HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

REVIEWING ICRC FINDINGS, GUIDANCE TO STATES ON D-SNP CONTRACTING OPTIONS

This week, our *In Focus* section reviews the recent technical assistance tool from the Integrated Care Resource Center (ICRC), detailing findings and guidance to states on dual eligible special needs plans (D-SNP) contracting options and strategies. The document, titled "*State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options*," (Link to PDF) was prepared by Mathematica Policy Research and the Centers for Health Care Strategies, in partnership with the Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office. As of February 2015, there were more than 1.66 million dual eligibles enrolled in a D-SNP across 40 states (including the District of Columbia and Puerto Rico), up more than 10 percent over the beginning of 2014, and up nearly 80 percent since 2010.

D-SNP Contracting Overview

The ICRC document highlights the reasons why D-SNP contracting with states has grown in recent years.

- Under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, and effective for the 2013 plan year, D-SNPs are required to have a contract with the state in which they operate. Although states are not required to enter into contracts with D-SNPs.
- States that have either abandoned their duals demonstrations, or never sought to develop a duals demonstration to begin with, are looking to D-SNPs as a vehicle for integrated care coordination arrangements across Medicare and Medicaid that may be less involved that a full financial alignment demonstration.
- States with managed long-term supports and services (MLTSS) programs in their Medicaid program see D-SNP contracts as an opportunity for greater care coordination.

D-SNP contracts with states must meet eight minimum MIPPA contracting requirements; however, many states go beyond the minimum MIPPA requirements, as detailed in **Table 1** below.

Table 1 – MIPPA Minimum Requirements and State Contracting Examples beyond MIPPA Minimums

MIPPA Minimum Contracting Requirements
The D-SNP's responsibility, including financial obligations, to provide or arrange for Medicaid benefits
The categories of eligibility for dually-eligible beneficiaries to be enrolled under the SNP (full benefit, Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), etc.)
The Medicaid benefits covered under the SNP
The cost-sharing protections covered under the SNP
The identification and sharing of information on Medicaid provider participation
The verification of enrollees' eligibility for both Medicare and Medicaid
The service area covered by the SNP
The contract period for the SNP
State D-SNP Contract Features That Go Beyond MIPPA Requirements
Increased requirements for coordination of D-SNP and Medicaid Services
Submission of MA quality/performance and/or financial reports to the state
Submission of CMS-required notices of plan changes to the state
Submission of CMS compliance notices and/or notices of low Star ratings to the state
Submission of D-SNP marketing materials to the state
Submission of MA grievance and appeals data to the state and/or coordination of grievance and appeals processes
Submission of MA encounter data and/or Part D drug event data to the state
Coordination of quality improvement and external quality review activities
Facilitation of Medicaid eligiblility redeterminations through the D-SNP
Waiving of Medicare's three-day hospital stay requirement for Medicare SNF coverage

ICRC's review of state D-SNP contracts found that states with established MLTSS programs, engaged D-SNPs, and Medicaid leadership with knowledge of Medicaid and Medicare managed care had the most detailed and extensive contract designs and leverage D-SNP contracting to effectively coodinate Medicaid and Medicare benefits.

D-SNPs and Medicaid MLTSS

The ICRC reviewed D-SNP contracts in twelve states, ten of which currently operate a Medicaid MLTSS program. While many states have mandatory enrollment in MLTSS plans on the Medicaid side, states or the federal government cannot mandate enrollment into a D-SNP. States and health plans may encourage enrollment from the same health plan offering a MLTSS plan and companion D-SNP, and the ICRC found that mandatory MTLSS enrollment generally increased the likelihood of enrollment in a companion D-SNP. In **Table 2** on the following page, we highlight the ICRC's findings on D-SNP and Medicaid MLTSS overlap, and include current D-SNP enrollment and market share information for each of the twelve states reviewed in the technical assistance document.

Takeaways from ICRC Analysis

The ICRC document concludes that states either pursuing or planning to pursue Medicaid MLTSS programs should explore entering into MIPPA contracts with D-SNP providers to increase the likelihood that D-SNPs will be available to link with the MLTSS program when needed. However, the ICRC notes that states with no plans to develop Medicaid MLTSS may not want to devote limited state resources to exploring D-SNP contracting.

Looking ahead at the increasing number of Medicaid MLTSS programs – with Iowa, Louisiana, Nebraska, and Pennsylvania all looking likely to implement in the next few years – Medicaid health plans should consider developing D-SNP capabilities in order to contract with states and maximize their ability to participate in the growing MLTSS market.

Table 2 – D-SNP and Medicaid MLTSS Linkages; Enrollment by Plan, February 2015

State	MLTSS	D-SNPs Must Have MLTSS Plan	MLTSS Plans Required to Offer D-SNP	D-SNP Enrollment	D-SNPs in Market	Enrollment (Feb. 2015)	Market Share
Arizona	Yes	Yes	Yes	75,891	UnitedHealth Group, Inc.	35,691	47.0%
					Southwest Catholic Health Network	19,224	25.3%
					IASIS Healthcare	9,314	12.3%
					Tenet Healthcare Corporation	3,143	4.1%
					The University of AZ Health Network, Inc.	2,352	3.1%
					Care1st Health Plan	1,719	2.3%
					MARICOPA COUNTY SPECIAL HEALTH CARE DISTRICT	1,507	2.0%
					Centene Corporation	1,486	2.0%
					Health Net, Inc.	1,455	1.9%
Florida	Yes	No	No	203,478	Humana Inc.	88,393	43.4%
					UnitedHealth Group, Inc.	34,237	16.8%
					WellCare Health Plans, Inc.	32,651	16.0%
					Aetna Inc.	18,020	8.9%
					America's 1st Choice Holdings of Florida, LLC	12,871	6.3%
					Simply Healthcare Holdings, Inc.	11,741	5.8%
					Anthem Inc.	2,567	1.3%
					Molina Healthcare, Inc.,	1,143	0.6%
					CIGNA	1,090	0.5%
					Centene Corporation	474	0.2%
					Guidewell Mutual Holding Corporation	291	0.1%
Hawaii	Yes	Yes	2016 Requirement	19,024	UnitedHealth Group, Inc.	11,875	62.4%
					WellCare Health Plans, Inc.	6,743	35.4%
					AlohaCare	406	2.1%
Massachusetts	Yes	Yes	Yes	33,685	UnitedHealth Group, Inc.	12,475	36.8%
					SWH Holdings, Inc.	10,104	29.8%
					Commonwealth Care Alliance, Inc.	6,231	18.4%
					Fallon Community Health Plan	4,187	12.4%
					Tufts Associated HMO, Inc.	868	2.6%
Minnesota	Yes	Yes	Yes	36,499	UCare Minnesota	10,174	27.9%
					Medica Holding Company	10,005	27.4%
					Blue Cross and Blue Shield of Minnesota	8,191	22.4%
					HealthPartners, Inc.	3,191	8.7%
					PrimeWest Central County-Based Purchasing Initiati	2,266	6.2%
					South Country Health Alliance	2,194	6.0%
					Itasca County Health & Human Services	478	1.3%
New Jersey	Yes	Not in 2015; must be Medicaid MCO	No	9,173	Anthem Inc.	6,642	72.4%
					UnitedHealth Group, Inc.	2,531	27.6%
New Mexico	Yes	Yes	Yes	9,850	UnitedHealth Group, Inc.	8,453	85.8%
					Molina Healthcare, Inc.,	1,307	13.3%
					Health Care Service Corporation	90	0.9%
Oregon	No	N/A	N/A	22,068	CareOregon, Inc.	9,717	44.0%
					ATRIO Health Plans	5,220	23.7%
					Agate Resources, Inc.	3,693	16.7%
					FamilyCare Incorporated	1,966	8.9%
					Samaritan Health Services	1,472	6.7%
Pennsylvania	In Planning	TBD	TBD	104,138	Gateway Health Plan, LP	41,906	40.2%
					CIGNA	24,491	23.5%
					UPMC Health System	18,537	17.8%
					Aetna Inc.	6,709	6.4%
					Health Partners Plans, Inc.	5,364	5.2%
					Geisinger Health System	4,464	4.3%
					Independence Health Group, Inc.	2,667	2.6%
Tennessee	Yes	No	2015 Requirement	66,433	UnitedHealth Group, Inc.	40,381	59.0%
					CIGNA	9,676	14.1%
					Humana Inc.	5,239	7.7%
					WellCare Health Plans, Inc.	5,103	7.5%
					Anthem Inc.	4,437	6.5%
					BlueCross BlueShield of Tennessee	3,597	5.3%
Texas	Yes	No	Yes (populous counties only)	134,071	UnitedHealth Group, Inc.	59,816	44.6%
					CIGNA	25,925	19.3%
					Anthem Inc.	23,888	17.8%
					WellCare Health Plans, Inc.	9,878	7.4%
					Molina Healthcare, Inc.,	6,352	4.7%
					Humana Inc.	4,233	3.2%
					Centene Corporation	2,705	2.0%
					Covenant Health - Hendrick Medical Center	1,274	1.0%
Wisconsin	Yes	Yes	No	18,674	UnitedHealth Group, Inc.	7,027	37.6%
					Independent Care Health Plan Inc.	5,803	31.1%
					Ministry Health Care, Inc.	2,440	13.1%
					Care Wisconsin First, Inc.	1,271	6.8%
					Centene Corporation	1,034	5.5%
					Community Care, Inc.	574	3.1%
					Molina Healthcare, Inc.,	476	2.5%
					Anthem Inc.	49	0.3%

Sources: ICRC Technical Assistance Tool; CMS SNP Enrollment Data, February 2015

HMA Medicaid Roundup

Alabama

Six Organizations Participating in Expansion of the Health Home Medicaid Program. On March 10, 2015, *AL.com* reported that six probationary regional care organizations will undertake care of 220,000 Medicaid patients with chronic diseases in the first test of the Health Home program. The goal of the program is to stop or slow the rising costs of Medicaid by transferring the risk and responsibility for patients to regional care organizations that will receive lump payments for individuals in the program. Medicaid spending in Alabama grew from $3.5 billion in 2000 to $5.2 billion in 2012. Read More

Arizona

Gov. Ducey Signs Legislation to Seek Medicaid Limitations. On March 6, 2015, *Arizona Daily Star* reported that Governor Doug Ducey signed legislation to ask the federal government to impose work restrictions on Medicaid and set a five year limit for beneficiaries. Last year, former Governor Jan Brewer rejected a similar measure, saying it could possibly kick out half a million people and increase costs from emergency room visits. The federal government has turned down similar requests as well. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Lawmakers Propose Bills To Bring In Medi-Cal Money. On March 4, 2015, *Los Angeles Times* reported that lawmakers announced bills SB 243 and AB 366 that would reverse cuts to doctors who treat Medi-Cal patients, boost hospital funding, and require higher payments from managed care plans that contract with the state. Senator Ed. Hernandez said the bills could cost at least $5 billion. Read More

Prime Healthcare Passes on $843 Million Deal to Buy Daughters of Charity. On March 11, 2015, *San Jose Mercury News* reported that Prime Healthcare Services announced it will not continue with a proposed deal to buy Daughters of Charity Health System for $843 million. Daughters of Charity could end up filing for bankruptcy reorganization, be sold piecemeal, or close down completely as a result. Prime stated that the restrictions set on the deal were too burdensome and restrictive to make the necessary changes for the system to operate and save money. Read More

Judge Outlines Plan to End Federal Receivership of State's Prison Health Care System. On March 10, 2015, *Twincities.com* reported that U.S. District Court

Judge Thelton Henderson outlined a plan to transition the state's prison health care system out of federal control. The 34 prisons must first pass inspections, which will take over a year. Since 2006, prisons were run by a federal receiver after conditions in prisons were found to be so poor that they violated inmates' constitutional rights against cruel and unusual punishment. Since then, the state spent $2 billion on prison medical facilities, doubled the prison health care budget to $1.7 million, and reduced inmate population by 40,000. Read More

Colorado

Exchange Board Orders Audit; Exchange and Medicaid Managers to Begin Talks. *Health News Colorado* reported that the state's health exchange has been facing problems that will need an additional $2 to $7 million to solve on top of $6.2 million in cost overruns for the exchange call center this year. The issues have led the exchange board to self-issue an audit. Lawmakers will also decide on a bill that would require an additional audit of the exchange. Gov. John Hickenlooper's deputy chief of staff, David Padrino, plans to bring Medicaid and exchange managers together for talks. Read More

Colorado HealthOP Signs Up 39 Percent of Individuals Through Exchange. On March 4, 2015, *The Denver Post* reported that the states's CO-OP, Colorado HealthOP, enrolled 140,000 individuals signing up through the Exchange. The 39 percent market share came after the CO-OP lowered premiums in its second year. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Senate Approves Medicaid Expansion. On March 10, 2015, *The Tampa Bay Times* reported that the Senate unanimously approved the Medicaid Expansion bill SPB 7044. However, the more conservative Florida House is unlikely to approve. Additionally, CMS would need to grant a waiver for the state to receive federal funding. The expansion plan will require beneficiaries to work 30 hours a week if childless or 20 hours otherwise; if unemployed, the time must be spent searching for employment, participating in job-training activities or furthering their education. Additionally, beneficiaries must pay monthly premiums based on salary. Read More

House Panel Rejects Medicaid Dental Changes. On March 10, 2015, *Health News Florida* reported that the House Health Innovation Subcommittee failed to pass HB 601, which would have carved out pediatric dental services from the statewide Medicaid managed care program. The bill, proposed by republican Representative MaryLynn Magar would have instead directed the state to provide pediatric dental care through prepaid dental plans. According to the article, critics of HB 601 included officials from the Medicaid health plans, who expressed concern that this could lead to attempts to carve out other services from the managed care system. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Deal Administration Reports on Tax Collection Increase. Governor Nathan Deal's administration announced last week that the state's tax collections for February 2015 exceeded $943 million, up $105.6 million (12.6 percent) from February 2014. So far in this fiscal year, net tax revenue is up 5.8 percent from the previous year.

Kansas

Gov. Brownback May Consider Expansion If Fully Paid For. On March 5, 2015, *Kaiser Health News* reported that Governor Sam Brownback suggested he may consider Medicaid expansion if a budget neutral bill was proposed stating that any bill he looks at must cover the state's share of costs. An administration spokesperson said Brownback must fully understand the fiscal impact of Medicaid and the cost implications if the federal government is unable to cover its share. Representative Mark Hutton also has concerns about the costs of expanding Medicaid but said lawmakers can't continue to ignore the issue. Hospitals need expansion to offset reimbursement cuts, especially rural hospitals. The Kansas Hospital Association released a report that said it would cost the state $312 million through 2020 to expand Medicaid. However, $2.2 billion in expected funds from the federal government would offset the state's costs. Read More

Maine

Gov. LePage to Cut Rates for Mental Health Services. On March 5, 2015, *Maine Public Broadcasting* reported that Governor LePage wants to cut reimbursement rates for mental health services. Currently, medication management in mental health clinics costs $56 per 15 minutes while in a private practice it costs $24 per 15 minutes. Other states, like Massachusetts, have rates that are 10 percent lower for specialists. The LePage administration is seeking to level out the costs and streamline them with other New England states. However, mental health providers claim the cuts are too drastic and that primary care physicians will be unable to handle the increase of complex mental health services. Providers and some lawmakers argue the cuts will cause patients to lose access to service. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Gov. Baker's Budget to Delay Medicaid Payments. On March 5, 2015, *The Boston Globe* reported that in order to make up the $1.8 billion state budget shortfall, Governor Baker will not cut Medicaid benefits, reimbursement rates, or narrow eligibility. Instead the Governor will require eligible beneficiaries to actively reenroll in Medicaid each year and, to maximize savings in the upcoming fiscal year, he will put off Medicaid payments to some managed care organizations, institutional facilities, and hospitals until on or after July 1, 2016.

The fiscal swap, or cash management, as officials call it, has been used as a strategy in Massachusetts since 2004. Read More

Montana

Republican Lawmakers Reject Medicaid Expansion. On March 11, 2015, *Kaiser Health News* reported that Republican lawmakers have killed Governor Bullock's Medicaid expansion bill. House lawmakers refused to advance the bill by requiring a three-fifths majority vote which is regarded as highly unattainable. Bullock stated that he is not done trying and is open to finding a solution with lawmakers. Read More

Sen. Buttrey New Expansion Bill Combines Health Care with Economic Development. On March 8, 2015, *Great Falls Tribune* reported that Sen. Ed Buttrey will debut his new bill Montana HELP (Health and Economic Livelihood Partnership) Plan, which would cover 70,000 people and provide job training, education, and help finding a job. The plan's goal is to make Medicaid temporary and serve as a bridge to the online marketplace or employer plans. Buttrey is projecting the bill will create 12,000 new jobs. Read More

New Hampshire

Medicaid Expansion Waiver Approved. On March 5, 2015, *Concord Monitor* reported that CMS has approved New Hampshire's Medicaid expansion waiver. The waiver allows new enrollees to be moved to a private plan using Medicaid funds. Enrollment in the expanded program topped 36,000. Read More

Fewer Uninsured Patients at Emergency Rooms since Expansion. On March 3, 2015, *The Republic* reported that since New Hampshire expanded Medicaid, the number of uninsured patients has decreased in emergency rooms, according to the New Hampshire Hospital Association. Since enrollment began, 35,000 have signed up. In 2014, the number of uninsured patients at emergency rooms dropped by 17 percent from the previous year, and the number of uninsured patients admitted to hospitals dropped by 16 percent. Read More

New Jersey

Karen Brodsky (Email Karen)

Nursing Homes Accumulating Millions in Delayed Bills from Slow Review Process. On March 6, 2015, *NJ Spotlight* reported that the slow review process in determining Medicaid benefit eligibility in nursing homes is costing millions in delayed bills. Lawmakers are hoping to advance legislation that requires the state to pay for 50 percent of the bills while eligibility is being determined. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Revised Incentive Payments for Patient Centered Medical Homes. Effective April 1, 2015, New York State is revising the incentive payments paid to providers working at practices that are recognized as a Patient-Centered

Medical Home by the National Committee for Quality Assurance (NCQA). New York's Medicaid program chose to use NCQA's PCMH recognition program as the basis for providing enhanced payment to PCMH providers. Beginning in 2010 Medicaid began a per member per month (PMPM) incentive payment based on a provider's level of recognition by NCQA. New York State has changed the PMPM to reflect the NCQA third iteration of PCMH standards, the 2014 standards. As of April 1, 2015, incentive payments for PCMH-recognized providers under the 2008 standards will be eliminated. Level 2 providers under the NCQA 2011 standards will see their incentive payments reduced from $4 PMPM to $2 PMPM; Level 3 providers under the 2011 standards will see their incentive payments reduced from $6 PMPM to $4 PMPM. Providers that achieve recognition under the more rigorous 2014 standards, which place a greater emphasis on integrating health information technology and behavioral health services into primary care, will receive incentive payments of $6 (Level 2) or $8 (Level 3). Providers are reimbursed directly through managed care plans for care provided to plan enrollees. The most recent quarterly report on PCMH, from September 2014, indicates that as of September, 5,769 practices had achieved some level of NCQA recognition; 4,393, or 76 percent, had achieved recognition under the 2011 Level 3 standards. Incentive payments during the first nine months of 2014 totaled almost $75 million.

Assembly Budget Proposals. The New York State Assembly released its one-house budget bill this week. It includes a number of items that affect the health budget.

- Eliminates the Governor's private equity demonstration projects, designed to enable private equity investors, partnered with academic medical centers, to invest in restructuring of hospitals.
- Eliminates the Governor's authorization of value-based payment arrangements between DSRIP Performing Provider Systems and insurers.
- Requires each DSRIP Performing Provider System to create a community advisory board that shapes, responds, and reports on operational activities and outcome measures, including the elimination of healthcare disparities, and which must include local Medicaid consumers as representatives.
- Reinstates Prescriber Prevails language, allowing prescribers to override managed care formularies.
- Reinstates Spousal Refusal, eliminating the requirement that a spouse be absent from the house in order to invoke spousal refusal, allowing an individual to establish eligibility disability assistance.

Transformation Agenda for People with Developmental Disabilities. Kerry Delaney, Acting Commissioner of the Office for People with Developmental Disabilities (OPWDD), announced the establishment of a stakeholder group to guide the shaping of its Transformation Agenda. The Transformation Agenda focuses on deinstitutionalization, employment, improved quality measurement and quality improvement, and self-direction. Services in New York are still largely residential facility-based care. The Transformation Agenda is consistent with federal policy encouraging a shift from institution-based care to home- and community-based services. OPWDD is trying to answer the question: how do we build our system to better support people with intellectual and

developmental disabilities now and into the future and make our system sustainable for years to come? The panel is charged with examining the challenges of implementing a managed care model for people with developmental disabilities, and ensuring its long-term fiscal sustainability. As part of the Medicaid Redesign Team Care Management for All agenda, Medicaid beneficiaries served through OPWDD will be brought into managed care on a voluntary basis beginning in October 2016, and on a mandatory basis beginning in October 2017. A managed care product designed to coordinate specialized developmental disability services, termed a Developmental Disabilities Individual Support and Care Coordination Organization (DISCO), is planned for 2016. A press release including panel membership can be found on the OPWDD website.

New York State Employment First Commission. In October 2014 Governor Cuomo signed an executive order to establish the Employment First Commission, tasked with creating an Employment First policy for New York, which makes competitive, integrated employment the first option when considering supports and services for people with disabilities. The initiative aims to increase the employment rate, and decrease the poverty rate, for New Yorkers who are receiving services from the State. The Employment First Commission is comprised of representatives from the Governor's office and State agencies. The state has three goals for its Employment First policy:

1. Increase the employment rate of individuals with disabilities by 5 percent;
2. Decrease the poverty rate of individuals with disabilities by 5 percent;
3. Register 100 businesses as having formal policies to hire people with disabilities as part of their workforce strategy.

The Employment First Commission released its recommendations in a report on March 1, 2015. The report puts forth 11 recommendations, which include cultural modeling of the integrated employment of individuals with disabilities; energizing demand through redesign of the New York Business Leadership Network to pursue the aggressive goal of engaging 100 business partners; building on the New York Employment Services System (NYESS) to fully adopt the Ticket to Work program; integrating the Medicaid Buy-In for Working People with Disabilities (MBI-WPD) into the on-line New York State of Health application portal; reducing barriers to transportation; supporting education that increases the integration of students in their communities; and expanding access to assistive technologies. The report can be found on Governor Cuomo's website.

Overnight Programs Helping Families of Dementia Patients. On March 9, 2015, *Kaiser Health News* reported that overnight programs, like Elderserve at Night, are providing an alternative treatment for patients with dementia. Because dementia patients are more alert at night, many families and caregivers struggle to take care of them. Overnight programs allow the caregivers to rest while providing stimulation for the patients throughout the night with various activities. Elderserve at Night is covered by some private insurers and New York Medicaid. Overnight programs cost $200 a night versus $320 for a typical nursing home. However, it is difficult to find overnight staffing. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Greystone Healthcare Buys 10 Ohio Skilled Nursing Facilities from Autumn Health Care. Greystone announced its acquisition of 10 skilled nursing facilities and therapy provider TheraTrust Inc. and a corporate office in Newark. Greystone already owns several facilities in Ohio including the Rehabilitation and Health Center of Gahanna in Columbus, home health services provider Executive Care and Greystone Hospice of Ohio. Read More

Hospitals in Central Ohio Are Doing Fairly Well, Others Are in Transition. A number of factors appear to be influencing how hospitals are doing. Some major factors of modernization and transformation appear to include:

- the shift from inpatient to outpatient care,
- greater use of 'observation status' for patients who have short stays in hospitals,
- growth in the number of overall beds, and
- Medicaid expansion

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Oregon

State Insurance Exchange, Cover Oregon, Dissolved. On March 7, 2015, *Los Angeles Times* reported that Governor Kate Brown signed a bill dissolving the state's health insurance Exchange, Cover Oregon. The state decided to switch to the federal Exchange in April after Cover Oregon proved to be extremely problematic and would have cost $248 million to fix. No one was ever able to enroll through the non-functioning website and had to enroll through paper applications. Read More

Pennsylvania

HMA Roundup – Matt McGeorge (Email Matt)

Pennsylvania Releases Detailed Medicaid Expansion Timeline. The Department of Human Services (DHS) today released an updated timeline detailing the commonwealth's plan for traditional Medicaid expansion as it moves away from the Healthy PA Private Coverage Option (PCO) plan championed by the previous Pennsylvania Governor. Under the new Medicaid Expansion plan undertaken by the Governor Wolf administration, individuals who were enrolled in the General Assistance and Select Plan program in December 2014 will begin to be transferred from the PCO to the HealthChoices program, the traditional Medicaid program in Pennsylvania. This phase, called Phase 1, will begin in April 2015 and be completed by June 1, 2015. New applicants will no longer be enrolled in the PCO and will be enrolled in the new Adult benefit package with coverage provided by the HealthChoices managed care organizations. In Phase 2, July 2015-September 2015, all remaining PCO enrollees will transition from PCO plans into the HealthChoices. Read More

Pennsylvania Official Addresses Glitch in Addiction and Mental Health Services. Ted Dallas, Acting Secretary for the Department of Human Services (DHS) recently acknowledged that a glitch in the department's system

mistakenly moved people with substance-abuse problems to Private Coverage Option (PCO). But even under the previous Pennsylvania Medicaid Expansion plan (see article above), the PCO plans were not intended to cover that population, and most PCO plans had not set up networks to cover addiction and mental-health treatment. The result was an immediate end to treatment for thousands of Pennsylvanians. DHS is planning to make sure providers that continued treating people through the mix-up are reimbursed. Dallas acknowledged some providers were "having cash-flow problems and other financial issues" and said the state was working to resolve them "on a case-by-case basis." Read More

Wolf Presses for Shift away from Medicaid Nursing Home Care. Gov. Tom Wolf is pushing for a shift in where Pennsylvania's elderly poor can receive long-term care, pressing ahead with initiatives that favor home and community-based services over admission to a nursing home. Wolf wants to double the number of seniors who get care in the home and community to more than 50 percent, up sharply from about 25 percent today. Wolf will expand choices for Medicaid seniors about where to get care by introducing managed care to long-term care in Pennsylvania. Under the arrangement, Medicaid managed care insurers will be paid a flat per-member-per-month fee to provide for all of a senior's health care needs, regardless of actual cost. Read More

Wolf Administration Broadens Number of Highmark Customers Eligible for UPMC Care. Gov. Tom Wolf reversed a decision by his predecessor Thursday, making it easier for Highmark insurance subscribers to stay with their UPMC doctors. The Wolf administration says it will interpret last year's consent agreement, particularly in regards to 'continuity of care', between Highmark and UPMC in a broader way. Highmark customers may be able use UPMC facilities at lower in-network rates under a consent agreement Highmark and UPMC signed last year. People covered by Medicaid and children with CHIP coverage can be treated at UPMC, as can all Medicare customers, except those with Highmark's Community Blue Medicare HMO plan. Read More

Texas

HMA Roundup – Dianne Longley (Email Dianne)

HHSC Expands STAR PLUS to Include Nursing Home Residents. After a six month delay, effective March 1, 2015, eligible Medicaid enrollees who live in a nursing facility will begin receiving basic health services and long term care through STAR+PLUS. Dual eligibles will continue to receive basic health care through Medicare and LTSS through STAR+PLUS. The roll-out of this latest expansion will expand Medicaid managed care to an estimated 87 percent of Texas Medicaid clients. HHSC has been planning for the expansion for nearly two years, but client concerns and logistical issues delayed the rollout from an initial deadline of September 1, 2016. To prepare for the expansion, HHSC conducted enrollment event at nursing facilities and provided one-on-one client assistance to help members select a health plan. Continuity requirements also were included to ensure new enrollees do not experience a lapse in services during the transition period. All STAR+PLUS health plans are required to participate in the nursing facility transition.

Duals Demonstration Program Begins Enrollment. Effective March 1, 2015 HHSC began rolling out the dual eligible demonstration program approved last

year by CMS. The program is limited to an estimated 147,000 dual eligible clients in the most populous six Texas counties: Bexar, Dallas, El Paso, Harris, Hidalgo and Tarrant. Enrollees with both Medicare and Medicaid benefits will begin receiving the full array of services through a single plan. Full implementation is expected to be completed sometime this summer.

North Texas Behavioral Health Authority Proposes ASO Arrangement to Replace NorthSTAR Program. A March 3, 2015 report from the North Texas Behavioral Authority (NTBHA) outlines its proposal to replace the existing NorthSTAR behavioral health managed care program with an administration services organization (ASO) contract to continue providing managed behavioral health services in Dallas, Ellis, Rockwall, Navarro, Hunt, and Kaufman counties. The NorthSTAR program was recommended for phasing out by the Sunset Advisory Commission. Under the proposal, the ASO contract would be competitively bid. The NorthSTAR contract is currently held by ValueOptions through August 2015. Read More

Lt Governor Dan Patrick, Senate Republicans Write Obama to Request Medicaid Flexibility. The newly elected Texas Lt. Governor Dan Patrick and all 20 Republican senators celebrated Texas Independence Day to "declare Texas independence from overreaching federal mandates like Obamacare." The Republican senators announced they have sent a letter to President Obama to request more flexibility within Medicaid to "design a program that is stable and sustainable for Texans." The letter specifically requests approval to implement:

- personal accountability requirements, including cost sharing, missed appointment fees and health savings accounts;
- tailored benefit packages;
- work requirements for able-bodied adults;
- reduced administrative burdens for providers;
- asset testing as part of eligibility criteria;
- reinstatement of the active renewal process;
- customized certification periods;
- exemption from the ACA health insurance issuer fee;
- exemption from ACA maintenance of effort requirements; and
- exemption from hospital presumptive eligibility.

The letter was released at a brief press conference attended by Patrick and Senator Charles Schwertner, who is currently chair of the Senate's Health and Human Services Committee and a practicing physician. A CMS official responded the federal government is committed to working with states to design programs that reflect a state's unique goals and objectives while meeting the law's goals and consumer protections. Texas House Member and Democrat Garnet Coleman responded by pointing out that suggesting health savings accounts for children is a ridiculous idea and that the Senate request list is out of touch and indicates the Senate is not serious about reform. A group of advocacy groups also criticized the list and stated the proposal represents the wrong priorities for Texas. Read More

Governor Appoints New Inspector General for Texas Health and Human Services Commission. Texas Health and Human Services Commission has a new Inspector General following the Texas Senate's unanimous approval of Stuart Bowen's appointment. Bowen was appointed by Governor Greg Abbott following the resignation of Doug Wilson, who was forced to resign by former Governor Rick Perry after the OIG office failed to meet performance

expectations and was part of questionable contracting practices that resulted in a $20 million no-bid contract award for Medicaid fraud tracking software. The OIG office was the subject of a scathing reviews released by the state auditor's and the Texas Sunset Commission.

Bowen is the former special inspector general for Iraq reconstruction and a former top aide to George W. Bush when he was governor and president. In accepting the position, Bowen announced he plans to focus not just on Medicaid and food stamp fraud, but all types of inefficiencies that waste taxpayer funds at the Texas Health and Human Services Commission.

New HHSC Chief Ethics Officer Appointed. Texas Health and Human Services Commission (HHSC) Executive Commissioner Kyle Janek announced the appointment of David Reisman to the newly created Chief Ethics Officer position at HHSC. Janek created the position to "help increase our emphasis on ethical behavior" following several investigations and legislative concern over improper, and potentially illegal, contracting activities within the HHSC organization. Resiman previously served as the executive director of the Texas Ethics Commission and most recently worked at the Cancer Prevention and Research Institute where he created an oversight and monitoring system for more than $1 billion in state grant funds. Before that, he worked on ethical issues at the Pentagon for the Army General Counsel's office. Reisman stated he wants to ensure employees know the circumstances that create a conflict of interest and how to avoid potential problems. He believes a centralized policy should be implemented for all five health and human service agencies under the oversight of HHSC.

Utah

Lawmakers Hope for Compromise on Medicaid Expansion. On March 9, 2015, *The Salt Lake Tribune* reported that the Senate and House are still hopeful they can reach a compromise on Medicaid expansion. The Senate is reportedly not giving House Majority Leader Jim Dunnigan's proposal, Utah Cares, a committee hearing, but rather taking it straight to the floor to vote on. However, Senate President Wayne Niederhauser predicts it will fail. Last week, the Healthy Utah bill proposed by the Senate was rejected by the House. Read More

National

Marketplace Enrollment Nears 11.7 Million. On March 10, 2015, *Reuters* reported that almost 11.7 million people have either signed up or reenrolled for insurance under a qualified health plan through the Marketplace, exceeding the projected 9.1 million. About 8.8 million signed up through the federally-run Marketplaces and 2.85 million through the state Marketplaces. In the federally-run Marketplaces, 87 percent qualified for a subsidy. Read More

Hepatitis C Drugs Raise Drug Spending by 13 Percent. Drug spending by insurers in the last year has risen by 13 percent. According to Express Scripts, the major contributing factor are the costly new hepatitis C medicines, where a single course of treatment can cost as much as $150,000. Express Scripts estimates that Hepatitis C drugs will also raise Medicare Part D costs by anywhere from $2.9 billion to $5.8 billion in 2015.

Industry News

MAXIMUS to Acquire Acentia. On March 9, 2015, MAXIMUS, an operator of government health and human services programs in the United States, United Kingdom, Canada, Australia and Saudi Arabia, announced that it entered a definitive agreement to acquire Acentia, a and provider of technology and management solutions. The transaction is valued at $300 million and is expected to close in third quarter 2015. Read More

SigmaCare Acquires HomecareCRM. On March 10, 2015, SigmaCare, a electronic health record technology partner, announced that it acquired HomecareCRM, a provider of customer relationship management for the home care industry, to launch an integrated marketing solution. The solution will focus on referral source management. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
March 26, 2015	Iowa	Amended RFP Release	550,000
March 27, 2015	Mississippi CHIP	Proposals Due	50,300
March, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
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 24, 2015	Mississippi CHIP	Contract Awards	50,300
April, 2015	Louisiana MLTSS - DD	RFP Release	15,000
May 1, 2015	Michigan	RFP Release	1,500,000
May 4, 2015	Georgia	Proposals Due	1,300,000
May 8, 2015	Iowa	Proposals Due	550,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
August, 2015	Michigan	Contract Awards	1,500,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,500,000
January 1, 2016	Iowa	Implementation	550,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry; 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		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Health Spring, Molina, Superior, United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15
California	17,846	39,731	42,473	44,804	48,976	51,527	58,945	122,908	123,079
Illinois	19,461	37,248	48,114	46,870	49,060	49,253	57,967	63,731	66,223
Massachusetts	13,409	18,836	18,067	17,739	17,465	18,104	17,918	17,867	17,763
New York								17	406
Ohio								68,262	66,892
South Carolina									83
Virginia		11,169	11,983	21,958	28,642	29,648	27,701	27,527	26,877
Total Duals Demo Enrollment	**50,716**	**106,984**	**120,637**	**131,371**	**144,143**	**148,532**	**162,531**	**300,312**	**301,323**

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

HMA News

HMA Webinar TOMORROW: *"Do the Right Thing: Culturally Responsive Health Care and the Federally Mandated CLAS Standards"*

Thursday, March 12, 2015
1:00pm Eastern
Link to Webinar Registration

HMA Information Services (HMAIS) will present the webinar, "Do the Right Thing: Culturally Responsive Health Care and the Federally Mandated CLAS Standards" at 1 p.m. EST Thursday, March 12.

The time for culturally responsive health care is now. Not only is it the right thing to do, but key elements are mandated by the federal CLAS (Culturally and Linguistically Appropriate Services) Standards. There is also a strong business case for culturally responsive health care; it drives patient satisfaction, helps improve outcomes, and brings a degree of economic viability to what is essentially an unfunded mandate. Unfortunately, many health care organizations find themselves either unfamiliar with the standards or lagging in the development and implementation of strategies for full compliance.

During this webinar, Health Management Associates Principal, Dr. Jeff Ring, will make the case for socially responsive health care and show your organization how to take the necessary steps to make it work for your patients and your organization.