HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 9, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

THIS WEEK

IN FOCUS

HMA PUBLISHES EVALUATION REPORT ON TOTAL COST OF CARE REGIONAL PILOT

This week, our *In Focus* section comes to us from HMA managing principal Sharon Silow-Carroll, senior consultant Diana Rodin, and consultant Annie Melia, of HMA's New York office. With support from the Robert Wood Johnson Foundation (RWJF), HMA recently conducted a qualitative evaluation of Phase

1 of the RWJF Total Cost of Care and Resource Use (TCOC) pilot. The TCOC framework, developed by HealthPartners and endorsed by the National Quality Forum (NQF), is an analytical tool that measures cost and resource use for virtually all care used by individuals. According to HealthPartners, TCOC is designed to "support affordability initiatives, to identify instances of overuse and inefficiency, and to highlight cost-saving opportunities."

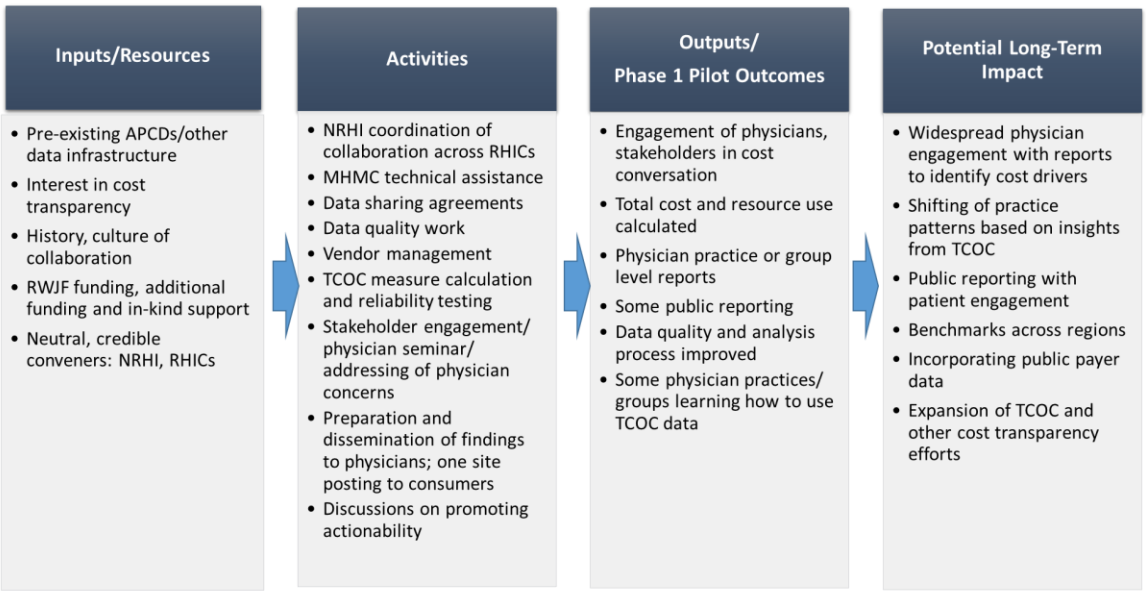
In 2013, the Robert Wood Johnson Foundation (RWJF) funded five regional health care improvement collaboratives (RHICs) to engage stakeholders, and work collaboratively with one another to measure TCOC using multi-payer commercial data, and publicly report the measures associated with primary care physician practices or groups by December 2014. RWJF also funded the Network for Regional Healthcare Improvement (NRHI) to lead and coordinate an effort test a standardized TCOC approach in multiple regions and establish national benchmarks for cross-regional analysis. The 18-month grants (11/1/2013 - 4/30/2015) constituted Phase 1 of the pilot. In Spring 2015, RWJF awarded these grantees and up to three additional regions Phase 2 funding to continue and expand their efforts. The objectives of HMA's evaluation were to assess the RHICs' early experiences with a collaborative approach to a standardized TCOC framework, and to identify promising practices and critical lessons for other community collaboratives, policymakers, funders, and stakeholders.

A key accomplishment of Phase 1 was the beginning of serious conversations among stakeholders about the potential benefits of cost transparency. With strong project management by NRHI and valuable technical assistance from one of the RHICs with prior experience using TCOC, by mid-2015 the five RHICs produced and shared TCOC measures with physician groups or practices. One RHIC had reported TCOC ratings publicly, while the others are planning to do so and/or considering how to publicly report in light of stakeholder skepticism about the data or their value for consumers.

Each RHIC's specific approaches and progress varied according to pre-existing data collection infrastructure, stakeholder dynamics and the local health care environment. All of the RHICs experienced challenges related to data quality issues, physician concerns, and questions about how best to make the reporting actionable for physicians and other audiences. The evaluation identified successful strategies such as use of a data quality checklist and involving physicians to help design and plan the project. Also, the evaluation highlights the importance of: allowing sufficient time for planning and stakeholder engagement; incorporating technical assistance to assure data quality; seeking physician input and feedback for making TCOC reports actionable; and collaborating with other RHICs to accelerate progress. These lessons may be applied to expanding TCOC efforts as well as to other regionally-based health care transparency and reform initiatives.

Overview of TCOC Pilot Findings

While each of the RHICs had unique experiences, the evaluation team's analysis of the key inputs or building blocks, challenges, preliminary outputs or accomplishments, and potential long term outcomes of the TCOC pilot is summarized below.



The RHICs participating in Phase 1 of the RWJF-funded TCOC pilot faced many challenges but also achieved significant progress. Their experiences reveal a number of lessons for other organizations pursuing total cost of care analysis and reporting, as well as to stakeholders, policymakers, and funders seeking to participate in or support collaborative health care cost transparency efforts. Following are some lessons and promising practices that emerged across the five RHICs from the TCOC Phase 1 experience.

State and local context matters. Participating RHICs shared common factors in their health policy environment and cultures that facilitated their progress implementing the multi-payer TCOC initiative. All had experience with quality measurement and most with public reporting of health care measures. They typically had a history of strong stakeholder collaboration and personal relationships among health care leaders. TCOC reporting typically aligned well with broader state priorities for payment and delivery system reform, and most RHICs highlighted active multi-stakeholder efforts to move toward value-based payment, often driven by state legislation and/or federal grants. In at least two states, payers had developed their own cost measures but saw the potential value of a standardized statewide TCOC measure.

All RHICs had some type of existing infrastructure to collect the needed data, whether all-payer claims databases (APCD) (Colorado, Maine), voluntary claims databases (Midwest, Oregon), or an existing reporting partnership with payers (Minnesota). Those without APCDs relied on strong relationships with their health plans to secure the data, particularly in Minnesota, where the health plans had the most responsibility for calculating the TCOC measures internally and the most experience doing so (particularly HealthPartners which developed the TCOC measure used across this pilot).

Differences in the starting points influenced rates of project progress. For example, Maine's MHMC already had experience using the TCOC measure at the start of the pilot, and had two roles: it was one of the five RHICs funded to implement the TCOC measure, and was also contracted as a Technical Advisor

to the other RHICs. Conversely, MHI was newer to cost measurement and reporting, and therefore had further to go.

A lengthy planning stage should be expected and scheduled. The TCOC public reporting goals and timeline shifted during Phase 1, but it appears the extra planning, engagement, and data cleaning efforts were necessary to build stakeholder confidence and resolve data issues. RHIC staff emphasized the importance of the process -- identifying and engaging the right people at the right level, presenting the initiative around the region, facilitating multi-stakeholder discussions and committees in a neutral space, and taking concerns seriously and thoroughly addressing them. More time and resources should be built into future efforts. At the same time, a balance must be struck between taking a cautious, deliberate approach and moving forward despite an imperfect measure.

Technical assistance is vital to address ongoing data challenges. All of the RHICs found that producing high quality data requires relentless scrutiny. Claims data face time lags and may not be complete or meet specifications when first submitted, and merging data from multiple sources exacerbates the challenges of the cleaning process. To improve reliability and validity of the findings and credibility with providers, the RHICs found it critical to examine the TCOC results from more than one time period and look for unexplained variability. Technical assistance from an experienced analyst is valuable, and a quality checklist can help identify and address problems early, when it is easier to request new data runs from payers and vendors.

Initial focus should be on actionable information for physicians. The first and perhaps most important target audience for multi-payer TCOC analysis is physicians, with practice-level reports the goal for identifying variation and opportunities for practice improvements. Bringing physician leaders into the planning process early can inform the development of the reporting, help reduce skepticism or resistance, and promote buy-in. Going forward, the main challenge is to disseminate the information with messaging and guidance for making it actionable. The detailed physician reports should be designed with input from the target audiences about both content and formatting (e.g., color-coding, explanation of the measure, tips for using the report). A successful roll-out will also require analytic support to some practices (particularly smaller, independent, and rural practices that lack such capacity or resources) on how to identify areas for improvement, and education or links to resources on practice improvement options. Finally, while some physicians will be interested in improving their referral and utilization patterns in order to provide better care, others – already burdened with myriad measurement and administrative burdens -- will likely need additional incentives to engage with a new performance measure.

Perception of public reporting benefits to consumers remains uncertain. In all five regions piloting the TCOC measure, there was uncertainty or skepticism about the benefits of TCOC public reporting to consumers. Without incentives tied to cost-sharing, consumers may not be interested in total cost ratings of physician practices and particularly larger physician groups. For those consumers who are interested, quality measures should be presented along with cost, to help them choose good "value" and avoid conclusions that high cost providers are automatically the best. The roll out of TCOC public reporting – utilizing user-friendly format and content, with a media campaign educating consumers on how to interpret and use the information – will be critical for

broadening engagement in TCOC. As additional RHICs develop public reporting, this will be an important area for sharing and evaluating strategies and best practices.

TCOC effort appears replicable under favorable conditions. The greatest promise for replicability and scaling of the TCOC initiative is in regions with existing multi-payer claims data collection, political will, a neutral convener, and relationships among stakeholders. Barriers will be greater in regions without a history of collaboration or culture of health care measurement and reporting. RHICs or other neutral entities are important to provide a trusted, safe space for stakeholders to express views and address concerns. Replication will require funding for start-up costs, and planning for sustainability. Most of the five RHICs had to supplement RWJF pilot funding with other sources. They are not certain how they will sustain the effort, and hope to identify value that providers, health plans, and others (such as accountable care organizations) will be willing to purchase. MHI reported that some physician groups expressed interest in potentially licensing the MHI data set after seeing TCOC and related quality and utilization data.

The collaborative model accelerates progress. RHIC collaboration, under strong project leadership from NRHI, has propelled each RHIC's efforts during Phase 1. The model emphasized shared learning and support, while allowing for some variation in design and stakeholder engagement based on local dynamics. The RHICs' support for this approach suggests that expansion of this collaborative model to additional RHICs will allow new organizations to learn from the early innovators. In fact, the collaborative model should be considered for other health care transparency and transformation projects as well.

TCOC is a tool that can complement other cost-reduction efforts. Analyzing and reporting TCOC alone will not reduce health care costs. All stakeholders agreed that other factors are necessary to make any real dent in the cost curve. However, they agreed that TCOC is a useful tool (in fact better than other cost measures that represent only one portion of health care costs) and could help inform and support efforts such as state-level payment and delivery system reforms that involve value-based health care or ACO development. Further, the impact of TCOC reporting would be strengthened by incorporating claims from other populations (Medicare, Medicaid, dual eligible population), and by tying TCOC performance to incentives – initially at the physician level, and eventually at the consumer level.

It will be important to study the continuing and expanding TCOC efforts in order to further identify and replicate successful implementation and dissemination approaches, avoid unsuccessful strategies, and begin to assess the impact of cost transparency on care delivery decisions, referral patterns, health plan contracting and network design, and selection of providers by consumers, employers, and other stakeholders. The next phase will be critical for evaluating the potential for multi-payer TCOC information to inform targeted strategies to improve value and reduce health care spending at the community level.

HMA Medicaid Roundup

Alaska

Alaska Medicaid Disability Program Looks to Cut New Enrollment by 75 Percent. On September 3, 2015, *Alaska Dispatch News* reported that an Alaska Medicaid waiver program for adults with developmental disabilities is looking to cut the number of new enrollees each year by 75 percent. The Intellectual and Developmental Disability waiver funds home-based care for nearly 2,000 people. It cost $160 million in 2015, split between state and federal Medicaid. Each year, approximately 200 people are granted waiver funds. Administrators are proposing to reduce this number to 50. The Alaska Department of Health and Social Service's Senior and Disabilities Services Division are taking public comments on the proposal until Sept. 17. Read More

Judge Rules Medicaid Expansion Can Begin; Dismisses Request to Block Enrollment. On August 28, 2015, *Alaska Dispatch News* reported that a state judge will allow Alaska to expand Medicaid, dismissing a request by the Legislature to temporarily block enrollment. The Legislature, which had approved $450,000 for spending on the lawsuit, sent a request for an emergency review to the Alaska Supreme Court. However, a Supreme Court review is optional. Read More

Arizona

Judge Rules Arizona Medicaid Expansion is Constitutional. On August 27, 2015, *The Arizona Republic* reported that a judge ruled that the Legislature's simple-majority vote to expand Medicaid is constitutional. Lawmakers approved a hospital assessment in 2013 to fund expansion. Opposing Republican lawmakers then went to court citing that the assessment was a tax and needed a two-thirds supermajority to pass. Judge Douglas Gerlach ruled that the assessment was a fee and therefore constitutional. Read More

Arkansas

State Officials Delay Medicaid Cancellations. On August 28, 2015, *The Baltimore Sun* reported that state officials suspended a push to terminate Medicaid coverage for thousands of beneficiaries who must still submit proof of eligibility. The federal government had requested Arkansas push the deadline in order to give beneficiaries 30 days rather than the 10 days the state has been using. The state has been checking the eligibility of 600,000 people. Over 55,000 people have had their coverage canceled. Read More

California

HMA Roundup – Varsha Chauhan (Email Varsha)

Legislators Pass Bill Delaying Transfer of Fragile Children Into Medi-Cal Managed Care. On September 7, 2015, *Kaiser Health News* reported that a bill to postpone moving approximately 31,000 medically fragile children to managed care passed both Houses and is awaiting Gov. Jerry Brown's signature. The state has been planning to fold the $2 billion California Children's Services program, serving 180,000 children with serious medical conditions, into Medi-Cal managed care. Starting next year, 31,000 children were to be moved to managed care plans. The bill, if signed into law, will delay this move until 2017. Read More

State Officials Begin Collecting Recoupment Money from Pharmacies Over Medi-Cal Cuts. On September 3, 2015, *California Healthline* reported that state officials began collecting money from pharmacies from payments made during a 10 percent Medi-Cal provider rate cut. Lawmakers approved the cuts in 2011, but they were put on hold for 18 months while courts deliberate their legality. The state finally began the process for charging providers on Aug. 28. The recoupment is planned for April 2016. Approximately 6,100 pharmacy providers will be affected. Read More

Laws to Regulate Psychiatric Medication in Foster Care Pass Senate. On September 2, 2015, *NPR* reported that a package of laws aimed to regulate prescriptions of psychiatric medication in foster homes passed the Senate. The reforms now move to the state assembly where they face no formal opposition. According to a Government Accountability Office report, children in foster care are prescribed antipsychotic medication at double to quadruple the rate of those not in foster care. Hundreds were taking five or more psychotropic medications at a time, while thousands were prescribed doses exceeding FDA-approved guidelines. A separate report by the inspector general at Health and Human Services found quality concerns in two-thirds of claims for psychotropic drugs paid by Medicaid, including "too many drugs (37 percent); wrong dose (23 percent); poor monitoring (53 percent); or wrong treatment (41 percent)." The reforms passed by the California Senate would better monitor children on medication and physicians who rely most heavily on prescribing medication. Social workers and caregivers would also receive training in the risks, benefits, and side effects of psychiatric medication. Read More

California Considering Dual Demonstration Extension. The California Medicaid Director wrote a letter to CMS expressing interest in considering an extension of the dual eligible coordinated care demonstration, Cal MediConnect. CMS had proposed to allow states to extend the scheduled end dates of the Coordinated Care Initiative demonstration. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

CGI Awarded Connect for Health Colorado Contract. CGI announced the award of a 5-year contract from Connect for Health Colorado for services that will improve call center performance, provide ongoing system maintenance and upgrades, and allow development of an online portal for health insurance brokers. Leveraging CGI's Atlas360 digital transformation solution, the

Colorado health insurance Marketplace is projected to save approximately 33% in operating costs over five years, for a total savings of $39.6 million. Read More

Medicaid Expansion Drives Down Uninsured Rate. On September 1, 2015, *Kaiser Health News* reported that a survey from the Colorado Health Institute found that the uninsured rate fell to 6.7 percent this year from 15.8 percent four years ago as a result of Medicaid expansion, making the Colorado Medicaid program the fourth fastest growing in the country. Nearly 1.3 million residents are now covered through Medicaid in the state. Meanwhile, the uninsured rate for children fell to 2.5 percent from 7 percent. Read More

Telehealth Guidelines Adopted. Colorado Medical Board members have adopted guidelines for the state to enact a new law expanding telehealth services to city dwellers as well as to the rural residents who already are seeing doctors and nurses increasingly via video or other electronic means.

Notably, the guidelines do not include some of the limits imposed by other states. For example, they:

- Do not require patients to meet in-person with doctors before using telehealth services,
- Don't require particular technology for the connection, and
- Don't mandate that patients have to be in a certain facility in order to conduct the visits. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Proposed Bill to Offer Financial Help to Dentists in Underserved Areas. On September 8, 2015, *Health News Florida* reported that a House Republican proposed a bill to create dental care access accounts which would use state and local funds to help dentists practicing in underserved areas. The funds may be used for expenses such as investment in facilities and equipment and repayment of dental-school student loans. Read More

State Predicts $635 Million Budget Surplus for 2016-17. On September 8, 2015, *Politico Florida* reported that state economists predicted Florida's budget for 2016-17 will have a $635 million surplus. State general revenue will grow by $31.5 billion. The forecast is on top of the $1.2 billion in increased expenses next fiscal year and a $1 billion reserve. Expenses are driven by a six percent increase in Medicaid costs, which are expected to be $24.9 billion next year. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Families, Georgia Families 360° Awards Announced. On September 9, 2015, Georgia's Department of Community Health (DCH) announced successful care management organization (CMO) bidders in the Georgia Families and Georgia Families 360° rebid. In addition to the three incumbent Georgia Families CMOs – Anthem's Amerigroup, Centene's Peach State, and WellCare – DCH has also made an award to CareSource Georgia. There were a little more than 1.3 million Georgia Families enrollees as of June 2015. Amerigroup successfully retained its Georgia Families 360° contract, which serves around 23,000 foster

care and adoption assistance members. Unsuccessful bidders included UnitedHealthcare, AmeriHealth Caritas, Gateway Shared Health, Humana, and Molina Healthcare. New contracts are set to be implemented on July 1, 2016. HMA reviewed the Georgia Families RFP in our February 11, 2015, Weekly Roundup.

DCH Board Meeting Summary. The DCH Board met on August 27, 2015. Chairman Norm Boyd announced that the sole agenda item was the review and approval of AFY16 and FY17 budgets. There was no review of minutes of the August 13th meeting. Commissioner Reese did not give a report.

Chief Financial Officer Elizabeth Brady gave a presentation which included FY2015 budget highlights, a review of the FY16 budget to date, and the AFY16 and FY17 budget requests.

Some of the FY15 budget highlights were:

- One in four Georgians receive health benefits through the Department of Community Health.
- 1.8M are in Medicaid, 158K are in PeachCare for Kids, and 621K are in the State Health Benefit Plan.
- 51% of the children in Georgia receive benefits through DCH.
- DCH ended the year with a $116M surplus, which went back into the General Fund
- The surplus was primarily due to lower CMO enrollment than had been projected (even though overall CMO enrollment grew).
- The total fund spend for Medicaid and PeachCare was $12.8 billion, of which $2.9 billion was state funds.
    - 97% of that was Medicaid and PeachCare health care expenditures.
    - 2.27% was DCH administrative cost.

Highlights of the current FY16 budget:

- $2.9 billion state funds
- 97% of that for Medicaid and PeachCare costs
- A $2M administrative cut in contracts

Cost drivers for FY16 and FY17 budgets:

- Growth
    - CMO rates
    - Enrollment (mostly Low-Income Medicaid)
- Pharmacy
    - Hepatitis C drugs
    - Cystic fibrosis drugs
    - Medicare Part D clawback payments
- Federal directives
    - Hospital presumptive eligibility
    - 1095-B reporting (Commissioner Reese commented that the state would be procuring a vendor for 1095-B reporting)

AFY16 budget request

TOTAL STATE FUNDS $103,966, 692

Benefit growth	$46.5 M
Hepatitis C drugs	$23 M

Cystic fibrosis drugs	$3.3 M
Hospital presumptive Eligibility	$9 M
Medicare Part D clawback	$4.2 M
State match for DSH payments to private hospitals	$16 M
Added expense for 1095-B reporting	$1.8 M

FY17 budget request:

TOTAL STATE FUNDS $111,768,609

Benefit growth	$87 M
Recognized enhanced FMAP	($21 M)
Hepatitis C drugs	$23 M
Cystic fibrosis drugs	$3.4 M
Hospital presumptive eligibility	$9 M
Medicare Part D clawback	$8.3 M
State match for DSH payments to private hospitals	$16 M
Added expense for 1095-B reporting	$1.8 M
Additional general obligation bond for IES	$3 M

The AFY16 and FY17 budgets were unanimously approved. The next Board meeting is September 10th. Chairman Boyd adjourned the meeting.

Illinois

Non-Profit MCO to Return up to $5 Million in Savings to State. On September 9, 2015, the Community Care Alliance of Illinois (CCAI), a wholly owned subsidiary of Family Health Network, announced that it will return up to $5 million in Medicaid managed care savings to the state. Family Health Network CEO Keith Kudla estimates that CCAI saved the state 10 percent of what costs would have been in fee-for-service for their patient population. CCAI serves non-dual eligible seniors and persons with disabilities in the Chicago and Rockford areas. Read More

Iowa

Iowa Rejects Insurers' Requests to Reconsider Awards for Medicaid Privatization. On September 6, 2015, *The Des Moines Register* reported that Iowa's Department of Human Services rejected the requests from Aetna, Meridian, and Iowa Total Care to reconsider its selection of companies to privately manage the state's Medicaid. The insurers alleged that nepotism and biases among members of the review committee contributed to the selection of the four winning bidders and that the state inconsistently scored proposals and did not properly consider the cases of fraud and mismanagement in the winning bidders. Iowa officials responded that the evaluations were comprehensive, structured, and objective. Read More

Louisiana

State Takes Over Nonprofit Insurer Louisiana Health Cooperative. On September 1, 2015, *The Advocate* reported that the Louisiana Department of Insurance took over Louisiana Health Cooperative through a court order issued by a district judge. The state allows insurers to be placed into rehabilitation under certain conditions, including when doing business would be hazardous to the company's policyholders, the public, or those the insurer owes money. The co-op was created with $66 million in federal loans. The Insurance Department stated it may not be able to pay off its debt. The co-op will no longer offer coverage after Dec. 31. Read More

Maine

DHHS Soliciting Comments from Public on Proposed Behavioral Health Home Rate Model. Maine's Department of Health and Human Services is concluding a public comment period this week on the proposed Behavioral Health Home rate model for the upcoming year. Under the proposed model, DHHS would convert to a single rate for both adults and children, rather than two separate rates. Based on the rate changes and billing policy changes, DHHS estimates the impact of the proposed rates is an 18 percent increase over current adult rates and a 34 percent increase over current children rates. Comments may be submitted in writing through Friday, September 11th, to Burns & Associates, Inc., who is assisting the department in their rate review. Read More

Massachusetts

Health Care Spending $632 Million Over Goal. On September 4, 2015, *Kaiser Health News* reported that according to Massachusetts' Center for Health Information and Analysis, health care spending last year was $632 million more than the state's goal. Spending shot past the 3.6 percent target and hit $54 billion, a 4.8 percent increase over the previous year. The jump may be attributed to MassHealth, which added 379,999 members and saw spending rise 19 percent to $2.4 billion. However, the influx may be temporary. An eligibility review revealed that enrollment fell by 205,000 members this year. Read More

Minnesota

State Works Through Massive MinnesotaCare and Medicaid backlog. On August 27, 2015, *TwinCities.com* reported that the state will work through the MinnesotaCare and Medicaid backlog by September. An estimated 40,000 low-income individuals who have either become ineligible or did not submit the necessary information in time will lose their government health care. Affected individuals kept their coverage from January through September while state and county workers were unable to verify eligibility. The backlog was caused by computer glitches and struggles with the software managing public health programs. Then in May, a problem with a federal database used to auto-renew enrollees further delayed the process. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Delivery System Reform Incentive Payment Year 1 First Quarterly Report. The state has posted the DSRIP Year One First Quarterly Report. Key accomplishments reported include:

- The state formally announced Performing Provider Systems (PPS) specific valuations for the 25 approved PPSs;
- PPSs submitted Domain 1 Implementation Plans inclusive of organizational components such as Governance, Workforce Strategy, Financial Sustainability, Cultural Competency and Health Literacy;
- DOH and its vendors hosted extensive stakeholder engagement activities and public events;
- The Value Based Payment (VBP) Workgroup, consisting of key stakeholders from various constituencies around the state, convened to review and refine the Roadmap to Value Based Payment.

The report also notes that the first DSRIP Performance Fund payments, totaling $866,738,947, were made, following the approval of the DSRIP Project Plans and the release of project plan valuations for the 25 PPSs. The report can be found on the DSRIP website.

Delivery System Reform Incentive Payment FAQs. The Department of Health posted an updated version of their DSRIP FAQs. The FAQs address every aspect of the DSRIP program, including DSRIP Eligibility and appeals, Performing Provider Systems, project domains and strategies, metrics and milestones, attribution, project valuation and payment. New to the August update are sections on the additional DSRIP funds allocated last month and a series of questions on data sharing and consumer opt-out provisions. The revised FAQ document can be found here.

DSRIP Timeline Revised. The DSRIP Year 1 Timeline has been updated to reflect changes to key DSRIP deliverable dates. Changes include an extension to the PPS remediation period for Implementation Plans and to the PPS First Quarterly Reports, to September 24, 2015. In addition, the mailing of the DSRIP Notice and Opt Out letters to Medicaid members may begin in November 2015. The DSRIP Year 1 Timeline is available here.

Joint Public Hearing. The Office of Alcoholism and Substance Abuse Services (OASAS) and the Office of Mental Health (OMH) will be holding a joint public hearing on their Statewide Comprehensive Plans for 2015-2019. Both agencies will receive input for consideration in the development of their respective statewide comprehensive plans and ongoing planning initiatives. The hearing will be held via videoconference among nine locations: Albany, Buffalo, Rochester, Syracuse, Binghamton, Ogdensburg, Manhattan, Staten Island, and West Brentwood. Registration for any of the public hearing sites listed above is available at http://www.omh.ny.gov/omhweb/planning/507/.

Basic Health Program Implementation. New York is one of two states that has decided to implement a provision of the Affordable Care Act known as the Basic Health Program. The Basic Health Program allows states to offer an insurance product to individuals with income between 150 – 200 percent of the federal

poverty level. New York has named this the Essential Health Plan, and insurers applying to participate in the health exchange, New York State of Health, for 2016 were allowed to apply as an Essential Health Plan as part of their submission. With a premium of $20 per month, the Essential Health Plan would provide less costly coverage for eligible individuals currently purchasing coverage through the Exchange. A recent report in Crains HealthPulse notes that in order for this to be a seamless transition, without changes in health benefits and disruption in provider relationships, the networks in the Essential Health Plan and the Exchange plan would have to be the same. As health plans put together provider networks for the August submission to New York State of Health, some providers were reluctant to accept reimbursement rates that were closer to Medicaid levels than to commercial rates.

Home Care Workers to Receive Minimum Wage. U.S. Secretary of Labor Thomas Perez sent a letter to Governor Cuomo advising him that New York must ensure that most home health care workers get at least minimum wage and overtime compensation. An article in the Times Union quotes Perez as saying that recent court action "requires the payment of minimum wage and overtime compensation to most home care workers." He indicated that nearly two million home care workers will now qualify for minimum wage and overtime protections.

Venture-Backed Insurance Start-Up Oscar. Bloomberg News recently profiled the venture-backed insurance start-up Oscar. Founded in response to the Affordable Care Act, Oscar currently provide insurance in the individual market in New York and New Jersey. As a highly regulated industry, health insurance has not attracted significant investment from private markets. Oscar markets to a technology-savvy customer base, with a website that allows enrollees to track and manage medical bills. Although Oscar lost $37 million in 2014, they are expanding to Texas and California this year. The company expects the losses to continue into next year, but they have the resources to continue operations. According to the report, here, Oscar was valued by investors at $1.5 billion, and it has more than $230 million in the bank.

New York Accountable Care Organizations. Crain's recently reported on the performance of New York State Accountable Care Organizations, indicating the results were a mixed bag. Across the 22 ACOs operating in NYS, ten reported expenditures below their benchmark, and five of those received shared savings payments. Payments ranged from $8.4 million to $1.7 million.

NYS Duals Demonstration – Fully Integrated Duals Advantage. NYS has indicated that they have applied to CMS to extend the duals demonstration initiative, FIDA, for an additional two years. CMS recently offered states participating in the duals demonstration the ability to apply for an extension, due to timing misalignment between the need to commit budgetary and program resources and the release of program evaluation findings. Enrollment in FIDA has been below what was anticipated, with fewer than 10,000 enrollees as of August 1. The Department of Health and CMS continue to do outreach and education to encourage participation, with two additional roundtables for plans and providers scheduled in September. Registration is required:

RSVP by September 14, 2015 for the Thursday, September 17 training here.

RSVP by September 25, 2015 for the Wednesday, September 30 training here.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Two Ohio Groups Awarded Federal Navigator Grants. An Ohio Association of Foodbanks led consortium of 10 organizations, and HRS/Erase, Inc. were respectively awarded $2 million and $274,392 in federal navigator grants according to an announcement by the federal Centers for Medicare & Medicaid Services announced on Wednesday September 2. In total, CMS awarded $67 million to support work to enroll Ohioans in health coverage through the federal health insurance marketplace. Open enrollment begins again November first.

Drug Addiction and Newborns. According to *Gongwer Ohio,* two Ohio legislators will soon introduce a bill dubbed "Maiden's Law" which is aimed at encouraging drug addicted pregnant women to seek both treatment and prenatal care without fear of child protection services taking away their newborns. The legislators hope the law helps to reduce incidents of children born with Neonatal Abstinence Syndrome and lower the state's high infant mortality rate. Under the legislation, public children's agencies would be barred from filing complaints only because a mother used a controlled substance while pregnant if she has enrolled in treatment before her 20th week of pregnancy and has completed or is in the process of completing the program at the time of birth. It also requires that these women maintain their prenatal and treatment related appointments. In light of treatment facility capacity and access challenges, the proposed bill is also said to include a safety net of judicial discretion for women who fail to the meet the 20 week deadline due to such issues. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Completes Switch to Traditional Medicaid Expansion. Pennsylvania Governor Tom Wolf converted former-Governor Tom Corbett's Medicaid expansion effort, called Healthy PA, in phases. The new governor moved immediately toward a more traditional expansion program, although the process took until September 1, 2015, to complete. On April 27, 2015, he announced the transition of 120,000 beneficiaries from the Healthy PA plan to HealthChoices. On July 27, 2015, the Department of Human Services moved the remaining beneficiaries from HealthyPA's private coverage option to HealthChoices. These enrollees had 30 days to select an insurance plan and were given "bridge" coverage until September 1, 2015. In a statement, the Pennsylvania DHS said that 440,000 enrollees have taken advantage of Medicaid expansion, and 216,000 newly eligible residents have signed up since April 27, 2015. Read More

Changes in Store for Consumers of Insurance Plans through Healthcare.gov. Highmark Health, which has dominated the Affordable Care Act online health insurance marketplace in Pennsylvania, is changing course. The Pittsburgh-based nonprofit announced this week that after losing $318 million in the first half of this year on those plans, it's going to offer fewer of them and expects a general shift toward including fewer providers in its networks, according to the Wall Street Journal. In Pennsylvania, rates don't take effect unless the state insurance department agrees that they're justified and approves them. Insurers

submitted their rate requests for 2016 months ago. A department spokeswoman said last week that they are still under review but that finalized rates will be made available before the marketplace open enrollment period begins on Nov. 1. Read More

Texas

Texas to Go Forward with $100 Million in Cuts to Children's Therapy. On August 26, 2015, *The Texas Tribune* reported that the Health and Human Services Commission will proceed with $100 million in cuts to therapy for poor and disabled children. The move will not be implemented Sept. 1 as previously planned. A hearing will be held for public comment. The cuts - $50 million a year for two years –passed by Legislature, were met with criticism. A lawsuit filed against the health commission argued the cuts would mean "immediate and irreparable injury" to children. Up to 60,000 may be affected. Read More

National

ACA Health Insurance Signups at 9.9 Million as of June 30. On September 8, 2015, *The New York Times* reported that as of June 30, approximately 9.9 million people have signed up under the Affordable Care Act, down from 10.2 million as of March 31. According to the U.S. Department of Health and Human Services, 84 percent were receiving tax subsidies. Florida saw the largest decline in enrollment. Georgia, Pennsylvania, North Carolina and Texas also saw declines. The administration's year-end goal is 9.1 million. Read More

Industry News

Molina to Acquire Providence Service Corporation's Behavioral and Mental Health Subsidiaries for $200 Million. On September 3, 2015, Molina Healthcare announced that it has entered a definitive agreement to acquire Providence Human Services and Providence Community Services for $200 million, subject to customary working capital adjustments. The transaction is expected to close during the fourth quarter of 2015. PHS is one of the largest national providers of accessible, outcome-based behavioral and mental health services and operates in 23 states and the District of Columbia. Read More

Maximus Releases DecisionPoint to Manage Long-Term Services and Supports Programs. On September 1, 2015, Maximus announced that it launched DecisionPoint, a solution to help states manage and coordinate care of long-term services and supports programs. DecisionPoint is designed around a patient-centered model, focusing on shifting care to home and community based settings. It provides design, development, and operational support for states, including pre-enrollment and post-enrollment services for beneficiaries. Read More

Cardon Outreach to Merge with Diversified Healthcare Resources. On August 26, 2015, Cardon Outreach announced that it will merge with Diversified Healthcare Resources, a provider of eligibility and enrollment services for California hospitals and healthcare facilities. No financial terms were disclosed. Read More

Express Scripts Names CEO Successor. Express Scripts has announced that current CEO George Paz will retire in May 2016, remaining on as non-executive Chairman going forward. Upon Paz's retirement, current company President Tim Wentworth will take on the role of CEO. Wentworth has been the President of Express Scripts since February 2014. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
October 1, 2015	Montana Expansion (TPA)	Proposals Due	70,000
September 1, 2015	Texas NorthSTAR (Behavioral)	Implementation	840,000
September 1, 2015	Texas STAR Health (Foster Care)	Implementation	32,000
September 30, 2015	Washington (SW - Fully Integrated)	Proposals Due	100,000
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
November, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
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	4/1/2016	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	Jul-15
California	122,908	123,079	124,239	122,520	122,798	122,846	120,452
Illinois	63,731	64,199	60,684	58,338	55,672	52,763	52,170
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705	17,671
Michigan					9,216	14,867	28,171
New York	17	406	539	6,660	7,215	5,031	7,122
Ohio	68,262	66,892	65,657	63,625	63,446	62,958	61,871
South Carolina		83	1,205	1,398	1,366	1,317	1,388
Texas			58	15,335	27,589	37,805	44,931
Virginia	27,333	26,877	27,765	27,349	30,877	29,970	29,507
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,262**	**363,283**

HMA News

New this week on the HMA Information Services website:

- **Colorado** Medicaid RCCO Enrollment Tops 900,000, Jun-15 Data
- **Washington** Medicaid Managed Care Enrollment Up 9.1%, Aug-15 Data
- **Maryland** Medicaid Managed Care Enrollment Falls 5.2%, Jul-15 Data
- **Texas** Medicaid Managed Care Enrollment Falls 1.6%, Jul-15 Data
- Public documents including the **Oregon** Coordinated Care Organization Model Contract, 2015 and the **Washington** Foster Care Proposals and Related Documents, 2014

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 Webinar Replay Available: ***"Medicaid Network Adequacy: A Proactive Approach to Ensuring and Demonstrating Compliance"***

HMA Principal Karen Brodsky (who previously oversaw managed care contracting for the state of New Jersey), discussed the warning signs state regulators look for when assessing the adequacy of a Medicaid managed care plan's network. She also outlined some practical ways plans can get out in front of these potential problems – not only demonstrating compliance to regulators but also improving access and satisfaction for members. **Link to Webinar Replay**

HMA Upcoming Webinar: ***"Sustainable Funding for Asthma-Related Home Interventions"***

Tuesday, Sept. 15, 2015
1 to 3 p.m. EDT

Register here for this free event.

HMA Upcoming Webinar: ***"Sustainable Evidence-based Integration: A Step-by-Step Guide to Integrating Behavioral Health into the Primary Care Setting"***

Tuesday, Sept. 22, 2015
1 to 2 p.m. EDT

Register here for this free event.

HMA Upcoming Webinar: ***"21st Century LTSS: A Roadmap to Improved Outcomes, Lower Costs and Better Lives for Individuals with Complex Healthcare Needs"***

Wednesday, September 23, 2015
1 to 2 p.m. EDT

Register here for this free event.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Pacific Northwest; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC. http://healthmanagement.com/about-us/

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