HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

KEY MEDICAID AND LEGISLATIVE ISSUES TO WATCH IN 2015

This week our *In Focus* section highlights key issues that are likely to dominate the Medicaid and health policy landscape in 2015 in states in which HMA has offices. The HMA team identified issues and milestones that will feature prominently in the Medicaid, health policy, and legislative agenda in the coming year.

California – Pat Dennehy & Don Novo

As California enters the second year of the ACA, Medi-Cal has grown to cover about 33 percent of the state's population. With the expansion comes concerns about access and quality of services.

California AG holds public hearings over sale of safety-net hospitals. The California Office of the Attorney General is holding public hearings every day this week over the contentious sale of six safety-net hospitals to Prime Healthcare Services, the *Inland Valley Daily Bulletin* reports (Nisperos, *Inland Valley Daily Bulletin*, 1/6).

Jones releases emergency rule over narrow provider networks. On Monday, the California Department of Insurance issued an emergency regulation that aims to address narrow provider networks in the state and improve residents' access to care, Capital Public Radio's "KXJZ News" reports. Jones announced the new regulation at his second-term inauguration.

Lawmakers introduce health bills on first day of legislative session. California lawmakers announced several bills, including many being reintroduced from last year. For example, state Sen. Ricardo Lara (D-Bell Gardens) introduced two measures:

- SB 4, which would expand Medi-Cal - California's Medicaid program - and subsidized coverage to undocumented immigrants; and
- SB 10, which would create an Office of New Americans to assist undocumented immigrants (McGreevy, "PolitiCal," *Los Angeles Times*, 12/1).

Primary care Medi-Cal providers about to be hit by double rate-cut. As of January 1, 2015, primary care providers will have their Medi-Cal reimbursement rates lowered significantly. A two-year Medicaid federal rate increase for primary care providers is due to expire on the first day of 2015. On the same day the California Department of Health Care Services plans to implement its state-ordered 10% reduction in reimbursement rates for fee-for-service Medi-Cal primary care providers (*CaliforniaHealthline*).

Drug Medi-Cal Waiver Amendment. On November 21, 2014, DHCS submitted a waiver amendment to CMS to expand Medi-Cal's Substance Use Disorder (SUD) program, known as Drug Medi-Cal (DMC), to the entire Medi-Cal population. The waiver amendment will bring the Childless Adult Medicaid expansion group into the DMC program. This amendment will also allow the State to extend the DMC Residential Treatment Service, as an integral aspect of the continuum of care, to additional beneficiaries. Historically, the Residential Treatment service was only available to pregnant/postpartum beneficiaries in facilities with a capacity of 16 or less beds. This waiver amendment will create a Residential Treatment service operable in facilities with no bed capacity limits.

California Counties will be required to opt-into the waiver by submitting a letter of intent to operate a county DMC program under the guidelines issued by DHCS to conform with California's waiver approval. The waiver will make improvements to DMC services by implementing a Continuum of Care to services available to address substance abuse. This Continuum of Care will include the coordination of Physical, Behavioral and Mental Health Services along with SUD services.

Preparing for the California's 1115 waiver renewal. The California Department of Health Care Services (DHCS) is preparing to amend their current 1115 demonstration, "Bridge to Reform," which recently entered its final year of the five year demonstration. California's current waiver authority expires on October 31, 2015. In July of 2014 California kicked off the renewal process of their next 1115 demonstration with the issuance of a white paper that built on the concepts of the state's current "Bridge to Reform" waiver with a focus on delivery of quality, cost effective care that can be further expanded and sustained over time. DHCS outlined six target areas of consideration for the renewal of the waiver that will focus on improving and strengthening the Medi-Cal delivery system while ensuring ongoing support for the safety net system. These objectives have been identified to be essential in improving the quality of care of beneficiaries, reducing costs and ensuring the long term viability of the Medi-Cal program. The State has held a series of stakeholder workgroups beginning in November 2014 and concluding in February of 2015. The stakeholder workgroups include participation of subject matter experts that discuss the key considerations likely to be included in the draft waiver. The six workgroups include:

DSRIP 2.0 – Delivery System Reform Incentive Payment	Outcomes and value oriented programs with a focus on population health, seeks to demonstrate advancement of Triple Aim goals. Key areas include; patient safety, complex patients and prevention
Housing/Shelter	Explore options of how Medicaid funding for shelter can increase quality, ensure continuity of care, deliver better health outcomes, and reduce total cost of care
Workforce	Explore strategies to attract new and retain current Medi-Cal providers through incentive programs focused on providers serving the Medi-Cal population
Safety Net Financing (DSH/SNCP bundled payments)	Explore innovative payment reforms that align incentives for safety net providers to coordinate the care for the uninsured
MCO/Provider Incentives	Explore incentive payments based on total cost of care reductions and performance on quality and outcome measures to help drive better alignment and care coordination between the mental health and the physical health care delivery systems.
Federal/State Shared Savings	Promote cost-efficiency and access through a shared savings initiatives

Colorado – Joan Henneberry

With the Republicans taking control in the state Senate as a result of the 2014 elections, most expect this to be an interesting and productive year for the legislature with shared responsibilities between parties; the Democrats still control the House and the Governor is a Democrat. Colorado has a long history of developing bipartisan public policy especially when there is shared leadership between the parties. Key topics for the 2015 session which opened on January 7, 2015 are:

- Last year legislation was passed to codify policies related to in-home supports. A new law that went into effect this month will expand "eligible care providers" to include family members who are now allowed to be reimbursed for their services. The act also finds that more effective in-home support is a "cost savings to the state."
- Senator John Kefalas intends to introduce a bill that lifts the cap on insurance-mandated treatment for autism, leaving the decision up to a provider as a medical necessity based on diagnosis.
- Legislators will likely pass a bill giving the state legislative audit committee more authority to oversee and audit the quasi-governmental Connect for Health Colorado state marketplace, created as part of the Affordable Care Act. The original enabling legislation gave the committee limited authority since the exchange does not receive any state general funds. But after a required program audit recently uncovered a lack of policies and procedures related to contracts and procurements, the legislative audit committee decided they would ask the full legislature for more authority. It is likely the bill will pass and be signed by the Governor.
- The top issue will be a decision regarding whether to refund taxpayers approximately $42.50 per adult, or retain those extra funds in the state budget to pay for things like education or increase the rainy day fund. The state is forecast to take in $200 million more in taxes next fiscal year than it's allowed to keep under the Taxpayer's Bill of Rights (TABOR,) a part of the state constitution designed to restrict the growth of state government to the rate of inflation and population growth. The legislature would have to agree via legislation to ask voters through a ballot initiative to keep the money instead of refunding it and the Governor has signaled he is fine with a refund to taxpayers. Most of the excess revenue comes from the first full year of marijuana taxes.
- Colorado was expected to sell close to $500 million worth of marijuana from both medical and recreational sales in 2014, with a roughly 50/50 split between recreational and medical sales. The pot industry is preparing to lobby for tighter restrictions including a statewide cap on the number of marijuana retail licenses to be allowed so they can maintain control of the market.

Florida – Elaine Peters

- **Florida Governor's Race** – Governor Rick Scott was sworn in on Tuesday and became the second Republican governor to win a second term – joining former Governor Jeb Bush. Scott narrowly won re-election in November over former Governor Charlie Crist in the most expensive gubernatorial race in state history. Scott will center his second

term on job growth, tax cuts and a reduced role for government. He will also push for higher spending on public schools and further limits on state university and college tuition rates.

- **Governor's Budget Recommendations** – Governor Scott is likely to announce his FY 2015-16 budget recommendations at the end of January. Scott repeated his campaign pledge to cut $1 billion in taxes in the next two years, including a further reduction in the corporate income tax and the elimination of the state tax on manufacturing. He also promised to back an increase in per-student funding for public schools to a historic level and he called for more $10,000 college degree programs and limits on increases in graduate tuition. Recently, economists projected a $1 billion surplus in 2015.
- **Legislative Session** – The 2015 Legislative Session convenes on March 3, 2015, and ends May 1, 2015 (60 days). Interim committee meetings of the Florida Legislature will be held in January (weeks of the 5th and 20th) and February (weeks of the 2nd, 9th, and 16th). Some of the key issues that will dominate Florida politics are the economy, reduced taxes, education, health care, gambling, and pension plans. Some of the major health care issues are:
    - **Medicaid Expansion** - A coalition of business interests and private citizens are pushing "A Healthy Florida Works" expanded Medicaid program. The proposal would accept billions of dollars available under the federal Affordable Care Act and provide coverage through private insurers to approximately 800,000 Floridians. Senate President Gardiner described the plan as "intriguing" and hasn't ruled it out. A similar plan failed to pass the House in 2013, but Speaker Crisafulli said he might consider expanding health care coverage via the private sector. The odds are still relatively small that legislation will pass to expand Medicaid.
    - **Medical Marijuana**: The Legislature approved a bill last year that would allow a limited form of medical marijuana, but state regulations are still not final that would allow sales of pharmacological marijuana to go forward. Doctors on January 1 were supposed to begin ordering strains of cannabis that are low in euphoria-inducing tetrahydrocannabinol, or THC, and high in cannabadiol, or CBD, for patients who suffer from severe spasms or cancer. The Department of Health recently told an audience in Orlando that the rule will require ratification from the Legislature as combined costs, for businesses to operate the cannabis industry and for the state to regulate it, would exceed $1 million over five years, triggering ratification. Supporters of broader medical marijuana, who failed to get the 60 percent approval required for a constitutional amendment in November, have promised to try again, either through the Legislature or at the ballot box.
    - **Dental Carve-out** – Bills are anticipated to be filed again this year that would attempt to carve-out Medicaid Prepaid Dental Health Plans serving children in Miami-Dade County, although that conflicts with Statewide Medicaid Managed Care (SMMC).

A dental carve-out would probably be more difficult to pass this year as SMMC has been fully implemented as of August 2014.

- **Legislative Budget Issues –** Some of the critical Medicaid budget issues for 2015 Legislative session will be:
  - **Low Income Pool** –Federal CMS approved a one-year waiver extension of LIP funding through June 30, 2015 to provide stability for providers during the transition to Statewide Medicaid Managed Care (SMMC). LIP funds for FY 2014-15 were increased to $2.167 billion and includes the following three existing funding streams: $1 billion LIP Program; $963.2 million Hospital Self-Funded (rate exemptions and adjustments); and $204.5 million Medical School Physician Supplemental Payments. CMS directed the Agency to commission a report from an independent contractor to review Florida's Medicaid financing system and sustainability of these funding mechanisms for payments and make recommended reforms to allow Florida to move toward managed care payments rather than relying on supplemental payments. A report is due to the Governor and Legislature by January 15, 2015 and a final report is due to CMS no later than March 1, 2015.
  - **Physician Fee Increase –** The Medicaid primary care physician (PCP) fee increase included in the ACA and funded 100 percent from federal funds expired December 31, 2014. This will result in a 52.5 percent reduction in fees for primary care services for eligible providers in 2015. It is likely that funding requests to continue the PCP rate increase will be submitted for all or a percentage of the rate increase.
  - **Florida Pediatric Society Lawsuit –** A federal judge ruled that Florida's state Medicaid budget was set at an artificially low level, causing pediatricians and other specialists for children to opt out of the insurance program for the needy. A hearing will be set later in January to determine how to proceed with the state toward a resolution. The lawyer who litigated the lawsuit on behalf of a group of pediatricians, dentists and nine children said their victory depends on whether the Legislature and Governor Rick Scott set aside enough money to improve medical and dental care for needy children. It has been reported that Florida would need to appropriate about $200 million in state matching dollars to improve the Medicaid program.

- **Procurements** – Florida has two significant procurements during 2015.
  - **Florida Healthy Kids (FHK)** - The Florida Healthy Kids Corporation issued a draft ITN on December 23, 2014 to re-bid the managed care plan contracts for the Healthy Kids component of the Florida KidCare program. Proposals are due

March 2, 2015. Awards are anticipated on April 15, 2015 with an October 1, 2015 implementation date.

- **Florida Medicaid Management Information System (FMMIS)** – The Agency is scheduled to release the FMMIS/DSS Fiscal Agent procurement on July 1, 2015. Awards are anticipated in December 2015. The Design, Development and Implementation (DDI) phase of the contract is anticipated to start June 2016 with Fiscal Agent operations starting July 1, 2018.

Georgia – Mark Trail

Georgia Families re-bid. The Georgia managed care program, Georgia Families, was originally bid in 2005 with initial contracts starting in 2006. While postponed several times, it will be re-bid in late January 2015. The scope of that program will include a full risk management of health care services (such as physical, behavioral, pharmacy, and dental) for the Low Income Medicaid and CHIP populations. All acute care services, with the exception of non-emergency transportation, are expected to be carved into the contracts, including pharmacy, dental, and behavioral health. Membership included is expected at about 1.4 million; and gross revenue approaching $4 Billion. The State completed a RFQC process to prequalify vendors. The following were approved as qualified to respond to the actual re-bid RFP when released.

- Amerigroup Georgia
- AmeriHealth
- Care Source Georgia
- Gateway Health Plan
- Humana
- Molina
- Peach State Health Plan
- United Health Care
- WellCare of Georgia

Primary Care Rate reduction. The affected primary care physician groups in Georgia are expected to request a continuation of the ACA Primary Care rate increase which officially expired on December 31, 2014. This advocacy is expected in both the Governor's Office and the Legislature.

Rural hospital access and funding is a continuing problem in Georgia. While some effort was made during 2014 to create a level of access between an urgent care center and a full emergency room, those efforts did not prevent the closure of additional hospitals in calendar year 2014. Targeted funding requests are expected in the 2015 Legislative Session. There is also a major shortage of primary care physicians in rural Georgia.

Medicaid expansion. Even though Governor Nathan Deal has stood firmly against it and last year easily defeated a pro-expansion Democrat, political support for expansion could grow, especially if there is continuing financial trouble for Georgia hospitals. The Georgia Hospital Association says it's the most difficult financial times ever for hospitals.

Other Issues to Watch:

- Some struggling hospitals are seeking alliances and partnerships with bigger, more profitable health systems. There is speculation if this will continue and who might partner with whom.

- Hospitals are expected to defend the state regulatory apparatus against attempts by physician groups looking to operate doctor-owned multi-specialty surgery centers. This certificate-of-need battle is expected to heat up in the Georgia General Assembly.
- Care Management for the Medicaid members in the Aged, Blind, & Disabled (ABD) categories remains undefined in the State. The Department of Community Health requested $18 million in state funds to support an ABD Care Management vendor to assist; however, it is not known if those funds will be included in the Governor's Budget.
- Several bills have already been pre-filed for the 2015/2016 Session; at least are two related to health care in Georgia:
    - HB 1 - A BILL to be entitled an Act to amend Chapter 34 of Title 43 of the Official Code of Georgia Annotated, relating to physicians, acupuncture, physician assistants, cancer and glaucoma treatment, respiratory care, clinical perfusionists, and orthotics and prosthetics practice, so as to change certain provisions relating to the use of marijuana for treatment of cancer and glaucoma; to provide for regulated medicinal use of cannabis and derivatives thereof to treat certain conditions.
    - HB 28 - A BILL to be entitled an Act to amend Article 2 of Chapter 34 of Title 43 of the Official Code of Georgia Annotated, relating to medical practice, so as to require Opioid Education and Pro-Active Addiction Counseling for patients who are prescribed Schedule II or III controlled substances by physicians for chronic pain for extended periods.

Illinois – Andrew Fairgrieve

- **Care Coordination rollout wraps up in Spring 2015.** It was reported that, as of January 2015, around 1.4 million Medicaid beneficiaries in Illinois have been enrolled in one of the care coordination (managed care) programs. Enrollment has been largely completed outside of Cook County. Another 700,000 enrollees are expected to be enrolled in a care coordination plan by April or May of this year.
- **Under new Governor, health administration changes coming.** Republican Governor-elect Bruce Rauner will take office on January 12, 2015. Rauner will be tasked with replacing departing Healthcare and Family Services (HFS) Director Julie Hamos. Rauner's pick to lead HFS will also need to appoint a new Medicaid Director after Theresa Eagleson stepped down from that position in December 2014. Her former deputy, Jim Parker, is serving as Medicaid Director in the interim. Additional appointments may be made to lead the Illinois Department of Public Health (IDPH), Department of Human Services (DHS), and potentially the Department of Insurance. All department heads will require approval of the Illinois General Assembly, in which both chambers are firmly held by the Democrats.
- **Revenue issues could impact Medicaid budget.** With the General Assembly's decision not to renew the state's income tax increase, and with continued lack of resolution in the state's pension system, revenue shortfalls could factor prominently in the legislative session this year. As one of the largest state programs, the Medicaid budget could be under

debate in 2015. Savings achieved through the care coordination rollout will likely be looked at to fill part of the budget hole, but additional cuts and reforms are possible.

- **Other issues in administration transition.** The futures of several significant health-related initiatives are in question as the Rauner administration takes office, including:
    - The state's 1115 "global transformation" Waiver, submitted to CMS last year;
    - The Alliance for Health proposals; and
    - The Accountable Care Entities (ACEs) and other provider-organized managed care entities serving the Medicaid population.

Indiana – Catherine Rudd

The Republican super majority continues for 2015 in both legislative chambers. The session began January 6, 2015, and will adjourn on April 15, 2015. The major issue this year is passing a biennial budget – although the details won't be fleshed out until after the April revenue forecast is issued. The December 2014 revenue forecast projected modest growth over the next three years. The Governor's priorities are passing a balanced budget and providing more funding for education.

No significant health care bills have been introduced yet. Although, there is likely to be a bill for a moratorium on new nursing home facility construction. This failed to pass last year and resulted in an ethics investigation of a legislator whose son was also a nursing home provider. More information on the nursing home moratorium is available here and here.

Massachusetts – Rob Buchanan & Tom Dehner

Change in Governor's Office. Governor-elect Charlie Baker will be sworn into office on January 8, 2015. The Republican, who previously served in various cabinet roles including secretary of health and human services, has named Mary Lou Sudders to oversee HHS programs. Governor Baker was previously the CEO of Harvard Pilgrim Health Care, the state's second largest commercial health plan. Secretary Sudders was the Department of Mental Health commissioner from 1996 to 2003, and a longtime mental health and child welfare advocate.

The first major opportunity for the new governor to articulate his health policy priorities will come when he files his first budget proposal for fiscal year 2016, which is due in early March. During and after the campaign, the governor indicated a strong interest in confronting Massachusetts' growing opioid abuse problem. He has also expressed support to "permanently increase pay for PCPs by seeking a waiver from Medicare to raise the rates paid to PCPs" and increasing provider price transparency.

Health Policy Commission. Since its formation in 2012, the Health Policy Commission has largely analyzed health care utilization and cost trends with an eye towards bolstering health care quality and limiting cost growth. The law that created the HPC sets a statewide health care cost growth benchmark (3.6 percent in 2013 and based on economic indicators in subsequent years) that is monitored by the HPC. For example, the HPC has also analyzed the cost impacts

of hospital mergers and acquisitions, in part to assess whether they increase or decrease the likelihood of the state meeting the cost growth benchmark. In 2015, the HPC may seek a greater role in the Massachusetts marketplace, particularly as hospital and other provider organizations consolidate or close. Two smaller community hospitals announced plans to close in 2014. In December 2014, the HPC sent a letter to the Executive Office of Health and Human Services asking to be allowed to weigh in with comments on impacts when hospitals notify the Department of Public Health of an impending closure. The HPC is also tasked with developing certification standards for accountable care organizations and patient centered medical homes, and both of these regulatory initiatives will likely advance in 2015.

Medicaid/MassHealth. The Massachusetts Medicaid and CHIP program, MassHealth, may be the subject of new reforms if recent advocacy efforts have any impact. The Massachusetts Medicaid Policy Institute, a research and policy arm of the Blue Cross Blue Shield of Massachusetts Foundation, issued a report in December 2014 that recommended that MassHealth streamline contracts with health plans and providers to bolster oversight ability and better analyze how effective different programs have been implemented. The report also recommended organizational changes to how the program is administered in order to strengthen the role of the state's Medicaid Director.

Another report, authored by HMA on behalf of the Massachusetts Association of Health Plans, suggests a variety of reforms and highlights recent losses experienced by MassHealth MCOs, particularly due to specialty pharmacy costs and members who are more acute than were assumed during rate development. The report suggest strategies for collaboration between MCOs and the state, based on models in other states.

Of particular interest this year will be whether the state pursues a strong agenda to implement Medicaid ACOs. Over the last several years, EOHHS has focused on implementation of its Primary Care Payment Reform Initiative (PCPRI) which provides shared savings and per-person payments to providers for primary care services.

1115 Waiver. In October 2014, CMS approved the Commonwealth of Massachusetts' request to extend the MassHealth Section 1115 Research and Demonstration Waiver through June 2019. The agreement is a five-year extension of Massachusetts' 1115 wavier and represents $41.4 billion in spending including over $20 billion in federal revenue. Under the terms of the waiver, Massachusetts received authorization to make payments from the Safety Net Care Pool (SNCP) for only the first three years of the five year period. The SNCP supports a variety of program expenditures including subsidies for certain exchange enrollees and safety-net provider payments related to uncompensated care and unreimbursed Medicaid costs. Under the waiver, the state must evaluate uses of SNCP funding for effect, adequacy, and accountability and submit a draft report to CMS on October 1, 2015.

Michigan – Esther Reagan

Key developments to watch include:

- Governor Rick Snyder will give his State of the State message later this month and offer his Executive Budget recommendation for the state fiscal year beginning October 1, 2015 in early February. Reduced revenue estimates reflect the potential for some reductions in state

government appropriations to compensate, but health care is high on the Governor's list of priorities so it is not anticipated that the Medicaid program will be impacted in any great way.

- The MI Health Link program, better known as the Medicare-Medicaid duals demonstration, is being implemented in four regions of the state. This demonstration could impact more than 100,000 duals and is set to occur in phases. The first phase includes two regions – the entire 15-county Upper Peninsula of the state (where one Integrated Care Organization – ICO – is available) and an eight-county region in the southwest corner of the state (where there are two ICO choices). The second phase includes two very populous one-county regions (Wayne and Macomb Counties), both of which are located in the southeast corner of the state. There are five ICO choices for duals in these two regions. Originally scheduled for implementation in 2014, this demonstration is now scheduled to kick off in February, with voluntary enrollments in the phase one regions effective March 1, 2015. Shortly thereafter, targeted duals who have not voluntarily enrolled will be passively assigned to an ICO with the ability to opt out. The same two-step process is also planned for the phase two regions in subsequent months. A major component of the demonstration is a requirement that the ICOs arrange for and provide long-term supports and services, both in nursing facilities and in community settings. An additional component is a requirement for coordination of behavioral health services through a contract with the Prepaid Inpatient Health Plans (PIHPs) in the state; the ICOs will pay the PIHPs for providing Medicare-covered behavioral health services but the state will directly pay the PIHPs for providing Medicaid-covered services. Implementation of this initiative has already been delayed two times. While Michigan has had a Memorandum of Understanding with CMS in place since early April, the necessary federal waivers have not yet been approved. Further delays are possible.
- The Healthy Michigan Plan, an expansion of Medicaid eligibility to non-elderly adults with income up to 133 percent of the federal poverty level, was implemented on April 1, 2014. The program was intended to offer health care coverage to as many as 320,000 individuals. By the end of 2015, enrollment in the program far exceeded initial estimates, with about 500,000 individuals approved for coverage. All Healthy Michigan Plan enrollees receive their health care coverage through the state's 13 Medicaid-contracted managed care organizations.
- Michigan's current Medicaid managed care contract, which has been in place since October 1, 2009, is scheduled to expire on September 30, 2015. An RFP to re-procure health plans to serve the Medicaid and Healthy Michigan Plan population, as well as the stand-alone CHIP population in the state's MIChild program (a new population for this contract), is expected in February. It is anticipated that the RFP will require bidders to focus on the state's objectives around health care integration, paying for value, patient-centered medical homes, and population health, all of which were identified as foundational components in the state's *Blueprint for Health*, the State Healthcare Innovation Plan. In a release issued on January 6, 2015, the state announced that the upcoming RFP will change the geographic regions

for contracting from those currently in place. This announcement will require current health plans to reassess and potentially modify their service areas for the future.

New Jersey – Karen Brodsky

New Jersey Legislative Agenda for 2015. New Jersey lawmakers will be interested in:

- Plans by the Division of Medical Assistance and Health Services (DMAHS) to address the implementation of a new statewide eligibility and enrollment system after the termination of the Hewlett Packard contract that put this project on hold. The contract termination has been cited as one reason for the backlog of Medicaid applications stemming from Medicaid expansion and HealthCare.gov enrollments;
- The timing and intent for the behavioral health administrative services organization (ASO) RFP, which has been drafted and is undergoing review by state officials. The behavioral health ASO RFP was originally planned as a component of the state's Comprehensive Medicaid Waiver, which began in October 2012;
- The status of the review and approval of Medicaid ACO applications by the DMAHS ACO Review Committee. P.L. 2011, Ch. 114 of August 2011 created the New Jersey Medicaid Accountable Care Organization Demonstration Project and after a protracted period the final regulations were released in May 2014. Applications submitted to DMAHS in July 2014.
- The status of the transition of long term services and supports from Medicaid fee-for-service to managed care, including:
    - performance of managed care organizations
    - feedback from stakeholders, including enrollees and providers
    - early indicators for program savings
- Status of the performance-based Delivery System and Reform Incentive Payment (DSRIP) program, which is a component of the Comprehensive Medicaid Waiver;
- Status of the evaluation of the Comprehensive Medicaid Waiver.

DMAHS will hold the first of its quarterly meetings of its Medical Assistance Advisory Council on January 12, 2015, during which additional priorities for 2015 may become available. This information will be included in the next edition of the HMA Roundup.

New York – Denise Soffel

Medicaid Redesign Team Reforms. Governor Cuomo established the Medicaid Redesign Team when he entered office in 2011. The goals of the MRT included reducing Medicaid spending, introducing a global spending cap for the Medicaid program, care management for all, and a focus on patient-centered medical homes and health homes. Under the ambitious "Care Management for All" agenda, the state plans to move virtually all Medicaid populations and benefits into a managed care environment; ultimately, 95 percent of Medicaid spending in the state will flow through managed care plans.

The Care Management for All agenda suffered some slippage in 2014. Many of the policy initiatives that were scheduled for implementation during 2014 have been delayed, with implementation pushed into 2015. As New York moves more vulnerable populations into managed care (people with developmental disabilities; individuals residing in nursing homes; people with serious mental illness), the implementation process and timeline has lengthened. Contributing factors include CMS review and approval, concerns raised by providers and consumers, and the complexity of required policy change. Work on New York's Delivery System Reform Incentive Payment program (DSRIP) absorbed the attention of the Department of Health, as well as the entire health care provider and stakeholder community, further exacerbating implementation delays.

DSRIP. In April 2014 CMS approved New York State's Section 1115 Medicaid waiver request, in the amount of $8 billion over 5 years. Most of the funding, $6.4 billion, is going toward a Delivery System Reform Incentive Payment (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 achieving predetermined metrics and milestones; incentive payments are not guaranteed. As with DSRIP plans in other states, payments are performance-based as project milestones are met. All projects will be evaluated against four performance measures: avoidable hospitalizations, cost savings, number of Medicaid beneficiaries affected, and the robustness of the evidence base supporting the intervention.

DSRIP applications were submitted to the state in December. They will be posted for public comment mid-January; awards will be announced mid-March. Extensive information about the state's DSRIP program can be found on their website.

Office for People With Developmental Disabilities (OPWDD) People First Waiver and DISCOs. OPWDD and the Department of Health are working with CMS on an agreement called the *People First* Waiver, a 1915 (b)/(c) concurrent Comprehensive Home and Community Based Services (HCBS) waiver. OPWDD currently serves 126,000 New Yorkers with developmental disabilities. Almost half its clients are dual eligible. Consistent with the Medicaid Redesign Team goal of care management for all Medicaid populations, New York plans to move individuals with intellectual/developmental disabilities into care management through Developmental Disabilities Individual Supports and Care Coordination Organizations (DISCOs). The managed care delivery system will allow individuals to enroll on a voluntary basis in a DISCO. Originally planned for October 2014, the state now expects that DISCOs will begin providing service in October 2015. DISCOs will be voluntary for both enrollees and providers, and will be implemented in select geographic regions across the state. The state hopes to create a mandatory managed care program for Medicaid beneficiaries with developmental disabilities, but they expect that full implementation will

take several years, as DISCOs are established and approved. The DISCO will be responsible for providing care management to its enrollees, based on the HCBS standards of the current 1915-c waiver, including the use of a care coordination team and coordination of care across waiver providers, specialists, behavioral health providers and long-term care providers. As part of DISCO implementation the state was required to establish an independent ombudsman program, providing consumer education and advocacy services and maintaining a state-wide database on consumer concerns and complaints.

Expansion of Managed Care – Nursing Homes. New York has again delayed transition of the nursing home population and benefit into Medicaid managed care, and now anticipates a start date of February 1, 2015. Originally scheduled for October 2013, the carve-in has been delayed several times as the Department of Health worked with stakeholders to develop the policy and implementation plan. Upon CMS approval, all eligible recipients over age 21 in need of custodial care will be required to enroll in a Medicaid managed care plan or an MLTC. Mandatory enrollment will begin in NYC in February, expanding to the suburban counties of Nassau, Suffolk and Westchester in April 2015, and to the rest of the state in July 2015. Beneficiaries currently in a skilled nursing facility will not be required to enroll in a plan; they will remain in the fee-for-service system. Six months after the mandatory program begins, individuals permanently placed in a nursing home will have the option of joining a Medicaid managed care plan on a voluntary basis. Members will not be subject to a lock-in provision; they can change plans at any time they choose in order to obtain access to a nursing home that is not part of their plan's network.

The state is encouraging plans to develop alternate payment arrangements with nursing home providers. The state is committed to managed care plans sharing both risk and reward with the providers in their networks. This requirement will not be imposed on managed care plans in the mainstream program for at least the first two years, to allow providers to begin preparing for risk arrangements.

Expansion of Managed Care - Behavioral Health. Behavioral health benefits are fragmented in the Medicaid program, with some aspects of care included in the managed care benefit while other services are carved out. New York intends to carve in all behavioral health benefits over the next 12 months. They are also establishing a new managed care product designed to meet the needs of individuals with serious mental illness. Initially scheduled for NYC implementation in April 2014, and already delayed for 9 months, the behavioral health carve-in was recently delayed an additional 3 months. The current expectation, which is dependent on CMS approval, is that implementation will begin in NYC in April 2015. The state has not yet released an RFQ for plans serving beneficiaries outside NYC, but expects its release sometime this spring, with an anticipated roll-out of September 2015.

As part of the behavioral health carve-in, all mainstream Medicaid managed care plans must demonstrate their capacity to take on care management for all individuals with a behavioral health diagnosis, and coordinate all the services that population will require. This includes services currently provided through the Office of Mental Health that fall outside the Medicaid benefit, such as Personalized Recovery Oriented Services (PROS), Intensive Psychiatric Rehabilitation Treatment (IPRT), partial hospitalization and outpatient rehab. They will be required to develop an interface with Local Government Units and social service systems related to housing, homelessness, criminal justice and

employment. All plans will be required to qualify to manage currently carved out services.

The state has also developed a new Medicaid benefit package designed specifically to meet the needs of individuals whose behavioral health diagnosis defines their need for health care services. Health and Recovery Plans (HARPs) are being designed as a product line to be offered by mainstream Medicaid managed care plans. HARP enrollment will be open to Medicaid beneficiaries with serious mental illness and/or substance use disorders, based on a pattern of high utilization/high cost. HARPs will be required to provide all the behavioral health services currently included in the state's Medicaid plan, as described above. In addition, they will be required to provide a number of services currently available through Section 1915 (i) home and community-based care waivers, including many recovery-oriented services such as crisis respite, family support, peer supports, and rehabilitation services (such as transitional and supported employment, supported education, respite and habilitation).

Demonstration to Integrate Care for Dual Eligible Individuals - Fully-Integrated Dual Advantage (FIDA). New York implemented mandatory assignment of certain dual-eligible beneficiaries into managed long-term care plans beginning in 2012; state-wide implementation will be completed early in 2015. The program is targeted at duals who require more than 120 days of community-based long-term care services. Building on mandatory managed long term care enrollment, these beneficiaries will be passively enrolled into a FIDA plan. Individuals who have been passively enrolled can opt out at any time. FIDA is limited to eight downstate counties (New York City, Nassau, Suffolk and Westchester). The state has indicated that 124,000 duals are eligible for participation, but are not releasing any enrollment projections. Twenty-two plans have executed a three-way contract with CMS and NYS, and completed Readiness Review. Originally scheduled for July 2014, FIDA implementation is now planned to begin January 2015.

Under New York's duals demonstration, Fully Integrated Dual Advantage (FIDA) plans will be required to enter alternate payment arrangements, including sub-capitation, bundled payments and shared savings.

As part of FIDA implementation the state was required to establish a participant ombudsman program. The Independent Consumer Advocacy Network (ICAN) is an independent, conflict-free entity that provides participants assistance in accessing care, understanding rights and responsibilities, and appealing adverse decisions.

Basic Health Program. In his 2014 budget Governor Cuomo established a working group to consider issues pertaining to the federal option to establish a basic health program. The workgroup was tasked with evaluating federal guidance related to basic health programs; discussing fiscal, consumer, and health care impacts of a basic health program; and considering benefit package, premium and cost-sharing options for a basic health program. Given system modifications that will be required, NY expects enrollment for the BHP will begin in October 2015.

Ohio – Sukey Barnum

Ohio Governor Kasich initially secured funding for Ohio's Medicaid expansion under the ACA through the State's Controlling Board rather than with approval of the General Assembly through the budget process due to lack of sufficient

support. Ohio's Controlling Board has approval authority over various state fiscal activities. Funding approved by the Controlling Board runs out at the end of this state fiscal year. Kasich's proposed biennial state budget is due out in early February. As that budget is being finalized this January, Ohio's new General Assembly is being sworn in. Ohio's new Speaker of the House, Rep. Cliff Rosenberger (R), is on record as opposed to the Medicaid expansion. He had served on the Controlling Board, but was removed just prior to the vote to fund the Medicaid expansion. If the Medicaid expansion is to continue, then funding must continue. Whether and how funding is secured to continue Ohio's Medicaid expansion will be debated this spring.

Pennsylvania – Mike Nardone

FY 2015-2016 Budget. Newly elected Governor Tom Wolf will face major budgetary challenges when he is sworn in to office later this month. According to estimates by the Independent Fiscal Office, Pennsylvania is facing a nearly $2 billion structural deficit in its 2015-16 state budget. Whatever steps are taken over the course of the next six months to close this gap, Medicaid is likely to be impacted since the program makes up 30% of the state general fund. However, , specific budget proposals related to Medicaid are not expected to come into focus until the new Governor gives his first budget address and issues his FY 2015-2016 budget in in early March. An increase in income and other taxes, including the Marcellus Shale tax, is also expected to be a component of the Governor's plan to reduce the budget deficit while the legislature remains focused on pension reform and state liquor store privatization.

Cabinet Appointments. A first order of business for Governor-elect Wolf is appointment of his health care team, including the Secretaries of the Departments of Human Services (DHS), Health, Aging, and Insurance. Wolf has said he plans to make all cabinet appointments by inauguration day, although these positions have yet to be announced. Cabinet department leaders are also subject to confirmation of by the State Senate.

Rollback of Healthy PA. Governor-elect Wolf ran on a platform that promised to undo Governor Corbett's Healthy PA Medicaid expansion waiver in favor of a straight Medicaid expansion building off the Pennsylvania HealthChoices managed care program. Estelle Richman, former Secretary of the Department of Public Welfare (now DHS) under Governor Rendell, has been leading this effort during the transition period. Among the changes the new Administration will be seeking is the elimination of new service limits proposed by Governor Corbett, particularly in the newly created "low-risk" benefit package. Even though not a significant budgetary item, it may be raised during budget discussions if the Republican controlled legislature decides to push back on a softening of the cuts proposed by Governor Corbett under Healthy PA. For its part, CMS has yet to approve the proposed "low-risk" health benefit package.

LTC Reform. Long term care reform is also expected to be a major focus of the incoming Administration as well as the legislature over the course of 2015. As the Pennsylvania population ages, nursing home care continues to be a major part of the Pennsylvania Medicaid budget. Pennsylvania ranks in the lower tier of states in terms of percentage of LTC dollars devoted to home and community-based services and LTC is the one component of the Medicaid budget that generally does not incorporate some form of managed care. The outgoing Corbett Administration will also be issuing the report from its Long Term Care Commission which may also help set the stage for these discussions, since most

of the relevant stakeholder groups were at the table. At a minimum, the LTC appropriation will be a focus of budget discussions in Pennsylvania for FY 2015-16.

Puerto Rico – Juan Montanez

- Implementation of the full risk managed care program is still scheduled for April 1, 2015, though four of five MCOs selected have no Medicaid experience in Puerto Rico and contract executions were delayed by at least one month. Readiness reviews are scheduled for February.
- Implementation of the Health Home pilot is still scheduled for April 1, 2015.
- The Medicaid state plan amendment that would have allowed the Commonwealth to transition tens of thousands of Mi Salud members into the Medicaid population within Mi Salud is still pending CMS approval despite months of deliberations. This is holding up implementation of the Governor's "basic health plan" initiative which he announced in October 2013.
- Awarding of $1.9 million in state innovation model plan design funds may lead to renewed discussions about health care reform, with some groups and legislators pushing for various forms of a single-payer system.
- Concerns about Mi Salud program sustainability remain after senior HHS officials met with Commonwealth officials late last year; the "burn rate" of ACA Medicaid funds suggests these funds will be exhausted long before the end of 2019.

Texas – Dianne Longley

Key Medicaid and Legislative issues for 2015:

- **1115 (DSRIP) Waiver Renewal**: The Medicaid waiver worth $29 billion is set to expire September 30, 2016. The Texas Health and Human Services Commission (HHSC) will submit the renewal application in September 2015 and has announced it intends to seek renewal at the current financing level or perhaps higher. Current financing includes $17.6 billion for the Uncompensated Care Pool and $11.4 billion for DSRIP projects. The Texas Legislature will likely provide some input into program changes and renewal activities as well as funding and state appropriation decisions that could impact the renewal.
- **Medicaid Expansion**: Several legislative proposals have been filed to expand Medicaid, but are unlikely to move forward in their present form. The incoming Governor, Greg Abbott (R), and Lt. Governor, Dan Patrick (R), as well as other high profile legislators have indicated they are willing to discuss the possibility of a Medicaid "block grant" strategy that would allow the state to decide how to expand and reform Medicaid without adhering to the requirements of the Affordable Care Act opposed by the overwhelmingly conservative Texas Legislature. A December report of HHSC recommended against expanding Medicaid but endorsed a federal waiver. Greg Abbott has expressed support for the idea of a block grant but has provided no details. Most recently he stated, "I am confident that the Legislature will look at a variety of different issues and approaches," but has provided no indication of the conditions under which he would support a proposal. Legislation introduced last session for a block grant was introduced by Republican

member John Zerwas, but failed to move out of committee. He does not plan to introduce a similar proposal this session.

- **HHSC Sunset Legislation to Continue and Reorganize Health and Human Services**: the Health and Human Services agencies and programs are up for Sunset review, under which the agencies will be abolished unless the Legislature acts to continue them through legislation. A report by the Texas Sunset Commission was highly critical of the HHSC enterprise and recommended substantial changes and consolidation of several programs to improve oversight and coordination of HHS services. Some of the recommended changes include:
    - Consolidate the five Health and Human Services agencies into one agency.
    - With regard to Medicaid managed care, require HHSC to regularly evaluate the appropriateness of data, automate data reporting processes, and comprehensively evaluate the Medicaid program on an ongoing basis.
    - Consolidate administration of Medicaid functions at HHSC.
    - Require HHSC to promote increased use of incentive-based payments by managed care organizations, including development of a pilot program.
    - Due to poor management at the office of inspector general (including his recent resignation due in part to the Sunset report), remove the gubernatorial appointment of the inspector general and instead require the inspector general to be appointed by and report to the HHSC executive commissioner.

  The Sunset legislative process is lengthy and complex, with hundreds of amendments typically added during the course of legislative hearings. Legislative proposals that are not likely to pass on their own are commonly added as riders or amendments to the Sunset bill during the final days of the session as a way to salvage proposals that otherwise would not have a chance of passage. Because of the importance of the Sunset bill, it is one of the most closely watched proposals and is usually one of the last bills to pass during the final days of the legislative session.

- **HHSC Procurement and Contract Management**: Due to recent revelations in the Austin American Statesman of significant problems with several high-profile, no-bid contracts awarded by HHSC, the Legislature has initiated an investigation to determine what went wrong and whether any laws were broken. In addition, the Sunset report recommended that HHSC better define and strengthen its role in both procurement and contract monitoring and focus "high-level attention" to systems contracting. Due to the high profile of the recent problems and the large sums of money involved, legislation is likely to be introduced to establish stricter requirements related to the contract procurement and management process. The legislation could be included as part of the Sunset bill or could be considered as a separate proposal.

- **Medicaid Managed Care Initiatives**: HHSC continues to implement managed care programs as required by legislation enacted in 2011 and 2013. Upcoming changes in the next year include the addition of nursing home facility coverage under STAR+PLUS (managed care for the aged, blind and disabled Medicaid population) beginning March 2015. Later this year, HHSC will announce the managed care organizations (MCOs) selected to provide services under the new STAR Kids program for children and young adults age 20 and younger who have Medicaid through SSI or 1915(c) waiver programs. Contracts will be signed by September 2015; coverage will become effective September 2016.
- **Dual Eligible Demonstration Pilot**: In March, HHSC plans to launch the dual eligible demonstration pilot, which will be available in six of the most populous service areas in the state. Locations and potential enrollment include: Bexar (26,452), Dallas (27,941), El Paso (19,645), Harris (47,160), Hidalgo (27,090), Tarrant (16,986). Participating health plans will include Amerigroup, Cigna-HealthSpring, Molina, Superior and United. Enrollees will be included if they meet all of the following criteria: 1) are age 21 or older, 2) receive Medicare Part A, B and D and receive full Medicaid benefits, and 3) are enrolled in STAR+PLUS. Health plans will be required to provide all Medicaid and Medicare services. Other duals may, but are not required to, enroll if they meet certain criteria.

HMA Medicaid Roundup

Alabama

Alabama to Implement Medicaid Delivery System Reforms. On December 18, 2014, the *Montgomery Advertiser* reported that Governor Robert Bentley announced changes to the way the state will deliver Medicaid. The state approved the probationary formation of six regional care organizations (RCOs) aimed to improve healthcare outcomes. Each RCO must demonstrate fiscal solvency, readiness to deliver services, and have a provider network in place by Oct. 1, 2016. It is estimated that 690,000 Alabamians would be enrolled once each RCO is approved in the fall of 2016. The RCOs have no relation to recent remarks by Governor Bentley about expanding Medicaid. Read more

Governor Bentley Says Block Grant Idea Consistent with Campaign Platform. On December 18, 2014, the *AL* reported that Governor Robert Bentley is defending his administration's support for a block grant for expanding Medicaid. Though Governor Bentley's campaign was against expanding Medicaid under ACA, he claims to have been considering this idea since 2010. The Alabama-designed plan is grouped with 33 other states in an appeal to be heard by the U.S. Supreme Court. Read more

State Medicaid Approves Alabama Community Care. On December 24, 2014, the *Franklin County Times* Alabama Community Care will provide Medicaid managed care to nearly 200,000 enrollees after being approved by state Medicaid officials. Alabama Community Care will work to establish medical homes and care coordination programs for all medical and behavioral care services. Alabama Community Care partnered with Sentara, a manage care provider based in Virginia. Read more

Arizona

Centene, Health Choice Awarded Behavioral Health Contracts. On December 18, 2014, Arizona Department of Health Services awarded Health Choice Integrated Care and Cenpatico Integrated Care, a subsidiary of Centene, with contracts for the northern and southern regions, respectively. Both companies received a three-year contracts will being October 1, 2015, with an option for a two-year extension. Read more

Arkansas

Governor Beebe Optimistic State Will Continue Medicaid Plan. On December 29, 2014, *Arkansas Business* reported that Governor Mike Beebe is hopeful that

the state will reauthorize the "private option," a product from when the state was debating whether to expand Medicaid. Governor Beebe states that it would be both bad public policy and politically disastrous for the legislature and Gov.-elect Asa Hutchinson not to reauthorize the program. Arkansas has currently more than 213,000 people enrolled. Read more

California

L.A. County ER Visits Shift to Private Hospitals Post ACA. On January 1, 2015, the *LA Times* reported that non-serious ailment admissions into ERs in Los Angeles County grew 3.9%, in line with the expected annual 3%-5% growth. While the county's three public hospitals reported a 9% decrease, several private hospitals saw double digit increases in outpatient visits. After the expansion of Medi-Cal, the share of ER visits by uninsured patients dropped to 13.9% in the second quarter of 2014 from roughly 20% the previous year, while the Medi-Cal share has been rising. The pace of growth in visits differed between the first and second quarter of 2014; visits rose 1.8% in the first quarter compared to the same quarter of 2013, while in the second quarter, visits rose 6.1% from the previous year, suggesting a lag in signups for Obamacare by some analysts. Read More

Rise in In-Home Supportive Services Cases under Scrutiny for Fraud and Abuse. On January 5, 2015, *Kaiser Health News* reported a large shift of the elderly and disabled population from nursing homes to in-home care due to costs and patient preference. In California, those with low incomes qualify for the government sponsored In-Home Supportive Services program, which now serves 490,000 clients and is the largest in the nation with a budget of $7.3 billion. However, caregivers are mostly untrained and unsupervised, leaving the client at risk for abuse and neglect. Kaiser found that only one in nine caregivers who become ad hoc nursing aides receive any training or authorization from physicians. Furthermore, 73% of clients are related to their caregiver and the screening process allows felons to become caregivers. Read more

District of Columbia

CareFirst to Spend $56 Million on Community Health Needs. On December 30, 2014, *The Washington Post* reported that CareFirst BlueCross BlueShield was ordered by insurance regulators to spend $56 million on community health needs in response to the company's $964 million cash reserve in 2011. The cash reserve exceeded the appropriate reserve level by $268 million. CareFirst's subsidiary, Group Hospitalization and Medical Services Inc., stated the surplus is for catastrophes and uncertainty in health reform. The subsidiary also said this could cause concern among regulators in Maryland and Virginia, where they do business. Read More

Florida

Orlando Health Chooses New CEO. On January 7, 2015, *Health News Florida* reported that effective April 2015, David Strong will take over as the new President and CEO of Orlando Health in place of interim CEO Dr. Jamal Hakim. Strong will leave his current position as CEO of Rex Healthcare in North Carolina. Read More

Assisted-Living Facilities Booming in South West Florida. On December 28, 2014, *News-Press.com* reported that the assisted-living industry is growing in South West Florida. As baby-boomers age, demand for new facilities is increasing, specifically for coastal Florida. New housing construction includes The Rose Garden of Fort Myers facility, a Lee Al Investors LLC facility, an Omega Communities facility, and two facilities by American House. Read More

Hawaii

Department of Human Services Extending Increased Reimbursements Paid to Providers by Six Months. On January 6, 2015, *Heartland* reported that Hawaii will be extending Medicaid fees paid to primary care providers for six months to prevent a 48% pay cut. The state is budgeting $5.5 million for the extension. The fee increase was originally enacted for two years through the Affordable Care Act and expired on December 31, 2014. Even with the extension, the state is still struggling with the health care system. Providers are hesitant to take on patients because low reimbursement rates can still exceed costs. Hospitals are being financially driven to keep patients in higher billable acute-care, causing a shortage of long term care beds. Read More

Iowa

CMS Approves Medicaid Waiver Amendments for Arkansas and Iowa. On January 5, 2015, *Modern Healthcare* reported that CMS provided new permissions to Republican-led states in efforts for the government to compromise with states in expansion. Arkansas was approved for imposing cost-sharing for beneficiaries below poverty level. The state will help residents making under the 138% purchase private plans on the exchange instead of enrolling in Medicaid. It then mandates these beneficiaries to make monthly contributions to a health independence account that covers cost-sharing. Iowa was approved to continue charging monthly premiums to beneficiaries under 138% of the federal poverty line. However, they cannot revoke coverage for the poorest beneficiaries failing to make premiums. The state was also approved to continue to decline to pay for non-emergency transportation through July 31st. Read More

CoOportunity Health Taken Over By State. On December 24, 2014, the *Des Moines Register* reported that the Iowa health insurance company, CoOportunity Health, was taken over by state regulators in an attempt to keep CoOportunity operating. CoOportunity has 120,000 members in Iowa and Nebraska, but has seen its available cash drop from 47 million dollars to 17 million dollars in just over a month. CoOportunity biggest struggle has been setting prices to match health risks. Read more

Kansas

Home-Care Attendants Call for Pay Increase. On December 18, 2014, the *Kansas City Star* reported that Governor Jay Nixon supports a wage increase for home care workers. The Department of Health and Senior Services is drafting an administrative rule to increase wages for home-care attendants by making sure vendors take less of a percentage from state funds. Separately, the union for home-care attendants is in the process of signing an agreement to raise the

minimum wage for workers to eight dollars and fifty-eight cents an hour. Read more

Lawsuit Against Sunflower State Health and Centene Alleges Extortion. On December 29, 2014, the *Wichita Eagle* reported that Jacqueline Leary demanded three million dollars weeks after being fired as vice president of network development and contracting for Sunflower. Leary claims she was wrongfully fired for protesting improper cost-cutting measures for Medicaid in Kansas, yet both companies state poor performance as the reason for her termination. Read more

Louisiana

DHH Receives Final Federal Approval for Hospital Public-Private Partnerships. On December 23, 2014, Louisiana's Department of Health and Hygiene (DHH) received federal approval for the state's hospital public-private partnerships structure. The state plan amendment approval retroactively covers financial payments made under the public-private partnerships going back to July 1, 2013. Read more

Massachusetts

Medicaid Funding Cut by $34 Million. On December 21, 2014, *Boston Business Journal* reported that 34 hospitals are affected by a $34 million cut in Medicaid funding, specifically disproportionate-share hospitals. Their rates are estimated to go up 10% for inpatient services and 5% for outpatient services. Furthermore, the state will only save $17 million of the $34 million because the federal government partially pays for supplemental funding. Read More

Health Policy Commission Requests Hospitals to Notify of Closures. On December 29, 2014, *Boston Business Journal* reported that the Health Policy Commission sent a request to the Executive Office of Health and Human Services to be notified of hospital closures to analyze the impact and report back to the Department of Public Health. The commission will have no regulatory power. It currently analyzes utilization trends, cost trends, and merger and acquisition costs. In the last year, two hospitals have closed: North Adams Regional Hospital and Quincy Medical Center, causing a backlash from their communities. Read More

Missouri

Lawmakers Face Opposition to Medicaid Expansion. On January 4, 2015, *The Kansas City Star* reported Missouri is continuing to see opposition to Obamacare and Medicaid Expansion. Republican Senators have promised to filibuster the expansion and opponents are proposing bills to prevent expansion. Concerns involve costs to the federal and state governments and the strain of adding people to the Medicaid program without changing how it functions. Opponents make up the majority of both legislative chambers so expansion is unlikely for 2015. This will negatively impact rural hospitals with huge cutback or closures. Read More

Montana

Two Proposals Compete for Medicaid Expansion Funds. On January 6, 2015, *Kaiser Health News* reported Montana is working to expand Medicaid. Montana's previous attempt at expansion in 2013 was struck down by the Republican legislature. This year, Democratic Governor Steve Bollock is putting forward a new proposal to provide Medicaid to anyone under the 138% Federal Poverty Line. Nine Republican legislators have a competing proposal that would expand Medicaid to those under the 100% FPL, with the notion that providing Medicaid to anyone above this income is a disincentive to work. The legislators further argue that anyone making 100% of the federal poverty line is eligible for subsidies on the exchanges. Montana's uninsured rate is currently 17%. Read More

North Carolina

Governor to Discuss Medicaid Expansion. On January 5, 2015, *PilotOnline.com* reported Republican Governor McCrory and two Senators will talk with President Obama on creating the state's own expansion program. McCrory has previously turned down Medicaid expansion but now says he is open to it if the program can be altered to cut down costs. The governor wishes to discuss what flexibility the state has and if they can develop their own state-specific program. According to a study by the Robert Wood Johnson Foundation and the Urban Institute, hospitals in North Carolina can lose $54 billion in reimbursements if the state does not expand Medicaid by 2022. Blue Cross Blue Shield of North Carolina is urging business leaders to lobby for the expansion to prevent further losses by hospitals and physicians. Read More

Oregon

Lynne Saxton Tapped to Head Oregon Health Authority. On December 18, 2014, *The Oregonian* reported that Governor John Kitzhaber selected Lynn Saxton to head the Oregon Health Authority (OHA). Lynne Saxton currently serves as executive director of Youth Villages Oregon, though she has also served as a board member for organizations such as Oregon Land Conservation and Development Commission, Portland Indian Leaders Roundtable, and Willamette University. Governor Kitzhaber believes Saxton can turn OHA's image around after OHA's difficult year with repeated failures dealing with Cover Oregon, the state's health insurance exchange website. Pending confirmation by the Oregon Senate, Saxton will start Jan. 20, 2015. Read more

Utah

Lawmakers Considering Limited Medicaid Expansion. On December 25, 2014, *My San Antonio* reported that Republican lawmakers, including Gov.-elect Greg Abbott, requested more information on the recent Medicaid expansion that took place in Utah. Gov.-elect Abbott is intrigued and interested in the flexibility with tailoring Medicaid funding to a plan unique to Texas called "The Texas Way." While the state is still deeply split on federal funding, the governor elect willingness to look at options has supporters of Medicaid expansion optimistic. Read more

Wyoming

Wyoming Legislature to Consider Medicaid Expansion Modeled After Indiana's Program. On December 18, 2014, the *Washington Post* reported that the Wyoming legislature will debate a proposal for expanding Medicaid during next year's session. The proposal loosely models the current Medicaid program in Indiana, including funds, contributions, and metrics. The Joint Labor, Health and Social Services Interim Committee voted to endorse this proposal, having rejected a proposal from Governor Matt Mead earlier this month. Medicaid Expansion would cover an estimated 17,600 people in Wyoming. Read more

National

Head of CMCS to Step Down. On December 19, 2015, *The Hill* reported that Cindy Mann will step down as deputy administrator and director of the Center for Medicaid and Children's Health Insurance Program Services after serving five years. Mann was instrumental in implementing ObamaCare and helping expand both Medicaid and CHIP where enrollments have spiked 16 percent. Vikki Wachino, previously the deputy director, will serve as interim deputy administrator. Read more

Director of Medicare-Medicaid Coordination To Leave CMS in January. On December 30, 2014, *Modern Healthcare* reported that Melanie Bella plans to leave the Medicare-Medicaid Coordination Office at the CMS in January. Bella's four-year tenure dealt primarily with improving coordinate care and reducing costs for dual-eligible beneficiaries. Tim Engelhardt, a deputy to Bella, will take over as acting director. Read more

CMS Enrollment Proposal Creates Conflict Between Insurers and Providers. On December 28, 2014, *Modern Healthcare* reported that the Obama Administration's guidance on dealing with provider networks has created a conflict of ideas between insurers and providers. The rule dealing with narrow networks includes proposals requiring drug formularies and provider directories to be made available in "machine readable" files and requiring insurers to use pharmacy and therapeutics committees to advise them on drug formularies. Insurers support the narrow networks as the insurers claim it reduces consumer premiums while consumer advocates and providers argue that consumers prioritize lower fares over their doctors and adequate coverage to meet their needs. Read more

Physicians to be More Selective Taking on New Medicaid Patients. On December 27, 2014, the *New York Times* reported that doctors and other providers will experience steep cuts in Medicaid payments when the two year "fee bump" ends December 31, 2014. An extension of the "fee bump" is unlikely with the new Republican Congress, forcing primary care doctors to be more selective in accepting Medicaid patients. Read more

Industry News

Addus HomeCare Acquires Priority Home Health Care, Inc. On January 5, 2015, Addus HomeCare Corporation, a provider of home and community-based services focusing on the dual population, announced their acquisition of Priority Home Health Care, Inc. Priority had revenues of $11 million as of December 31, 2014. The acquisition will substantially increase Addus HomeCare's presence in Ohio, which Addus President and CEO Mark Heaney said "is on the forefront of transitioning its Medicaid long-term care programs to managed care organizations, and all of Priority's offices are located in areas designated for participation in the state's dual eligible demonstration pilots." Read more

Accenture Wins Five-Year, 563 Million Dollar Contract With HealthCare.Governor On December 29, 2014, *Modern Healthcare* reported that Accenture won a five-year, 563 million dollar contract to continue its work on the federal health exchange website, HealthCare.Governor Accenture current contract was ending in January but CMS extended it by six months to avoid possible disruption during open enrollment. Accenture's help to the once troubled website has now fostered 2.5 million enrollees. Read more

Anthem Announces Simply Healthcare Holdings Acquisition. On December 22, 2014, Anthem announced the acquisition of Simply Healthcare Holdings and its subsidiaries, Simply Healthcare Plans and Better Health. Under the deal, Anthem will increase its Medicaid and Medicare membership in Florida to more than 500,000. Financial terms and transactions were not disclosed. The deal is expected to close the first half of 2015. Read more

Express Scripts Expands AbbVie's New Hepatitis C Medication. On December 22, 2014, Express Scripts announced that it will significantly expand access to include AbbVie's hepatitis C drug, Viekira Pak. Viekira Pak was determined clinically equivalent to Harvoni and Sovaldi. Starting January 1, 2015, 75 percent of three million Americans with hepatitis C will be eligible for access to Viekire Pak. Read more

CVS, Gilead Reach Deal on Hepatitis C. Gilead's Harvoni and Sovaldi will be the only Hepatitis C medications covered on CVS's formulary. AbbVie's Hepatitis C drug, called Viekira Pak, will only be available to patients given approval because of medical exceptions or through prior authorization. Read More

Centene Acquires LiveHealthier. On January, 5, 2015, *St. Louis Post-Dispatch* reported Centene Corp. acquired LiveHealthier Inc., a technology and service based health management adviser to government organizations, large employers, and unions. LiveHealthier is already a partner with Nurtur, Centene's Health and Wellness business. Centene has not yet announced the acquisition or its terms. Read More

The Ensign Group Announces Acquisitions. Effective Jan. 1, The Ensign Group has announced the acquisitions of Riverwalk Post-Acute and Rehabilitation, a 60-bed SNF, Rock Canyon Respiratory and Rehabilitation Center, an 81-bed SNF and the Villas at Rock Canyon, a 17-bed independent living and assisted living operation, all located in Colorado. The company has also acquired in Arizona, Alarys Home Health, a Medicare and Medicaid certified home health agency. In Texas, The Ensign Group has acquired Hospice of the South Plains, and the Mildred and Shirley L. Garrison Geriatric Education and Care Center, a 103-bed SNF. With these acquisitions, The Ensign Group now has a growing portfolio of 140 facilities, 11 hospice agencies, 13 home health agencies, two home care businesses and 15 urgent care clinics across 12 states. Read More

The Corridor Group Acquires Healthcare Management Solutions (HMS). On January 6, 2015, The Corridor Group announced its acquisition of HMS Healthcare Management Solutions, Inc. HMS provides consulting and revenue cycle management to healthcare and hospice providers, long-term care facilities, physician practices, acute care hospitals, and residential care homes. The acquisition will expand TCG's post-acute expertise to include facility-based long-term care providers and physician practice. HMS President and CEO, Donna Galluzzo, was named President of the newly combined company. Read More

Start-up BeneStream Helps Employers Identify Medicaid Eligible Workers. On January 7, 2015, *Kaiser Health News* reported a new start-up, BeneStream, is helping employers identify workers eligible for Medicaid and providing support to sign up. The company screens employees for $40 each in addition to a monthly $20 charge if they receive Medicaid coverage. CEO Benjamin Geyerhahn says this allows employers to save money by not paying a share of the worker's premiums nor risking any penalties. BeneStream has worked with 81 firms and signed up over 1,500 employees. In 2015, it will expand their client base from restaurants to include home health and nursing homes. Read More

Christopher Palmieri Leaves VNSNY Choice. Christopher Palmieri resigned as President of NVSNY Choice Health Plans, a home health care agency, merely a month after the former president, Mary Ann Christopher. The resignations followed a $35 million Medicaid settlement with New York state and federal officials. Dr. Hany Abdelaal will take over as president.

RFP Calendar

Date	State	Event	Beneficiaries
Mid/Late January, 2015	Louisiana MLTSS - Frail Elderly	RFP Release	50,000
Mid/Late January, 2015	Louisiana MLTSS - DD	RFP Release	15,000
Late January, 2015	Georgia	RFP Release	1,300,000
January/February, 2015	Michigan	RFP Release	1,500,000
February 1, 2015	South Carolina Duals	Implementation	68,000
February 1, 2015	Louisiana	Implementation	900,000
March 1, 2015	Michigan Duals	Implementation	70,000
April 1, 2015	Rhode Island (Duals)	Implementation	28,000
April 1, 2015	Puerto Rico	Implementation	1,600,000
June, 2015	Georgia	Contract Awards	1,300,000
July 1, 2015	Washington Duals	Implementation	48,500
July 1, 2015	Missouri	Implementation	398,000
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
Fall 2015	Louisiana MLTSS - Frail Elderly	Implementation	50,000
January 1, 2016	Georgia	Implementation	1,300,000
Early 2016	Louisiana MLTSS - DD	Implementation	15,000
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; WellPoint/Amerigroup (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; Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	178,000	Application			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	
Rhode Island*	Capitated	28,000	X	5/12/2014	9/1/2014		4/1/2015		
South Carolina	Capitated	53,600	X			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			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
Washington	Capitated	48,500	X	5/15/2013	6/6/2013	11/25/2013	7/1/2015	9/1/2015 11/1/2015 1/1/2016	UnitedHealthcare
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**11 Capitated 5 MFFS**	**1.35M 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 four states with active dual eligible demonstration enrollments in a capitated model as of this week's publication.

State	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
California	3,445	15,322	17,846	39,731	42,473	44,804	48,976	51,527	58,945
Illinois	106	444	2,281	5,552	7,963	8,064	8,632	12,651	
Massachusetts	13,191	13,274	13,409	18,836	18,067	17,739	17,465	18,104	
Virginia				11,169	11,983	21,958	28,642	29,648	27,701
Total	**16,742**	**29,040**	**33,536**	**75,288**	**80,486**	**92,565**	**103,715**	**111,930**	**N/A**

Source: State enrollment reporting compiled by HMA

HMA WELCOMES…

Sukey Barnum, Principal – Columbus, Ohio

Sukey was previously employed as a Senior Consultant in HMA's Columbus office in 2003. Sukey comes to HMA most recently from Kunz, Leigh and Associates where she worked as a Delivery Manager. In this role Sukey was responsible for establishing the Columbus practice in conjunction with a business development practice lead and was also charged with managing the delivery of services for KL&A's new market and office in Columbus. Several of her areas of responsibility included talent recruitment; opportunity assessment and proposal development; staff management; development of delivery guidelines for Ohio business; and project management for targeted projects such as automating Medicaid's processing of Medicare denied claims and implementing changes to Ohio Medicaid's coordination of benefits with Medicare in the context of Ohio's dual eligible Managed Care program.

Prior to her work with KL&A, Sukey was with CNSI in Olympia, WA for nine years where she served in several roles during her tenure. Her most recent role was Executive Account Manager over CNSI's contract with the State of Washington. Her responsibilities included MMIS Certification as well as operations and maintenance; design, development, implementation , and operations of Washington's system supporting the EHR Medicaid Incentive Payment Program and subsequent enhancements to support meaningful use requirements; and the design, development, and implementation of the MMIS 5010 compliance initiative. Sukey also served as a Project Manager and a Functional Manager during her time with CNSI. Additional roles that Sukey has served include Senior Health Policy Analyst for the Washington State Health Care Authority; Senior Consultant with HMA in our Columbus office; Chief, Bureau of Consumer and Program Support, Assistant Chief, Bureau of Consumer and Program Support, and Project Manager with the Office of Ohio Health Plans, Ohio Department of Job and Family Services; Consultant with the Ohio Child Support Enforcement Agency Director's Association; and Consultant with The Ohio State University and Ohio Department of Development.

Sukey received her Master of Public Administration degree from The Ohio State University and her Bachelor of Arts degree majoring in philosophy/minoring in dance from Oberlin College. She is also a certified Project Management Professional through the Project Management Institute.

Mel Borkan, Principal – Columbus, Ohio

Mel comes to HMA most recently from the Ohio Department of Medicaid where she has worked in many different roles over the past 28 years. She most recently served as the Medicaid Deputy Director and the Chief Strategy Officer for the last six years. In this role, Mel was responsible for all ACA eligibility and enrollment Medicaid work including APD construction, Gate Reviews, federal negotiation, budgeting, procurements, invoicing, business work plans, business DDI and M&O, State policy modifications (MAGI conversions, verifications, contingency plan), and business UAT; migration from the Legacy System to a new integrated system, negotiated a federal redetermination waiver; implemented a new Medicaid Claims Payment system; and implemented

incentive payment programs for eligible providers and eligible hospitals for adoption and meaningful use of federally certified EHR systems.

Prior to her role as the Deputy Director and Chief Strategy Officer, Mel served as the State budget and eligibility expansion Project Manager (SCHIP, pregnant women, parents, prisoner reintegration) under the new Governor; Project Manager for 'Mission, Vision, Values Project;' Assistant Deputy Director for Disability Policy; Chief of the Medicaid Bureau of Consumer and Program Support; Chief of the Medicaid Bureau of DD Services; and State Serious and Immediate Jeopardy Coordinator for Medicaid Division of Long Term Care. Additional positions that Mel has held include Behavioral Specialist with Franklin County Board of Developmental Services; Regional Program Manager for Voca Corporation; Executive Director for Residential Services of Licking County; and Program Administrator for the Columbus Developmental Center.

Mel received her Bachelor of Science degree in Special Education/Applied Behavioral Analysis from The Ohio State University.

Jim Downie, Principal – Columbus, Ohio

Jim comes to HMA most recently from the Ohio Department of Job and Family Services (Medicaid) where he has worked in many different roles over the past 29 years. He most recently served in a trilogy of roles over the past three years as Chief of State and Federal Compliance, Department of Medicaid Portfolio Manager, and Project Manager for the certification of Ohio's new MMIS system. In these roles, Jim was responsible for the development, submission, negotiation, and monitoring of all Ohio Medicaid Advance Planning Documents; prioritization, coordination, tracking, and assigning of Project Managers for all Medicaid projects; and overall management of the Certification of Ohio's new MMIS system from document compilation, Toolkit preparation, CMS response and negotiation, site visit preparation and execution, and follow-up.

Prior to his most recent tri-role with Medicaid, Jim served as the Medicaid Information Technology System Financial Work Stream Lead and the Project Manager for the Reinstatement of Medicaid for Public Institution Recipients with the Medicaid Project Management Office; Medicaid Coordinator for the Ohio Administrative Knowledge System, Interagency Contract Consultant for Medicaid Programs, Budget Support, Medicaid Administrative Claiming Lead, and Acting Bureau Chief/Plan Operations with the Medicaid Deputy Director's Office; Interagency Contract Manager for Medicaid Programs with the Medicaid Bureau of Consumer Access; Assistant to the Assistant Deputy Director for Disability Policy with the Medicaid Deputy Director's Office; and various other positions with the Medicaid Bureau of Consumer and Program Support, Medicaid Case Mix and Systems Administration Unit, Medicaid Bureau of Facility Contracting, Medicaid Bureau of DD Services, and Medicaid Division of Long Term Care. Additionally, Jim served as an Independent Contract Manager with the Government Resource Center

Jim received his Bachelor of Science degree in Production and Operations Management from The Ohio State University.

Warren Lyons, Principal – San Francisco, California

Warren comes to HMA most recently from HealthRIGHT 360 where he served as the Chief Operating Officer. In this role Warren was responsible for leading and managing the organization's comprehensive array of healthcare services for individuals with complex behavioral health needs as well as the successful

operation of all clinical programs including program planning, budgets, implementation, operation, compliance, and outcomes.

Prior to his work with HealthRIGHT 360, Warren was the Chief Strategy and Integration Officer for the Alameda County Medical Center. Here he drove strategy development and execution with respect to market positioning and branding, legislative advocacy and health policy positioning, service line positioning, and system integration; supported all grant sourcing and application processes for federal and state grants; and improved integration of current and new clinical programs with medical staff endorsements to form a physician organization. Warren also worked for Temple University Health System/Temple University Hospital for over seven years in several different roles – Chair, Board of Directors for the Philadelphia Neighborhood Health Center Inc.; CEO , Temple Health System Transport Team Inc.; COO, Temple Physicians Inc.; and Director, Operations Support. During his time with Temple, Warren directed internal system integration, hospital reengineering, service excellence, strategic and operational alternatives, business plan development, and oversight on major consulting engagements related to performance improvement. He also established a helicopter/ambulance expansion of successful ground critical care transportation services producing 6,200 transports, 1,500 transfers, and $5.1 million of hospital margin. Additional positions that Warren has held include Executive Director/CEO, Abington Health Services and Executive Director/CEO, The Community Health Alliance with Abington Memorial Hospital; Vice President, Marketing and Planning with Victory Memorial Hospital; Director of Planning for MacNeal Hospital; and Assistant Administrator with Heritage Hospital – PCHA.

Warren received both his Master of Public Health degree and his Master of Business Administration degree from Columbia University. He received his Bachelor of Arts degree in philosophy (Magna cum Laude) from Fordham University. Warren is also a Fellow with the American College of Healthcare Executives.