HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 21, 2015

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THIS WEEK

IN FOCUS

HIGHLIGHTS FROM KAISER/HMA 50-STATE MEDICAID DIRECTOR SURVEY

This week, our *In Focus* section reviews highlights and shares key takeaways from the new Kaiser Commission on Medicaid and the Uninsured (KCMU) report, ***Medicaid Reforms to Expand Coverage, Control Costs and Improve Care: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2015 and 2016***, released on October 15, 2015. The report, published annually, was prepared by Vernon K. Smith, Ph.D., Kathleen Gifford, and Eileen Ellis from HMA and by Robin Rudowitz, Laura Snyder, and Elizabeth Hinton from KCMU. HMA's Barbara Edwards, Jenna Walls, and Dennis Roberts also contributed to the report.

The findings in this report are drawn from the 15th consecutive year of the KCMU and HMA budget survey of Medicaid officials in all 50 states and the District of Columbia. This survey reports on trends in Medicaid spending, enrollment, and policy initiatives for FY 2014 and FY 2015. The report highlights policy changes implemented in state Medicaid programs in FY 2015 and those planned for implementation in FY 2016 based on information provided by the nation's state Medicaid Directors. Policy changes and initiatives described in this report include those related to eligibility and enrollment, managed care, delivery and payment system reforms, provider payment rates, and covered benefits (including prescription drug policies). The report also looks at the key issues and challenges now facing Medicaid programs.

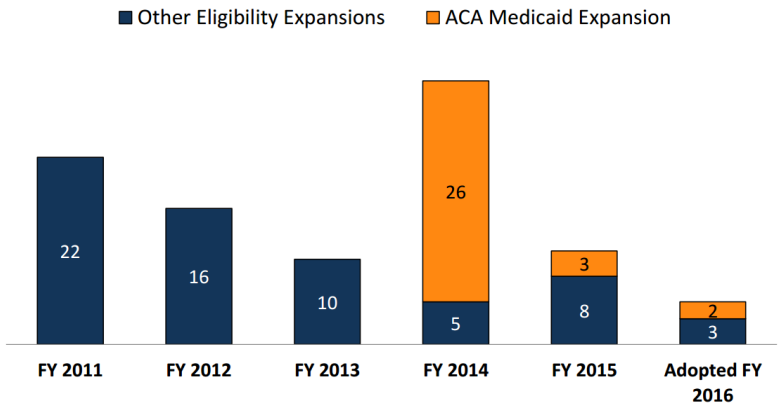
Key Report Highlights

In the following sections, we highlight a few of the major findings of the report. This is a fraction of what is covered in the 50-state survey report, which also includes findings on policy changes regarding provider reimbursement, long-term care rebalancing, pharmacy cost controls and other benefit changes, provider assessments and taxes, and program integrity initiatives.

Medicaid Eligibility Standard Changes

- As of October 2015, 31 states (including DC) have adopted the ACA Medicaid expansion, with three states expanding in FY 2015 (New Hampshire, Pennsylvania, Indiana) and two states in FY 2016 (Alaska, Montana).
- Other eligibility changes adopted or planned in FY 2015 and FY 2016 were small, targeting a limited number of beneficiaries.
- A number of states are eliminating coverage for beneficiaries with incomes above 138 percent of poverty, many of whom qualify for Marketplace subsidies.
- A few states had received or were seeking waivers to implement changes to premiums that were primarily related to the ACA coverage expansions (Arkansas, Indiana, Iowa, Michigan, and Montana).

Figure 1 – Number of States with Eligibility Expansions/Enhancements FY 2011-2016

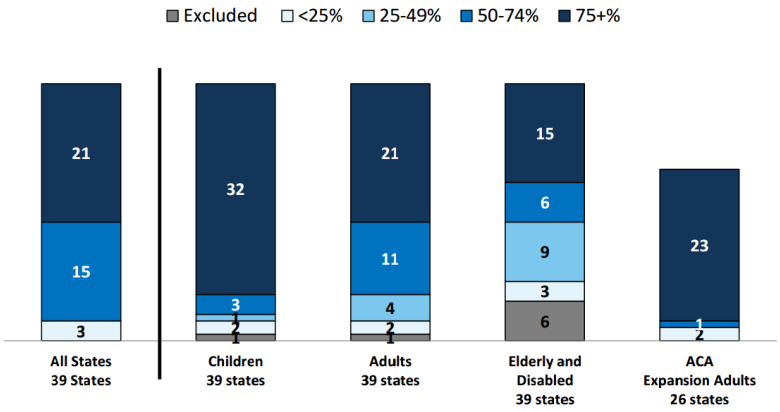


SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2011-2015.

Medicaid Managed Care Policy Changes

- As of July 2015, a total of 48 states used some form of managed care to serve the Medicaid population, including 39 states (including DC) that contracted with risk-based managed care organizations (MCOs) to serve their Medicaid enrollees.
- Among the 39 states with MCOs, 21 reported at least 75 percent of all Medicaid beneficiaries were enrolled in MCOs.
- In FYs 2015 and 2016, the trend toward increased use of MCOs continues, as five states (Florida, Indiana, Iowa, Louisiana, Rhode Island) end their primary care case management (PCCM) programs and transition populations to MCOs. Other states are moving more eligibility groups, geographic areas, and benefits into MCOs.

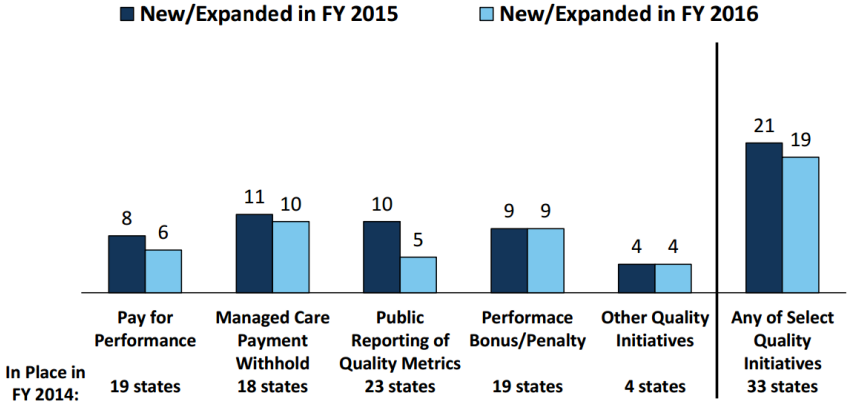
Figure 2 – MCO Penetration Rates for Select Groups of Medicaid Beneficiaries, as of July 1, 2015



SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

- As more states rely on MCOs for acute physical health care, a growing number of states are focusing on integration of physical health, behavioral health, and long-term services and supports (LTSS) under the umbrella of managed care as a priority policy direction.
- In FY 2015, a total of 21 states implemented new or expanded quality initiatives, and 19 states planned to do so in FY 2016. The most common new or expanded initiatives in FY 2015 and FY 2016 were the adoption or increased use of managed care payment withholds.

Figure 3 – Number of States with Select Medicaid Managed Care Quality Initiatives, FYs 2014-2016



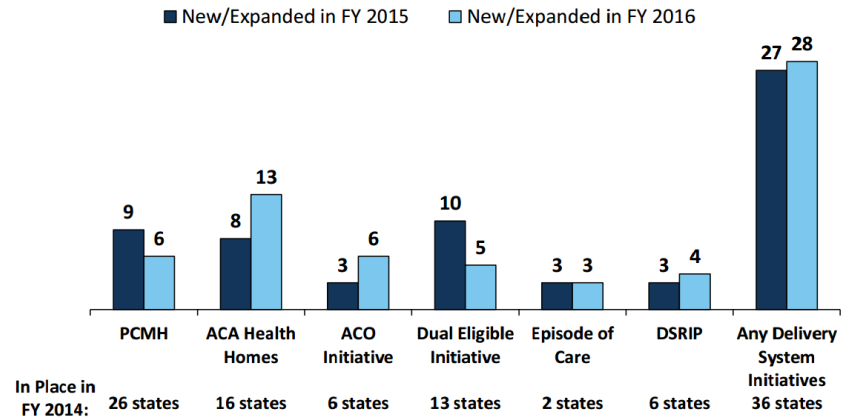
SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

- As of July 1, 2015, 19 of the 39 states that contracted with comprehensive risk-based MCOs specified a minimum loss ratio (MLR) for all or some plans. State Medicaid MLRs vary, but most are set at 85 percent. A few states noted that their MLRs varied by type of plan or population.

Emerging Delivery System and Payment Reform Initiatives

- Thirty-seven (37) states in either FY 2015 or FY 2016, including 27 states in FY 2015 and 28 states in FY 2016, reported adopting or expanding one or more initiatives that seek to reward quality and encourage integrated care. Initiatives include patient-centered medical homes (PCMHs), Health Homes, Accountable Care Organizations (ACOs) as well as other initiatives to coordinate physical and behavioral health care and better manage the care of persons with multiple chronic conditions.
- Nearly a quarter of states are implementing initiatives in FY 2015 or FY 2016 to coordinate care and financing for dual eligible beneficiaries.
- A more limited number of states are implementing episode-of-care and DSRIP initiatives.

Figure 4 – Number of States with Delivery System Reform Activity, FYs 2014-2016

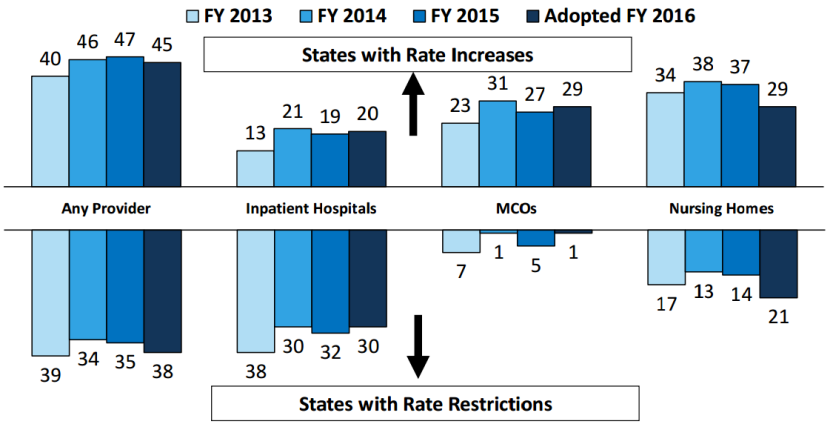


SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

Provider Rates

- In both FY 2015 and FY 2016, more states implemented or planned provider rate increases (47 and 45 states) compared to rate freezes/restrictions (35 states and 38 states) in those years.
- The number of states with rate increases exceeded the number of states with freezes/restrictions in FY 2015 and FY 2016 across all major categories of providers (physicians, MCOs and nursing homes) except for inpatient rates for hospitals.

Figure 5 – Number of States Implementing Provider Rate Changes in FY 2013 – FY 2015 and Adopted for FY 2016



SOURCE: KCMU Survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2015.

- In FY 2015, two states eliminated provider taxes (a hospital tax in DC and a cosmetic surgery tax in New Jersey). For FY 2016, three states and DC reported plans to add provider taxes. DC has a new hospital tax. Connecticut is adding a tax on ambulatory surgery centers. Michigan and Utah are adding taxes on ambulance providers.
- States were asked whether in the future they planned to use increased provider taxes or fees to fund all or part of the costs of the ACA Medicaid expansion that will occur in calendar year 2017 and beyond when the 100 percent federal match rate for expansion costs starts to decline. Seven of the expansion states (Arizona, California, Colorado, Indiana, Kentucky, Nevada and Ohio) responded that they had such plans.

Medicaid Policy Reactions to High-Cost Specialty Drugs

In this year's survey, states were asked to comment on whether their state had adopted or planned to adopt coverage, reimbursement, or managed care policies targeting specialty or high-cost drugs in FYs 2015 or 2016.

- Nineteen (19) states reported implementing new clinical prior-authorization requirements, and 11 states indicated that they were standardizing clinical criteria across both fee-for-service and managed care.
- In contrast, in FY 2016, two states (California and Connecticut) reported plans to liberalize their previously more restrictive prior-authorization polices for hepatitis C drugs, making them more widely available.

Looking Ahead: Perspectives of Medicaid Directors

When asked to identify the top priorities and issues for FY 2016 and beyond, Medicaid directors listed the following:

- **Continued Implementation of ACA Provisions.** Many directors reported that implementing the Medicaid expansion and expanding access to care for residents who have not had insurance continues to be a key priority.
- **Controlling Costs.** While cost control is not as acute a problem as during the recession, states still report that controlling costs and spending is a top priority. Looking ahead to FY 2017, a few states implementing the Medicaid expansion reported that finding general funds for the state share of Medicaid spending beginning in January 2017 is an upcoming challenge.
- **Medicaid Managed Care Expansion Challenges.** States mentioned that expanding the scope of managed care involves a number of specific challenges, including the procurement and contracting for Medicaid health plans, the need for effective oversight of MCO contracts and performance, and the new potential challenges from the recently proposed CMS rules for Medicaid managed care.
- **Information Technology Systems.** In almost half of states, systems and administrative initiatives were listed as a top priority for FY 2016. Medicaid directors noted continued strain on administrative resources, in particular staff, as Medicaid programs are working to implement a number of major initiatives across multiple arenas.
- **Population Health, Social Determinants of Health.** Broader efforts to improve population health are emerging priorities for Medicaid directors. Pursuing these significant goals, however, has caused Medicaid to evolve into a major player in transforming the overall health care system.

Links to Kaiser/HMA 50-State Survey

Link to Executive Summary (PDF)

Link to Full Report (PDF)

HMA Weekly Roundup Highlight

Special Highlight on CO-OP Closures. On October 1, CMS announced that it would pay only 12.6 cents on the dollar of money owed to CO-OPs and other plans under the three-year risk corridor program designed to stabilize premiums in the Marketplaces to account for sicker patients enrolled in some plans. In the wake of this notice, seven CO-OPs have announced that they will be winding down operations this year and will not offer plans in 2016 because of losses associated with the unexpectedly low risk-corridor payments. In addition, Land of Lincoln CO-OP in Illinois announced that it will cap enrollment in 2016 to provide a sufficient operating cushion to offset the roughly $42 million that the CO-OP now will not be paid as a result of reductions in the risk corridor program. See CMS' announcement here.

CO-OPs and state insurance commissioners expressed concern that the state requirements for regulatory capital either could not be met now or would be at risk later in the year without the expected federal payments designed to account for higher claims from newly insured people in the Marketplace. After the CMS decision, some insurance commissioners did not provide "credit" for additional CMS payments owed for subsequent years, regarding future payments to be unreliable The promised federal payments had been booked as receivables for most CO-OPs. Notably, the closings are occurring among CO-OPs that had achieved significant market success such as Colorado, Kentucky, and New York. Some of the affected CO-OPs announced that they had expected to operate with positive margins in 2016 before the change in CMS policy and were expected to be in the Marketplaces starting in November. (Read More) According to the *Wall Street Journal*, CO-OPs who counted on the risk corridor payments to offset their expected higher risk are apparently contemplating legal action. (Read More)

As CO-OPs and other small plans exit the market in response to the risk corridor decision, the competitive position of the larger insurance companies that can withstand the risk corridor shortfall can be expected to improve. The CO-OPs that are withdrawing from the market pursuant to state insurance department determinations will continue in business through the end of the year, with the coverage for members remaining intact and claims expected to be paid. Once claims have been paid, the remaining amounts will go back to the federal government to repay loans that initially established the CO-OPs. However, as reported by *Politico,* premiums in states with CO-OPs were more than 8 percent lower than premiums in states without CO-OPs in 2014. (Read More) According to an analysis in *Health Affairs*, if premiums in states with CO-OPs ranged from 2 percent to 5 percent lower on average than premiums in states without CO-OPs, the savings to the federal government would amount to $6.9 billion to $17.4 billion over 10 years, assuming all 23 CO-OPs remained in operation. (Read More) With the departure of 7 CO-OPs from the market, those savings can be expected to diminish.

HMA Medicaid Roundup

Alabama

Governor Leaves Door Open on Medicaid Expansion Someday. On October 20, 2015, *AL.com* reported that when asked if the state was nudging toward Medicaid expansion, Governor Robert Bentley replied, "I wouldn't say nudging toward it. But we are certainly looking at that; not right now. We are not at that stage right now." He went on to say that the state needs to realistically look at funding for rural doctors and primary care doctors. Read More

Arkansas

Governor Asa Hutchinson Proposes Medicaid Integrity Unit. On October 15, 2015, *Arkansas News* reported that the Department of Human Services' Division of Medical Services and the Office of Medicaid Inspector General are proposing a new Medicaid Integrity unit at the request of Governor Asa Hutchinson. The unit will use data analytics and industry practices to identify systematic sources of waste. DHS and OMIG will then collaborate on correcting the existing policies, providing new training for DHS and provider staff, and addressing shortcomings in the current claim processing procedures. Read More

Human Services Director Testifies on MLTSS Cost Control Potential. On October 21, 2015, *Arkansas Online* reported that the director of the state Department of Human Services testified to legislators this week that the state will have a better chance of controlling its Medicaid costs if the Medicaid long-term supports and services (LTSS) and other Medicaid beneficiaries with complex care needs are transitioned to managed care. The state solicited RFI responses earlier this year on a potential managed care transition that would include ABD, dual eligibles, and users of LTSS. Read More

California

HMA Roundup – Don Novo (Email Don)

Sutter Health Sees Higher Revenue as Outpatient Activity Grows. On October 16, 2015, *Modern Healthcare* reported that Sutter Health, the Sacramento, Calif.-based system, continued to benefit from higher Medicaid payments and a decrease in uninsured. But like many of its peers, the 25-hospital group is grappling with higher labor and supply costs. Read More

Audit: Agencies Have improved Emergency Preparedness. On October 16, 2015, *California Healthline* reported that a new state audit finds that the California Department of Public Health and the Governor's Office of Emergency Services are better prepared to respond to emergencies after several deficiencies were

found in 2013, such as inadequate training and funding. The audit removes the agencies' high-risk classifications. Read More

Blue Shield of Calif. Agrees To Limit Premiums, Recalculate Rebates. On October 15, 2015, *California Healthline* reported that Blue Shield of California has agreed to a state Department of Managed Health Care order to limit its premiums for certain policies in 2016 and 2017, as well as to recalculate its medical loss ratio estimates for 2015 and 2016. DMHC and Blue Shield said the insurer's recently approved acquisition of Care1st Health Plan did not influence the agreement. Read More

Governor Brown Signs More Health Care-Related Bills Into Law. On October 14, 2015, *California Healthline* reported that Governor Brown has signed into law several health care-related bills, including one to establish a closed prescription drug formulary in the state's workers' compensation program and another measure requiring crisis pregnancy centers to provide information about abortion, contraception, and prenatal care. Read More

Brown Vetoes Medi-Cal Bills, Citing Expected $1.1B Budget Deficit. On October 13, 2015, *California Healthline* reported that Governor Brown vetoed several proposed tax credits and six Medicaid bills that would have added new health benefits for low-income residents. In his veto messages, Brown cited a $1.1 billion deficit resulting from the state Legislature's failure to rework the expiring managed care organization tax. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Colorado HealthOP to Shut Down. On October 16, 2015, *The Denver Post* reported that the Colorado Division of Insurance dropped HealthOP from the state Insurance Exchange, citing that it no longer meets state capital reserve requirements. The co-op will no longer be able to sell or renew policies on the Exchange for 2015. It will continue to pay claims for the rest of 2015 for its current 83,000 members. HealthOP is the seventh co-op to collapse, along with ones from Kentucky, Louisiana, Iowa/Nebraska, Nevada, New York, and Tennessee. The collapse was largely a result of lower reimbursements for risk-corridors. CMS said insurers would be reimbursed for 12.6 percent of the $2.87 billion claimed. HealthOP received only $2 million. The co-ops aggressive strategy of slashing premiums resulted in signing up 40 percent of all the policies sold on the Health Exchange. The co-op had to take on about $72 million in low-interest federal loans. At the end of 2014, it reported a net loss of $23 million. It has been under state supervision since February. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

LIP Funding Increase Unlikely. On October 20, 2015, *Tampa Bay Times* reported that lawmakers are unlikely to increase the Low Income Pool program funding. Last week, the federal government capped funding at $608 million for 2016. However, the state budget is still early in the process and lawmakers may still put money in hospitals through other methods. Sen. Rene Garcia, chairman of the Senate Health and Human services Appropriations Committee does not

expect that to happen, but is willing to work with the House on ideas. Read More

Department of Health Offers Compromise on Screenings for Children's Medical Services. On October 19, 2015, *Health News Florida* reported that the Florida Department of Health offered a compromise for determining eligibility for Children's Medical Services that could allow the department to resume enrolling special-needs kids. The compromise would consider medal professionals' opinions as part of the screening process. Florida was ordered by Judge Darren Schwartz of the Division of Administrative Hearings to cease using a screening tool that relied on a five-question survey completed by parents. Approximately 9,000 kids no longer qualified for CMS services when the screening tool went into effect. Read More

Florida, CMS Finalize Deal on LIP Funding. On October 16, 2015, *Politico Florida* reported that CMS has approved a deal with Florida to bring in $1.6 billion in supplemental Medicaid funding for the Low Income Pool program between now and June 30, 2017. CMS will require special terms and conditions. The deal reduces LIP funding from $1 billion this year to $608 million in Fiscal year 2016-17, in part because the federal government will exclude any uncompensated care costs for people who would be eligible for coverage under Medicaid expansion but are not covered because the state did not move ahead with expansion. Additionally, eligible providers will be split between two groups, hospital and school physician practices, and will be placed in tiers based on the ratio of uncompensated charity care to the percentage of their privately insured patient care. Read More

Cigna Leaves Florida Health Insurance Exchange for 2016. On October 15, 2015, *Health News Florida* reported that Cigna is withdrawing from the Florida Health Insurance Marketplace, citing fraud and abuse in out-of-network substance abuse clinics and labs. Among the abusive practices mentioned in an email to brokers from the company were kickbacks for referrals and excessive testing. The decision to pull out applies to 2016 plans for individuals and families available through the federal Exchange. In 2015, Cigna had seven plans in 23 counties, covering approximately 30,000 Floridians. Cigna will return to the Florida marketplace Exchange in 2017. Read More

LIP Funding, Increasing Access to Health Care, and Lowering Costs on Agenda for Legislature Session in January. On October 14, 2015, *Miami Herald* reported that the agenda for the next legislature session in January will focus on funding for the Low Income Pool program, in addition to lowering health care costs and increasing access. The House and Senate are already at odds. The House will oppose any efforts to expand Medicaid and will look to solutions based on innovation and choice, not government programs. This includes cutting regulation and opening up the health care industry to more market forces. The Senate, however, pushed for using Medicaid expansion dollars to give private health care to low income Floridians last spring. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Get Covered Illinois Names Exchange Offerors for 2016. On October 20, 2015, *Crain's Chicago Business* reported on the participating health insurance companies on the Illinois Exchange for 2016, known as Get Covered Illinois. Insurers offering plans for 2016 are:

- BCBS of Illinois
- UnitedHealthcare
- Health Alliance
- Humana
- Celtic Insurance (Centene)
- Coventry Health (Aetna)
- Land of Lincoln Health (CO-OP)
- Harken Health (United subsidiary)

Assurant Health will exit the Illinois market, as its parent company winds down its health insurance business. Land of Lincoln Health announced this week that it will be limiting enrollments for 2016. Earlier this year, Get Covered Illinois laid off a significant portion of its staff and transitioned from the Governor's administration to the Department of Insurance in August. Read More

Indiana

New State Law Allows Counties to Help Inmates Get Medicaid Coverage. On October 20, 2015, *Tribune Star* reported that a new state law was approved allowing counties to enter into agreements with the Family and Social Services Administration to make Medicaid available for to eligible inmates and coordinate benefits to those transitioning to civilian life. The county would pay FSSA's share of Medicaid costs incurred. The Medicaid rates are expected to be lower than the current hospital and physician costs, but exact cost savings will not be known for a year. Read More

Iowa

Medicaid Privatization Savings Questioned. On October 15, 2015, *The Des Moines Register* reported that Iowa has no documentation or expert support that privatizing its Medicaid program will save taxpayers $51 million during the first six months. Lawmakers are concerned that the Department of Human Services' savings estimate may not be accurate. Iowa law does not mandate that research materials be maintained as public records. Read More

Kentucky

Kentucky May Repeal Medicaid Expansion After Election. On October 16, 2015, *ABC News* reported that Kentucky may become the first state to repeal expansion depending on the outcome of the governor election. Republican nominee, Matt Bevin, has said that the state can no longer continue to pay for the health insurance of "able-bodied adults." Bevin plans to repeal the current plan and replace it. After Governor Steve Beshear expanded Medicaid, 400,000 people signed up and the uninsured rate dropped from 20.4 percent in 2013 to under 10 percent last year. Read More

Louisiana

Gubernatorial Candidates Willing To Expand Medicaid. On October 17, 2015, *The Baltimore Sun* reported that the four main contenders vying to become the next governor said that they are willing to expand Medicaid. However, the three GOP candidates have caveats on what type of expansion program they would consider. Current Governor, Bobby Jindal, has refused to accept federal health care money to expand Medicaid services. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Legislative Committee Calls for Changes to Help Medicaid Insurers. On October 21, 2015, *The Boston Globe* reported that a House panel consisting of legislators and health care executives assembled by the House Speaker is calling for changes to help sustain Medicaid managed care organizations. In 2014, the insurers collectively lost $137million. The committee will issue a report on Wednesday that asks officials to alter enrollment rules for more stable membership. It will also urge health plans to adopt new payment models designed to rein in costs by reimbursing doctors for keeping patients healthy. Read More

State to Notify Insurers and Providers Flagged for Excessive Cost Growth. On October 14, 2015, *Boston Business Journal* reported that the Health Policy Commission will notify insurers and providers with excessive cost growth and may demand performance improvement plans. However, it is still unclear how the data will be used. In 2016 a new portion of the 2012 health cost containment law will authorizing the commission to require performance improvement plans for entities whose excessive cost growth is deemed to threaten the state's overall benchmark of keeping medical expense growth below that of gross state product, according to commission officials. Read More

Michigan

HMA Roundup – Eileen Ellis (Email Eileen) & Esther Reagan (Email Esther)

Protests Submitted Over Michigan Medicaid Contract Awards. On October 14, 2015, *Crain's Detroit Business* reported that the Michigan Department of Health and Human Services' Medicaid contract award recommendations have sparked controversy with plan executives over the county assignments. HAP Midwest Health Plan may be shut out of the Southeast Michigan market, from which it has built its 100,000-member plan. Susan Schwandt, a spokesperson for HAP Midwest, stated the plan will immediately appeal the state's decision. Physicians Health Plan, owned by Sparrow Health System, lost all of its counties for 2016. Centene was not awarded a Medicaid contract in Michigan at all. The contracts begin January 1 and are worth $42 billion. The recommendations will go before the State Administrative Board in mid-November before the contracts are final. Read More

Doctors' Hospital of Michigan in Pontiac Stays Open from Emergency Lender $1.5 Million Financing Deal; May Get Private Ownership. On October 18, 2015, *Detroit Free Press* reported that Doctors' Hospital of Michigan in Pontiac avoided closure with an emergency lender $1.5 million financing deal. The lender, a

family-run private equity firm, is now the leading candidate to buy the hospital. The company filed Chapter 11 in July as well as back in 2008. Read More

Lawmakers and Advocates Call for State Law to Establish Mandatory Nurse-to-Patient Ratios and Prohibit Mandatory Overtime. On October 16, 2015, *Detroit Free Press* reported that lawmakers and nurse advocates called for a state law establishing mandatory nurse-to-patient ratios and prohibiting mandatory overtime. Nurse staffing shortages across the nation have led to nurses working double shifts, sometimes to the point of exhaustion. The proposed bill would require hospitals to maintain ratios of one nurse to every five patients in rehabilitation and intensive care settings. The bill would apply to public facilities. Read More

Nebraska

Nebraska Issues Statewide Medicaid MCO RFP. On October 21, 2015, Nebraska published a request for proposals (RFP) for a statewide rebid of their Medicaid managed care programs, integrating physical and behavioral health for nearly all Nebraska Medicaid beneficiaries statewide. The new contracts will also carve-in pharmacy benefits. Populations covered under the new program include children, adults, ABD, dual eligibles, and individuals receiving long-term care in an institution or in HCBS setting. However, long-term care services themselves are carved-out; the state has long been planning a separate managed long-term care program. The state intends to award two or three statewide contracts to cover nearly 239,000 Medicaid members with annual Medicaid spending of around $1.8 billion, of which roughly $800 million is long-term care. Proposals are due to the state on December 22, 2015, with a plan to announce intent to award on January 29, 2016, and final contract awards on March 1, 2016. The new contracts will go live on January 1, 2017.

New Hampshire

Three Big Changes on Health Care Exchange in 2016. On October 15, 2015, *NH Business Review* reported that there will be three big changes on the New Hampshire health insurance exchange in 2016. Approximately 40,000 people who obtained coverage through Medicaid expansion will be moved to the state marketplace. Fines for individuals who do not buy coverage will double. And lastly, Centene will replace Assurant on the individual exchange market. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Rockland County LTC Facility Closing. Rockland County is proceeding with a plan to close the county-owned Summit Park Hospital and Nursing Care Center. The facility includes a 57-bed long term acute care hospital, a 321-bed skilled nursing facility, and a 41-bed unit dedicated to Alzheimers and dementia care. According to Rockland County Executive Ed Day the facility is losing $800,000/month. The county had been in negotiations with a prospective buyer, but negotiations failed. Read More

NY State of Health Announces 2016 Health and Dental Plans. NY State of Health, the state's official health plan Marketplace, announced the insurers that will offer health and dental plans to individuals and small business owners in 2016. A total of 16 health insurers are expected to offer individual coverage for 2016 on the Exchange. NY State of Health (NYSOH) also announced the insurers that will be offering the new Essential Plan, New York's Basic Health Program offering. Information about the approved health insurance plans and their rates can be found on the Department of Financial Services website. Two plans that operate on the Exchange, Oscar and North Shore-LIJ CareConnect, will not be offering an Essential Plan. Health Republic, a CO-OP that was offered on the marketplace in 2014 and 2015 will not be available in 2016, as the Department concluded their financial situation made on-going operation untenable. Persons enrolled in Health Republic will receive a renewal notice providing information about how to select another plan for 2016. Maps of the 2016 Health and Dental Plans are available here and here.

North Carolina

North Carolina Overhauling Medicaid to Deal with Rising Costs. On October 20, 2015, *Kaiser Health News* reported that North Carolina is reshaping Medicaid in an effort to keep rising costs in check. Using various health care models, doctors, hospitals, and insurers will be responsible for more costs. From 2010 to 2013, North Carolina struggled with huge Medicaid cost overruns. The new overhaul relies on a hybridization of a managed care model and accountable care organizations to save costs. The state will set budgets up front for whomever it puts in charge of managing care. If those managers go over budget, they are on the hook. Additionally, lawmakers set a cap of 12 percent for how much money can go toward administrative costs and profits. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio Releases a Revised HCBS Transition Plan for Public Comment. Ohio's Office of Health Transformation has posted a newly revised Draft Transition Plan for public comment following the state's receipt of preliminary feedback from the Centers for Medicaid and Medicare Services (CMS). The state will refine the plan based on comments it receives by November 15, 2015, and submit a final draft transition plan to CMS by December 2, 2015. Read More

Kaiser Foundation Update on States Uninsured Rates. A new report by the Henry J. Kaiser Family Foundation updates, by state, uninsurance rates, based on 2015 Medicaid eligibility levels and 2015 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) sources. The new report estimates that Ohio's rate of uninsured has fallen by half, to 8.7 percent. That number could fall further. About two thirds of Ohio's non-elderly uninsured are estimated to be eligible either for Medicaid at no cost or for tax credits to subsize private coverage. The rate of Ohioans estimated to be eligible for but not enrolled in Medicaid was 48%, the fourth highest rate in the nation. Since the January 2014 Medicaid expansion, about 600,000 Ohioans have secured coverage, taking total Medicaid enrollment in Ohio to over 3 million. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania's DHS Issues Procurement for Enrollment Assistance Broker. The Department of Human Services is seeking a Grantee to provide assistance with various enrollment activities to Medical Assistance (MA) consumers who are eligible to receive health related services through the MA Program. This assistance includes helping consumers in selecting or changing their Physical Health Managed Care Organization (PH-MCO) and making Primary Care Practitioner (PCP) selections, as well as providing information regarding service providers under the HealthChoices Program. Questions regarding the RFA are due November 4, 2015. Proposals are due December 1, 2015. Read More

Pennsylvania Approves 2016 Health Insurance Rate Increases. The Pennsylvania Insurance Department just released the 2016 rates for individual and small-group insurance plans offered under the Affordable Care Act. A list that shows both the requested and approved rate changes for individual and small-group plans is available here. The rates that were ultimately approved and released today "are significantly lower than were originally proposed." The department said 12 of the companies offering individual health plans have increases under 10 percent, and all 23 companies offering small-group health plans will have increases under 10 percent. The department noted that when the Affordable Care Act Marketplace was launched in 2014, insurance companies had no claims history with which to estimate how many claims the newly insured population would file, or how much those claims would cost insurers. According to the department, "In many cases, insurers underestimated the cost of the claims individuals newly insured would file, and the premiums charged to cover these costs are now being set at a level to more accurately reflect insurers' anticipated costs." Read More

Health Information Exchange Authority Gains 3 New HIOs. As health information exchanges (HIEs) continue to present enormous healthcare benefits, three HIE groups in Pennsylvania have signed on to unite via an eHealth partnership, to bring care coordination and interoperability across the entire state. According to a press release, ClinicalConnect HIE (CCHIE), HealthShare Exchange of Southeastern Pennsylvania (HSX), and Keystone Health Information Exchange (KeyHIE) have joined together as a part of the Authority's Pennsylvania Patient & Provider Network (P3N). The three networks will be joining eVantageHealth of St. Luke's University Health Network to increase information exchange across the state. "By signing the P3N agreement, each of these HIOs has taken the critical first step toward full participation in the statewide health information exchange," said Authority Executive Director Alix Goss. "Benefits to patients will be achieved as more providers connect to P3N-participating HIOs, leading to improvements in care coordination, patient safety, and healthcare quality." Through the P3N, healthcare providers who join a health information organization will also benefit from the Public Health Gateway, a single point of contact for reporting into Pennsylvania's various registries, including cancer, immunization, disease surveillance, electronic laboratory reporting, and clinical quality measurement. The Public Health Gateway is funded in part through the use of enhanced federal dollars obtained by the Pennsylvania Medicaid program's Health Information Technology initiative. Read More

Proposed Bill Could Move CHIP from the Department of Insurance to the Department of Human Services. On October 21, 2015, *Pittsburgh Post-Gazette* reported that a bill being considered in the House may move the Children's Health Insurance Program from the Department of Insurance to the Department of Human Services in an effort to save money and help families enrolled in the program. Currently, thousands of children move between CHIP and Medicaid every month. State officials say that having one state agency manage eligibility and one IT system would help provide a more seamless coverage for children. There are 150,000 children enrolled in CHIP in the state. Read More

Vermont

Green Mountain Care Board Calls for Lawmakers to Address the Medicaid Cost Shift. On October 16, 2015, *VPR* reported that the Green Mountain Care Board is saying Vermont is facing a health care affordability crisis that may be restricting access to primary care in certain areas. Dr. Allan Ramsay, a key member of the board is asking lawmakers to address the Medicaid cost shift in order to make coverage more affordable. Ramsay stated that Vermont needs to develop a payment reform system that has roughly the same rates for all of the various payers including Medicaid, Medicare and the private insurance companies. Read More

House Committee on Health Care Meets to Discuss Medicaid Budget Problems. On October 15, 2015, *VPR* reported that the House Committee on health care convened to discuss the state's Medicaid program. Three month into the fiscal year, the Medicaid budget is already running $105 million over projections, for which taxpayers may be on the hook for $40 million. Lawmakers are slowly coming to grips with the significant cost overruns in the program but are unsure what is causing the budget problems or how to pay for them. Elected officials will need to decide how to re-balance the balance. Read More

Virginia

Virginia Medicaid Bureau Seeking Public Comments on Possible Substance Abuse Coverage Expansion Waiver. On October 14, 2015, *Richmond Times-Dispatch* reported that Virginia is looking into applying for a demonstration waiver to "provide substance use disorder services not currently offered or different from what's currently offered." The state is soliciting public comments on the possible waiver request. The demonstration will allow Virginia to target certain populations, target certain providers, and create services not covered previously under the state plan. Currently under the state program, primarily pregnant women and children receive substance abuse services, leaving a gap for inpatient detox for adults. Read More

National

HHS Predicts 10 Million People to Have Marketplace Coverage at End of 2016. On October 15, 2015, *The New York Times* reported that the Department of Health and Human Services predicts that by the end of 2016, 10 million people will have coverage through the Affordable Care Act's marketplaces, up 100,000 from June 2015. Secretary Sylvia Burwell called the estimate a strong and realistic goal. She stated that there are fewer uninsured individuals and they are harder

to reach. The Congressional Budget Office predicted in March that enrollment would be 11 million this year and 21 million in 2016. Read More

MACPAC October Meeting to be Held October 29. The October Medicaid and CHIP Payment and Access Commission (MACPAC) meeting will be held next week, October 29, 2015, from 9:30am to 4:45pm, in Washington, DC. The October meeting will cover:

- Discussion of a draft of the Commission's upcoming congressionally mandated report on Medicaid payments to disproportionate share hospitals (DSH)
- Affordability of children's coverage, including out-of-pocket spending in the CHIP compared to the coverage offered on the Exchanges
- Findings from a comprehensive, nationwide inventory of functional assessment tools; how states determine functional eligibility for Medicaid-covered long-term services and supports
- Policy levers that can affect federal and state spending on Medicaid and the considerations in designing policies to reduce the rate of growth in spending
- Recent trends in fee-for-service and managed care drug spending and rebates, and factors contributing to drug spending's recent growth.

A full agenda and meeting materials will be posted here prior to the meeting.

Former Foster Kids May Lose Medicaid Coverage by Moving Out of State. On October 20, 2015, *Kaiser Health News* reported that some former foster children are losing Medicaid coverage by moving to a different state. Under the health law, former foster children who age out of the system are eligible for free Medicaid coverage until they turn 26. However, coverage is only guaranteed in the state where they received foster care services. Only about a dozen stated extended benefits to cover other states. Advocates are hoping to change the law at the federal level. Reps. Karen Bass, D-Calif., and Jim McDermott, D-Wash., have proposed legislation that would allow former foster youths to qualify for Medicaid in any state. Sen. Bob Casey, D-Pa., has also introduced a similar bill. Read More

Study: Medicaid Rejecting Nearly Half of Hepatitis C Drug Requests. A new study found that Medicaid is denying more claims for Hepatitis C drugs than Medicare or private insurance. Of 2,350 patients who were prescribed the treatment in the first six months that it was on the market, 16 percent were denied coverage after an appeal. But of the 504 Medicaid patients, 46 percent were denied. Read More

Industry News

UnitedHealth to Enter 11 More Exchanges. On October 15, 2015, *The New York Times* reported that UnitedHealth will enter 11 more public insurance Exchanges next year. United currently has 550,000 enrollees from 24 state Marketplaces. In 2016, premiums are expected to go up by over 10 percent. Read More

Community Intervention Services Acquires Northstar Psychological Services. On October 15, 2015, H.I.G. Capital announced that its portfolio company, Community Intervention Services, completed the acquisition of Northstar Psychological Services, an Alpharetta, Georgia-based provider of community-based behavioral health services. No financial terms were disclosed. Read More

Hospital Shares Drop After HCA Holdings' Third Quarter Earnings Projection Misses Estimates. On October 15, 2015, *Bloomberg Business* reported that after HCA Holdings, Inc., released third-quarter projections that missed analysts' estimates, the hospital chains' shares dropped. HCA shares fells 7.8 percent. The company stated that the proportion of uninsured patients and labor costs increased and emergency room admissions rose. Tenet Healthcare Corp. and Community Health Systems shares also fell. Read More

Epic Health Services Acquires Medco. On October 20, 2015, Epic Health Services, a Dallas-based provider of pediatric skilled nursing, therapy, and enteral services and a portfolio company of Webster Capital, acquired Houston-based Medco. Medco provides enteral therapy services, respiratory equipment and incontinence products, as well as specialty pharmacy, diabetic, urological, ostomy and wound care supplies and products to patients throughout Texas and Louisiana. No financial terms were disclosed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
November 16, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
November 17, 2015	Pennsylvania HealthChoices	Proposals Due	1,700,000
December 22, 2015	Nebraska	Proposals Due	239,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 7, 2016	Indiana	Technical Proposals Due	900,000
January 15, 2016	Pennsylvania MLTSS/Duals	Proposals Due	450,000
March 1, 2016	Nebraska	Contract Awards	239,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
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	Nebraska	Implementation	239,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	450,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	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	Aug-15	Sep-15
California	122,908	123,079	124,239	122,520	122,798	122,846	120,452	116,470	117,307
Illinois	63,731	64,199	60,684	58,338	55,672	52,763	52,170	51,631	49,663
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705	17,671	17,518	17,337
Michigan					9,216	14,867	28,171	35,102	42,728
New York	17	406	539	6,660	7,215	5,031	7,122	9,062	8,028
Ohio	68,262	66,892	65,657	63,625	63,446	62,958	61,871	62,418	59,697
South Carolina		83	1,205	1,398	1,366	1,317	1,388	1,380	1,530
Texas			58	15,335	27,589	37,805	44,931	56,423	45,949
Virginia	27,333	26,877	27,765	27,349	30,877	29,970	29,507	29,200	29,176
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,262**	**363,283**	**379,204**	**371,415**

HMA NEWS

New this week on the HMA Information Services website:

- **Maryland** Medicaid managed care is down 8.2%, Sept-15 Data
- Asthma, high blood pressure, and diabetes prevalence maps for **New York, Pennsylvania, Texas, Michigan**, and **Florida**
- **Ohio** Medicaid managed care enrollment share, Sep-15 Data
- Public documents such as the **Kentucky** Medicaid MCO 2015 procurement responses, **Louisiana** HCBS Supports Management RFI, and the **Kansas** Aging and Disability Resource Center RFI and responses
- Plus upcoming webinars on *Capitalizing on the Fast-Moving World of Digital Health Innovation* and *Making the Business Case for Team Coaching: Behavior-Based Training for Leaders of Highly Effective Healthcare Organizations*

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

HMA's Don Novo, Donna Laverdiere to Feature on California HealthCare Foundation Webinar

Wednesday, October 28, 2015

10:00 AM to 11:30 AM (Pacific)

Link to Webinar Info, Registration

With funding from the California HealthCare Foundation (CHCF), the San Francisco Department of Public Health (SFDPH) commissioned a report on options and recommendations for a public benefit program to support the affordable purchase of health insurance for San Franciscans. During this free webinar, Health Management Associates (HMA), the UC Berkeley Center for Labor Research and Education and the San Francisco Department of Public Health will present and discuss their findings as part of an expert panel.

Certified Community Behavioral Health Center Planning Grants Awarded

On October 19, 2015, the Substance Abuse and Mental Health Services Administration (SAMHSA), in conjunction with the Centers for Medicare & Medicaid Services (CMS) and the Assistant Secretary of Planning and Evaluation (ASPE), announced planning grants to 24 states to begin the process of establishing Certified Community Behavioral Health Centers (CCBHCs). The one-year planning grants, totaling $22.9 million, obligate each of these states to establish a Medicaid prospective payment system (PPS) for CCBHCs, certify at least two CCBHCs in their state, and complete an application (due in October 2016) to be one of eight demonstration states that will receive enhanced Medicaid funding through a PPS rate for the delivery of CCBHC services.

CCBHCs were introduced in Section 223 of the Protecting Access to Medicare Act as a means of ensuring more uniformity of Medicaid behavioral health services across states. The vision of CCBHCs is improved comprehensive community-based mental health and substance use disorder treatment for individuals, removal of health care silos through formalized care coordination partnerships, and assimilation and use of evidence-based treatment practices on a more consistent basis. CCBHCs will have to adhere to state-specific program requirements defined across six program areas (staffing, accessibility, care coordination, service scope, quality/reporting, and organizational authority) consistent with certification guidance issued by SAMHSA. The planning grants will be used by states to accomplish program and payment design elements described in states' planning grant applications. At the end of the planning grant period, eligible states may apply to become one of eight demonstration states that will receive enhanced Federal Medical Assistance Percentage (FMAP) for services provided through CCBHCs during the demonstration period.

Health Management Associates was grateful for the opportunity to collaborate with the National Council for Behavioral Health to support a number of states in their applications for the planning grant. HMA worked with the states highlighted below on their applications.

States	Grant Amount	States (Cont.)	Grant Amount
Alaska	$769,015	Missouri	$982,373
California	$982,373	Nevada	$933,067
Colorado	**$982,372**	New Mexico	$982,373
Connecticut	**$982,372**	**New Jersey**	**$982,372**
Illinois	$982,373	**New York**	**$982,373**
Indiana	**$982,373**	North Carolina	$978,401
Iowa	**$982,372**	**Oklahoma**	**$982,373**
Kentucky	$982,373	Oregon	$728,054
Maryland	**$982,373**	Pennsylvania	$886,200
Massachusetts	$982,373	**Rhode Island**	**$982,373**
Michigan	**$982,373**	Texas	$982,373
Minnesota	$982,373	Virginia	$982,373

Congratulations to all the grantee states.