HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 3, 2014

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Kartik Raju
Email

THIS WEEK

- IN FOCUS: UPDATE ON NEW YORK DSRIP PROGRAM
- HEALTHYPA MEDICAID EXPANSION WAIVER APPROVED
- COLORADO LAUNCHES MFFS DUALS DEMO
- INDIANA HIP 2.0 WAIVER POSTED FOR PUBLIC COMMENT
- TENNESSEE, WYOMING GOVERNORS CONSIDER MEDICAID EXPANSION OPTIONS
- GEORGIA ANNOUNCES INTENT TO AWARD BEHAVIORAL ASO CONTRACT TO VALUEOPTIONS
- GEORGIA BUDGETS FOR ELEVATED HEP C TREATMENT EXPENSES
- NEW JERSEY RELEASES DETAILS ON ACO DEMONSTRATION APPLICANTS
- HOSPITAL MERGER ACTIVITY CONTINUES IN NEW YORK
- COUNIHAN NAMED CMS MARKETPLACE CEO
- STEHLE NAMED ARKANSAS MEDICAID DIRECTOR
- MICHIGAN DCH DIRECTOR HAVEMAN STEPS DOWN
- CENTENE ANNOUNCES NEW CLAIMS PROCESSING CENTER IN FERGUSON, MISSOURI
- PEAL TO JOIN WELLCARE AS DIRECTOR OF BUSINESS DEVELOPMENT

IN FOCUS

UPDATE ON NEW YORK DELIVERY SYSTEM REFORM INCENTIVE PAYMENT PROGRAM

This week our *In Focus* section comes to us from HMA Principal Denise Soffel in our New York office. Denise provides an overview and update on New York's Delivery System Reform Incentive Payment (DSRIP) program, which is aiming to drive Medicaid savings through a shift towards greater community-based care delivery.

NY DSRIP Update

In April 2014 CMS approved New York State's Section 1115 Medicaid waiver request, in the amount of $8 billion over five years. Most of the funding, $6.4 billion, is going toward a DSRIP program. The DSRIP program is designed to achieve a 25 percent reduction in avoidable hospital use among the Medicaid population, including avoidable readmissions, admissions for ambulatory-sensitive conditions, and avoidable emergency department visits. An explicit goal of New York's DSRIP program is the transformation of the health care delivery system, directing care away from hospital use and toward a community-based delivery system. The program is also designed to move payment from a fee-for-service model and into value-based purchasing arrangements, with risk being shared among groups of providers. Finally, DSRIP is meant to be a collaboration among health care providers, social service providers and community-based organizations, working together in a Performing Provider System (PPS) to improve population health. Money will be distributed upon achievement of predetermined metrics and milestones; incentive payments are not guaranteed. Finally, the agreement with CMS requires that milestones be achieved state-wide. Should some PPSs or some geographic regions fail to meet delivery system improvement metrics, incentive payments to all PPSs will be reduced.

Last month in response to public comment, New York State announced some modifications to its planned DSRIP program. Three changes were introduced: a new project was added to the DSRIP menu; the attribution logic that assigns Medicaid beneficiaries to Performing Provider Systems (PPSs) was revised; and the way that project valuation is calculated was modified.

New Project – "The 11th Project"

The state had been encouraged to find a way to bring uninsured New Yorkers into the DSRIP project, so PPSs would be incentivized reach out to the uninsured and target them for inclusion in specific DSRIP projects. The state also recognized that it has a sizeable number of Medicaid beneficiaries that, while enrolled in the program, were unconnected to the delivery system and had no or minimal utilization of health care services. In response to these two concerns, CMS and the state agreed to create a new project, "Patient and Community Activation for Uninsured, Non-Utilizing and Low-Utilizing Populations."

The project has two components: to improve patient activation and engagement in their own health care, and to increase the use of primary and preventive care. The project will use the Patient Activation Measure (PAM) as a way of monitoring changes in individual patient self-management capability. Each PPS will establish its baseline PAM score based on a sample of uninsured, non- and low-utilizing patients in its PPS, and those scores will be monitored over the life of the DSRIP project to measure the effectiveness of the PPS in improving patient-level knowledge and activation. The project comes with a very high index score (which reflects the complexity of the given DSRIP project) – 56 out of 60 points – and will effectively be available to only public hospitals across the state, as they have the right of first refusal for the 11th project. Given its impact on overall project valuation, it is likely that every public hospital will in fact take on the 11th project.

Changes in Attribution

Attribution is the process by which Medicaid beneficiaries are assigned to a PPS. Each Medicaid beneficiary can be assigned to only one PPS, but not all Medicaid beneficiaries will necessarily be assigned. The attribution algorithm uses geography, patient visit patterns and loyalty, and primary care provider assignment to attribute a member to a PPS.

Over 1 million Medicaid enrollees use no Medicaid services over the course of a given year. An additional 750,000 have fewer than three visits and demonstrate no connection to a primary care provider. These Medicaid beneficiaries will not be attributed to a PPS and will not contribute to PPS project valuation, except for two circumstances: the PPS has decided to participate in the 11th project, or the PPS is the sole PPS operating in that geographic region. In those cases, all Medicaid beneficiaries, including non-users and low-utilizers, will be attributed to the PPS. Further, for those PPSs participating in the 11th project, all uninsured in the region will also be attributed to the PPS.

In recognition that some populations use unique networks of services, the attribution formula will begin by identifying three population subcategories and assigning those beneficiaries to a PPS based on a loyalty algorithm that is specific to their population subcategory. The three populations are developmental disabilities, long-term care, and behavioral health. The Department of Health estimates that these groups represent fewer than 1 million beneficiaries. All other Medicaid beneficiaries will be attributed based on utilization and loyalty patterns, with a five-step assignment algorithm. The first consideration is whether they are enrolled in a health home; then by whether they have a primary care provider associated with a PPS; where they receive ambulatory care; whether they have had an emergency department visit, and finally whether they have had an inpatient stay. This revision strengthens the importance of connection to care management, either through a health home or through a PCP.

Project Valuation

Beneficiary attribution is directly related to project valuation and therefore to the maximum incentive payment potentially available to the PPS. Maximum project valuation is calculated by multiplying a number of factors for each DSRIP project undertaken, summed across all the projects:

- Project index score, which reflects the complexity of the given DSRIP project;
- Project plan application score, reflecting the quality of the overall PPS application;
- Number of attributed beneficiaries (Medicaid, non-and low-utilizing as appropriate, uninsured as appropriate)

PPSs approved to do the 11th project will get a 10-point bonus added to their project plan application score, further increasing project valuation, in recognition of the challenge and cost of outreach to these populations. The state has further suggested that PPSs that are the sole PPS in a geographic region may be awarded additional bonus points.

New Guidance on Creating Integrated Delivery Systems

The state released a new version of the Project Toolkit that provides a more detailed description of the state's expectations for PPSs planning to become integrated delivery systems. The DSRIP project *Create Integrated Delivery Systems that are focused on Evidence-Based Medicine/Population Health Management* has the highest project index score of all the DSRIP projects. Below is a summary of the components of the project.

Rationale

Reducing avoidable hospital activity requires a new vision, with the formation of an integrated delivery system that is community-oriented and incorporates the full continuum of patient care needs including medical, behavioral, long term care, post-acute, and social. This new vision will require an organizational structure with committed leadership, clear governance and communication channels, a clinically integrated provider network, and financial levers to incentivize and sustain interventions to holistically address the health of the attributed populations.

An integrated delivery system will need to demonstrate how it will function as a "coordinated network" and not as configuration of independent organizations. An integrated delivery system will expand access to high-quality primary care, participate in payment reform, rebalance/restructure health delivery (including hospital and nursing home bed reduction), enhance community-based services (especially behavioral health services), and be driven by a comprehensive community needs assessment and an internal emphasis on quality improvement.

Core Components

- Develop a clearly articulated governance model for the IDS, incorporating participating providers and meaningful consumer and patient representation. The governance model should also promote increased collective accountability for quality of care improvements.
- Health Homes (HH) and Accountable Care Organizations (ACOs) are encouraged to consider evolving into IDSs. True integration requires a broader governance structure, broader health information-sharing capabilities, real service integration, and a vision that incorporates a population management strategy that is more in depth than that applied to the populations eligible for Health Home or ACO services in their current system.
- Re-balance the health care delivery system in ways that are consistent with the health care needs of the community served. Each IDS will need to complete and continuously update a comprehensive community-based health needs assessment and develop and implement a comprehensive strategy and action plan for development of ambulatory/community-based health care services, acute care bed reduction, and development of key community partnerships including primary care services, behavioral health services, long term care, pharmacy, school based health clinics, social services including social support services, housing, and Health Homes, public safety/criminal justice, and local governmental units.

- Ensure that patients requiring care coordination receive appropriate health care, including integrated medical and behavioral health care, post-acute care, long term care, and social and public health services. These activities should be done in concert with relevant Health Homes and Medicaid Managed Care Plans. Any patients admitted to any hospital in the IDS should have access to well-coordinated discharge planning and systems for tracking care outside of hospitals, to ensure that all critical follow-up services are in place and recommendations are followed.
- By DSRIP Year 3, all eligible participating providers in the Performing Provider System's integrated delivery system will need to be connected to the local Regional Health Information Organization (RHIO)/Statewide Health Information Network of New York (SHIN-NY) and be actively sharing information across all key clinical partners.
- Expand access to high-quality primary care based upon the findings of the community needs assessment. This expansion will require both an increase in primary care capacity and a commitment to meeting 2014 Level 3 PCMH standards and/or the standards established by the state for the Advanced Primary Care Model by Year 3 of DSRIP.
- Contract with Medicaid Managed Care and other payers as a single system and be paid using a value-driven payment system. Systems will need to prepare to take on performance risk and possibly insurance risk as part of their drive toward payment reform.
- Evolve the provider compensation and performance management systems to reward providers for improved patient outcomes through the provision of high-quality, coordinated care.
- Develop process improvement capabilities and strategies such as Lean to ensure efficiency and effectiveness within the delivery system.
- Utilize, where appropriate, community health workers, Peers and culturally competent community-based organizations to assist with patient outreach and navigation.
- Demonstrate a clear cultural competence and willingness to engage Medicaid members in the design and implementation of system transformation, including addressing issues of health disparities.

HMA
MEDICAID
ROUNDUP

Arkansas

DHS Names Dawn Stehle State Medicaid Director. On August 25, 2014, the *Arkansas News Bureau* reported that the Arkansas Department of Human Services has named Dawn Stehle as the State Medicaid Director. Stehle was named interim Medicaid Director after former Director Andy Allison stepped down in June. Stehle has been working in the DHS since 2006 and most recently served as the Director of Health Care Innovation. Read more

California

HMA Roundup – Alana Ketchel

Health-related Bills Reach Governor for Signature. The governor has until September 30, 2014, to sign into law a number of healthcare-related bills that have passed the Legislature. Some of these bills include the following:

- **SB964** – Requires DMHC to perform annual reviews for access to care and network adequacy separately for Medi-Cal managed care and the individual market.
- **SB 1124** – Limit Medi-Cal estate recovery funding to long-term care.
- **SB 18** – Ensures state accepts $6 million from the California Endowment to fund Medi-Cal renewal assistance, with a federal match.
- **AB 1522** – Mandates up to three days of paid sick leave a year for part-time and temporary workers, excluding home health care workers.
- **AB 1174** – Establishes a Virtual Dental Home demonstration project to expand access to preventive dental services for underserved children.

Ventura County Medi-Cal Health Plan Subpoenaed for Records of Financial Dealings with State Medicaid Contractor. On August 29, 2014, the *Los Angeles Times* reported that the California attorney general's office has issued a subpoena to Ventura County's Medi-Cal health plan, Gold Coast Health Plan, as part of an investigation into the financial dealings between the health plan and Medicaid contractor Xerox Corp. The health plan paid Xerox $2.3 million in 2010 to manage its operations and Medicaid claims; an April 2014 audit faulted Gold Coast for outsourcing too much operational control to Xerox. Read more

Medi-Cal Asset Seizure Bill Passes Unanimously in State Senate and Assembly. On August 27, 2014, the *San Jose Mercury News* reported that the California Senate and Assembly unanimously approved a bill that would limit

the state's ability to seize assets from the estates of Medi-Cal recipients. The bill addresses a federal government allowance for states to recover assets from Medi-Cal recipients 55 and older after they die to recoup the expenses of health care services. If signed into law, the bill would prohibit the state from recovering from estates of surviving spouses and would provide ways for beneficiaries to find out how much of their estate is "recoverable" upon the beneficiary's death. The bill now heads to Governor Jerry Brown's desk for consideration. Read more

California Prisons Begin Using High-Priced Hepatitis C Drug Sovaldi. On August 25, 2014, the *California Healthline* reported that California Correctional Health Care Services began using Sovaldi last month to treat inmates infected with hepatitis C virus. Sovaldi, which offers high efficacy in treating hepatitis C without many of the debilitating side effects of other treatments, has made headlines for its extremely high cost of around $84,000 for a full course of treatment. About 93,000 Californians in Medi-Cal and in the state prison system have chronic hepatitis C; treating all of these individuals with Sovaldi would cost the state around $6.6 billion. Because prison systems typically pay full retail prices for drugs, the cost of Sovaldi could significantly affect the system's budget. Read more

Field Poll Shows Californians in Favor of Tougher Rules on Health Insurance Rates. On August 20, 2014, *Kaiser Health News* reported that California residents are showing strong support for Proposition 45, which would give the state's insurance commissioner the power the veto health insurance rate increases. Health insurance rates in the state are currently overseen by the Department of Managed Health Care and the California Department of Insurance; the Departments do not have the power to block rate changes by insurance companies. Opponents of Proposition 45 argue that negotiating with the government on rates could lead some insurers to pull out of the market, which would have an especially strong impact in areas with limited insurance coverage. Read more

Covered California to Offer Adult Dental Coverage. On August 20, 2014, Covered California announced it will offer new family dental plans in early 2015 for an additional cost. In addition, all individual insurance plans will offer pediatric dental benefits. Enrollment in a family dental plan is optional. The primary intent is to expand access to affordable dental coverage. Read more

Medi-Cal Beneficiaries Denied Access to Genetic Testing. On August 20, 2014, the *San Francisco Chronicle* reported that Medi-Cal beneficiaries still lack access to genetic testing. In 2001, Medi-Cal implemented a moratorium on new medical service providers, including labs that provide genetic testing. This has left beneficiaries without access to new, more effective, and cheaper genetic testing technologies, going against federal guidelines which authorize a variety of genetic tests for eligible pediatric patients. California Children's Services programs around the state are assessing the scope of the problem. Read more

Audit Reveals Medi-Cal Drug Deficiencies. On August 19, 2014, the California State Auditor released a report concerning the Department of Health Care Services' (DHCS) administration of the Medi-Cal Drug Treatment Program, which offers substance abuse services to Medi-Cal beneficiaries. Auditors found that the state's poor coordination and lack of oversight allowed for fraudulent activity, including approving payment to ineligible providers and paying claims

for deceased patients. DHCS offered a response that details how it will carry out the auditors' recommendations. Read more

Colorado

HMA Roundup – Joan Henneberry

HCPF Begins Enrollment into the Accountable Care Collaborative Medicare-Medicaid Program. In its August newsletter, the Department of Health Care Policy and Finance announced that it is partnering with CMS to implement a new program designed to better coordinate care for clients who are eligible for both Medicare and Medicaid. After two years of negotiating one of the few fee-for-service dual demonstration models, Medicaid began enrolling full benefit Medicare and Medicaid clients into the Accountable Care Collaborative (ACC): Medicare-Medicaid Program on September 1, 2014. The program will integrate and coordinate physical, behavioral, and social health needs for over 50,000 full-benefit Medicare-Medicaid clients. The initiative builds on the infrastructure, resources, and provider network found in the Accountable Care Collaborative (ACC) Program, which connects clients with providers, community services, and social services to help meet client needs. Clients who participate in this program keep all their Medicare and Medicaid benefits and services and now have free assistance to achieve their health care goals and make Medicare and Medicaid work better together for them. Clients have the right to keep all their current benefits and the same doctors. Full benefit Medicare-Medicaid enrollees that are not already participating in an integrated system of care will be passively enrolled in the program and are able to opt-out of the program if they wish. The Department will phase in enrollment for this program, enrolling approximately 7,500 clients over the next seven months. The first group of clients received enrollment materials the last week of July. Read more

HCPF Releases Home and Community Based Services (HCBS) Transition Plan. In its August newsletter, the Department of Health Care Policy and Finance reported on its Home and Community Based Services (HCBS) Transition Plan. In January 2014, CMS issued the final rule for HCBS settings, to be in effect March 2014. These rules require assurances that all residential and non-residential service settings allow individuals to reside in home-like settings and be integrated fully in their communities. CMS mandated that all states must submit a transition plan explaining how the new rules will be implemented within the next five years. This requirement includes an overall transition plan as well as a transition plan for each waiver. Colorado has created a state plan, which can be found here. Comments regarding the Draft Transition Plan are due by September 10, 2014.

Florida

HMA Roundup – Elaine Peters

AHCA Releases Statewide Medicaid Enrollment Numbers for August. On August 21, 2014, the *Tallahassee Democrat* reported that only one-third of Medicaid recipients transitioning into Managed Medical Assistance (MMA), or managed care, statewide chose their own health insurance plan, according to the Agency for Health Care Administration (AHCA). Those who did not select a plan were automatically enrolled into one by the state. Enrollment for the general Medicaid population started in May and ended in August. About 2.66

million (75 percent) of the state's 3.53 million Medicaid beneficiaries have been enrolled into an MMA Plan; this includes 2.54 million beneficiaries enrolled in Standard MMA plans and 117,000 beneficiaries enrolled in Specialty MMA plans. About 870,000 residents are still enrolled in fee-for-service Medicaid; it is likely that a portion of these enrollees are in the midst of transitioning to an MMA plan. Fourteen insurance companies signed five-year contracts to provide services in the regular Medicaid program. Staywell (WellCare), Sunshine Health (Centene), and Amerigroup have the largest presence statewide. Comprehensive statewide MMA enrollment (by region) is provided in the tables below. Read more

Comprehensive Statewide Medicaid Enrollment August 2014								
Total MMA	Type	R1	R2	R3	R4	R5	R6	R7
TOTAL MMA STANDARD & SPECIALTY	MMA	86,144	100,561	223,913	264,884	161,587	369,989	339,764
PACE	PACE					149	1	
MEDIPASS*	MPASS	117	29	74	27	8	47	156
FEE FOR SERVICE	FFS	30,138	29,327	78,006	81,242	61,409	109,477	108,911
FEE FOR SERVICE - out of state	FFS							
TOTAL ALL		116,399	129,917	301,993	346,153	223,153	479,514	448,831

Comprehensive Statewide Medicaid Enrollment August 2014							
Total MMA	Type	R8	R9	R10	R11	TOTAL	Market Share
TOTAL MMA STANDARD & SPECIALTY	MMA	184,764	222,537	224,064	479,952	2,658,159	75.30%
PACE	PACE	224	80		389	843	0.00%
MEDIPASS*	MPASS	48	284	11	57	858	0.00%
FEE FOR SERVICE	FFS	53,137	71,762	73,223	173,892	870,524	24.60%
FEE FOR SERVICE - out of state	FFS					1,561	
TOTAL ALL		238,173	294,663	297,298	654,290	3,531,945	100.00%

Georgia

Department of Behavioral Health and Developmental Disabilities Selects ASO Vendor. On September 2, 2014, the Georgia Department of Behavioral Health and Developmental Disabilities posted its Notice of Intent to Award the Administrative Services Organization (ASO) contract to ValueOptions for a fixed contract price of just under $7.7 million. Read more

DCH Approves Amended FY 2015 Budget and Proposed FY 2016 Budget. On August 28, 2014, the Department of Community Health (DCH) met and approved the Amended FY 2015 budget, along with the proposed FY 2016 budget. Of note in the Amended FY 2015 budget is a $24 million increase in state funds to pay for expensive hepatitis C drugs (for a total of $70 million in funds), as well as a $21 million increase in state funds to pay for various ACA effects (including presumptive eligibility and 12-month eligibility). The Amended budget also restored a cut for unrealized savings from the ABD Care Management RFP, which could be implemented in late spring 2015. The 2016 budget proposes allocating $18 million in state funds to cover the initial costs associated with the ABD Care Management contractor. Both budgets will be sent to the Governor's Office of Planning and Budget for consideration and potential inclusion in the Governor's proposal in the overall state budget. Read more

Nearly One-Third of Georgia Medicaid Applications Still in Limbo Due to Technological Issues. On August 27, 2014, the *Atlanta Journal-Constitution/Kaiser Health News* reported that roughly one-third of Georgia's Medicaid applicants, or 27,000 residents, are still unsure if they will get

Medicaid coverage months after applying for Medicaid through the state's health insurance marketplace. The delay in processing these applications was the result of communication problems between the state and federal governments' computers. While the state has managed to process 70 percent of backlogged applications, it is unclear how long it will take to process the remaining applications that are still in limbo. Read more

Idaho

DHHS Investigates Optum Idaho for Possible Breaches in Patient Privacy. On August 29, 2014, *AP*/the *Miami Herald* reported that the U.S. Department of Health and Human Services is investigating state Medicaid behavioral health program contractor Optum Idaho for possibly violating patient-privacy laws. Several health care providers have reported that Optum sent them patient information meant for other providers. Optum officials said they have fixed the problem and that none of the patient information went outside the network of providers. Read more

Providers Report Untimely Payments, Decreased Services from State Medicaid Contractor Optum. On August 25, 2014, AP/the *Merced Sun-Star* reported that service providers across the state are raising complaints that Optum Idaho has provided inadequate and untimely reimbursements and cut services needed by at-risk patients. Optum, a unit of United Behavioral Health, was hired by the state 11 months ago to help the state transition from Medicaid fee-for-service to managed care. But providers have reported receiving pennies on the dollar for their services, forcing them to take out lines of credit to pay their staff and keep their doors open. The Department of Health and Welfare has no plans to fine or sue Optum over the payment issue, citing that Optum is doing its job and rectifying payment issues. Providers also report that Optum has cut back community-based rehabilitation services, which providers warn could lead to increased hospitalization rates. Read more

Illinois

HMA Roundup – Andrew Fairgrieve

Illinois Exchange Draws Interest from Three New Players in 2015. On August 21, 2014, the *Chicago Tribune* reported that three new insurers are planning to offer qualified health plans on the Illinois Exchange in 2015. UnitedHealthcare and Assurant Health are the two traditional insurers planning to enter the Illinois market. United participated in a limited number of state Exchanges in 2014, while Assurant Health is planning to enter the Exchange market for the first time in 2015, targeting 16 states. The third new entrant is a partnership between Centene's IlliniCare, which participated in 2014, and two Chicago hospitals, Swedish Covenant and Sinai Health System. Read more

Illinois' Shared MMIS Project with Michigan Progressing Slowly. On August 27, 2014, *Government Technology* reported that the shared Medicaid Management Information System (MMIS) project between Illinois and Michigan is still years away from full implementation. The delay is reportedly due to a November 2013 decision to address the governance model between CMS and the states, rather than move into the provider enrollment stage, which is now more than six

months behind schedule. The shared MMIS project is now targeting July 2018 for a tentative finish date. Read more

Cook County Health and Hospitals System Renegotiates CountyCare Administration Contract. On August 29, 2014, *Crain's Chicago Business* reported that the Cook County Health and Hospitals System is renegotiating its contract to administer CountyCare, its Medicaid managed-care program. The amended contract with IlliniCare Health Plan Inc. will be shortened to three years, with the option for two one-year extensions. The total contract amount will drop by $216 million to just under $1.58 billion. Centene Corporation, the vendor hired to manage coverage for CountyCare members, will be asked to manage coverage for 150,000 people, 28 percent more than anticipated when the contract was first signed four months ago. County health officials say that the changes were necessary because the additional members, most of whom have been covered in traditional fee-for-service Medicaid, have different health needs than the 115,000 adults newly insured through ACA Medicaid expansion. Read more

Cook County Considers $70 Million Contract With ACO to Coordinate Patient Care. On August 26, 2014, *Crain's Chicago Business* reported that the Cook County Health and Hospitals System is proposing to spend up to $70 million with a new for-profit company called Medical Home Network ACO to coordinate the treatment of about 80,000 Medicaid patients. Medical Home Network ACO uses data analysis to help facilities and providers provide better coordinated care for Medicaid beneficiaries, who often receive care from multiple providers. By improving communication between the various providers and facilities that treat each Medicaid patient, the ACO aims to reduce healthcare costs and improve health outcomes. Read more

Indiana

CMS Posts Healthy Indiana Plan 2.0 1115 Waiver. On August 22, 2014, CMS reported to Indiana Medicaid Director that the Healthy Indiana Plan (HIP) 2.0 1115 waiver application meets the requirements for a complete application request. HIP 2.0 proposes to provide a high-deductible health plan and an account similar to a health savings account called a "Personal Wellness and Responsibility (POWER) Account" to uninsured adults ages 19 through 64 with incomes up to 133 percent of the federal poverty level. The waiver has now been posted on Medicaid.gov, with public comment period from August 22, 2014, through September 21, 2014.

Massachusetts

MassHealth to Suspend One Care Passive Enrollment in Month of October. On August 20, 2014, the Community Catalyst reported in its *Dual Agenda* newsletter that MassHealth has cancelled the October round of passive enrollment into its One Care managed care plans for dual eligibles. Members of the Disability Advocates Advancing Our Healthcare Rights coalition support this decision, arguing that without hard data, it is difficult to determine what the consumer experience is like under the One Care plans. Suspending passive enrollment for October will give participating plans and the state time to assess the quality of care and services being provided to enrollees and will allow plans to build capacity to accommodate the needs to current and future members. Read more

Michigan

HMA Roundup – Eileen Ellis (Email) and Esther Reagan (Email)

From the HMA Michigan Update:

DCH Director James Haveman Steps Down. On August 28, 2014, Governor Rick Snyder announced that Michigan Department of Community Health (DCH) Director James Haveman has resigned effective September 12, to focus on his health. Mr. Haveman was appointed to the DCH position in 2012, a position he also held from 1996 to 2003; he served previously as the Department of Mental Health director from 1991 to 1996. Governor Snyder has named DCH Deputy Director Nick Lyon as the next department director. Read more

Medicaid Managed Care Enrollment Activity. As of August 1, 2014, there were 1,479,675 Medicaid beneficiaries, including Healthy Michigan Plan (HMP) beneficiaries, enrolled in 13 Medicaid Health Plans (HMOs); this is a net decrease of 69,089 since July. The enrollment total reflects an increase of 81,523 new HMP enrollees since July but a decrease of 150,612 non-HMP Medicaid enrollees. The Michigan Department of Community Health (DCH) stated that the significant decrease in non-HMP enrollees was, in part, because the federal government permitted the state to delay processing Medicaid redeterminations (and case closures) for the first four months of the calendar year. Whether there were other issues affecting this enrollment decline was still being investigated by DCH at press time. As the enrollment reports reflect, every county in the state is served by at least one Medicaid Health Plan. Auto-assignment of beneficiaries into the HMOs is now in place in every county in the state, and there are at least two HMOs serving every county in the Lower Peninsula. Beneficiaries in all 15 counties in the Upper Peninsula are auto-assigned, through the federal "Rural Exception" authority, to the one HMO serving the counties, the Upper Peninsula Health Plan.

Healthy Michigan Plan Enrollment. Enrollment in the Healthy Michigan Plan (HMP) continues to grow. The Michigan Department of Community Health (DCH) reports that between April 1 and August 25, 2014, a total of 373,171 individuals were approved for HMP coverage. Read more

Minnesota

Home Care Workers Unionize, But Support is Not Unanimous. In August 27, 2014, the *Star Tribune* reported that nearly 27,000 home care workers in Minnesota will join the Service Employees International Union after an August 26 vote, representing one of the largest union expansion efforts in the state's history. Workers who supported the unionization argue that they will now have access to better training and more negotiating power to get higher pay and better job stability. But some workers have expressed explicit desire not to have union affiliation imposed on them. Because of this, the vote is very likely to trigger a legal challenge. Read more

Mississippi

For 2015 State Insurance Exchange, Magnolia Premium Rates to Decrease, While Humana Rates Will Increase. On August 22, 2014, the *Mississippi Business Journal* reported on premium rates for health plans being offered within and outside of the state's health insurance Exchange in 2015. The two insurers participating in the Exchange, Humana and Magnolia Health Plan, cover about 42,000 people and 20,000 people, respectively. Those insured on the Exchange by Magnolia can expect premiums to go down by 25 percent. Meanwhile, those insured with Humana can expect to pay 6.5 percent more in premiums. Residents on group plans offered outside of the Exchange will see higher premiums as well. Read more

Missouri

Call Center Delays Impede Medicaid Sign Ups. On September 2, 2014, *WGEM* reported that Missourians trying to use a call center to sign up for the state's Medicaid program are experiencing long delays, prompting many to hang up. The Department of Social Services has told YoungWilliams, the company that runs the call center, to correct the problems within five business days of August 29 or the state might withhold 10 percent of the company's next monthly payment. Read more

Nevada

CMS Agrees to Double Reimbursement Rate for Inpatient Psychiatric Care. On August 30, 2014, the Nevada Appeal reported that CMS has approved Nevada's request to more than double the reimbursement rate for inpatient psychiatric services in hospitals. The daily reimbursement rate will increase from $460 to $944. The new rate is retroactive to July 1. The reimbursement increase could encourage facilities to provide adult inpatient psychiatric care, which could help accommodate the behavioral health needs of the state's Medicaid expansion population. Read more

New Jersey

HMA Roundup – Karen Brodsky (Email)

DMAHS Releases Details on ACO Demonstration Applicants. The State Department of Human Services, Division of Medical Assistance and Health Services released the details of applications it has received for a three-year Accountable Care Organization demonstration project. Applicants are required to be a nonprofit organization serving a minimum of 5,000 Medicaid beneficiaries within a designated region. The ACOs will be required to contract with 100 percent of the hospitals, 75 percent of the primary care providers, and at least four mental health providers within the intended service region. The Department received eight applications for the ACO demonstration:

ACO Demonstration Applicants		
Applicant Name	**Service Area**	**# Medicaid beneficiaries in proposed service area**
Camden Coalition of Healthcare Providers (CCHP)	City of Camden (Zip Codes 08101, 08102, 08103, 08104, 08105)	35,178
Coastal Healthcare Coalition, Inc.	City of Atlantic City (Zip codes 08401, 08404, 08405) and Ventnor City (Zip Code 08406)	14,647 Medicaid cases in 2013
Greater Newark Health Care Coalition	Newark (Zip Codes 07103, 07108, and 07112)	35840
New Brunswick Health Partners	City of New Brunswick and adjacent Franklin Township (Zip Codes 08901, 08903, 08873)	6,000
Passaic County Comprehensive ACO, Inc.	Paterson (Zip Codes 07501,07502,07503)	15,000
Healthy Cumberland Initiative, Inc.	Cumberland County (Zip Codes 08302, 08311, 08314, 08323, 08324, 08327, 08332, 08345, 08349, 08353, 08360, 08361)	27,952
Healthy Gloucester Initiative, Inc.	Gloucester County (Zip Codes 08066, 08096, 08097)	5,659
Trenton Health Team	City of Trenton (Zip Codes 08608, 08609, 08611, 08618, 08629, 08638)	47,271
TOTAL	-	**187,547**
SOURCE: NJ DMAHS		

The total number of Medicaid beneficiaries covered in the applicants' proposed service areas represent 11.6 percent of the Medicaid lives covered in the state. Applicants will be required to submit a Gainsharing Plan to the Department within 12 months of acceptance into the ACO Demonstration project. Each applicant has also established a Quality Committee to develop a common set of quality standards (based on a list of mandatory and voluntary quality measures provided by the state) for ACO-participating members. The Quality Committee must also take baseline quality measurements for providers and establish remedial actions to advise underperforming providers. The state accepted comments on the ACO applications through August 27, 2014. Read more

New Mexico

Lawsuit Argues Medicaid Evaluations Could Jeopardize Services for the Disabled. On August 24, 2014, *AP/KRQE* reported that New Mexico families that include members with developmental disabilities are suing the state on the grounds that a new method for evaluating Medicaid services eligibility puts beneficiaries at risk of losing their services. The family members filed the lawsuit in January after their loved ones lost some of their services. The office of Governor Susana Martinez says that the changes in determining eligibility were meant to get people off waiting lists for services. Read more

New York

HMA Roundup – Denise Soffel

Hospital Mergers Continue. Continuing a wave of hospital mergers across NYS, Hudson Valley Hospital Center has taken the first steps to pursue a partnership with New York-Presbyterian Health System. The hospital's Board of Directors voted unanimously to pursue the affiliation, which would require state approval.

In Rochester, two additional hospitals have indicated they plan to join the Rochester Regional Health System. United Memorial Medical Center and Clifton Springs Hospital have approved agreements to join the system, which was formed earlier this year through the merger of Rochester General and Unity Health Systems.

Crain's reports that NYU Langone has been engaged in talks with Lutheran HealthCare regarding options to work together in Brooklyn in some type of strategic partnership, although no official agreement has been reached.

Certificate of Public Advantage Regulations Posted. The state has posted proposed regulations that establish a process to encourage appropriate collaborative arrangements among health care providers who might otherwise be competitors, if the benefits of such arrangements outweigh any disadvantages likely to result from a reduction of competition. Competitors who want to collaborate under the state's DSRIP program can apply for a Certificate of Public Advantage (COPA). COPA would allow for the sharing and referral of patients, technology, staff, medical, diagnostic of laboratory facilities including "the implementation of clinical integration programs and payment mechanisms that involve the sharing of data and resources to develop, implement and monitor the effectiveness of, and adherence to, performance standards, clinical protocols, and evidence-based practices." Parties that receive a COPA would be immune to federal and state antitrust laws. In reviewing requests for a COPA, the state must consider the impact on health services in the community, including quality, access, and cost, as well as the implications of reduced competition.

The revised regulations are open for public comment through September 26 and will take effect upon publication of a notice of adoption. A Notice of Revised Rulemaking appears in the August 27 State Register, and a copy of the full text of the regulatory proposal is available on the Department's website.

Delay in DSRIP Application Release. The Department of Health announced a delay in the release of the DSRIP project plan application. A draft of the application was to be released on August 22, with a 30-day public comment period before the final application release in September. Those dates have been pushed back 30 days, so the draft application is now scheduled for release on September 22. The application due date of December 16 has not changed. As they develop their DSRIP proposals, Emerging Performing Provider Systems will have less time to review application questions and the scoring methodology that will be used to evaluate their applications. Read more

Delay in Health Homes for Children. In response to stakeholder comments submitted on the Draft Health Home Application to Serve Children, the state has amended the anticipated scheduled for expanding Health Homes to children. The new schedule extends the due dates by six months for the release of the final Health Home Application to Serve Children, the submission of applications, and the anticipated date children would begin to be enrolled in Health Homes. The schedule has been revised to be responsive to stakeholder requests to the state to provide more time to form networks and partnerships and to submit applications. In addition, the revised schedule will also provide more time to:

- extend the timeframe to review and approve Applications;

- work with Centers of Medicare and Medicaid (CMS) to seek State Plan Amendments;
- develop and provide informational and training Webinars to Health Homes, care managers, and other systems of care; and
- assist with readiness by providing more time between the implementation of other Medicaid Redesign initiatives that will impact Health Homes and other providers (i.e., the shift of the adult behavioral health benefit to managed care and the enrollment of HARP members in Health Home).

Read more

DSRIP Community Needs Assessment. The Department of Health posted the second part of its webinar on how to conduct a community needs assessment for a DSRIP application. A new aspect of the needs assessment process is identified. PPSs will be required to identify the strengths and weaknesses of the current health care delivery system and specify how those factors contribute to avoidable hospital use. They will be asked to articulate a future state for the delivery system that uses resources more effectively to respond to community need and that supports reductions in avoidable hospital use. This should include an assessment of fewer inpatient hospital beds, greater community-based health care infrastructure, and better integration of behavioral and physical health.

The PPS will have to indicate how the DSRIP projects selected by the PPS move the health care delivery system from its current design to the envisioned delivery system. The webinar can be viewed from the DSRIP website.

Ohio

State Moves 5,000 from Long-Term Facilities to Their Own Homes. On August 17, 2014, the *Columbus Dispatch* reported on the state's efforts to transition Medicaid beneficiaries from long-term care facilities into community-based settings in an effort to improve health outcomes and decrease healthcare costs. Participants of the state's Home Choice program, who are Medicaid recipients living in long-term care facilities, work with caseworkers and community partners to get housing, make moving arrangements, and set up necessary support services in or near their place of living. In addition to helping program participants regain their independence, the program facilitates community-based support services, which cost significantly less than comparable services at long-term facilities. Ohio is a leader among the 44 states participating in the federal program known as Money Follows the Person, which pays states extra Medicaid funds to transition long-term facility residents into home- and community-based settings in the hope of saving tax dollars in the long run. The Home Choice program recently transitioned its 5,000th member from a long-term facility to a home, far surpassing its initial goal of 2,000 transitions. Read more

Oregon

New Federal Directive Could Threaten Medicaid Funding Model in Oregon. On August 24, 2014, *AP*/the *Register-Guard* reported that new federal regulations could jeopardize the state's system of funding care for Medicaid beneficiaries. The state currently gives its 15 regional coordinated care organizations the freedom to spend Medicaid funds in ways they believe will improve help and reduce costs to the state. But the federal government now says the state should go back to the traditional way of budgeting and tracking funds. This change could lead to substantial cost increases that could eventually force the state to reimburse the federal government much of the $1.9 billion it was awarded in 2012 to support Oregon's Medicaid funding model. Read more

Pennsylvania

HMA Roundup – Mike Nardone

HealthyPA 1115 Waiver Approved. On August 28, 2014, the Centers for Medicare and Medicaid Services (CMS) announced approval of Pennsylvania's 1115 Demonstration Waiver to expand Medicaid coverage to adults with incomes up to 133 percent of the Federal Poverty level as authorized by the Affordable Care Act. The centerpiece of a package of health reforms proposed by Pennsylvania Governor Tom Corbett, the HealthyPA plan would rely on a Private Coverage Option (PCO) in extending coverage to the Medicaid expansion population and make significant changes to the existing Medicaid program. The Commonwealth estimates that an additional 600,000 individuals will have access to coverage when the program begins in January 2015.

> **PCO Option.** Under the terms of the waiver, most adults in the Medicaid expansion group will be eligible for the PCO, which will be administered by the state through contracts with commercial managed care plans offering a benefit package based on the state's benchmark essential health benefit plan. Among the expansion population, only those deemed to be "medically frail" would not participate in the PCO. Through a request for application process, the state has approved nine health plans, including two non-Medicaid plans, to provide this coverage in nine regions throughout the state. Individuals above 100 percent of poverty will be required to pay a premium equal to 2 percent of their income beginning in year two of the demonstration in order to receive coverage but may be able to qualify for a reduction in premiums based on performance of certain Healthy Behaviors, specifically completion of an annual wellness exam and timely payment of premiums. The premiums would be in lieu of existing Medicaid co-payments which remain in effect for others in the Medicaid program and the PCO program with incomes less than 100 percent of FPL. Individuals failing to pay the monthly premium for three consecutive months may be dis-enrolled from coverage, but may re-enroll without a waiting period. The Healthy PA plan also establishes an $8 co-payment for the non-emergent use of the emergency room, to be implemented by a subsequent state plan amendment and not part of this approval package.

Consolidation of Existing Medicaid Benefit Packages. In addition to the Medicaid expansion component, the Governor's HealthyPA plan would streamline and consolidate the benefit package for those currently eligible for Medicaid benefits. Specifically, the plan would reduce the number of current Medicaid categories of assistance and accompanying benefit packages for adults from 14 to 2, creating a "low risk" and "high risk" plan. The high risk plan would be intended for individuals with higher health care needs, such as Medicaid recipients who are aged, blind, and disabled or those who are medically frail and not participating in the PCO. The consolidation of benefit packages will result in new limits on services and reductions in current Medicaid benefits. Details on the redesigned benefit packages have not been agreed upon and were not announced as part of the waiver approval but will be the subject of subsequent state plan amendments (SPAs) to be submitted by the state. In the waiver approval letter, CMS indicated it had been in active discussions with Pennsylvania on the SPAs implementing the new benefit packages and had "reached agreement on the overall benefits approach."

The final approved waiver does not include the work requirement originally sought by the Corbett Administration as a condition of receiving benefits; however, Pennsylvania did announce it would be establishing a voluntary work program for HealthyPA and Medicaid participants. Under the Encouraging Employment program, which will begin in Year 2 of the demonstration, participants will be assigned a Healthy PA Career Coach and registered in the state's Job Gateway program to assist with employment and job training related activities. The CMS approval letter acknowledges this new state-funded program which will be established outside the demonstration authority and indicates that health coverage provided by Medicaid and the demonstration will not be impacted by this state initiative.

In addition to the waivers required to establish the PCO option and charge premiums above 100 percent of poverty in lieu of other Medicaid co-payments, Pennsylvania was granted authority to not provide non-medical emergency transportation to those in the PCO for the first year of the demonstration. Documents related to HealthyPA, including the CMS approval letter and 1115 Standard Terms and Conditions, and documents released by the state related to the HealthyPA announcement can be found on the Department of Public Welfare's website.

South Carolina

State Health and Corrections Department Consider Signing Up Recently-Released Inmates for Basic Healthcare Coverage. On August 24, 2014, the *Post and Courier* reported that recently released inmates in South Carolina might soon be able to enroll in the Healthy Connections Checkup program, which provides primary care screenings and family planning benefits to residents whose income falls below 194 percent of the federal poverty level. The state hopes that enrolling recently released inmates into the program will decrease the number of ER visits by this population, curb future health costs, and decrease the likelihood of recidivism. Corrections Director Bryan Stirling said that the prison system and the state are still in preliminary discussions about the program. Read more

Tennessee

Haslam May Submit Medicaid Expansion Plan This Fall. On August 28, 2014, *AP*/the *Tennessean* reported that the state could soon submit a proposal to the federal government to expand Medicaid in Tennessee. This would represent the first time that Governor Bill Haslam submits a plan. In March 2013, the Governor expressed interest in designing a plan that would use federal funds to help low-income residents buy private health insurance. The Governor, who has recently been in contact with federal DHHS officials regarding the prospect of expansion, has not publicly stated exactly when an expansion proposal will be submitted but has indicated that he will "probably go to (Washington) sometime this fall with a plan." Read more

Lawmakers Question TennCare Director on Continuing Delays With Application Processing System. On August 27, 2014, *Government Technology* reported on talks between state lawmakers and TennCare Director Darin Gordon regarding progress on the Tennessee Eligibility Determination System (TEDS), the still unfinished application processing system that has led to long delays in coverage for thousands applying for TennCare, the state's Medicaid program. Since TEDS was not set up to handle TennCare enrollment when open enrollment began last October, the state directed people to sign up through the federal HealthCare.gov site, which was not set up to handle this. TennCare awarded a $35.7 million contract with Northrup Grumman to build TEDS; the contractor has so far received only $4.7 million of this payment. Gordon told lawmakers he could not yet give a firm date for the new system to go online, but he assigned partial blame for the delay to the federal government for its delay in providing the state with guidance on creating a new enrollment system. Read more

Texas

HHSC Files Lawsuit Against Xerox for Approving Millions in State Funds for Unnecessary Dental Services. On August 26, 2014, *KXAN* reported that Xerox is facing a second lawsuit from the Texas Health and Human Services Commission (HHSC) stemming from allegations that the company paid out hundreds of millions of dollars for dental braces that were not medically necessary. HHSC also reports that Xerox is refusing to turn over patient records, which the state needs in order to comply with federal regulations. The state awarded the company a Medicaid claims administration contract but terminated the contract in May of this year. Read more

Virginia

Commonwealth Coordinated Care Releases MMP Enrollment Updates for Stakeholders. On August 22, 2014, Commonwealth Coordinated Care (CCC) provided updates on the process of automatic assignment into the state's Medicare-Medicaid Plans (MMP). The City of Radford (Roanoke Region) is now open to automatic assignment. Eligible beneficiaries will receive their automatic assignment letters by September 1, and their automatic coverage will begin on November 1. Henry County and City of Martinsville (also in Roanoke Region) are now available for eligible beneficiaries to opt-in to CCC. Eligible beneficiaries in the cities of Harrisonburg and Staunton

(Western/Charlottesville Region) and the city of Alexandria, Arlington, City and County of Fairfax, City of Falls Church, Fauquier, Loudoun, and Manassas Park City (Northern Virginia) can opt-in to CCC, but will not automatically be assigned to a plan, since only one plan currently is available in these areas. Automatic assignment will occur once two plans become available. Read more

Wyoming

Mead to Inform State Legislature Regarding His Medicaid Expansion Discussions with Federal Officials. On August 21, 2014, *AP*/the *Times Union* reported that Governor Matt Mead has met with federal officials to discuss the possibility of Wyoming agreeing to Medicaid expansion to 17,600 low-income adults. Mead says he wants to present information on the federal government's best offer to the state legislature when it meets again in January. The legislature has repeatedly rejected federal funding for Medicaid expansion; however lawmakers this year asked Mead to explore a possible deal in order to save the state money. Expanding Medicaid would net the state roughly $60 million in federal funds per year and could alleviate the high cost of uncompensated care provided by Wyoming hospitals, which totals about $200 million annually. Read more

National

States to Help Pay ACA Insurer Tax. On September 2, 2014, *USA Today*/*Kaiser Health News* reported that taxpayers will help pay for some of the $8 billion in taxes owed by health insurance companies by September 30 per the ACA health insurer fee. States and the federal government will spend at least $700 million this year to pay the tax for their Medicaid health plans. The three dozen states that use Medicaid managed care plans will give those insurers more money to cover the new expense. Private insurers are passing the tax onto policyholders in the form of higher premiums, and Medicare health plans are covering the tax via higher reimbursement from the federal government. Read more

Non-Expansion States Give Up Millions in Medicaid Funds. On September 2, 2014, the *State* reported on a recent Urban Institute study detailing the financial consequences faced by the 23 states not expanding Medicaid. The study finds that if the states that currently reject non-expansion dollars continue to do so for the next eight years, they will pay $152 billion in taxes to extend the program in other states, while receiving nothing in return. That money would pay for 37 percent of the cost to expand Medicaid in the 27 remaining states and Washington D.C. over that time. The non-expansion states would also receive a combined $386 billion in federal Medicaid dollars from 2013 to 2022 if they expanded Medicaid. Several of the current non-expansion states are in the midst of either proposing or considering ways to expand Medicaid, including Pennsylvania, Indiana, Wyoming, Tennessee and Utah. Read more

Consumers on the Hook if They Receive Health Insurance Subsidies Mistakenly. On August 29, 2014, *Kaiser Health News* reported that consumers getting government subsidies for health insurance who are later found ineligible for those payments will owe the government, although not necessarily the full amount. The rule is of particular concern to the 300,000 people facing a September 5 deadline to confirm immigration status or citizenship. Many of those people are reporting website difficulties or other issues which are

impeding their ability to provide additional information; these people worry that if they fail to meet the deadline, they will be deemed ineligible for subsidies, lose their coverage and will be forced to pay the subsidies back. Read more

Nine States Sign Health Care Block Grant Compact. On August 28, 2014, *Governing* reported that nine states have signed on to a movement that would pull regulation of most of the nation's health care insurance systems from the federal government. The movement, called the Health Care Compact, proposes using federal funds (in the form of block grants) to allow states to design and operate their own Medicare, Medicaid and other health care programs. The movement reflects the belief of some legislators that states can do a better job at managing health programs and expenses than the federal government. Read more

For Newly-Covered Medicaid Beneficiaries, Accessing Mental Health Care Can Be Difficult. On August 28, 2014, the *New York Times* reported that limited supply of providers can make it difficult for new Medicaid beneficiaries to access critical mental healthcare services. Many private therapists refuse to accept Medicaid, which pays on average about 66 percent of what Medicare does. Many therapists also report that Medicaid paperwork takes too much time to complete and that the beneficiaries are too hard to treat. Read more

CBO Projects Lower Medicare and Medicaid Costs Over Next Ten Years. On August 27, 2014, *Kaiser Health News* reported that the Congressional Budget Office (CBO) projected the 10-year projected cost of Medicare and Medicaid will drop by $89 billion. Despite this long-term projected drop, CBO found that federal spending for major health care programs will jump this year by $67 billion. Most of this short-term increase is attributed to Medicaid expansion and federal subsidies for private health insurance. Read more

HHS and CMS Announce New Members of Management Team Ahead of 2015 Open Enrollment. On August 26, 2014, the U.S. Department of Health and Human Services announced the appointment of two new members of the management team selected to ensure a successful 2015 Open Enrollment for the Health Insurance Marketplace. Kevin Counihan will join the CMS team as Marketplace Chief Executive Officer. In this role, Counihan will be responsible for leading the federal Marketplace, managing relationships with state Marketplaces, and running the Center for Consumer Information and Insurance Oversight, which regulates health insurance at the federal level. Counihan most recently served as Connecticut's Health Insurance Exchange CEO. In addition to Counihan's hire, Lori Lodes has been named the new Director of Communications for CMS. Read more

CMS Announces Comprehensive Autism Coverage Must Be Available for All Medicaid and CHIP Children Under 21. On August 26, 2014, *Kaiser Health News* reported that comprehensive autism services will be a mandatory offering for children under all state Medicaid and CHIP plans, according to a July announcement from CMS. Several states currently provide limited coverage for Medicaid/CHIP children in certain age groups, but the new policy would require mandatory coverage for anyone under 21. The full range of autism services fall under the "early and periodic screening, diagnostic and treatment services" (EPSDT) provision of the healthcare law. While the new coverage rules went into effect on July 7 after the CMS announcement, many states are still setting up procedures for implementing the new policy. Read more

Industry News

Centene Announces New Claims Processing Center in The City of Ferguson, Missouri. On September 2, 2014, Centene Corporation announced plans to build a new claims processing center in Ferguson, Missouri, creating 150 to 200 full-time jobs with health benefits. The facility will process claims from Centene's Missouri-based Home State Health Plan and overflow from its other health plans across the country. Read more

Magellan Complete Care of Florida Expands Services to Members in Tallahassee, Jacksonville, Tampa Bay, and Surrounding Areas. On September 2, 2014, Magellan Health announced that Magellan Complete Care of Florida expanded its services to members in its four remaining regions (Regions 2, 4, 5 and 6), encompassing Tallahassee, Jacksonville, Tampa Bay, and surrounding areas. Magellan Complete Care of Florida is the nation's first and only Medicaid specialty plan for individuals living with serious mental illnesses. The plan expects to enroll as many as 50,000 members by the end of the year. Read more

Healthcare Software Company TriZetto Could Be Put Up For Sale; Deal Could Be Worth $3 Billion. On August 20, 2014, the *Denver Business Journal* reported that the Colorado-based healthcare software company TriZetto Corporation may be put up for sale by its private equity owners, raising the possibility of another health care IT player or private equity fund buying the company in a deal worth as much as $3 billion. Reuters, citing unnamed sources, reported Wednesday that London-based private equity group Apax Partners is exploring the sale of TriZetto. Apax has tapped JP Morgan Chase to organize an auction, Reuters said. TriZetto provides business administrative software to 200,000 physicians and to health insurance companies which provide coverage to more than half of the insured U.S. population. It reported $676 million in 2013 revenue. Read more

WellCare, Amerigroup Name New COOs for Florida Operations. On August 28, 2014, *Health News Florida* reported that two major health care groups have named Chief Operating Officers for their Florida operations. Liz Miller has been promoted to the position at WellCare of Florida; she has served as vice president of Product Operations since 2012. Amerigroup Florida named Judi Peterson as its new COO, effective September 2. Read more

DHHS Medicaid Policy Developer Margaret Peal to Join WellCare as Director of Business Development. On August 27, 2014, *WRAL* reported that Margaret Peal will leave her position at the North Carolina Department of Health and Human Services to join WellCare as director of business development. Peal helped Governor Pat McCrory develop a Medicaid reform plan centered on establishing local doctor networks to care for Medicaid patients. WellCare lobbyists have worked on behalf of a competing measure put forward by Senate leaders. Read more

RFP Calendar

Date	State	Event	Beneficiaries
TBD	Delaware	Contract awards	200,000
TBD	Texas NorthSTAR (Behavioral)	Contract Awards	840,000
September 1, 2014	Texas Rural STAR+PLUS	Implementation	110,000
September 12, 2014	Indiana ABD	Proposals Due	85,000
September 16, 2014	Washington Foster Care	Proposals due	25,500
September 26, 2014	Louisiana	Proposals Due	900,000
October 9, 2014	Arizona (Behavioral)	Proposals Due	23,000
October 24, 2014	Louisiana	Proposals Due	900,000
October 30, 2014	Texas STAR Kids	Proposals Due	175,000
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
January, 2015	Georgia	RFP Release	1,250,000
February 1, 2015	Washington Duals	Implementation	48,500
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
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
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		7/1/2014	
Connecticut	MFFS	57,569						TBD	
Hawaii		24,189	Not pursuing Financial Alignment Model						
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	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	2/1/2015	4/1/2015	Regence BCBS/AmeriHealth; UnitedHealth
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Wisconsin	Capitated	5,500-6,000	X	Not pursuing Financial Alignment Model					
Totals	**11 Capitated 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 Correctional Health Expertise Tapped for Stateline Article

Link to Article

HMA Managing Principal Donna Strugar-Fritsch is a featured expert in Christine Vestal's story, "Too Sick for Prison Health Care." The *Stateline* article, which has appeared in *Governing* and *Kaiser Health News*, takes a look at providing health care to an aging prison population and what that means for states. A nationally recognized correctional health care expert, Donna has a BSN with a master's in public administration and is a certified correctional health care professional. Donna is located in HMA's San Francisco office. She and HMA consultants across the country are using their vast expertise to help states navigate the challenges associated with prison health care.

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/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.