HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

HMA IT ADVISORY SERVICES (ITAS) TEAM ISSUE BRIEF #1: TELEHEALTH IT

This week, our *In Focus* section comes from HMA Principal Jean Glossa, MD, of our IT Advisory Services (ITAS) team. HMA's ITAS team is continuously tracking and assessing the impact of developments in the health care information technology (HCIT) industry that have the potential to be transformational by changing the way that health care services are managed and delivered. This is the first in a series of *In Focus* briefs that elaborate on these developments and our team's perspective on the potential impact for various stakeholders in the health care system.

The first three briefs, to be published over the next several months, will cover the following topics, in this order:

1. **Telehealth IT (this issue)**: The movement to "value-based care", the challenges that consumers often have to access providers in a timely fashion, and economic drivers are converging to advance the adoption of "telemedicine" as an effective means to deliver care enabled by IT.
2. **Consumer engagement IT:** Increasingly, consumers are expected to be more engaged in and knowledgeable about their healthcare. Providers are encouraging the use of patient portals; information is being made public about procedure charges and hundreds of thousands of mobile health applications are available on smartphones. These tools and initiatives are just some of the methods that the healthcare system is employing to encourage consumers to become more active healthcare participants. Effective consumer engagement will remain a requirement in any model that seeks to lower costs while improving outcomes.
3. **Emerging interoperability guidelines including eLTSS and HL7 FHIR:** Given the growing recognition that information system interoperability will be critical for providers and consumers to maximize the use of health care IT, multiple efforts are currently underway to establish guidelines that health care IT solution providers can adopt to facilitate exchange of information between systems.

HMA ITAS Issue Brief #1: Telehealth IT

As delivery system reform focuses more on value based payment models and less on traditional fee-for-service approaches, there are increasing opportunities to use emerging technologies such as telemedicine (telehealth) to improve access to care in a cost-effective manner. In this article we will focus on three key issues that states are addressing regarding the "practice" of telemedicine in their states:

1. Physician licensure
2. Direct-to-consumer telehealth
3. Payment models

Background

The American Telemedicine Association (ATA) defines telemedicine as the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.[1] There are multiple modalities of telemedicine including but not limited to:

- Point-to-point teleconferencing for tele-psychiatry,
- Remote patient monitoring for post discharge CHF, and
- Direct-to-consumer applications where patients can access care via their smart devices from any location.

These modalities can offer creative and effective ways to increase access to specialty care, reduce unnecessary ED use, and monitor home bound patients.

[1] American Telemedicine Association. (n.d.). Accrediting safe online healthcare services. Retrieved from http://www.americantelemed.org/accreditation/online-patient-consultations/program-home#.VVoVaWfbLIV

Many states are in the process of reviewing and updating regulations (or, in some instances, legislating) to enable and/or encourage the adoption of telemedicine in their states. According to the Federation of State Medical Boards, there are 200 proposed state legislation/bills related to telemedicine pending at this time.[2]

Physician licensure

A key factor for states to address is physician licensure for telemedicine. Physicians must be licensed in the state where the patient is located at the time of the medical encounter which is referred to as the "originating site." The Federation of State Medical Boards (FSMB) Interstate Medical Licensure Compact will streamline the process by which physicians are licensed in participating states. The regulation was not written specifically for telehealth, but the expanding use of telehealth was the driving force behind the proposal, and telehealth will certainly benefit. Alabama just became the last of the minimum seven states required to move forward with the compact. Many other states are considering joining the multistate agreement that will take approximately one year to fully implement.

States can receive guidance from other agencies such as the Federation of State Medical Boards and the American Medical Association. The FSMB adopted a *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (April 26, 2014).[3] The American Medical Association also issued a policy statement in 2014. These guiding principles outline the appropriate use of telemedicine technologies and define the use cases for reimbursement of services.[4] The ATA issues policy statements, practice guidelines, and just recently, updated their state by state gap analysis. The ATA also created a report card for each state based on reimbursement, licensure, scope of practice, and other requirements surrounding the practice of medicine via telemedicine in each state.

Direct-to-consumer telehealth

One of the largest areas of growth has been in the area of direct-to-consumer (DTC) telehealth. This line of business offers patients the ability to meet with a provider from a nonclinical setting, such as their home or work, and via phone or audio/visual from their computer, tablet or smart phone. When given the choice, many users choose to simply call rather than use video. These services can be available to consumers as a self-pay method, or as a health plan benefit as a way to avoid unnecessary ED visits. In an effort to monitor the quality of these services, the ATA now offers the ATA Accreditation Program for Online Consultation. Two hundred and fifty organizations have applied; the first two have been approved.[5]

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[2] Federation of State Medical Boards. (n.d.). Telemedicine legislative report. Retrieved from http://services.statescape.com/Search/GetReport.aspx?pageid=legis

[3] Federation of State Medical Boards. (2014). Model policy for appropriate use of telemedicine technologies in practice of medicine. Retrieved from http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf

[4] American Medical Association. (2014). AMA adopts telemedicine policy to improve access to care for patients. Retrieved from http://www.ama-assn.org/ama/pub/news/news/2014/2014-06-11-policy-coverage-reimbursement-for-telemedicine.page

[5] American Telemedicine Association. (n.d.).

Along with the increase in access these services offer, such services have raised questions as to the appropriateness of establishing a doctor-patient relationship in this manner and as to whether or not the provider can obtain adequate information in order to render a diagnosis and recommend a treatment plan. Questions regarding adequate follow up and continuity of care have been raised.

DTC telehealth was especially impacted most recently in Texas where the Texas Medical Board adopted controversial new rules regarding the practice of telemedicine. The rules placed limits on how a doctor-patient relationship can be established via telemedicine. Except for mental health visits, the rules require that a telepresenter be with the patient at the time of the visit. The rules are supported by the Texas Medical Association. Critics argue this new rule will put limits on access to care via telemedicine, but the Board states these new rules provide safeguards and add clarity to the scope of practice. Given the lack of primary care physicians in large areas of Texas, many worry that the new rules will make it even more difficult to receive care. The final rule will be enacted in June.[6]

Payment Models

In recent months, there has been significant activity in the area of developing defensible, sustainable models for compensating providers and telemedicine IT solution providers for the cost of telemedicine services. Two challenges in achieving this are that (1) different states define telemedicine differently, and (2) Medicaid coverage for telemedicine varies by state, although the large majority of state Medicaid plans cover some element of telemedicine. Medicare, especially "traditional" Medicare, is much more restrictive, particularly regarding originating site limitations. Medicare requires that the patient be located in a Health Care Provider Shortage Area (HPSA) or outside a Metropolitan Statistical Area (MSA) as defined by the U.S. Census Bureau. Moreover, the originating site cannot be the patient's home; rather, the patient must be in a clinical facility. The Next Generation ACO initiative announced recently by CMS has more flexibility regarding the originating site so that home bound patients can receive telehealth services as part of this new model. Pending federal legislation proposed changes to these current Medicare restrictions. These include:

- The Telehealth Modernization Act (HR 691) to promote the provision of telehealth by establishing a Federal standard for telehealth.
- The Telehealth Enhancement Act (HR 2066).

Additionally,

- CMS added the new service code 99490 to the fee schedule for chronic care management (CCM) which can include professional services for receiving and reviewing data from remote monitoring programs.
- The Medicare Access and CHIP Reauthorization Act (MACRA) references telehealth in three areas:
    - Merit-based incentive payments for the use of telehealth for timely communication of test results, timely exchange of clinical

[6] Texas Medical Board. (2015). TMB adopts rules expanding telemedicine opportunities. Retrieved from http://www.tmb.state.tx.us/dl/DAD89645-F81F-CF51-6FF8-D0E20891625A

information to patients and other providers, and use of remote monitoring or telehealth is included as a means of care coordination.

- Incentive payments for alternative payment models.
- A new provision requiring a GAO study and report on the use of telehealth in federal programs and in remote patient monitoring services.

More Information

For more information on the Telehealth Issue Brief and ITAS team, please contact Jean Glossa, MD, (jglossa@healthmanagement.com) and Juan Montanez (jmontanez@healthmanagement.com).

HMA Medicaid Roundup

Alabama

Gov. Bentley Promises to Veto Austerity General Fund Budget. On May 14, 2015, *Montgomery Advertiser* reported that Governor Robert Bentley plans to veto a $1.64 billion budget approved by the House Ways and Means General Fund Committee. The budget slashes all state agencies by $204.16 million. The budget cuts five percent, or $34.2 million, from the state's Medicaid Agency. Read More

Alaska

House Finance Committee Not Moving Forward with Medicaid Expansion Proposal. On May 14, 2015, *Alaska Dispatch News* reported that the House Finance Committee is not moving ahead with Medicaid expansion. The committee spoke little of the bill and more on the larger issues of the Medicaid program. According to Governor Bill Walker, the committee also refused to take public testimony during the special session hearings. Read More

Arizona

Legislature Reduces Welfare Benefits and Seeks to Force Medicaid Beneficiaries to Have Job. On May 18, 2015, *Associated Press* reported that the state Legislature reduced the lifetime limit for welfare recipients to 12 months, the shortest window in the nation. At least 1,600 families, including 2,700 children, will be dropped on July 1, 2016. The Legislature also passed a law seeking to require Medicaid beneficiaries to have a job and to cut off benefits after five years. Arizona is currently facing a $1 billion budget deficit. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Anthem Blue Cross Sued for Refusing to Cover Harvoni. On May 18, 2015, *Los Angeles Times* reported that a woman named Shima Andre sued Anthem Blue Cross for refusing to cover the $99,000 cost of the hepatitis C drug, Harvoni. Anthem claims the drug was not medically necessary because Andre did not have advanced liver damage and not enough liver scarring.. Read More

Audit Identifies 335 Dentists with Questionable Medicaid Billing. On May 17, 2015, *Los Angeles Daily News* reported that an audit by the U.S. Department of Health and Human Services found 329 dentists and six orthodontists with questionable billing for pediatric work. They were paid $118 million in 2012.

Two-thirds claimed a large number of procedures per day. Nineteen received high payments per child. One claimed multiple steel crowns and other procedures on children. The California Department of Health Care Services stated it will increase monitoring of providers with questionable billing. Read More

Connecticut

Department of Social Services to Classify Hep C Drugs as Preferred Medicaid Drugs. On May 15, 2015, *Hartford Courant* reported that Connecticut will make hepatitis C drugs more accessible to Medicaid patients. Sovaldi, Harvoni, and Viekira Pak will be classified as preferred drugs. The Department of Social Services will also streamline the prior authorization process to a one page-document. The process has been criticized for limiting access to expensive treatments. Changes will take effect July 1. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Hospital Association Objects to Gov. Scott's Profit-Sharing Proposal. On May 19, 2015, *Health News Florida* reported that the Florida Hospital Association sent a letter to Governor Scott objecting to the profit-sharing proposal to cover LIP costs and instead urging him to support Medicaid expansion. Hospitals had a Monday deadline to submit data information requested by the Governor regarding their health care finances. However, the Safety Net Hospital Alliance of Florida pointed out that 80 percent of the data is already collected by the state Agency for Health Care Administration. The other data is not available. Read More

Hospitals Say Gov. Scott's Financial Data Request Ambiguous or Impossible. On May 18, 2015, *Health News Florida* reported that although hospital executives want to cooperate with Governor Rick Scott's request for data on services, profits, costs, and patient outcomes, hospitals say some of the questions are ambiguous or confusing, while others are impossible to answer. Hospitals will ask for clarification for certain questions but for others, they don't have the information. Other questions ask for information about payment information from private insurers that is covered under confidentiality clauses in contracts. However, the Florida Hospital Association stated that state hospitals believe in and support price and quality transparency. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

State Analyzing Medicaid Waiver Plan. On May 14, 2015, *Georgia Health News* reported that Governor Nathan Deal requested for the state Department of Community Health to study a Medicaid waiver plan, generated by the Grady Health System as an alternative to Medicaid expansion. The waiver plan will use federal matching on Medicaid dollars to set up pilot sites to provide coverage to the uninsured and manage their care. Grady Health System and Memorial Health will serve as two initial sites. The commissioner of the state Department

of Community Health, Clyde Reese, stated that he does not see a waiver program starting earlier than July 1, 2016. Read More

State Rate Increases Approved. On May 14, 2015, the Board of Community was called to order. The board unanimously approved:

- Medicaid Physician Rate Increase for Antepartum Care, Public Notice, Initial Adoption (Total: $18.1 million, State: $5.9 million)
- Physician Rate Increase for Primary Care, Public Notice, Initial Adoption (Total: $52.8 million, State: $17.2 million)
- Georgia Medicaid Air Ambulance Rate Increase for Adult Medicaid Members, Public Notice, Initial Adoption (Total: $1.5 million, State: $500,000)
- Reimbursement to FQHCs and RHCs for the Purchase and Insertion of Long Acting Reversible Contraceptives, Public Notice, Initial Adoption
- Nursing Home Services Rate Update, Public Notice, Initial Adoption (ABD – Total: $26.8 million, State: $8.7 million)
- Inpatient Hospital Prospective Payment System Methodology Change, Public Notice, Initial Adoption

Illinois

Report: Illinois Prison Medical Care Does Not Meet Minimal Constitutional Standards. On May 20, 2015, *Chicago Sun Times* announced that a report filed with the U.S. District Court found that medical care in Illinois prisons failed to "meet minimal constitutional standards with regards to the adequacy" of the program. The report found treatment delays, haphazard follow-up care, chaotic record-keeping, and many other problems that may have put the lives of inmates in danger. The Illinois Department of Corrections disputed the court-ordered report, claiming it paints an incomplete picture of the medical system in place and criticized the researchers for only visiting 25 facilities. Read More

Kansas

Proposal to Eliminate State's Earned Income Tax for Medicaid Expansion. On May 19, 2015, *Kansas Health Institute* reported that some legislators are considering a proposal to expand Medicaid in exchange for eliminating the state's earned income tax. However, Shawn Sullivan, the state's budget director warned that cutting the tax credit will jeopardize the state's federally funded temporary Assistance for Needy Families block grant. While conservatives are in favor of eliminating the tax but oppose expansion, moderates and liberals favor expansion and oppose eliminating the tax. Kansas must come up with $400 million to balance the state's budget. Read More

Maryland

State Issues RFP to Develop Integrated Delivery Network Serving Dual Eligibles. On May 15, 2015, Maryland issued an RFP for the Development of Medicaid Integrated Delivery Network for Dually-Eligible Individuals. Proposals are due on June 18, 2015. The integrated delivery network is

anticipated to be similar to an accountable care organization. The Medicaid IDN will be piloted in a limited geographic area, with the possibility to expand statewide.

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Hospital Industry Divided Over Legislation Seeking to Strengthen Role of Health Policy Commission. On May 14, 2015, *The Boston Globe* reported that new legislation could make it harder for health systems to pass mergers and acquisitions by strengthening the role of the Health Policy Commission. The Commission will not have the authority to block mergers but will be able to refer deals to the attorney general for further review. Lahey Health System and Steward Health Care System back the legislation while the Massachusetts Hospital Association is against it. Read More

Nonprofit Health Insurers Cite ACA Taxes and Fees for $124 million in Losses. On May 15, 2015, *The Boston Globe* reported that four of the state's largest nonprofit health insurers say they lost $124 million in the first three months of the year as a result of large taxes and fees from the health care law. BCBS of Massachusetts had the largest operating loss of $73 million. It paid $87 million in taxes and fees this year. Tufts Health Plan lost $24 million, Harvard Pilgrim $20 million, and Fallon $7 million. The insurers do not expect significant losses to continue through the year. Read More

Minnesota

Budget Negotiations Focus on Health and Human Services. On May 13, 2015, *Minnesota Public Radio* reported that negotiations between Gov. Mark Dayton and legislative leaders on the two-year state budget are focusing on health and human services programs. Specifically, a House Republican plan hopes to eliminate MinnesotaCare, which will run out of funding when a health care provider tax ends in 2019. Senate Majority Leader Tom Bakk believes a task force or study on MinnesotaCare may be created. Read More

Task Force to Address MNsure Potential Changes. On May 18, 2105, *StarTribune* reported that a new $500,000 task force will examine the future of MNsure, MinnesotaCare, and the chance for federal waivers after lawmakers could not reach an agreement on competing proposals. The task force is to provide a report to the Legislature by Jan. 15, 2016. Read More

Missouri

Lawmakers Question Savings from Medicaid Managed Care. On May 15, 2015, *St. Louis Post-Dispatch* reported that since Gov. Jay Nixon expanded Medicaid managed care, some lawmakers are questioning how much the state is actually saving from the managed care system. According to a Mercer report, Missouri has seen average annual savings of 1.7 percent versus the expected 3 to 6 percent. Additionally, managed care consumers performed worse than traditional Medicaid consumers on five out of six clinical quality measures. Under the state's budget for the upcoming year, Missouri will be expanding

managed care statewide, adding 200,000 mostly rural residents to managed care. Read More

Nevada

Proposed Bill to Privatize Medicaid Services for Elderly, Blind, and Disabled. On May 17, 2015, *Las Vegas Review-Journal* reported that Assembly Bill 310 proposed to move Medicaid services for the elderly, blind, and disabled to managed care organizations. However, Nevada Assembly Majority Leader Paul Anderson, who sponsored the bill, stated that the bill has "zero chance" of making it through the legislative process. Read More

New Hampshire

Community and Home-Based Providers Plead for More State Funding, Criticize Governor and Lawmakers for Chronic Underfunding. On May 19, 2015, *Chicago Tribune* reported that Choices for Independence, a Medicaid-waiver program for home-based health care, ended FY2014 with a $5.1 million surplus. The state Department of Health and Human Services now plans to use that money for other budget holes. However, advocates for community and home care say that money is rightfully theirs; there has not been a rate increase since 2009 and lack of funding makes it harder for people to access a full level of care in a timely manner. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Out of Network Consumer Protection Bill Introduced. On May 14, 2015, *NJ Spotlight* reported that New Jersey Assembly lawmakers introduced a bill to control for inappropriate out-of-network billing practices, establish a process to resolve billing disputes between providers and insurers, and require insurers to update their web-based provider directories at least every 20 days. A-4444, entitled the Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act -- was introduced by Assemblymen Craig J. Coughlin (D-Middlesex), Gary S. Schaer (D-Bergen and Passaic) and Troy Singleton (D-Burlington), as well as Senator Joseph F. Vitale (D-Middlesex). Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Primary Care Physician Shortage. The Healthcare Association of NYS released its annual report on physician supply in NYS. They report that the state continues to experience a shortage of physicians, especially primary care physicians, in upstate NY. They note that a number of reasons help explain the challenge of recruiting and retaining physicians, including the aging of the primary care workforce, a decline in the number of medical residents choosing to enter primary care, and a lack of interest in practicing in rural parts of the state. The report is a summary of a physician survey conducted annually by

HANYS, and captures the views and experiences of survey respondents. The report can be found on the HANYS website.

Enrollment in Fully Integrated Dual Advantage Programs. The table below shows enrollment by plan in New York's dual demonstration program as of May 1, 2015. This includes the first waves of passive enrollment, which occurred in April and May. Almost 45,000 individuals have chosen to opt out of the FIDA program.

FIDA Plan	Enrollment	Market Share
Aetna Better Health	128	1.8%
AgeWell New York	92	1.3%
AlphaCare Signature	57	0.8%
ArchCare Community Advantage	23	0.3%
CenterLight Healthcare	367	5.1%
Elderplan FIDA Total Care	261	3.6%
EmblemHealth Dual Assurance	58	0.8%
FIDA Care Complete	86	1.2%
Fidelis Fully Integrated Dual Advantage (FIDA)	494	6.8%
GuildNet Gold Plus	921	12.8%
Healthfirst AbsoluteCare	812	11.3%
HealthPlus Amerigroup	366	5.1%
ICS Community Care Plus	358	5.0%
Integra	107	1.5%
MetroPlus	93	1.3%
North Shore-LIJ FIDA LiveWell	48	0.7%
RiverSpring FIDA Plan	212	2.9%
SWH Whole Health	105	1.5%
VillageCareMAX Full Advantage	129	1.8%
VNSNY CHOICE FIDA Complete	2,094	29.0%
WellCare Advocate Complete FIDA	404	5.6%
Total All FIDA Enrollment	**7,215**	

Enrollment by plan can be found on the CMS website.

DSRIP Payments May be Increased. Crain's Health Pulse reported the possibility of an additional $1 billion for the state's Delivery System Reform Incentive Payment program, currently funded at $6.4 billion over 5 years. According to Crains, the potential increase in funding was in reaction to major New York City institutions' making clear to health officials that they believed they had been shortchanged by the amount of money awarded to their Performing Provider System through DSRIP. PPSs received notice of their DSRIP funding last week, but the public announcement of the awards, which had been scheduled for May 8, is still pending.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

House Proposes Medicaid Rule Requiring Monthly Payments. On May 13, 2015, *The Columbus Dispatch* reported that the House included provisions in the state budget requiring all children, parents, and adults younger than 65 to make payments to a health-savings account. Contributions will be 2 percent of income or $1, whichever is greater. If a payment is over 60 days late, the beneficiary will

lose coverage for 12 months. A report by the Center of Community Solutions warns that thousands may lose coverage as a result of the proposal. Read More

Medicaid Provisions in Ohio's House Approved Budget May Create Barriers to Health Care for Poor Women and Worsen Infant Death Rates. According to a new report out by Policy Matters Ohio, the House approved version of Ohio's proposed budget creates barriers in Medicaid that impact the health of poor women and infants because of changes that require: premium payments in addition to co-pays; lock out periods for missed payments; reductions to the eligibility ceiling for pregnant women, reduced eligibility for family planning services and reduced eligibility for breast and cervical cancer treatment. According to Wendy Patton, report author and senior project director for Policy Matters Ohio, Ohio's infant mortality rate was 47th among the states and District of Columbia in 2011, worse than almost every other state. Policy Matters Ohio worries that the House budget provisions make care harder to get and keep for low income women, those most at risk for infant mortality. Read More

Transparency, Report Cards and the Ohio Hospital Association. The Ohio House version of the budget added language that would require health care providers to share cost information and create a new hospital report card, but now, in the Senate, concerns are being raised about the lack of details surrounding the proposals. The Ohio Hospital Association now advocates that cost transparency measures be studied by a commission outside of the budget process. A representative for OHA said the association is working with its members to develop alternative price transparency language for the budget. Look for these discussions to continue throughout the budget process. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

PA Medicaid Expansion Shift Requires Some Beneficiaries to Change Plans. Gov. Tom Wolf's administration has been transitioning beneficiaries as he dismantles his GOP predecessor's alternative Medicaid expansion. Under former Gov. Tom Corbett's Healthy Pennsylvania program, the state built a second Medicaid managed-care plan known as the private coverage option (PCO), which was separate from the state's traditional Medicaid program, HealthChoices. About 250,000 people were enrolled in the program as of April. As many as 600,000 residents were expected to be eligible for expanded Medicaid. In late April, 121,234 PCO enrollees were moved to HealthChoices, and the remaining members will be transitioned by September 1. For the most part, beneficiaries were expected to be able to stay with the same payer, as most companies had both a PCO and HealthChoices offering, but that wasn't the case for Capital BlueCross, which had enrolled 20,000 people in its PCO plan. The state worked with Capital BlueCross to find a way for it to become a HealthChoices vendor, but the options were few so the company has been working with the state to ensure a seamless transition to a new plan for its beneficiaries. Read More

Even After Record Low Recidivism Rates, Corrections Head Sees More Room for Improvement. Acting Department of Corrections Secretary John Wetzel says he is excited about the 2013 recidivism rates - some are the lowest in more than a decade. As for the future, Wetzel sees Medicaid expansion as a tremendous

opportunity. About 70 percent of inmates enter prison with addictions. Many more would likely be able to get help through Medicaid when released. Wetzel says the department is already trying a few programs to provide comprehensive addiction treatment, including a shot that blocks cravings for opioids. Read More

UPMC: No Obligation to Renew Medicare Advantage Contract with Highmark. UPMC plans to terminate its Medicare Advantage contract with insurer Highmark for 2016. Dr. Dennis Gabos, a cardiologist at UPMC Passavant, estimated two-thirds of his patient interactions are Medicare-related. And of those, perhaps half or more have some kind of Highmark insurance coverage. UPMC, meanwhile, is hoping to prevail in court, asking Commonwealth Court to rule as a "matter of law" that the Pittsburgh hospital network's decision to terminate its Medicare Advantage contract didn't violate the state-mediated agreement governing UPMC's breakup with Highmark. In an April 27 court filing, the state attorney general's office and the departments of Insurance and Health wrote that UPMC and Highmark have not complied with consent decrees entered into in 2014, and the agencies want the courts to force the two Pittsburgh companies into arbitration. UPMC's response, filed Tuesday, says the hospital network is within its rights to pull out of the contract, even though the consent decree identifies Highmark's over-65 customers as a "vulnerable population" who should have access to UPMC hospitals. Read More

Rhode Island

Opponents of Medicaid Overhaul Fear Cuts to Hospitals and Nursing Homes Serving the Poor. On May 19, 2015, *Providence Journal* reported that some speakers at the House Finance Committee hearing on Governor Raimondo's Reinventing Medicaid initiative were concerned that the immediate cuts of the overhaul may hurt providers serving the poor. With the proposed 2.5 percent Medicaid payment cut, Lifespan, for instance, would lose $22 million. Opponents also said that although some of the funds can be returned through incentive pools, the proposals are "too vague and prospective" to offset the hits they will suffer. Most speakers on the committee supported the long-term innovations. Raimondo's budget amendment would save approximately $91 million. Read More

Texas

Billions of Dollars on the Line as Texas Negotiates Uncompensated Hospital Care. On May 20, 2015, *The Texas Tribune* reported that safety-net hospitals and clinics are bracing themselves for an uncertain future. In FY2013, over 300 providers received $3.9 billion for uncompensated care from the state's 1115 waiver. Harris Health System received the most in the state with $395 million to cover approximately 64 percent of its patients. President and CEO George Masi stated that the funding is "absolutely crucial for our mission statement." Read More

51 Percent of Texas Nursing Homes Rated One or Two Stars. On May 14, 2015, *Kaiser Health News* reported that access to highly rated nursing homes in some states can be limited. In 11 states, 40 percent or more of nursing homes received the two lowest ratings. Texas has the highest amount, with 51 percent of homes

rating below/much below average. Louisiana is at 49 percent and Oklahoma, Georgia, and West Virginia are at 46 percent. Consumer advocates say the reasons for this are not enough staff, weak staffing rules, low pay, low financial penalties, and reluctance to close homes in fear of displacement. Nursing home officials blame insufficient Medicaid payments. For instance, Texas averages $133 a day per resident in Medicaid payments, which is among the lowest in the country. Read More

Utah

Gov. Herbert and House Leader Dunnigan Confident of Medicaid Expansion Compromise by End of July. On May 14, 2015, *The Salt Lake Tribune* reported that a legislative session consisting of Governor Gary Herbert, House Majority Leader Jim Dunnigan, Senate President Wayne Niederhauser, House Speaker Greg Hughes, and Sen. Brian Shiozawa, promised to come up with a compromise between the Senate and House Medicaid expansion bills by the end of July. Dunnigan stated it is an ambitious goal, but a special session consisting of the full Legislature will consider the plan. Read More

Vermont

House, Senate Approve Heavily Reduced Compromise Health Care Reform Bill. On May 16, 2016, *Burlington Free Press* reported that the House and the Senate approved a $3.2 million compromise health care reform bill. The original House proposal was for $11.9 million and the original Senate proposal was for $10.68 million. The approved bill includes $760,000 for cost-sharing subsidies, $940,000 to stabilize Medicaid reimbursements to health care providers, $1 million for the Blueprint for Health managed care system, and $300,000 for educational loan repayments to physicians. The health care reform funding will be raised through a tobacco tax. Read More

Virginia

Over 40 Percent Opt Out of Managed Care Dual Eligible Program. On May 17, 2015, D*aily Press* reported that of the 66,000 eligibles for the Commonwealth Coordinated Care pilot program, over 40 percent have either opted out or disenrolled from the program. Commonwealth Coordinated Care is a three year pilot program serving dual eligibles through managed care. The program began last March and does not expect to reach the projected savings of $44 million without full enrollment. Read More

Wisconsin

Finance Committee to Reject Gov. Walker's Family Care Plan. On May 14, 2015, *The Baltimore Sun* reported that leaders of the Legislature's finance committee said they plan to reject Governor Scott Walker's budget proposal to expand Family Care, a Medicaid program that provides managed long-term care for the elderly and disabled. The proposal would also end the IRIS program, a long-term care program that provides self-directed assistance with bathing, dressing, and other needs. Walker's state budget seeks a federal waiver to expand Family Care services by January 1, 2017. Read More

National

Health Law Tax Could Cost States $13 Billion by 2023. On May 18, 2015, *Associated Press* reported that insurers are raising prices for individual, small business, and Medicaid coverage to cover the costs of the Health Insurance Providers Fee. The tax was meant for insurers to help pay for the expansion of coverage. But states end up paying 54 cents for every dollar of the insurance tax. States with the most managed care will be hurt the most. Florida and Pennsylvania are estimated to pay up to $1.2 billion over a decade. Texas will pay up to $1 billion. Read More

CMS Optimistic About Dual Eligible Demos Despite High Opt Out Rates. On May 15, 2015, *Modern Healthcare* reported that CMS acknowledges the high opt out rates in the Financial Alignment Initiatives but remains hopeful, stating it's not the red flag some have made it out to be. The demonstrations hope to improve care and reduce costs for over 1.7 million dual eligible beneficiaries in 11 states. However, only 26 percent, or 450,844, have signed up as of May 1. Read More

Former CBO Director Says Subsidies Assumed for All States. On May 19, 2015, *The Hill* reported that in regards to the King v. Burwell case, Doug Elmendorf stated that subsidies were assumed for both state exchanges and federally-run exchanges. Elmendorf, who was director of the Congressional Budget Office at the time of ACA's passage, said this assumption was never in question. Other congressional aides also said it was not their intention to limit the subsidies. However, in the Supreme Court case, the more conservative justices may only look at the plain text of the law. Read More

Republican Senator Bill Cassidy to Propose Patient Freedom Act, ACA Replacement. On May 14, 2015, *The Hill* reported that Louisiana Senator, Bill Cassidy, plans to introduce a bill to replace the Affordable Care Act. The Patient Freedom Act will let states opt out of ACA mandates for employers, individuals, and insurers, and instead receive tax credits for health savings accounts. Catastrophic medical plans for those without insurance will still be available. Cassidy expects the plan to roll out in 12-18 months. Read More

Industry News

Molina to Acquire Michigan-based HealthPlus Medicaid Contracts. On May 15, 2015, Molina Healthcare announced an agreement to acquire the Medicaid and MIChild (Michigan's CHIP program) assets of HealthPlus Partners, Inc. HealthPlus Partners, Inc. is a wholly owned subsidiary of HealthPlus of Michigan with around 90,000 Medicaid members in six Michigan counties, as well as 6,000 MIChild members. Molina already serves approximately 256,000 Medicaid members in the state as of March 2015. Molina anticipates completing the transaction during the third quarter of 2015. Read More

Kindred House Calls to Expand to Three Additional States. On May 14, 2015, Kindred Healthcare, Inc. announced that it will be expanding Kindred House Calls services to three additional states. Kindred House Calls is a Home-Based Primary Care company providing primary care to individuals in assisted living facilities, independent living, and home and select specialty services for patients without access to traditional outpatient care settings. Kindred House Calls has approximately 70 practitioners and serves 10,000 patients.

RFP Calendar

Date	State/Program	Event	Beneficiaries
May 8, 2015	Michigan	RFP Release	1,600,000
May 14, 2015	Georgia	Proposals Due	1,300,000
May 19, 2015	Iowa	Proposals Due	550,000
May 22, 2015	Kentucky	Proposals Due	1,100,000
May, 2015	Mississippi CHIP	Contract Awards	50,300
May, 2015	Florida Healthy Kids	Contract Awards	185,000
Spring, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Spring, 2015	Louisiana MLTSS - DD	RFP Release	15,000
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Kentucky	Implementation	1,100,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
July, 2015	Georgia	Contract Awards	1,300,000
July 31, 2015	Iowa	Contract Awards	550,000
August 3, 2015	Michigan	Proposals Due	1,600,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000

Dual Eligible Financial Alignment Demonstration Calendar

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

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care; Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	6/1/2015	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Health Spring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***11***			

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

Dual Eligible Financial Alignment Demonstration Enrollment Update

Below are enrollment totals in the states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15
California	48,976	51,527	58,945	122,908	123,079	124,239	122,520
Illinois	49,060	49,253	57,967	63,731	64,199	60,684	58,594
Massachusetts	17,465	18,104	17,918	17,867	17,763	17,797	17,474
New York				17	406	539	6,660
Ohio				68,262	66,892	65,657	63,625
South Carolina					83	1,205	1,398
Texas						20	15,141
Virginia	28,642	29,648	27,701	27,333	26,877	27,765	25,563
Total Duals Demo Enrollment	**144,143**	**148,532**	**162,531**	**300,118**	**299,299**	**297,906**	**310,975**

Source: State enrollment data and CMS enrollment data, compiled by HMA

HMA News

HMA Upcoming Webinar: *"New York State's Ambitious DSRIP Program: A Case Study"*

Thursday, May 28, 2015
1:00 PM Eastern
Register Here

New York has by far the most ambitious Delivery System Reform Incentive Payment (DSRIP) Program in the nation. The program has a clear focus on full health system transformation and payment reform. The state will invest $6.4 billion to incentivize collaboration among health care providers, social service providers, and community-based organizations to dramatically alter the way health care is delivered to Medicaid recipients. The primary goal: a 25% reduction in avoidable hospital use over five years. Getting there will require huge investments in community-based care, improvements in key quality metrics like hospital readmissions, and the continued shift from traditional fee-for-service payment models to value-based care.

During this webinar, you'll hear from Health Management Associates Principal Denise Soffel, PhD, who has been on the front lines helping New York plan, develop, and implement its DSRIP initiative.

HMA Welcomes…

Mary Kate Brousseau, Senior Consultant – Washington, DC

Mary Kate Brousseau comes to us mostly recently from the Primary Care Coalition of Montgomery County, MD where she served most recently as the Breast Health Initiative Director and as the Manager of Breast Health Initiative and Special Projects for several years prior. In these roles, Mary Kate led all initiatives, including process improvement activities to adopt the PCC primary care based model in safety net clinics in three jurisdictions; developed and facilitated a regional learning community with representation from over 50 safety net clinics, hospitals, and private radiology groups from eight jurisdictions; and managed the Medicaid Transition Project to provide technical assistance and trainings to safety net primary care providers.

Prior to her work with the Primary Care Coalition, Mary Kate served as an Operations and Policy Analyst with the Oregon Breast and Cervical Cancer Program in the Office of Family Health, Oregon Department of Human Services. Here she coordinated the development, implementation, and evaluation of the statewide screening program; developed and provided training and technical assistance for clinical providers and staff; maintained program accountability with funding agencies; and drafted testimony, fiscal, and overall analysis for two bills directly relating to screening and treatment services through the Program proposed during the state legislative session.

Additional roles that Mary Kate has served in include several roles with the Oregon Primary Care Association (Community Development and Technical Assistance Coordinator; Recruitment, Retention, and SEARCH Program Coordinator; and Recruitment and Retention Coordinator); Health Education

Coordinator for the Latin American Youth Center/MANY AmeriCorps Program; and Data Specialist/Research Assistant with the Cancer Control Department at Georgetown University Medical Center.

Mary Kate received her Master of Public Health, International Health degree from Oregon State University and her Bachelor of Arts degree in Spanish from the University of Virginia.