September 12 letter to HHS Secretary Burwell, members of the New York Congressional delegation raised concerns about CMS's ongoing pursuit of Medicaid disallowances as a result of the payment rate methodology for providers of services to individuals with intellectual/developmental disabilities. New York's Medicaid program has been under review by the Health & Human Services (HHS) Office of the Inspector General, to determine the acceptability of Medicaid costs for services provided to the Medicaid population in New York State-Operated Intermediate Care Facilities for the Developmentally Disabled (ICF/DD). The initial review period includes claims for services provided from April 1, 2010 through March 31, 2011. Last month CMS issued a disallowance notification in the amount of $1.26 billion as a result of this review. CMS also indicated it will be initiating a similar review of the two subsequent fiscal years, with a comparable amount of Federal aid at risk if CMS is successful. The letter notes that NYS intends to appeal the decision, given that CMS had approved the payment rate methodology, and was imposing the disallowance after the fact. Given the amount of money at stake, any disallowance would have a significant impact on the Medicaid budget. Further, CMS has expressed its plan to review and seek additional disallowances for subsequent years. Should those reviews prove successful, a comparable amount of federal aid is at risk. The Congressional letter suggests that it would be inappropriate to begin any further review until the appeals process has been concluded.

Launch of the NYS Health Profiles Website. Acting Commissioner of Health Howard A. Zucker, M.D., J.D., announced the launch of the redesigned New York State Health Profiles website. The New York State Health Profiles, which is maintained within the State Health Department's public website, is a consumer-oriented portal providing centralized access to health care information in four areas: hospitals, nursing homes, home health agencies and hospice programs, and physicians. Users can view details about the quality of care and inspections at health facilities and compare them to national and statewide averages. Changes to the Health Profiles include: centralized access to all profiles in a single, location; modernized access using updated technology; and improved usability for consumers, including an ability to search for and compare quality measures across facilities in a given region.

The initial launch includes the fully redesigned hospital profile, enabling consumers to search for hospitals and clinics by county or region, service, designation (i.e., perinatal, trauma, stroke centers), and more. The nursing homes, home health agencies and hospice programs sections of the Health Profiles portal will be similarly modernized in the near future.

Nursing Home Carve-In Likely to be Delayed Again. CMS has still not approved the expansion of the 1115 waiver that will allow the State to require new nursing home residents to enroll in mainstream Medicaid managed care and MLTC plans. The state Medicaid Redesign Team website still indicates a start date of October 1, but this seems increasingly unlikely. Department of Health staff indicates it is likely that the carve-in will again be postponed, probably to January 1, 2015. The initial transition guidance had indicated a June 1, 2014 start date: "Effective June 1, 2014, in NYC, Nassau, Suffolk and Westchester counties all eligible beneficiaries age 21 and over, in need of long term placement in a nursing facility, as defined by §1919(a)(1)(C) or 42 U.S.C. 1396r, requirements for nursing facilities, will be required to join a Medicaid Managed Care Plan (MMCP) or a Managed Long Term Care Plan (MLTCP)."

Expansion of Mandatory Managed Long-Term Care Delayed. Leading Age New York reports that due to the delay in the July MLTC implementation approval from CMS, DOH has re-evaluated their original proposal for moving to mandatory MLTC throughout the rest of state. The original timeline completed the transition to mandatory managed long-term care for dual-eligible in needs of 120 days or more of community-based long-term care services at the end of the 2014 calendar year. The revised timeline extends to February 2015.

Behavioral Health Carve-In and Establishment of Health and Recovery Plans. The behavioral health carve-in, which is scheduled to occur January 2015 in NYC and six months later in the rest of the state, includes two separate components. All plans must be prepared to take on care management for all individuals with a behavioral health diagnosis, and coordinate all the services that population will require. The second component is specific to Medicaid beneficiaries with serious mental illness. The state has designed a new product called a HARP (Health and Recovery Plan). HARP enrollment will be open to Medicaid beneficiaries with serious mental illness and/or substance use disorders, based on a pattern of high utilization/high cost. HARPs will be required to provide all the behavioral health services currently included in the state's Medicaid plan, as well as a number of services currently available through Section 1915 (i) home and community-based care waivers. The state issued a Request for Qualifications that all plans were required to complete. The state has completed its initial review of responses to the RFQ. The state has

indicated that responses to the RFQ were not as strong as they had hoped. Individual letters were sent to each plan identifying deficiencies, and the state agencies have committed to working with the plans as part of on-the-ground readiness review.

To assist behavioral health providers, New York State has contracted for a Managed Care Technical Assistance Center (MCTAC). MCTAC will be led by NYU's McSilver Institute in partnership with the National Center on Addiction and Substance Abuse (CASA) at Columbia University. MCTAC will provide tools and trainings that will assist providers in improving business and clinical practices, as they transition to Medicaid managed care. Readiness trainings for both plans and providers are scheduled across the state during the month of September. Although the state has not announced a delay in implementation, a January 1, 2015 start for New York City, is increasingly unlikely as CMS has not approved the HARP plan, and readiness reviews have not yet begun. The state had planned to release a revised RFQ for non-New York City plans, but given the demands on agency staff, that is also likely to be delayed.

North Dakota

Lawmakers Discuss Medicaid Expansion and Budget. On September 10, 2014, the *Bismarck Tribune* reported on the future of Medicaid expansion in the state of North Dakota. So far, 13,000 residents have signed up for Medicaid since expansion began in the state. State Department of Human Services Executive Director Maggie Anderson told members of the interim Government Services Committee that that additional state funding for Medicaid expansion will be a topic of discussion in the 2015 session due to a decrease in federal funding. Read more

Ohio

Performance Reporting for Commercial and Managed Care Plans to Begin in November. On September 17, 2014, the Ohio Office of Health Transformation announced that the state's largest commercial health insurance plans and Medicaid managed care plans will begin reporting performance data on six high cost episodes of care – asthma, chronic obstructive pulmonary disease (COPD), perinatal, total joint replacements (TJR), and acute and non-acute percutaneous coronary interventions (PCI). The first performance reports will be shared with providers in November 2014. This is the first step in a comprehensive plan, called the Episode-Based Payment Model, to set quality of care as a priority, rather than quantity of care. Details about the Episode-Based Payment Model can be found here.

State Lowers Expenses for Inmate Healthcare Because of Medicaid Expansion. On September 16, 2014, the *Columbus Dispatch* reported that Ohio paid $10.3 million less of health care for prisoners in the 2014 fiscal year, mostly due to Medicaid expansion. Medicaid began covering most of the inmate medical costs on July 1, 2013, after Governor John Kasich decided to expand Medicaid in the state. Read more

Feds Question Ohio's Sales Tax on Medicaid Managed Care Insurers. On September 12, 2014, the *Columbus Business First* reported that the federal government may end Ohio Medicaid's 5.5 percent sales and use tax on private

insurers managing Medicaid in the state. The state uses the tax revenue to acquire federal matching funds for Medicaid; but the U.S. Department of Health and Human Services has stated that taxing a subset of healthcare services or providers is not fair. Read more

Ohio Achieves Home and Community-Based Services Targets One Year Ahead of Schedule. On September 10, 2014, the Ohio Department of Medicaid announced it surpassed the 50-percent spending target for home and community-based services one full year ahead of the federal deadline. In June 2013, the state was awarded $169 million in additional federal Medicaid matching funds as a result of the state's commitment to direct half of all Medicaid long-term care funding to home and community-based services (rather than more expensive nursing homes and other institutions) by September 30, 2015. Read more

Oregon

Oregon and Gilead Sciences Still Not Settled on Price for Sovaldi. On September 15, 2014, the *Oregonian* reported that the state of Oregon and Gilead Sciences, the manufacturer of an expensive new drug for hepatitis C, may be able to compromise on cost. The state and Gilead had recently reached an impasse on the drug's distribution; Gilead offered to take a third off the list price so long as the state dropped any limitations on consumers' access to the drug. But lawmakers at a state House Health Care Committee hearing this week said that Gilead might be open to dropping that demand. After the hearing, Gilead released a statement that did not confirm or deny this; they instead stated their "willingness to provide supplemental rebates if the state agrees to provide appropriate levels of access for patients with chronic hepatitis C." Read more

Pennsylvania

HMA Roundup – Mike Nardone

Auditor General Requests Details on $48 Million Spent by Corbett Administration to Prepare for Healthy PA Program. On September 16, 2014, the *Harrisburg Patriot News* reported that Auditor General Eugene DePasquale has asked Governor Tom Corbett for details on $48 million spent by the Commonwealth to date to prepare for the launch of the Healthy PA program, Pennsylvania's recently approved Medicaid expansion program. The $48 million was a reference to a figure quoted by a member of the Governor's staff and reported in a recent press account. In his September 12 letter to Gov. Corbett, the Auditor General requested copies of all contracts, including the requests for proposals and/or sole source justification documents and itemized billing statements, for all contracts related to Healthy PA in order to determine if any additional review is necessary. A spokeswoman for Governor Corbett dismissed the request as politically motivated and the Department of Public Welfare clarified that the state so far has spent $5.2 million of an estimated $43.5 million, mostly in federal funds, to prepare for Healthy PA, with most of these dollars going toward information technology/systems costs. Read more

Study on Number of Uninsured Pennsylvania Children Released. In its latest annual State of Children's Health Care report, the Pennsylvania Partnerships for Children reports that 144,000 Pennsylvania children (or roughly 1 in 20) lack

health insurance – a statistic that has dropped only slightly in recent years. In releasing the report, the group noted that the recent federal decision to approve Pennsylvania's Healthy PA might have a "ripple effect" of covering more children in the years ahead. The report also found that more could be done to make sure insurance coverage is being used in a preventive, cost-effective manner. Of the approximately 1.26 million Pennsylvania children insured through Medicaid or CHIP, about one-third are not receiving annual dental visits critical to promoting good oral health; fewer than half of 2-year-olds are receiving recommended screenings to detect elevated lead levels in the blood; about 15 percent are not receiving timely vaccinations against preventable illnesses or diseases; and the percentage of children benefitting from regular check-ups with primary care providers has remained relatively stable, while the percentage of hospital admissions for children has increased for the second year in a row.

Pennsylvania Organizations Receive Navigator Grants. On September 11, 2014, *PennLive* reported that Pennsylvania organizations will receive about $2.4 million to continue funding for "navigators" to help people sign up for insurance coverage available through the Affordable Care Act when enrollment reopens November 15. Organizations slated to receive a share of the grant funding include Resources for Human development, a Philadelphia-based non-profit agency, the Pennsylvania Association of Community Health Centers, the Pennsylvania Mental Health Consumers Association, and Mental Health America. The funding to these Pennsylvania organizations is part of the $60 million in grants allocated by HHS to 90 organizations across the country that will serve as navigator organizations for individuals served by Federally-run health insurance marketplaces under the ACA. About 318,000 Pennsylvania residents signed up for coverage through the Federal marketplace during the first open enrollment period, which ended March 31. Read more

Rhode Island

Rhode Island Medicaid Issues First Guidelines for Sovaldi. On September 11, 2014, Rhode Island NPR reported that the Rhode Island Executive Office of Health and Human Services has posted its first guidelines for approving coverage of Sovaldi, the expensive but highly effective new treatment for hepatitis C. In order for a Medicaid beneficiary with the disease to access the drug, they must be "pre-authorized," meaning they must meet certain criteria for disease genotype, disease progression and past response to other hepatitis C treatments. Read more

Washington

Washington Hospitals See $154 Million Decrease in Charity Care Spending in First Half of 2014. On September 14, 2014, the *Seattle Times* reported hospital charity care costs in Washington have decreased nearly $154 million in the first half of 2014 compared to the first half of 2013, likely due to the ACA's focus on reducing the number of uninsured patients. Charity care numbers were provided by the Washington State Hospital Association. Around 600,000 residents have signed up for health insurance through Medicaid under the expanded eligibility guidelines or through private plans. While charity cases are declining, most hospitals report seeing about the same number of patients each

year, suggesting that previously uninsured residents have now acquired health insurance. Read more

Wisconsin

State Will Need $760 Million More for Health Care Over Next Two Years. On September 16, 2014, the *Milwaukee Journal-Sentinel* reported that the state needs $760 million more to pay for health care for low-income residents over the next two years. The new spending figures are presented in the health departments spending request for the next two-year budget. The request assumes the state will resolve the $93 million gap in its Medicaid budget but will not opt for Medicaid expansion under the ACA. Read more

National

Senate Holds Hearing on CHIP Funding. On September 16, 2014, the *New York Times* reported on a hearing held by the Senate Finance Subcommittee on Health Care to discuss CHIP's track record and to determine future funding for the program. The program, which provides coverage to about 8 million children, received bipartisan support at the hearing; however some lawmakers stated the program should be re-examined in order to ensure it meets the needs of low-income kids without allowing redundancies in coverage. Funding for CHIP is set to expire next year. Advocates for CHIP believe the program offers more generous benefits to children than they would receive from private insurance plans subsidized by the federal government. Advocates also expressed concern that kids currently eligible for CHIP might not qualify for coverage in the health law's online marketplaces. Subcommittee Chair Senator Jay Rockefeller (W.Va.) introduced a bill earlier this year to extend CHIP's funding through 2019. The bill also provides incentives for states to expand CHIP coverage and improve dental care for kids. Meanwhile, the Medicaid and CHIP Payment and Access Commission recommended only a two-year extension, arguing that would be long enough to address any issues that might arise by signing kids up for new options available from the ACA. Read more

MACPAC Holds Public Meeting September 18-19, 2014. On September 18 and 19, the Medicaid and CHIP Payment and Access Commission (MACPAC) will hold a public meeting in Washington, D.C. The Chair of MACPAC, Diane Rowland, and Vice Chair David Sundwall will open the meeting with an overview of MACPAC's Work Plan for 2014-2015. Various Commission Analysts will then discuss the future of CHIP, including states' financing for the program. Stakeholders will then discuss Medicaid expansions in states that opted to offer new beneficiaries Premium Assistance to purchase private health plans. The meeting will end with a review of Medicaid and CHIP enrollment in 2014 and accounts of early experiences of new Medicaid enrollees. Read more

Rockefeller Institute Reports State Tax Collection Decline in Q2 2014. In its September 17, 2014, data alert, The Rockefeller Institute reported a significant trend of declining personal income tax and total tax collections across a majority of states. According to the report, 29 states reported declines in overall tax collections in Q2 2014 as compared to Q2 2013, while 36 states reported declines in income tax collections over the same period. Some of the major declines can be attributed to legislative changes, the overall trend shows a 7.1 percent

decrease in personal income taxes and 1.7 percent decrease in overall tax revenues. Sales taxes, meanwhile, are up 4.2 percent across all states. Read more

New ACOs Deliver Substantial Savings, Improve Care. On September 16, 2014, the U.S. Department of Health and Human Services/CMS reported that Medicare Accountable Care Organization (ACOs) have improved patient care and produced hundreds of millions of dollars in savings for the program. ACOs in the Pioneer ACO Model and Medicare Shared Savings Program generated over $372 million in total program savings for Medicare ACOs. The ACOs also outperformed published benchmarks for quality and patient experience last year and improved significantly on almost all measures of quality and patient experience this year. Read more

Marketplace Consumers Could Lose Insurance Unless They Provide Information on Immigration Status, Citizenship and Income. On September 15, 2014, the *Washington Post* reported that 115,000 immigrants who purchased health insurance through the federal insurance marketplace will lose their coverage at the end of September because they missed the deadline to provide the proof of citizenship or immigration status. The deadline for submitting these documents was September 5. These individuals can still submit documentation; so long as they are still eligible, they will be able to regain coverage. Separately, about 363,000 consumers could lose their federal subsidies if they do not clarify information on their incomes before September 30. The income information provided by these individuals differs from that on federal tax records. CMS will start sending notices to these individuals this week. Read more

Passive Renewal of Health Plans Offers Consumers Convenience, But Includes Caveat. On September 14, 2014, the *New York Times* reported that the consumers who receive automatic renewal of health plans they purchased through the federal marketplace could receive inaccurate information related to costs and other aspects of coverage for the upcoming year. While the automatic renewal process was put in place for consumer convenience, the federal government is emphasizing that consumers should revisit the marketplace to make sure they are getting the right amount of financial assistance and compare to other health plans. The feds said they did not have the ability to compute 2015 subsidies from the income data currently available to them; thus, consumers should go back to the marketplace and report changes to income or family size, which will affect the amount of their subsidies. Read more

Next-Generation Hepatitis C Drug Will Be Even More Expensive Than Sovaldi. On September 12, 2014, *Reuters* reported that Gilead Science's next generation drug for treating hepatitis C will cost even more money than the current treatment, Sovaldi, which costs $84,000 per treatment. The new drug, scheduled to launch next month, will be the first all-oral treatment for the virus. The drug will also have a shorter treatment regimen for some patients (8 weeks versus 12 weeks) and a higher cure rate (99 percent versus 90 percent) compared to the current Sovaldi treatment. U.S. regulators are expected to decide by October 10 whether to approve the new drug. Read more

Industry News

Ascension and Envision Healthcare Form Joint Venture. On September 15, 2014, Envision Healthcare announced that it has entered into an agreement with Ascension Health to form a joint venture to provide an array of post-acute services including home care, hospice care and infusion therapy to individuals in communities served by Ascension's Health Ministries. The new venture will initially include five of Ascension Health's 23 communities, with the first phase of the agreement beginning at the end of 2014. Read more

Cognizant to Acquire TriZetto Corporation in $2.7 Billion Deal. On September 15, 2014, Cognizant Technology Solutions Corp. announced that it acquired healthcare IT solutions provider TriZetto Corporation from Apax Partners for $2.7 billion in cash. This represents the biggest deal in Cognizant's history. Healthcare currently accounts for 26 percent of Cognizant's revenue; the acquisition of TriZetto should help the company increase its healthcare revenue even further. Read more

Advocate Health and NorthShore University HealthSystem to Merge. On September 12, 2014, *CBS* reported that Advocate Health Care and NorthShore University HealthSystem plan to merge to create Advocate Northshore Health Partners, which would be the largest non-profit hospital system in Illinois. The merger would create a network of 16 hospitals, 6,000 physicians, 45,000 employees and more than 350 care sites, serving approximately 3 million patients a year in northern and central Illinois. Officials said current patients should not have to switch doctors if the merger goes through; rather, they will just have a larger group of providers to choose from. Read more

Nautic Partners Acquires All Metro Health Care Services, Inc. On September 11, 2014, Nautic Partners, LLC announced that it has acquired home care agency All Metro Health Care Services, Inc. All Metro is a leading provider of home- and community-based services in New York, New Jersey and Florida. Healthcare Financing Group led the financing for the transaction; no financial terms have been disclosed. Sellers include BBH Capital Partners. Read more

Civitas Solutions, Inc. Announces Pricing of IPO. On September 16, 2014, special needs home and community-based care provider Civitas Solutions Inc. raised $199 million in its IPO. The company, which markets its services nationally as The MENTOR Network, priced 11.7 million shares at $17 per share (below $20-$23 range), for an initial market cap of around $628 million. It will trade on the NYSE under ticker symbol CIVI. Barclays was listed as left lead underwriter. The company reported an $18.3 million net loss on around $1.2 billion in revenue for 2013. Vestar Capital Partners remains the company's majority shareholder following the IPO. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
September 26, 2014	Louisiana	Proposals Due	900,000
October 9, 2014	Arizona (Behavioral)	Proposals Due	23,000
October 24, 2014	Louisiana	Contract Awards	900,000
October 30, 2014	Texas STAR Kids	Proposals Due	175,000
December, 2014	Georgia	RFP Release	1,250,000
January 1, 2015	Michigan Duals	Implementation	70,000
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
January 1, 2015	New York Behavioral (NYC)	Implementation	NA
January 1, 2015	Washington Foster Care	Implementation	25,500
January 1, 2015	Texas Duals	Implementation	168,000
January 1, 2015	New York Duals	Implementation	178,000
February 1, 2015	Louisiana	Implementation	900,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
July 1, 2015	Washington Duals	Implementation	48,500
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
January 1, 2016	Georgia	Implementation	1,250,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa		62,714	Not pursuing Financial Alignment Model						
Idaho		22,548	Not pursuing Financial Alignment Model						
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	1/1/2015	4/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri		6,380	Not pursuing Financial Alignment Model						
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X			10/25/2013	7/1/2014	1/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	168,000				5/23/2014	3/1/2015	4/1/2015	Amerigroup, Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013	3/1/2014	5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	7/1/2015	9/1/2015 11/1/2015 1/1/2016	UnitedHealthcare
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 5 MFFS**	**1.35M Capitated 513K FFS**	***12***			***11***			

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

‡ Capitated duals integration model for health homes population.

HMA News

Governing Article Draws on HMA's Expertise

Governing's Chris Kardish tapped the expertise of HMA Managing Principal Joan Henneberry for his article, "States Making Long-Term Contraception More Accessible". The Governing article examines how and why states are making Long-Acting Reversible Contraception more accessible to patients and doctors. Read more

HMA Upcoming Appearances

Community Healthcare Care Association of New York State (CHCANYS) Statewide Conference and Clinical Forum 2014

Vern K. Smith, PhD – Keynote Speaker

October 19, 2014

White Plains, New York

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