Health Management Associates

HMA Weekly Roundup

Trends in State Health Policy

January 13, 2016

RFP Calendar

Dual Eligibles Calendar

HMA News

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In Focus

Key Medicaid and Legislative Issues to Watch in 2016

This week our *In Focus* section highlights key issues that are likely to dominate the Medicaid and health policy landscape in 2016 in states in which HMA has offices. The HMA team identified issues and milestones that will feature prominently in the Medicaid, health policy, and legislative agenda in the coming year.

California – Don Novo

Governor Jerry Brown released his 2016-17 budget proposal on January 7, 2016. The 2016-17 budget proposal projects General Fund 2016-17 fiscal year revenue to be $2.4 billion higher than in the previous year. Revenue for the 2015-16 fiscal year is expected to be $3.5 billion higher than originally projected because the rate of economic growth was greater than originally assumed.

The governor's proposed 2016-17 budget reflects higher-than-anticipated revenue collections and projects the Budget Stabilization Account (BSA), also known as the Rainy Day Fund, to contain a surplus of $4.5 billion. The 2016-17 budget revenue projections would require an additional transfer of $3.1 billion set aside as required by Proposition 2. Of this amount, $1.56 billion would be deposited into the BSA and $1.56 billion allocated towards payment of budgetary debt. In additional to the BSA, the state also has the "Special Fund for Economic Uncertainties," in which the state deposits unspent funds. The governor's 2016-2017 budget allocates an additional $2.2 billion into this fund, bringing total state reserves to $10.2 billion by the close of the 2016-2017 budget year.

Medi-Cal

- **Medi-Cal Funding** – Medi-Cal general fund spending is projected to grow 8 percent, from the 2015-2016 funding level of $17.7 billion to $19.1 billion in 2016-2017.
- **MCO Tax** – The budget includes a tax reform package to extend a federally allowable MCO tax, assuming the revenues are placed in a special fund and are used to restore the 7 percent reduction to IHSS services ($236 million annually). The budget assumes the tax would be in place for three years. In the budget press conference, the Administration stated that the compromise package would encompass the MCO tax, the corporate income tax, and the gross premiums tax and would result in a $90 million net benefit to the private managed care industry. Health plans would also be allowed to charge "differential rates" for Californians enrolled in Medi-Cal managed care plans compared to other health plan enrollees.
- **Medi-Cal Enrollment** – The budget assumes an increase of about 200,000 enrollees in 2016-17 as compared to an increase of 1.5 percent in 2015-16. Over a third of the state's population is enrolled in Medi-Cal, which has a total caseload of 13.5 million. Caseload growth is expected to normalize now that the expansion population has shifted into Medi-Cal. Caseload growth will also be impacted by upgrades to the state eligibility system, which may remove people from the rolls who should have been determined ineligible.
- **Optional Medi-Cal Expansion –** The budget assumes a cost of $740.2 million general fund as the state's 5 percent share of funding the optional Medi-Cal expansion beginning in Federal Fiscal Year 2017.
- **Undocumented Children** – The budget includes $182 million to provide full-scope Medi-Cal benefits to an estimated 170,000 undocumented children. Coverage will begin May 1, 2016.
- **Eligibility System Upgrades** – The budget includes $169.9 million in 2016-17 and the following year to continue upgrades to the eligibility systems used by counties.
- **Mental Health and Substance Use Disorder Services** – The budget includes $90.9 million for residential treatment services expanded under the new Drug Medi-Cal waiver authority approved in August 2015, which allows state and county official's flexibility to select quality providers to provide substance use disorder treatment, assessments, and

case management. The budget also includes $11.9 million to implement a Performance Outcomes System to track outcomes of Medi-Cal Specialty Mental Health Services for children and youth.

- **Coordinated Care Initiative (CCI) –** Continued operation of the CCI program is highly dependent upon the extension of the MCO Tax. Under current law, the CCI program must remain cost effective. If the MCO Tax expires, the budget projects 2016-17 program cost to be $130 million. Both increased program participation and the continuation of the MCO Tax will be necessary for CCI to meet cost effectiveness requirements of the law authorizing the Initiative. If cost-effectiveness is not met during the 2016-17 budget year, the program will cease operations in January 2018.
- **Medi-Cal 2020 Waiver** – The budget includes the finalized provisions of the Medi-Cal 2020 waiver, which provides $6.2 billion in federal funding over five years. The provisions of the final waiver include:
    - Public Hospital Redesign and Incentives in Medi-Cal (PRIME) program, the new five-year extension of the safety net care pool, which will support alternative payment methodologies and better integration of care. This program builds upon the current Delivery System Reform Incentive Payment (DSRIP) Program. The state is committing that 60 percent of Medi-Cal beneficiaries will receive all or a portion of their care through systems that utilize alternative payment methodologies by the end of the waiver period ($7.5 billion in state and federal share).
    - Global Payment System, which will implement a global payment structure for public hospitals, to focus on the value of care provided, not volume ($2.9 billion in state and federal share).
    - Dental Transformation Incentive Program, which will establish incentives to providers who provide oral health services to Medi-Cal beneficiaries under three domains: early childhood preventative dental screening, caries risk assessment and treatment, and continuity of care.
    - Whole Person Care Pilot Program, provides counties with new options to provide integrated care for high-risk, vulnerable populations in county-based voluntary programs through coordination of physical and behavioral health, along with social services addressing social determinants of health in a patient-centered manner.

In-Home Supportive Services (IHSS)

- The budget includes $9.2 billion for the IHSS program for 2016-17, an increase of 8.4 percent over the revised 2015-16 budget.
- Average monthly caseload is estimated to be 490,000, an increase of 4.9 percent.
- The budget proposes to restore the 7 percent cut to service hours with proceeds from the assumed managed care tax, at an estimated cost of $236 million.

- Providing overtime pay to IHSS workers will cost an estimated $942 million in 2016-17. Implementation of the federal overtime regulations is expected to start on February 1, 2016.

The Full Budget Summary for 2016-2017 is available here.

Colorado – Lee Repasch

Governor Hickenlooper submitted a $26.98 billion budget for FY 2017, which included $373 million in cuts made necessary by a slowing economy, as well as $189 million in Taxpayer Bill of Rights (TABOR) mandated taxpayer refunds. Hickenlooper's request represents a 0.4 percent decrease in spending compared with the FY 2016 budget, with the biggest cuts targeting higher education, hospitals, and state building maintenance. The reductions are intended to offset increased costs in K-12 education and Medicaid, as well as to cover a projected deficit in the current year budget.

On the Medicaid front, the budget includes $80 million for new Medicaid enrollees, as the Medicaid population is expected to increase 4.7 percent to 1.35 million Coloradans in FY 2017. Though the overall appropriation to the Department of Health Care Policy and Financing will be flat, the General Fund to the department will increase by $135.6 million or 5.4 percent. The budget request also includes a provider rate reduction of 1 percent, excluding primary care physicians under the federal "1202" designation and those providing services to the developmentally disabled.

Finally, the budget recommends a cut in the Hospital Provider Fee of $100 million in order to reduce TABOR-mandated taxpayer refunds by $100 million. Hospitals would, therefore, lose not only the $100 million from the provider fee but also the $100 million match from the Federal Government, resulting in a net loss of $200 million. Revenue from the Provider Fee has been used, in part, to fund the Medicaid expansion. An attempt to exclude the provider fee from the TABOR revenue limit by transforming the provider fee into an "enterprise fund," advocated by the governor, failed in the Republican-controlled senate during this year's legislative session.

Florida – Elaine Peters

Lawmakers are scheduled to begin work in Tallahassee on January 12, instead of the usual March date for the opening of the 60-day session. The legislature is ready to show that it can govern again, after four regular and special sessions in 2015. Some of the key issues that will dominate Florida politics are the budget, the economy, reduced taxes, education, health care, water, and gambling. Major health care issues are the following:

Budget – Although Lawmakers have more money this year because of an improving economy, they will still face pressures as they try to pass a new state budget in the range of $79 billion for the 2016-17 fiscal year. A key issue is the amount of the budget surplus and how much of Governor Scott's $1 billion tax-cutting package will be included in the new budget, which takes effect July 1. Increased funding for public education and a growing Medicaid budget as well as a reduction in federal funding for Florida hospitals will complicate the final budget deal.

- **Low Income Pool (LIP)** – Federal officials reduced the LIP program from $2 billion to $1 billion in FY 2015-16 and further reduced the program to $608 million in FY 2016-17. Lawmakers will need to

determine the amount of additional state funds that are needed, if any, to cover the loss of federal funds and determine a funding allocation methodology. The governor's budget revised the LIP and DSH funding allocations and also proposed hospital rate reductions.

- **Medicaid Expenditures** – Although there will not be a fight this year over expanding Medicaid, lawmakers will spend this year's session discussing ways to keep Medicaid costs under control. Medicaid makes up more than 31 percent of the state budget and is the largest single program in the Florida budget. Even without expansion, Medicaid spending grows each year. Medicaid expenditures are estimated to be $25.2 billion in FY 2016-17, which reflects a need of an additional $570.5 million in general revenue funds.

Medicaid Dental Carve-out – Lawmakers have proposed legislation that could potentially carve-out dental services from Medicaid managed care. The bill requires the Agency to provide a comprehensive report to the governor and legislature by December 1, 2016, that examines how effective the Medicaid managed care plans have been in improving access, satisfaction, delivery, and value in dental services. The report must also examine historical trends in costs, utilization, and rates by plan and statewide. The legislature may use this report in 2017 to determine the scope of dental benefits in the Medicaid program in future procurements and whether to provide the benefit separate from medical benefits.

Hospital Transparency – Governor Scott's Commission on Healthcare and Hospital Funding has been meeting over the last six months to review taxpayer funding for hospitals, insurers, and healthcare providers as well as the affordability, access, and quality of healthcare services provided to Florida families. The governor's health care transparency proposal places caps on how much Florida hospitals can charge patients and also requires the Agency to post the average amount in gross charges and the average accepted amounts per inpatient admission for every hospital. Additionally, the governor's proposed budget includes funds for an All-Payer Claims Database (APCD). Lawmakers have proposed wide-ranging bills that seek more transparency about the prices of services at hospitals and other types of health-care facilities, although the bills filed specifically prohibit the development of an APCD without legislative approval. Legislation has also been filed to address balance billing, the majority of which happens when patients have to go to emergency rooms, where the average consumer may not know whether a provider is in or out of network.

Health Care– Lawmakers have filed several bills to improve access to health care while also driving down costs. The legislation includes letting patients see primary care physicians without involving insurance companies, expanding the scope of physician assistants and advanced registered nurse practitioners to prescribe medications under certain circumstances, creating new "recovery centers" for postsurgical care, allowing patients to spend the night at same-day surgery centers, and eliminating the state certificate of need (CON) process that specifies where new hospitals can be built. Legislation has also been filed relating to overhauling the state group health insurance plan.

Nursing Home Prospective Payment System –The governor's proposed budget provides funds to contract with an independent consultant to develop a plan to convert nursing home cost-based reimbursement to a prospective payment system (PPS) to better align reimbursement with Statewide Medicaid Managed

Care (SMMC). Lawmakers have previously adopted DRG's for hospital inpatient services and funded a study last year to review implementation of a PPS for hospital outpatient services to be implemented this coming year. Lawmakers will consider whether or not to fund a study to move to a prospective payment systems for nursing facilities.

Medical Marijuana: The Department of Health continues to work on implementing a bill lawmakers passed in 2014 to allow limited forms of medical marijuana for patients who suffer from severe spasms or cancer. Administrative rule challenges delayed the application process. Fourteen administrative challenges were recently filed to the state's newly-awarded medical marijuana licenses. Lawmakers have filed legislation that could broaden the types of marijuana that are available to at least some patients. Also, supporters of much-broader legalization of medical marijuana are gearing up to try to pass a ballot initiative in November, after barely falling short in 2014.

Express Enrollment – Florida received approval for an amendment to Florida's 1115 MMA Managed Medical Assistance waiver to allow Express Enrollment. The Agency intends to implement Express Enrollment beginning in early January 2016. Express Enrollment does not impact the Long-term Care program. Read More

Statewide Medicaid Managed Care (SMMC) – On January 7, 2016, the Agency released data that shows that more than 77 percent of Florida Medicaid Long-term Care patients have experienced an improved quality of life. On December 21, 2015, the Agency released data that reflects SMMC delivering the highest level of care in program history as well as HEDIS and CAHPS scores show rising levels of care and consumer satisfaction.

Request to Amend Florida's 1115 MMA Waiver - On January 12, 2016, the Agency provided notice of its request to amend Florida's 1115 Managed Medical Assistance (MMA) waiver related to the Hemophilia Program to allow for up to three vendors in order to provide the state the flexibility to contract with one to three vendors, amend the waiver to include payment in MMA capitation rates for nursing facility services for recipients under the age of 18 years, and amend the waiver to allow flexibility for Specialty Plans that do not have sufficient numbers of eligible members for the mandatory Performance Improvement Projects (PIPs) to conduct PIPs on other topics that have more impact on their members, with the Agency approval. The 30-day public notice and public comment period will be held January 12, 2016, through February 11, 2016. Read More

Florida Medicaid Management Information System (FMMIS) – On November 30, 2015, CMS notified the Agency that additional information or changes were required to the draft ITN for the procurement of a new fiscal agent, FMMIS and DSS/DW contracts. This is the result of new guidance from CMS related to procurement strategies for MMIS re-procurement strategies. The ITN is to reflect that the MMIS and systems integrator are different contractors. This will result in changes to the procurement schedule, including the date the Agency anticipated posting the Invitation to Negotiate (ITN). The Agency expects to issue a new Procurement Strategy within the next 60 days. The Florida MMIS contract with HP has been in effect since July 1, 2008, and will expire June 30, 2018. Read More

Georgia – Kathy Ryland & Danielle Pavliv

The Georgia General Assembly opened its 2016 session on January 11. Lawmakers anticipate a relatively short 40-day session that will end in mid- to late March, in order to prepare for primary elections on May 24. Key issues to watch in the 2016 session include education funding reform, casinos and gambling legalization, and transportation and infrastructure. Republican Governor Nathan Deal is expected to outline his priorities for the year in his State of the State address, scheduled for Wednesday, January 13, 2016.

Major health care issues to monitor during the 2016 session include:

- **Medical Marijuana:** After successfully pushing through legislation that legalized use of low-THC cannabis oil for those with certain medical conditions in 2015, Representative Allen Peake is planning to introduce legislation that would allow for regulated cultivation of medical marijuana in Georgia. House Speaker David Ralston has indicated support for a cultivation measure and has expressed openness to including a provision that would allow conditions for medical marijuana use to be determined by medical professionals. However, Governor Nathan Deal has expressed concern over cultivation and distribution in Georgia and has refused to support such a measure. Read More

- **Funding for Pregnancy Services:** The Georgia Life Alliance will push a measure that would support the provision of pregnancy services – such as free pregnancy tests, ultrasounds, and education programs – for non-profit pregnancy centers as an alternative to abortion funding, following national controversy over Planned Parenthood in 2015. Lieutenant Governor Casey Cagle has declared support for the advocacy group's proposal. Read More

- **Medicaid Coverage/Expansion:** The Georgia Hospital Association and Georgia Chamber of Commerce are working together to examine ways to insure more Georgians. Traditional Medicaid expansion seems unlikely, given cost concerns from Governor Deal and a dearth of support from Republican legislators. However, it is possible the state may consider a more limited, alternative expansion through a waiver.

- **Affordability:** The Georgia Chamber of Commerce has listed as a legislative priority in 2016 cost containment in employer-sponsored health insurance.

- **Rural Health Care:** House Speaker David Ralston expressed hope that if a Republican is elected President in November, legislators may be able to use the waiver process to provide block grants to support rural hospitals. The Georgia Chamber of Commerce has commissioned a study to examine possible policy solutions to improve healthcare access. Read More / Read More

- **Certificate of Need (CON):** Providers and hospitals may look to revive debate surrounding the CON program. Although the issue was last considered in 2008, House Judiciary Chairman Wendell Willard is a strong advocate of CON reform and last year sponsored an ultimately unsuccessful bill that would have revised CON requirements for destination cancer hospital Cancer Treatment Centers of America. CON regulation requires hospitals and providers to obtain permission from

the state before building many types of new healthcare facilities and before offering particular types of services. Opponents have argued that CON is anti-competitive and is less relevant than in the past, due to a shift away from fee-for-service toward managed care.

Health care-related bills returning from the first year of the 2015-2016 legislative session include:

- Therapy: Link to Bill
- Dental carve-out: Lawmakers are likely to reconsider a measure that would allocate Medicaid funds specifically for oral health care. Link to Bill

The Medical Association of Georgia has outlined several legislative priorities for 2016:

- Preserving physician autonomy
- Support Medicaid reform to ensure payment adequacy, reduce administrative burdens, reinforce the physician-patient relationship, and promote quality medicine (including Patient-Centered Medical Home adoption)
- Support primary care funding
- Requiring health insurers to be equitable and transparent when entering into contracts
- Continue funding the state's prescription drug monitoring program (PDMP) Read More

New lawmakers on the Health and Human Services Committee this year include:

- Senator JaNice VanNess (R-Rockdale), Senate District 43
- Representative Betty Price (R-Roswell), House District 48
  - The only MD in the legislature
  - Wife of U.S. Rep. Tom Price (R-GA), House Budget Committee Chairman
- Representative Jodi Lott (R-Evans), House District 122
  - Registered nurse, co-owner of Evans Rehabilitation Services

Illinois – Andrew Fairgrieve

Budget Situation: Illinois enters 2016 still without a FY 2016 budget, which should have gone into effect July 1, 2015. There continues to be little momentum between republican Governor Bruce Rauner's administration and the democratic supermajorities in both the Illinois House and Senate. The impact of the budget situation has been somewhat mitigated due to a series of court orders to keep payments flowing to Medicaid providers and health plans, as well as the utilization of stop-gap measures and other funding sources. With many legislators occupied by March primaries and the general election this Fall, Illinois may enter FY 2017 in a similar situation.

Governor Rauner is set to give his state of the state address on January 27, to be followed by his budget address the third week in February. At the Medicaid Advisory Committee (MAC) meeting on January 8, 2015, Department of Healthcare and Family Services (HFS) staff explained that they are in the process of preparing a budget request for FY 2017, but no details were publicly available at this time.

Medicaid Managed Care Plan Transitions: As part of Governor Rauner's new policies on Medicaid, Illinois has eliminated the provider-organized Accountable Care Entity (ACE) and Care Coordination Entity (CCE) models. As a result, these entities were forced to transition to a full-risk managed care entity or partner with or sell to an existing Medicaid health plan. With most of these arrangements finalized, and another three expected to be finalizing in coming weeks, the resulting transitions mean that nearly 400,000 Medicaid beneficiaries in the Family Health Plan/ACA Adults population have already or will be shifting plans (and to a full-risk arrangement) in the first half of 2016. An additional 5,000 or 6,000 beneficiaries in the non-dual ABD Integrated Care Program will also be transitioning. This significantly reduces the number of care coordination entities in the Medicaid program, with around 10 provider-organized plans acquired, partnering, or ceasing operations.

Massachusetts – Rob Buchanan

MassHealth Delivery System and Payment Reforms. Over the past year, the Massachusetts Executive Office of Health and Human Services (EOHHS) has been engaged in an extensive public and stakeholder input process to inform the design of new payment and delivery system models, foster dialog across different parts of the delivery system, and inform discussions with CMS regarding the state's 1115 Medicaid demonstration waiver. The engagement effort was one of the first steps that Governor Charlie Baker's announced after coming to office in January 2015. He named Mary Lou Sudders, former Department of Mental Health commissioner, to oversee EOHHS programs and Daniel Tsai as Assistant Secretary of MassHealth. EOHHS has held eight stakeholder listening sessions and numerous individual stakeholder meetings across the state as it seeks to develop new MassHealth payment and delivery system models.

Based on stakeholder feedback, EOHHS is considering development of several MassHealth accountable care models. One model contemplates a fully integrated delivery system where an ACO/MCO entity takes on full risk for a population of individuals who actively enroll or select the ACO. In this model, ACOs would receive up-front, prospective payments, manage a provider network, and pay claims. Another ACO model under consideration would involve regular fee-for-service payments to providers throughout the year with periodic retrospective reconciliations with an ACO compared to a risk-adjusted budget. The retrospective model would attribute members based on utilization patterns and/or selection of a primary care provider. Specific design elements (e.g., payment model details, member incentives, ACO levers for population health management under each model) are actively being discussed in workgroups and will be decided on in the coming months for their attributed members. EOHHS anticipates moving forward with detailed technical designs in January/February 2016 and issuing a plan for public comment by March.

MassHealth is also exploring linking payment and care delivery reform strategies with Massachusetts' conversations with CMS about its 1115 waiver. The current 1115 waiver extends through June 2019; however, the waiver only authorizes payments from the Safety Net Care Pool (SNCP) for the first three years of the five year period. Like other states that have implemented Delivery System Reform Incentive Programs (DSRIP) as part of their 1115 waivers, Massachusetts is considering committing to concrete and measurable improvement targets on cost, quality, and member experience while making the case for upfront CMS investment in new care delivery models. Access to this

new funding would be contingent on providers partnering to better integrate care. More information is available here.

Accountable Care Organization Certification Standards. In December 2015, the Massachusetts Health Policy Commission (HPC) released proposed ACO certification standards for public comment. The HPC is an independent state agency whose mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and investment programs. The purpose of the certification program is to complement existing local and national care transformation and payment reform efforts, validate value-based care, and promote investments by all payers in efficient, high-quality, and cost-effective care across the continuum. Responses must be received by the HPC by January 29, 2016. The HPC anticipates that it will approve final regulations in February/March 2016 and begin accepting certification applications in spring/summer 2016. More information is available here.

Fiscal Year 2017 State Budget. State budget leaders anticipate another tight year for the Massachusetts budget. Governor Baker's administration identified as a $320 million gap between projected spending and revenues for the 2016 fiscal year and announced emergency cuts totally $50 million. The governor is anticipated to release his proposed state budget for fiscal year 2017 on Wednesday, January 27. Kristen Lepore, Secretary of Administration and Finance said in December that the state faces a "significant structural gap" moving into fiscal 2017 and predicted "another difficult budget year."

Michigan – Esther Reagan & Eileen Ellis

Four major healthcare milestones were achieved in 2015:

- The MI Health Link program – the state's Medicare-Medicaid duals demonstration – was implemented in four geographic regions of the state and serves approximately 35,000 beneficiaries.
- The Medicaid managed care contract was re-procured for the first time since 2009, which expanded the market penetration for some incumbent health plans , dramatically reduced – and in one case eliminated – the footprint for others, and did not approve any new entrants.
- The waiver amendment required to continue the Healthy Michigan Plan (HMP) – the state's Medicaid expansion program serving about 600,000 Michiganders – was approved by the federal Centers for Medicare & Medicaid Services (CMS).
- The state's stand-alone Children's Health Insurance Program (CHIP) for children – MIChild – was converted to a Medicaid expansion, resulting in a change in scope of coverage for the children to full Medicaid benefits and requiring about 5,500 of the 31,000 MIChild enrollees to join Medicaid health plans.

One other major change occurred in 2015. The state's two departments responsible for administering all public health and social services programs, including cash assistance, behavioral health and Medicaid, were merged into a single "mega-department" called the Michigan Department of Health and Human Services (MDHHS).

Issues to watch for in 2016 include the following:

- The administrative agenda for MDHHS in 2016 is expected to include, among other things, further work toward aligning the programs now administered "under one roof" to better serve the state's citizens. It is also expected that MDHHS will advance the population health agenda included in the new Medicaid managed care contract.
- Michigan received a model testing grant from CMS for its State Innovation Model (SIM) initiative called *Blueprint for Health Innovation*. The initial test sites, including designated Community Health Innovation Region backbone agencies and Accountable Systems of Care, will be selected in early 2016, and the first wave of model testing will begin in October 2016. Based on the four pillars and five foundational concepts of the SIM, HMA anticipates that strategies will be developed in 2016 to increase integration of care, expand use of patient-centered medical homes and accountable systems of care, move payment models away from volume toward value, and improve population health.
- Michigan Governor Rick Snyder will make his State of the State address on January 19th and present his fiscal year (FY) 2016-17 budget recommendation in early February. The state's fiscal year begins on October 1. It is anticipated that the state's revenue situation will, at a minimum, preclude any further expansions in coverage. Revenue issues for the FY 2016-17 budget include the following:
  - Healthy Michigan Plan (HMP) Funding – Beginning with calendar year 2017, the federal share of HMP funding decreases from 100 percent to 95 percent. While the HMP program will still save state money compared to not having the plan, the cost of the HMP in FY 2016-17 is greater than what it was in FY 2015-16 by $117 million according to estimates in a report released by Michigan's House Fiscal Agency.
  - Medicaid Special Financing – Particularly challenging for development of the FY 2016-17 budget is the loss of revenue from the Medicaid Managed Care Use Tax. Michigan has been told by the federal government that it may no longer use these funds for Medicaid as of January 1, 2017. This tax currently contributes a combined total of nearly $600 million to the General Fund and School Aid Fund. Under current state law Michigan's Health Insurance Claims Assessment (HICA) will increase from 0.75 percent to 1.0 percent on January 1, 2017, when the Medicaid Managed Care Use Tax is eliminated. This small increase in HICA should generate an additional $80 million per year, which is a small fraction of the lost revenue due to the end of the Use Tax.
  - In addition, the HICA is scheduled to sunset on January 1, 2018. While legislation has been introduced and has passed the House of Representatives to extend the HICA for several more years, the state senate has yet to agree on that proposal.
- Governor Snyder has declared a state of emergency for Genesee County, including the city of Flint, due to health and safety issues caused by lead in the drinking water. As a cost savings measure, the city had terminated an agreement with Detroit to "import" water and switched

back to its own system, fed by the Flint River. Using this more corrosive water resulted in a high level of lead in the water, which allegedly was not quickly identified. Efforts have begun to address the health issues associated with high lead levels in the citizenry and to re-establish the importation of water from Detroit. There have already been and will no doubt be additional costs to the state associated with resolving this issue. Whether these costs will be significant enough to impact other areas of the state budget are as yet unknown. It has been estimated, for example, that the cost to replace lead-soldered service lines in the many affected areas of Flint could exceed a billion dollars.

New Jersey – Karen Brodsky

Items New Jersey lawmakers will be following:

- Republican Governor Chris Christie's 2016 presidential campaign as he continues to promote a pro-growth, low-tax agenda. In his January 13, 2016, annual state of the state address he cited the following priorities for the next year:
    - Expand anti-addiction efforts with the expansion of the Recovery Coach Program into six more counties and re-open Mid-State Correctional Facility as a drug abuse treatment facility for prison inmates.
    - Commit $100 million to increase access to mental health and substance use services, including an increase in reimbursement rates for providers of these services and an increase in coordinated care through three regional ACOs.
    - Abolish the estate tax.
    - Improve the state's charter school system and provide regulatory reforms.
- The state's financial health - the state has the second lowest credit rating of the 50 states.[1] It has a reported high pension liability, at about $90 billion, which is likely to increase in 2016, and Christie and the legislature are far apart on how to manage this long term.
- The status of the implementation of the approved Medicaid ACOs P.L. 2011, Ch. 114 of August 2011 created the New Jersey Medicaid Accountable Care Organization Demonstration Project and, after a protracted period, the final regulations were released in May 2014. Seven applications were originally submitted to the Division of Medical Assistance and Health Services (DMAHS) in July 2014. One applicant subsequently withdrew. Three ACOs were certified by DMAHS to begin in July 2015: Camden Coalition of Healthcare Providers, Healthy Greater Newark ACO, and Trenton Health Team. Each selected agency will be submitting a gainsharing plan by June 30, 2016, for review and approval by the state. Once the plan is approved, gainsharing payments will be distributed according to the plan. Lawmakers will be following the particulars of each gainsharing plan and the ability for each ACO to meet gainsharing expectations.

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[1] *New Jersey Policy Perspective*

- The status of the Supports Program under the Division of Developmental Disabilities, which went live on July 1, 2015, and shifted their delivery system from a state contracted to a fee-for-service model.
- The ongoing status of the transition of long term services and supports from Medicaid fee-for-service to managed care, including:
  - performance of managed care organizations and under the contract
  - feedback from stakeholders, including enrollees and providers
  - indicators for program savings.
- Status of the evaluation of the 1115 Comprehensive Medicaid Waiver and its renewal. The waiver was approved for the period October 1, 2012, to June 30, 2017. The state will begin its work to renew the waiver in 2016, which could include amendments to existing programs. The state filed its Demonstration Year 3 report on November 10, 2015, with CMS for the period July 1, 2014 – June 30, 2015. It can be found here.

DMAHS will hold the first quarterly meetings of its Medical Assistance Advisory Council on January 20, 2016, during which additional priorities for 2016 may become available. This information will be included in the next edition of the HMA Roundup.

New York – Denise Soffel

Economic Outlook: New York is doing well. Tax collections are up 12 percent over last year. Job growth is the higher than the national average, and the state's credit rating is the highest it has been in 40 years. The governor's budget is unlikely to be controversial, although the 2 percent spending cap that Governor Cuomo has imposed on the state budget since he was elected may get some push-back from the legislature this year.

Delivery System Reform Incentive Payment: In April 2014 CMS approved New York State's Section 1115 Medicaid waiver request, in the amount of $8 billion over five years. Most of the funding, $6.4 billion, is going toward a Delivery System Reform Incentive Payment (DSRIP) program. The NY DSRIP program is designed to achieve a 25 percent reduction in avoidable hospital use among the Medicaid population, including avoidable readmissions, admissions for ambulatory-sensitive conditions, and avoidable emergency department visits. DSRIP is meant to be a collaboration among health care providers, social service providers, and community-based organizations, working together in a Performing Provider System (PPS) to improve population health. As with DSRIP plans in other states, payments are performance-based as project milestones are met. Money will be distributed upon achieving predetermined metrics and milestones. incentive payments are not guaranteed.

Twenty-five PPSs were approved for participation in DSRIP, and year-one activities began on April 1, 2015. Initial payments to the PPSs were made in May. the second payment is expected in January 2016. PPSs are in the process of building internal project management capacity and establishing project-specific workgroups, are contracting with providers and community-based organizations necessary to successfully implement projects, and are developing models for funds flow between the PPS and downstream partners. Plans for cultural competency and health literacy were due to the state in December 2015.

DSRIP implementation will continue to dominate NYS health care conversations over the coming year.

Value Based Payment: As part of New York's DSRIP program, the state must develop a plan for comprehensive payment reform, moving from fee-for-service to value-based purchasing. Payment reform is meant to ensure the long-term sustainability of the changes made as a result of the DSRIP investments. New York State developed a roadmap for payment reform in concert with a large stakeholder group that was approved by CMS in July 2015 and has convened an extensive work group process to develop recommendations for implementation. The Department of Health will now review the recommendations to determine which should be adopted.

New York does not foresee a single path towards payment reform. Rather, it aims to give managed care plans, DSRIP performing provider systems (PPSs), and providers a menu of options, allowing them to select those that fit their strategy, local context, and ability to manage innovative payment models. Among the options described:

- Total care for the total population – a global capitation arrangement between a managed care plan and a PPS that includes all expenditures for all members attributed to that PPS.
- Integrated primary care – a contract between a managed care plan and a patient-centered medical home or advanced primary care provider to be reimburse based on the savings and quality outcomes they have achieved. This model focuses on savings due to reduced avoidable hospital use, particularly for conditions where well-managed primary care has been shown to reduce hospital use (i.e., behavioral health, diabetes, asthma).
- Episodic bundles of care – a contract between a managed care plan and a PPS or group of providers for patient-focused bundles of care (such as for maternity care, stroke, or depression) that includes inpatient and outpatient care, diagnostic testing, and treatment within a single payment. Bundled payments may also be considered for managing chronic conditions, with a full-year-of-care bundle that includes all condition-related costs.
- Total care for special needs populations – an approach for some specific high-cost populations whose comorbidity or disability require highly specific and costly care needs, for whom New York has already developed a population-specific managed care approach and payment. This includes the multi-morbid disabled (the MLTC/FIDA-eligible population), those with serious behavioral health conditions (the HARP-eligible population), and those with developmental disabilities (the DISCO-eligible population).
- Fee-for-service for preventive care – purely preventive activities such as immunizations and evidence-based health screenings will remain reimbursed on a fee-for-service basis to encourage their use.

Managed care plans and PPSs are free to create combinations of value-based payment arrangements. Plans can also contract directly with provider groups within a PPS using any of the strategies identified. Finally, plans and PPSs can identify various levels of risk assumption on the part of the PPS and/or provider, shifting to greater levels of assumed risk over time. Level 1 value

based payments include upside shared savings. Level 2 includes both upside and downside risk sharing, with both upside and downside shared risk being mediated by quality outcomes. Level 3 represents partial or global capitation.

A statewide goal of 80 percent to 90 percent of total managed care plan-PPS/provider payments (in terms of total dollars) will have to be captured in at least Level 1 value based payments, and 25 percent or more in at least level 2 by the end of year five.

Office for People with Developmental Disabilities (OPWDD) People First Waiver and Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs): As part of the People First waiver, the Office for People with Developmental Disabilities has been preparing for the establishment of managed care plans designed for people with Intellectual/developmental disabilities, called Developmental Disabilities Individual Support and Care Coordination Organizations (DISCOs). As reported to the OPWDD Transformation Panel, as actuaries began to review the DISCO model, they concluded that I/DD providers would be unable to meet the cost of creating a managed care plan, specifically in funding the reserve requirements. They are now considering the option that groups of I/DD providers that have begun organizing to create a DISCO function as an ACO, and take on care coordination functions without taking on full financial risk. The ACO DISCOs would work in partnership with a managed care plan. This model provides four benefits: it allows the DISCOs to include health benefits as part of the coordinated benefit package (the original DSCIO model limited care coordination to I/DD services and excluded acute and behavioral care services). it eliminates the problem of funding reserves. it uses an 1115 waiver instead of a 1915B waiver, which offers greater flexibility and less federal oversight. and it retains the core objective of the DISCO, which is to have I/DD providers do care coordination for their patients. The model remains a voluntary program and is not likely to begin enrollment until at least September 2016. The state estimates that 120,000 Medicaid beneficiaries statewide will be eligible for enrollment in DISCOs.

Expansion of Managed Care – Nursing Homes: New York State has completed the transition of the nursing home population and benefit into Medicaid managed care. All eligible recipients over age 21 in need of custodial care are now required to enroll in a Medicaid managed care plan or an MLTC. Beneficiaries currently in a skilled nursing facility are not required to enroll in a plan. they will remain in the fee-for-service system, although they have the option of joining a Medicaid managed care plan on a voluntary basis. Members will not be subject to a lock-in provision. they can change plans at any time they choose in order to obtain access to a nursing home that is not part of their plan's network.

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

Expansion of Managed Care - Behavioral Health: Behavioral health benefits have historically been fragmented in the Medicaid program, with some aspects of care included in the managed care benefit while other services are carved out.

New York began carving in all behavioral health benefits in October 2015 in New York City and is scheduled to complete the carve-in across the rest of the state in 2016.

As part of the behavioral health carve-in, all mainstream Medicaid managed care plans have had to demonstrate their capacity to take on care management for all individuals with a behavioral health diagnosis and to coordinate all the services that population will require. This includes services currently provided through the Office of Mental Health that fall outside the Medicaid benefit, such as Intensive Psychiatric Rehabilitation Treatment (IPRT), partial hospitalization, and outpatient rehab. The state has also developed a new Medicaid product, known as Health and Recovery Plans (HARPs), to be offered by mainstream Medicaid managed care plans. HARP enrollment will be open to Medicaid beneficiaries with serious mental illness and/or chronic substance use disorders, based on a pattern of high utilization/high cost. HARPs are required to provide all the behavioral health services currently included in the state's Medicaid plan, as well as a number of services currently available through Section 1915 (i) home and community-based care waivers, including many recovery-oriented services such as crisis respite, family support, peer supports, and rehabilitation services (such as transitional and supported employment, supported education, respite, and habilitation). HARPs will begin providing HCBS services in New York City in January 2016. rest-of-state implementation is planned for later in 2016.

Demonstration to Integrate Care for Dual Eligible Individuals - Fully-Integrated Dual Advantage (FIDA): New York State is participating in the federal Demonstration to Integrate Care for Dual Eligible Individuals by establishing what is called Fully Integrated Dual Advantage (FIDA) plans. FIDA builds on the mandatory assignment of certain dual-eligible beneficiaries into managed long-term care plans, specifically duals who require more than 120 days of community-based long-term care services. FIDA is limited to eight downstate counties (New York City, Nassau, Suffolk and Westchester). Beneficiaries in these counties are being passively enrolled into a FIDA plan. Individuals who have been passively enrolled can opt out at any time. Enrollment began in New York City and Nassau in January 2015. enrollment in Suffolk and Westchester has been delayed due to programmatic concerns.

The state had originally estimated that 124,000 duals were eligible for participation, but enrollment has been disappointing: over 57,000 individuals have chosen to opt out of the program. The Department of Health and CMS began a stakeholder outreach process in September 2015 to understand why program enrollment was lagging. As a result, the state announced a series of reforms, which are intended to improve flexibility for the participant, plans, and providers. Some of the changes include:

- The participant's right to choose the Interdisciplinary Team (IDT) members.
- A more flexible IDT, with added accommodations and fewer restrictions for IDT training, provider participation, member meeting times, and the development of the participant's Person Centered Service Plan (PCSP).
- Primary Care Providers may sign off on a completed PCSP without attending IDT meetings.

- Plans have authorization over any medically necessary services included in the PCSP that are outside of the scope of practice of IDT members
- Ease of transition and timing of assessments for FIDA Plan enrollment.
- Simplified procedures for information sharing and communication.

Passive enrollment into FIDA has been suspended, and expansion of FIDA into Suffolk and Westchester counties, originally scheduled for March 2015, will be delayed until at least mid-2016, when DOH has had the opportunity to monitor the impact of these changes. DoH and CMS remain committed to FIDA, and CMS is undertaking a review of payment rates to determine whether rates need to be adjusted.

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

FIDA-IDD Demonstration: In November 2015, CMS, NYS DoH, and the New York OPWDD announced an agreement to create a Demonstration program known as Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities (FIDA-IDD). Key objectives of this initiative are to deliver person-centered care, improve the participant experience in accessing care, promote independence in the community, improve quality, eliminate cost shifting between Medicare and Medicaid, and achieve cost savings for the state and federal government through improvements in care and coordination.

The FIDA-IDD program will offer more opportunities for individuals to direct their own services, be involved in care planning, and live independently in the community. Individuals' existing Medicare and Medicaid benefits will be provided through an integrated benefit design that also include a dedicated interdisciplinary team to address each individual´s medical, behavioral, long-term supports and services, and social needs. New York and CMS expect to contract with Partners Health Plan to coordinate the delivery of covered services for individuals who are eligible and who elect to enroll voluntarily. While the FIDA demonstration plan approved by CMS in 2013 allows for up to 10,000 duals with IDD to enroll in a FIDA-IDD plan, PHP, a plan established by the Nassau County AHRC Foundation, expects its enrollment will be no more than 5,000. PHP intends to serve the New York downstate region (New York City, Long Island, Rockland, and Westchester Counties). PHP is the only plan that completed the Medicare approval process necessary to operate as a FIDA-IDD plan. PHP will be required to perform a comprehensive assessment using the "It's All About Me" (IAM) tool, which describes the functional status, needs, and wishes of a person with IDD across 24 domains and determines a recommended list of actions based on the person's current status.

Basic Health Program: 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 percent and 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. All plans under the BHP will cover essential health benefits, including inpatient and outpatient care, physician services, diagnostic services,

and prescription drugs among others, with no annual deductible and low out-of-pocket costs. Preventive care, such as routine office visits and recommended screenings, will be free. New Yorkers were able to enroll in the Essential Plan during the 2015 NYSOH open enrollment period. the BHP will start on January 1, 2016.

Ohio – Mel Borkan

The Republican majority continues for 2016 in both legislative chambers and the Governor's Office. With Governor John Kasich's continued presidential run, most expect 2016 to be an interesting year. The Governor's State of the State speech is later this month. Governor Kasich is just beginning the last three years of his second and final term. Ohio is currently in the first year of its new biennial budget, passed last summer. November 2018 will see election for a new governor, who will take office January 2019. And, a new president takes office January 2017.

Key Medicaid and legislative issues for 2016 are expected to include some issues first raised in 2015:

- **Personal responsibility and the transition off Medicaid** - During consideration of the budget, the Ohio House proposed and the Senate agreed to implement a new program, called the *Healthy Ohio Program*. It is intended to speed up the transition off of Medicaid and requires the Ohio Department of Medicaid to seek a federal waiver to implement Health Savings Accounts for every non-disabled adult enrolled in Medicaid regardless of income. Each Healthy Ohio enrollee would be required to deposit 2 percent of family income up to a $99 annual limit into an HSA administered by their health plan. Ohio Medicaid is required to deposit an additional $1,000 annually into each person's account. Healthy Ohio enrollees would also be required to pay copayments if there is a balance in their HSA. Health plans would not be permitted to pay for any service for a Healthy Ohio enrollee until the individual's HSA is exhausted. Work to gain federal approval for this initiative is expected to be challenging since no state has received federal approval to terminate a person's Medicaid eligibility for not paying premiums or contributions to a health savings account for Medicaid enrollees with income below 100 percent of poverty.
- **Infant mortality** - Ohio's infant mortality rate continues to exceed the national rate and is significantly higher than rates in other industrialized nations. In 2014, 955 infants died before their first birthday. That is a rate of nearly 6.7 deaths for every 1,000 live births in the state, and an improvement over 2013 when the rate was 7.4 infant deaths per 1,000 live births. Data released by the Ohio Department of Health suggests that infant mortality is improving in the state, except for infant mortality rates for African-American infants, who die at more than twice the rate of white infants. In fact, the infant mortality rate for African-American infants was actually up in 2014, at 14.3 per 1,000 over 2013 at 13.8 per 1,000. Read More

  For State fiscal years 2016 and 2017, the state's two-year budget includes new support for the Administration's efforts focused on reducing infant mortality, including preserving Medicaid coverage for children and pregnant women up to 200 percent of poverty. Other budget initiatives include but are not limited to enhanced care management, additional

services in home visitation, including cognitive behavioral therapy and depression screenings, additional disease screenings for newborns, additional funding for targeted projects in Appalachia, and annual reporting on the effectiveness of meeting the health care needs of pregnant women, infants, and children.

- **Medical marijuana** – In a lengthy, confusing, and expensive effort, Ohio lawmakers defeated a multi-million-dollar ballot effort to legalize marijuana. Some legislators have now indicated that they would like to get more information on the potential medical benefits of marijuana and may create a task force on the subject and potentially a pilot program.
- **The drug epidemic** – Ohio is certainly not the only battlefront for the war on heroin, but, as Ohio Attorney General Mike DeWine told "60 Minutes" in November, it is now impacting every part of Ohio, from the inner cities to the rural areas. And heroin is not the only drug of choice. The Administration's new budget initiatives include efforts to modernize the Medicaid mental health and substance abuse benefits. Expect to see more legislative attention and policy initiatives in 2016. Some efforts underway already include a new tool that links the pharmacy or doctor's electronic system with the Pharmacy Board's Ohio Automated Rx Reporting System
- **Managed Behavioral Health Care** - Behavioral health benefits are fragmented in the Medicaid program, with some aspects of care included in the managed care benefit while other services are carved out. The state's new budget adds additional services to the Medicaid behavioral health benefit package and targets improvement in care coordination through managed behavioral health care. Ohio intends to carve all behavioral health benefits into managed care by January, 2018.
- **Payment innovation and PCMH** - Payment innovations to reward better care continue to be a key focus for the Administration, its state agency partners, and private-sector health plans and providers. The ultimate goal is to achieve better health, better care, and cost savings. The Governor's Advisory Council on Payment Innovation identified experts who helped the state design health care payment models that increase access to patient-centered medical homes (PCMH) and reward value when high-cost episodes occur. In December 2014, the state was awarded a $75 million State Innovations Model (SIM) grant to implement the new payment models. PCMH is a team-based care delivery model led by a primary care provider who comprehensively manages a patient's health needs, emphasizing health care value and quality. Read More

Oregon – Nora Leibowitz

Exchange Technology Decision. Oregon must decide this year whether the state will try to buy its own health insurance Marketplace technology or stick with the federal Marketplace infrastructure as a supported state-based Exchange. Legislators have very little interest in spending money on technology after rollout problems with a previous contractor in 2012-14, but the state is also aware that the federal technology will cost participating insurers 3 percent of premiums on top of the state's administrative fee.

Shortened Legislative Session, Waiver Planning. Planning for the next Medicaid waiver – the legislature will want to weigh in, but won't have much time to do so during the one month session. (in even numbered years, the Oregon legislature meets for 1 month in February, in odd years it meets for a full session)

Moda Health Financial Issues. Moda Health is one of the state's biggest insurers, has the lion's share of exchange lives, and runs a Medicaid Coordinated Care Organization in eastern Oregon, ran in to financial trouble in 2015 when it only received pennies on the dollar under the federal risk corridor program.

Corporate Tax Discussions. Corporate taxes are under discussion, which would add a 2.5 percent tax on top-line sales, or gross receipts, of companies with more than $25 million in Oregon sales. The state's Legislative Revenue Office estimates about 1,000 companies would be affected. While this is an issue that will be voted on by Oregonians in November, it will likely show up as a discussion during session.

Pennsylvania – Julie George

MLTSS Procurement: Community HealthChoices. Pennsylvania will transition to managed long term services and supports (MLTSS) in 2016 with the new Community HealthChoices program. Community HealthChoices (CHC) is a significant shift from the commonwealth's current approach to providing these services and will enhance care for seniors and persons with disabilities through better coordination of care. The goal is that more Pennsylvanians will be served in the community instead of in nursing homes or other facilities. CHC will support individuals dually eligible for Medicare and Medicaid, older adults and adults with physical disabilities in the most integrated settings possible. CHC will serve an estimated 450,000 individuals, including 130,000 older persons and adults with physical disabilities who are currently receiving LTSS in the community and in nursing facilities. While initially scheduled to be released in November 2015, the RFP was delayed to receive more feedback from stakeholders on draft portions of the agreement and to allow MCOs and providers more time to coordinate. The procurement is currently on deck for the first quarter of 2016.

Selection of HealthChoices Bidders. HealthChoices, the Department of Human Services' mandatory Medicaid Managed Care Program issued an RFP and received 11 proposals in November 2015. The new contracts will likely be awarded in the first quarter of 2016. DHS has identified more than half a dozen goals for re-bidding the contracts, including improving care coordination, promoting value-based payment incentives and emphasizing a patient-centered approach. HealthChoices will set targets for all contracted MCOs to increase the percentage of value-based or outcome-based contracts they have with hospitals, doctors, and other providers to 30 percent of medical funds they receive from DHS within three years.

FY 2016-2017 Budget. As of January 13, 2015, a complete FY 2015-2016 budget had not yet been accomplished. After a six month impasse, a partial budget was passed on December 29, 2015. With the major outstanding issue of public school funding still unresolved, tensions between Democratic Governor Tom Wolf and the Republican House and Senate remain high. With a final agreement on his 2015-16 spending plan still elusive, Governor Wolf will roll out his second budget to a joint session of the state House and Senate on Feb. 9.

It's almost certain to include a renewed push for a severance tax on natural gas drillers and the suite of tax increases that Wolf wanted included in his first year budget.

Prison Medicaid Suspension. Pennsylvania Department of Human Services Secretary Ted Dallas announced his office would move to suspend, rather than terminate, Medicaid enrollment for prisoners in state facilities. Pennsylvania, like many states, terminates Medicaid enrollment upon incarceration regardless of finding of guilt, and individuals are required to reapply when they are released. The move will require a major change to the state's computer systems but is expected to be in place by the middle of this year. It is part of multiple approaches which includes a pilot program that will allow prisoners in state and county facilities to reapply for Medicaid while still incarcerated.

Texas – Dianne Longley

The Texas Legislature meets biennially, and is not scheduled to meet until January 2017. However, during the 2015 legislative session, numerous bills were passed with requirements that include enactment through 2016. Following is an overview of several of those initiatives and other Health and Human Services priorities for the year.

Health and Human Services System Transformation. HHSC will continue implementation of legislation enacted in 2015 that requires re-organization of the health and human services system. As a result of the "sunset" legislation, HHSC has completed initial consolidation of the functional and administrative services provided through the Department of Assistive and Rehabilitative Services (DARS) and the Department of Aging and Disability Services (DADS) as part of a two-year implementation process. Among the dozens of provisions that will be addressed in 2016 are:

- Continued re-structuring of the agencies' contracting process and oversight activities.
- Consolidation at HHSC of all rate-setting activities currently occurring through multiple agencies.
- Increased focus on manage care organizations' performance data and development of a dashboard identifying key performance data for agency leadership.
- Streamlining of Medicaid provider enrollment and credentialing processes.
- A study of Medicaid managed care organizations' network adequacy and required reporting on use of emergency departments by enrollees.
- Development of a pilot program to promote wider use of incentive-based payments by MCOs.
- Discontinuation of the NorthSTAR behavioral health services program by December 31, 2016, and reallocation of funding to other models for integrating BH services and primary care in the NorthSTAR service area.
- Adoption and implementation of significant operational changes in activities of the Office of Inspector General (OIG), including transfer of programs from OIC that are better situated within HHSC.

HHSC has created an internal team of implementation staff who are leading "core functions" of transformation that includes a system-wide inventory of responsibilities, roles, resources, and interactions and interdependencies both

inside and outside the HHS system. The agency will report to a Legislative Oversight Committee appointed by the Governor, Lieutenant Governor, and Speaker of the House to oversee transition activities.

Renewal of DSRIP waiver. Texas is in the fifth and final year of the current Delivery System Reform Incentive Payment (DSRIP) Medicaid waiver, which expires September 30, 2016. HHSC submitted a waiver renewal application in September, requesting a five-year continuation of both the DSRIP program and funding for the Uncompensated Care (UC) pool. Although the state has not yet received any formal written feedback from CMS, based on early discussions in November, HHSC believes an initial one to two year DSRIP extension is probable, which will allow more time for negotiating the later years in the extension. HHSC staff also have reported that CMS has indicated Texas' UC request is more than what CMS believes is warranted. HHSC will be providing additional analysis to support their request.

Implementation of STAR Kids. HHSC is preparing for the launching of the new STAR Kids managed care program for children and youth age 20 and younger who receive Medicaid through SSI or 1915(c) waiver programs. The STAR Kids contract was recently awarded to eight MCOs (Amerigroup, Blue Cross Blue Shield, Children's Medical Center, Community First, Driscoll Health Plan, Superior, Texas Children's Health Plan, and United). Coverage is slated to begin November 1. Individuals in the Medically Dependent Children Program (MDCP) will receive both acute care and long term services and supports). Enrollees in other 1915(c) waivers will receive acute care services. HHSC is conducting statewide informational meetings with providers and future enrollees in preparation for the rollout and will continue providing regular updates for stakeholders.

Behavioral Health Services Study. HHSC and the Department of State Health Services (DSHS) have issued a Request for Proposals for the evaluation of DSHS' statewide behavioral health services. The study is a directive of the Texas Legislature, the results of which will be provided to the Legislature by the end of 2016 and prior to the beginning of the 2017 legislative session. The evaluation will include mental health, substance use, and inpatient and outpatient services and will focus on the benchmarking of performance measures to national norms and standards; development of performance measures and payment systems that align with the Substance Abuse and Mental Health Services Administration and CMS; the collection and analysis of state and national longitudinal data that measures the efficiency and effectiveness of behavioral health services; and the development and/or expansion of a publicly-available web-based dashboard to compare the performance of behavioral health service providers.

Medicaid Procurements. HHSC recently announced that they intend to release a new RFP for the Medicaid STAR and STAR+PLUS programs and CHIP. Although a date for the RFP has not been provided, we anticipate it will be released late spring or early summer. No additional details have been released.

HMA Medicaid Roundup

Arizona

Health and Advocacy Groups Push to Restore KidsCare. On January 7, 2016, *The Arizona Republic* reported that a coalition of health and advocacy groups are pushing to restore KidsCare, a health insurance program that used to provide coverage to thousands of low-income children. Enrollment for KidsCare was frozen in 2010, and the program was completely abolished in 2014, with the idea that children would be covered under the Affordable Care Act. However, many families that were sent to the federal marketplace could not afford the plans. Arizona Representative Regina Cobb proposed a bill to restore KidsCare eligibility for families earning between 138 percent and 200 percent of the federal poverty level. Read More

Colorado

Co-Op Shut Down Leaves Many Uninsured. On January 6, 2016, *The Denver Post* reported that more than half of Colorado HealthOp's members have not found any health coverage on the state Exchange after the co-op shut down. Of HealthOp's 82,000 members, 64,000 were on the state Exchange. Only 25,000 have found a replacement policy through the Exchange. Overall, however, Connect for Health Colorado, the state Exchange, reported success in getting people to sign up. During the enrollment period, 132,263 bought private insurance, 35,269 received Medicaid, and 2,031 were enrolled in the Child Health Plan Plus program. From 2014, the Exchange saw a 13 percent increase in sign-ups. Read More

Republican Leaders Oppose Hospital Provider Fee. On January 6, 2016, *The Denver Business Journal* reported that Republican legislative leaders have stopped efforts to reenact the hospital provider fee, which would increase funding for Colorado's transportation system by $800 million over the next four years. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia and U.S. Department of Justice Remain at Impasse. Georgia has fundamental disagreements with the Justice Department over what is required under a 2010 settlement agreement to improve care for people with mental illness and developmental disabilities. On January 6, 2016, *Georgia Health News* reported that despite a federal judge's push to reach an agreement, Georgia and the U.S. Department of Justice remain at an impasse. U.S. District Court Judge

Charles Pannell told the two sides to prepare for a formal hearing in late March. Read More

Idaho

Governor Otter Announced $30 Million Program to Address the Coverage Gap. On January 7, 2016, *The Charlotte Observer* reported that Governor C.L. "Butch" Otter announced a $30 million program to provide coverage to Idahoans who qualify for neither health insurance subsidies nor Medicaid. The plan would be state-funded and is not an expansion of Medicaid. Approximately 78,000 people will be eligible. The program would provide preventative primary medical care services, such as acute care, chronic condition management, and limited in-office behavioral health services. Providers would be paid $32 monthly for each enrolled participant. Read More

Illinois

Illinois Appeals Court Rules Hospitals' Tax Exemptions Law is Unconstitutional. On January 7, 2016, *Modern Healthcare* reported that an Illinois appeals court ruled that the 2012 law meant to provide clarity around exemptions for not-for-profit hospitals is unconstitutional. The law states that the value of certain charitable and other services offered by a hospital must exceed the estimated value of its property tax liability if it is to get a property and sales tax exemption. The Illinois 4th District Appellate Court ruled it unconstitutional. The case is expected to go to the state Supreme Court. Read More

Kentucky

Governor Bevin Moves to Shut Down State Exchange and Transition to Federal Exchange. On January 11, 2016, *The Washington Post* reported that Governor Matt Bevin informed the HHS Secretary Sylvia Mathews Burwell of his plans to close down Kynect and transition everyone to the federal Exchange. He stated that Kynect "adds no value" given the existence of HealthCare.gov. Read More

Louisiana

Governor Edwards Signs Order to Expand Medicaid. On January 12, 2016, *The New York Times* reported that Governor John Bel Edwards signed an executive order expanding Medicaid. Approximately 298,000 uninsured adults will be eligible. Read More On January 6, 2016, *Chron* reported that Governor-elect John Bel Edwards was aiming to expand Medicaid by July 1. Edwards said he would issue an executive order within 24 hours from being sworn in. To do this, the state will need to hire nearly 250 new health department workers to handle the enrollment and find $2 million in the budget for salaries, training, and equipment. Read More

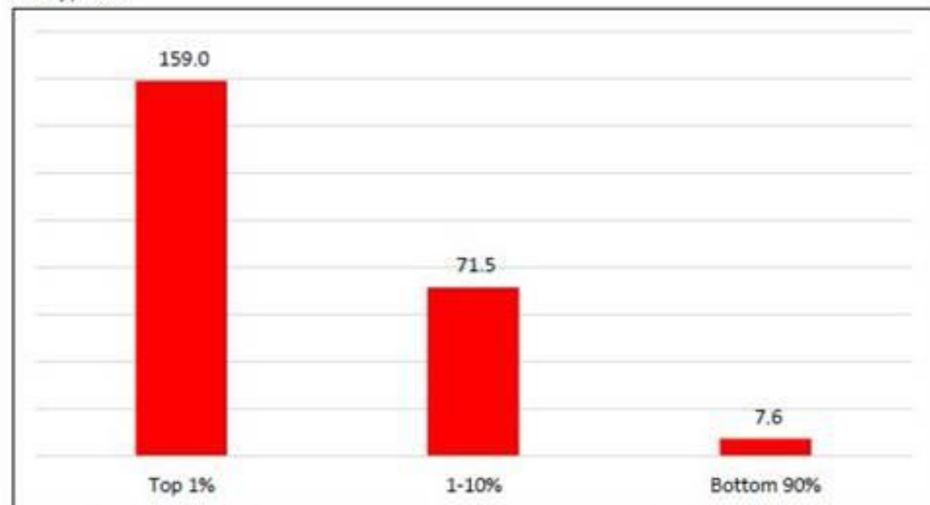
Missouri

Missouri Plans Statewide Medicaid Managed Care Bid for Second Quarter 2016. Missouri has formalized plans to issue a RFP this spring for the transition to statewide Medicaid managed care by May 2017. The RFP, set to be released at the end of April, will rebid existing contracts in 54 counties, as well as expand Medicaid managed care to the entire state under a statewide contracting approach. The state anticipates awarding statewide contracts to three plans for a potential contract term of five years. Missouri awarded contract renewals to Aetna, Centene, and WellCare in the three existing regions in July, 2015. Read More

New Jersey

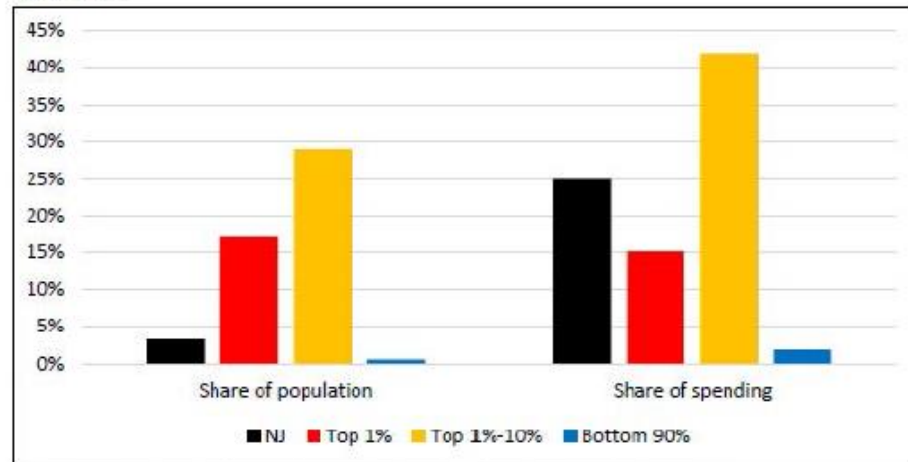
HMA Roundup – Karen Brodsky (Email Karen)

New Jersey high utilizer report findings released. The Rutgers Biomedical and Health Sciences (RBHS) Working Group just released a report, "Analysis and Recommendations for Medicaid High Utilizers in New Jersey", outlining findings from Medicaid spending research and offering recommendations to state policy makers and medical providers. This report was funded by the Robert Wood Johnson Foundation. Data was analyzed from fee-for-service claims and NJ FamilyCare managed care encounter records; input from an extensive stakeholder group was also incorporated into the report. The report highlights several key findings by the RBHS group about high utilization of medical services in New Jersey, including demographic breakdowns of usage, health need specifications of the top 1 percent of spenders, and avoidable hospitalization trends. Among the findings, the highest adult utilizers had an avoidable hospitalization rate of 159 per 1,000.



In addition, individuals receiving long term services and supports were disproportionately represented among the highest utilizers.

Figure 5: Representation of the Long-Term Services and Supports (LTSS) Population within Spending Groups, 2013*



*LTSS includes individuals eligible for services in the community, at home, or in facilities.

- The LTSS population accounts for 3.3% of statewide Medicaid enrollment but they account for 24.9% of statewide Medicaid spending.
- The LTSS population is disproportionately represented in the higher spending groups.
- Within the 1-10% spending group, the LTSS population accounts for a disproportionately large percentage of total spending.

The recommendations are separated into five categories of care:

1. Integration of Behavioral and Physical Health – Models Treating the Whole Person
2. Identify and Develop Interventions for Populations with Persistently High Costs
3. Expand Opportunities to Coordinate Social Service and Public Health Initiatives with Medicaid
4. Adopting Best Clinical Practices
5. Strengthening Infrastructure and Accountability

The above five areas are further broken into timeframe specific-categories: "near-term", "medium-term", and "longer-term." These recommendations give a multi-wave approach for feasible and long-lasting solutions to address the high cost of Medicaid spending. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

Delivery System Reform Incentive Payment Program Timeline (DSRIP)**.** The Department of Health has posted a revised DSRIP timeline, reflecting recent changes to key DSRIP deliverables. The updates include the date for performance payments to be released to PPSs, the release of the Mid-Point Assessment Tool for public comment in early February, and the release of a revised draft Value Based Payment Roadmap in late March. A new DSRIP Year 2 Timeline, which begins April 1, 2016, has also been released.

Adult Behavioral Health Home and Community Based Services Provider Designation. As a part of the State's Health and Recovery Plan (HARP) for individuals with serious mental illness and substance use disorders, a list of Adult Behavioral Health Home and Community Based Services was developed. The initial designation process for BH HCBS was completed in March 2015 for New York City and December 2015 for the rest of state. The list of designated agencies, along with the services for which they have been approved, is available on the OMH website. All agencies wishing to provide BH HCBS must apply to be designated for each service they would like to provide. Applicants may apply at any time for a designation; however, the state will update the designation lists only quarterly.

Comprehensive Home and Community Based Services (HCBS) Waiver Renewal. The Office for People with Developmental Disabilities has posted its 1915 (c) Comprehensive Home and Community Based Services (HCBS) Waiver Renewal, which is now available for public comment. The public comment period is open through January 25, 2016. Based upon its review of public comment, the state will then submit the renewal application to CMS for approval. The waiver renewal is retroactive to October 1, 2014 and will span a five year period, running through September 30, 2019.

The renewal includes updated information about the HCBS Settings Transition Plan and identifies that, beginning in 2016, some people enrolled in the OPWDD Comprehensive HCBS Waiver may choose to enroll in a managed care program called the FIDA-IDD (Fully Integrated Duals Advantage for Individuals with Intellectual and Developmental Disabilities). Other changes in the renewal include a new way to fund people who are new to Residential and Day Habilitation Services and who need extra support from staff until the provider agency's costs can be included in the agency's existing funding. The renewal also requests a multi-year phase-in to a new Respite fee methodology. Information regarding the public comment process is available on the OPWDD website. Read More.

Office for People with Developmental Disabilities Transformation Panel Draft Recommendations Released. Office for People with Developmental Disabilities Acting Commissioner Kerry A. Delaney established a stakeholder process in February 2015 whose charge was to re-imagine the OPWDD system. OPWDD has released a draft report of the Transformation Panel that lays out its recommendations. The recommendations are organized into five categories:

1. Residential Support - an affordable housing strategy that meets the range of needs of individuals with I/DD.
2. Employment and Life in the Community - new approaches that promote real and meaningful involvement in community life.
3. Self-Determination - moving away from a regimented approach and making self-direction—the ability to exercise control of one's own supports and services— available.
4. Supporting Staff and Family Caregivers - ensure resources are available to families who are caring for their loved ones at home and steps are taken to plan for long-term residential support.
5. System Platforms - use data to measure the effectiveness of what we do, measuring outcomes and rewarding providers who achieve results for people, including platforms like value-based.

OPWDD will be accepting public comment on the recommendations through January 22. More information is available on the OPWDD website.

North Carolina

State Officials Working to Meet Deadlines to Transition Medicaid to Managed Care by 2018 or 2019. On January 13, 2016, *Citizen-Times* reported that the new Division of Health Benefits is on track to meet deadlines in March and June on overhauling Medicaid. If a tight schedule is kept, the state can see a new managed-care system by 2018 or 2019. The division must provide an oversight committee with a formal report that includes recommendations on additional changes to Medicaid law by March 1. By June 1, the division must submit formal requests to alter how Medicaid and NC Health Choice comply with the new payment and treatment method to federal Medicaid regulators. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

MLTSS Subcommittee Meeting of Medical Assistance Advisory Committee. On January 6, 2016, the Managed Long Term Services and Supports subcommittee of the Pennsylvania MAAC held their monthly meeting.

Office of Long Term Living Updates. Kevin Hancock of OLTL discussed the upcoming MLTSS procurement, Community HealthChoices. The contract will require two new services: pest eradication and expanded employment services. It will also tweak the language to clarify "assisted living" is a service setting per the HCBS rule, and not a new service. Although the initial Continuity of Care period will be 180 days, once CHC has begun, any new enrollees will have a 60 day COC period. When asked for clarification on the enrollment and eligibility determination process, the department replied they are "working to make it less complicated". Per the current schedule, the Department of Human Services plans to release the official Community HealthChoices RFP at the end of January.

Tennessee

Hospital Systems Pledge $450 Million in Community Benefits if Merger Approved. On January 7, 2016, *Modern Healthcare* reported that Wellmont Health System and Mountain States Health Alliance have pledged $450 million in community benefits if authorities approve the proposed merger. Benefits would consist of improving community health, enhancing healthcare services, expanding healthcare choices and access to care, enhancing healthcare value, investing in health research and education, and attracting and retaining a strong workforce, according to a news release. The merger currently faces a number of regulatory hurdles. Wellmont is a six-hospital system serving Tennessee and Virginia, and Mountain States is a 13-hospital system serving Kentucky, North Carolina, Tennessee, and Virginia. Read More

Virginia

Governor McAuliffe Proposes New Plan on Medicaid Expansion to Republicans. On January 9, 2016, *The Washington Post* reported that McAuliffe will try to win over Republicans for the third year in a row on Medicaid expansion. McAuliffe proposed to pay the state's portion of the federal health-care program with a 3 percent tax on hospital revenue and tie some of the projected savings from expanding Medicaid to favorite projects of Republican lawmakers. However, Republicans said they would not hesitate to strip out the funding. Read More

National

Federal Officials to Tighten Enrollment Period Rules. On January 12, 2016, *The Wall Street Journal* reported that the Obama administration will eliminate some criteria for late Exchange sign-ups and make other criteria language clearer. Officials are hoping to hold down costs that insurers blamed on late sign-ups; insurers stated that rules were broad enough to allow people to wait until they were sick to buy insurance. The agency has also created an enforcement task force to ensure that people are being honest and said that the task force has terminated coverage for some consumers who did not have legitimate reasons for enrolling outside the deadline. Read More

Medicaid Directors Say CMS Standardization of Access to Care Measures Inappropriate. On January 8, 2016, *FierceHealthPayer* reported that the National Association of Medical Directors sent a letter to CMS, stating that it would be inappropriate to set standard thresholds for access to care in Medicaid. The association said it would limit states' abilities to set their own framework based on the healthcare landscape. However, CMS claims indicators such as appointment times, wait times, and call center times are reasonable. Read More

Providers Say CMS Medicaid Rule to Ensure Access to Care Falls Short. On January 6, 2016, *Modern Healthcare* reported that providers are asking for additional measures to be tracked regarding the new Medicaid rule. The rule was published in October of last year, outlining how Medicaid agencies must monitor access, particularly when they cut payment rates for providers. Although physicians and hospitals have praised the effort, they want CMS to do more to make sure beneficiaries have access to care. The American Medical Association said states should be required to track wait times for appointments by provider type and access to alternative office hours, and CMS should require an analysis of Medicaid fee-for-service rates compared with Medicaid managed care rates. Read More

Congress Investigating Impact of Medicaid Waivers Ending Non-Emergency Transportation Coverage. On January 7, 2016, *Modern Healthcare* reported that with Medicaid expanding under the ACA, some states have asking to waive the requirement for non-emergency transportation. CMS has approved the waivers coming from only a few Republican-led states. However, advocates say the move can prevent people from getting to dialysis, chronic-care visits, or mental health appointments. Senator Ron Wyden and Senator Frank Pallone, asked the Government Accountability Office to investigate the impact of the waivers. Read More

CMS Proposes Medicaid-Funded Addiction Treatment. On January 7, 2016, *Kaiser Health News* reported that the federal government is proposing to fund 15 days of inpatient rehab per month for anyone enrolled in a Medicaid managed care plan. However, advocates have urged that 15 days is not nearly enough time for people addicted to drugs to get clean and stay clean. According to Dr. Jeffrey Samet, a professor at Boston University's Clinical Addiction research unit, there is little research on the optimal length for inpatient stay. As a result, private insurance plans have varying coverage. Read More

Employers Turn to Medicaid to Insure Lowest-Paid Employees. On January 7, 2016, *Kaiser Health News* reported that employers are looking to Medicaid for health care coverage of low-paid workers without facing penalties. Startups, like BeneStream, move workers from private insurance to Medicaid to help firms shift their costs to the government. CEO Benjamin Geyerhahn reports average savings of 250 percent. However, large companies like Wal-Mart and McDonalds have faced criticism for moving the burden of cost to taxpayers. Read More

Industry News

GuildNet Completes Acquisition of EmblemHealth Medicaid MLTC, Duals Membership. On Wednesday, January 13, 2016, it was announced that EmblemHealth, New York's largest health insurer, has completed the sale of its Medicaid Managed Long Term Care (MLTC), Medicaid Advantage Plus, and Fully Integrated Dual Advantage (FIDA) membership to GuildNet. FIDA is the state's dual eligible demonstration program. Cain Brothers served as the sole advisor to EmblemHealth in the deal.

Aetna Expects to Close Humana Acquisition This Year. On January 12, 2016, *The New York Times* reported that Aetna's CEO, Mark Bertolini, announced that he is expecting to close a deal to acquire Humana this year. The U.S. Department of Justice is currently reviewing the deal. Critics have voiced concerns how the mergers will affect consumers, including higher prices. Aetna said it expects regulators to wrap up document requests in the next month and move onto discussions with the company. Read More

15 State Attorneys General Join Investigation of Health Insurer Mergers. On January 11, 2016, *The New York Times* reported that about 15 state attorneys general joined the Justice Department's investigation of the Aetna and Humana merger and the Anthem and Cigna merger. Connecticut, Florida, Iowa, Massachusetts, and Tennessee are among the states; others asked not to be named since the investigation is not public. The mergers are expected to be under tough lengthy reviews by federal antitrust enforcers. The deals would bring the total number of nationwide insurers from five to three. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
January, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
February 5, 2016	Nebraska	Letter of Intent to Contract	239,000
March 1, 2016	Iowa	Implementation	550,000
March 15, 2016	Nebraska	Contract Awards	239,000
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
March, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
TBD Winter/Spring 2016	Virginia MLTSS	RFP Released	130,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
April 29, 2016	Missouri (Statewide)	RFP Released	700,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
June, 2016	Oklahoma ABD	RFP Released	177,000
July 1, 2016	Missouri (Statewide)	Proposals Due	700,000
July, 2016	Georgia	Implementation	1,300,000
August, 2016	Oklahoma ABD	Proposals Due	177,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
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
March 1, 2017	Virginia MLTSS	Implementation	130,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
TBD 2017	Oklahoma ABD	Implementation	177,000
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, 2015, and into 2016.

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	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
California	122,520	122,798	122,846	120,452	117,449	117,307	117,179	116,538
Illinois	58,338	55,672	52,763	52,170	50,631	49,586	48,779	53,136
Massachusetts	17,621	17,637	17,705	17,671	17,518	17,179	12,657	12,366
Michigan		9,216	14,867	28,171	35,102	42,728	37,072	36,335
New York	6,660	7,215	5,031	7,122	9,062	8,028	9,942	8,005
Ohio	63,625	63,446	62,958	61,871	62,418	59,697	61,428	61,333
South Carolina	1,398	1,366	1,317	1,388	1,380	1,530	1,355	1,359
Texas	15,335	27,589	37,805	44,931	56,423	45,949	56,737	52,232
Virginia	27,349	30,877	29,970	29,507	29,200	29,176	27,138	28,644
Total Duals Demo Enrollment	**312,846**	**335,816**	**345,262**	**363,283**	**379,183**	**371,180**	**372,287**	**369,948**

HMA NEWS

New this week on the HMA Information Services website:

- Medicaid managed care enrollment updates for **California, Michigan, Arizona**, and more
- **Florida** Medicaid FFS Rate Trends, 2012-2015
- Public documents such as the **Massachusetts** MLTSS Draft Databook and the **New Hampshire** TANF Care Coordination Model Design RFP
- Plus upcoming webinars on *"Making Healthcare Data Actionable: Solutions for Converting Data into Information for More Effective Reporting, Decision Making, and Strategic Planning"* and *"Value-Based Payment Readiness: A Self-Assessment Tool for Primary Care Providers, FQHCs, and Behavioral Health Providers"*

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 WELCOMES…

Suzanne Gallagher, Principal – Southern California

Prior to joining HMA, Suzanne Gallagher served as a director of advisory services for a healthcare-focused advisory and consulting firm where she spent almost 10 years advising financial investors on strategic and operational issues as they related to healthcare policy and managed care. Ms. Gallagher has led over 300 due diligence engagements providing integrated analysis focused on federal, state, private pay, and market research, offering clients a perspective on relevant reimbursement, regulatory, and legislative matters.

Prior to 2006, Ms. Gallagher held several positions at CarePlus Health Plan, a Medicaid managed care plan, acquired by Amerigroup in 2005, including Director of Marketing, Director of Strategic Planning and Government Relations. She also served as the Director of Government Relations at the Greater New York Healthcare Facilities Association, a non-profit healthcare trade association providing services to the NYC long term care industry.

Ms. Gallagher received a Masters of Public Administration in Health Care Management and Policy from New York University and a Bachelor of Arts degree focused on Political Science from Kean University.

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