HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 15, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Kartik Raju
Email

THIS WEEK

IN FOCUS

HIGHLIGHTS FROM KAISER/HMA 50-STATE MEDICAID DIRECTOR SURVEY

This week, our *In Focus* section reviews highlights and shares key takeaways from the Kaiser Commission on Medicaid and the Uninsured's (KCMU) new report, ***Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015***, released on October 14, 2014. The report, published annually, was prepared by Vernon K. Smith, Ph.D., Kathleen Gifford, and Eileen Ellis from HMA and by Robin

Rudowitz and Laura Snyder from the Kaiser Commission on Medicaid and the Uninsured. HMA's Jenna Walls and Dennis Roberts also contributed to the report.

The findings in this report are drawn from the 14th consecutive year of the KCMU and HMA budget survey of Medicaid officials in all 50 states and the District of Columbia. This survey reports on trends in Medicaid spending, enrollment, and policy initiatives for FY 2013 and FY 2014. The report highlights policy changes implemented in state Medicaid programs in FY 2014 and those planned for implementation in FY 2015 based on information provided by the nation's state Medicaid Directors. Key areas covered include changes in eligibility and enrollment, delivery systems, provider payments and taxes, benefits, pharmacy programs, program integrity and program administration.

Report Summary Points

- As predicted in last year's report, states are implementing a host of ACA-related eligibility and enrollment changes in Medicaid. In addition to changes required by the ACA in all states to streamline Medicaid eligibility and enrollment processes, 31 states made eligibility expansions in FY 2014, the most common being implementation of the Medicaid expansion.
- States' focus on delivery system reforms in Medicaid programs continued to build in FY 2014 and FY 2015. Of the 39 states (including DC) with MCOs, over half in FY 2014 and FY 2015 reported specific policy changes to increase the number of enrollees in risk-based managed care by adding eligibility groups, making enrollment mandatory, or expanding to new regions. Additionally, states show significant activity in home and community-based services (HCBS) and other delivery system initiatives.
- 2014 and 2015 will stand out as years of significant change for state Medicaid programs because of the ACA, as well as other transformative changes underway. States are expanding managed care and at the same time implementing new delivery system and care coordination arrangements. Medicaid programs are also focusing on long-term care delivery through the expansion of HCBS. Meanwhile, economic recovery has allowed states to implement provider rate increases, as Medicaid Directors still report staffing and resource constraints amidst the significant changes across all states.

Key Report Highlights

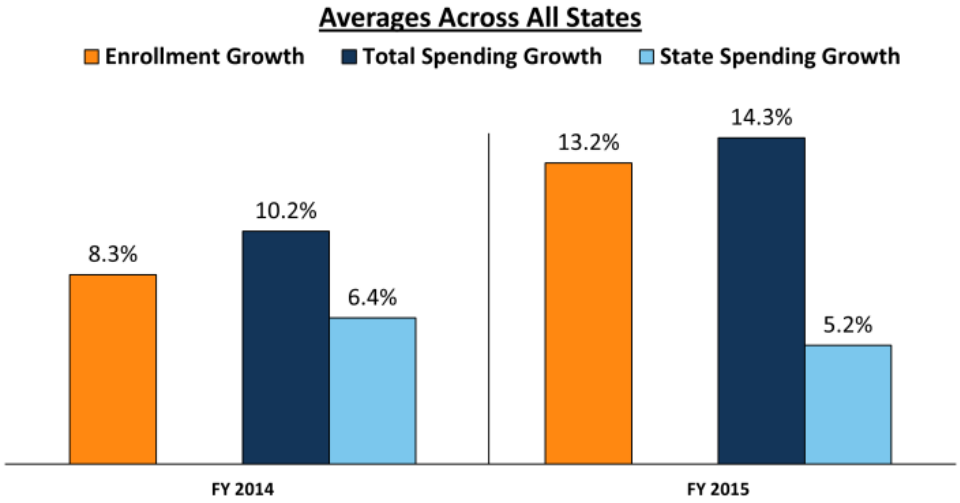
In the following sections, we highlight a few of the major findings of the report. This is a fraction of what is covered in the 50-state survey report, which also includes findings on policy changes regarding provider reimbursement, long-term care rebalancing, pharmacy cost controls and other benefit changes, provider assessments and taxes, and program integrity initiatives.

Anticipated Medicaid Enrollment and Spending Growth

- The 28 states (including DC) that have expanded Medicaid for FY 2015 expect to see an 18 percent increase in enrollment and an 18.3 percent increase in total Medicaid spending in FY 2015, on average.

- Anticipated spending growth is driven mostly by new enrollment that is fully federally financed. State spending in expansion states is projected to increase at a slower rate of 4.4 percent in FY 2015.
- Across all states, enrollment is anticipated to increase by 13.2 percent, with total spending up 10.2 percent and state-only spending up 5.2 percent.

Figure 1 – Year-Over-Year Medicaid Spending and Enrollment Growth, SFY 2013 to SFY 2014 and SFY 2014 to SFY 2015



NOTE: Data show the year over year change in spending between SFY 2013 and SFY 2014 as well as between SFY 2014 and SFY 2015.

SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.

Medicaid Eligibility Standard Changes

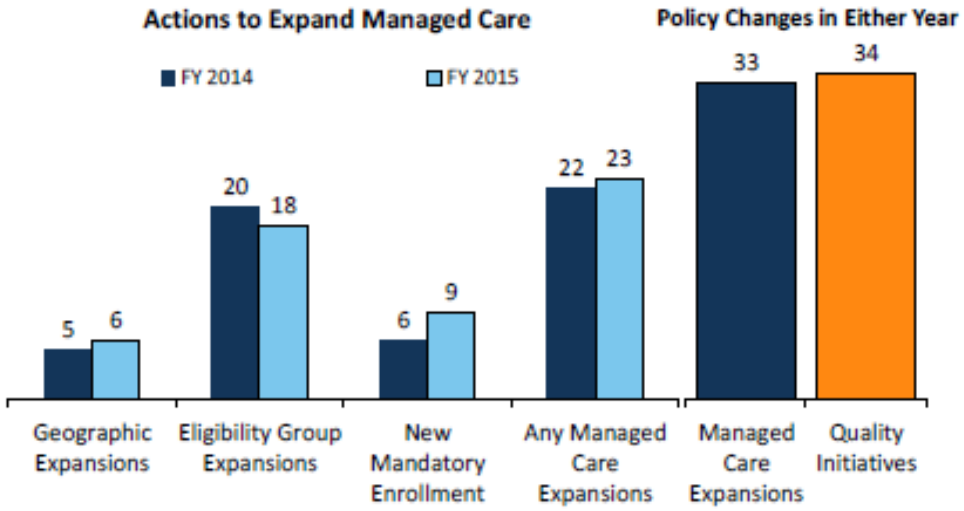
- In FY 2014, 31 states (including 26 states that have expanded Medicaid), implemented increased eligibility, while only four states implemented eligibility changes that were purely negative.
- Additionally, 24 states implemented changes to Medicaid eligibility pathways in response to the availability of other coverage options such as the Marketplace/Exchange.
- For FY 2015, 8 states are planning to increase Medicaid eligibility, while only 6 states are implementing changes in response to availability of other coverage options.

Medicaid Managed Care Policy Changes

- Of the 48 states that operate some form of managed care, a total of 13 states operate both MCOs and a PCCM program, while 26 states (including DC) operate MCOs only and 9 states operate PCCM programs only. In addition, 20 states contracted with one or more limited-benefit risk-based prepaid health plans to provide behavioral health, dental care, maternity care, non-emergency medical transportation, or other benefits.

- Among the 39 states (including DC) with MCOs, 16 states reported that over 75 percent of their beneficiaries were enrolled in MCOs as of July 1, 2014.
- Of the 39 states (including DC) with MCOs, a total of 33 states indicated that they made specific policy changes to increase the number of enrollees in MCOs; no states with MCOs took any action designed to restrict MCO enrollment. The most common strategy was to expand voluntary or mandatory enrollment to additional eligibility groups (20 states in FY 2014 and 18 states in FY 2015.) The eligibility group most commonly added to MCOs was the newly eligible adult group in states adopting the ACA Medicaid expansion.

Figure 2 – Number of States Implementing Managed Care Expansions and Quality Initiatives, FY 2014/FY 2015

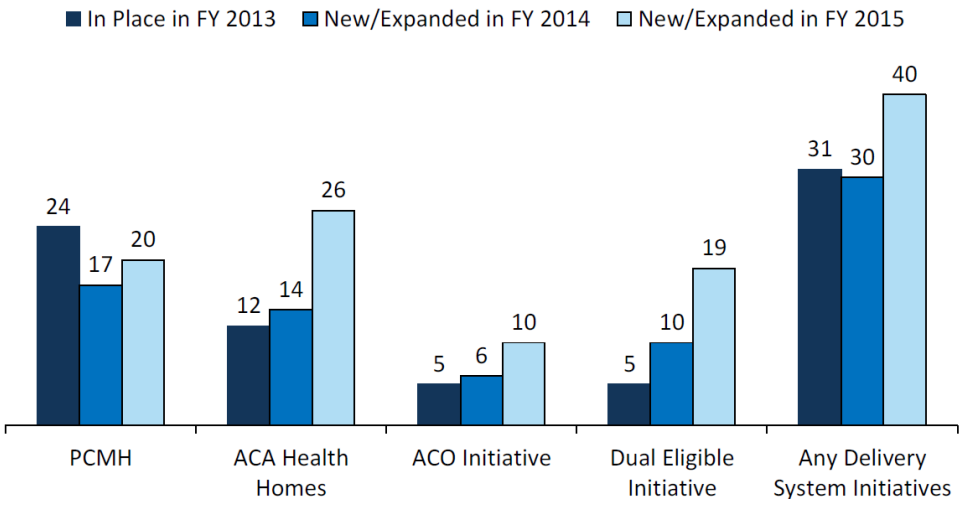


SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.

Other Delivery System and Payment Reform Initiatives

- In addition to risk-based Medicaid managed care, states are increasingly implementing other delivery system and payment reform initiatives, such as patient-centered medical homes (PCMH), ACA health homes, accountable care organizations (ACOs), and dual eligible financial alignment demonstrations.
- In FY 2013, 31 states had some delivery system initiative in place. Thirty states have new or expanded initiatives underway in FY 2014, and 40 states are implementing new or expanded initiatives in FY 2015.

Figure 3 – Number of States Implementing Delivery System Reform Activity, FY 2013 – FY 2015



NOTE: Expansions of existing initiatives include rollouts of existing initiatives to new areas or groups and significant increases in enrollment or providers. Dual Eligible Initiatives include both those through the CMS financial alignment demonstration and those outside of the CMS financial alignment demonstration.

SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2014.

Medicaid Policy Reactions to High-Cost Specialty Drugs

- In this year's survey, virtually every state indicated concern regarding recently approved high-cost specialty drugs, especially Sovaldi. States were asked to comment on the whether they had adopted or planned to adopt new coverage and reimbursement policies to address Sovaldi in FY 2014 or FY 2015.
- Twenty-two states commented that new clinical prior authorization criteria were already in place or under development. One state (New Jersey) noted that it was exploring clinical protocols to restrict Sovaldi utilization – an unusual step for a state with no Medicaid PDL and only minimal pharmacy prior authorization requirements.
- Seven states indicated that they were standardizing the clinical criteria across both fee-for-service and managed care, and seven states reported plans to carve-out Sovaldi and/or related drugs or partially supplement and/or provide pass-through payments to managed care plans for some of the costs of Sovaldi, some on a temporary basis.

Looking Ahead: Perspectives of Medicaid Directors

When asked to identify the top priorities and issues for FY 2015 and beyond, Medicaid directors listed the following:

- Payment and delivery system reform was the major priority listed by many Medicaid directors, with a particular interest in achieving greater value and performance.
- Integration of behavioral health services or long-term services and supports (LTSS) into physical health were also mentioned as priorities.

- A number of states mentioned efforts to improve quality of care, with a focus on outcomes and improvements in population health measures, in some cases associated with system improvements and better data analytics.
- Continued implementation of ACA is a priority across the states, with major upgrades to eligibility systems and MAGI eligibility rules underway. Meanwhile, states continue to enroll newly eligible individuals under the Medicaid expansion.
- New eligibility systems, MMIS, and other information technology/systems were listed by a majority of states as top operational priorities.
- Finally, states indicated budget stability and cost control as a significant priority going forward.

Links to Kaiser/HMA 50-State Survey

Link to Executive Summary (PDF)

Link to Full Report (PDF)

HMA Medicaid Roundup

Arizona

Department of Corrections Agrees to Improve Health Care Services in Prison Population. On October 14, 2014, the *Arizona Republic* reported that the Arizona Department of Corrections (DOC) has reached a settlement agreement regarding a class action lawsuit alleging that the Department provided inadequate healthcare services to its 33,000 inmates. The lawsuit, filed in 2012, argues that the inadequate services provided to inmates led to several deaths and the poor health of the prison population. The settlement will hold the DOC responsible for (among other things) better monitoring patients with diabetes, hypertension and other chronic conditions. The settlement also requires DOC to decrease the amount of time prisoners with serious mental illness spend in solitary confinement, as well as to provide mental health services for these individuals. Prisoners' attorneys will monitor the care provided by the DOC's contracted provider, Corizon, to ensure the state is in compliance. Read more

California

HMA Roundup – Alana Ketchel (Email Alana)

Outgoing Senator to Launch Mental Health Foundation. On October 8, 2014, the *Sacramento Bee* reported that Senator Darrell Steinberg is leaving the legislature at the end of the month. The Senator says he will start a foundation focused on mental health policy issues, which is the area he focused on during his time in the Senate. Read more

Autism Benefit Amendment Filed with CMS. On October 8, 2014, the *California Healthline* reported that the State has submitted a state plan amendment to federal officials outlining rules regarding the addition of autism therapy as a Medi-Cal covered benefit. The state broadened eligibility requirements and therapies in response to stakeholder feedback. The state deleted a statement that limited eligibility to beneficiaries who "exhibit excesses or deficits of behaviors that significantly interfere with home and community services." The state also agreed to broaden allowed therapies beyond applied behavior analysis. DHCS is holding a stakeholder meeting on autism issues October 16. Read more

Covered CA Confirms Immigration Status of Majority of Consumers, But 10,000 Still in Danger of Losing Coverage. On October 14, 2014, the *Los Angeles Times* reported that the Covered California exchange is planning to cancel coverage for people who failed to provide documentation of citizenship or legal residency. While the exchange was able to clear the lawful presence status of the majority of consumers using a federal data hub, or by collecting additional documents from these consumers, 10,474 people have still not provided

documentation. Pre-termination notices will be sent to these remaining people who still need to confirm their citizenship or lawful presence in the US to maintain their covered status. Read more

Colorado

HMA Roundup – Joan Henneberry (Email Joan)

Health Officials Announce Privacy Breach. On October 10, 2014, *AP*/the *Denver Post* reported that Colorado health officials accidentally violated the medical privacy of about 15,000 people in a recent postcard mailing. The postcards were mailed between July 30 and September 3 as part of a survey sent to people receiving behavioral health services through Medicaid or the Department of Human Services' Office of Behavioral Health. Protected health information was shared in the mailings; financial information and Social Security numbers were not disclosed. The state agency that sent the postcards has notified impacted clients and has revised policies to prevent future incidents. Read more

740 Immigrants Losing Healthcare Coverage for Missing Eligibility Determination Deadline. On October 8, 2014, the Health Care Advocacy Program reported that 740 immigrants in Colorado are losing their health care coverage for failing to meet an eligibility determination deadline. According to Connect for Health Colorado Communications Director Luke Clarke, the Exchange contacted 1,600 immigrants in June 2014 to inform them of the deadline. The Exchange also reached out to brokers and health coverage guides in an effort to reach as many people as possible. Two immigrant advocacy groups have filed civil rights complaints, arguing that the notices sent by the exchange were not provided in multiple languages as required by the ACA's nondiscrimination requirements; notices were provided only in English and Spanish. Read more

Delaware

Aetna's Delaware Physicians Care Medicaid Plan to Pull Out of Market. On October 15, 2014, Aetna Medicaid announced that Delaware Physicians Care will not renew its contract to participate in the State of Delaware's Medicaid and other assistance programs. Aetna Medicaid President/CEO Pamela Sedmak said the company was unable to agree on a rate agreement with the State that would cover the costs of operating the plan. Service will continue through the end of the year; Delaware Physicians Care will work with the State to transition its 137,000 members to another Medicaid plan. Delaware Physicians Care was one of five respondents to the Medicaid rebid RFP issued earlier this year. Contract award announcements have been delayed over the past several months. The other four bidders on the RFP are Magellan, Riverside Health, United Healthcare, and Highmark BlueCross, with United the only other incumbent. Read more

Insurance Commissioner Rejects Rate Hike Proposals from Highmark. On October 8, 2014, the *News Journal* reported that Delaware's Insurance Commissioner, Karen Weldin Stewart, rejected nine rate increase requests by Highmark Blue Cross Blue Shield. Highmark requested premium increases of 17.6 percent on four plans and 15 percent on five others. Commissioner Stewart

rejected any increase on one of the plans and reduced the other eight requests to 9.9 percent. About 3,300 individual policyholders are covered by the plans. These plans are considered "grandfathered" and are not required to meet terms of the law that mandate certain essential health benefits. Read more

Florida

HMA Roundup - Gary Crayton & Elaine Peters (Email Gary/Elaine)

Crist and Scott Discuss Stances on Medicaid Expansion in Florida as Election Approaches. On October 13, 2014, *AP/Health News Florida* reported on gubernatorial candidates Charlie Crist and Rick Scott and their stances on Medicaid expansion in Florida leading up to the November 4 election. Scott and state Republicans have rejected the measure in the past, citing concerns that the feds will not be able to cover Medicaid expenses. Scott, who has wavered in his stance on expansion in the past, now explains that he will not stand in the way of the Legislature passing expansion while the feds cover 100 percent of the bill; however, he does not support the prospect of the state financing a portion of expansion costs in the future. Crist says that, if elected, he would call for a special session of the Legislature and attempt to expand Medicaid and would even consider expanding the program by executive order if the Legislature were unwilling. Read more

Indiana

HHS Secretary Burwell and Governor Pence to Continue Working toward a Medicaid Expansion Alternative for Indiana. On October 9, 2014, the *Indianapolis Star* reported on Governor Mike Pence's recent meeting with HHS Secretary Sylvia Burwell to discuss the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion plan. Both Burwell and Pence reported that they have not yet reached agreement on all issues related to HIP 2.0; neither has specified what the disagreements are about. Indiana's current eligibility rules for Medicaid are among the most stringent in the country, and about 15 percent of the adult population remains uninsured. Read more

Kansas

Democratic Gubernatorial Candidate Paul Davis Proposes Reversing KanCare Change. On October 8, 2014, the *Sacramento Bee* reported that Democratic challenger Paul Davis has proposed reversing part of Republican Sam Brownback's Medicaid overhaul in order to improve care access for the developmentally disabled. Advocates for the developmentally disabled have voiced concerns that Brownback's decision to shift the state's Medicaid program to privatized managed care has created an unnecessary level of bureaucracy in securing services for this population. Davis said that if he is elected governor, he will conduct a review of KanCare and remove in-home support services for the developmentally disabled from the program. Read more

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

St. Elizabeth's Medical Center Gets New President. On October 10, 2014, the *Boston Globe* reported that Steward Health Care has named Dr. Roger D. Mitty president of its flagship hospital, St. Elizabeth's Medical Center in Brighton. Dr. Mitty is currently the chief of gastroenterology and is also an associate professor at Tufts University Medical Center. Mitty replaces Kevin Hannifan, who is resigning after less than 18 months in the position. Read more

Governor Patrick: Health Connector Website Repairs Will Cost State $26 Million. On October 6, 2014, WBUR Boston NPR reported that fixing the Massachusetts Health Connector website will cost the state approximately $26 million, according to Governor Deval Patrick. This is significantly lower than the $1 billion repair cost estimated by the Pioneer Institute report earlier this month. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Several Behavioral Health Bills Released by Senate Health, Human Services and Senior Citizens Committee. On October 14, 2014, *NJ Spotlight* reported that Senator Joseph F. Vitale (D-Middlesex) sponsored a reimbursement bill (S-2374/A-3717) to increase the rate of reimbursement for 340 mental health and substance abuse treatments to match market rates. Another bill sponsored by Senator Vitale and Senator Robert Gordon (D-Bergen and Passaic), S-2376/A-3718, would create a grant program to enable primary care providers (PCPs) at federally qualified health centers (FQHCs) to consult with specialists online. This would improve PCP access to specialist knowledge on best evidence-based treatments of common medical problems, thereby extending the services PCPs can offer their patients and reducing the costs for specialty care. Additional bills were introduced to address drug addiction—for example, to inform patients about the potential for addiction to opioid drugs prescribed for pain. Read more.

Department of Human Services, Division of Family Development Releases Temporary Aid to Needy Families (TANF) Draft State Plan for Public Comment. The Work First New Jersey (WFNJ) program has been modified pursuant to final Federal Regulations at 45 CFR Part 260, et seq. to provide preventative and supportive services to keep families from entering or re-entering the welfare system. These include, but are not limited to, diversion from cash assistance and pre- and post-TANF supportive services, such as transportation, child care, and case management services. The program's revisions to the WFNJ/TANF state plan for federal fiscal year 2015 are posted on the DHS website for public comment until November 24, 2014. Comments can be submitted to Jeannette Paige-Hawkins, Director of the Division of Family Development, at P.O. Box 716, Trenton, NJ 08625-0716. Comments can also be hand delivered to Quakerbridge Plaza, Building 6, Mercerville, NJ 08619. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

Hospital Mergers Continue. On October 10, 2014, *Capital New York* reported that NYU Langone Medical Center, based in Manhattan, is considering a strategic partnership with Lutheran Medical Center in Brooklyn. The two institutions have already agreed to partner in operating a new health care center in Brooklyn at the site of the former Long Island College Hospital. The article notes that Lutheran Medical Center is applying to become a Performing Provider System through New York's DSRIP program, and their letter of intent indicates that NYU Langone would provide administrative infrastructure and expertise to the PPS. Read more

On October 9, 2014, *Crain's HealthPulse* reported that New York-Presbyterian Hospital took another step toward taking over Hudson Valley Hospital Center by filing a certificate of need application to establish a parent entity that would take over responsibility for operating the hospital. Read more

DSRIP Reporting Guide. A draft manual of DSRIP measurement and reporting requirements was released by the Department of Health for public comment. It describes the process by which improvement goals will be calculated and identifies the specific clinical metrics that will be used for each of the potential DSRIP projects. Performance measures will be developed to capture the population for which a particular intervention is recommended. Some measures will apply to everyone in the PPS; others will apply to a smaller sub-set based on age or diagnosis. Performance goals will be based on the top decile performance of zip codes for Medicaid recipients in NYS for each measure. PPSs will receive incentive payments for demonstrating improvements that meet or exceed annual targets. In addition to the overall DSRIP goals of reducing potentially avoidable hospital use, system transformation metrics include such things as the number of providers meeting meaningful use criteria and achieving PCMH accreditation; HEDIS measures on access and availability of services; CAHPS measures on access; and changes in Medicaid spending for emergency and inpatient services and on primary care and community-based behavioral health. Project-specific clinical measures rely on metrics captured through NCQA or AHRQ. Read more

Office of the Medicaid Inspector General Annual Report. On October 9, 2014, the Office of the Medicaid Inspector General (OMIG) released its Annual Report for 2013. It reports a record level of Medicaid recovery and cost-savings of over $2 billion to the state's Medicaid program. OMIG identified more than $226 million through audit activities, which included the areas of fee-for-service and managed care audits, with $104 million and $47 million identified for recovery, respectively. Corporate Integrity Agreement (CIA) monitoring and enforcement efforts resulted in more than $55 million of avoided costs to the Medicaid program. CIAs are offered by OMIG to providers with a history of program integrity issues as an alternative to exclusion from the Medicaid program, when exclusion might lead to negative outcomes such as service shortages within a given geographical area. Finally, in 2013 OMIG ended Medicaid program participation for more than 702 providers and referred an additional 164 providers to the Medicaid Fraud Control Unit for potential criminal prosecution. Read more

Transportation Carve-out for Medicaid Managed Care Enrollees. The Medicaid Redesign Team identified non-emergency medical transportation as an area where cost savings could easily be achieved. Under the Transportation Reform Initiative, the Department of Health is phasing in a Medicaid fee-for-service non-emergency medical transportation (NEMT) management program under which transportation services are carved out of the Medicaid managed care benefit package. The first NEMT program for managed care enrollees was implemented in the Hudson Valley Region in January 2012, with additional counties in the region moving to the NEMT manager in March and September of 2012. Implementation in New York City began in January 2013. An additional 24 counties in the Finger Lakes and Northern New York moved to the NEMT manager on January 2014. On January 1, 2015, emergency and non-emergency transportation services for all Medicaid managed care enrollees will be carved-out of the managed care benefit package for managed care enrollees in seven additional counties in Western New York. Read more

Ohio

Ohio Medicaid Expansion Faces Roadblock in 2015. On October 14, 2014, *Kaiser Health News* reported that Medicaid expansion funding could be cut next July when state lawmakers prepare the next budget. Governor John Kasich managed to expand Medicaid in Ohio last year, despite heavy opposition by Republican lawmakers; over 367,000 Ohioans have enrolled in the program since then. However, Medicaid spending must be reauthorized by state lawmakers as part of the state's two-year budget cycle. The current budget cycle ends in June 2015, meaning that Medicaid expansion funding could be cut if there are enough votes to do so. Read more

Delays in Payment for MyCare Ohio Services Cause Some Caregivers to Stop Offering Services. On October 12, 2014, the *Columbus Dispatch* reported that home health workers caring for the elderly and disabled continue to experience problems receiving payment for their services, forcing many to stop offering these services. In May, the state started the MyCare Ohio program, a managed-care program for Ohioans who receive health coverage from both Medicare and Medicaid. But managed care enrollees tell the state that their access to care is being limited due to delays in authorizations for physical therapy, prescriptions and other services, and delays in payment. Ohio Medicaid spokesperson Sam Rossi stated that health plans are actively making efforts to help caregivers resolve their payment problems. Enrollees also express concern about whether they will have access to serves when traveling outside their region's coverage area, a concern the state has still not addressed. Read more

Pennsylvania

HMA Roundup – Matt Roan (Email Matt)

Insurers Retreating from Healthy PA. On October 7, 2014, the *Pittsburgh Tribune-Review* reported that some of the health insurers who have applied to provide coverage under Healthy PA, Governor Corbett's alternative approach to Medicaid Expansion, have announced that they are backing out of the program entirely, or scaling back the regions in which they plan to offer coverage. Highmark has announced that they are walking away from the program altogether, citing an inability to agree to reasonable reimbursement rates that

would support offering plans that resemble private coverage. UPMC has also announced that it may limit the number of regions where it will offer coverage due to difficulty building provider networks based on state reimbursement that would require provider rates to be more aligned to Medicaid reimbursement levels than higher commercial insurance rates. With Highmark's departure, eight plans remain in the program; all of those plans except one, Capital Blue Cross, currently offer coverage under the state's existing Medicaid Managed Care program, Health Choices. The Department of Public Welfare had previously announced that Healthy PA enrollees would have a choice of three plans in each region, but now a spokesperson for DPW has said that there will be a choice of at least two plans. DPW has not announced which plans will be available in each of the nine Healthy PA regions that align with the Federally Facilitated Health Insurance Marketplace regional service areas. Read more

PA Senate Approves Bill to Regulate Health Insurance Navigators. The Pennsylvania Senate passed a bill this week (SB 1268) to regulate Health Insurance Navigators certified under the Affordable Care Act to assist consumers in accessing coverage through the Health Insurance Marketplaces. The bill would require navigators to register with the Pennsylvania Department of Insurance, pay a registration fee, and pass a criminal background check. The bill also lists activities that Navigators are prohibited from engaging in, which includes responding to consumers questions about policy provisions or coverage. Violations of the prohibitions can result in fines up to $5,000. The Pennsylvania Insurance Department has opposed the legislation, stating that in the first year of open enrollment for the Marketplaces, there have been no complaints of inappropriate actions by Navigators. The bill now heads to the PA House for consideration; if passed, the provisions would go into effect in February of 2015, or as of the end of the 2015 open enrollment period, whichever is later.

State Takes Highmark to Court over Consent Decree Violation. On October 10, 2014, the Pittsburgh Post-Gazette reported that the Pennsylvania Attorney General's Office and the Departments of Health and Insurance have petitioned Commonwealth Court to find Highmark in contempt of a consent decree signed this past summer in the ongoing battle between Highmark and its rival UPMC. The state contends that Highmark violated the decree by offering a new narrow-network Medicare Advantage plan offering, which it calls Community Blue. The new Highmark Plan option features a $0 monthly premium, but the network does not include UPMC hospitals. According to the terms of the consent decree, Highmark had agreed to maintain UPMC facilities as "in network" for plans serving vulnerable populations, including Medicare recipients. Highmark contends that the consent decree was not meant to limit the establishment of new plan offerings and has said that state insurance regulators were aware that the Community Blue plan would be marketed during the current Medicare open enrollment period. Meanwhile, Highmark has counter-sued the state, asserting that state regulators do not have the authority to override CMS, which has already approved the Community Blue plan. Read more

South Carolina

South Carolina DHHS Director Tony Keck to Resign. On October 6, 2014, *FITSNEWS* reported that South Carolina Department of Health and Human Services director Tony Keck will resign within the next few months. Keck has held this position since 2011; under his direction, enrollment into the state's Medicaid program has increased dramatically. Enrollment is set to increase by 16 percent in the current fiscal year, even higher than the average 12 percent growth rate in states that have opted to expand Medicaid. Read more

National

Gilead Sciences Gets FDA Approval for New Hepatitis C Drug. On October 10, 2014, the *New York Times* reported that Harvoni, a new treatment for hepatitis C from Gilead Sciences, has won approval from the Food and Drug Administration. The new drug requires only a once-a-day pill, making it the first all-oral regimen for many patients infected with the virus. The drug is approved only for the genotype 1 subtype of the virus, which accounts for about 70 percent of cases in the United States. The treatment will cost $1,125 per pill, more than Gilead's current blockbuster hepatitis C treatment Sovaldi (which costs $1,000 per pill); but Harvoni can be taken for less time for many patients, and without additional drugs. Still, the high price of Harvoni has many insurers and state Medicaid programs concerned about how to accommodate demand for the drug. Read more

New Version of Healthcare.gov Will Be Streamlined, Easier to Use. On October 8, 2014, the *Los Angeles Times* reported that the federal government's revamped healthcare.gov website will work much more quickly and reliably this year. Last year's rocky rollout of the site prompted the website staff to perform full tests of the site this year beginning October 7, a full 5 ½ weeks before the next open enrollment period begins. Seventy percent of consumers will be able to use a new streamlined version of the site, which will cut the number of pages they need to click through to 16, down from 76 last year. The remaining 30 percent of consumers will be able to use the older enrollment system. After website testing is completed, officials will develop methods for more consumers to use the streamlined system. The new version of the site is also designed to work well on smartphones and other mobile devices, which was considered a top priority by consumers. Read more

Psychiatric Boarding a Continuing Concern in Many States. This month, *Governing* magazine reported on the growing nationwide problem of psychiatric boarding. As states continue to slash mental health budgets, about half of all states admit to boarding psychiatric patients in emergency rooms until beds in more appropriate facilities become available. Mental health officials argue that to prevent boarding and increase access to appropriate psychiatric services, states must increase capacity at psychiatric facilities while simultaneously providing more community-based care options such as mobile crisis units and case management teams. Read more

Industry News

Kindred Healthcare and Gentiva Health Services Reach Merger Agreement. On October 9, 2014, Kindred Healthcare, Inc., and Gentiva Health Services, Inc., announced that the companies have entered into a definitive merger agreement under which Kindred will acquire all outstanding shares of Gentiva common stock for $19.50 per share in a combination of cash and stock. Gentiva shareholders will receive $14.50 per share in cash and $5.00 of Kindred common stock; the total transaction is valued at $1.8 billion. The combined company will serve more than 1 million patients per year, operate in 47 states, and employ approximately 109,000 individuals, making it the 78th largest private employers and 4th largest healthcare employer in the United States. Read more

Carondelet Health Sells Two Kansas City Area Hospitals to Prime Healthcare Services. On October 14, 2014, the *Kansas City Star* reported that Carondelet Health (part of Ascension Health) signed a definitive agreement to sell its two Kansas City area hospitals, St. Joseph Medical Center and St. Mary's Medical Center, to for-profit hospital chain Prime Healthcare Services. The two hospitals can accommodate 450 beds and have 900 staffed physicians. The terms of the sale remain confidential. Read more

Extendicare Health Services to Pay $38 Million in Settlement. On October 10, *AP* reported that Extendicare Health Services, Inc., has agreed to pay $38 million in a settlement regarding allegations that it billed Medicare and Medicaid for substandard care at 33 facilities in eight states. The Justice Department accused the company of failing to provide appropriate care, follow safety protocols, or maintain enough skilled nurses. These actions led to injuries and additional health problems for some patients. The company has not admitted to any wrongdoing. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
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 Webinar: *"Managed Care and Individuals with Intellectual and Developmental Disabilities: Innovative Approaches to Care Coordination"*

Tuesday, November 4, 2014
1:00 PM Eastern
Register Here

There is a growing focus among states on improved care coordination for Individuals with Intellectual and Developmental Disabilities (I/DD). Strategies vary, from traditional managed care arrangements to accountable care organizations and innovative partnerships involving physicians, hospitals, developmental disability and behavioral health providers, nursing homes, and others. During this webinar, HMA's Shane Spotts, a leading expert on trends in managed care and I/DD, will provide an overview of the most recent initiatives, including an assessment of what's working and why.

HMA's Accountable Care Institute Launches Quarterly Case Studies

As part of its effort to share experiences related to the development of community-specific integrated delivery systems that provide a better patient experience, control costs, and provide vehicles for the integration of medical, behavioral, and social approaches to maintaining and enhancing health status, the Accountable Care Institute (ACI) has launched an initiative to send and post relevant case studies on a quarterly basis that describe a specific health care challenge, solution, and the subsequent results. To receive these quarterly case studies, please sign up here. To see the first ACI case study that was released last week on Cook County Health and Hospital System, please click here.

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

Sandra Sperry, Principal – Chicago, Illinois

Sandra comes to HMA most recently from her own consulting company, SPS and Associates, LLC, where she has been the Principal and CEO for the last 10 years. Some of the engagements that Sandra has had through SPS include executive management compliance coaching resulting in redesign of assessment and documentation for national Medicare Advantage contractor; business development consultation to East Coast revenue cycle firm including proposal development, presentation, compliance consultation, and redesign of business templates; assessment of case management systems and infrastructure supporting pay-for-performance, ICD-10 conversion, and compliance sensitive documentation; and JCAH and Magnate readiness preparation.

Prior to her role with SPS, Sandra was a Principal and Executive Vice President with Managed Transitions, LLC in New Jersey. Here she did consultations that included strategic planning, executive team coaching, and regulatory response/planning for an evolving health system in NC. She also served as the interim EVP/COO for a three-hospital system in one of Chicago's culturally diverse and economically challenged communities with a 75% Medicaid payer base.

Additional roles that Sandra has served in include Senior Vice President/Chief Operating Officer and Senior Vice President/Patient Services for New York University Downtown Hospital; New York University Medical Center; Morton Plant Hospital and Health System in Clearwater, Florida; and Children's Memorial Hospital in Chicago.

Sandra received her MS in Nursing from the University of Phoenix. She was a Johnson & Johnson Wharton Fellow with the Wharton School at the University of Pennsylvania and received an Advanced Professional Certificate in Quantitative Analysis and Health Planning from New York University. Sandra received her Master of Public Administration/Health Care Administration from New York University and a BA in Psychology from Northeastern Illinois University. She is a Fellow of the American College of Healthcare Executives, a Certified Master Executive Coach with the Behavioral Coaching Institute, and a licensed RN in New York.

Margaret Tatar, Principal – Sacramento, California

Margaret comes to HMA most recently from the California Department of Health Care Services, where she served as the Assistant Deputy Director of Delivery Systems for the past few years. In this role, Margaret managed initiatives related to the state's shift to managed care, including the transition of over 300,000 seniors and persons with disabilities to managed care, transition of the Healthy Families Program to managed care, expansion of California's remaining fee-for-service counties to managed care; transition of Low Income Health Program to managed care; CA Duals Demonstration program, Cal MediConnect, and mandatory long term services and supports in eight counties, and Medi-Cal expansion as authorized by ACA. Additional responsibilities included the introduction of matrix management to promote efficiencies/collaboration across divisions; development and promotion of training programs to promote enhanced understanding of managed care

delivery systems; and the development of publicly assessable dashboards to measure efficacy of programs and promote transparency.

Prior to her role with the Department of Health Care Services, Margaret was the Executive Director of Public Affairs for CalOptima for nine years. Here she lead all public affairs, key external communications, and strategic alliances for the agency. Margaret managed all state and federal representatives, including Sacramento-based lobbyists, local communications consultants, and DC lobbyists. She directed the development and management of all plan policies and procedures, including internal committees to support effective and thorough policy review and approval.

Margaret has also served as Policy and Planning Manager for the County of Orange, Office on Aging; District Office, California Assembly Member for Assemblywoman Lynn Daucher, 72nd California Assembly District; Senior Legislative Attorney for the Colorado General Assembly, Office of Legislative Legal Services; Chief Legislative Counsel for the Federated States of Micronesia, Yap State Legislature. She was also in private practice in Pennsylvania.

Margaret received her J.D. from Villanova University School of Law and her BA in Latin with a concentration in French from Bryn Mawr College in Pennsylvania.