HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 19, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

NORTH CAROLINA MEDICAID REFORM PROPOSAL SUBMITTED TO LEGISLATURE

This week, our *In Focus* section reviews the Medicaid reform proposal submitted to the North Carolina state legislature by the state's Medicaid department, the North Carolina Department of Health and Human Services (DHHS). The report, released on March 17, 2014, was required by the legislature under Session Law 2013-360. Under the law, DHHS was required to develop a detailed plan, known as the Partnership for a Healthy North Carolina, to reform the state's Medicaid program. The legislature is expected to vote on the proposal as early as May 2014. After some consideration, it was revealed late last year that North Carolina would not be pursuing a traditional risk-based managed care model for the Medicaid program. Instead, the reforms detailed in this proposal would:

1. Establish provider-led Medicaid accountable care organizations (ACOs) for the management of physical health;
2. Continue the consolidation and strengthening of the Local Management Entity Managed Care Organizations (LME-MCOs) providing services for the mental health, substance abuse, and intellectual and developmental disabilities (IDD) populations; and
3. Streamline and strengthen the coordination of Medicaid long term services and supports (LTSS).

DHHS anticipates savings of $15 million ($3 million in state appropriations) in the first year of the new program, increasing to $329 million ($110 million in state appropriations) by the fifth year of the program, bringing five-year total savings to $987 million ($326 million in state appropriations). North Carolina currently spends around $13 billion annually on the Medicaid program, serving an average monthly enrollment of 1.8 million beneficiaries.

While the proposal has the backing of Governor Pat McCrory's administration, there have already been reports since the release of the plan of strong opposition to the proposal from at least one key state senator. As such, we do not view approval of the proposal as guaranteed.

Below we summarize the proposed structure of the Medicaid reforms and highlight key takeaways from each of the three major recommendations listed above.

Medicaid ACOs

The Medicaid ACO structure would build upon the state's existing network of patient-centered primary care medical homes serving the Medicaid population. DHHS proposes expanding beyond the medical home model to integrate specialty care and hospitals, while providing financial incentives for meeting quality and cost-savings goals.

- ACOs would include physicians in a group practice, joint venture arrangements between hospitals and physicians, networks of individual physician practices, and hospital-employed physician networks.
- Additionally, safety net organizations, such as critical access hospitals, federally qualified health centers (FQHCs), and rural health clinics may participate in or form their own ACOs.
- ACOs would be required to form a legal entity, such as a corporation, partnership, limited liability company, or foundation recognized by the state of North Carolina.
- Primary care providers (PCPs) would be limited to participating with only one ACO at a time, while other providers could participate in multiple ACOs.
- The DHHS proposal sets a goal of 40 percent of Medicaid beneficiaries covered by an ACO in the first year, increasing to 90 percent by the fourth year. While the proposal does not require mandatory provider participation in the ACO model, it does suggest the possibility of reduced reimbursements to non-ACO-participating providers if ACO coverage is not meeting targets.
- Beneficiary assignment to an ACO would be based on PCP selection, with an auto-assignment process favoring geographic convenience for those beneficiaries who do not select a PCP.

- DHHS proposes including the dual eligible population in the Medicaid ACO model at this time, with a provision for opting out of the ACO. DHHS intends to further pursue financial alignment for dual eligibles after launching the ACO model.
- Shared savings/losses will be based on benchmark spending amounts, and the amount of shared savings/losses will increase over the first five years of the program, placing greater risk on ACOs in later years. Additionally, within each program year, an ACO's share of savings/losses will vary within a predetermined range based on ACO quality performance. Award and penalty caps will be set for each year as a defined percentage of benchmark spending.
- Under the proposal, ACOs that launch within the first two years of the program will have the option for interim payment calculations and possibly an early-savings share distribution to enhance cash flow.

LME-MCOs for the Mental Health, Substance Abuse, and IDD Populations

North Carolina Medicaid's behavioral health population is currently served by 10 LME-MCOs receiving capitation under a 1915(b)/(c) managed care waiver, in place since April 2013. DHHS is consolidating these 10 LME-MCOs into a four-region model, with a target completion date of July 2016. Additionally, the reform proposal indicates that the state would implement additional measures into the next round of LME-MCO contracts to advance the program, as well as pursue additional IDD waiver slots, require risk-sharing pilot programs with providers, and require sub-capitation arrangements with a minimum percentage of providers.

Medicaid LTSS Reform

DHHS proposes a series of reforms to the state's Medicaid LTSS system including:

- Identifying and strengthening points of entry into the LTSS system, including community-based organizations and web-based portals for self-screening;
- Informing beneficiaries about the breadth of LTSS service options through an options counselor program that will be referred to as an "usher";
- Building and strengthening holistic systems of care coordination through a uniform assessment tool, increased integration of the LTSS beneficiary's PCP, and a pilot care model for individuals with traumatic brain injury;
- Elevating workforce competencies in case management, options counseling, transition planning, and integrated care; and
- Developing an IT structure to support the LTSS system.

Links to DHHS Medicaid Reform Proposal Documents

Link to DHHS Press Release

Link to DHHS Medicaid Reform Proposal (PDF)

HMA Medicaid Roundup

California

HMA Roundup – Alana Ketchel

Medi-Cal Statewide Formulary Proposal Reviewed. Medi-Cal, California's Medicaid program recently announced its intention to develop a statewide formulary similar to that currently used in the Texas Medicaid program. According to Medi-Cal, the intent of a statewide formulary is twofold. First, it will provide consistent access to and continuity of pharmaceutical care for Medi-Cal beneficiaries as well as standardization for Medi-Cal providers whether a beneficiary is in fee-for-service or one of the many Medi-Cal managed care plans.

Secondly, the proposal will allow the Medi-Cal program to maximize rebates for pharmaceutical expenditures, specifically where there have been significant shifts in populations and utilization from traditional fee-for-service to managed care delivery systems.

To bring stakeholders up to speed on the proposal, the California Department of Health Care Services (DHCS) is holding a series of conference calls with various groups. On March 18, 2014, DHCS held separate calls with providers and pharmaceutical manufacturers. During these calls DHCS noted the following aspects of the statewide formulary proposal:

1. To ensure transparency, the proposal will allow all entities outside of DHCS to monitor and provide input and feedback to changes in the drugs listed on the single statewide formulary, as well as utilization controls placed on those drugs.
2. The formulary will be considered a "core" benefit for Medi-Cal fee-for-service, Medi-Cal managed care plans and the family planning program (referred to as FPACT). Plans would not be able to impose utilization controls on core benefit drugs.
3. The core benefit design sets a minimum coverage requirement, allowing managed care plans to add additional drugs to their individual formularies.
4. DHCS will negotiate supplemental rebates with manufacturers for all drug utilization including managed care.
5. The estimated timeline for implementation is 12 to 18 months post enactment of legislation. This time is based on the need to adjust managed care contracts, negotiate new supplemental rebate contracts with manufacturers and obtain approval from CMS via the State Plan Amendment process.

6. DHCS made it clear that it is not contemplating carving drugs (e.g., antipsychotic drugs and drugs to treat HIV) back into the capitation rate of managed care plans.

DHCS will continue to reach out to stakeholders for input and also is seeking any additional input regarding the proposed concept and draft statutory language which is available through the California Department of Finance.

Concerns Raised Over Launch of Cal MediConnect. On March 16, 2014, the *San Bernadino County* Sun discussed recent concerns about moving elderly and disabled Californians into managed care plans through Cal MediConnect, a new state pilot project. The project aims to help dual-eligibles access more coordinated medical care, but several groups have expressed concerns that these residents are not being given the necessary information to make informed decisions about whether to join the project or stay with their current providers. Read more

Covered California Achieves One Million Enrollees. On March 17, 2014, Covered California announced that over one million Californians selected a health plan through the exchange. The exchange well exceeded its enrollment projections, with nearly two weeks left in the first enrollment period. Read more

Panel Deems New Hepatitis C Drug to be Poor Value. On March 10, 2014, the California Technology Assessment Forum (CTAF) voted that Gilead's new Hepatitis C drug, Sovaldi, was a "low value" treatment. The price for the drug is set at $84,000 for a 12-week regimen. The new drug is viewed as superior to older alternatives because of its once-a-day regimen and increased treatment effectiveness. The panel, composed of insurance industry-affiliated medical experts, determined that reduced health care spending on complications would not cover Sovaldi's upfront costs even after 20 years. Read more

Ventura County Behavioral Health Department Awarded Expansion Grant. On March 13, 2014, the *California Healthline* reported that Ventura County was awarded a $7.6 million grant to fund 20 new staff positions. The funding will go toward expansion of existing services as well as development of new offerings. Read more

Blue Shield Establishes ACO with Inland Healthcare Providers. On March 12, 2014, *Valley News* reported that Blue Shield of California is partnering with Inland Empire providers to establish an accountable care organization. The six participating physician groups will contribute 27,300 patients to the new care model. The Inland Empire ACO will be active for two years with the potential for extension. Blue Shield is working with EPIC Management, LP to develop the ACO. Read more

Colorado

HMA Roundup – Joan Henneberry

High Salaries for Exchange Employees Anger Affordable Care Act Skeptics. On March 18, 2014, the *Denver Post* reported that salary and management of the Colorado marketplace is under fire once again because of salaries and bonuses to employees. According to state health care exchange records, one-fifth of exchange employees made more than $100,000 in annual salary and bonuses in 2013, with the executive director's pay exceeding $190,000. Nearly half of the 36 exchange employees make more than $80,000 annually. These salaries are primarily funded with federal exchange start-up dollars but eventually the exchange, including salaries, will be sustained through assessments on products sold in the marketplace. The current fees on plans is 1.4 percent on each policy sold through the exchange. CEO Patty Fontneau recently asked

her board to increase the fees and it declined. The state legislature approved a bill this year calling for a thorough audit of the marketplace and its operations by the state auditor. Read more

Florida

HMA Roundup – Gary Crayton and Elaine Peters

Senate Democrats Say Medicaid Expansion Could Save State $470 Million. On March 17, 2014, the *Miami Herald* reported on recent studies by the Florida Agency of Health Care Administration and other organizations that estimated expanding Medicaid would save the state $470 million in general revenue. Senate Democrats, who presented the estimates to lawmakers this week, hope to convince Republicans who oppose Medicaid expansion to support two bills that have been presented on the issue this year. The Senate members framed the cost savings in terms of specific improvements that can be implemented to address pressing issues faced in various non-health sectors in the state. Read more

Georgia

HMA Roundup – Mark Trail

State May Allow Struggling Hospitals to Reduce Service Offerings. On March 14, 2014, Georgia Public Broadcasting discussed a recently proposed regulation change that may allow hospitals to downsize their services in order to remain financially viable. The proposal would likely allow struggling hospitals to "downsize to a facility that includes emergency room, surgery and childbirth services." Department of Community Health Commissioner Clyde Reese announced that he would ask the board of the agency to elaborate on the rules for such "step-down" facilities. The proposal comes as many rural facilities in Georgia have closed or are in danger of closing due to financial stress. Read more

General Assembly Passes Bill Restricting Medicaid Expansion. On March 18, 2014, the *Augusta Chronicle* reported that Georgia's General Assembly has passed a bill that will give the Republican-dominated Legislature authority over whether to loosen the rules for governing how much money people can make and still qualify for Medicaid. Many Republican lawmakers in the state oppose Medicaid expansion because of its long-term costs to the state. Read more

Hawaii

Lawmakers Assess Financial Strength of Hawaii Health Connector Exchange. On March 14, 2014, the *Washington Times* reported that Hawaii lawmakers will consider using money from the state's general fund to finance the Hawaii Health Connector if the program cannot support itself. State lawmakers met this week with Tom Matsuda, the exchange's interim executive director, to assess the exchange's financial viability and discussed how the state might be able to help. The exchange has run into technical issues since it went live and has suffered low enrollment and low revenues as a result. In addition to proposing use of state funds, lawmakers have also suggested that the state insurance commission charge a fee to insurers not participating in the exchange. Read more

Iowa

Iowa Plans to Help Newly Released Inmates Apply for Medicaid Coverage. On March 12, 2014, the *Des Moines Register* reported that Iowa is planning on granting health insurance to inmates as they leave prison. Officials from the state corrections and human services departments are setting up a method for inmates to enroll in Medicaid coverage through the state's Health and Wellness Plan. This coverage would include much needed mental health and addiction treatment. Assistant deputy director for the Department of Corrections, Katrina McKibbin, hopes the initiative will help newly paroled and released prisoners adjust to the outside world, increasing their quality of health and overall public safety. Read more

Maine

Maine Insurance Start-up Wins Vast Majority of Exchange Enrollees Statewide. On March 16, 2014, the *Bangor Daily News* reported that Maine Community Health Options has enrolled 80 percent of the ACA customer market in Maine. The start-up insurer, which was conceived just three years ago, enrolled more consumers than the well-established Blue Cross Blue Shield Plan, its only rival. The insurer is part of a group of 23 successful insurance co-ops around the country that cover a combined 300,000 Americans by combining low premiums with innovative benefit designs. Co-ops have also gained a large market share in New York, Iowa, Nebraska, Colorado, Kentucky, Wisconsin, South Carolina, Utah, Montana, Nevada and New Mexico. Federal authorities have approved several co-ops to expand their operations to neighboring states. Read more

House Advances Medicaid Expansion Bill. On March 19, 2014, the *Bangor Daily News* reported that the House has advanced a Medicaid expansion bill in a 97-49 vote. The bill would expand Medicaid to more than 70,000 low-income Mainers through insurance coverage from managed care organizations. However, it is unlikely the bill will gain enough support to pass when it is presented for additional votes in the House and Senate; additionally, Governor Paul LePage has stated that he will veto the bill. Read more

Massachusetts

HMA Roundup – Rob Buchanan

Massachusetts Cuts Ties With CGI. On March 17, 2014, *The Wall Street Journal* reported that Massachusetts state officials have decided to end the state's relationship with CGI Group, Inc., the company that created the state's error-prone online health insurance exchange. Tens of thousands of residents have experienced difficulties with the website while attempting to register for insurance coverage. Sarah Iselin, special assistant to Governor Deval Patrick, says that the state aims to end its collaboration with CGI and have a fully functioning exchange website by next fall. It is currently unclear what group will replace CGI and how the state will handle the transition. Read more

Steward Health to Merge Two Network Hospitals. On March 17, 2014, the *Boston Business Journal* reported that for-profit hospital network Steward Health Care System will merge two of its hospitals north of Boston, Merrimack Valley Hospital and Holy Family Hospital. The board of directors of the two hospitals will also merge. The company says the merger will help cut costs while maintaining the same level of acute care services. Read more

Michigan

HMA Roundup – Esther Reagan

Update on HIPF Adjustment. Gov. Rick Snyder's Executive Recommendation for Fiscal Year 2014-2015, which begins October 1, 2014, includes a 2.5 percent increase in capitation rates for MCOs contracted to serve the Medicaid population. The proposed increase has been identified as necessary to meet federal "actuarial soundness" requirements as well as the need by affected MCOs to pay the Health Insurance Providers Fee (HIPF), a non-deductible excise tax applied to premium revenue and required under the Affordable Care Act. On February 27, 2014, the Michigan Association of Health Plans Executive Director, Rick Murdock, provided testimony to the Senate Appropriations Subcommittee on Community Health. In his testimony, Murdock expressed concern that the proposed 2.5 percent adjustment in reimbursement to Medicaid MCOs would not fully account for new plan costs under the ACA. He projected a need for an additional 2.0 percent increase ($130.0 million) in funding to adequately account for new health plan liability.

84,000 Medicaid Applications Stalled Due to Marketplace Glitches. On March 17, 2014, the Michigan Department of Community Health reported that processing of 84,000 applications for Medicaid coverage is being delayed because of glitches in the insurance marketplace website. Department spokeswoman, Angela Minicuci, said that the federal government has not been returning complete information about Medicaid applicants back to the state, thus stalling the enrollment process. This issue is also expected to delay the processing of Medicaid applications under the state's Medicaid expansion program. Minicuci also said that the department is trying to contact people who may have applied for Medicaid online to encourage them to apply again, now that the marketplace is more functional. Read more

Minnesota

Documents Shed Light on Problematic Insurance Exchange Website. On March 12, 2014, *Kaiser Health News* reported on management failures and technical glitches that have affected the state's MNsure insurance exchange website. Exchange officials have blamed tight deadlines and changing federal guidelines for the website's shortcomings. However, internal documents suggest that top exchange officials managed the project poorly and did not focus enough on quality assurance or the site's technological infrastructure. Documents also show that the website was not properly tested before going live for public enrollment. MNsure interim CEO, Scott Leitz, says that the exchange team is hiring additional staff and focusing on repairing website functionalities in order to increase enrollment before the open enrollment period ends later this month. Read more

MNsure Requesting More Flexible Use of Federal Grants to Boost Customer Service. On March 12, 2014, the *Pioneer Press* reported that MNsure wants to spend an additional $12.5 million this year to repair its troubled website and call center. The organization is seeking federal approval for changing plans to spend grant funds, which would allow an additional $10 million for information technology and $2.5 million for better customer service operations. The proposed spending changes are aimed at improving the customer experience on the website and increasing enrollment numbers, which have lagged due to the site's technical glitches. The changes would also allow MNsure to maintain a balanced budget for fiscal year 2015. MNsure's

interim CEO believes that federal approval is likely, as the state is requesting spending flexibility, not more money. Read more

Missouri

Missouri Senate Bill Would Expand Medicaid Managed Care. On March 13, 2014, the *Columbia Daily Tribune* reported that the Missouri Senate health committee has approved a bill in a 6-4 vote to privatize Medicaid statewide. The bill would shift more of the 840,000 low-income Missourians covered under the MO HealthNet Medicaid program into managed care Medicaid policies run by insurance companies. The bill aims to improve coordination of care for patients and to reduce cost for services. The legislation does not include provisions to expand Medicaid as outlined by the Affordable Care Act, a possibility that has been previously rejected by Republican lawmakers. The bill will now move to the full senate for debate. Read more

Nebraska

Medicaid Expansion Debate Begins in Legislature. On March 19, 2014, Nebraska Radio Network reported that the state's legislature has begun debating the "Wellness in Nebraska" Medicaid Expansion Act, which would use $2.1 billion in federal dollars to buy private health insurance coverage for about 54,000 residents. Senator Kathy Campbell, who sponsored the bill, says the bill is tailored to Nebraska and that it would require enrollees to pay small premiums and take measures to stay healthy. Opponents of the bill argue that Medicaid expenses the state will incur to keep the program running once the federal government decreases its financial support would pull money away from other priorities. Read more

HHS Issues RFP for a Comprehensive Care Management System. This week, the Nebraska Department of Health and Human Services issued a Request for Proposal (RFP) to develop and implement a comprehensive care management system to improve the quality and consistency of care for individuals residing at facilities operated by the behavioral health, developmental disabilities, or veterans' homes divisions. This new system will include practice management functionality and serve as an electronic health records system.

Nevada

Nevadans Consider Legal Action Over Issues With Nevada Health Link. On March 15, 2014, the *Las Vegas Review-Journal* reported that Nevadans who have experienced difficulty obtaining insurance coverage through the Nevada Health Link exchange are considering legal action. Since the exchange went live, website glitches, provider contract issues and coverage mix-ups have prevented many residents from enrolling or receiving insurance coverage once enrolled. A potential surge in legal cases has prompted lawyers and patients to assess how they might prove damages, and how much responsibility can be assigned to the state and the exchange designer. Read more

New Hampshire

House Finance Committee Votes in Favor of Medicaid Expansion in New Hampshire. On March 19, 2014, *Modern Healthcare* reported that the New Hampshire House Finance Committee passed a bill that would use federal Medicaid money to pay

for private health insurance for about 50,000 low-income adults. New Hampshire is one of six states that have not yet made a decision on Medicaid expansion. Under the bill, which was passed by the state Senate last week, the program would end in 2016 when the federal government's required contribution drops below 100 percent, unless it is reauthorized. The bill will now move to the full House, where it is expected to pass. Read more

State HHS Officials Consider Expanding Dental Services for Uninsured. On March 15, 2014, the *Keene Sentinel* discussed a push by state officials to include dental coverage in New Hampshire's Health Protection Plan for Medicaid expansion. While Medicaid would provide coverage to as many as 50,000 low-income adults, it only covers emergency dental care for this group. Previous attempts to expand dental coverage to the uninsured have been turned down in the legislature to save money. If the state accepts Medicaid expansion, it may have the opportunity to use any savings generated by the program to add dental care services to the state Medicaid plan. Read more

New Jersey

HMA Roundup – Karen Brodsky

Medicaid Payment System Extended for Two Years For Nursing Homes. On March 17, 2014, *NorthJersey.com* reported that current residents in county-run nursing homes can stay with the existing fee-for-service system of Medicaid payments for at least two more years when the state switches to a new managed care system on July 1. The new managed care system aims to make it easier for seniors to afford home health services so they can avoid moving to nursing homes; however, many seniors currently in nursing homes have expressed concerns that they would not qualify for Medicaid services under the new system. This short-term solution will provide a combined $23 million this year to counties that provide nursing home services. Read more

NJ Enrollment Backlogs Ongoing Amidst Delayed Rate-Setting Guidance. On March 13, 2014, *NJ.com* reported that there remain serious backlogs in processing new health insurance members, leaving thousands of New Jersey residents in limbo. Some newly enrolled individuals have not received member ID cards, which is impeding pre-authorizations and filled prescriptions. Delays in processing new enrollees and renewals have held up some provider payments. Insurance carriers rely on state and federal guidance to set rates each year, but late guidance for 2014 and final approval of rates in December ultimately shortened the time for insurers to implement changes and process enrollments. The Department of Banking and Insurance operates a hotline for consumers who need help accessing their covered benefits. The complaint hotline is (800) 446-7467. Read more

NJ Bill Would Require Hepatitis C Tests of Baby Boomers. On March 13, 2014, *NJ Spotlight* discussed a bill (S-876/A-2555) sponsored by Senator Joseph Vitale (D-Middlesex) that would put into practice recommendations from the Centers for Disease Control and Prevention (CDC) to require health providers to offer hepatitis C (HCV) tests to all patients born between 1945 and 1965. The CDC has noted that three-quarters of 2.7 million to 3.9 million people afflicted with HCV are baby boomers, many of whom contracted the blood-borne infection through needle sharing or from blood transfusions or organ donation. Although effective treatments are available to clear HCV infection from the body, most persons with HCV do not know they are infected, do not receive needed care (e.g., education, counseling, and medical monitoring), and are not evaluated for treatment. Some health care provider organizations have objected to the additional costs and logistical challenges. Read more

Kessler Leads Charge against Congressional Proposals. On March 17, 2014, *NJ Spotlight* highlighted efforts by Dr. Bruce Gans, chief medical officer at the Kessler Institute for Rehabilitation, to stave off reimbursement cuts and regulatory restrictions on inpatient rehab hospitals (IRHs). Congress is considering a proposal that would increase from 60 percent to 75 percent the minimum number of patients with a set of 13 specified conditions that IRHs must treat to receive Medicare payments. Another proposal would equalize federal payments between rehab hospitals and nursing homes for certain conditions. Gans is the current chairman of the American Medical Rehabilitation Providers Association (AMRPA), an industry trade group for inpatient rehab hospitals. AMRPA is concerned that the proposal will lead to closures of smaller rehab hospitals and hurt IRH patients, who have enjoyed better long-term clinical outcomes than those treated in nursing homes, according to a recently released AMRPA study. Read more

New York

HMA Roundup – Denise Soffel

NY State of Health Update. As of March 18, 2014, New York reported that 666,397 people had enrolled in a health plan through the state's health exchange, reflecting about a 13 percent increase over last week's figures. More than 70 percent of those enrollees had been previously uninsured. The mix of enrollees has shifted slightly toward Medicaid, with 327,020 sign-ups for private insurance plans and 339,377 enrollees in Medicaid. Read more

Medicaid Enrollment Update. Medicaid enrollment numbers that are routinely reported by the Department of Health show slight declines over recent months. The Medicaid Redesign Team (MRT) Global Cap report indicates that total Medicaid enrollment declined from 5.39 million in September to 5.34 million in December, a decline of about one percent. These numbers fail to capture Medicaid enrollments that are being processed through New York State of Health, the state's health exchange. According to Department staff, as of mid-March, over 312,000 Medicaid enrollments have been completed through the exchange. When exchange numbers are included, Medicaid enrollment in December increased over September by 23,000 individuals. Medicaid enrollment through the exchange has accelerated, including 68,000 enrollments in January and 111,000 enrollments in February.

New York Delays Release of Behavioral Health RFQ. New York State is delaying the release of "New York's Request for Qualifications (RFQ) for Behavioral Health Benefit Administration: Managed Care Organizations and Health and Recovery Plans." Final release of the RFQ is scheduled for March 21, 2014.

Revisions to Managed Care Model Contract. Community-based long-term services and supports (LTSS) were carved into the mainstream Medicaid managed care contract beginning in August 2011. The Department of Health is making changes to the mainstream Medicaid managed care contract in response to persistent concerns about the transition of beneficiaries who are currently using community-based LTSS into mainstream (not managed long-term care) plans. The state has identified a number of due process issues, as well as lapses in the provision of LTSS services, that contract revisions are designed to address. Problems include service gaps during transition periods, reductions and terminations in care, and lack of care management.

Managed care plans will be required to develop mechanisms for identifying new enrollees who are in receipt of LTSS services, including review of fee-for-service experience of all new enrollees, targeted outreach to auto-assigned members, and

reminders to LTSS providers that they should review Medicaid eligibility and enrollment status for their clients. Plans will be required to provide 90 days of transitional care, meaning that plans are not allowed to change the level or quantity of LTSS services during the first three months of enrollment. All requests for transitional care must be authorized at the fee-for-service level and amount. Plans will be required to develop a person-centered services plan for all members in receipt of LTSS. Changes in the contract will be effective May 1, 2014.

Senate Releases 2014 Budget Proposal. The Republican-controlled New York State Senate released its 2014 budget proposal. The budget includes a provision that would de-fund the state Health Exchange, New York State of Health. The Senate budget would deny the governor's request for $54 million in funds for operations for New York State of Health, based on the argument that the executive order establishing the exchange asserted that no state or county tax dollars would be used for development or operation of the exchange. The Senate budget resolution also establishes an 1115 Waiver Distribution Review Council to oversee and make recommendations about how the state will allocate $8 billion in Medicaid waiver funds, emphasizing the need for geographic equity in the distribution of the funds. The Senate would also require more reporting on the Medicaid global cap spending, requiring a monthly accounting report. The Senate budget expands the governor's proposed private equity demonstration program from five business corporations to ten.

Three-way budget negotiations began this week with the goal of agreement on a final budget by March 31. A significant point of controversy remains over the governor's desire for corporate and property tax cuts.

Health Insurance Market Competition. On March 17, 2014, the Kaiser Family Foundation released a study looking at the impact of health exchanges on insurance market competition in seven states, including New York. Of the seven states, New York's exchange market was found to be the most competitive, and is also more competitive than its pre-ACA individual, direct-pay market. New York has 16 plans offering products through the exchange, seven of which hold greater than five percent market share. The eleven insurers that had previously participated in the individual market saw their market share drop from 91 percent of the direct-pay market to 70 percent of the exchange enrollment. Five new insurers have entered the exchange individual market, several of which were already Medicaid managed care providers. Wellpoint and UnitedHealthcare both had significant market share in the individual market, and have seen their market share decline as a result of the expanded number of insurers participating in the exchange. Read more

North Carolina

DHHS Requesting Federal Approval of Extended Deadline for Medicaid Recertification. On March 12, 2014, WRAL Raleigh reported that the North Carolina Department of Health and Human Services is requesting a federal waiver to extend the deadline for recertifying Medicaid recipients under new MAGI income due to ongoing difficulties with the state's NC Fast benefits management system. The waiver would also allow state DHHS workers to use the state's old Medicaid system, EIS, to recertify cases. According to state Medicaid director, Sandy Terrell, this would significantly speed up the recertification process, as Medicaid case files already exist in the old system and would not have to be reentered. Under current guidelines, residents' information must be processed through the state's NC Fast benefits management program in order to be recertified for Medicaid, but technical issues with the program have delayed this process. Read more

Oklahoma

Senate Approves Medicaid Privatization Plan. On March 13, 2014, the Oklahoma Senate passed a bill (25 to 21) that would establish a pilot study to privatize the management of Medicaid services. The Oklahoma Medicaid Reform Act of 2014 would provide healthcare to low-income residents through a private, state-contracted company. Opponents of the bill worry that privatization will siphon money away from health care providers, thus discouraging them from treating Medicaid patients. The bill now heads to the House, where it is expected to undergo changes. Read more

Pennsylvania

HMA Roundup – Matt Roan

CMS Extends Deadline for Healthy PA Waiver Comments. The Center for Medicaid and Medicare Services (CMS) has extended the deadline for public comment on the Healthy PA waiver request submitted by Pennsylvania last month. The extension was announced after Governor Corbett submitted a modification to the waiver request that would make changes to elements of the plan designed to encourage employment. Under the modification, enrollees would no longer be required to engage in work search activities as a condition of eligibility, but there would be a one-year pilot with incentives to encourage enrollees to seek work. The new deadline for public comment is April 11, 2014. Comments can be submitted by visiting here.

PA State Supreme Court Hears Arguments on Community Health Clinic Closures. Last week, the State Supreme Court heard arguments in a case brought by the SEIU to prevent the planned closure of 26 state-run community health clinics across the Commonwealth. The SEIU contends that the PA Department of Health cannot close the health centers without the approval of the state legislature. The closures are part of a plan to consolidate community health services and have community health nurses deliver more services in the field rather than in a clinic setting. The SEIU pointed to the elimination of 22 nurse positions and seven nurse layoffs. Read more

Philadelphia Mayor Urges Health Coverage for Former Inmates to Lower Crime. On March 14, 2014, CBS News reported that Philadelphia city officials identified health coverage for former inmates as a key component of a strategy to reduce crime and recidivism. According to the Mayor's Office of Reintegration, more than 90 percent of ex-offenders lack health coverage, and without some form of Medicaid expansion, many will continue to lack access to health insurance. Nearly 15 percent of the prison population suffers from serious mental illness, and officials recognize that being able to connect released inmates to services and treatment drastically improves reintegration efforts. The City of Philadelphia releases approximately 37,000 inmates annually, most of whom do not currently qualify for Medicaid. Read more

Jefferson Health Executive Named Chairman of PA eHealth Partnership Authority. On March 13, 2014, Governor Tom Corbett appointed Jefferson Health System Executive Vice President and Chief Legal Officer, David F. Simon, to be the new Chairman of the PA eHealth Partnership Authority. The Authority was established as a replacement for the PA eHealth Collaborative, and coordinates statewide efforts related to health information technology and the implementation of health information exchange. In addition to his role at Jefferson Health System, Simon serves as the President and CEO of the Accountable Care Organization of Pennsylvania, a group of hospitals, physicians and other providers working with the Medicare program to enhance collaboration and control costs. Read more

Jefferson Health System and Main Line Health End Financial Arrangements. On March 18, 2014, the *Philadelphia Inquirer* highlighted the financial split between Main Line Health and Thomas Jefferson University Hospitals. The move runs counter to recent trends of consolidation and financial partnership between hospitals and health systems. The two systems plan to continue collaborating on patient care. The two organizations had joined forces in 1995, forming Jefferson Health System, one of the first such health systems in the Philadelphia area. According to leadership at Jefferson, the separation will allow both organizations to operate more nimbly and without the constraints of a corporate relationship, which the Jefferson executive described as "limiting." Read more

Rhode Island

Faster Medicaid Enrollment Could Cost Rhode Island More Than Originally Thought. On March 13, 2014, the *Providence Journal* reported on the fiscal effects of Medicaid expansion in Rhode Island. According to data released by the House Fiscal Advisory staff last week, Rhode Island will have to pay $14.2 million to cover new enrollees in 2017 and $33.6 million the following year. These estimates are significantly higher than projections made last year. The estimates come as the state continues to sign up residents for health insurance coverage at a faster rate than anticipated. Read more

Texas

HMA Roundup – Dianne Longley

Texas Makes Final Effort to Enroll Residents for Insurance Coverage. On March 17, 2014, the *Washington Post* discussed Texas' final push to enroll residents for health insurance coverage before the end of the open enrollment period on March 31. Nearly one in four Texans are uninsured, and the state lags far behind the other most populous states in terms of enrollment under the ACA. Enrollment has been a challenge for a variety of reasons, including an inability of many uninsured to pay insurance premiums and intense criticism of the health care law statewide. Enrollment drives and campaigns will be taking place regularly around the state over the next two weeks. Read more

Texas HHS Commission Delays STAR+PLUS Medicaid Managed Care Transition to 2015. To allow more time to address stakeholder concerns, the Texas Health and Human Services Commission (HHSC) has postponed moving nursing facility residents into STAR+PLUS Medicaid managed care to March 1, 2015. In an effort to work with stakeholders to ensure a successful transition, the HHSC will host a series of information sessions on several Medicaid managed care initiatives, including the STAR+PLUS transition. Read more

Utah

Governor Optimistic About Medicaid Talks. On March 17, 2014, the *Times Union* reported that Governor Gary Herbert is optimistic that the federal government will be open to his alternative plan to expand health insurance coverage in Utah. Herbert's plan, which is tailored to increase access to care while protecting Utah's long-term finances, would use federal funds to purchase private health insurance coverage for up to 110,000 low-income residents. Utah legislators failed to agree on any Medicaid expansion plan before closing their 2014 session last week, but they will continue

debating Medicaid-related issues throughout the year. It is unclear if Herbert will have a plan ready for lawmakers to consider next year, but the governor hopes this week's negotiations will gain his plan the necessary federal approval. Read more

Vermont

Vermont Encourages Coordinated Care to Alleviate Growing Health Care Costs. On March 12, 2014, *The Kansas City Star* discussed Vermont's plans to encourage coordinated patient care as a means of reducing the growth of health care costs. The state's Medicaid program and insurers participating in the Vermont Health Connect exchange will participate in a three-year program that will "encourage health care providers to keep patients healthy rather than provide expensive, sometimes unneeded tests." Under the program guidelines, providers who work together to provide health care for less money would be allowed to use part of the savings to invest in their own practices and facilities. Read more

Virginia

Medicaid Expansion Impasse Delays State Budget Approval. On March 12, 2014, the *Washington Post* reported that disagreement over Medicaid expansion has delayed the legislature's action on Virginia's state budget for fiscal year 2015. Legislators now have the chance to round up support for or against Medicaid expansion before they reconvene in a special session on March 24 to decide on the issue. Expansion supporters argue that expanding Medicaid to 400,000 low-income Virginians will improve health care facilities' bottom lines. Opponents cite that the federal government will not be able to finance the expansion, and that the burden will then fall on the state. If the impasse is not resolved by the beginning of the new fiscal year on July 1, the state government could be forced to shut down. Read more

Washington

Washington Maintains Strong Insurance Enrollment Figures. On March 12, 2014, the *Seattle Times* reported that nearly 800,000 Washingtonians have gained insurance coverage through the state-run Healthplanfinder marketplace or Medicaid enrollment under the Affordable Care Act. Washington remains among the leaders in ACA-related enrollment. Read more

Wisconsin

Brett Davis Steps Down as Wisconsin Medicaid Director. On March 12, 2014, the *Milwaukee Journal Sentinel* announced that Wisconsin Medicaid Director, Brett Davis, is stepping down to take a job in the private sector. Davis "was in charge of implementing Gov. Scott Walker's plan to move adults above the federal poverty line from the BadgerCare Plus public health care plan into the private insurance marketplace" and expanding access to BadgerCare Plus to certain low-income single adults. A replacement for Davis has not yet been named. Read more

National

MACPAC Delivers March 2014 Report to Congress. On March 14, 2014, the Medicaid and CHIP Payment and Access Commission (MACPAC) delivered its March 2014 report to Congress. In this report, the Commission continues its focus on the issue of insurance stability. The report also addresses the future of CHIP, as federal funding for the program is currently scheduled to dry up after fiscal year 2015. Read more

Exchange Enrollment Hits 5 Million. On March 17, 2014, the Obama administration announced that nationwide Exchange enrollment has hit 5 million. About 800,000 Americans have selected health plans on the state and federal insurance marketplaces since the beginning of March. This figure brings the administration closer to its goal of enrolling 6 million Americans by the end of March. Read more

Sebelius Believes Insurance Premiums Will Increase in 2015. On March 12, 2014, *The Wall Street Journal* reported that health insurance premiums will likely go up in 2015. At a meeting of the House Committee on Ways and Means, Health and Human Services Secretary, Kathleen Sebelius, testified that she believes premiums will go up, "but at a smaller pace than what we've seen since 2010." The actual impact of the new health care legislation on premiums is still unknown, as insurers have only just begun weighing their rates for next year. Read more

HHS to Ease Financial Burden on Insurers after Shaky ACA Rollout. On March 13, 2014, *Kaiser Health News* reported that the Department of Health and Human Services (HHS) may give insurers a financial break because of the issues they have experienced during the ACA rollout. Insurers are currently required to spend at least 80 percent of their premiums on medical care or consumer rebates, but the problematic marketplace launch and the government's decision to let consumers keep substandard plans caused insurers to spend more money on administrative costs than anticipated. The HHS will therefore propose a temporary ruling that will allow a higher proportion of premiums to be spent on administrative costs. Read more

House Approves Bill to Lessen Readmission Penalty for Hospitals Serving Many Dual-Eligibles. On March 13, 2014, *McKnight's Long-Term Care News* reported that the House has approved a bill that would allow hospitals treating a high percentage of patients eligible for both Medicare and Medicaid to get a break on readmissions penalties, which are included in the Affordable Care Act. The American Hospital Association supports the measure. Read more

Industry Research

Milliman Updates Report on HIPF for Medicaid Health Plans of America. A report from actuarial firm Milliman and commissioned by Medicaid Health Plans of America examines the effect of the Affordable Care Act health insurer fee (a.k.a. the health insurance tax) on the Medicaid program and Medicaid health plans.

The report, "ACA Health Insurer Fee: Estimated Impact on State Medicaid Programs and Medicaid Health Plans," an update of a 2012 Milliman study that reflects new state Medicaid expansion decisions, shows how the tax, designed to help fund health reform, will cost the Medicaid program $37.7 billion over the ten year period 2014-2023 according to a moderate growth scenario. This breaks down to a $13.6 billion cost to the states and the federal Medicaid program about $24.1 billion due to the state-federal Medicaid matching formula. Read more

Industry News

Venrock Raising $200 Million for Healthcare Investment. On March 13, 2014, *MedCity News* reported that venture capital firm, Venrock Healthcare Capital Partners, is raising a $200 million fund to invest in life sciences and IT companies. This will be the second health care-specific fund the firm has raised, after a $194 million investment in 2009. Read more

Active Day/Senior Care Acquires Twelfth Facility in New Jersey. On March 17, 2014, Clearview Capital announced that its portfolio company, Active Day/Senior Care, Inc., has acquired Young at Heart senior care center of Brick Township, New Jersey. The name of the center has been changed to Senior Care of Brick. This represents the twelfth New Jersey acquisition for Active Day/Senior Care, Inc., which operates more than 75 centers in eleven states. Read more

American Medical Response Makes New Acquisitions and Transportation Contracts. On March 19, 2014, Envision Healthcare announced that its subsidiary, American Medical Response (AMR), has acquired Life Line Ambulance and MedStat EMS of Arizona and Mississippi, respectively. These acquisitions will generate estimated annual revenues of $36 million and employ more than 250 million clinicians and support team members. The company also announced it has secured a new managed transportation contract and expanded others, which will generate estimated net-new annual revenues of $37.5 million and provide more than 110 jobs in Florida. Read more

Trizetto Names Eckert CEO. On March 17, 2014, Trizetto Corporation announced the appointment of Andrew Eckert as CEO, concluding a ten-month search process. Eckert had been serving as CEO of CRC Health Group, a national provider of substance abuse treatment services. Previously, Eckert had been CEO at Eclipsys Corporation, ADAC Labs, and SumTotal Systems. Read more

Castlight Health Goes Public. On March 14, 2014, Castlight Health's stock rose nearly 150 percent on its first day of trading as a public company, following an 11.1 million share offering at $16 per share. Read more

RFP Calendar

Date	State	Event	Beneficiaries
March 21, 2014	Puerto Rico	Proposals Due	1,600,000
April 1, 2014	Maryland (Behavioral)	Proposals Due	250,000
April 1, 2014	California Duals	Passive enrollment begins	456,000
April 4, 2014	Delaware	Proposals Due	200,000
April 8, 2014	Texas STAR Health (Foster Care)	RFP Release	32,000
April 11, 2014	Puerto Rico	Contract Awards	1,600,000
May 1, 2014	Virginia Duals	Passive enrollment begins	79,000
May 1, 2014	Florida acute care (Regions 2,3,4)	Implementation	681,100
May 1, 2014	Texas NorthSTAR (Behavioral)	Proposals Due	840,000
May 12,2014	Rhode Island (Duals)	Proposals due	28,000
Late May, 2014	Indiana ABD	RFP Release	50,000
June 1, 2014	Illinois Duals	Passive enrollment begins	136,000
June 1, 2014	Florida acute care (Regions 5,6,8)	Implementation	811,370
June 6, 2014	Texas STAR Health (Foster Care)	Proposals Due	32,000
June 12, 2014	Delaware	Contract awards	200,000
July 1, 2014	Puerto Rico	Implementation	1,600,000
July 1, 2014	Florida acute care (Regions 10,11)	Implementation	828,490
July 1, 2014	South Carolina Duals	Passive enrollment begins	68,000
July 1, 2014	Michigan Duals	Implementation	70,000
July 1, 2014	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
Mid-July 2014	Texas STAR Kids	RFP Released	200,000
August 1, 2014	Florida acute care (Regions 1,7,9)	Implementation	750,200
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
Late October 2014	Texas STAR Kids	Proposals Due	200,000
November 3, 2014	Georgia ABD	Implementation	320,000
January 1, 2015	Vermont Duals	Implementation	22,000
January 1, 2015	Ohio Duals	Passive enrollment begins	115,000
January 1, 2015	Washington Duals	Passive enrollment begins	48,500
January 1, 2015	Maryland (Behavioral)	Implementation	250,000
January 1, 2015	Delaware	Implementation	200,000
January 1, 2015	Hawaii	Implementation	292,000
January 1, 2015	Tennessee	Implementation	1,200,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION CALENDAR

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
Arizona		98,235	Not pursuing Financial Alignment Model						
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013		4/1/2014	Alameda Alliance; CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; WellPoint/Amerigroup (CareMore)
Colorado	MFFS	62,982				2/28/2014		7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	3/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Iowa	MFFS	62,714						TBD	
Idaho		22,548	Not pursuing Financial Alignment Model						
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013		30 days prior to passive	7/1/2014	AmeriHealth Michigan; Coventry; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; UnitedHealthcare; Upper Peninsula Health Plan
Missouri	MFFS‡	6,380					10/1/2012		
Minnesota		93,165	Not pursuing Financial Alignment Model						
New Mexico		40,000	Not pursuing Financial Alignment Model						
New York	Capitated	178,000				8/26/2013	10/1/2014	1/1/2015	
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Oregon		68,000	Not pursuing Financial Alignment Model						
Rhode Island	Capitated	28,000	X	5/12/2014	9/1/2014			4/1/2015	
South Carolina	Capitated	68,000	X			10/25/2013	7/1/2014	1/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth); WellCare Health Plans
Tennessee		136,000	Not pursuing Financial Alignment Model						
Texas	Capitated	214,402						TBD 2014	
Virginia	Capitated	78,596	X	5/15/2013	TBD	5/21/2013		5/1/2014	Humana; Health Keepers; VA Premier Health
Vermont		22,000	Not pursuing Financial Alignment Model						
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	10/1/2014	1/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 6 MFFS**	**1.2M Capitated 520K FFS**	***12***			***9***			

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

‡ Capitated duals integration model for health homes population.

HMA News

HMA to Host Seminar on Care Transformation in Chicago – April 11, 2014

HMA's Accountable Care Institute is offering a one-day seminar on exploring the transformation from volume-based care to value-based care. The seminar will be held on ***April 11 from 8:30am–4:00pm*** at ***Mt. Sinai Hospital in Chicago, Illinois***. The seminar is ideal for provider organizations, FQHCs, clinicians, and community-based social service partners seeking to transform care and develop accountable care structures. The event is free, but space is limited, and will be on a first-come, first-served basis. For more information and to register, please visit: **Care Transformation Seminar Registration**

HMA Prepared to Assist Providers with Medicare BPCI Opportunity

CMS recently announced a limited-time open application period for additional participants to be considered for the Medicare Bundled Payments for Care Improvement (BPCI) initiative. The BPCI is an exciting and innovative opportunity for hospitals, post-acute care providers, and physician group practices to earn upside savings under episodic Medicare payment bundles. The BPCI open application period is an unexpected opportunity that is unlikely to occur again for three years. Eligible providers must apply for entry by April 18, 2014.

HMA Principal Stacy Mitchell and Senior Consultant Mike Fazio are an experienced bundled payments team with expertise in the BPCI program. Stacy and Mike successfully helped clients enter the program for BPCI's initial launch on January 1, 2014. They are ready to put their experience and expertise to work for clients to help navigate the challenges and opportunities that come with this innovative opportunity.

To learn more about how HMA can help take advantage of this BPCI opportunity, please contact Stacy Mitchell (717) 836-7760, smitchell@healthmanagement.com or Mike Fazio (617) 720-7800, mfazio@healthmanagement.com.

HMA Upcoming Appearances

"The Health of Healthcare in the U.S."
California Capital Summit Breakfast
Brooke Ehrenpreis – Moderator
March 21, 2014
Los Angeles, CA

"Transforming Medicaid: What it Means for States and Your Audience"
Association of Health Care Journalists – Health Journalism 2014
Joan Henneberry – Presenter
March 29, 2014
Denver, Colorado

"HIT: Creating Connectivity between Jails and Communities"
Health Reform and Criminal Justice: Building Connectivity Conference
Capri Dye – Panelist
April 4, 2014
Wilmington, Delaware

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