HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 1, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

CMS PUBLISHES MEDICAID MCO RATE SETTING GUIDE

This week our *In Focus* section reviews the *2015 Managed Care Rate Setting Consultation Guide* published by the Centers for Medicare & Medicaid Services (CMS) in late September 2014. The guide provides instructions to states as they set capitated rates for Medicaid MCOs for the 2015 calendar year, both for the historical and newly eligible Medicaid managed care populations. It addresses

information CMS expects states to provide in their actuarial certifications, including data sources, benefit, and non-benefit cost justifications, and other rate development considerations. While many states and their actuarial partners likely consider much of the CMS rate setting guide to be standard practice, we view this as an increased level of CMS oversight on the rate-setting process.

The full CMS Rate Setting Consultation Guide is available here.

Rate-Setting Data

CMS is requiring that states adhere to a rigoroous process in setting capitation rates for 2015 and beyond. This includes instructions on the requirements around identifying rate-setting data sources (claims data, encounter data, etc.), as well as the timing of data and any adjustments made to the data in the actuarial process. Additionally, states are asked to identify unused data sources and why they were unused, as well as any improvements to the rate-setting data or new data sources that could be used going forward.

Non-Benefit Costs

States' actuarial certifications must describe the development of projected non-benefit cost within capitation rates. This includes similar requirements on data, assumptions, and methodologies as mentioned above. Of particular note, states will be required to describe how they are building health plan margins into the capitation rates, as well as taxes, fees, and assessments. Presumably, this will include the Health Insurance Providers Fee (HIPF) though that is not identified specifically.

Rate Range Development and Final Contracted Rates

CMS makes note in the rate setting guide that any adjustments made at the end of the rate-setting process that are not adequately justified may not be considered actuarially sound. Final contracted rates must either match the certified capitation rates or be within the rate ranges in the actuarial certification.

ACA Expansion Population Rate-Setting

In CMS' rate setting guidance for the newly eligible Medicaid expansion population, there is allowance for variation in the capitation rates, but the same principles and requirements around rate justification and actuarial soundness apply as for the historical Medicaid population. Of particular note, CMS explicitly prohibits variation in capitation rates due to the enhanced federal medical assistance percentage (FMAP) rate for newly eligible Medicaid beneficiaries. Additionally, states that have expanded Medicaid in 2014 must provide actual experience data in the rate setting justification for 2015 rates.

HMA Medicaid Roundup

Alaska

Alaska Files Claim Against Xerox Over Medicaid Payment System. On September 25, 2014, the *Alaska Dispatch News* reported that the Alaska Department of Health and Social Services has filed a claim against technology vendor Xerox State Healthcare for its glitch-filled rollout of the state's Medicaid payment system. The Department alleges that Xerox breached its contract after it failed to properly implement the Medicaid payment software system; when the system went live in October 2013, it failed to issue timely and accurate payments to Alaska health care providers. The Department has demanded that Xerox produce a corrective action plan to repair the system. Read more

California

HMA Roundup – Alana Ketchel

Governor Signs More Healthcare Bills Into Law, Vetoes Others. On September 25 and 26, 2014, Governor Jerry Brown signed the following health-related bills into law:

- **SB 1053**: This bill requires most health plans, including Medi-Cal managed care plans, to cover contraceptive methods at no cost. The bill sought to build on the parallel federal law which calls for "reasonable medical management techniques," a statement the bill's author felt lacked clarity. Read more
- **SB 18**: With this bill, the state will accept a $6 million grant from the California Endowment to help with renewal of Medi-Cal coverage. The bill, which Brown originally struck down during budget negotiations, is expected to provide a federal match that will bring the total funding to $12 million. Read more
- **SB 964**: Increases insurer oversight in response to narrow networks, including annual reviews of Medi-Cal managed care plans to ensure beneficiary access. Read more
- **SB 1004**: Requires the state to help ensure Medi-Cal managed care plans offer palliative care benefits. Read more
- **AB 1962:** Requires dental health plans to report a medical loss ratio. Read more

- **AB 1174:** Mandates Medi-Cal to cover teledentistry services starting January 1, 2015 and expands the scope of practice for dental assistants and hygienists. Read more
- **SB 1052:** Requires insurers to update and post monthly formulary information via a standard template; also requires Covered California to post formulary information to support comparison shopping. Read more

The Governor also vetoed the following bills:

- **SB 1124:** This bill would limit the seizure of assets from Medi-Cal beneficiaries' estates after they die. In a statement to the Senate, the Governor cited the need to consider the costs of increasing estate protection, although it may be a good goal. Read more
- **AB 1877:** This bill would allow VSP Global to set up a separate vision care marketplace with links to the Covered California website. Read more

Medi-Cal Application Backlog to Drop Significantly Within Six Weeks. On September 24, 2014, the California *Healthline* reported that the Department of Health Care Services Director, Toby Douglas, stated that the backlog of Medi-Cal applications is down to 250,000 and will decrease even further by the beginning of November. Read more

Rural Californians Struggle with Access in Medi-Cal Managed Care. On September 23, 2014, *the San Francisco Chronicle* reported that rural residents are experiencing difficulty accessing specialists and pharmacies under the shift to managed care plans. Many residents report having to travel long distances to see providers since the providers in their area do not accept Medi-Cal patients, reportedly due to low reimbursement rates. Read more

Florida

Florida Hospitals to Expand, Partner. On September 25, 2014, *Health News Florida* reported that UF Health Shands Hospital is moving forward with a $415 million planned expansion. The new building will include 216 beds, 20 operating rooms, and two towers that will house neuromedicine and cardiovascular services. Jacksonville's Baptist Health also announced this week that it will become the third member of the University of Texas MD Anderson Cancer Network. Read more

HCA to Close Edward White Hospital in St. Petersburg. On September 23, 2014, *Health News Florida* reported that HCA West Florida will close the Edward White Hospital in St. Petersburg by the end of November. HCA cited increasing operating costs and competition from nearby facilities as the primary reasons for the closure. The announcement marks the first closure of a state-run hospital in the state since 2010. HCA said the services offered at Edward White will shift to three nearby facilities it also owns: Northside Hospital, Palms of Pasadena Hospital, and St. Petersburg General Hospital. Read more

Georgia

Independent Report Finds that Georgia's Disabilities System Reform Needs More Work. On September 24, 2014, *Georgia Health News* reported on the state of Georgia's mental health system, as outlined by an independent reviewer earlier this month. The reviewer reports that while the mental health system is offering much more robust services this year compared to previous years, the report argues that the state still "remains out of compliance" with services and infrastructure required to transition the developmentally disabled from institutional settings to community settings. Read more

Indiana

Over 200 Hoosiers Share Their Responses to the Healthy Indiana 2.0 Proposal During Public Comment Period. On September 28, 2014, the *Indianapolis Star* reported on the public comments submitted on the Healthy Indiana Plan (HIP) 2.0 proposal to the Department of Health and Human Services. Comments on Governor Pence's HIP 2.0 were mixed; some commenters enthusiastically supported the plan for expanding insurance to the uninsured and for its high reimbursement rates compared to regular Medicaid. Others expressed concerns about expanding the current HIP program, which experienced delays in application processing. The federal government has not set a deadline by which it has to decide on the proposal. Read more

Kansas

Lawmakers Call for Committee to Investigate KanCare Contracting. On September 29, 2014, the Kansas Health Institute reported that members of the KanCare Oversight Committee called for a separate committee to be appointed to investigate whether legal or ethical boundaries were crossed when the Brownback administration contracted with three managed care organizations to privatize Medicaid. In 2012, United Healthcare, Amerigroup, and the Sunflower State Health Plan (Centene) were awarded contracts to administer the state's $3 billion Medicaid program. Those questioning the contract awards argue that several former members of the Brownback administration had professional ties to the managed care companies, raising questions about the ethics behind the contract awards. The office of Governor Brownback maintains that the contracts were awarded based on merit and that even the losing bidders have stated that the process was open and fair. Read more

New Payment Rule for In-Home Care Raises Concerns for Providers and Beneficiaries. On September 29, 2014, the Kansas Health Institute reported on the potential consequences of a new rule that will require state Medicaid programs to pay home care workers minimum wage and overtime. The rule, due to take effect January 1, 2015, would cost Kansas $13-$16 million annually. Caretakers and advocates for the disabled and elderly worry that the new rule could reduce Medicaid funded in-home services for the 11,000 Kansans receiving these services. Angela de Rocha, a spokesperson for the Kansas Department of Aging and Disability Services (KDAD), said the agency does not intend to cut hours off of case plans to deal with the ruling. The Brownback administration has asked the Department of Labor to exempt Kansas from the

ruling or delay its implementation so that the state can implement the structural and financial changes needed to support the rule. Read more

Massachusetts

Governor Patrick Appoints Actuary John Bertko to Health Connector Board. On September 25, 2014, the *Boston Business Journal* reported that Governor Deval Patrick has appointed John Bertko to be an actuarial consultant for the Massachusetts Health Connector. Bertko previously served as the chief actuary at Covered California, the state-based exchange in California. Prior to that, he was director of special initiatives and pricing in the Center for Consumer Information and Insurance Oversight at CMS. Bertko will hold a three year term on the Health Connector Board, ending June 2017. Read more

Michigan

HMA Roundup – Esther Reagan & Eileen Ellis

Healthy Michigan Plan Releases Latest Enrollment Figures. Enrollment in the Healthy Michigan Plan (HMP), Michigan's Medicaid expansion (reform) program continues to grow. The Michigan Department of Community Health (DCH) reports that between April 1 and September 29, 2014, a total of 404,643 individuals were approved for HMP coverage.

The DCH updates HMP enrollment statistics on its website weekly and includes a breakdown of enrollment by county. Not surprisingly, more than half of the newly approved HMP beneficiaries reside in the state's five largest counties:

September 29, 2014 Healthy Michigan Plan Enrollment	
Wayne	109,897
Macomb	30,527
Oakland	29,912
Genesee	26,489
Kent	20,009
Five-County Total	**216,834**
Statewide Total	**404,643**

The DCH website also includes information for HMP applicants and enrollees, providers, and health plans. Program policy and publications are available along with information about the form used for the Health Risk Assessment. A set of Frequently Asked Questions is provided, and the HMP waiver protocols are also available on the site.

With few exceptions, new HMP beneficiaries are required to enroll in the Medicaid Health Plans (HMOs) to receive their health care benefits. As of September 1, 2014, there were a total of 281,027 HMP beneficiaries enrolled in the HMOs. HMP enrollment totals by health plan are expected to increase again in October as individuals continue to enroll in the program and choose an HMO or are assigned to an HMO if they do not select a plan.

September 2014 Healthy Michigan Plan Enrollment			
Medicaid Health Plan	**Voluntary Enrollees**	**Auto-Assigned Enrollees**	**Total Enrollees**
Blue Cross Complete of MI	20,520	2,746	23,266
CoventryCares of MI	2,547	3,425	5,972
HAP Midwest Health Plan	9,971	6,564	16,535
Harbor Health Plan, Inc.	727	1,551	2,278
HealthPlus Partners	15,554	2,369	17,923
McLaren Health Plan	27,880	7,153	35,033
Meridian Health Plan of MI	47,567	21,886	69,453
Molina Healthcare of MI	23,926	9,009	32,935
PHP Mid-MI Family Care	1,802	889	2,691
Priority Health Choice, Inc.	16,900	3,317	20,217
Total Health Care	6,641	3,766	10,407
UnitedHealthcare Comm. Plan	26,214	9,283	35,497
Upper Peninsula Health Plan	8,815	5	8,820
Total	**209,064**	**71,963**	**281,027**

Read more

UMichigan Think Tank Releases Paper on ACA and Essential Health Benefits. On September 19, 2014, the Center for Healthcare Research and Transformation (CHRT) at the University of Michigan released a new policy paper entitled *The ACA and Essential Health Benefits: Overview of the New Coverage Standards in the Individual and Small Group Markets*. The paper discusses how essential health benefits required by the Affordable Care Act were defined and implemented, what plans must cover them, and how this has changed the insurance market. An analysis of the implementation process in Michigan is also provided. Read more

Beaumont Health-Oakwood-Botsford Hospital Affiliation Announced. On September 3, 2014, the head of the new Beaumont Health announced an affiliation of the three hospitals in the Royal Oak-based Beaumont Health System, the four hospitals in Dearborn-based Oakwood Healthcare and Farmington Hills' Botsford Hospital. The combined health care system will create one of the largest in the state, employing more than 33,000 individuals and operating 3,337 hospital beds in the eight facilities. The announcement noted that the consolidation will allow significant opportunities to leverage purchasing power to save money. Read more

Montana

Legislative Finance Committee Unanimously Approves No-Confidence Resolution on MMIS System Contractor. On September 30, 2014, *AP*/the *Great Falls Tribune* reported that the Montana Legislative Finance Committee unanimously supported a no-confidence resolution regarding Xerox Corporation's ability to fulfill its $70 million contract to create a new computer program to manage the state's Medicaid payments. The project is already two years behind schedule. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Gains Two More Marketplace Plans in 2015. On September 26, 2014, *NJ Spotlight* reported that two more insurers will participate in New Jersey's federally-facilitated health insurance marketplace in 2015. UnitedHealthcare and Oscar Health Insurance will compete with current marketplace insurers AmeriHealth New Jersey, Horizon Blue Cross Blue Shield of New Jersey, and Health Republic Insurance of New Jersey for individual enrollees. Their enrollments as of March 2014 were as follows:

Marketplace Carrier	1st Quarter 2014 Total Enrollment	Marketshare
AmeriHealth Inc.	34,427	59%
Health Republic Ins. of NJ	2,523	4%
Horizon BCBSNJ	21,570	37%
Total	**58,520**	**100%**

Source: NJ Department of Banking and Insurance

UnitedHealthcare entered the Marketplace in four states last year and will increase its participation in up to 24 states next year. Oscar Health Insurance is a new insurer that offered individuals coverage on New York's state-based exchange in 2014. New Jersey will be its second Marketplace state. Read more.

Division of Mental Health and Addiction Services Releases Substance Abuse Prevention RFP. On September 26, 2014, the Department of Human Services (DHS) Division of Mental Health and Addiction Services (DMHAS) issued an RFP for Statewide Services and Special Projects for Substance Abuse Prevention. It contains funding opportunities divided into two (2) parts: Part 1 - Community-Based Services, and Part 2 - Special Projects. Funding for all services will be provided by the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and administered by DMHAS over a five year period. Total funding availability, subject to appropriations, is $5,750,000. Part 1 provides approximately $5,200,000 for community-based service contracts and Part 2 offers approximately $550,000 for special projects service contracts.

A mandatory bidders conference is scheduled for October 10, 2014 at the Hamilton Technology Center Auditorium, 1200 Negron Drive, Hamilton, New Jersey, 08691. Space is limited to one person per organization. Organizations can either register online or contact Helen Staton at Helen.Staton@dhs.state.nj.us or at 609-633-8781. Proposals are due on October 30, 2014. Final awards will be announced on December 15, 2014 with a project start date of January 1, 2015. A copy of the RFP can be found here.

New York

HMA Roundup – Denise Soffel

Draft DSRIP Project Plan Application. The NY Draft DSRIP PPS Plan Application materials are now available for public review and comment. The state is required to engage the public and all relevant stakeholders and provide a public comment period of 30 days. The draft material, which is posted on the DSRIP website, includes four documents:

1. **DSRIP PPS Organizational Application** – The Organizational Application includes sections that summarize the PPS's organizational structure, community health issues, and capabilities to implement a successful PPS. The application includes a description of the governance structure, a description of the community needs assessment, the workforce strategy, data sharing and rapid cycle evaluation approaches, cultural competency and health literacy strategies, DSRIP budget and flow of funds, financial sustainability of the PPS, bonus points, and the attestation of the application. This section represents 30 percent of the overall project application score.
2. **DSRIP Project Plan Applications** – Each PPS will submit no fewer than five projects and no more than 11 projects. The Draft DSRIP Project Plan Application outlines the project-specific requirements and the data used for scoring purposes. Project scoring is based largely on the scale of implementation, meaning the relative size of the target population benefiting from the project, and the speed with which the project can be implemented.
3. **Domain One DSRIP Project Requirements Milestones and Metrics** – This document lays out the process milestones and metrics for each project. Specifically, the document identifies the deliverable needed to be completed as well as the documentation that will be required to verify that project requirements have been successfully achieved.
4. **DSRIP PPS Application Scoring Guide** – The scoring guide tool provides an overview of how the applications will be scored. The guide provides an overview of the process and an example of how one project for one PPS will be scored. The guide also identifies the bonus point process.

The draft DSRIP application materials can be found here.

Home and Community Based Services for Health and Recovery Plan Enrollees. New York will begin offering a Medicaid managed care product designed to meet the needs of beneficiaries with serious mental illness and/or substance use disorders in April 2015 in New York City; October 2015 in the rest of the state. The Health and Recovery Plans (HARPs) will provide an enhanced benefit that includes an array of home and community-based services. Programs that wish to provide HCBS through a HARP must apply to be designated and must meet state-determined staffing and service criteria. The state has recently posted a draft of the Provider Manual that describes the basic requirements for entities that wish to participate. These entities include behavioral health contracted and non-contracted providers, including those that provide rehabilitation, employment, community-based treatment, peer support, and crisis services; state entities providing behavioral health services; hospitals providing specialized behavioral health services; licensed/certified residential, inpatient and organizations providing mental health and/or substance use disorder clinical services; and programs that are currently providing outreach, peer, vocational, or rehabilitative services to people with substance use disorders (SUD) that are funded through Alternatives to Incarceration, Ryan White Federal funding, or funding from NYC Department of Health and Mental Hygiene or the AIDS Institute.

The Provider Manual includes definitions for each of the services that may be offered through a HARP, as well as a list of the service components. Services include:

- Psychosocial Rehabilitation (PSR)
- Community Psychiatric Support and Treatment (CPST)
- Habilitation/Residential Support Services
- Family Support and Training
- Mobile Crisis Intervention
- Short-term Crisis Respite
- Intensive Crisis Respite
- Education Support Services
- Empowerment Services- Peer Supports
- Non-Medical Transportation
- Pre-vocational Services
- Transitional Employment
- Intensive Supported Employment (ISE)
- Ongoing Supported Employment

Conflict-Free Evaluation and Enrollment Center. As part of its implementation of mandatory managed long-term care for Medicaid beneficiaries requiring more than 120 days of community-based long-term care, NYS has developed a process for evaluating the need for long term care services and supports that is independent and conflict-free. As of October 2014, the state is implementing a Conflict-Free Evaluation and Enrollment Center for individuals seeking community-based long-term care services. Maximus, the state's enrollment broker, will serve as the center, providing evaluation services as well as educating beneficiaries about options for enrollment. The center will evaluate eligibility for managed long term care (MLTC) using the UAS-NY prior to enrollment in an MLTC. If a consumer is found eligible they will be counseled about their plan options (partially capitated plans, PACE, Medicaid Advantage Plus, or the FIDA duals demonstration), and guided through enrollment. Once enrolled, the plan will be required to perform an assessment in order to determine the care plan. This process is only for people who are newly eligible for MLTC services. Individuals currently enrolled in MLTCs, or those currently residing in nursing facilities, will not need to be reassessed.

North Carolina

Lawmakers Plan to Continue Discussions About Medicaid Overhaul. On September 24, 2014, *AP*/the *Charlotte Observer* reported that lawmakers plan on spending more time discussing the possibility of a Medicaid overhaul in North Carolina before the General Assembly reconvenes early next year. Earlier this year, the House and Senate approved two differing proposals for reforming Medicaid. Read more

National Institute of Health Awards UNC Grant to Study and Facilitate Prison-Based Medicaid Enrollment. On September 24, 2014, *CNS News* reported that the National Institute of Health (NIH) has awarded a $380,000 grant to the University of North Carolina (UNC) Chapel Hill to sign prisoners up for Medicaid via Prison-based Medicaid enrollment assistance programs (PBMEAPs). About 700,000 prisoners are released from prison each year in the state; providing these individuals access to health services can help them

manage chronic physical and mental health conditions and also reduce the likelihood of recidivism. The UNC study will look at prisoners' rate of Medicaid enrollment, their post-release outcomes, and their attitudes about health care access. It will also examine how PBMEAPs could save the prison system money. Read more

Pennsylvania

HMA Roundup – Matt Roan

Department of Public Welfare Releases RFI for MMIS Modernization. On September 29, 2014, the Pennsylvania Department of Public Welfare (DPW) released a Request for Information (RFI) to solicit information that will be used to assist with the development of an RFP for the Medicaid Managed Information System (MMIS) modernization procurement. DPW is seeking information that will help establish specifications and requirements, timeframes, and cost structures for the project. DPW also aims to identify potential vendors that are capable of providing the required services to support MMIS modernization. Responses to the RFI are due on October 31, 2014. Read more

PA Department of Public Welfare Describes Eligibility Criteria for Reformed Medicaid Benefit Packages. On September 25, 2014, the Department of Public Welfare presented details on its definition of "Medically Frail," which will determine whether enrollees are placed in the high risk or low risk benefit package created as a part of the Governor's Healthy PA Medicaid reforms to replace the 16 Medicaid benefit packages currently in place. DPW officials shared the definition of Medically Frail and described the screening tool that will be used to determine medical frailty. The Medically Frail population that will receive the high risk benefit package will include:

- Individuals with a disabling mental disorder
- Individuals with chronic substance use disorder
- Individuals with serious and complex medical conditions
- Individuals with a physical disability
- Individuals with an intellectual or developmental disability
- Individuals with a disability determination based on Social Security criteria

The Department also explained that for current Medicaid enrollees, DPW will analyze claims history using an algorithm to assign the enrollee to the high risk or low risk plan based on the medically frail definition. Enrollees will receive a notice telling them to which category they have been assigned. If the enrollee was assigned as low risk, they will have an opportunity to complete a Health Care Needs Questionnaire, the outcome of which may confirm their status as Medically Frail and would result in assignment to the high risk benefit package. Enrollees who continue to be categorized as low risk will have an opportunity to appeal the determination. For new enrollees who have no claims history, DPW will rely on the Health Care Needs Questionnaire. The Questionnaire was developed with assistance from the University of Michigan and has been field tested with current Medicaid enrollees. New enrollees will complete the questionnaire as part of the application process. Applicants may decline to answer any or all of the questions, but doing so may result in automatic assignment to the low risk plan. Enrollee's health care needs will be re-assessed annually, if an enrollee experiences a change in health status in the middle of a

year they can petition to be re-categorized as medically frail and moved to the high risk benefit package by contacting their county assistance office.

DPW did not release details on what is and is not included in the two new benefit packages, but they indicated that enrollees will be provided with an explanation of how their benefits have changed.

Hearing on Blues Merger Scheduled. On September 29, 2014, the *Scranton Times-Tribune* reported that a proposed merger of Highmark Blue Shield and Blue Cross Blue Shield of Northeastern PA (NEPA) will move one step closer to reality. The Department of Insurance has announced a public hearing on the matter scheduled for November 12 in Scranton, PA. Highmark and NEPA are two of the four Blues plans operating in Pennsylvania, which also include Independence Blue Cross in Philadelphia and Capital Blue Cross in Harrisburg. Read more

PA State Government takes a Loan from the PA Treasury as General Fund Dips into the Red. *Lancaster Newspapers, Inc.* reported that Pennsylvania's General Fund balance fell to negative $20 million earlier this month, causing the Corbett administration to request a loan from the PA treasury in order to meet cash obligations. While such a financial maneuver is not unusual for the state, critics of the Governor's budget policies have pointed out that never before has borrowing to cover cash flow occurred this early in the fiscal year. PA Treasurer Rob McCord has said that Governor's Corbett's reliance on one-time revenue sources to balance the state's budget and his unrealistic revenue projections have contributed to the state's precarious financial position. Read more

UPMC Study Finds Negative Return on Investment from Employee Wellness Programs. On September 24, 2014, the *Pittsburgh Tribune-Review* reported on a recent assessment by the University of Pittsburgh Medical Center Health Plan (UPMC) related to employee wellness programs. The study tracked 14,000 UPMC workers who voluntarily participated in the wellness program over a five-year period. While the program resulted in health improvements for some participants, overall the group experienced higher healthcare costs over the course of the study. The study confirms findings of other studies which question the cost effectiveness of employee wellness programs. According to a study conducted by the RAND Corporation, lifestyle components of wellness programs, such as weight loss and exercise initiatives, had a negative return of 50 cents for every $1 invested. Read more

Puerto Rico

ASES Continues Negotiations With Insurers to Select Manager for Mi Salud. On September 30, 2014, *Caribbean Business* reported that the Puerto Rican government has missed a self-imposed deadline to select the insurer(s) that will manage its "Mi Salud" Medicaid health insurance program. The Health Insurance Administration (ASES by its Spanish acronym) said that it would name an insurer by September 30; Agency chief Ricardo Rivera now says that decision will be delayed by as much as two weeks. ASES explains that financial negotiations with insurers are the reason for the delay. Read more

Texas

HHSC to Re-Issue Data Project Procurement This Fall. On September 24, 2014, the Texas Health and Human Services Commission announced its plans to re-issue an RFP for a major data project this fall. According to HHS Executive Commissioner Kyle Janek, the bids received by the state for the original procurement were higher than expected. The state will issue a new RFP with a revised scope of work. Read more

Wisconsin

Molina to Reduce Marketplace Rates 11 Percent on Average for Individual Plans. On September 24, 2014, the *Milwaukee Business Journal* reported that Molina Healthcare plans to decrease its rates an average of 11 percent in 2015 for the individual health plans. Senior VP Lisa Rubino said that the insurer expects 2015 enrollees to be in better health than this year's enrollees. Molina's price reduction comes as two new entrants, UnitedHealthcare and Managed Health Services Insurance Corp. (Centene), expect to join the 2015 Wisconsin marketplace. Molina will also add a bronze-level plan to its offerings next year (it currently only offers a silver- and a gold-level plan). Read more

National

OIG Finds that Many New Medicaid Enrollees Face Challenges Finding Care. On September 30, 2014, *Medical Economics* reported on a new report by the Inspector General of the Department of Health and Human Services which calls for greater oversight of Medicaid managed care programs around the country. According to the report, newly enrolled Medicaid beneficiaries in some states must endure long wait times or travel long distances to find a doctor that is accepting new Medicaid patients. The report also states that state standards for access to care "often apply to all areas within a state and do not take into account differences between urban and rural areas. Without standards for specific provider types or areas, states may not be able to hold plans accountable for ensuring adequate access to care." The Inspector General says state and federal officials must do more to ensure beneficiaries have access to care. CMS Administrator Marilyn B. Tavenner said she expected to provide additional guidance to states on improving their standards for access to care. Read more

Texas and Florida Expand Medicaid for School-Age Children. On September 29, 2014, *Kaiser Health News* reported that Texas and Florida are expanding Medicaid eligibility for children between the ages of 6 and 18 under a provision of the ACA. The states were among 21 states required to increase Medicaid eligibility for school-age children by 2014. Children are typically better off in Medicaid compared to other government insurance programs because Medicaid offers broader health benefits at a lower cost. Texas and Florida saw increases of 254,000 and 137,000 school-age kids, respectively, over the past year. Read more

Congressional Committees Request Information from Insurance CEOs Regarding Best Practices in Medicaid Managed Care. On September 25, 2014, Chairmen and Ranking Members of the House Energy and Commerce and the Senate Finance Committees wrote to the CEOs of three managed care companies in an effort to better understand the role private managed care plans play in the

Medicaid program. The legislators requested that the CEOs of Medicaid Health Plans of America, Association of Community Affiliated Plans (ACAP) and America's Health Insurance Plans (AHIP) identify, evaluate, and highlight best practices in Medicaid managed care. Responses to this request are due by November 15. Read more

Lawmakers Consider Extension of CHIP During Lame Duck Session. On September 25, 2014, the *Commonwealth Fund/CQ HealthBeat* reported on efforts to extend the Children's Health Insurance Program (CHIP). Democrats from both chambers have introduced bills that would renew the program's funding and make policy adjustments; efforts are expected to focus on establishing a four-year extension during the lame duck session. Republicans have adapted a slower pace to the renewal process, opting to first gather input from states and other stakeholders about how to improve the program before its funding expires in September 2015. Read more

Senators Call on CMS to Expand PACE Program to More Seniors. On September 25, 2014, *AP*/the *Washington Post* reported that more than a dozen U.S. senators from both parties are calling on the federal government to broaden the Program of All Inclusive Care for the Elderly (PACE) to include more seniors. PACE is open to Medicaid-eligible seniors and people with disabilities who need nursing home care; the program allows individuals to stay in their own homes and receive coordinated care from a team of providers and social workers in their community. The senators want CMS to allow PACE in more types of community settings, like adult day health centers or senior centers, and to expand access to the program, particularly in rural areas. Read more

HHS Reports Hospitals Will Save $5.7 Billion in Uncompensated Care Costs Due to ACA. On September 24, 2014, *Kaiser Health News* reported hospitals are projected to save $5.7 billion this year in uncompensated care costs as states are expanding their Medicaid programs to cover more uninsured Americans. According to the Department of Health and Human Services (HHS), states that have expanded Medicaid will see about 74 percent of those savings. Read more

HHS Awards Funds to Health Centers. On September 12, 2014, Department of Health and Human Services Secretary Sylvia M. Burwell announced awards totaling $295 million in Affordable Care Act funding to 1,195 health centers in every state, the District of Columbia, and U.S. territories. The awards are intended to help the health centers increase access to comprehensive primary health care services for as many as 1.5 million new patients nationwide by hiring health care providers and staff, staying open for longer hours, and expanding the care they provide to include new services such as oral health, behavioral health, pharmacy, and vision services. The Secretary's announcement includes a link to information about specific awards in each state. Read more

2015 Navigator Grants. On September 8, 2014, Department of Health and Human Services Secretary Sylvia M. Burwell announced Navigator grant awards totaling $60 million in Affordable Care Act funding to 90 organizations in states operating Federally-Facilitated and State Partnership Marketplace Exchanges. The awards support preparation and outreach activities for Marketplace enrollment in year two and build on lessons learned during the first year. A list of all HHS Navigator awardees can be found here.

Industry News

US Community Behavioral Announces Acquisition of Wisconsin Autism Company. On September 30, 2014, community-based behavioral services provider US Community Behavioral, LLC announced it has acquired Integrated Development Services (IDS), a Wisconsin-based provider of Autism Spectrum Disorder treatment services. The acquisition will provide IDS with the support infrastructure and capital to expand its operations throughout the Midwest. The terms of the transaction were not disclosed. Read more

Optum to Acquire MedSynergies, Inc. On September 30, 2014, *Market Watch* reported that healthcare information and technology services company Optum has entered into a definite agreement to acquire MedSynergies, Inc. MedSynergies provides physician practice management, revenue management, physician referral management, and other business services to physician groups aligned with large health systems, serving more than 9,300 care providers across the U.S. Read more

Sabra Acquires Portfolio of 21 Independent Living Facilities from Affiliates of Holiday Retirement. On September 29, 2014, Sabra Health Care REIT, Inc. announced that on September 25, 2014 it completed the acquisition of 21 independent living facilities located in 15 states from affiliates of Holiday Acquisition Holdings Corp. for a total cash purchase of $550 million. Read more

Caregiver Homes Receives Highest Status of Case Management Accreditation from NCQA. On September 15, 2014, Caregiver Homes Network, Inc. announced that it has achieved the highest accreditation states of Case Management Accreditation from the National Committee for Quality Assurance (NCQA). NCQA's Case Management Accreditation is a comprehensive, evidence-based accreditation program dedicated to quality improvement that can be used for case management programs in provider, payer, or community-based organizations. The highest accreditation status extends accreditation to an organization for three years. Caregiver Homes is the eighth company nationally to earn NCQA case management accreditation, and the first home and community-based services provider to do so. Read more

RFP Calendar

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

Dual Eligible Financial Alignment Demonstration Calendar

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

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

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

‡ Capitated duals integration model for health homes population.

HMA News

HMA Upcoming Webinar: *"The Missing Link: Stable Housing as a Key Determinant of Health in Medicaid Populations."*

Tuesday, October 21, 2014
10:00 AM Eastern
Register Here

HMA's Mike Nardone will discuss the link between housing and Medicaid-financed health care. John Lovelace, president of UMPC for You, will offer a case study of his organization's growing, three-year-old Shelter Care Plus program for the homeless. William C. Kelly, Jr., strategic advisor of Stewards of Affordable Housing for the Future (SAHF), will discuss the Medicaid business case for housing as a platform to serve the health needs of other low-income populations.

HMA Upcoming Appearances

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

Vern K. Smith, PhD – Keynote Speaker
October 19, 2014
White Plains, New York

HMA Welcomes…

Josh Rubin, Principal - New York, New York

Josh comes to HMA most recently from LRN where he has served as the Chief of Staff. In this role, Josh was responsible for all personnel and other aspects of the office of the CEO; oversaw content production, including keynote speeches, magazine articles, blog posts, and tweets; and initiated and oversaw special projects throughout the company. Prior to LRN, Josh was the Vice President and Chief Operating Officer for the Mental Health Association of New York City for several years. In this role he had executive responsibility for overall operations as well as new business development including existing service expansion, establishment of new business lines and creation of strategic partnership with government, and not-for-profit and private entities. Previous to his work with MHA of NYC, Josh was the Director of Policy and Planning for YAI Network in NYC. Here Josh served as senior manager and advisor to the CEO and President with a particular emphasis on board relations and staff communications. He diversified funding by establishing new service lines and managed all legislative affairs at the city, state, and federal level with an emphasis on advocacy.

Additional positions that Josh has held include City of New York Department of Health and Mental Hygiene – Assistant Commissioner for Chemical Dependency, Assistant Commissioner for Mental Hygiene Policy, Chief Policy

Officer, Chief Administrative Officer, and Special Assistant to the Executive Deputy Commissioner; Rappaport Summer Intern with the State Legislature Mental Health Caucus in Boston, MA; and Program Associate/Program Assistant/IT Coordinator/Executive Assistant with The Coalition of Behavioral Health Agencies.

Josh received his Master in Public Policy with a concentration in Political Advocacy and Leadership from Harvard University. He received his Bachelor of Arts in Religion and the Humanities from the University of Chicago.

Mike Engelhard, Principal – Costa Mesa, California

Mike comes to HMA most recently from Gold Coast Health Plan where he has served as the Chief Executive Officer for the past few years. In this role, Mike was responsible for directing the daily operations of GCHP (County Organized Health System for Ventura County) to include Board relations, finance/accounting, health services, quality, operations, and human resources. He successfully turned the health plan around in less than two years with achievements that included: saved the plan from threatened conservatorship by the State of CA; successfully closed-out multiple pre-existing state corrective action plans by changing operations; turned $9M negative equity into $29M positive equity through focused improvements in operations, management of rates from CA, and hiring medical management staff to appropriately control utilization of services; improved claims operations; and absorbed membership growth of more than 50% while maintaining quality, access and financial goals.

Prior to his role with GCHP, Mike was the Interim CEO and Chief Financial Officer for CalOptima for four years. Mike was responsible for overall financial operations including financial planning and analysis, accounting, procurement, risk management, investment management, and health network financial oversight. Previous to that, Mike worked with Health Net, Inc. for seven years where he began as the Director of Financial Analysis in Corporate Business Planning for two years, was then promoted to Vice President of Investor Relations for Corporate Communications for three years, and was ultimately promoted to Vice President and Regional Finance Officer of Senior Products Division for the last two years of his tenure.

Additional positions that Mike has held include Corporate Development/Finance Division with Kinko's, Inc.; Vice President and Financial Analysis Manager/Retail Banking Division of Great Western Bank; Vice President and Division Finance Manager/Credit Administration with First Interstate Bank; and Nuclear/Environmental Engineer with Bechtel National, Inc.

Mike received his MBA in Finance from Columbia University and his Bachelor Science in Nuclear Engineering from the University of California at Santa Barbara.

Jeff Ring, Principal – Costa Mesa, California

Jeff comes to us most recently from White Memorial Medical Center in Los Angeles, CA where he has served as the Director of Behavioral Sciences and Cultural Medicine for the Family Medicine Residency Program. Over his 19 year tenure, Jeff was responsible for developing and implementing the Behavioral Sciences curriculum to include assessment and treatment of psychological disorders, how social conditions impact health status, culturally responsive

healthcare, mind-body medicine, physician-patient communication, and physician well-being.

Concurrent to his work at White Memorial Medical Center, Jeff has served as a Faculty member in the Masters in Academic Medicine Program for the Keck School of Medicine at the University of Southern California. In this role he taught a virtual classroom professionalism course on "Enhancing Faculty Skills in Teaching Culturally Responsive Medicine." Jeff also served as a core faculty member for the HRSA-funded Faculty Development of Family Medicine Fellowship for several years.

Prior to joining White Memorial, Jeff was an Associate Professor in Multicultural Community Psychology with the California School of Psychology in Los Angeles. In this role he researched socio-cultural aspects of psychopathology, intercultural laboratory, multicultural mental health, and clinical interviewing. Additionally he was responsible for research and grant writing, dissertation supervision, clinical supervision, conference organizing, and campus governance.

Jeff received his Ph.D. and his M.A. in Clinical and Community Psychology from Boston University. He received his Bachelor degree in Psychology from the University of California, Berkeley. He is a licensed Psychologist in the state of California and is fluent in Spanish.

Lisa Shugarman, Senior Consultant – Costa Mesa, California

Lisa comes to HMA most recently from The Scan Foundation where she served as the Director of Policy for the past five years. In this role, Lisa was responsible for the oversight and conduct of policy-related grant-making and strategic investments at both the federal and state levels. She directly engaged state agencies and CMS on issues related to the Dual Eligibles Integration Documentation and uniform assessment for long-term care. Prior to The Scan Foundation, Lisa was a Health Policy Researcher for The Rand Corporation for nine years. Here she conducted health-related research and policy analysis; managed $2.4M in grant/contract funds; and had primary research interests centered on the organization and financing of health care systems and long term care, quality of care, health outcomes, and program evaluation.

Additional positions that Lisa has held include Lecturer with the University of Southern California; Research Associate with the University of Southern California; and Project Manager/Research Assistant with the Institute of Gerontology at The University of Michigan.

Lisa received her Ph.D. in Health Services Organization and Policy from The University of Michigan School of Public Health. She received her BA in Social Welfare, Minor in Public Policy (High Honors) from the University of California – Berkeley.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Olympia, Washington; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC. http://healthmanagement.com/about-us/

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