HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 21, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

HEALTH MANAGEMENT ASSOCIATES LAUNCHES HMA INFORMATION SERVICES

This week, HMA Principal Carl Mercurio highlights a new business line for Health Management Associates, HMA Information Services. (HMAIS), an online resource for Medicaid data. For more information on HMAIS, or to subscribe, contact Carl at:

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Bringing Order to Chaos

If you are the head of strategic planning, research, procurement, or product development at a Medicaid health plan, you have no doubt received the following phone call from your boss at some point in your career:

"A new Medicaid RFP is out. We need everything you can find on the market, and we need it yesterday."

The same goes for provider organizations, pharmaceutical companies, and vendors assessing the Medicaid market for strategic planning and business development purposes.

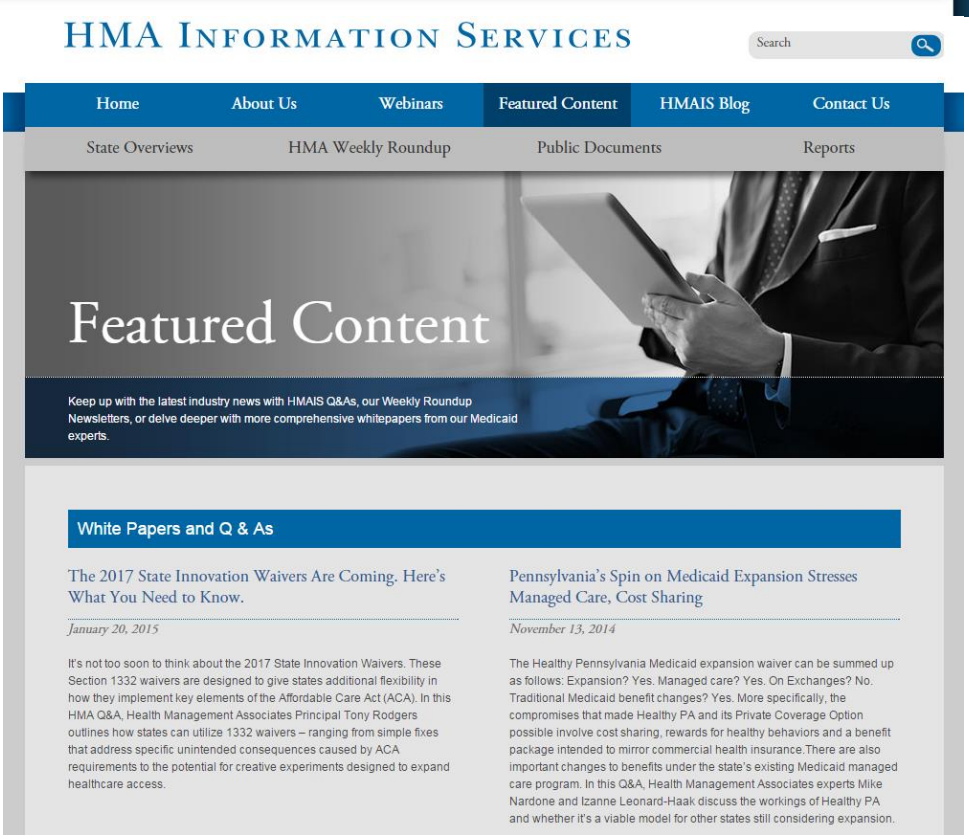
One-Stop Medicaid Resource

HMA is pleased to announce an online information resource that gives you what you need at the click of a mouse. We have spent the past six months developing and testing HMA Information Services (HMAIS), which leverages the information gathering capabilities of more than 100 consultants and is focused entirely on state-sponsored health care programs.

"There is a clear market need for a one-stop website that provides competitive information on the structure of Medicaid in each state," says Carl Mercurio, head of the newly formed HMAIS.

The site pulls together Medicaid enrollment data, health plan financials, and the latest on expansions, waivers, duals, aged, blind, and disabled (ABD) populations, long-term care, accountable care organizations, and patient-centered medical homes. There is also a public documents library with copies of Medicaid RFPs, responses, model contracts, and scoring sheets.

HMA enhances the publicly available information with an overview of the structure of Medicaid in each state, as well as a proprietary HMA Medicaid Managed Care Opportunity Assessment.



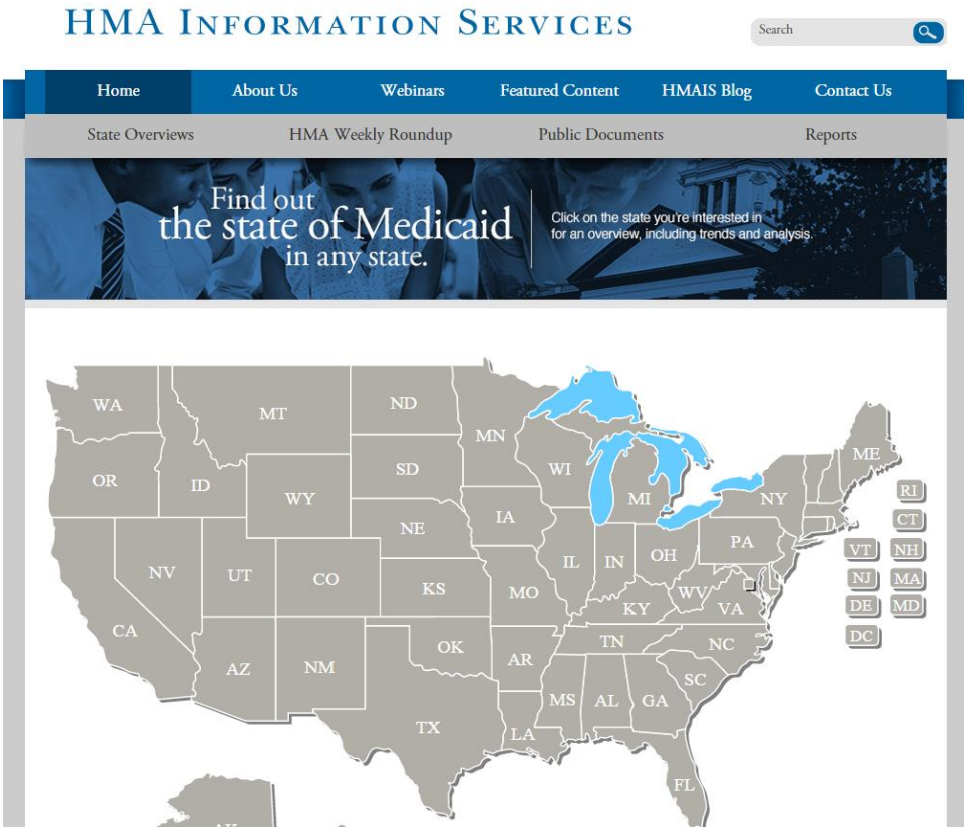
Two Information Sites in One

A comprehensive website, https://hmais.healthmanagement.com offers two components. In the first component visitors encounter contains free information and insights, such as webinars, HMA Q&A, the HMA Weekly Roundup, and other offerings. These draw upon the unmatched depth and breadth of expertise among our HMA consultants. The second component is a subscription-based service for those who want more detailed Medicaid-related information.

The focal point of the subscription service is an extensive data library – an invaluable tool for Medicaid planning purposes. The data library includes information about Medicaid health plans, spending and enrollment, market share and trends, RFPs, and much more. This password-protected site provides access to all current employees of a subscribing organization, including unlimited downloads of charts, graphs, Excel files and PowerPoint slides for use in internal documents and presentations. Data includes, but is not limited to:

- RFP calendar and Opportunity Assessments for Medicaid managed care by state
- Overviews of Medicaid and Medicaid managed care programs by state
- Medicaid managed care plan financials broken down by state and by plan
- Medical loss ratios (MLRs), per member, per month (PMPM) rates, premiums, and medical costs by plan
- Enrollment
    - Total Medicaid and expansion

  - Medicaid managed care by plan
  - Managed LTC/ABD
  - Dual eligibles
  - SNP by plan
- Utilization metrics by plan
- Searchable archive of state Medicaid news and events
- Public documents related to Medicaid procurements
  - RFPs/RFAs/RFIs
  - Vendor proposals
  - Scoring sheets
  - Model contracts



Intuitive, User-Friendly Interface

Users access the subscription site through an interactive map of the United States. By simply clicking on any state or Washington, DC, users go to a state-specific web page that includes the type of critical, time-sensitive information needed for Medicaid procurements and market analysis.

All of the information is updated regularly and available in downloadable Excel spreadsheets, PowerPoint slides and PDFs for use in reports, business plans, and presentations.

The site has advanced keyword search features – allowing users to search for information nationally and by state. A query for "Florida enrollment," for example, would return downloadable Excel spreadsheets containing current and historical Medicaid enrollment figures and market share data for each Medicaid

managed care plan in the state and for each of the state's various Medicaid programs. There are also files containing total statewide Medicaid and CHIP enrollment.

State overviews also include a chronological archive of news and updates, allowing for easy scanning of the latest developments. This is the first time that archived news and analysis from HMA's highly regarded Weekly Roundup has been available in an easy to search format.

Focus on Key Medicaid Metrics

To date, the site includes information on 41 states and Washington, DC – including every state with full-risk Medicaid managed care. Additional states will be added shortly.

Most of the information is focused on Medicaid managed care, but over time HMA plans to expand the database to include information about providers, vendors, program characteristics, and other relevant information. In summary, the database serves as a repository of information about each state's Medicaid program, which we will continue to update as the programs evolve.

For more information on HMAIS or to subscribe, contact Carl Mercurio at:

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HMA Medicaid Roundup

Alaska

Alaska has Highest Health Plan Premiums in Nation. On January 15, 2015, *Kaiser Health News* reported that Alaska has the most expensive insurance marketplace under federal health law. Prices in rural areas, including those of Alaska, Wyoming, Nevada, and California, have been among the most expensive in the nation and have shown to be triple the price of the least expensive areas, which include Albuquerque, Phoenix and Tucson. Areas with a small number of insurers competing are also higher cost. Alaska's premiums for the lowest Silver plan rose 28 percent in the last year. The state currently has only two insurers offering products. This limited competition and high cost of living is contributing to rising costs. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

No Plans for California to Make Up For Expiring 'Medicaid Fee Bump.' On December 31, 2014, the *Los Angeles Times* reported that California officials have no plans to make up for an expiring federal pay incentive designed to entice doctors to treat low-income patients. The end of the subsidy with the start of the new year could result in steep pay cuts for many doctors participating in the California Medicaid program, called Medi-Cal. Read more

California State Senate Report Recommends Long-term Care System Overhaul. With over 30% of Medi-Cal funds going to long-term care and the implementation of the new Coordinated Care Initiatives for Dual Eligibles, a recent California Senate report says that California's long-term care system for elderly residents needs to be overhauled. The report, titled, "A Shattered System: Reforming Long-Term Care in California," was issued by the state Senate Select Committee on Aging and Long Term Care. According to the report, long-term care is provided to about five million Californians through 112 different programs and 20 state departments. The report calls on the state to consolidate long-term care services. The report highlights programs among which there is "duplication" and encourages the state to reform such programs so that resources can be shifted to "fit the needs of more people, as opposed to letting some of these programs just exist because they've existed for a long period of time." In addition, the report calls on the state to improve workforce development and train additional long-term care workers. Read more

Pharmacists Move Toward Broadening Scope of Practice. On January 20, 2015, *California Healthline* reported that pharmacists are about to finish the process of creating an additional regulatory framework. This includes expanded

immunization authority and expanded authority surrounding travel medication. The new regulations must be approved by the California Board of Pharmacy, which is meeting January 27 and January 28. After approval, the second phase will involve getting payers to recognize and respond to the changes. The California Pharmacists Association expects that getting private payers and Medi-Cal to adapt to the new services will require a lot of work. Medicare, however, is already in the works of getting approval from Congress to reimburse pharmacists. Read More

California Rejects UnitedHealth's Bid to Sell Products Statewide on the Exchange. On January 15, 2015, *Los Angeles Times* reported that California rejected a bid from UnitedHealthcare to offer policies to individuals statewide under the Affordable Care Act. In 2013, UnitedHealthcare exited California's individual market when the exchange, Covered California, launched. The insurer will now have to wait until 2017 to try again to sell statewide in California. Executive director of Covered California, Peter Lee, said established insurers should not be allowed to come in after rivals stepped up at the start of the exchange and made significant investments. The new rules state that plans like United, that were operating prior to the exchanges, can only operate in five of the 19 regions. Newly licensed insurers can operate anywhere in the state. California's four largest insurers in the exchange accounted for 94% of the enrollment in the first year. Read More

New Budget Proposal Allocates $300 million for High-cost Drugs. On January 12, 2015, *Capital Public Radio* reported that Governor Jerry Brown proposed a budget of $300 million for high-cost drugs, specifically Hepatitis C medication. Each drug regimen costs approximately $85,000 per person. The budget would provide access to the drugs for a few thousand people in prisons and those covered under Medi-Cal. Read More

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Legislature Again Takes Up Biosimilars Legislation. For the second time in three years the Colorado legislature will be voting on a bill allowing pharmacists to substitute generic biotech for established brand-name biological drugs, if a patient's doctor is notified of the change. The proposal, Senate Bill 71, revives an idea that failed two years ago. The legislation comes as the first biotech generic drugs in the U.S. are poised to reach the market. The "biosimilars" legislation proposed in 2013 gained early support but then died amid lobbying for and against the measure from biotech drug manufacturers. Read more

Connect for Health Colorado 2014 Annual Report Released. Connect for Health Colorado officials released their 2014 annual report and argued they had a successful first full year of operations and that 2015 enrollment problems are manageable. Acting CEO Gary Drews testified before a legislative committee on January 15 that the exchange could be self-sustaining after remaining monies from $177.7 million in federal grants were used up in 2015. He also noted that the board and staff need to complete additional strategic planning to ensure financial sustainability. Currently the exchange assesses a $1.25 per policy charge on carriers but they have authority to increase that fee to $1.80. They also charge a 1.4 percent administration fee to carriers on premiums, partly a

holdover from the former high-risk pool financing. Those fees are still less than the $3.50 charged by the federal exchange.

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida May Debate Medicaid Expansion. On January 18, 2015, *The Daytona Beach News-Journal* reported that new factors may open the door for state leaders to debate Medicaid expansion in the 2015 Legislature. Businesses could lose over $250 million in penalties from the employer mandate. Hospitals will lose $22.6 billion over the decade in lower reimbursements from Medicaid and Medicare patients that will not be offset by expanded coverage under the ACA. On July 1, 2015, the federally-funded Low Income Pool program will expire, costing hospitals $2.2 billion. One initiative to expand Medicaid is "A Healthy Florida Works," which looks at expansion outside of traditional requirements. The Florida Chamber of Commerce also said it would support a modified form of Medicaid expansion. Governor Rick Scott stated he would support expansion only if the federal government takes on all the costs and does not lower support to 90% by 2020. Read More

Georgia

HMA Roundup – Mark Trail & Kathy Ryland (Email Mark/Kathy)

Georgia Managed Care RFP Delayed Until February 2015. In a January 20, 2015, presentation by the Georgia Department of Community Health (DCH) on the Governor's proposed amended fiscal year (AFY) 2015 and FY 2016 budget recommendations, it was indicated that the RFP for the Medicaid Care Management Organizations (CMO) procurement would be released in February, not January as previously indicated. Awards are anticipated to up to four statewide plans in July 2015, with a go-live date of July 1, 2016.

Governor Presents Amended Fiscal Year 2015 and Fiscal Year 2016 Budgets. The Governor presented both his proposed AFY 2015 and FY 2016 budgets to the Legislature this week. Both will be considered separately, first by the House then by the Senate. Differences are then resolved by a joint Conference Committee for final vote by each Chamber. The AFY 2015 budget will be considered first, then the FY 2016 budget. Highlights from the Medicaid and CHIP portions of the AFY 2015 and FY 2016 budgets follow. Link to budget documents.

AFY 2015 Medicaid and CHIP budget highlights:

- $252.98 million ($80.37 million state funds) reduction in funds for growth in Medicaid ABD based on projected need.
- $59.3 million ($19.7 million state funds) increase in funds for new Hepatitis C drugs.
- $171.81 million ($65.26 million state funds) increase in funds for growth in low-income Medicaid, based on projected need.
- $49.47 million ($16.48 state funds) increase in funds for presumptive eligibility enrollment and to continue 12-month eligibility reviews as required by ACA.

FY 2016 Medicaid and CHIP budget highlights:

- $153.91 million in state funds only reduction due to increase in FMAP rates for FY 2016.
- $70.04 million ($22.83 million state funds) increase in funds for new Hepatitis C drugs.
- $171.28 million ($55.89 million state funds) increase in funds for presumptive eligibility and "woodwork" enrollment and to continue 12-month eligibility reviews as required by ACA.

Georgia to Consider Medicaid Expansion. On January 15, 2015, *Gwinnett Daily Post* reported that according to Republican Senator, Chuck Hufstetler, the General Assembly may hold a hearing on the idea of expanding Medicaid. Historically, Georgia has been opposed to expansion. Governor Nathan Deal said it would cost too much money and the state passed a bill requiring legislative approval to expand Medicaid. However, some state senators are now saying there is no longer a zero percent chance of it happening. Since 2013, five hospitals have closed in the state. Expanding Medicaid would alleviate some financial pressures by increasing reimbursements to hospitals. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Governor Appoints Former Aetna Executive to Lead HFS. On January 16, 2015, Governor Bruce Rauner announced the appointment of Felicia Norwood to lead the Illinois Department of Healthcare and Family Services (HFS). Norwood has spent much of her career with Aetna, serving most recently as the President of the Mid-America region from 2010 through 2013. Norwood also previously served as a health policy adviser to former governor Jim Edgar's administration in the early 1990s. There has been no word at this time on the appointment of a Medicaid director.

Iowa

Governor Announces Intentions to Privatize Medicaid. On January 20, 2015, *The Des Moines Register* reported that Governor Terry Branstad announced plans to transition the state's Medicaid program to private MCOs in an effort to save $51.3 million through the first six months of the year. Iowa already has two limited managed care contracts in place for certain Medicaid services. Branstad's plan will increase the array of services. The Department of Human Services requested a formal plan from the governor by March 1. Read More

Governor Proposing to Close Two Mental Institutes. On January 15, 2015, *The Des Moines Register* reported that Iowa Governor, Terry Branstad, proposed to close two of the state's four institutes for people with mental illness. Branstad said population counts at these institutions have declined while costs have soared. If the proposal is passed, admission to the facilities will fully end in February. The proposal has met opposition on both the Republican and Democratic sides. Rep. Dave Heaton said Southern Iowa is short of psychiatric inpatient services and the facilities have already stopped accepting new patients. Democratic Sen. Amanda Ragan is also concerned with what will happen to patients in addition to the employees who will lose their jobs and the

communities of Mount Pleasant and Clarinda. Mental health advocates hope the state will open smaller facilities and that the proposed closures will not just cut beds. Read More

Kansas

Policy and Contractual Changes in Budget for Medicaid. On January 16, 2014, the *Kansas Health Institute* reported that under Governor Sam Brownback's budget proposal, Medicaid would see "policy and contractual changes" to save $50 million. The budget would increase the privilege fee on MCOs from 1 percent to 5.5 percent. Medicaid eligibility would no longer be determined by the Kansas Department for Children and Families. The responsibility would transfer to the Kansas Department of Health and Environment to reduce incorrect eligibility approvals. In addition, prescription drug reimbursement procedures would be altered: the pharmacy dispensing fee would be adjusted, pricing formula would be changed, and billing requirements for drug testing codes would be changed. These proposals are intended to allow the state to more closely regulate mental health drugs. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Massachusetts Temporary Medicaid Program Ending in Feb. On January 15, 2015, *WWLP.com* reported that a temporary Medicaid program will end in February. However, only 25 percent of enrollees have secured coverage for when their benefits end. Residents were enrolled in temporary health plans last fall when technical issues on the exchange made it impossible to sign up for a plan under the ACA. The state considers these 414,000 residents as "wildcards" because it is unclear if they became employed and will no longer be eligible for Medicaid. Maydad Cohen, incoming interim director of the Connector, the state's exchange, anticipates this will be the busiest period of open enrollment. Read More

Michigan

HMA Roundup – Esther Reagan (Email Esther)

Government Restructuring in Michigan. Governor Rick Snyder gave his fifth State of the State message to the Legislature on Tuesday, January 20, 2015. After providing several examples of progress made since he took office – in economic growth, getting more Michiganders into the work force through improved skilled trades education, and increased access to health care through expansion of the Medicaid program, to name a few – he then spoke of his proposal to create a "River of Opportunity" to help streamline and personalize programs that help people needing assistance. He said that the goal of government should be to help people, not to perpetuate a multitude of distinct and overlapping programs. The Governor noted that implementation of some aspects of a more streamlined approach to holistic service delivery and improved population health will require federal waiver authority; he cited the need to standardize income eligibility requirements across several federal programs as an issue that will need to be addressed.

To that end, he said an Executive Order would soon be issued to combine the Departments of Community Health (DCH) and Human Services (DHS) into a single "mega" department called Health and Human Services. These two departments currently administer the state's cash, food, social services and medical assistance programs that encompass about 46 percent of the state budget and serve a combined population of more than 2.5 million people with 14,000 staff. At this time it is unclear if the current director of DCH and interim director of DHS, Nick Lyon, will be chosen to lead the new department. While not emphasized in the message, it is anticipated that some of the programs currently administered in these departments, such as workforce training, may be relocated to a different department.

The Governor also emphasized the need to fund improvements in the state's roads and bridges, many of which are very deteriorated, said he will create a new energy agency in government to combine the Public Service Commission with economic development and environmental concerns, and encouraged a continued focus on education to allow students to earn college credits while in high school.

Michigan Budget. Governor Snyder will release his Executive Budget Recommendation for the state fiscal year beginning October 1, 2015 on February 11, 2015. It is expected to include reductions in funding for several state government programs as a result of lower-than-anticipated revenues. Budget reductions for the current fiscal year are anticipated as well. A recent Consensus Revenue Estimating Conference, which included representatives from both the Senate and House Fiscal Agencies and the Department of Treasury and State Budget Office, agreed that revenues for the current fiscal year are now expected to be more than $300 million lower than previously estimated, and a shortfall for the upcoming fiscal year in a similar amount is also expected.

Healthy Michigan Plan. As of January 20, 2015, enrollment in the Healthy Michigan Plan – Michigan's version of a Medicaid expansion initiative – has reached 523,040. The vast majority of these enrollees (about 425,000) have income below poverty and almost 52 percent of the enrollees are women. About 46.5 percent of the enrollees are between the ages of 19 and 34; 39.6 percent are between the ages of 35 and 54; and 13.9 percent are between the ages of 55 and 64. Virtually all of these enrollees are already or soon will be enrolled in one of the state's Medicaid managed care organizations for their health care services. Since program implementation on April 1, 2014, enrollees have received more than 350,000 primary and preventive care visits.

Minnesota

Home Health Care Workers Agree on Contract. On January 15, 2015, *StarTribune* reported that home health care workers agreed on a contract to raise pay, fund training, and offer pay protections. The contract will also provide five days of paid time off. It will affect 27,000 home health care workers who voted last summer to unionize. Read More

Missouri

Senator Pushes for Expansion for Veterans. On January 20, 2015, *The Kansas City Star* reported that Senator Ryan Silvey is proposing a bill to expand Medicaid coverage for veterans and their families. Silvey stated that efforts to expand the entire Medicaid program will run into high opposition from Republican leaders, who already declared expansion dead. The senator hopes to decrease the coverage gap between those who qualify for Medicaid and those who qualify for subsidies. This gap includes thousands of veterans and their families who don't qualify for any assistance. Read More

Montana

New Proposal for Medicaid Expansion. On January 19, 2015, *Great Falls Tribune* reported that Governor Steve Bullock put forth a new bill for Medicaid expansion called the Healthy Montana Plan. The proposal is based on the Healthy Montana Kids program and will expand benefits to adults. The bill will terminate, however, if federal government funding ever goes below 90%. Read More

New Hampshire

Medicaid Expansion Waiver Expects Approval. On January 14, 2015, *insurancenewsnet.com* reported that New Hampshire Health and Human Service officials are expecting to get approval from CMS on the state's Medicaid expansion waiver. The approval is needed by March 31 to continue the New Hampshire Health Protection Program. The waiver requests approximately $50 million annually for five years. This amount would be matched by state, county, and local expenditures. Read More

Expansion Pushes to Enroll Ex-Inmates. On January 18, 2015, the *Daily Journal* reported that New Hampshire is focusing on enrolling ex-inmates who are newly eligible for Medicaid due to expansion. Of the 140 people leaving prison each month, 90 percent will now be eligible for Medicaid. Under the ACA, Medicaid covers substance abuse and mental health. The state hopes that by allowing ex-inmates to use these benefits, the number of those who return or break parole will drop. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Hewlett-Packard (HP) will reimburse New Jersey $7.5 million following terminated contract. According to the January 8, 2015, issue of *Philly.com* the state's Department of Human Services will receive a reimbursement from the contractor it hired in 2009 to replace its eligibility and enrollment system. The system was scheduled to launch in July 2014. DHS spent more than $17 million on the HP contract and will get back almost half of the cost due to failures by HP to implement the Consolidated Assistance Support System (CASS). DHS is planning to restart the project with another contractor. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

DSRIP Applications Posted. Twenty-five emerging Performing Provider Systems submitted applications to participate in the Delivery System Reform Incentive Program (DSRIP). The applications, as well as the Community Needs Assessments conducted by each group, can be seen here. Every PPS indicated that it intends to pursue the project that addresses the need for integration of behavioral health and primary care, including co-location of behavioral health staff in the primary care setting, as well as bringing primary care into behavioral health settings. The second most frequently included project is also the most ambitious: creating an integrated delivery system that focuses on evidence-based medicine and population health, and moving away from fee-for-service payment toward value-based payment and shared risk.

The posting of the applications triggers the beginning of a 30-day public comment period. Simultaneously, the applications are being scored by the independent assessor, Public Consulting Group (PCG). Their recommendations are due the first week in February. Per the terms and conditions approved by CMS, the scoring recommendations will then be reviewed by the Project Approval and Oversight Panel, an independent group of stakeholders whose job is to advise the Commissioner of Health whether to accept, reject or modify those recommendations. Project Plan awards are expected in early March, and the start of DSRIP year 1 begins April 1.

Waiver Renewal. New York's 1115 waiver, the Partnership Plan, scheduled to expire at the end of 2014, has been extended for 90 days. CMS expects five-year renewal will be granted before the end of March 2015.

Medicaid Eligibility and Enrollment. The Kaiser Family Foundation recently released findings from its annual survey of Medicaid and CHIP eligibility, enrollment, renewal and cost-sharing policies. Judy Arnold, Director of the Division of Eligibility and Marketplace Integration in the NYS Department of Health, participated in a panel discussion and shared New York's experience. She noted that Medicaid enrollment grew by 500,000 in 2014, and that the overwhelming majority of that was among people who had been eligible for coverage prior to the ACA's Medicaid expansion. In New York, the ACA meant converting what had been a waiver population under Family Health Plus to Medicaid. Arnold noted that many individuals came in seeking coverage through the exchange, but were found to be Medicaid-eligible. New York has a fully-integrated, online eligibility system, with telephonic and online assistance available. New York has a single application for an entire family that calculates eligibility on an individual basis for each family member. A very sizeable number of New York families have mixed eligibility, as the CHIP program covers children up to 400 percent FPL. The eligibility system allows individuals to move seamlessly between Medicaid and enrollment in a private plan, through the exchange, as eligibility changes due to income fluctuations. In October 2014, the system added the ability to do administrative renewals. Over the next year New York intends to expand the system to include eligibility for populations that are non-Modified Adjusted Gross Income (MAGI) eligible.

Arnold identified three challenges that the state had to resolve: electronic verification of immigration status; the need for on-going systems changes as federal rules evolve; and moving the large volume of Medicaid records from the

legacy system to the new, integrated eligibility system. Of these, Arnold noted, the federal rules on immigrant eligibility have been the most problematic as it significantly increased the complexity of the rules, adding to development cost.

DSRIP and Value-Based Payment. As part of the Terms and Conditions approved by CMS, New York must develop a roadmap for amending its Medicaid managed care contracts. DSRIP investments must be supported by the managed care plans as a core component of long-term sustainability. Comprehensive payment reform, and a move away from fee-for-service and toward value-based payment, are key components of the DSRIP strategy. State Medicaid Director, Jason Helgerson, has declared the current fee-for-service (FFS) financing system "morally bankrupt;" and that it must be replaced with a system that rewards providers for keeping people well. By DSRIP year 5 all Medicaid managed care plans must employ non-FFS payment systems that reward value over volume for at least 90 percent of their provider payments. A webinar has been posted on the DSRIP web site that addresses questions about value-based payment and the role of managed care plans in transforming payment policies. The slides for the webinar can be found here; a link to the webinar is on the DSRIP Webinars and Presentations tab.

North Carolina

New Board Will Manage State's Medicaid Program. On January 15, 2015, *CharlotteObserver.com* reported that a new eight-member board, called Health Benefits Authority, will manage the operations of North Carolina's Medicaid program in place of the Department of Health and Human Services. A General Assembly subcommittee endorsed the bill. The Health Benefits Authority will act independently from the department and receive an annual amount to operate the program. Medicaid Director Robin Cummings said the board is superfluous. He stated that the department is already doing the same things as the board and its inclusion adds complexity to the situation. Read More

Pennsylvania

HMA Roundup – Matt McGeorge (Email Matt)

Governor Wolf Identifies Nominee for Secretary of Human Services. Governor Wolf announced through a press release on his transition website, his nomination for Secretary for the Department of Human Services (DHS), Theodore "Ted" Dallas. Dallas was recently the Secretary of Human Resources in Maryland and prior to that he served in Pennsylvania State Government under the Rendell administration. In his role as Secretary of Human Services, Dallas will be expected to transition the Pennsylvania Medicaid program away from the Healthy PA initiative, which was the Corbett Administration's alternative to Medicaid expansion. The newly inaugurated Governor also announced nominees for the Secretary of the Department of Health: Karen Murphy, and for Physician General: Rachel Levine. Secretary Gary Tennis, with the Department of Drug and Alcohol Programs, will remain in the position he has held since January 2012. Read more

Healthy PA Interim Healthy Benefit Plan. The Pennsylvania Department of Human Services issued a Medical Assistance Bulletin to clarify benefit scope for the interim Healthy PA benefit plan. The bulletin states that CMS, which has yet

to approve the Healthy PA benefit plan, has advised DHS that the beneficiaries who are assigned to the Healthy PA benefit plan must receive current Medicaid benefits. To comply, DHS will apply the State's current less restrictive categorically needy scope of benefits as the interim Healthy PA benefit plan. Read more

Healthy PA Program Encountering a Number of Problems. Even as the Corbett Administration comes to a close, implementation of the outgoing Governor's alternative to Medicaid Expansion, Healthy PA, continues and a number of problems and concerns are being reported. The *Pittsburgh Post-Gazette* reports that people are experiencing delays with enrollment and individuals who need drug and alcohol services are being placed in plans that do not offer these services. Read more

Pennsylvania Must Pay Back Almost $49 Million to Settle Medicaid Case. According to the Department of Justice, the Pennsylvania Medicaid program allowed non-citizens, who were not eligible, to receive Medicaid and other federally-funded benefits from 2004 to 2010. As reported by *Modern Healthcare*, the state's Department of Human Services stated that it remains committed to "protecting taxpayer funds" but the Department did not make an admission of liability. The settlement results in $48.8 million being paid to the federal government. Read more

Despite Demand, Video Health Exams Largely Not Covered by Insurance in Pennsylvania. The value of telehealth goes beyond access to care to include public health benefits such as allowing patients who are sick with communicable diseases to stay at home rather than risk exposing other patients in a waiting room. According to an article in the *Pittsburgh Post-Gazette*, even though many providers see a benefit to telehealth visits, they will not see patients in this manner because it is not reimbursable by health insurance companies in Pennsylvania. Reasons why insurance companies in Pennsylvania do not reimburse for telehealth visits include: a lack of national telehealth parity legislation, Medicare not covering telehealth visits and Pennsylvania being slow to take up a legislative solution. Even health plans that do reimburse for telehealth visits, such as UPMC health plan, indicate physicians are not widely using telehealth technology in their practices. Read more

South Carolina

Lawsuit Reaches Deal on Inmate Mental Health. On January 15, 2015, *CharlotteObserver.com* reported that the lawsuit filed by Protection and Advocacy for People with Disabilities against the Department of Corrections has reached a deal. The judge ruled in a preliminary agreement that prisons will need to hire more mental health specialists, create safer surroundings, and offer more monitoring for mental illness among inmates. The lawsuit, filed in 2005, alleged a lack of effective counseling and reliance on tactics like isolation and force to subdue mentally ill prisoners. The Department of Corrections appealed the ruling, saying it has made changes to its mental health services. Governor Nikki Haley appropriated $4 million to diagnosing and treating mentally ill prisoners in her executive budget proposal. Read More

Texas

HMA Roundup – Dianne Longley (Email Dianne)

Texas Health and Human Services under Investigation. The Texas Health and Human Services agency continues to be the focus of investigations and allegations of misconduct surrounding the award of a no-bid contract worth more than $100 million to 21CT to provide data analytics designed to assist with Medicaid fraud investigations. On January 15, HHSC Commissioner Kyle Janek's chief of staff, Erica Stick, announced her resignation after being placed on administrative leave in December. Erica Stick is the wife of former HHSC Deputy Inspector General and Chief Counsel, who is the center of the investigation as the broker of the contract. On January 16, Janek's deputy chief of staff, Casey Haney, also resigned after revelations that HHSC paid $97,000 in college tuition for Haney to pursue a master's degree while working at HHSC. Janek approved the tuition payment but has stated he did not realize the fees were being paid up front in violation of HHSC policy.

Subsequent to these revelations, two long-time legislators have called for Janek's resignation. Senator John Whitmire (D-Houston), the longest serving member of the Texas State Senate, asked for Janek's immediate resignation based on Janek's role in missteps and a lack of "credibility to fix the numerous conflicts of interest, broken policies, and potential violations of the law that have occurred during your leadership of the agency." Following Whitmire's announcement, State Rep. Garnett Coleman (D-Houston) also called for Janek's resignation. Janek is a former state senator and was appointed Commissioner by outgoing Governor Rick Perry.

Janek has so far refused to step down and stated he has the support of Governor-elect Greg Abbot. Abbot has not called for Janek's resignation but announced he is deploying an "independent strike force" to investigate the agency. Billy Hamilton, a long-time capital insider and former deputy comptroller, will head the investigation for Abbot, who took office on Tuesday, January 20. In addition, the Texas State Auditor and the FBI are also conducting separate investigations of HHSC activities.

Governor-Elect Enlists Government Veterans to Review Medicaid and Social Services Programs. On January 14, 2015, *The Dallas Morning News* reported that Governor-elect Greg Abbott has hired former deputy comptroller, Billy Hamilton, and Agriculture Department financial officer, Heather Griffith, to review contracting practices and oversight in Medicaid and social services programs. The review comes after scrutiny of two major contracts with technology company 21CT and with AT&T. The $105 million AT&T telecom deal was partly managed by state employees formerly from AT&T, while the $20 million award for 21CT involved a former lobbyist of the tech company who was a partner of a high-ranking Health and Human Services Commission (HHSC) official. The comprehensive, independent review will look into management, operations, and contracting at HHSC. Read More

Texas Legislature Begins Biennial Session. The 84th Texas Legislative Session was called to order on Tuesday, January 13. Incumbent House Speaker, Joe Straus (R-San Antonio), easily survived a challenge from tea-party supported Member, Scott Turner. This will be Straus' fourth term as Speaker. As part of his acceptance speech, Straus promised to address traffic problems and reduce taxes, and will "work to end abuses by those who grant and receive state

contracts," which is a reference to the ongoing turmoil at the Health and Human Services Commission. He further stated, "Using taxpayer resources for personal gain will not be tolerated. This House should lead by example, holding ourselves to the highest ethical standards and remembering that public service is about the public."

Incoming Texas Lt. Governor, Dan Patrick (a former state senator), also took office on January 20. The Texas Senate is expected to adopt new rules that will make it easier for Republican Senators to pass proposed legislation than in previous sessions. The current "two-thirds" rule requires that at least 21 of the 31 senators support a proposed bill before it will be considered by the Senate. The Senate has 20 Republican members, and Patrick has stated he supports replacing the two-thirds rule with a simple majority requirement.

Committee member assignments for the new Session are expected by the end of the month, at which time hearings on legislative proposals will begin. Read More

Vermont

Governor Shumlin Proposes Payroll Tax to Fund Medicaid. On January 15, 2015, *Brattleboro Reformer* reported that Governor Peter Shumlin is proposing a 0.7% payroll tax to raise $82.8 million for Medicaid. Shumlin hopes to bring Medicaid payments to doctors and hospitals up to where they are for Medicare. Currently, Medicaid pays only 60% of costs to doctors. The rest is picked up by insurance companies and self-insured employers. Shumlin's proposal strives to lower premiums and encourage providers to accept Medicaid beneficiaries. The tax would be effective January 1, 2016. Read More

Vermont Looks to Leave Fee-For-Service Model. On January 14, 2015, *VPR* reported that Vermont officials hope that by 2017, the state will leave the current fee-for-service payment model and enact a comprehensive payment reform system. According to Al Gobeille, Chairman of Green Mountain Care Board, the current system rewards quantity versus quality. Vermont is also focusing on the Medicaid-Medicare cost shift. Governor Peter Shumlin will increase reimbursements in his upcoming budget proposal. Read More

Wyoming

Legislature to Begin Medicaid Expansion Hearings. On January 18, 2015, *Casper Star Tribune* reported that the Wyoming Legislature will start hearings this week on Medicaid expansion as the Joint Appropriations Committee continues budget meetings. Without expansion, the state's Medicaid program will need $80 million in funds. Republican Governor, Matt Mead, who has opposed expansion, is now considering it. Mead said that although he doesn't like the ACA, federal tax dollars are paying for it anyway. The Wyoming expansion proposal does not include the health savings plan component. Read More

National

CMS Administrator, Marilyn Tavenner, to Resign. On January 16, 2015, *Bloomberg* reported that Marilyn Tavenner announced in a staff email she will leave her post at the end of February. Tavenner was the Administrator of the Center for Medicare and Medicaid Services and directed the rollout of Obamacare. She was largely deemed responsible for the collapse of healthcare.gov when it first opened, in addition to enrollment miscalculations in 2014 that counted 393,000 individuals twice. Tavenner was administrator since 2011 and head of CMS since 2013. She will be replaced by former UnitedHealth Group executive, Andy Slavitt. Read More

Senate Finance Chair Seeks Repeal of Health Insurer Fee. On January 16, Senate Finance Chairman Orrin Hatch (R-UT) and Senator John Barrasso (R-WY) reintroduced the Jobs and Premium Protection Act. The legislation, similar to that introduced in the 113th Congress, would repeal the health insurance tax (HIT) included in the Affordable Care Act. The cost to repeal the tax is estimated at $11.3 billion in 2015. It rises to $14.3 billion by 2018.

Supreme Court to Rule If Providers Can Sue States Over Medicaid Pay Rates. On January 21, 2015, *Kaiser Health News* reported that the Supreme Court will be ruling on whether providers have the right to sue the states over inadequate Medicaid payment rates. Idaho is asking the Supreme Court to make it illegal for providers to sue for higher payments in court. In the former Idaho case, Armstrong vs. Exceptional Child Center, the court found that providers were entitled to increased Medicaid payments, after the state flat lined payments from 2006 through 2014. Other cases ruling in favor of providers have already taken place in states, including California, Illinois, Massachusetts, Oklahoma, Texas, and District of Columbia. Chief Justice John G. Roberts Jr. is worried the Supreme Court case will open the door "to a flood of lawsuits" from providers. Read More

Overtime and Minimum Wage Regulations Overturned for Home Health Care Workers. On January 15, 2015, *The Associated Press* reported that federal U.S. District Judge Richard Leon overturned regulations requiring minimum wage and overtime for home health care workers. Leon claimed the proposed regulations should go through Congress than be decided judicially. The Labor Department rules would have affected two million home health care workers and broadened the number of those eligible for minimum wage and overtime. The law, as it was passed in 1974, currently exempts such employees from wage and overtime requirements. Read More

163,000 New Enrollees Under Health Care Law. On January 14, 2015, *The New York Times* reported that in the last week, 163,000 more people signed up for subsidized insurance, bringing the total to 6.8 million within 37 federally run states. By February 15th, the administration hopes to have enrolled 9.1 million people nationwide. Read More

Industry News

U.S. Healthcare Executives say the Affordable Care Act Will Not be Repealed. On January 15, 2015, *Reuters* reported that U.S. healthcare executives said that the Affordable Care Act (referred to as Obamacare) will not be removed despite Republican lawmakers seeking to replace it with their own health reforms. Executives at the J.P. Morgan Healthcare Conference said the law is too entrenched and the court will not take coverage away from the millions already enrolled. However, Republican opponents are hoping the Supreme Court will end federal tax subsidies and repeal the ACA when it rules in June. Republicans are also seeking to make changes to specific policies, including the employer mandate and the definition of a full- time employee. Read More

Centene's Magnolia Health Partnering with Dental Health & Wellness. On January 15, 2015, *MarketWatch* reported that Magnolia Health, a subsidiary of Centene, has partnered with Dental Health & Wellness to administer dental benefits for Mississippi Medicaid and CHIP members. Read More

Humana in Exclusive Deal with Gilead. On January 14, 2015, *Modern HealthCare* reported that Humana announced it was in an exclusive deal to offer Gilead Science's Hepatitis C drugs to its members. Humana's low third-quarter profits were partially due to high specialty drug costs. Other insurers have recently been making similar deals with pharmaceutical companies in efforts to cut costs. Anthem announced an agreement with Gilead for Hepatitis C drugs. Express Scripts recently made a deal with AbbVie for its own Hepatitis C option. However, some physicians feel that the deals are taking away consumer choice and do not cut any costs for the consumer. Read More

Humana and Boulder Community Health to Form ACO. On January 15, 2015, Humana announced it will enter a partnership with Boulder Community Health to form an Accountable Care Organization. The ACO will serve Colorado's insurance marketplace, currently enrolling through February 15, 2015. It will focus on preventive care, chronic conditions, and disease management. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
January 30, 2015	Florida Healthy Kids	RFP Release	185,000
January, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
January/February, 2015	Michigan	RFP Release	1,500,000
February 1, 2015	South Carolina Duals	Implementation	68,000
February 1, 2015	Louisiana	Implementation	900,000
February, 2015	Georgia	RFP Release	1,300,000
March 1, 2015	Michigan Duals	Implementation	70,000
March 2, 2015	Florida Healthy Kids	Proposals Due	185,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
April 15, 2015	Florida Healthy Kids	Contract Awards	185,000
April, 2015	Louisiana MLTSS - DD	RFP Release	15,000
July 1, 2015	Washington Duals	Implementation	48,500
July 1, 2015	Missouri	Implementation	398,000
July, 2015	Georgia	Contract Awards	1,300,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	178,000	Application			8/26/2013	1/1/2015 4/1/2015	4/1/2015 7/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X			10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A			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
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	
Totals	**11 Capitated 5 MFFS**	**1.35M Capitated 513K FFS**	***10***			***11***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the four states with active dual eligible demonstration enrollments in a capitated model as of this week's publication. *Please note revised enrollment totals in Illinois; previous version of the table overstated duals demonstration enrollment for December 2014.*

State	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
California	3,445	15,322	17,846	39,731	42,473	44,804	48,976	51,527	58,945
Illinois	455	2,831	19,461	37,248	48,114	46,870	49,060	49,253	57,967
Massachusetts	13,191	13,274	13,409	18,836	18,067	17,739	17,465	18,104	
Virginia				11,169	11,983	21,958	28,642	29,648	27,701
Total Fully Integrated	**17,091**	**31,427**	**50,716**	**106,984**	**120,637**	**131,371**	**144,143**	**148,532**	**N/A**

Source: State enrollment reporting compiled by HMA

HMA News

HMA Q&A Looks at Section 1332 Waivers

Link to Q&A

Section 1332 waivers are designed to give states additional flexibility in how they implement key elements of the Affordable Care Act. In this Q&A, Health Management Associates Principal, Tony Rodgers, outlines how states can utilize 1332 waivers – ranging from simple fixes that address specific unintended consequences caused by ACA requirements to the potential for creative experiments designed to expand healthcare access.

HMA Webinar Explores Planning Integrated Care for Underserved Populations

Wednesday, January 28, 2015
3:30 to 5:00 p.m. EST
Link to Registration

Just in time for those planning to apply for SAMHSA's $1.6 million Primary and Behavioral Health Care Integration (PBHCI) opportunity, HMA's integration experts will discuss key factors for successfully planning, coordinating, and delivering integrated healthcare to high need, vulnerable populations in any setting.

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