HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 1, 2015

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THIS WEEK

IN FOCUS

OKLAHOMA ISSUES ABD CARE COORDINATION RFI

This week, our *In Focus* section reviews the request for information (RFI) issued by the Oklahoma Health Care Authority (OHCA), soliciting input on a care coordination model, or combination of models, to serve the SoonerCare (Medicaid) aged, blind, and disabled (ABD) population. In early May, Governor Mary Fallin signed into law HB 1566, which directs OHCA to issue a request for proposals (RFP) for ABD care coordination in 2016. Oklahoma does not currently operate a fully capitated managed care program, although more than 100,000 Medicaid adults are enrollment in SoonerCare Choice, the state's

primary care case management (PCCM) program. This RFI seeks input from interested care coordination vendors on an array of potential care coordination models for the more than 137,000 ABD SoonerCare members.

Target Population

As of May 2015, there were around 825,700 total SoonerCare enrollees. Of these, 135,400 are ABD adults. According to the RFI, the ABD population accounts for just over 16 percent of total enrollment, but more than 46 percent of annual SoonerCare spending. In state fiscal year 2014 (SFY 2014), total Medicaid expenditures for the ABD population exceeded $2.4 billion. Total potential spending under a managed care model will be highly dependent on the inclusion or exclusion of long-term supports and services (LTSS), such as nursing facility and home and community based waiver services.

RFI Goals & Objectives

According to the RFI, OHCA has nine major objectives for the final care coordination model. The RFI seeks primarily to solicit information related to the first objective, but also addresses the other eight objectives, as follows:

1. Determine the best market-based approach(es) to serving Oklahoma's ABD members;
2. Improve health outcomes by ensuring members receive the most clinically appropriate evidence-based health care services delivered in a person-centered manner and in the least restrictive environment;
3. Incorporate requirements for the use of standard, performance-based quality metrics and value-based payment systems;
4. Improve coordination among providers, thereby reducing unnecessary costs, while maintaining high quality of care;
5. Strengthen providers' accountability for attainment of improved health outcomes;
6. Maintain and enhance effective systems of Long-Term Services and Support;
7. Provide efficient and effective health services and care coordination to eligible members;
8. Realize administrative and health care cost savings through efficient management and appropriate utilization of services; and
9. Ensure provider and member satisfaction with appropriate benefits.

Care Coordination Models

OHCA's RFI is broad in its request for recommended care coordination models, asking respondents to describe their capabilities to provide care coordination under each recommended model for the ABD population. The care coordination model options range from traditional Medicaid fee-for-service, risk-based arrangements with providers, partial capitation, and fully capitated MCOs. The RFI also asks for recommendations on shared savings, including the Medicare Shared Savings Program, the Program of All-inclusive Care for the Elderly (PACE), and the inclusion of LTSS, HCBS, health homes, and waivers.

Proposed Timeline

OHCA's proposed timeline for the care coordination RFP is detailed below, with the RFI question and answer process and the kickoff of monthly stakeholder meetings set for this month (July 2015). Responses to the RFI are due in August 2015, and OHCA is set to finalize the care coordination model (or models, if

multiple models are selected) to be implemented in November of this year. Per the current timeline, a final RFP would be released in June 2016, with responses due in August, 2016.

Timeline	Date
RFI Released	June, 2015
RFI Q&As, Stakeholder Meeting Kickoff	July, 2015
RFI Responses Due	August, 2015
Care Coordination Model(s) Finalized	November, 2015
Draft RFP to CMS for Approval	March, 2016
RFP Released	June, 2016
RFP Responses Due	August, 2016

Link to OHCA ABD Care Coordination:

http://okhca.org/about.aspx?id=17366

HMA Medicaid Roundup

Alabama

Pediatricians Worry About Medicaid Rate Cuts. On June 28, 2015, *Montgomery Advertiser* reported that pediatricians are concerned about Medicaid cuts. Pediatricians receive 30 to 50 percent of their funding from Medicaid. Furthermore, 52 percent of persons eligible for Alabama Medicaid are under the age of 18. A provider cut may cause pediatricians to cut services and/or staff, which could also hurt privately-insured children's access to care as well. Read More

Patients in Long-Term Care Rely on Medicaid Funding. On June 28, 2015, *Montgomery Advertiser* reported that according to the Alabama Medicaid Agency, three out of every four individuals in the state's nursing homes receive Medicaid coverage. As a result, many sick patients on long-term care rely on funding for Medicaid. The most frequent conditions of those entering nursing homes include congestive heart failure, pulmonary disease, and stroke. Advocates fear that cuts by legislators could be devastating. Read More

Alaska

Alaska Freezes Medicaid Inflation-Based Rate Increases, 1.6 to 2.6 Percent Annually. On June 29, 2015, *Alaska Dispatch News* reported that the Alaska Department of Health and Social Services announced it will freeze inflation-based rate increases for providers, which range from 1.6 to 2.6 percent each year. The state is expected to realize savings of $8 million from the freeze. Beginning July 1, the Alaska Medicaid program will already see a reduction of $51.9 million in state funds, equivalent to a loss of $100 million when including federal matching on expenditures; Gov. Bill Walker proposed a $21 million cut and the Legislature added an additional $31.9 million. Read More

California

HMA Roundup – Warren Lyons (Email Warren)

Governor Jerry Brown Signs $167.6 Billion State Budget. On June 24, 2015, Governor Jerry Brown signed a $167.6 billion state budget. The budget allots $32 billion for health care programs, $18 billion of which is for Medi-Cal. Below are the key elements affecting the state's healthcare programs.

- **Health Care Reform Implementation –** The Budget assumes additional Medi-Cal caseload of 3.7 million individuals and costs of $16.9 billion related to the implementation of the Affordable Care Act. Approximately 1.4 million additional people will receive Medi-Cal

benefits under the current 50-50 state-federal cost allocation, which amounts to total costs of $2.9 billion for this population of which $1.4 billion will come from the California General Fund. The federal government is paying nearly 100 percent of the costs of the remaining 2.3 million new individuals in the Medi-Cal program resulting from the Medicaid expansion. Total Medi-Cal enrollment is expected to rise from 7.9 million in 2013 to 12.4 million in 2015-16, covering nearly one-third of the state's population.

- **Expand Medi-Cal for Children Regardless of Immigration Status –** The Budget includes $40 million in General Fund expenditures to expand full-scope Medi-Cal coverage to qualified low-income immigrants under the age of 19 effective May 2016. The federal government shares in the cost of emergency- and pregnancy-related services.
- **Presidential Immigration Actions –** On November 20, 2014, the President announced executive actions that would allow certain undocumented immigrants to temporarily remain in the United States without fear of deportation. These actions were intended to provide stability to the immigrants' families and boost the economy. On February 16, 2015, a federal district court enjoined implementation of these actions. The Budget includes partial-year 2015-16 costs of $20.9 million ($16.8 million General Fund) for Medi-Cal for qualified individuals, which presumes the courts allow the federal government to proceed with implementing the executive actions beginning October 2015 and that full implementation will occur over 24 months.
- **Dental Provider Rate Restoration –** The Budget restores the previously implemented 10-percent provider rate reduction for Medi-Cal dental providers at an annual cost of $60 million (special and federal funds).
- **Provider Rates –** Chapter 3, Statutes of 2011 (AB 97), reduced most Medi-Cal provider rates by up to 10 percent. The 2014 Budget Act assumed retroactive recoupment of rate reductions for some services in fee-for-service Medi-Cal. The 2014 Budget Act exempted additional providers/suppliers, including high-cost prescription drugs, specialty physician services, various distinct-part nursing facilities, Bay Area Community Based Adult Services Centers, and nonprofit pediatric dental surgery centers. The Budget reflects an estimated $152 million annual General Fund cost for these exemptions and delays. The Budget also increases managed care rates by $125 million General Fund in 2015-16. Additional rate increases will be considered as part of a special legislative session on healthcare financing.
- **Skilled Nursing Quality Assurance Fee –** The Budget extends a quality assurance fee on skilled nursing facilities and provides for a 3.62-percent increase in reimbursement rates in 2015-16. This fee leverages additional federal funding that offsets General Fund expenditures in these facilities.
- **Behavioral Health Treatment –** The Budget includes $228.7 million ($114.3 million General Fund) in 2015-16 for behavioral health treatment services for individuals with Autism Spectrum Disorder up to 21 years of age. The services are now a required Medi-Cal benefit.

- **Children's Health Insurance Program (CHIP) Reauthorization —** On April 16, 2015, the President signed the Medicare Access and CHIP Reauthorization Act. The Act reauthorizes CHIP through September 2017 and includes enhanced federal funding for the CHIP program effective October 1, 2015. The Budget includes General Fund savings of $381 million in 2015-16 as a result of the Act.

- **Health Homes Program—** The Budget includes $61.6 million in non-state funds for additional payments to health plans that participate in the Health Homes Program beginning January 2016. The program will be funded primarily through federal funds, with the non-federal funding coming from non-state sources. Chapter 642, Statutes of 2013 (AB 361), permits DHCS to develop a health homes program that would enhance care management and coordination for beneficiaries with complex needs. The program will provide comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. **Caregiver Resource Centers —** The Budget provides $4.9 million General Fund for caregiver resource centers, an increase of $2 million. These facilities focus on providing information and services to families who provide care to family members that suffer from chronic or degenerative cognitive disorders that affect adults, such as Alzheimer's, stroke, or traumatic brain injury.

- **In-Home Supportive Services (IHSS) Overtime —** In January 2015, a federal court vacated the United States Department of Labor rule that required overtime pay for IHSS workers under the Fair Labor Standards Act. The federal government appealed this decision and in the interim, the state has halted implementation of IHSS overtime until the federal courts decide the legality of the rule. The Budget contains $270 million General Fund in 2015-16 with an assumed October 1, 2015 effective date if the federal rule is upheld.

- **In-Home Supportive Services 7-Percent Restoration —** The Budget includes a one-time General Fund augmentation of $226 million in 2015-16 to restore service hours. An ongoing fund source will be addressed through a special legislative session on healthcare financing.

The health care provisions of the state budget can be found here.

California Med-Cal Specialty Mental Health Services Waiver Approved. On June 29, 2016, *California Healthline* reported that CMS approved California's specialty mental health services waiver for the next five years. The waiver extends to June 30, 2020, covering patients with serious mental illnesses. Read More.

During the ninth waiver renewal which covers the time period July 1, 2015 – June 30, 2020 the SMHS consolidation waiver program will include the following new and/or updated projects/activities:

- **MHP Contract.** The State has finalized standard contract language and has contracts in place between DHCS and the MHPs. The effective date of the contract was May 1, 2013. This contract will be in place for a period of five years and two months extending until June 30, 2018, to conform to the State fiscal year.

- **EQRO Contracts.** The State conducted a procurement process to ensure that an ongoing external quality review process is in place in accordance with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E commencing with Section 438.10. The EQRO contract with Behavioral Health Concepts was secured by the State for FY 2014/15 through FY 2016/17 with an option to extend the contract for two additional one-year extension periods. The EQROs review has commenced.
- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Performance and Outcomes System for Mental Health Services.** In 2012, in accordance with Senate Bill 1006 (Chapter 32, Statutes of 2012), the California State Legislature enacted a process for the DHCS to develop a plan for an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mental health services to support the improvement of outcomes at the individual, program, and system levels and to inform fiscal decision-making related to the purchase of services.

Study Estimates Cost of Hepatitis C Medication for Taxpayers at $512 Million to $5.1 Billion. On July 1, 2015, *Kaiser Health News* reported that an analysis by the California Association of Health Plans estimates that taxpayers may pay between $512 million to $5.1 billion for Hepatitis C medication in prisons, state hospitals, or through state-funded programs such as Medi-Cal. Charles Bacchi, CEO of the association, states that the high costs are not sustainable for health plans, consumers, or taxpayers. The California budget allotted $228 million in additional funds for specialty drugs to treat Hepatitis C in state-funded programs. Read More

35 Counties Grant Healthcare to Illegal Immigrants. On June 26, 2015, *Los Angeles Times* reported that 35 more California counties granted healthcare to illegal immigrants, bringing the total to 47 counties. The latest group of 35 are mainly small, rural counties managed by the state County Medical Services Program. Officials stated that a few thousand may become eligible for benefits. In addition, the state budget signed by Gov. Jerry Brown also covers all illegal immigrant children. Read More

Court Rules Law Allowing Nursing Homes to Make Medical Decisions for Mentally Incompetent Residents is Unconstitutional. On June 26, 2015, *Kaiser Health News* reported that a law allowing nursing homes to make medical decisions on behalf of mentally incompetent residents was found unconstitutional by Judge Evelio Grillo. Grillo ruled that the law violated residents' due process rights because nursing homes were not required to contact patients or give them a chance to object. However, the medical decisions being made could result in significant consequences, including death. The law had been in effect for over 20 years. Read More

Connecticut

Medicaid Reimbursement Rate Cuts Mark Trend for Providers; Experts Fear Diminishing Access. On June 25, 2015, *The CT Mirror* reported that lawmakers are continuing to look to adjusting Medicaid rates to save money. As a result, many providers and advocates are beginning to fear negative impacts on access to care in Medicaid. Radiologists, for instance, saw a cut of 42.5 percent this spring, causing many to stop taking new Medicaid patients. Experts say that rate

cuts will have large consequences since physicians are not required to treat Medicaid patients. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida FY 2015-16 Budget. The Florida House and Senate ended their three-week 2015-A Special Legislative Session on Friday, June 19, approving a $78.7 billion state budget ($29.0 million general revenue) for the year beginning July 1, 2015 and avoiding a government shutdown. The budget provides more than $400 million in tax cuts for Florida families. The budget does not include any federal funds to expand health care coverage under Medicaid. The Legislature agreed to use $400 million in state funds to offset the expected loss of federal aid to hospitals under the Low Income Pool Program. The Medicaid Program is funded at $24.5 billion to serve an estimated 3.9 million Medicaid beneficiaries. The KidCare Program is funded at $405.2 million to serve an estimated 238,546 children. Governor Rick Scott signed the budget on Tuesday, June 23, vetoing more than $460 million in projects as part of the process. A summary of the major Medicaid programs funded in the budget are detailed below as well as proposals that were vetoed.

Major Medicaid Programs Funded

- **Low Income Pool (LIP)** - $1.0B to continue the LIP program to support health care providers that provide uncompensated care to Florida residents who are uninsured or underinsured.
- **Hospital Reimbursement** - $1.0B ($400M in general revenue) to increase and maintain hospital reimbursement rates.
- **Graduate Medical Education** - $100M for the Graduate Medical Education Startup Bonus Program to expand residency slots in physician specialties facing statewide supply shortage.
- **Provider Access** - $28.6M to increase access to primary care services and to reduce and prevent unnecessary emergency room visits and inpatient hospitalizations.
- **Outpatient Prospective Payment System** - $0.5M to contract with a consultant to study a transition from cost-based reimbursement for outpatient services to a prospective payment system.
- **Program of All Inclusive Care for the Elderly (PACE)** - $3.0M for an additional 156 PACE slots in Palm Beach County.
- **Long Term Care Waiver Waitlist**- $3.2M to serve 212 individuals on the Medicaid LTC Waiver waitlist who have been classified as a priority score of four or higher.
- **Brain and Spinal Cord Injury Program Waiver Waitlist**- $1.0M to serve an additional 25 individuals currently on the waiting list that are at the greatest risk for institutionalization.
- **Developmentally Disabled iBudget Waiver Waitlist** - $40.7M to expand the Medicaid Individual Budget (iBudget) waiver to serve an estimated 2,000 critical needs individuals on the wait list.

- **Waiver Support Coordinator Rate Increase** - $8.1M for an 18% uniform rate increase for Waiver Support Coordinator providers.
- **Personal Supports Provider Rate Increase** - $5.1M for a 2.5% uniform rate increase for personal supports providers to increase compensation for direct care staff.
- **Florida Medicaid Management Information System** - $5.7M to contract with a third party consulting firm to provide IV&V services to the FMMIS/DSS/Fiscal Agent procurement project.
- **Advanced Data Analytics and Detection** - $3.0M for the Data Analytics and Detection services which will detect and deter fraud, waste, and abuse in Medicaid and other public benefit programs within the state.

Medicaid Proposals Vetoed

- **Private Duty Nursing Rate Increase -** $1.7M for a 3% rate increase for private duty nursing services provided by a Licensed Practical Nurse (LPN).
- **Pediatrician Rate Increase -** $3.0M for a 2% Pediatrician rate increase.
- **ICF/DD Rate Increase** - $3.9M for a 1.6% rate increase for ICF/DD and eliminates the statutory freeze.
- **Program of All Inclusive Care for the Elderly (PACE)** - $1.0M for an additional 50 PACE slots in Pinellas County.

Administrative Challenge Filed Against Florida Department of Health for Screening Out Patients from Children's Medical Services Network. On June 29, 2015, *Health News Florida* reported that a family has filed a challenge to a new state process that is removing children from the Children's Medical Services Network without accepting public input or following other rule-making requirements. The challenge centers on a new eligibility screening tool being used to evaluate children. As of May 1, the Department of Health found that 2,065 of 7,427 children screened were no longer clinically eligible. Critics say the tool just shifts children out of the program and into managed care. The petition filed hopes to reinstate all the children in the network. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Suit Filed against State's Health Care Regulatory Process. On June 30, 2015, *Georgia Health News* reported that two doctors filed a lawsuit challenging the Georgia certificate-of-need program. The program is a set of regulations governing the creation and expansion of medical facilities, which Dr. Hugo Ribot and Dr. Malcom Barfield claim is unconstitutional and restricts competition. They also claim the CON laws encourage and facilitate state-granted monopolies. If the lawsuit is successful, it may create a national precedent for overturning CON laws, which exist in 36 states. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Fiscal Year Begins Without Budget as Legislature Works on Temporary Fix. On July 1, 2015, Illinois began its 2016 fiscal year with no budget in place after Governor Bruce Rauner vetoed most of the legislature's budget bills last week. After using a parliamentary procedure to hold on to budget bills passed in late May for almost a month, the democrat-controlled legislature sent the bills to the Governor on June 22. Three days later, and just five days before the start of the new fiscal year, the Governor vetoed almost the entire budget. The veto included the budgets for the Department of Healthcare and Family Services, and the Department on Aging and the Department of Human Services.

On June 30, 2015, the *Chicago Sun Times* reported that democrats are planning a vote on a temporary one-month budget for July 1, 2015, (*as of the time of publication, a vote has not occurred*). The temporary budget fix would include Medicaid funds and funding for other human services programs. However, Governor Rauner's budget director issued a memo indicating that the proposed one-month budget does not meet balanced budget requirements and would thus be unconstitutional.

If a budget agreement or temporary fix is not reached, the timing of when medical providers could feel the impact will vary. Due to a backlog of unpaid bills from FY 2015, many providers will continue to see payments for some time and likely would not have seen FY 2016 payments, even with a budget, until the end of summer. Expedited providers will see an impact as soon as claims for FY 2016 dates of service are processed, although billing and processing lags delay this impact for a couple of weeks. Of greater concern would be a Government shut down if payroll cannot be met mid-month. At that point, processing of FY 2015 payments could potentially stop, as could other functions related to the Medicaid program, such as prior approval of services.

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Attorney General Releases Health care Costs Trends Report, Shifts Conversation to Behavioral Health. On June 30, 2015, *Common Health* reported that Attorney General Maura Healey released a health care cost trends report, which takes stock of behavioral health benefits. In Massachusetts, 79 percent of residents enrolled in MassHealth or ConnectorCare have coverage that separates general medical care from mental health. For members of commercial health plans, 31 percent have the additional coverage. Healey's report states that the state needs a better system of sharing patient information between medical and behavioral health providers, and more coordination of care. Read More

Three Insurers Challenge Health Connector's Risk Adjustment Program. On June 25, 2015, *Worcester Business Journal Online* reported that Fallon Health, Minuteman Health, and Health New England asked the Health Connector Insurance Authority to review the risk adjustment program. The program, meant to discourage insurers from avoiding sick patients, may negatively impact smaller carriers financially, leaving them to potentially pay millions of dollars. In the letter, it states "Massachusetts' risk adjustment program attempts to cure a problem which does not exist, unfairly penalizes smaller regional

carriers while benefiting larger carriers and will de-stabilize, rather than stabilize, the merged marketplace." Read More

Former HHS Secretary, John Polanowicz, Joins Steward Health Care. On June 25, 2015, *The Boston Globe* reported that John W. Polanowicz, former state secretary of Health and Human Services, was hired as Executive Vice President of Network, Insurance, and Physician Operations for Steward Health Care System. Read More

New Hampshire

Executive Council Approves Four-Month Extension of Medicaid Managed Care Contracts, $145 Million MMIS Funding. On June 25, 2015, *Concord Monitor* reported that the Executive Council approved a four-month extension of the state's current Medicaid managed care agreements with Well Sense Health Plan and NH Healthy Families, while the state finalizes new contracts with providers, a Medicaid billing system, and substance abuse and mental health-related initiatives. The contracts were set to expire on July 1. The state will then move to Step 2 of their initiative to transition to Medicaid managed care, which involves adding several new groups of people, "including residents who have developmental disabilities, who require in-home supports, who have acquired brain disorders, and who rely on nursing home services." The Council also signed off on $145 million of funding for the state's Medicaid Management Information System. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Medicaid agency approves three out of six New Jersey Medicaid ACO applicants for a demonstration that begins July 1, 2015. On June 30, 2015 *NJBIZ* reported that three of six Medicaid ACO applicants were approved to begin a three-year demonstration project effective July 1, 2015. The Camden Coalition of Healthcare Providers, Trenton Health Team, and the Healthy Greater Newark ACO (an organization affiliated with the Greater Newark Healthcare Coalition) represent the approved applicants. The New Jersey Health Care Quality Institute issued a press release on the approvals and said ""New Jersey's Medicaid ACO pilot presents an opportunity to test a regional data-driven, patient-focused approach to providing more coordinated health care services that will bring about better patient experiences, encourage doctors to be more effective and efficient, reduce medical errors, and more actively engage patients in their health care." The demonstration will be evaluated by the Rutgers Center for State Health Policy. Read More

Key changes occur in New Jersey's health, insurance, and human service leadership. On June 22, 2015 *PolitickerNJ* reported on changes to Christie administration's top leadership. Mary O'Dowd, the state's commissioner for the Department of Health since 2011 is departing and was unanimously approved by the Senate Judiciary Committee to transition to her new role on the board of Horizon Blue Cross Blue Shield, the largest health insurer in the state. Banking and Insurance Commissioner Ken Kobylowski will leave the administration to join AmeriHealth New Jersey as senior vice president of provider contracting and network operations effective July 13, 2015. In addition, acting Human

Services Commissioner, Elizabeth Connolly was formally nominated as Commissioner of the Department of Human Services. Read More

State of New Jersey files Public Notices. The state of New Jersey filed two public notices in the past week, detailed below:

1. **Medicaid and Developmental Disabilities Divisions file for 1115 waiver amendment to Supports Program.** On June 25, 2015 the Division of Medical Assistance and Health Services (DMAHS) together with the Division of Developmental Disabilities issued a public notice of its plans to file an amendment to the 1115 demonstration waiver with the Centers for Medicare and Medicaid Services (CMS) to implement changes to the Supports Program. The amendment would create two new eligibility groups for the Supports Program and allow individuals in the Supports Program who are eligible for and in need of private duty nursing services to access those services through Managed Long Term Services and Supports program (MLTSS).
2. **State seeks CMS approval for a State Plan Amendment (SPA) regarding the health care subsidy fund payment.** On June 25, 2015 the Departments of Human Services and Health announced its plans to file a SPA with CMS to implement state fiscal year 2016 budget provisions. The public notice describes the methodology for arriving at each eligible hospital's SFY 2016 charity care subsidy allocation. Comments are due by July 30, 2015.

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Care Advisory Review Panel

The Medicaid Managed Care Advisory Review Panel (MMCARP) met by teleconference on June 25. The MMCARP, an oversight panel established by the NYS legislature, is charged with reviewing the capacity of the Medicaid managed care program to meet the needs of all Medicaid beneficiaries. The meeting included updates on managed long-term care and FIDA, the duals demonstration program, and the behavioral health carve-in.

- **Managed Long-Term Care.** The remaining counties in upstate NY have all received CMS approval to begin implementation of the transition to a mandatory MLTC program for dual-eligible individuals requiring more than 120 days of community-based long-term care. The transition to a mandatory MLTC program began in September 2012 in New York City and has gradually expanded across the rest of the state. The last counties to be approved for transition include Chautauqua, Chemung, Essex, Hamilton, Schuyler, Seneca and Yates for June 2015, and Allegany, Clinton, Franklin, Jefferson, Lewis, and St. Lawrence for July 2015.
- **FIDA.** FIDA enrollment was 4,407 as of June 2, 2015, down from 5,920 on May 1. Opt-outs have risen to 47,702. Passive enrollment, suspended in June, will include 3,908 individuals in July and 5,584 individuals in August. Concerns about low enrollment and high opt-out rates led the state to conduct an outreach event for providers, offering an overview of the FIDA program and highlighting the benefits of FIDA, best practices, and experiences. In response to concerns raised by plans, the

Interdisciplinary Team policy has been revised. Revisions address the timing of IDT meetings, as well as simplifying administrative processes and sign-off.

- **Behavioral Health Reform.** Planning for the behavioral health carve-in continues in NYC. The state has received draft Special Terms and Conditions from CMS that would authorize the changes and reports that they are very close to approval. Readiness reviews are under way for the 10 plans that have received conditional designation as a qualified plan and/or a Health and Recovery Plan (HARP). HARPs are a specialized integrated product line for people with significant behavioral health needs and will be operated by Medicaid managed care plans. On-site reviews are underway with final designation expected for August. Not every plan has decided to offer a HARP: two of the eight plans (Affinity and Wellcare) have opted not to operate a HARP. These two plans serve about 15 percent of HARP-eligible individuals. Those individuals will receive a letter from NY Medicaid Choice explaining their options: to remain in the plan they are currently enrolled in, or to switch plans so they can enroll in a HARP and receive the enhanced benefits available through the HARP. All other HARP-eligible individuals will be passively enrolled in the HARP operated by their current Medicaid managed care plan with the opportunity to opt out.

  Medicaid managed care plans will be required to contract with all Office of Mental Health licensed providers and Office of Alcohol and Substance Abuse Services certified providers serving five or more plan members for a period of at least two years and must pay the current Medicaid fee-for-service rates. Home and community based services newly available through the HARPs will be paid outside the HARP premium for at least two years, as the plans have no history with these services to allow them to be built into the rates.

DSRIP Program Awards. Governor Cuomo announced specific Delivery System Reform Incentive Payment funding allocations to 25 provider networks across New York State. These allocations represent the maximum potential funding that each Performing Provider System is eligible to receive under the DSRIP program. This funding is intended to allow health care providers to implement reforms that reduce avoidable hospitalizations, improve care and reduce costs. DSRIP requires providers to collaborate by forming a Performing Provider System (PPS) to implement projects focusing on system transformation, clinical improvement, and population health improvement. The ultimate goal of these projects is to achieve a 25 percent reduction in avoidable hospital use over five years.

The Governor's press release indicated that the total award amount included approximately $1 billion in additional federal funds, increasing the total DSRIP funding from $6.3 billion to $7.3 billion, confirming an earlier report in *Crain's*. As reported in *Capital NY*, however, a spokesperson for CMS refuted that claim, indicating that no additional federal funds have been made available and that the state was providing the funding.

Medicaid Spending Declines. The Governor's press release also indicated that New York's Medicaid spending per person dropped to a 13 year low over the past 12 months. As part of the Medicaid expansion resulting from the Affordable Care Act, enrollment in Medicaid has increased by more than 500,000

to 6.2 million, a growth of nine percent. At the same time, annual spending per recipient fell to $8,223 - the lowest level in more than ten years. Overall Medicaid spending growth has slowed to 1.4 percent per year since 2011, when Governor Cuomo established the Medicaid Redesign Team. Prior to that, the 2003-2010 rate of increase was 4.3 percent annually. A chart detailing total Medicaid spending per recipient is available here.

Public Forums on Behavioral Health Service Agency Integration. The New York State Office of Alcoholism and Substance Abuse Services (OASAS) and the New York State Office of Mental Health (OMH) will host a series of fact-finding forums to consider the appropriateness of consolidating the missions of OASAS and OMH into an integrated and unified behavioral health services agency. OASAS Commissioner Arlene Gonzalez-Sanchez and OMH Commissioner Ann Sullivan, MD, and Paul Samuels, Esq., Chair of the New York State Behavioral Health Services Advisory Council (BHSAC), are jointly chairing a Steering Committee which will assess and report its findings on the value of creating an integrated behavioral health services agency to improve service delivery, streamline the transition to Medicaid Managed Care, and enhance the treatment outcomes for people currently receiving behavioral health services in New York State. The Chairs seek public input into the question of whether a new behavioral health agency should be created and whether the creation would improve the care for populations currently served by both agency funded/licensed programs. For information about the dates and locations of the forums, see here.

EmblemHealth Credit Rating Downgraded. Fitch Ratings has lowered the credit rating of EmblemHealth from BBB- to BB+. EmblemHealth, formed through the merger of Group Health Incorporated (GHI) and HIP Health Plan of New York (HIP), provides health care coverage and administrative services to approximately 3.2 million people. This includes 231,000 Medicaid individuals enrolled in HIP, EmblemHealth's Medicaid managed care plan. According to Business Wire, the rating downgrade primarily reflects EmblemHealth's poor 2014 and first quarter 2015 financial performance. HIP and GHI combined reported a net loss of $40 million in the first quarter of 2015 after reporting a combined net loss of $494 million in 2014. In contrast, from 2010 through 2013 HIP and GHI generated a combined net profit each year, and the companies' combined net income averaged $152 million.

EmblemHealth recently announced that its President and CEO, Frank Brancini, will step down as of September 1, 2015. Karen Ignani, formerly President and CEO at America's Health Insurance Plans, has been named as his successor.

New York Essential Health Benefit Options. The ACA provides states with the opportunity to change their Essential Health Benefit for 2017. NY State of Health hosted a webinar to describe the ten options available for the exchange and highlight their differences as compared to each other and to the current EHB. The State was accepting public comments through June 29; it will submit its plan selection to CMS on July 1. HHS will issue a notice of proposed rulemaking in August and open a subsequent public comment period. The NYSOH presentation can be found on the NYSOH website.

North Carolina

Governor Pat McCrory Will Continue Discussions on Expansion Waivers after Supreme Court Ruling. On June 26, 2015, *Winston-Salem Journal* reported that Governor Pat McCrory still believes that Medicaid is broken and must be reformed but is pleased the Supreme Court ruling has provided final clarity on the law. McCrory stated that he will continue discussions with the Obama administration regarding waivers. In the past four months, he was unable to receive the waivers he proposed. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio's new budget. The budget as signed, includes a variety of important tax, education, health care and other provisions that will shape the policy and political work ahead, even as the Governor begins to turn his attention more fully towards the White House. Some actions reported in the Columbus Dispatch include:

- Vetoing an item prohibiting the State's Controlling Board, a legislative spending oversight panel, from authorizing the spending of unanticipated money that exceeds $10 million or 10 percent of the initial appropriation. There was concern that legislators could use the provision to block the release of dollars for Ohio's Medicaid expansion
- Vetoing a measure that would have allowed working poor married couples receiving Medicaid to obtain a waiver to keep it if they made too much money

The general revenue fund budget is expected to increase about 15 percent over the budget period. Read More

Oklahoma

Medicaid Leaders Will Not Reduce Provider Rates. On June 24, 2015, *NewsOK* reported that the Oklahoma Health Care Authority leaders will no longer cut nurse practitioner and physician assistant rates. The initial proposals were met with opposition from the medical community. Finally, after receiving more data regarding the current and future budgets, the agency decided to hold off on cuts. The Health Care Authority must still make approximately $40 million in budget cuts. Read More

Oregon

HMA Roundup – Nora Leibowitz (Email Nora)

Oregon Medicaid Plans Making Strides in Health Metrics. In 2012 Oregon revamped the state's Medicaid program (called the Oregon Health Plan), moving from traditional managed care to "Coordinated Care Organizations" (CCOs), entities that were charged with managing the physical, behavioral and dental health for members. The goal is to improve health outcomes while reining in costs. The state tracks 33 measures, including 17 tied to financial

incentives. It also tracks financial data in the form of cost and utilization information.

2014 data were just made available, the first time that full year data were assessed for some key measures for the 434,000 Oregonians newly enrolled in the Oregon Health Plan since January 2014, the first year of the state's Medicaid expansion under the ACA. Despite taking on so many new members, the CCOs made significant progress, reducing emergency department use and increasing use of primary care providers. Other changes include:

- Decreased hospital admissions for short term complications from diabetes;
- Decreased hospital admissions for chronic obstructive pulmonary disease;
- Increased enrollment in patient-centered primary care homes; and
- Improvements in the Screening, Brief Intervention and Referral to Treatment (SBERT) measure for alcohol and drugs.

All CCOs showed improvement, and 13 of the 16 CCOs earned 100% of their 2014 quality pool payments. Three percent of the monthly capitation is withheld from CCOs to fund the annual quality pool. This is the first year that the state has taken data from provider electronic health records, rather than relying solely on claims data. This shift signals a move from a focus on process measures to health outcomes.

The regional CCOs work with providers to improve outcomes for members while lowering costs. By doing so, the organizations meet certain metrics set by the state and receive incentive payments. These payments are part of the state's effort to reduce overall spending on Medicaid, which is a key condition in exchange for the $1.9 billion the state received from the federal government to implement its Medicaid transformation. Oregon promised to reduce state and federal Medicaid spending by $11 billion over 10 years and lower the cost curve two percent in the next two years. The full report is available here.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Following Supreme Court Decision, Pennsylvania Withdraws Plan to Create Exchange. As a result of the Supreme Court ruling in favor of health-exchange subsidies in *King v. Burwell,* Pennsylvania Governor Tom Wolf said, "My administration will be notifying the federal government that we will be withdrawing our plan to set up a state-based health insurance marketplace in Pennsylvania. "I took steps to protect Pennsylvania's consumers by putting in place a contingency in the event the Supreme Court ruled people are not eligible for subsidies, but I am pleased to say that we will no longer need to rely on this plan." Read More

Pennsylvania Governor Vetoes Entire Republican Budget Bill. Democratic Gov. Tom Wolf made good on his threat and swiftly vetoed the Republican-crafted spending plan Tuesday night just hours after the GOP's huge majorities in the Legislature sent it to him on the last day of the state government's fiscal year. Republicans sent the $30.2 billion, no-new-taxes bill to Wolf after negotiations between the two sides stalled in recent weeks. The budget bill

passed the Senate on Tuesday and the House on Saturday. But it passed without any Democratic lawmaker's support, making it extremely unlikely that Republicans could muster the two-thirds majority in both houses to override the veto. The absence of a budget as the new fiscal year began was not expected to have an immediate effect on services because agencies can tap surpluses and special funds, but the situation could deteriorate if the impasse drags on. The state will lose the authority to pay its vendors for work done from Wednesday on. Read More

Pennsylvania Concludes Public Input Period for Medicaid MLTSS Planning Process. Pennsylvania state agency officials held the final two of six Public Input Sessions related to the Commonwealth's Managed Long term Care Services and Supports (MLTSS) Discussion Paper on June 23 in Harrisburg and June 26 in Philadelphia. About 200 people attended each meeting including managed care industry representatives, provider organizations, advocates, beneficiaries and other stakeholders. At each session, presenters were given 5 minutes to address remarks to a panel of Pennsylvania state senior leaders including, Ted Dallas, the Secretary of the Department of Human Services, Teresa Osborne, the Secretary of the Department of Aging, and Jennifer Burnett, the Deputy Secretary for Long Term Living.

Similar themes emerged from both hearings. While not universal, the general sentiments were supportive of the states' plan to better manage long term care services and supports, though many speakers expressed concerns about the speed with which the state planned to move forward toward MLTSS. A number of speakers suggested that the state allow more upfront time for stakeholder input to the planning process. In addition, consumer representatives in Philadelphia stressed the need for more transparency overall and establishment of an ongoing stakeholder advisory group through and after implementation. Other speakers suggested that the state at least allow more time between the implementation of Phase 1 (the South West Zone) and the next two phases (South East Pennsylvania and the rest of the state) to incorporate changes as a result of lessons learned in the first phase. Some presenters suggested that the state should consider aligning the MLTSS regions with the 5 zones configured for HealthChoices (the Medicaid mandatory managed care program in Pennsylvania) in order to allow more consistency in the various Medicaid delivery systems. A representative of the for-profit nursing homes testifying in Philadelphia recommended that the state pilot different models, including a provider-led model, in geographically targeted areas of the state, with ample time to evaluate results, prior to pursuing a statewide approach.

A Managed Care Coalition representative asked that the MLTSS implementation be added to the planned re-procurements of the HealthChoices physical health program later this year. Several presenters expressed concern about an emphasis on cost savings and asked that any savings be reinvested in care for persons needing LTSS. Many commenters asked that the state pay close attention to the readiness of provider networks before moving forward in any zone. Some presenters were worried about the ability to have a choice of home and community based providers. Home care providers stressed the need for adequate rates to support availability of HCBS services. At least one speaker suggested beneficiaries have the option to return to FFS if they could not get the provider they wanted. Presenters in Philadelphia stated that a recent transition to a statewide fiscal management agent had led to disruption in the provision of person-directed services, with many personal attendants going unpaid, and

stressed importance of a more seamless transition in a managed care model. The state was also challenged to use all the potential federal options in the state toolbox, including Community First Choice, Balancing Incentive Program and Money Follows the Person in implementing MLTSS. A representative of the nursing home providers challenged the state to avoid stacking the deck against nursing homes and to incorporate protections to ensure that persons who could not reside in the community be provided needed nursing home care. It was also suggested that the state incorporate an effort of maintenance for existing LTSS beneficiary services. Several Area Agencies on Aging were represented and suggested that they be included in the mix for the new program. There were also pitches made for an ombudsman, housing supports, streamlined eligibility and supporting the integration of behavioral health and Medicare Special Needs Plans (SNPs).

Tennessee

Insure Tennessee Advocates Hopeful after Supreme Court Ruling. On June 29, 2015, *The Tennessean* reported that advocates of Gov. Bill Haslam's Insure Tennessee plan are hopeful the recent Supreme Court ruling and an upcoming presidential visit will change the environment for the debate on expansion. However, opponents still argue that expanding Medicaid carries with it too many unknowns and a distrust of the federal government. Haslam was unsure what effect the ruling would have on the debate. The next chance for lawmakers to formally debate expansion will be at the start of the next legislative session in January. Read More

National

CMS Issues Reinsurance Payment Report as Part of Premium Stabilization Efforts. On June 30, 2015, the Centers for Medicare & Medicaid Services (CMS) announced it has released a report detailing estimated reinsurance payments by insurer, and concluding that, based on preliminary analysis, the reinsurance program is working as intended. According to CMS, it was determined that the number of eligible high cost claim expenses were lower than originally anticipated for 2014, leading the agency to reimburse all eligible claim expenses at 100 percent rather than 80 percent, per CMS regulations. For 2014, over $7.9 billion in reinsurance payments will be made to 437 insurers nationwide. Read More

States Consider Regional Networks or Switch to Federal Marketplace after Supreme Court Ruling. On June 26, 2015, *The Wall Street Journal* reported that some states operating their own exchanges may join the federal marketplace, according to policy experts. After the Supreme Court ruling to uphold subsidies on the federal exchange, states facing financial strain of running an exchange may consider switching over or forming regional exchanges. Specifically, exchanges in smaller states have faced lower than expected enrollment, high technology costs, and low revenues. Some of these states are also considering increasing insurer fees to boost revenues. Read More

Industry News

Centene Acquisition of Agate Resources Approved. On Thursday, Centene Corporation, which has sought to purchase Eugene, Oregon based Agate Resources, Inc, received approval of the sale from the Oregon Insurance Commissioner. Agate is the parent company of Trillium Community Health Plan, Inc., one of Oregon's Coordinated Care Organizations (CCOs), providing Medicaid services to 100,000 Oregon Health Plan members in Lane County, Oregon. Trillium also serves approximately 3,500 Medicare Advantage members and offers a product sold on Oregon's health insurance marketplace. Trillium CEO Terry Coplin and the current management team will continue to lead local operations.

Oregon Insurance Commissioner Laura Cali reviewed over 50 public comments on the sale. A number of people indicated concern about a loss of local control. Some suggested that an out-of-state for-profit would not provide the service and access needed by plan members. Trillium is a for-profit entity, along with 9 of the other 16 Medicaid CCOs in Oregon. While some worry that profit rather than service will be prioritized, others hope that Trillium will benefit from the resources and infrastructure of a larger parent organization. Trillium was one of two CCOs that closed to new enrollment due to difficulty meeting the needs of an expanded enrollee population.

In her decision to approve the sale, Commissioner Cali found "no material or reasonable objections" to the sale, noting the sale would not "substantially reduce the security of and service to be rendered to policyholders." Read More.

Ensign Group Acquires 10 Nursing and Assisted Living Operations in Arizona. On July 1, 2015, The Ensign Group announced that it will purchase 10 skilled nursing and assisted living facilities in Arizona, effective July 1, 2015. The facilities are:

- Granite Creek Health and Rehabilitation Center, a 107-bed skilled nursing facility located in Prescott, Arizona;
- Citadel Post Acute, a 110-bed skilled nursing facility located in Mesa, Arizona;
- Heritage Court Post Acute of Scottsdale, a 52-bed skilled nursing facility located in Scottsdale, Arizona;
- Lake Pleasant Post Acute Rehabilitation Center, a 105-bed skilled nursing facility located in Peoria, Arizona;
- South Mountain Post Acute, a 118-bed skilled nursing facility located in Phoenix, Arizona;
- La Canada Care Center, a 124-bed skilled nursing facility located in Tucson, Arizona;
- Mountain View Care Center, a 114-bed skilled nursing facility located in Tucson, Arizona;

- The Citadel Retirement Community, an 135-unit assisted living and an 185-unit independent living campus located in Mesa, Arizona;
- Las Fuentes Resort Village, an 82-unit assisted living and an 181-unit independent living campus located in Prescott, Arizona; and
- Mountain View Retirement Village, a 99-unit assisted living and a 102-unit independent living campus located in Tucson, Arizona.

Ensign Group Acquires Washington Skilled Nursing Facility. On July 1, 2015, The Ensign Group announced that it acquired Olympia Transitional Care and Rehabilitation, a 125-bed skilled nursing facility in Washington, effective July 1, 2015.

RFP Calendar

Date	State/Program	Event	Beneficiaries
July 1, 2015	Missouri	Implementation	398,000
July 1, 2015	Kentucky	Implementation	1,100,000
July 1, 2015	Mississippi CHIP	Implementation	50,300
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
September, 2015	Georgia	Contract Awards	1,300,000
September, 2015	Pennsylvania HealthChoices	RFP Release	1,700,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (Phase I)	450,000

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; Cigna-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 (*exiting demo*); 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), Cigna-HealthSpring, 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 Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active demonstration enrollment.

State	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
California	48,976	51,527	58,945	122,908	123,079	124,239	122,520	122,798	122,846
Illinois	49,060	49,253	57,967	63,731	64,199	60,684	58,338	55,672	53,328
Massachusetts	17,465	18,104	17,918	17,867	17,763	17,797	17,621	17,637	17,506
Michigan								9,216	14,867
New York				17	406	539	6,660	7,215	5,031
Ohio				68,262	66,892	65,657	63,625	63,446	62,958
South Carolina					83	1,205	1,398	1,366	1,317
Texas						58	15,335	27,589	37,805
Virginia	28,642	29,648	27,701	27,333	26,877	27,765	27,349	30,877	29,970
Total Duals Demo Enrollment	**144,143**	**148,532**	**162,531**	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,628**

HMA News

New this week on the HMA Information Services website:

- Managed Long-Term Services and Supports RFP Calendar
- Medicaid Disease Prevalence Maps for NY and CA
- MLRs Average 87.7 percent for 203 Medicaid MCOs in 2014
- Plus public documents for NC house-passed Medicaid ACO legislation and the *King v. Burwell* Supreme Court decision

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA's Linda Follenweider and Donna Strugar-Fritsch to Present at Annual Correctional Health Leadership Institutes

July 10-11, 2015
Long Beach, California

HMA's Linda Follenweider (Chicago, Illinois) and Donna Strugar-Fritsch (San Francisco, California) will present at the National Commission on Correctional Health Care's annual Correctional Health Leadership Institutes. Their session, titled "A Call for New Paradigms in Correctional Health" will highlight the challenges and leverage points in bringing innovations in primary care from the community into correctional settings. Read More

HMA Partners on Report Assessing Home Interventions for Asthma Patients

Link to Report

The Green & Healthy Homes Initiative® (GHHI®) recently released "Sustainable Funding and Business Case for GHHI Home Interventions for Asthma Patients." HMA partnered with GHHI to create the publication which assesses ways in which effective, comprehensive home interventions can be integrated with the healthcare system payment structure.

The report identifies sustainable health-related funding streams for asthma-related home interventions, looks at payment structures, and examines the business case for healthcare payers to fund these services. HMA Managing Principals Jack Meyer, Gaylee Morgan and Mike Nardone explored medical payment models and other funding streams related to health based housing.

This report is the first in a series of GHHI papers that will address new pathways for sustainable funding in alignment with the healthcare system as GHHI works to advance the dialog about housing as a platform for health. The Osprey Foundation and the JPB Foundation provided support for this report.

The GHHI is a national nonprofit organization dedicated to breaking the link between unhealthy housing and unhealthy residents. Formerly known as the Coalition to End Childhood Lead Poisoning, GHHI replaces stand-alone housing intervention programs with an integrated, whole-house approach that produces sustainable green, healthy and safe homes.

Latest HMACS Blog Post Reflects on the Importance of Social Justice

With two major SCOTUS decisions last week on access to affordable health care and same-sex marriage, and with President Obama's eulogy for South Carolina state senator Clementa Pinckney in mind, HMA Community Strategies (HMACS) reflects on the importance of social justice in the United States in its latest blog post. HMACS emphasizes why social justice is still an essential part of working towards the creation of healthy, equitable, and sustainable communities across the country. Jackie Laundon, HMACS Junior Associate, authored this June blog post.