HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 3, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

MEDICAID MANAGED CARE RFIS ISSUED IN ARKANSAS, PENNSYLVANIA

This week, our *In Focus* section reviews two requests for information (RFIs) issued by Arkansas and Pennsylvania to inform upcoming potential or planned procurements. Arkansas is soliciting information on a potential request for proposals (RFP) for Medicaid managed care organizations (MCOs) to serve more than 170,000 Medicaid beneficiaries who are users of behavioral health services, individuals with developmental disabilities, or users of long-term supports and services (LTSS). Pennsylvania, meanwhile, is soliciting information to develop an RFP to rebid the existing HealthChoices Medicaid managed care program, which serves around 1.7 million beneficiaries, and to develop

strategies to improve the provision of physical and behavioral health services across a broad set of goals. Below we review the key takeaways from the Arkansas and Pennsylvania RFIs.

Arkansas BH, DD, and MLTSS RFI

RFI Responses Due: June 15, 2015

The Arkansas Department of Human Services (DHS) is exploring opportunities to contract with one or more risk-based MCOs to provide managed long-term supports and services (MLTSS) to the behavioral health population, individuals with developmental disabilities, and the aged, frail, and physically disabled population. In state fiscal year (SFY) 2014, there were 170,149 individuals under the scope of this RFI, including 109,850 behavioral health users, 20,261 individuals with DD, 31,700 LTSS users, and 9,168 individuals in two or more of these categories.

As illustrated in **Table 1**, below, the behavioral health population accounts for roughly $595 million in annual spending, with an average monthly per capita cost of $420; individuals with DD account for $653 million in annual spending, with an average monthly per capita cost of nearly $1,978; and users of LTSS account for more than $902 million in annual spending, with an average monthly per capita cost of $2,208. In total, the populations covered under this RFI accounted for more than $2.1 billion in SFY 2014 Medicaid fee-for-service spending.

Table 1 – Arkansas BH, DD, LTSS Unique Members and Spending (SFY 2014)

	Unique Recipients	$ in Millions (except for Per Capita Monthly)						
		Inpatient/ Institutional	Outpatient/ Community	In-Home	Pharmacy	Case Mgmt	Total Spending	Per Capita Monthly
Behavioral Health	117,807	$152.64	$318.64	$108.57	$597.90		$594.90	$420.82
Individuals with DD	27,525	$178.50	$267.85	$199.20		$5.48	$653.28	$1,977.84
LTSS	34,071	$707.56	$18.68	$173.16		$3.30	$902.70	$2,207.89
Total Population	170,149						$2,150.88	$1,53.43

Source: Arkansas DHS, Data Appendix

In addition to meeting general requirements, prospective MCOs would be required to demonstrate how they meet expectations for payment and delivery system reform, which include:

- Improving the current service delivery system
- Enhancing early intervention
- Incentivizing cost-effective care
- Improving care coordination
- Improving screening and assessment
- Matching level of care to need
- Aligning incentives with outcomes
- Promoting coordinated care through innovative approaches, and
- Decreasing administrative burdens.

In the RFI, Arkansas DHS requests input on the design of the managed care model, ranging from a specialty services-only model to a full population-based coverage model. Respondents are also asked to provide input on the level of Medicare integration that should be required, such as a requirement to integrate with Medicare Advantage Special Needs Plans (SNPs).

Link to Arkansas RFI and Data Appendix

Pennsylvania HealthChoices RFI

RFI Responses Due: June 26, 2015

Pennsylvania's Department of Human Services (DHS) released an RFI on May 29, 2015, requesting feedback from Medicaid MCOs and other stakeholders to inform the HealthChoices reprocurement planned for later this year. As of April 2015, HealthChoices served around 1.7 million beneficiaries across five managed care regions. In fiscal year 2014, Pennsylvania HealthChoices MCO spending exceeded $9.8 billion. HealthChoices currently includes a separate physical health and behavioral health component.

Pennsylvania DHS has outlined several discussion areas in the RFI that respondents are asked to address:

- **The Triple AIM:** how to improve health outcomes and care and lower health care costs
- **Coordination of Care:** how to improve care coordination between physical and behavioral health services and promote new primary care models, such as patient centered medical homes and health homes
- **Value-Based Purchasing:** how to promote methodologies that reward providers for value they create and how to modify DHS contracting with MCOs to increase value
- **Community-Based Public Health Initiatives:** how DHS could use the HealthChoices program to support community-based public health initiatives
- **Consumer Access:** how to improve access to services, especially in rural and underserved areas
- **Provider Experience:** suggestions to improve provider experiences and strategies to encourage increased provider enrollment
- **Medical Assistance Transportation Program:** suggestions for improvements to the Medical Assistance Transportation Program

Respondents are free to suggest other topics that would be useful to DHS in improving HealthChoices.

As of March 2015, there were roughly 1.6 million HealthChoices physical health members served by seven MCOs, as detailed in **Table 2** below. AmeriHealth Caritas is the largest MCO, with around a one-third share of the market.

Table 2 – Pennsylvania HealthChoices Enrollment by MCO, March 2015

HealthChoices Physical Health MCOs	Regions Served	March 2015 Enrollment	Market Share
AmeriHealth Caritas	Southeast; Lehigh/Capital; New West; New East	492,539	30.9%
UPMC	Southwest; Lehigh/Capital; New West;	257,706	16.2%
Gateway	Southwest; Lehigh/Capital; New West;	250,435	15.7%
Health Partners	Southeast;	168,716	10.6%
United Healthcare	Southeast; Southwest; Lehigh/Capital;	158,506	9.9%
Aetna Better Health	Statewide	142,351	8.9%
Geisinger	New East	125,294	7.9%
Total Enrollment - All MCOs		**1,595,547**	

Source: Pennsylvania DHS Enrollment Data, March 2015

Link to Pennsylvania RFI

HMA Medicaid Roundup

Alabama

Medicaid Reform Bill Passes House, Heads to Governor Bentley. On May 28, 2015, *The Birmingham Business Journal* reported that the Medicaid bill to establish integrated care networks (ICNs) that would contract with Medicaid to provide long-term care services for home health and nursing home patients passed the House. The bill, already approved by the Senate, now heads to Governor Robert Bentley for signature. The state is expected to save up to $1.5 billion in the first ten years of the ICN program. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

California Seeking Approval to Use Medicaid Funds to Provide Housing to Medically Fragile Homeless People. On June 2, 2015, *The Daily Beast* reported that California is seeking federal permission to use Medicaid funds to provide housing for the most medically fragile homeless people. The state hopes to expand a state initiative that selected 100 ill homeless people to live in an apartment complex with a medical clinic. Under the ACA, many homeless residents with chronic illnesses, such as mental disorders and substance abuse, became eligible for Medicaid. Realizing the potential costs of serving this new population, California sought to find a solution. CMS, however, has previously denied a similar proposal from New York. Read More

Kaiser Report: Easier Access to Health Care for Newly-Insured Adults. A Kaiser Family Foundation report looking at 4,555 California adults age 19-64 found that those who were newly-insured had an easier time accessing health care than those who were uninsured. The report found that 61 percent of the newly-insured had a usual source of healthcare compared to 43 percent of the uninsured. The newly-insured were also more likely to have used medical services than the uninsured (58 percent compared to 45 percent). However, they still faced some challenges; 35 percent of the newly insured said they postponed or went without needed health care and 47 percent said it was somewhat or very difficult to afford the monthly premium. Read More

Inmate Medical Care Lacking in Private Operators. On June 1, 2015, *Los Angeles Times* reported that the federal court-appointed medical receiver of the state's prison system filed a report with the court indicating that little progress has been made in resolving or improving medical care provided to inmates in seven contracted lockups. According to the report, all seven prisons lacked accountability and failed to employ qualified physicians to meet a state

requirement of providing doctor availability at least five days a week. This has resulted in sick inmates returning to state-operated prisons for care. The corrections department will not seek damages. Instead it is asking contract operators to increase doctor and nurse availability and revise training and auditing requirements. Read More

Department of Managed Health Care Publishes Datasets to California's Open Data Portal. On May 28, 2015, *California Healthline* reported that DMHC published its first datasets to the Open Data Portal. The datasets included information on DMHC enforcement actions, Independent Medical Review decisions, and premium rate filings. Read More

SB 493 to Allow Pharmacists to Distribute Contraception without Prescription. On May 21, 2015, *California Healthline* reported that a 2013 bill will go into effect allowing women to request contraception from a pharmacist. The pharmacist will be able to write the prescription after routine screening protocols. Read More

Western Dental to Stop Accepting New Denti-Cal Patients; Close Two Offices. On May 21, 2015, *California Healthline* reported that Western Dental will no longer accept new patients covered by Denti-Cal at 13 offices beginning June 1. CEO Simon Castellanos said the company will transition more offices to traditional insurance each month. The company will also close two offices. Western Dental stated low reimbursement rates and a sharp increase in demand for services as the reason for the transition. Read More

Regular Dental Care Rising for Young Children. On May 21, 2015, UCLA released a new policy brief studying dental care and health insurance of California children from 2003 to 2012. They found that 75 percent of young children aged 2-5 had a regular dental checkup in 2012 compared to only 50 percent of low-income household children and 60 percent of higher-income children a decade earlier. According to the study, some of the improvement is attributable to a $7 million grant from First 5 California that provided preventive dental health training and education for dental and medical providers. Additionally, Medi-Cal and Healthy Families promoted greater awareness of dental benefits. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Children's Hospital Medicaid Certification Threatened. Children's Hospital Colorado could lose Medicaid certification system-wide if it does not correct deficiencies cited in a state and federal investigation of its satellite facility at Memorial Hospital Central in Colorado Springs. The state continues to monitor Children's efforts to take required corrective actions so it can be taken off "termination track" and continue to receive Medicaid payments. Its deadline is July 6. Read More

Connecticut

House Passes Health Care Bill That Changes Approval Process For Sales of Hospitals. On May 31, 2015, *The CT Mirror* reported that the House approved a controversial health care bill that revises the approval process for the sale of hospitals, requiring the Office of Health Care Access to consider if a proposed

hospital sale could reduce competition and drive up prices, in addition to requiring the buyer to submit a plan showing expected changes in the next three years. The bill also establishes a statewide system for sharing patients' medical records, increases provider and insurer transparency, and restricts certain hospital billing practices. The bill now goes to the Senate for approval. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Senate Passes FHIX Expansion Bill. On June 3, 2015, the *Orlando Sentinel* reported that the Florida Senate passed a bill (SB 2A) to expand Medicaid, with provisions for work requirements, premiums, and cost-sharing. If implemented, the bill could expand coverage to as many as 800,000 Florida residents. However, the House is likely to continue its resistance to expanding health coverage as part of the ongoing budget debate. House leaders have indicated there are not enough votes to pass the Senate's bill as a likely vote on Friday approaches. Read More

Statewide Medicaid Managed Care (SMMC) Capitation Rate Drafts to be Released. The Agency for Health Care Administration expects to provide health plans (LTC and MMA) draft rates for the September 2015 – August 2016 period by June 5, 2015. An all–plan meeting has been scheduled for June 25, 2015 to address LTC rates (9:30 AM – 11:30 AM) and MMA rates (1:00 PM – 3:30 PM).

CMS Wary of Approving a State LIP Plan. On June 1, 2015, *Health News Florida* reported that without knowing more about Florida's plans for the future, CMS is wary to approve a state proposal for LIP funding. Florida has yet to provide a viable plan for 2016-17 when funding is further reduced to $600 million. Without a plan, CMS is hesitant to sign off on transitional funding for 2015-16. Read More

Safety Net Hospitals Warn Gov. Scott's Proposal Will Have Devastating Impact. On May 29, 2015, *Miami Herald* reported that hospitals who provide uncompensated care said that Governor Rick Scott's plan to draw down federal health care money by relying on them to raise funds will only benefit for-profit hospitals that try to avoid the uninsured. The plan will end up slashing revenues to teaching, public, and children's hospitals by $302 million. Jackson Memorial Hospital will see revenues cut by $84.7 million the first year and $135 million the second year. Additionally, Miami Dade County would put up $320 million in tax money to draw down $490 million federal funds. However, it will only receive $100 million in return.

Gov. Rick Scott to Veto FHIX 2.0. On May 28, 2015, *Miami Herald* reported that Governor Rick Scott stated he will not go forward with the Senate's Florida Health Insurance Affordability Exchange program, claiming it would become a tax increase. FHIX 2.0 would expand coverage to over 800,000 residents. The state would pay $5 billion over 10 years to draw $50 billion in federal revenue to cover the uninsured. Gov. Scott said the cost will likely be a lot higher, especially when considering the history of Medicare. The state currently spends $900 million of local tax dollars to draw down $1.2 billion in federal revenue to raise reimbursement rates and pay for services that uninsured patients cannot afford. Read More

Louisiana

Senate Committee Passes Hospital Funding Measure, Now Headed to Senate Floor. On May 31, 2015, *The New Orleans Advocate* reported that the Senate Health and Welfare Committee passed House Concurrent Resolution 75. The measure allows hospitals to assess fees on themselves to receive more federal money for uncompensated care. The money would only be available if the state expands Medicaid to include an additional 240,000 residents who make too little to buy adequate insurance on the private market. HCR 75 was already approved by the House and is now headed to the Senate floor. Because it is a legislative resolution, Governor Bobby Jindal would not be able to veto the measure if passed. House Speaker Chuck Kleckley stated the resolution does not expand Medicaid but rather it provides an option to go forward for when there is a new governor in six months. Read More

Michigan

Proposed State Budget Cuts Medicaid HMO Funding 1 Percent, Gives Hospitals $450 Million. On May 31, 2015, *Crain's Detroit Business* reported that the proposed FY 2015-16 state budget will cut the funding for Medicaid HMOs by 1 percent, roughly $22.2 million. This includes a $9.4 million general fund reduction in laboratory fees paid. Additionally, 133 hospitals will receive over $450 million in additional federal Healthy Michigan Medicaid funds and $160 million in graduate medical education payments under the bill. The budget approved by House and Senate conference committees still needs to pass the full Legislature. Read More

New Hampshire

Uninsured Emergency Room Visits Drop 22 Percent After Medicaid Expansion. On May 25, 2015, *New Hampshire Public Radio* reported that the number of emergency room visits by uninsured patients has dropped 22 percent from April 2014 through March 2015. Over 39,000 people have enrolled In Medicaid since expansion began on July 1. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

DMAHS issues public notice of plans to amend the Alternative Benefit Plan (ABP) to include Managed Long Term Services and Supports. On May 22, 2015 New Jersey's Medicaid program released public notice of its plan to submit a state plan amendment (SPA) to the Centers for Medicare and Medicaid Services (CMS) to enable Medicaid expansion enrollees' access to managed long term services and supports, which includes custodial nursing facility services. If approved, the SPA would also provide these individuals with access to mental health and substance abuse services and intermediate care facilities for individuals with intellectual disabilities. Comments or inquiries on the proposed SPA are being accepted for a 30-day period and may be sent to:

Margaret Rose, DMAHS
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P.O. Box 712, Mail Code #26
Trenton, New Jersey 08625-0712
Fax: 609-588-7343
E-mail address: Margaret.Rose@dhs.state.nj.us

State of New Jersey issues RFI for Health Benefits Coordinator RFP. New Jersey recently accepted comments, questions, recommendations, and responses to a Request for Information (RFI) in anticipation of issuing a Request for Proposal (RFP) for the competitive re-procurement of contract #1392 Health Benefits Coordinator Medicaid Managed Care Programs. This contract is currently held by Xerox under a contract extension scheduled to run through December 31, 2015.

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Care Contracts Renewed. *Crain's HealthPulse* reports that the state recently approved new 5-year contracts for the 16 health plans participating in New York's Medicaid managed care market. Contract amounts varied from $24.5 billion (HealthFirst, with 940,000 members) to just under $1 billion (Total Care, a Today's Options of NY plan, with 38,000 members). Plan rates are regional, and also include risk adjustment to reflect specific plan membership. The Crains piece includes a link to a full list of plan contracts.

Health Plan Rate Requests. Health plans participating in New York State of Health, the NY health exchange, have filed rate requests with the Department of Financial Services for the 2016 year. According to the *Daily News*, rate requests submitted would, if approved, boost premiums by an average of 13.5% for individual policies and 14.3% for small group policies offered through NYSOH. It is likely however, the proposed increases will be reduced as they are reviewed by the Department of Financial Services. Under NY's prior approval law, DFS has broad rate review authority. The law provides DFS the authority to review and approve health insurance premium rate increases on existing policies. The rate applications are reviewed. And the Department may disapprove or modify an insurer's request for a premium rate increase if it is unreasonable, excessive, inadequate or unfairly discriminatory. A year ago, insurers submitted requests that would have increased the average rate for individual policies by 12.5%. The state eventually approved rates that rose 5.7%. A chart posted on *Capital New York* documents the range of rate requests for the 18 plans participating in the individual market. The rate requests show UnitedHealthcare seeking the largest increase at 22%; 7 plan's requests were between 10 and 15 percent, and 8 plan's requests were below 10 percent. Two plans actually requested lower rates for 2016, including MetroPlus (down 5.5 percent) and Independent Health (down 9.4 percent).

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Lawmaker Introduces a Bill Authorizing Pharmacists to Grant Emergency Prescriptions in Ohio: A bill permitting a pharmacist to enter into a consulting agreement with one or more physicians through which the pharmacist could, under certain conditions, manage a patient's drug therapy and treatment has been introduced. Under the agreement, a pharmacist could add, subtract and modify medications for patients in certain situations. Representatives of several hospitals, including OSU and the Cleveland Clinic recently testified in support of the bill, as did Dan Sullivan, chair of the Ohio American College of Physicians Health and Public Policy Committee. Read More

Work on Ohio's Budget is Wrapping up in the Senate: Subcommittee reports and amendments will be public soon as the Senate prepares to release its version of the budget bill on June 8. Testimony on the bill is expected that week on Senate changes and a floor vote in the Senate is expected June 17. Senate Medicaid Committee Chairman Sen. Dave Burk said his panel mostly focused on provisions related to infant mortality, behavioral health, payment innovation and developmental disability system changes. They also considered hospital franchise fee proposals and the proposed Healthier Ohio program. Testimony can be found at *Gongwer* (here).

Ohio Governor Rescinds Collective Bargaining for Home Health Workers: Governor Kasich has issued an executive order rescinding two executive orders former Governor Ted Strickland issued in 2007 and 2008 that established collective bargaining for independent, self-employed home health and child care providers. Governor Kasich linked the previous orders to efforts to provide health insurance for these workers. However, the federal marketplace and Medicaid now provide other ways for these workers to potentially obtain health care insurance. According to GONGWER, the Service Employees International Union District 1199 President Becky Williams blasted the governor's rescission as "another unsafe, unfair attack on Ohio's middle class families." SEIU District 1199's Ohio Healthcare division represents nearly 13,000 workers, according to the union. Read More

Medicaid Behavioral Health, What's Next? Governor John Kasich's proposed budget included provisions focused on rebuilding Ohio's behavioral health system and transitioning the delivery system to managed care. But the path has been anything but smooth, as new services, new rates and billing redesign discussions continue by the Administration's BH design team. The team's focus has been on changes that ensure coverage for higher income individuals with severe mental illness; redesigning the BH Medicaid benefit; and integrating these services into managed care. With the Senate version of the budget expected next week, the House Representative who chaired the chamber's Finance Health and Human Services Subcommittee announced that he is working on separate legislation for BH system redesign as a forum for discussions with the Administration and the Senate. Provider impact and timely and adequate payment, as well as predetermined standards for any redesigned behavioral health benefit are said to be included in the separate legislation.

New Rates for Ohio Home Care Providers: After several efforts to change Home Care reimbursement over the past few years, Ohio Medicaid has succeeded in getting Joint Committee on Agency Rule Review (JCARR)

approval for rule changes. In a contentious hearing that lasted more than two hours, John McCarthy, the Director of the Department of Medicaid explained the Department's approach to modernizing rates for nurses and medical aides. Opposing testimony was also heard from home health care providers and home health care patients. The new rules will decrease the base rate for agency and non-agency nurses and aides and increase the unit rate used to determine pay for visits that go beyond the current one hour base rate timeframe. The Department has argued that the new rate formula will help to limit workers being over reimbursed when multiple patients are served within one hour.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medical Assistance Advisory Committee, Pennsylvania Department of Human Services (DHS) – May 28, 2015.

- HealthChoices update. Over 120,000 people have transitioned from the Private Coverage Option (PCO) to HealthChoices which concluded phase one of the transition. The department was aggressive in stakeholder communication and outreach: it developed a newsletter, created flyers and other outreach materials for grocery stores and pharmacies, and continues to update the HealthChoices website. The DHS HealthChoices website will be updated weekly to report the number of individuals that have enrolled.
- Office of Medical Assistance Programs Update. The department is planning to re-procure the HealthChoices physical health managed care program. An RFP will be issued in September, 2015.
- Office of Long Term Living Update. The Home and Community Based Services transition plan was due March 17 to CMS. DHS submitted statewide transition plans for all of the waivers and noted that three of the six individual transition plans have been approved: Attendant Care, Aging and Independence waivers. OLTL is developing a participant review tool which will allow the department to evaluate appropriate assessments. Later in the fall, there will be a public comment period on the revised plan.

Pennsylvania Invites Comment on Medicaid Managed Long-Term Services and Supports Planning Process. On June 1, 2015, the Departments of Human Services (DHS) and Aging (PDA) released a discussion document that is the next critical step in Governor Wolf's plan to improve care coordination and to move to a Medicaid Managed Long-Term Services and Supports (MLTSS) program. The discussion document reports that by contracting with MCOs, MLTSS will create a capitated model that will improve care coordination and health outcomes while allowing more individuals to live in their community. DHS and PDA will engage stakeholders to ensure that the system is person-centered, breaks down barriers, and fills in the gaps that exist in the long-term care services and supports system. Over the next few months, the departments will meet with recipients, caregivers, advocates, providers and other stakeholders through the public input process. Written comments and feedback may be submitted via email to RA-MLTSS@pa.gov. For more information and to view the discussion document, visit www.dhs.state.pa.us/foradults and click on Managed Long-Term Services and Supports. Read More

PA Attorney General Targets Nursing Homes. On May 31, *The Philadelphia Inquirer* reported that last year, the Pennsylvania Attorney General's Office issued subpoenas to dozens of nursing homes statewide, demanding facts about their staffing - an opening salvo in a probe that could force the homes to pay big fines. According to the article, the AG's office says the process will improve conditions and pay off for the state's elderly. The Cohen, Milstein, Sellers & Toll law firm (a Washington DC based firm), stands to pocket up to $21 million of the first $100 million of any fines extracted by state prosecutors. Amid growing controversy, the firm and others like it have been shopping similar cases to attorneys general nationwide. The Pennsylvania nursing homes are fighting back. In a lawsuit filed in Commonwealth Court against Attorney General Kane and Cohen Milstein, they are asking a judge to throw out the firm's contract and rip up the subpoenas. In their suit, the nursing homes fault Cohen Milstein's tactics, saying the firm is relying on an "unapproved, unsanctioned and unadopted" model - developed by a personal-injury law firm in Texas - to measure their staffing levels. No fines have yet been imposed or collected, and it's unclear when or how the court might rule. Read More

Judge Rules UPMC Must Accept Highmark Medicare Advantage Members. UPMC must continue to see Highmark's Medicare Advantage members on an in-network basis as the two sides negotiate terms on disputed payments, a judge ruled Friday. UPMC quickly issued a statement afterward saying it will appeal the decision to the state Supreme Court. Commonwealth Court President Judge Dan Pellegrini, in granting a motion filed by the state, said UPMC shall remain an in-network provider for Highmark Medicare Advantage Plan members for the duration of the five-year consent decrees signed last summer. He also ordered that the two Western Pennsylvania health care giants make no change to their business relations, "no matter how small," without court approval. Judge Pellegrini set a schedule for arbitration, saying UPMC and Highmark must submit a joint statement "identifying all remaining and unresolved issues" by July 1 and name an arbitrator to resolve those issues. He further ordered both sides to "complete the arbitration of outstanding issues" by September 30, 2015. Read More

Texas

HMA Roundup – Dianne Longley (Email Dianne)

Federal Judge Puts Telemedicine Rules on Hold. A federal judge has barred implementation of new telemedicine rules, claiming the rules were "suspect." In April, the Texas Medical Board (TMB) adopted rules that would require telemedicine providers to establish a physician-patient relationship via an in-person visit or through a visit that would include a remote provider at the patient site to convey patient information to the remote diagnosing physician. Once the relationship is established, future telemedicine services could be provided without the in-person assistance but services would be limited to conditions diagnosed via the initial "in-person" visit. Other provisions clarify that a physician-patient relationship may not be established through an online questionnaire or questions and answers exchanged through e-mail, text, chat or telephonic evaluation or consultation. At the public hearing for rule adoption, numerous business leaders objected to the rules, arguing they imposed an unnecessary requirement, would result in increased health insurance costs for employers and employees who use these services, and would unnecessarily

restrict rural residents' access to health care. The rules were scheduled to take effect June 3rd, but were immediately challenged by Dallas-based Teladoc, a national telemedicine provider.

The TMB and Teladoc have been engaged in ongoing legal challenges regarding the TMB's efforts to impose requirements related to telemedicine services that Teladoc providers have consistently argued are unwarranted and illegal. TMB previously filed an emergency rule in February to impose the same requirements enacted in April, but a district court issued a temporary restraining order based on a motion filed by Teladoc. TMB responded by enacting the same requirements through the normal, rather than emergency, rulemaking process. Teladoc's latest suit against TMB alleges the Board is protecting Texas physicians from competition and argues the rules violate federal antitrust laws because they significantly impair its business model. TMB argued the rules are crucial to ensuring patient safety and quality care. In arguments before the court, TMB also argued that Teladoc was being speculative when it argued the new rules would lead to increased prices for patients and fewer choices.

In his ruling, the Judge disagreed with TMB's assertions, stating, "Plaintiffs' evidence shows the average costs of visits to a physician or emergency room are $145 and $1,957, respectively, and the cost for Teladoc consultation is typically $40." He also ruled the Board's arguments against Teladoc were "poorly founded." In a public statement, Teladoc CEO Jason Gorevic said the company operates in 48 states and Texas is the only state where they have ended up in court. Gorevic pointed out they have now been to court six times in Texas and have been successful every time. A trial date has not been set for the lawsuit.

Texas Legislative Session Ends; $61.2 Billion Medicaid Budget Enacted. The biennial Texas legislative session ended June 1, 2015 with adoption of what lawmakers described as a "conservative budget" that increased Medicaid/CHIP funding by $2.1 billion over the previous two-year budget that ends August 31, 2015. The budget for all Health and Human Services funding totals $77.17 billion, an increase of $2.65 billion over FY 2014-2015. The Legislature allocated $61.2 billion (All Funds) for total Medicaid funding across multiple agencies, including $51.6 billion at the Health and Human Services Commission, which administers Medicaid and CHIP programs. The budget includes:

- Approximately $1.7 billion in General Revenue funds for projected caseload growth (including transition of children from CHIP to Medicaid)
- $587.7 million to reimburse MCOs for the cost of the Affordable Care Act (ACA) Health Insurance Providers Fee and associated federal income tax
- $712.6 million for add-on payments to safety net hospitals, trauma hospitals and rural hospitals
- $327.6 million to fund an additional 5,601 long-term-care waiver clients at the Department of Aging and Disability Services and additional clients in the STAR-PLUS managed care program
- $1.8 billion for CHIP, which is a decrease of $164.9 million from 2014-2015 due to the transition of certain children from CHIP to Medicaid

- $30.9 million for CHIP providers' ACA Health Insurance Providers Fee and income tax increase
- $189.2 million for increased claims administrator costs
- $31.5 million to fund additional services for individuals with intellectual and development disabilities
- $77.7 million to increase the base pay of Community Attendant Care Workers to $8.00 per hour and for rate enhancements across community-based programs

Funding does not include anticipated increases in cost due to medical inflation, higher utilization and increased acuity. Budget writers acknowledged lack of funding for these costs will likely lead to a need for increased funding before the end of the biennium. Those additional costs are typically dealt with as an emergency appropriation when the Legislature reconvenes, which will be in January 2017. The Legislature also did not fund the requested primary care provider payment increase to Medicare rates, which the Texas Medical Association says will lead to more providers withdrawing from Medicaid.

More than 100 legislative riders related to Health and Human Services funding were also included in the appropriations legislation. Among the riders is an HHSC "cost containment rider," which lists ways to achieve mandated savings for Medicaid and several riders related to quality improvement programs and new reporting requirements for MCOs. A summary of these and other key riders and other Medicaid legislation will be included in next week's issue of the Roundup.

Texas Health and Human Services Commission Releases Draft MMIS RFP. The Texas Health and Human Services Commission published a draft MMIS Request for Proposal to request comments prior to release of a final proposal. Comments on the draft are due no later than June 29, 2015. The draft indicates HHSC intends to award a four year contract with an option for three one-year extensions. Objectives for the procurement are described as follows:

- Procure a 'take over in place' contract. The Contractor will maintain existing technology and business operations currently performed by Accenture State Healthcare Services, LLC and its subcontractors at the Riata Trace facilities in Austin, Texas. The Contractor will maintain the current Disaster Recovery site located at the AT&T facility in Dallas, Texas.
- Ensure that critical services continue to be provided to Texas' medical benefit program clients and providers without interruption or delay, and with no degradation in quality.
- Continue efficient and effective business functions and processes in support of Texas' medical benefit programs.
- Improve integration among the State's healthcare delivery systems.

The RFP comes more than a year after HHSC terminated its contract with Xerox Corp. based on accusations that Xerox staff approved thousands of requests for braces that weren't medically necessary. Audits by HHSC found that Xerox failed to properly review requests, which resulted in hundreds of millions of dollars in fraudulent claims. HHSC subsequently contracted with Accenture, a Xerox subcontractor, to take over as the lead vendor until the state could rebid

the contract. HHSC has indicated it intends to break the administration contract into as many as five separate contracts to make it easier to take action against a vendor. The RFP does not include dates indicating when the final RFP will be published.

The draft RFP is available here.

Utah

GOP Lawmakers Hope for Medicaid Deal with Gov. Herbert; Not Certain They Will Meet Deadline. On May 28, 2015, *Casper Star Tribune* reported that Republican lawmakers still hope to find an agreement with Governor Gary Herbert over Medicaid expansion by July 31, though they are not confident in meeting the deadline. There remain concerns about enrollment and costs inflating beyond estimates, which the state would be on the line to cover. Read More

Vermont

Vermont Struggles to Afford Medicaid Expansion. On May 20, 2015, *Bennington Banner* reported that without a dedicated funding source, the state is struggling to afford Medicaid expansion. Governor Peter Shumlin's proposed $90 million health care payroll tax to increase Medicaid payments to providers was previously rejected by the Legislature. Reimbursements could have been equivalent to Medicare at 80 percent. By January, Medicaid is expected to be at a $40 million deficit. However, Shumlin stated that Vermont is still leading the nation in health care reform. Read More

National

CMS Issues New Medicaid Managed Care Regulations. On June 2, 2015, *Governing* discussed the largest changes in the new rules CMS issued last week regarding Medicaid managed care. The article highlights five key areas of focus in the proposed rule: (1) quality ratings; (2) medical-loss ratio (MLR); (3) network adequacy; (4) long-term care; and (5) accreditation and monitoring. HMA's Matt Roan and Lisa Shugarman are quoted by *Governing* in the article. Read More

Health Insurers Propose Double Digit Premium Hike for 2016 Individual Policies. On June 1, 2015, *The New York Times* reported that many health insurers are proposing 10 percent or higher hikes on premiums for individual health insurance exchange plans. Insurers claim rising prescription drug costs and expansion costs as reasons for the increase. Blue Cross Blue Shield of North Carolina requested a 26 percent premium increase and plans in Illinois and Florida are also proposing 20 percent hikes or higher. This was the first time plans were able to use a year's worth of exchange date on which to base their premiums. However, regulators may reject the increases or pressure plans to lower the rates. Read More

Industry News

Acadia Announces Three Acquisitions: Belmont Behavioral Health, Care UK, and a Choices Lifestyle Facility. On June 2, 2015, Acadia Healthcare Company announced three acquisitions. In the U.S., Acadia purchased the assets of Pennsylvania-based Belmont Behavioral Health, which is part of Einstein Healthcare Network. In the U.K., Acadia purchased the operations of Care UK and a facility from Choices Lifestyle. The combined purchases add 17 inpatient behavioral health facilities with approximately 500 beds for Acadia. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
June, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
June, 2015	Louisiana MLTSS - DD	RFP Release	15,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Kentucky	Implementation	1,100,000
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 3, 2015	Michigan	Proposals Due	1,600,000
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	1,600,000
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 (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	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 (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

HMA News

HMA Webinar Replay: First Take on New Medicaid Managed Care Regulations

Link to Webinar Replay

On May 28, 2015, HMA Information Services hosted the webinar, "HMA's 'First Take' on New Medicaid Managed Care Regulations."

CMS just released a new set of proposed Medicaid managed care and CHIP regulations – the first major update of federal rules for health plans in state-sponsored programs in more than a decade. The changes seek to align Medicaid managed care regulations with those of other government-sponsored programs, while at the same time fostering innovation, transparency, quality and financial viability. Like all such rules, details matter. And at more than 650 pages, these proposed rules have a lot of details to digest. It will take weeks – if not months – to fully understand the ins and outs of the new regulations. However, an initial read reveals several important themes likely to dramatically impact Medicaid managed care going forward.

Newest HMACS Blog Post Addresses Feminine Norms and STEM

Link to HMACS Blog

Access to education, and access to and achievement in science, technology, engineering, and math (STEM) subjects are key to higher-paying jobs and career advancement later in life, but many girls continue to miss these opportunities. In the most recent blog post, HMACS discusses girls and STEM, particularly the role that feminine norms play in discouraging girls' participation in these fields. The post also highlights the model curriculum that HMACS developed with TrueChild to respond to this problem. This mini-curriculum of a half-dozen hour-long exercises provides activities that highlight, challenge, and ultimately change rigid feminine norms. To date, the pilots have shown significant change in the girls' attitudes towards math and science, as well as shifts in their perceptions of what it means to be a girl. HMACS staff Marci Eads, PhD, and Robyn Odendahl, along with TrueChild executive director Riki Wilchins, co-authored this most recent post.

HMA Upcoming Appearance: Karen Brodsky to Present at 2015 State Health Research and Policy Interest Group Meeting

June 13, 2015
Minneapolis, Minnesota

HMA Principal Karen Brodsky, along with Angie Fertig (Medica Research Institute), Erin Taylor, and Sarah Gollust will be presenting State Health Access Reform Evaluation (SHARE findings) at the State Health Research and Policy Interest Group Meeting preceding the 2015 AcademyHealth Annual Research Meeting (ARM) on June 13, 2015. Read More

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