HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 5, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

THIS WEEK

IN FOCUS

RHODE ISLAND REACHES AGREEMENT WITH CMS ON DUALS DEMONSTRATION MOU

This week, our *In Focus* section reviews the completed memorandum of understanding (MOU) between Rhode Island and the Centers for Medicare & Medicaid Services (CMS) for the state's capitated dual eligible financial alignment demonstration, known as the Integrated Care Initiative (ICI). The MOU paves the way for the Rhode Island Executive Office of Health and Human Services (EOHHS) to implement Phase II of the ICI later this year. EOHHS previously launched Phase I of the ICI in November 2013, coordinating

only Medicaid benefits for the dual eligible population and users of long-term supports and services (LTSS). Phase II, scheduled to begin no sooner than December 1, 2015, could enroll as many as 30,000 dual eligibles in a combined Medicare-Medicaid Plan (MMP).

Integrated Care Initiative Overview

Phase I of the ICI included two model options for coordinating care for dual eligibles and users of LTSS. The first was an enhanced primary care case management (PCCM) model, known as the Connect Care Choice Community Partners (CCCCP). The second option was a Medicaid health plan model, including integrated LTSS benefits, known as Rhody Health Options (RHO). Phase II of the ICI will integrate Medicare and Medicaid benefits in a financial alignment demonstration model under a three-way contract between the state, CMS, and a single contracted health plan.

Eligible Populations

Phase II of the ICI will be available statewide to any individual dually eligible for Medicare and Medicaid, including:

- Long-term nursing facility residents;
- Individuals with intellectual and developmental disabilities (IDD);
- Individuals with serious and persistent mental illness;
- Individuals eligible for LTSS in the community;
- Individuals residing in the community without LTSS needs; and
- Individuals with End Stage Renal Disease (ESRD).

As with other capitated financial alignment demonstrations, there will be a voluntary opt-in period, followed by a passive auto-enrollment period. However, enrollees may opt out of MMP enrollment at any time.

Individuals are excluded from enrollment in the demonstration if they have only partial Medicaid or Medicare eligibility; are in the Medicaid "spend down" category; reside at Tavares, Eleanor Slater, or any out-of-state hospital; are eligible for the Medicaid buy-in program for workers with disabilities, known as the Sherlock Plan in Rhode Island; or are in hospice. However, an individual may elect to receive hospice care while enrolled in the demonstration.

Additionally, individuals in the Program of All-Inclusive Care for the Elderly (PACE) may opt to disenroll from PACE and enroll in the demonstration but will not be passively enrolled.

Payments to MMPs under the ICI Phase II

As with other capitated dual eligible demonstrations, rate setting will occur between CMS and the State of Rhode Island. Medicare and Medicaid will each contribute to the capitation rate, consistent with projected baseline spending projections. Aggregate savings percentages will be applied equally to the Medicaid and Medicare Part A and B components of the capitation rate. Additional quality withhold percentages will be deducted from the capitation rate to be earned back based on a set of quality measures.

The demonstration years, aggregate savings, and quality withhold percentages for participating MMPs are detailed in the table below.

	Demonstration Year/Timing	Aggregate Savings	Quality Withhold
1	December 1, 2015 to December 31, 2016	1.0%	1.0%
2	January 1, 2017 to December 31, 2017	1.25%	2.0%
3	January 1, 2018 to December 31, 2018	3.0%	3.0%

Medicaid risk corridors will be in place, per the table below, based on percentage gain/loss in each demonstration year (DY).

DY	Gain/Loss	MMP Share	CMS/EOHHS Share
DY1	0% to 1.5%	100%	0%
	1.5% to 5%	30%	70%
	> 5%	10%	90%
DY2	0% to 2%	100%	0%
	2% to 6%	30%	70%
	> 6%	10%	90%
DY3	0% to 2.5%	100%	0%
	2.5% to 7%	30%	70%
	>7%	100%	0%

Additionally, the Medicare component of the capitation payment will be risk adjusted based on a Rate-to-FFS methodology outlined in the MOU.

Enrollment Timing

Enrollment for Phase II of the ICI is to begin no sooner than December 1, 2015, with a two month period of opt-in enrollments only. Based on this timing, a schedule for passive enrollment follows.

Enrollment Wave	Date	Population
Wave 1	February 1, 2016	Eligible for LTSS in community
Wave 2	March 1, 2016	Nursing facility-based LTSS
Wave 3	April 1, 2016	Not eligible for LTSS
Wave 4	May 1, 2016	Individuals with SMI

Participating MMP

Neighborhood Health Plan of Rhode Island will be the sole contracted MMP for Phase II of the ICI and will be known as Neighborhood INTEGRITY. Neighborhood Health Plan currently serves as the lone Rhody Health Options plan under Phase I of the ICI. EOHHS will enter into a three-way contract with Neighborhood Health Plan and CMS prior to implementation of Phase II.

Current ICI Phase I Enrollment

As of May 1, 2015, there were more than 21,500 individuals enrolled in Phase I of the ICI, including 17,700 Rhody Health Options enrollees served by Neighborhood Health Plan, and more than 3,800 enrollees in the CCCCP enhanced PCCM model.

Setting	RHO	CCCCP	Total ICI Enrollment
Nursing Home >90 Days	2,850	249	3,099
ID/DD	1,654	409	2,063
Community w/ LTSS	1,239	382	1,621
SPMI	1,258	491	1,749
Community no LTSS	10,254	1,697	11,951
MA Only	445	609	1,054
Total	**17,700**	**3,837**	**21,537**

Source: Rhode Island Long Term Care Coordinating Council Meeting (May 13, 2015)

Link to MOU:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/RhodeIsland.html

HMA MEDICAID ROUNDUP

Alabama

Governor Bentley Opposes House $156 Million Medicaid Cuts. On August 4, 2015, *AL.com* reported that Governor Robert Bentley is disappointed by the House budget committee vote to slash $156 million from Medicaid. He stated that without adequate Medicaid funding, hospitals, specifically rural hospitals, will not be able to survive. Read More

Alabama Rural Hospitals Struggle to Survive. On August 1, 2015, *The Baltimore Sun* reported that eight rural Alabama hospitals have closed over the last 15 years, while others, including Wedowee Hospital, are struggling to survive. Low Medicare and Medicaid reimbursements and a large number of poor and uninsured patients threaten the viability of rural hospitals. Randolph County will vote on a one-cent sales tax designed to raise money to construct a new hospital. If the tax referendum fails, Tanner Health Systems will close. Read More

Arizona

Governor Ducey to Propose Medicaid Waiver for Co-Pays and Health Saving Accounts. On August 2, 2015, *The Republic* reported that Governor Doug Ducey is seeking federal approval for Medicaid co-pays and 2 percent income payments to a health saving account for able-bodied adults. Co-pays would cap at 3 percent of annual income and would only be charges on services deemed a poor use of the program (e.g. unnecessary emergency room visits or missed appointments). The changes would affect approximately one quarter of the state's 1.7 million Medicaid recipients. The goal is to encourage recipients to find work and save the state money. If approved, changes will go into effect October 2016. Read More

Lawmakers Challenge Constitutionality of Medicaid Hospital Assessment. On July 30, 2015, *The Charlotte Observer* reported that a lawyer representing 36 Republican lawmakers urged Maricopa County Superior Court Judge Douglas Gerlach to rule that the Arizona Medicaid plan hospital fee is unconstitutional because it passed with only a bare majority. However, a lawyer representing Medicaid Director Tom Betlach argued the type of fee imposed to help fund Medicaid expansion is exempt from the supermajority requirement. The hospital assessment fee went into effect in 2013. In the first nine months, hospitals paid $143 million to the state but received $488 million in payments for caring for patients who did not qualify for Medicaid. Read More

Arkansas

Governor Hutchinson Temporarily Suspends Medicaid Terminations. On August 4, 2015, *THV11* reported that Governor Asa Hutchinson said the state will stop sending Medicaid termination notices for the next two weeks while the Department of Human Services catches up on a backlog of responses from recipients verifying their income. The state had already terminated coverage for 35,000 people. Read More

California

HMA Roundup – Varsha Chauhan (Email Varsha)

KFF Survey Finds 68 Percent of Previously Uninsured Have Coverage after ACA's Second Enrollment Period. On July 30, 2015, The Kaiser Family Foundation released a new survey, the *Kaiser Family Foundation's Longitudinal Panel Survey*, looking at the uninsured in California since the Affordable Care Act's implementation. It found that 68 percent of those who were previously uninsured have gained coverage. Of the newly insured, 34 percent gained coverage through Medi-Cal, 14 percent through their employer, and 12 percent through Covered California. The recently insured are also half as likely to say they have had problems paying medical bills in the past year and 86 percent say their health needs are being somewhat or very well met. Read More. *Kaiser Health News* further discussed the findings of the survey, including how health care costs no longer rank as the top financial concern for Californians. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Governor Scott Orders Hospital and Insurer Medicaid Contracts to be Examined. On August 3, 2015, *Politico* reported that Governor Rick Scott is ordering the Office of Medicaid Program Integrity to examine the Medicaid contracts of all hospitals and insurers who did not respond to July 17 request for information. He stated that action must be taken to ensure taxpayers are not being overcharged. Any contract between a hospital and insurer exceeding a statutory 120 percent Medicaid cap will be modified or cancelled. Cancelled contracts could jeopardize a hospital's Low Income Pool payments. Read More

Medicaid HMOs Must Still Provide Home Health Services Despite Contract Issue. On July 31, 2015, *Miami Herald* reported that the Agency for Health Care Administration (AHCA) will require Medicaid HMOs to continue providing home health services, medical equipment, and infusion drugs to patients after Univita Health, which coordinates and provides home medical services for most of Florida's 13 Medicaid HMOs, lost its accounts with the HMOs. Univita was hired last year during the rollout of the state's Medicaid managed care program. Read More

Governor Scott Opposes Additional Medicaid Funding; Blames Rising Costs ACA. On August 5, 2015, *Health News Florida* reported that Governor Rick Scott is blaming rising Medicaid costs on the Affordable Care Act. Florida legislators will need to come up with $579 million to fill the gap for the safety net health care program, which will cost $24.8 billion in 2016-17. Additionally, health

insurers are seeking a $400 million raise and a 12 percent rate increase from the state. Scott opposes increasing state funds for the Medicaid program, blaming the health care law for the rising costs. He states the rising costs and insurer requests are impossible for the state fulfill. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Southern Regional Medical Center Files Bankruptcy for Prime Healthcare to Legally Take Assets. On July 30, 2015, *Clayton News Daily* reported that Southern Regional medical Center filed chapter 11 bankruptcy. This allows Prime Healthcare Foundation to legally buy the hospital's assets from the county. Read More

Iowa

DHS Posts Medicaid Redesign Waiver Documents for Public Comment. Iowa has made the waiver proposal documents for the Iowa High Quality Health Care Initiative available for public comment through August 24, 2015. The proposals include a new 1915(b) waiver to implement statewide Medicaid managed care, as well as amendments to the following existing waivers: the Iowa Wellness Plan waiver, the Iowa Family Planning Network waiver, and the state's 1915(c) waivers for children's mental health, persons who are elderly, and persons with intellectual disabilities. The waiver documents, information on the public comment process, and dates and locations for public hearings are available here.

Louisiana

New Safety Net Hospital Opens, Replacing Charity Hospital. On August 1, 2015, *The Washington Post* reported that after ten years since Hurricane Katrina, New Orleans opened a full-scale safety net hospital to replace Charity Hospital. In the aftermath of Katrina, medical services had been scattered across the city. University Medical Center New Orleans was built with $1.1 billion of federal, state, and private money. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

CMS ranks New Jersey the highest among states in hospital readmission penalties. NJ Spotlight's August 5, 2015 edition reported that New Jersey fared the worst in the country for having too many patients readmitted to the hospital soon after discharge. The CMS Readmission Reduction Program, in its fourth year, assesses penalties in the form of reduced Medicare reimbursements when a hospital exceeds the standard for acceptable patient readmissions. Sixty-four out of 65 hospitals were penalized. Read more.

New York

HMA Roundup – Denise Soffel (Email Denise)

Behavioral Health Transition to Managed Care Approved. NYS has received CMS approval to amend its 1115 Medicaid waiver to begin implementation of the behavioral health carve-in that will enable qualified Managed Care Organizations (MCOs) throughout the state to comprehensively meet the needs of adults with behavioral health needs. This carve-in includes two components: bringing behavioral health services into Mainstream Medicaid Managed Care and establishing Health and Recovery Plans (HARPs), a new type of health plan, operated by mainstream Medicaid MCOs, for eligible adults with Serious Mental Illness (SMI) and Substance Use Disorders (SUD). HARP eligibility criteria has been determined by the State based on diagnosis and utilization patterns. HARP eligibles cannot be dual enrolled (receiving both Medicare and Medicaid) or participating in a program with the Office for People With Development Disabilities (OPWDD). HARPs will offer an enhanced benefit package of home and community based services (HCBS) to eligible enrollees that will assist individuals in integrating into the community and achieving recovery-oriented life goals. The transition will begin in NYC in October 2015 and expand to the rest of the state in April 2016. For more information and to view the transition timeline, see the MRT website.

Aligning Payment Reform across Public Payers. NYS recently released a draft proposal that describes a series of efforts to align value-based payment initiatives between the state's Medicaid program and the Medicare program. Both NYS and CMS have begun to develop payment systems that move away from fee-for-service payments and toward value-based payment that reward quality outcomes. NY's Medicaid Payment Reform Roadmap was approved by CMS in July 2015. The **Draft Medicare Alignment Paper** outlines an approach that aligns CMS payment reform efforts for Medicare to the NYS Medicaid Payment Reform Roadmap. NYS' alignment proposal includes the following components:

- NYS proposes to allow its providers and Managed Care Organizations to include Medicaid beneficiaries in CMS innovative payment models. These have already been included in the Roadmap as off-menu options that would be automatically accepted as valid Level 1 or higher VBP arrangements.
- In parallel, NYS requests CMS to allow NYS providers to include Medicare FFS beneficiaries (including both Medicare FFS-only and Duals) in the VBP Arrangements outlined in the NYS Payment Reform Roadmap.
- Simultaneously, NYS will work with its Medicare Advantage plans to realize a complimentary alignment
- Finally, NYS proposes to allow Montefiore Health System to be the first Accountable Care Organization in the country to encompass both duals and Medicaid- and Medicare-only beneficiaries, managing population health and assuming financial risk across the entire spectrum.

The Alignment Proposal is available for **public comment** through the end of the month. Public comments should be submitted to dsrip@health.ny.gov by 3:00 PM on August 31, 2015. The proposal can be accessed here.

New York State of Health 2015 Open Enrollment Report. NY State of Health, the NY health exchange, released a report summarizing its experience during the second open enrollment period, which ended February 28, 2015. Since the exchange began operation in October 2013, 2,143,413 New Yorkers have enrolled in coverage through the NYSOH Individual Marketplace. This includes 415,352 people enrolled in qualified health plans (with and without financial assistance), 1,568,345 people enrolled in Medicaid, and 159,716 enrolled in Child Health Plus (CHP).

Starting in October 2014, renewal notices were sent to more than 300,000 QHP households that were enrolled in NY State of Health in 2014. 86 percent of individuals who were sent renewal notices renewed their coverage for 2015. In addition, another 147,092 people newly enrolled in QHPs. Nearly three-quarters of QHP enrollees receive financial assistance to lower the cost of their coverage. More than half (54 percent) of enrollees in subsidized QHPs have incomes at or below 200 percent of the Federal Poverty Level (FPL).

Through February 28, 2015, 1,568,545 individuals enrolled in Medicaid through NY State of Health. This includes 1,220,271 enrollees who renewed 2014 coverage and 348,074 enrollees who are new to the Marketplace. Through the Affordable Care Act, New York expanded Medicaid eligibility levels to 138 percent of FPL to all eligible adults. Since New York's eligibility levels already largely met this new federal standard prior to the Affordable Care Act, this expansion affects only single and childless adults whose eligibility had previously been set at less than or equal to 100 percent of FPL. Approximately 10 percent of Medicaid enrollees are part of the expansion population.

The report includes detailed demographic data on enrollees. It also includes enrollment numbers by plan, by metal tier, and by region. The report can be found on the NYSOH website.

Waiver Programs' Integration into Medicaid Managed Care. As part of the Medicaid Redesign Team's Care Management for All policy, individuals currently receiving care through the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) Waiver programs will be transitioned into the Medicaid managed care system. The Department of Health is working to develop policies and procedures that will ensure the smooth transition of these services into the managed care program. DoH recently decided to extend the implementation date for the transition of waiver services to managed care from January 1, 2016, to January 1, 2017, and has established a workgroup assist in the development of the transition plan for submission to CMS. The Department has invited representatives from various stakeholders and providers to participate in the workgroup, and meetings will be open to the public. Meetings will be held in Albany at Empire State Plaza, Meeting Room 2 on the following dates:

- August 24, 2015, 1:00 - 3:00 pm
- November 18, 2015, 1:00 - 3:00 pm
- January 27, 2016, 1:00 - 3:00 pm

2016 Health Insurance Premium Rates. The New York State Department of Financial Services (DFS) announced health insurance rates for 2016, including rates for the NY State of Health, the state's official health plan Marketplace. Since 2010, when NYS enacted legislation re-introducing rate regulation, DFS has broad rate review authority. The law provides DFS the authority to review and approve health insurance premium rate increases on existing policies.

Overall, DFS cut insurers' requested 2016 rates by more than 30 percent in the individual and small group markets, which will save policyholders more than $430 million.

On average, insurers requested a 10.4 percent rate increase in the individual market. DFS reduced the average increase more than 30 percent, to 7.1 percent, which is below the average increase in health care costs of approximately 8 percent. Around one-half of the rate increase is due to reductions in a federal reinsurance program. Among the 17 plans offered in the individual market, DFS approved 5 plans" submissions without reduction; 1 plan (Oxford/United HealthCare) saw its rate proposals reduced by double digits. In the small group market insurers requested a rate increase of 14.4 percent on average. DFS cut the requested rates by 32 percent, to 9.8 percent. A chart summarizing the requested and approved rates can be found on the DFS website.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Legislation, but not Licensure Ahead for Home Health Care. The home health care industry, was often in the news in the recently concluded budget season on issues ranging from payment rates to questions about identifying the employer of record for independent, non-agency caregivers. Ohio is one of only a handful of states that does not license home care agencies, and Ohio has no plan to begin licensing anytime soon. Instead, legislation is being drafted, particularly for independent, non-agency providers, to require providers to be certified if they provide home care to patients. The legislation will also make clear that the state is not the employer of record for independents and gives individuals on Medicaid who use these caregivers more control over who cares for them by adding 'self-direction' as an option in all home and community waiver program. Read More

Healthcare Efficiencies Study Committee to begin Regional Meetings. A new Healthcare Efficiencies Summer Study Committee will hold regional meetings over the next two months to talk about healthcare cost and transparency, according to Speaker Cliff Rosenberger. The goal is to produce reports and potential legislative recommendations, according to *Gongwer News Service*. Read More *(Subscription Req.)*

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania hospital association says Wolf's proposed tax hike would hit hard. According to Andy Carter, president and CEO of The Hospital & Healthsystem Association of Pennsylvania, PA Governor Tom Wolf's proposed 2015-2016 state budget includes an 18 percent tax increase on hospitals. According to the Association, the Governor's proposed budget, including hospitals funding cuts of $36.5 million ($17.5 million in state money, and $19 million in federal funds) would be felt in burn care centers, obstetrical and neonatal care units, and rural critical access. The Association also refers to a statewide tax called the Hospital Quality Care Assessment implemented in 2010. The assessment was established by the PA Department of Human Services, formerly the Department of Public Welfare, jointly, with the Hospital

Association. According to Carter, the association agreed to it at that time because hospitals received added Medicaid payments. A Wolf spokesman Jeffrey Sheridan, explains that the governor's budget "does not cut payments to hospitals when considering funding from all sources, including the added volume of newly expanded Medicaid enrollees." Wolf on June 30 vetoed a $30.1 billion budget. Carter said the hospital association supports the vetoed Republican budget. Read More

Updates from Pennsylvania's July Medical Assistance Advisory Committee Meeting. ***Office of Long Term Living (OLTL) Update.*** Jen Burnett, Deputy Secretary for Long Term Living provided an update on the feedback the OLTL received on the MLTSS discussion document. The three main themes of the feedback received were: 1. Consumer Choice 2. Community-Based Care and 3. Ongoing stakeholder engagement "nothing about us without us." Burnett also confirmed that the MLTSS RFP will be aligned to the 5 HealthChoices regions and that OLTL is working on a concept paper describing the approach and the proposed authorities that would be used for MLTSS which will be submitted to CMS in August. In addition, she provided an update on current activities related to LTSS noting that a new RFP will be issued in November for Financial Management (FM) Services. They will award contracts to multiple vendors, and consumers will have choice in terms of who they use to help with FM in Self-directed models. The selected FM vendors will continue to operate after the implementation of MLTSS, even though self-directed services will be paid through the plans. In August 2015, OLTL will issue an RFP for Home Modification vendors. In each HealthChoices zone they will select two vendors who will act as brokers for home modification services***. Office of Medical Assistance Programs Update.*** Leesa Allen, Acting Deputy Secretary provided an update on the HealthChoices RFI. A document summarizing the feedback received through the RFI process has been posted to the DHS website and puts a strong emphasis on BH-PH coordination, Value-based payment, access to care, and the provider experience. Allen stated that the Department is still on track for an RFP release in September 2015.

Medicaid Expansion in Pennsylvania: While not perfect, it is effective. As previously reported, earlier this year, Pennsylvania became one of 30 states that expanded the Medicaid program under the Affordable Care Act, to an estimated 700,000 Pennsylvanians living below 138 percent of the Federal Poverty Level. While there has been much controversial political debate about Medicaid expansion, an issue brief provided by the Kaiser Family Foundation describes the personal health benefits and improvements of the Medicaid Program to the expanded population such as care through a primary care doctor and related preventive and chronic services, including cancer screenings, diabetes control, blood pressure monitoring and cholesterol checks. This routine care might likely otherwise be delayed due to cost or increased financial strain. Conversely, the positive benefits of a Medicaid program must be weighed against its current challenges such as Emergency Room overutilization and access to providers and provider specialist services. Much remains to be seen as states progress in various stages of expansion, and with unique challenges for each state program. Read More

Budget pinch hits counties soon. A representative from the County Commissioners Association reports that the cash flow stopped by delays in an approved PA 2015-2016 budget will primarily affect county payment for services for mental health, intellectual disabilities and drug and alcohol abuse treatment.

As an example, Lackawanna county remarks on a $1.5 million state payment overdue for children and youth services. Without a budget, the state Department of Human Services lacks authority to make most fiscal 2015-16 payments to counties and other grant recipients for locally run programs. Now that a month has passed, the Lackawanna county director is concerned about a delay in cash flow over two months, which is fast approaching. Read More

Local hospice chosen for test program expanding access for Medicare patients. Hospice & Community Care, formerly known as Hospice of Lancaster County, and Hospice of Central Pennsylvania, located in Dauphin County were selected for a new Federal trial program beginning January 1, 2016 that provides hospice care to select Medicare patients receiving treatment intended to cure advanced cancer, chronic obstructive pulmonary disease, congestive heart failure and AIDS. The program will pay hospice $200 to $400 per month for every patient that hospice delivers care at their homes. Medicare expanded the program from 30 to about 140 hospices nationwide in 2015 including four hospice organizations in Pennsylvania. According to Medicare, fewer than half of its eligible beneficiaries use hospice care, and most of them use it only for a short period of time. This may get patients into hospice care earlier. Read More

Puerto Rico

Medicare Cut and Medicaid Fund Shortage Leading to Health Care Crisis. On August 2, 2015, *The New York Times* reported that Puerto Rico's health care system is headed for a crisis. Over 60 percent of Puerto Ricans receive Medicare or Medicaid. The 75 percent of Puerto Rico Medicare beneficiaries enrolled in Medicare Advantage potentially will face higher out-of-pocket costs and possible reductions in covered services when 11 percent cuts to Medicare Advantage take effect in January, 2016. The resolution of Puerto Rico's larger debt crisis could also have significant implications for Medicaid. Read More

Texas

Lawmakers Order Cuts to Medicaid Acute Care Therapy. On August 4, 2015, *The Dallas Morning News* reported that Texas lawmakers slashed $350 million of the $1.4 billion funding for acute care therapy from the two-year budget. Approximately 18 to 20 percent will be cut across the board for full service home health agencies. The cuts will take effect September 1 and may threaten the jobs of speech, physical, and occupational therapists. Over 30 lawmakers are urging to delay the cuts and explore an alternative method. Read More

National

States Look to 1332 Waivers to Modify Healthcare Law. On August 2, 2015, the *Washington Examiner* reported that states are beginning to shift their attention to state innovation waivers, which begin in 2017. The "1332 waivers," if approved, allow the states to modify benefits and subsidies, as well as reduce or eliminate fines for individuals lacking coverage or employers for failing to provide it. Arkansas, Minnesota, New Mexico, and Hawaii created working groups to look into applying for the waiver. Rhode Island was authorized by the state legislature to begin the application. Colorado legislators are in discussion as well. Read More

States and Insurers Critical Of New Medicaid Long-Term Care Rules. On July 29, 2015, *Modern Healthcare* reported that although patient advocates praise CMS' proposed Medicaid managed care rules for long term care, states and health plans are expressing concern. The rules define LTSS and lay out policies to protect beneficiaries and ensure access to care. Insurers are critical of provisions such as allowing beneficiaries to switch plans or switch to fee-for-service from managed care if their provider is not in the plan's network. They claim this undermines the use of managed care. Meanwhile, state Medicaid agencies are concerned about a proposal requiring states to "establish credentialing and re-credentialing policies for individual and organizational providers participating in their managed-care programs." Read More

State Medicaid Directors Warn New CMS Rules Would Impose Heavy Federal Control. On July 29, 2016, *Modern Healthcare* reported that the National Association of Medicaid Directors has stated that the new CMS rules regarding Medicaid managed care plans would reduce the role of state Medicaid agencies in supervising how the program operates in their states. The association claims the proposed regulations would remove the state's ability to drive innovation in managed care delivery or to tailor the program to the needs of the local population. Additionally, health insurers are objecting to the 85 percent medical loss ratio, saying that benefits and services offered by MCOs do not easily fit into the commercial medical loss ratio calculation. Read More

Study Finds Tax-Exempt Hospitals Spend as Much on Free or Subsidized Care as For-Profit Hospitals. On August 4, 2015, *The Washington Post* reported that a study by the University of California San Francisco found that nonprofit hospitals are spending the same amount as for-profits on free or subsidized care. Under the law, hospitals can use exemptions in exchange for public health goods, community health assessments, or public outreach for health. However, the study shows that despite the billions of dollars in tax breaks, nonprofits are not spending more on charity care. The study looked at 264 hospitals in California, the only state where for-profit hospitals are required to report non-reimbursed payments. It found that for-profits spend 1.4 percent of total operating expenditures on free care and nonprofits spend 1.9 percent, with a third of nonprofits spending less than 0.9 percent. Read More

Federal Officials Ask States to Cut Back Big Rate Increases Requested by Insurers for 2016. On August 3, 2015, *The New York Times* reported that federal officials are urging states to regulate proposed insurer rates for 2016 and cut back big rate increases. Some insurers across the country have requested increases of 10 percent to over 40 percent. Administration officials fear the large increases could lower public support for the Affordable Care Act, increase costs to consumers and the federal government, and increase Republican opposition. However, health insurers argue that they lost money on policies sold in the new public marketplaces, where customers were sicker than expected. In New York, insurers requested an average 10.4 percent increase. State officials have reduced the increase to 7.1 percent after cutting excessive or unreasonable requests. Read More

Increased Competition Held Down Premiums In the Federal Marketplace. On July 30, *The Washington Post* reported that a new Health and Human Services Department report found that there was increased competition on the federally run health insurance marketplace, which helped hold down premium growth in 2015 compared to 2014. The report looked at 35 states that did not set up their own exchange. Approximately 59 percent of counties in these states gained at

least one new insurer. The counties with at least one new insurer saw premium growth for silver plans was 8.4 percent lower than those whose competition stayed the same or decreased. Read More

Industry Research

GAO Report Finds Medicaid Expansion States Better Able to Treat Mental Illness and Addiction. On August 3, 2015, *Governing* reported the Government Accountability Office found that states that expanded Medicaid are better able to treat low-income people suffering from mental health disorders or addiction without negative fiscal repercussions. Behavioral health officials in these states reported that Medicaid expansion increased the quality and availability of treatment options. The GAO estimates that 17 percent of low-income, uninsured people have a behavioral health condition. Read More

Industry News

Molina to Acquire Medicaid Assets of Integral Health Plan. On August 3, 2015, Molina Healthcare of Florida announced that it entered a definitive agreement to acquire certain assets of Integral Health Plan's Medicaid business. Integral Health Plan, d/b/a Integral Quality Care, is a provider service network and full-risk health plan with over 90,000 Medicaid enrollees. The transaction is expected to close during the fourth quarter of 2015. Read More

Community Health Systems to Create New Publicly Traded Hospital Company. On August 3, 2015, Community Health Systems announced its plans to create a new publicly traded hospital company called Quorum Health Corporation, based out of Tennessee. The new company will consist of 38 hospitals across 16 states and Quorum Health Resources, a hospital management and consulting business. The plan is intended to be completed by the first quarter of 2016. Read More

The Ensign Group Acquires 15 Assisted Living Facilities in Wisconsin. On August 3, 2015, The Ensign Group announced that it acquired 15 assisted living operations in Wisconsin, effective August 1, 2015. As part of the transaction, Ensign assumed a long-term master lease with an option to buy the real estate. Read More

Memorial Health Seeking Strategic Partner. On July 30, 2015, the *Savannah Morning News* reported that Memorial University Medical Center is seeking a strategic partner to come onboard by the end of the year. CEO Maggie Gill stated that the move has been under discussion for approximately two years and is intended to increase the hospital's resources, services, and capability. The trend towards partnerships has been witnessed throughout Georgia in efforts to maintain the competitiveness of independent hospitals. Read More

AmeriHealth Caritas Hosts Forum to Commemorate 50th Anniversary of Medicaid. On July 30, 2015, AmeriHealth Caritas hosted a forum to commemorate the 50th anniversary of Medicaid and to discuss the creation of a new health care paradigm. Speakers included Governor Jan Brewer, Former Governor of Arizona; Senator Bob Casey, Jr., U.S. Senator, Pennsylvania; Congressman John Conyers, Jr., U.S. Congressman, Michigan; Daniel J. Hilferty, President and CEO, Independence Health Group; Elizabeth Holmes, Founder and CEO, Theranos; Governor Michael O. Leavitt, Former Governor of Utah and Founder and Chairman, Leavitt Partners; Governor Terry McAuliffe, Governor of Virginia; and Paul A. Tufano, Chairman and CEO, AmeriHealth Caritas. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
August 3, 2015	Michigan	Proposals Due	1,600,000
August 17, 2015	Iowa	Contract Awards	550,000
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	Montana Expansion (TPA)	Contract Awards	70,000
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	30,000	X	5/12/2014	9/1/2014	7/30/2015	12/1/2015	2/1/2016	Neighborhood INTEGRITY
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***			***12***			

** 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	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
California	122,908	123,079	124,239	122,520	122,798	122,846
Illinois	63,731	64,199	60,684	58,338	55,672	53,328
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705
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	27,333	26,877	27,765	27,349	30,877	29,970
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,827**

HMA News

New this week on the HMA Information Services website:

- Updated Medicaid managed care enrollment and market share data for:
  - **South Carolina; New York; Georgia; Illinois; Michigan;** and more.
- Plus public documents including the **New York** Behavioral Health Transition to Managed Care Update, **Texas** RFI for Managed Care Pilot Provisions for IIDD, and **Alaska** RFP for Home and Community-Based Services; 1915(i) and 1915(k) Implementation.

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.

Four HMA Presentations Featured at MESC 2015

HMA staff will be featured in four presentations at the upcoming Medicaid Enterprise Systems Conference (MESC) from August 17th to 20th, in Des Moines, Iowa. MESC is an annual meeting for State, Federal and private sector individuals to provide opportunities for the exchange of ideas related to Medicaid systems and heath policy affected by those systems. More Info

"State Perspectives for Achieving Compliance with ACA and Improving Provider Enrollment"
HMA Speaker: Stephanie Denning
Tuesday, August 18th, 9:30am – 10:30am

"Enterprise System Integrator: A Better Way to Manage Your Medicaid IT Portfolio"
HMA Speaker: Sandy Berger
Tuesday, August 18th, 3:00pm – 4:00pm

"Leveraging Health Information Exchange to Enhance Interagency Data Sharing"
HMA Speaker: Matt McGeorge
Tuesday, August 18th, 3:00pm – 4:00pm

"Actionable Quality Data: Validating, Aligning and Effectively Using"
HMA Speaker: Izanne Leonard-Haak
Wednesday, August 19th, 8:00am – 9:00am

HMA will also have a booth in the MESC 2015 Exhibit Hall, at booth #25.

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