HEALTH MANAGEMENT ASSOCIATES

# HMA Weekly Roundup

Trends in State Health Policy

*January 27, 2016*




RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

**Edited by:**
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

## THIS WEEK



## IN FOCUS

### CMS ISSUES MEDICAID DRUG REBATE AND REIMBURSEMENT RULE

This week, our *In Focus* section reviews the Covered Outpatient Drugs final rule published by the Centers for Medicare & Medicaid Services (CMS) on January 21, 2016, addressing Medicaid drug reimbursement and changes to the Medicaid Drug Rebate Program. The rule finalizes several provisions of the Affordable Care Act (ACA) and addresses three goals: assisting states and the federal government in managing drug costs, establishing the sustainability of the Medicaid Drug Rebate Program, and creating a fairer pharmacy reimbursement system. The full Covered Outpatient Drugs rule is available in a pre-publication

version online until February 1, 2016, when it will be published on the Federal Register website. A link to the pre-publication version is available here.

## Key Provisions of Final Rule

**Average Manufacturer Price (AMP) Changes.** The final rule establishes a clear definition for AMP, which is based on data collected monthly by CMS, and impacts both manufacturer rebate amounts and reimbursement values for certain generic drugs. Additionally, the rule provides a clear definition for what constitutes a manufacturer's "best price," as well as addresses statutory definitions around retail community pharmacies and wholesalers.

**Medicaid Drug Rebate Program Expanded to "5i" Drugs.** Additionally, the rule creates an AMP definition for inhalation, infusion, instilled, implanted, or injectable drugs (referred to as 5i drugs). By establishing this definition, states can begin to collect rebates for these drugs.

**Federal Upper Limit (FUL) and Pharmacy Reimbursement.** The final rule updates the FUL formula, which limits reimbursement, for select generic drugs. This update is intended to incentivize pharmacies to utilize generic drugs more, as the pharmacy costs will be regularly updated. Additionally, the final rule:

- Establishes FUL calculation exception, allowing for a higher FUL for select drugs based on acquisition costs.
- Establishes actual acquisition cost (AAC) as the basis for determining ingredient cost reimbursement, intending to align payments more accurately with marketplace prices, while ensuring access.
- Ensures that the dispensing fee reimbursement to pharmacies reflects the cost of the professional services and cost to dispense the drug.
- Requires states to evaluate both the ingredient cost reimbursement and the professional dispensing fee reimbursement when proposing changes to either.

**Medicaid Drug Rebate Program Expanded to Territories.** The final rule amends the definition of "states" to include the territories of Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands, allowing these territories to begin collecting rebates on Medicaid-funded drug expenditures.

## Anticipated Financial Impact

In addition to the changes mentioned above, the final rule includes the already implemented provisions of the ACA around the extension of the Medicaid Drug Rebate Program to Medicaid managed care organizations (MCOs), as well as increased rebate percentages on brand name drugs. CMS estimates the impact of these provisions at $17.7 billion in savings from 2010 through 2014, with most of those savings ($13.7 billion) going to the federal government, and the remainder to states.

The final rule provides annual estimates of savings due to the FUL provisions of the rule (table below), which amounts to $1.61 billion in federal savings, and more than $1.1 billion in state savings from FY 2016 through FY 2020.

| $ Millions | FY 2016 | FY 2017 | FY 2018 | FY 2019 | FY 2020 | Total FY 2016 - 2020 |
|---|---|---|---|---|---|---|
| Federal | $ (180) | $ (355) | $ (355) | $ (360) | $ (360) | $ (1,610) |
| State | $ (125) | $ (250) | $ (250) | $ (250) | $ (250) | $ (1,125) |
| **Total** | **$ (305)** | **$ (605)** | **$ (605)** | **$ (610)** | **$ (610)** | **$ (2,735)** |

## Current Medicaid Drug Rebate Program Data

The total sum of all Medicaid drug rebates totaled just over $24 billion in rebates to the federal government and states as of federal fiscal year 2015. The table below provides state-by-state details on the national Medicaid Drug Rebate Program, as well state sidebar rebate agreements.

| ($ Millions) | Drug Rebate (Total) | Drug Rebate (National) | Drug Rebate (State Sidebar) | MCO Rebate (National) | MCO Rebate (State Sidebar) | ACA Offset (FFS) | ACA Offset (MCO) |
|---|---|---|---|---|---|---|---|
| **U.S. Total** | **$ (24,002.53)** | **$ (10,527.56)** | **$ (842.29)** | **$ (10,983.88)** | **$ (207.16)** | **$ (755.38)** | **$ (686.26)** |
| Alabama | $ (330.84) | $ (305.74) | $ (13.39) | $ - | $ - | $ (11.72) | $ - |
| Alaska | $ (28.89) | $ (27.64) | $ - | $ - | $ - | $ (1.25) | $ - |
| Arizona | $ (395.30) | $ (7.73) | $ - | $ (366.08) | $ - | $ (0.75) | $ (20.75) |
| Arkansas | $ (216.85) | $ (155.21) | $ (51.45) | $ - | $ - | $ (10.19) | $ - |
| California | $ (2,633.33) | $ (1,829.02) | $ (165.18) | $ (485.25) | $ - | $ (133.05) | $ (20.84) |
| Colorado | $ (375.24) | $ (344.72) | $ (9.27) | $ (3.41) | $ (0.22) | $ (17.62) | $ - |
| Connecticut | $ (583.48) | $ (522.01) | $ (33.82) | $ - | $ - | $ (27.65) | $ - |
| Delaware | $ (129.51) | $ (109.72) | $ (8.92) | $ (3.29) | $ - | $ (4.49) | $ (3.08) |
| Dist. Of Col. | $ (83.69) | $ (41.42) | $ (2.14) | $ (36.72) | $ - | $ (1.80) | $ (1.63) |
| Florida | $ (1,316.04) | $ (380.30) | $ (28.44) | $ (766.10) | $ (55.86) | $ (37.10) | $ (48.24) |
| Georgia | $ (486.57) | $ (277.56) | $ (19.65) | $ (162.78) | $ - | $ (18.06) | $ (8.52) |
| Hawaii | $ (60.97) | $ (0.27) | $ - | $ (56.52) | $ (0.00) | $ (0.01) | $ (4.16) |
| Idaho | $ (104.54) | $ (92.89) | $ (6.63) | $ - | $ - | $ (5.02) | $ - |
| Illinois | $ (577.65) | $ (349.99) | $ (29.26) | $ (157.16) | $ - | $ (29.09) | $ (12.15) |
| Indiana | $ (615.70) | $ (538.23) | $ (15.34) | $ (27.40) | $ - | $ (33.57) | $ (1.16) |
| Iowa | $ (258.83) | $ (233.00) | $ (13.16) | $ (0.00) | $ - | $ (12.66) | $ (0.00) |
| Kansas | $ (224.71) | $ (1.64) | $ (0.02) | $ (209.89) | $ (2.66) | $ (0.18) | $ (10.31) |
| Kentucky | $ (431.08) | $ (41.43) | $ (2.13) | $ (371.72) | $ - | $ (2.01) | $ (13.79) |
| Louisiana | $ (385.17) | $ (63.53) | $ (25.35) | $ (276.39) | $ - | $ (11.60) | $ (8.30) |
| Maine | $ (141.24) | $ (127.04) | $ (7.68) | $ - | $ - | $ (6.52) | $ - |
| Maryland | $ (504.63) | $ (191.20) | $ (19.61) | $ (174.18) | $ (9.33) | $ (48.40) | $ (61.91) |
| Massachusetts | $ (541.92) | $ (264.12) | $ - | $ (242.84) | $ - | $ (18.89) | $ (16.08) |
| Michigan | $ (813.51) | $ (462.49) | $ (30.72) | $ (283.36) | $ - | $ (26.23) | $ (10.70) |
| Minnesota | $ (436.93) | $ (207.82) | $ (11.61) | $ (198.45) | $ - | $ (12.72) | $ (6.34) |
| Mississippi | $ (237.78) | $ (126.22) | $ (11.29) | $ (88.47) | $ - | $ (5.83) | $ (5.97) |
| Missouri | $ (542.18) | $ (504.26) | $ (32.06) | $ 17.18 | $ 1.19 | $ (24.24) | $ - |
| Montana | $ (60.88) | $ (57.45) | $ - | $ - | $ - | $ (3.43) | $ - |
| Nebraska | $ (98.49) | $ (88.11) | $ (5.64) | $ - | $ - | $ (4.73) | $ - |
| Nevada | $ (180.98) | $ (104.26) | $ (4.32) | $ (61.51) | $ - | $ (7.02) | $ (3.87) |
| New Hampshire | $ (97.24) | $ (16.27) | $ (1.05) | $ (71.54) | $ (4.27) | $ (0.90) | $ (3.20) |
| New Jersey | $ (632.40) | $ (37.02) | $ - | $ (575.86) | $ - | $ (1.70) | $ (17.82) |
| New Mexico | $ (200.78) | $ (4.63) | $ - | $ (189.81) | $ - | $ (0.17) | $ (6.17) |
| New York | $ (2,204.43) | $ 382.68 | $ (22.10) | $ (2,296.82) | $ - | $ (54.16) | $ (214.03) |
| North Carolina | $ (906.12) | $ (802.13) | $ (68.12) | $ - | $ - | $ (35.87) | $ - |
| North Dakota | $ (13.76) | $ (9.66) | $ - | $ (3.16) | $ - | $ (0.62) | $ (0.32) |
| Ohio | $ (1,068.01) | $ (295.41) | $ (13.97) | $ (719.75) | $ - | $ (14.38) | $ (24.49) |
| Oklahoma | $ (228.90) | $ (200.46) | $ (14.55) | $ - | $ - | $ (13.89) | $ - |
| Oregon | $ (283.97) | $ (86.01) | $ (1.18) | $ (182.80) | $ (4.77) | $ 2.68 | $ (11.89) |
| Pennsylvania | $ (996.03) | $ (50.47) | $ (1.75) | $ (881.22) | $ - | $ (4.86) | $ (57.73) |
| Rhode Island | $ (85.39) | $ (12.11) | $ (0.24) | $ (67.03) | $ - | $ (0.91) | $ (5.10) |
| South Carolina | $ (244.65) | $ (50.69) | $ (3.68) | $ (175.04) | $ - | $ (4.87) | $ (10.36) |
| South Dakota | $ (33.79) | $ (32.39) | $ - | $ - | $ - | $ (1.40) | $ - |
| Tennessee | $ (608.53) | $ (507.87) | $ (67.71) | $ - | $ - | $ (32.94) | $ - |
| Texas | $ (1,870.27) | $ (441.69) | $ (35.29) | $ (1,191.94) | $ (126.73) | $ (25.37) | $ (49.26) |
| Utah | $ (111.86) | $ (61.84) | $ (0.75) | $ (40.39) | $ - | $ (4.74) | $ (4.15) |
| Vermont | $ (96.92) | $ (84.53) | $ (8.55) | $ - | $ - | $ (3.84) | $ - |
| Virginia | $ (322.31) | $ (12.52) | $ (2.37) | $ (283.59) | $ - | $ (8.99) | $ (14.84) |
| Washington | $ (390.64) | $ (81.55) | $ (0.77) | $ (299.81) | $ - | $ (1.30) | $ (7.21) |
| West Virginia | $ (305.13) | $ (227.02) | $ (15.32) | $ (46.58) | $ (4.50) | $ (10.02) | $ (1.69) |
| Wisconsin | $ (479.39) | $ (418.39) | $ (36.45) | $ (4.21) | $ - | $ (20.16) | $ (0.19) |
| Wyoming | $ (25.07) | $ (22.57) | $ (1.36) | $ - | $ - | $ (1.14) | $ (0.00) |

*Source: CMS-64 Expenditure Reporting, FY 2015*

HMA Medicaid Roundup

# California

## HMA Roundup – Don Novo (Email Don)

**State's Four Largest Health Plans May Owe $10 Billion in Back Taxes.** On January 21, 2016, *San Jose Mercury News* reported that Kaiser Permanente, Anthem Blue Cross, Blue Shield of California, and Health Net could owe $10 billion in state back taxes. The legal case alleges that the health plans avoided paying a state tax on health insurance premiums, claiming that they are not insurers, and are therefore not subject to the tax. The four plans control nearly 70 percent of the health insurance market in California. Read More

**Report Finds Only 40 Percent of Medi-Cal Sacramento Children Use Dental Services.** On January 21, 2016, *The Sacramento Bee* reported that in Sacramento County, only 40 percent of children in Medi-Cal managed care plans use the dental services they are eligible for, despite a five-year effort to bring more dentists into Medi-Cal managed care plans, expand community clinics, and educate families about the importance of dental care, according to a report by Barbara Aved Associates. Sacramento is the only county in California where Medi-Cal consumers are required to enroll in a managed care plan for dental services. Yet in 2014, two-thirds of the 140,000 eligible children did not receive any preventive dental care services. The Medi-Cal Dental Advisory Committee requested the report as an update to a 2010 study that found multiple failures and shortfalls in pediatric dental care in Sacramento County. Read More

**Senate Health Committee Approves Aging and LTC Bill.** On January 14, 2016, *California Healthline* reported that a bill to reform the way the state handles senior care was unanimously approved by the Senate Health Committee. The bill will set up a coordinating council and make the integration of long-term care and aging issues the responsibility of the state's HHS Secretary. It would also create a statewide long-term care plan with benchmarks and timelines for implementation of that plan to be updated every five years. The bill now moves to the Senate Committee on Appropriations. Read More

**Lawmakers Propose Reviving Pharmaceutical Cost Transparency Act.** On January 12, 2016, *KQED* reported that state lawmakers are looking to revive Assembly Bill 463, the Pharmaceutical Cost Transparency Act, first proposed last February, to increase drug cost transparency. The bill would require pharmaceutical companies to report production and marketing costs associated with any drug treatment priced at $10,000 or more. Drug makers oppose the bill, saying the information is proprietary. Read More

# Florida

## HMA Roundup – Elaine Peters (Email Elaine)

**Nursing Homes Seeking Higher Medicaid Rates.** On January 22, 2016, *Naples Daily News* reported that nursing homes are seeking to restore the automatic annual 1 percent increase in Medicaid payments that was stopped in 2011. The increase would provide an additional $12.8 million in state funding and $20.2 million in federal funding. The request comes as lawmakers consider big tax cuts for business. Lawmakers said there are other budget issues to consider that leave little room for an increase in spending for nursing homes. Read More

**Medical Care Advisory Committee.** On January 19, 2016, the Florida Medical Care Advisory Committee met and provided updates on the following topics: 1115 MMA Waiver Amendment; Low Income Pool (LIP); and SMMC Program Update: MMA managed care (quality, report cards, consumer satisfaction survey); LTC managed care (quality, patient satisfaction survey, evaluation). Information and presentations from the meeting may be obtained here.

**Quarterly Reports.** This report examines the continuity of Medicaid coverage in Florida. Continuity ratios are presented for Medicaid enrollment and for enrollment in each Statewide Medicaid Managed Care (SMMC) health plan. The report covers monthly turnover in Managed Medical Assistance (MMA) and Long-term Care (LTC) enrollment, shifts between fee-for-service (FFS) delivery and SMMC enrollment, changes from one SMMC plan to another, plan mergers and acquisitions, and the percentage of eligible recipients who enrolled in an MMA Specialty plan.

**House Committee Backs Multi-State Nursing Licensing Bill.** On January 27, 2016, *Sayfie Review/The News Service of Florida* reported that the House Health & Human Services Committee approved HB 1061, which would allow Florida to enter into a compact with around 25 states to allow nurses to practice across state lines. The measure is reportedly backed by House republicans, and has received support from the Florida Nurses Association, the Florida Hospital Association, and AARP. A similar Senate bill has yet to be heard in committee. Read More

# Georgia

## HMA Roundup – Kathy Ryland (Email Kathy)

**GOP Senator Predicts Medicaid Expansion Will Happen Despite Republican Protests.** On January 24, 2016, *AJC.com* reported that Senator Fran Millar (R-Dunwoody) stated that Medicaid expansion is inevitable. Millar said during a show called "The Lawmakers" that Georgia is lacking sufficient access to many portions of the state. He believes the state will ultimately expand Medicaid, though he does not know how long it will take. Read More

# Hawaii

**Lawmakers Propose Bill to Offer Long-Term Care Benefits to Seniors.** On January 21, 2016, *The Washington Post* reported that state lawmakers proposed a bill that would make Hawaii the first state to offer long-term care benefits to seniors. Eligible seniors would receive $70 per day for a year to pay for family

caregivers, in-home aides, or help offset the cost of safety equipment. To cover these costs, the bill would ask for a 0.5 percent increase in the general excise tax. Read More

## Idaho

**Governor Otter's Medicaid Gap Proposal Heads to Committees.** On January 20, 2016, *The Charlotte Observer* reported that Governor Otter's proposal to provide basic medical care for residents in the Medicaid gap has been split into two separate bills that are headed to two separate committees. Both must approve in order for it to succeed. The funding for the proposal will be reviewed by the Revenue and Taxation Committee, while the structure of the program will be reviewed by the House Health and Welfare Committee. The proposal will cost an estimated $30 million. Read More

## Illinois

**Governor Blames Democrats for Recent Social Service Cuts.** On January 25, 2016, the *Chicago Tribune* reported that Governor Bruce Rauner is blaming House and Senate democrats for not working toward a budget deal that could have averted the continued cuts in social services across the state. Days earlier, Lutheran Social Services of Illinois announced it was shuttering programs for drug and alcohol treatment, recent parolee housing, and a children's shelter, as well as eliminating 750 positions, due to more than $6 million owed to the organization by the state. While Medicaid and other programs have been propped up by court rulings, many state-funded programs are running out of funds or delaying reimbursements as the state has been without a budget since July 2015. Read More

## Iowa

**Iowa Medicaid Director Confident of March 1 Managed Care Transition.** On January 25, 2016, *Iowa Public Radio* reported that Iowa's Medicaid Director, Mikki Stier, says she is "very confident" the state will be ready to launch statewide Medicaid managed care on March 1, 2016. Stier told the Senate Human Resources Committee on Monday that 75 percent of Medicaid providers have now signed with at least one MCO, and 45 percent have signed with all three, addressing one of the major concerns that led CMS to delay implementation from January 1. Read More

**Judge Denies WellCare's Request to Continue Medicaid Operations.** On January 22, 2016, *The Gazette* reported that Judge Robert Blink denied WellCare of Iowa's request to continue Medicaid operations until it is able to appeal a state arbiter's decision to throw out its Medicaid contract. The judge also denied Aetna's request to stop implementation and reopen the bidding process. Read More

**Legislators Find October Medicaid Savings Report on Privatization Troublesome.** On January 21, 2016, *The Des Moines Register* reported that legislators are looking into the "additional key observations" of an October 30 Milliman report on Medicaid privatization. The report shows six-month baseline savings of $36.6 million, approximately $15 million less than was budgeted by

Governor Branstad's administration. Furthermore, payments for maternity healthcare will be delayed by two months, which would shift $9.3 million from the current fiscal year. The report also found that ending contracts with current private companies managing some aspects of the Medicaid program would save the state $10.5 million in administrative costs. Read More

## Kansas

**Medicaid Expansion Plan Introduced.** On January 26, 2016, the *Kansas Health Institute* reported that the state's hospital association has pushed forward a Medicaid expansion bill modeled after the program implemented last year in Indiana. The bill, introduced this week in House and Senate committees, would cover approximately 150,000 lives. Like the Indiana model, enrollees above 100 percent FPL would be required to pay into personal health care spending accounts and coverage may be terminated for non-payment. The bill may still face opposition, as some lawmakers object to expanding Medicaid while individuals with disabilities are still on support services waiting lists. Read More

**Advocates Urge Governor and Legislators to Stop Citing Waiting Lists As Reason to Oppose Medicaid Expansion.** On January 21, 2016, *Kansas Health Institute* reported that the Big Tent Coalition, the state's largest disability advocacy group, urged Governor Sam Brownback and legislators to stop citing waiting lists as a reason to oppose Medicaid expansion. Brownback's administration refused to expand Medicaid for the last year while disability waiting lists exist, calling it, "morally reprehensible" to do so. However, the executive director of the Disability Rights Center, Rocky Nichols, said it is empty rhetoric and that the proposed budget is actually cutting funds for home and community-based services. The governor's budget proposes to increase funding for physical disability services by $2 million in the current fiscal year but then decrease it by about $1.6 million in the fiscal year that begins in July. Developmental disability services would get a $1.2 million decrease in the current fiscal year and a $500,000 increase in the next. Read More

**Kansas Medicaid Enrollment System Savings Overestimated.** On January 25, 2016, the *Kansas Health Institute* reported that the new Medicaid enrollment system in the state is now expected to generate far less than the $300 million in savings anticipated over the next 10 years. According to a Legislative Post Audit report, the Kansas Eligibility Enforcement System (KEES) implementation and operation has exceeded anticipated costs and many of the assumptions behind the savings calculations were flawed. Read More

## Kentucky

**Governor's Budget Would Protect Medicaid from Budget Cuts.** On January 26, 2016, the Lexington Herald-Leader reported that Governor Matt Bevin plans to exempt Medicaid from any immediate budget cuts under his $21 billion two-year budget plan released this week. The Governor still intends to shut down the state's health insurance Exchange, known as Kynect, this year. His budget plan further notes that the Governor's administration is pursuing a federal Medicaid waiver to "redesign and revamp" the program. Read More

## Louisiana

**DHH Optimistic About Medicaid Expansion Approval.** On January 22, 2016, *The Times-Picayune* reported that the Department of Health and Hospitals Secretary Dr. Rebekah Gee is optimistic Medicaid expansion will receive federal approval after meeting with federal officials. Governor John Bel Edwards signed the Medicaid expansion executive order on January 12. Read More

## New Hampshire

**Republicans to Outline Medicaid Expansion Overhaul.** On January 27, 2016, *New Hampshire Public Radio* reported that New Hampshire's republican lawmakers will put forth a proposal this week to continue the Medicaid expansion, which is set to expire at the end of the year when federal funding drops below 100 percent. The revised structure will include work requirements and premium payments, with the state's share of the expansion costs to be covered by funds from the insurance premium tax and Medicaid hospital assessment. Read More

## New Jersey

### HMA Roundup – Karen Brodsky (Email Karen)

**NJ Health Care Quality Institute (NJHCQI) facilitated "Fear of Tiers" event.** On January 21, 2015 NJHCQI led a stakeholder panel discussion at Princeton University to debate the state's recent controversy over tiered networks. *NJBIZ* reported on the meeting and noted that the legislature has been reviewing bills that seek to address regulatory gaps in the system for approving tiered networks. Panelists held differing views over how to define the quality standards for tiered networks. One researcher shared that tiered networks can have significant market impacts. Health plans were not represented on the panel, which some stakeholders thought could have informed the discussion. Read more

**Governor Christie vetoes bill that would require non-profit hospitals to pay annual community service contribution.** On January 25, 2016 *NJSpotlight* reported on the reactions of stakeholders to Governor Chris Christie's pocket veto of Senate bill 3299 1R that sought a statewide solution for challenges to more than 60 nonprofit hospitals in the state that are exempt from property taxes. While the bill would have maintained the tax exemption, it proposed an annual per-bed daily fee to be paid to local municipalities. The New Jersey Hospital Association supported the bill while the League of Municipalities has asked bill sponsors to share more about the fee rationale. Read more

## New York

### HMA Roundup – Denise Soffel (Email Denise)

**HARP Market Share.** New York City has begun implementation of Health and Recovery Plans (HARPs), a Medicaid managed care product designed for individuals with serious mental illness and/or substance use disorders. Individuals who have been determined HARP-eligible and who are enrolled in a Medicaid managed care plan that operates a HARP have been auto-assigned

into the HARP, with the ability to opt out and remain in their mainstream plan, should they prefer. Crains HealthPulse reported on enrollment for HARPs for December 2015. There are 37,000 beneficiaries enrolled in a HARP. Among the six New York City Medicaid managed care plans offering a HARP enrollment ranges from 2,153 (UnitedHealthcare) to 14,050 (Healthfirst). Two Medicaid managed care plans – Affinity HealthCare and Wellcare – have chosen not to offer a HARP; their HARP-eligible members are being offered the option of switching plans to take advantage of the enhanced benefit package offered through HARPs. Market share for HARP members does not track closely with market share for Medicaid managed care overall, indicating that some plans provide care to a disproportionate share of individuals with serious behavioral health conditions.

| Medicaid Managed Care Enrollment December 2015 | HARP Enrollment # | HARP Enrollment % | Total Enrollment # | Total Enrollment % |
|---|---|---|---|---|
| Fidelis Care | 5,970 | 16.1% | 441,154 | 17.4% |
| Healthfirst | 14,050 | 37.9% | 857,956 | 33.9% |
| Empire BCBS HealthPlus | 4,210 | 11.3% | 378,158 | 14.9% |
| HIP | 3,024 | 8.1% | 149,421 | 5.9% |
| MetroPlus | 7,698 | 20.7% | 416,152 | 16.4% |
| UnitedHealthcare Community Plan | 2,153 | 5.8% | 291,648 | 11.5% |
| **Total Enrollment - NYC** | **37,105** | **100.0%** | **2,534,489** | **100.0%** |

**Centerlight Healthcare Agrees to Settlement.** Attorney General Eric Schneiderman announced a $47 million settlement with CenterLight Healthcare and CenterLight Health System, resolving allegations that CenterLight Healthcare's Select Medicaid Managed Long Term Care Plan fraudulently billed Medicaid for services they did not provide to more than 1,200 Medicaid recipients. Under the settlement, CenterLight Healthcare admitted that it enrolled Medicaid beneficiaries who were referred by social adult day care centers even though the beneficiaries were not eligible to receive managed long-term care under the plan, and that the centers were providing services that did not qualify for reimbursement under New York State Department of Health standards. CenterLight receives over $3,000 a month per member from New York's Medicaid program as part of its MLTCP. Under the settlement, New York's Medicaid program will receive $28,050,652.04 and the United States will receive $18,700,434.70. In addition to its payment of the $47 million under the settlement, CenterLight is entering into a two-year agreement with an independent compliance monitor and the Attorney General's Medicaid Fraud Control Unit. That agreement requires CenterLight to comply with all terms of its MLTCP contract and DOH policies, and monitor and revise compliance policies if necessary.

This is the second settlement from the Attorney General's Office involving a managed long-term care plan in New York, based on allegations that the managed long-term care plan enrolled members through social adult day care centers who were ineligible. In October 2014, the Attorney General announced a $37 million settlement with VNS Choice, Visiting Nurse Service of New York, and VNS Choice Community Care regarding similar allegation related to its MLTCP.

**New York City Support for NYC Health + Hospitals.** New York City Mayor Bill de Blasio released his preliminary budget for the coming fiscal year, an $82.1 billion preliminary budget that would immediately direct $337 million to NYC

Health + Hospitals, New York City's public hospital system, to provide financial support while the system develops a restructuring plan. The system lost $263.6 million in the first quarter of its current fiscal year. According to City and State, the mayor does not anticipate any hospitals closing because of the reorganization, but rather will consider ways to consolidate multiple services in fewer buildings. NYC H+H President Dr. Ram Raju had previously announced a renewed attempt to increase enrollment in MetroPlus, NYC H+H's managed care plan, as an additional strategy for shoring up the system.

**DSRIP Quarterly Reports.** The Department of Health has posted Second Quarterly Reports of DSRIP Year 1 for all 25 Performing Provider Systems participating in the DSRIP program, covering PPS activity through September 30, 2015. The Second Quarterly Report for each PPS can be accessed on the DSRIP website. The second payment to PPSs was released following validation of the reports by the state's Independent Assessor. The PPS's earned $165,965,413 out of a possible $168,387,230 (98.5%) in DSRIP waiver funds for this period. The results of the Independent Assessor's reviews and the breakdown of performance payments earned for each PPS can be found in the Achievement Value (AV) Scorecards here. AVs are determined based on PPS progress toward the project-specific goals it established in its initial application.

**Standard and Poor's Assessment of NYS Insurance Market.** Crain's HealthPulse highlighted a recent report prepared by Standard and Poor's that examines the impact of the Affordable Care Act on NY's insurance market. New York State is one of the largest insurance markets in the country and ranks near the top in terms of population, insured rates, and competition. The state boasts roughly 20 million residents, an insured rate of more than 90%, and 16 companies operating on the state health insurance marketplace in 2015. The report identifies three broad themes:

- Uninsured rates have fallen since the rollout of the ACA, both in New York State and nationally.
- The drop in uninsured rate has come at a cost of weak operating performance for insurers in this line of business.
- Uncertainties remain about how much insurers can rely on the federal and state risk-mitigation programs to buffer against volatility related to the ACA roll-out.

The report notes that competition and premium rate regulation have made New York a difficult market for health insurers. S&P's analysis of insurers' 2014 financial statements showed that 12 plans lost a combined $160 million in the individual market, with Emblem Health and United HealthCare both reporting losses of over $35 million.

**Health Marketplace Reports enrollment tops 2.7 million.** In an effort targeted at the final week of open enrollment on the health marketplace, NY State of Health, the State's official health plan marketplace, has accelerated its outreach efforts. A recent press release notes that to date, more than 2.7 million people are enrolled in health insurance through NY State of Health, including 1.9 million enrolled in Medicaid, and 827,000 enrolled in non-Medicaid coverage. This includes 210,000 children enrolled in Child Health Plus; 260,000 individuals enrolled in a Qualified Health Plan and 356,000 people in the new Essential Plan, a new and more affordable option for lower income New Yorkers.

**DSRIP Project Approval and Oversight Panel.** The DSRIP Project Approval and Oversight Panel (PAOP) met last week to review progress of thirteen Performing Provider Systems located in the downstate region. PAOP had reviewed the 12 upstate PPSs in November 2015. Each PPS made a presentation to the panel focusing on progress during the first quarter of DSRIP (April 1 – June 30, 2015). Each PPS addressed the following topics: Workforce, Primary Care, County Collaboration, CBO/Cultural Competency, Funds Flow, Behavioral Health and Alignment with the NYS Prevention Agenda. Individual PPS presentations are available on the DSRIP website.

# *Ohio*

## HMA Roundup – Mel Borkan (Email Mel)

**State Budget Invests $9.1 Million in Mental Health to Help Young Children Stay in School**. *The Dayton Daily News* is reporting that $9.1 million set aside in the state's new two-year budget could benefit 75 counties. The financing would cover up to 64 mental health consultants who will work with teachers and at-risk students in programs such as Head Start, preschool and child care settings. Some consultants are already in classrooms. The initiative is targeted to reducing disruptive classroom behavior that can lead to expulsion by training teachers to address behavior issues while putting consultants in the classroom. A spokesman for the Department of Mental Health and Addiction Services says the goal is to address any mental health and wellness issues early to give children a better chance at success. Read More

**Report Released on Path to Ending HIV/AIDS Epidemic.** The Center for Community Solutions (CCS) has just released a report highlighting the convergence of several efforts underway in Ohio that suggest a path forward to end the HIV/AIDS epidemic in Ohio. According to John Corlett, President and Executive Director of CCS and author of the CCS report, those efforts include recent recommendations made by the General Assembly's Joint Medicaid Oversight Committee (JMOC) entitled, "Review of the Ohio Department of Health Treatment Programs." Corlett also points to recommendations from a 2014 report by Mathematica Policy Research for ODH and a recent paper from the Ohio AIDS Coalition on ending the HIV epidemic in Ohio, "Breaking the Silo, Flattening the Cascade, Ending the HIV Epidemic in Ohio." The CCS report includes seven recommendations and can be found here. The JMOC Staff Report and Ohio AIDS Coalition Report can be found here and here.

# *Pennsylvania*

## HMA Roundup – Julie George (Email Julie)

**MAAC Meeting Highlights.** The Department of Human Services held a monthly meeting of the Medical Assistance Advisory Council (MAAC) on January 21, 2016. The following updates were presented.

Office of Medical Assistance Programs Updates. Deputy Secretary of OMAP, Leesa Allen provided an overview of the FY 2015-2016 Budget line item changes included in Act 10a. The budget demonstrates reduction in capitation and the Fee-For-Service budget. The majority of the line item reductions were related to supplemental payments for critical access hospitals, burn centers, and obstetrical/ neonatal supplemental payments. The newly passed Act 32

(formerly HB 1332), changed the title of the Public Welfare Code to "Human Services Code" and added observation services payments effective July 1, 2016 which does include reimbursement for both hospitals and practitioners. The HealthChoices Physical Health Managed Care re-procurement has not yet been finalized. At this time DHS cannot supply an expected timeframe for completion. Children's Health Insurance Program (CHIP) has now officially moved from the Pennsylvania Insurance Department to the Department of Human Services. This was an operations and policy move.

Office of Long Term Living Updates. There have been changes in the Fair Labor Act related to the way person-directed services are acquired (including travel). Changes include:

- Workers receive minimum wage, (currently set at $7.25/hr) and overtime over 40 continuous hours (live-in workers are excluded from this change)
- Personal assistance providers who previously claimed a tax emption for delivering companion services are no longer exempt (since they do not meet the definition of companion services)
- The program no longer permits more than a 1-1 relationship with participants and employees for person-directed services; in the past a 1:5 ratio was acceptable.

There were no minimum wage impacts based on the current OLTL providers for DHS. Based on the current provider historical data, 4100 workers will be impacted by the overtime change with a related $3.086 million fiscal impact. Thirty-nine providers will be impacted by the 1:5 to 1:1 ratio of providers to participants. OLTL implemented a policy for exemption of overtime: workers will receive straight time if live-in and also working more than 40 hours per week. This will not impact the Office of Developmental Programs since there is a 40 hour per week limit on ODP services.

MLTSS Procurement Update. The procurement for Community HealthChoices, the Pennsylvania's MLTSS program is on schedule for release of the RFP in February. Themes were shared in the January 21st Third Thursday Webinar (transcript pending here). Kevin Hancock, Chief of Staff, indicated that the rate setting process in underway and would be released in the draft agreement attached to the RFP.

Office of Mental Health and Substance Abuse Services Updates. According to OMHSAS Deputy Secretary Dennis Marion, Pennsylvania was selected for a federal grant for Certified Community Clinics. Seventy-four clinics, equal in geographic distribution across the state, expressed interest. Applications will be distributed in Mid-November and at least 2 clinics will be selected.

Office of Developmental Programs Updates. Effective May 1, 2016, amendments to the Consolidated and P/FDS Waiver will:

- increase the number of participants from 13,300 to 13,900
- remove the provider self-assessment from monitoring (but add it to the qualification process prior to enrollment)
- Impose the 40 hour cap on services

- Increase the cap on incremental units (for 15 min units) from 480 to 1440, but the day limit of 40 hours remains
- Remove the ability for individuals to decline a referral to the Office of Vocational Employment
- Remove the 6 month evaluation for job hunting

HCBS Final Rule (Federal) Transition Plan Update. The Home and Community Based Services Final Rule State Transition Plan encompasses all nine 1915(c) waivers. The Transition Plan itself is a state document to determine compliance required by the federal government. The Plan presents a due date of March 17, 2019 (within 5 years of the rule effective date). The findings, in alignment of the federal rule, are included as Appendix I of the Transition Plan. There are no conflicts, only areas where information must be added. The statewide plan will include the waivers as an appendices for easy updates. The policy changes for the Office of Developmental Programs include updates to service definitions and updates to Chapter 51 state regulations (will be Chapter 61). The policy changes for the Office of Long Term Living include the Community HealthChoices MLTSS program and updated services definitions, standards, policies.

**DHS Posts Addendum to Office of Medical Assistance Programs FFS Clinical Review RFI.** The Department of Human Services has posted a Flyer/Addendum to solicitation RFI 2016 DHS OMAP FFS. The purpose of this Request for Information (RFI) is to gather information about state-of-the-art applications and systems capabilities and functionalities designed to streamline the process for clinical review of requests for prior authorization of services in the Department of Human Services (Department), Medical Assistance (MA) program, Fee-for-Service (FFS) delivery system. The Department currently requires approval of a broad array of healthcare services including inpatient hospital services, and outpatient medical, pharmacy, and dental services. Responses are due on February 26, 2016. Read More

**PA Insurance Commissioner Targets Surprise Balance Bills to Protect Health Care Consumers.** Insurance Commissioner Teresa Miller today announced a proposed solution to protect health care consumers from surprise balance bills and is soliciting public comment on the proposal. Surprise balance bills happen when a consumer receives emergency care or has made a good faith effort to use health care providers and facilities in the consumer's health insurance network, but has unexpectedly received a service from a provider or at a facility that is out-of-network, then receives a bill for that service. The goal of this proposal is to take consumers out of billing disputes between insurers and health care providers. The proposal provides several options for insurers and health care providers to reach agreement on payment. If the provider and insurer cannot reach an agreement on payment, the matter would go to arbitration. Both sides would submit their offers with supporting documentation, and the arbitrator's decision would be binding. In no case would the consumer be liable for anything beyond the cost-sharing due for the service if it had been rendered by an in-network provider. A link to the proposed solution and information on how to offer comments can be found at http://www.insurance.pa.gov, by clicking on "Proposed Balance Billing Solution." The deadline for offering comments is February 29, 2016. Read More

**Fines to Pennsylvania nursing homes increasing.** Data show the Pennsylvania Department of Health has quietly been increasing the penalties assessed to

substandard nursing home operators. The number of fines and provisional licenses for regulation violations among the 700 nursing homes more than tripled in the second half of 2015 from the first six months of the year, according to figures provided by the department. State Secretary of Health Karen Murphy said in a recent interview that nothing changed recently about the manner in which nursing homes are evaluated or penalized. She attributed the increase in fines and provisional licenses during Governor Tom Wolf's first year in office to a growing number of investigations stemming from public complaints about nursing homes, which rose to 2,598 last year from 1,943 in 2014. Dr. Murphy said she presumed the increase in complaints resulted from dropping a requirement imposed in 2012 that complainants had to identify themselves. Regardless of any quality indicators, Dr. Murphy acknowledged following the attorney general's lawsuit in July that review was warranted of how the health department performs its oversight function. Read More

## *Tennessee*

**Tennessee Hospital Association to Resume Push for Medicaid Expansion.** On January 26, 2016, the *AP/Baltimore Sun* reported that the Tennessee Hospital Association is planning a new effort to get Medicaid expansion passed in the state after legislation failed last year. The Association's president, Craig Becker, said the group is spending around $400,000 to found a nonprofit called Tennesseans for a Responsible Future, with the belief that once President Barack Obama is no longer in office, republican lawmakers in the state will be more willing to approve expansion legislation. The Association's member hospitals have pledged to fund the entire state share of the expansion costs. Read More

## *Utah*

**Lawmakers to Discuss Various Medicaid Expansion Plans During Legislative Session.** On January 24, 2016, *Deseret News* reported that state lawmakers will discuss Medicaid expansion during the Legislative session this year, despite years of never reaching a resolution. Multiple bills have been proposed, some looking for full expansion, while others are seeking waivers from the federal government. However, analysts are not confident that the coverage gap will be closed. Read More

## *Vermont*

**Governor Shumlin Proposes Medicaid Changes for Women and Independent Doctors to Fill Budget Gap.** On January 21, 2016, *VTDigger* reported that Governor Peter Shumlin's budget proposal would raise taxes on independent doctors and dentists, provide more low-income women with long-acting birth control, and cut some pregnant women from Medicaid to fill a Medicaid gap of $50 million to $60 million in fiscal year 2017. By providing long-acting reversible birth control to women who have just given birth, Shumlin plans to save $4.7 million in state and federal Medicaid dollars. He also hopes to save $2.25 million by moving lower-middle-income pregnant women off Medicaid. Women no longer eligible for Medicaid would need to buy their health insurance through Vermont Health Connect. Shumlin is also proposing a 2.35 percent provider tax

on independent doctors and dentists. The revenue would be used to increase reimbursement levels for providers who see Medicaid patients. Read More

## Virginia

**State Seeks Additional $110 Million for Services to Residents with Severe Disabilities.** On January 23, 2016, *The Washington Post* reported that to comply with a federal court settlement, Governor Terry McAuliffe's administration is seeking an additional $110 million in funding to provide more services for residents with severe disabilities. The state's waiting list currently has about 10,100 names. The Department of Behavioral Health and Developmental Services is also looking to expand services to families of the disabled; shut four institutions, and finance the construction of more homes or apartments for the disabled. The state has been struggling to comply with the terms of a 2012 federal court settlement. Read More

## Wyoming

**Committee Rejects Medicaid Expansion.** On January 20, 2016, *Casper Star Tribune* reported that a state legislative committee rejected Governor Matt Mead's Medicaid expansion proposal, voting to remove expansion out of the budget recommendations it will send to the Legislature. The Legislature can still consider a stand-alone bill or a proposed amendment to the budget recommendations. Read More

**Hospitals Concerned Over Medicaid Expansion Rejection.** On January 25, 2016, *Casper Star-Tribune* reported that state hospitals are losing over $100 million a year from uncompensated care. With the recent legislative rejection of Medicaid expansion, hospitals worry that if their losses continue, they will need to cut services or change ownership and management. If Wyoming approved Medicaid expansion, an estimated $268 million in federal funds would be available over the next two years. Read More

## National

**CBO Lowers Exchange Enrollment Projections.** On January 25, 2016, *CQ Roll Call* reported that the Congressional Budget Office is lowering its estimates for Exchange enrollment in 2016 from 21 million to 13 million. The CBO had previously estimated that around 15 million people would receive subsidized coverage in 2016 and that an additional 6 million people would purchase unsubsidized coverage through an Exchange. Revised estimates predict that 11 million people on average would get subsidized coverage and two million would buy unsubsidized coverage.

**HHS Report Finds Most Medicaid Children Not Receiving All Required Dental Care.** On January 25, 2016, *The Washington Post* reported that according to a federal report on California, Indiana, Louisiana, and Maryland, three out of four children covered by Medicaid are not receiving all the required dental care. Furthermore, one in four are not seeing a dentist at all. All four states reported that they do not routinely track whether children are receiving all the required services. The states also reported shortages of dental providers who accept Medicaid and challenges in educating families about the importance of dental

care. CMS is trying to work with states to decrease barriers and seeks ways to increase the number of providers. Read More

**Federal Standardization of Marketplace May Reduce Consumer Out-of-Pocket Spending.** On January 22, 2016, *Kaiser Health News* reported that a new analysis by Avalere found that the proposed 2017 federal marketplace standards could increase coverage of certain services and drugs, while lowering out-of-pocket costs for consumers. The proposed changes would create six plan options at the bronze, silver, and gold metal levels, each with standard deductibles, maximum out-of-pocket spending limits and copayments or coinsurance for various services. Primary care and specialist doctor visits and prescription drugs would not be subject to the deductible in the standard silver- and gold-level plans. Instead, consumers would pay a flat copayment for the visit. Read More

**Kaiser Survey Finds States Simplified Medicaid Sign-Ups and Renewals.** On January 21, 2016, Kaiser Health News reported that according to a Kaiser Family Foundation survey of 50 states, the process to sign-up or renew Medicaid has improved in the last few years. For instance, 49 states take online applications, up from 37 in 2013, and 49 states take applications by telephone, up from 15 in 2013. Medicaid enrollment is at nearly 72 million, up by over 13 million in the last two years. Additionally, 43 states this year used electronic data from sources such as the Internal Revenue Service and the Social Security Administration to verify an applicant's income. Read More

**Most States Turn to Telemedicine To Help Treat Prisoners.** On January 21, 2016, *The PEW Charitable Trusts* reported that many states are turning to telemedicine to treat prisoners, who are often in remote areas. This provides safety for doctors, lowers the cost of transporting prisoners to hospitals, and increases the pool of doctors willing to participate, which in turn makes health care more available to prisoners. Read More

**MACPAC Public Meeting Scheduled for January 2016.** MACPAC's first public meeting of the year has been scheduled for January 28, 2016. The agenda includes a review of a draft chapter in its March 2016 report to Congress on the affordability of children's coverage; presentation on a new analysis comparing low- and moderate-income families' out-of-pocket spending for employer-sponsored insurance with their out-of-pocket costs for separate CHIP programs; and a discussion on functional assessment tools that states use to determine eligibility for Medicaid long-term services and supports. Click here for the full agenda.

**CMS To Help Co-ops Find Investors.** On January 21, 2016, *CQ Roll Call* reported that CMS is looking to make it easier for private firms to invest in the remaining health insurance co-ops. CMS will issue a guidance to address financing for the co-ops. The agency has not addressed the pressing issue of risk adjustment. Co-ops asked CMS last year to be exempt from the program for three to five years, since many of their customers are relatively healthy.


## Industry News

**California Department of Insurance Holds Hearing on Centene-HealthNet Merger.** On January 25, 2016, *California HealthLine* reported a "wary and aggressive tenor" at the California Department of Insurance hearing regarding Centene's pending acquisition of HealthNet. The insurers and a panel of experts were questioned on the potential impact of market consolidation on premiums, as well as concerns that Centene might pull out of the individual and small group market in the state. The Department of Insurance is taking comments on the proposed acquisition through January 29, 2016. At this time, Insurance Commissioner Dave Jones did not give a timeline for a decision to approve the sale. Read More

# RFP Calendar

| Date | State/Program | Event | Beneficiaries |
|---|---|---|---|
| February 5, 2016 | Nebraska | Letter of Intent to Contract | 239,000 |
| February, 2016 | Pennsylvania MLTSS/Duals | RFP Released | 450,000 |
| 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 and 2015.

| State | Model | Duals eligible for demo | RFP Released | RFP Response Due Date | Contract Award Date | Signed MOU with CMS | Opt- in Enrollment Date | Passive Enrollment Date | Health Plans |
|---|---|---|---|---|---|---|---|---|---|
| **California** | Capitated | 350,000 | X | 3/1/2012 | 4/4/2012 | 3/27/2013 | 4/1/2014 | 5/1/2014<br>7/1/2014<br>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 17 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;<br>10/1/2013 | |
| ***Totals*** | **10 Capitated<br>5 MFFS** | **1.3M Capitated<br>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 | Jul-15 | Aug-15 | Sep-15 | Oct-15 | Nov-15 | Dec-15 |
|---|---|---|---|---|---|---|
| California | 120,452 | 117,449 | 117,307 | 117,179 | 116,538 | 115,743 |
| Illinois | 52,170 | 50,631 | 49,586 | 48,779 | 53,136 | 54,770 |
| Massachusetts | 17,671 | 17,518 | 17,179 | 12,657 | 12,366 | 12,285 |
| Michigan | 28,171 | 35,102 | 42,728 | 37,072 | 36,335 | 34,858 |
| New York | 7,122 | 9,062 | 8,028 | 9,942 | 8,005 | 6,811 |
| Ohio | 61,871 | 62,418 | 59,697 | 61,428 | 61,333 | 59,887 |
| South Carolina | 1,388 | 1,380 | 1,530 | 1,355 | 1,359 | 1,331 |
| Texas | 44,931 | 56,423 | 45,949 | 56,737 | 52,232 | 48,085 |
| Virginia | 29,507 | 29,200 | 29,176 | 27,138 | 28,644 | 27,103 |
| **Total Duals Demo Enrollment** | **363,283** | **379,183** | **371,180** | **372,287** | **369,948** | **360,873** |

# HMA NEWS

## HMA Information Services Adds Hospital, Provider Data

HMA Information Services, a leading subscription database of Medicaid and government-sponsored healthcare information, is expanding into the hospital and provider market.

HMAIS has recently added hospital and provider information in a dozen states, with others expected to come online in the weeks ahead. Data for each state includes rankings of acute care hospitals by Medicaid inpatient days and percentage of total bed days from Medicaid. Also included are historical Medicaid fee trends for more than 25 key physician procedures. HMAIS also has capitated rates paid to Medicaid managed care plans in states like Arizona, Florida, New Jersey, and Ohio; and accountable care organizations in states like Oregon.

Since its launch in January 2015, HMAIS has quickly become a leading source of Medicaid managed care information, including state-by-state breakdowns of Medicaid plan financials and enrollment; procurement documents like RFPs, responses, and scoring sheets; comprehensive RFP calendars; state budget documents; and proprietary overviews of state Medicaid programs in all 50 states and DC.

"We are adding hospital and provider information to meet the growing needs of the provider community for information on how to best serve vulnerable populations and manage risk in the Medicaid and government-sponsored markets," said Carl Mercurio, head of HMA Information Services.

For additional information or a demonstration of HMAIS, contact Carl at cmercurio@healthmanagement.com or 212-575-5929.

## HMA Collaborates with NYAPRS Collective on *Value-Based Payment, Partners, and Propositions* Conference

The New York Association of Psychiatric Rehabilitation Services (NYAPRS) Collective is collaborating with the Managed Care Technical Assistance Center (MCTAC) and HMA on a conference, *Value-Based Payment, Partners, and Propositions*, to be held January 28-29, 2016, in Saratoga Springs, New York. HMA's Meggan Schilkie, Art Jones, MD, Ellen Breslin, Juan Montanez, Deborah Zahn, and Sarah Barth will be joined by other state and national experts in a series of discussions that suggest how behavioral health providers can best position themselves and develop the right partnerships to thrive in a value-based payment environment. More information at http://www.nyaprs.org/

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

*http://healthmanagement.com/about-us/*

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