HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 17, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

CMS RELEASES REPORT ON DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATIONS

This week, our *In Focus* section comes to us from HMA Atlanta's Danielle Pavliv, who reviews a report published on January 21, 2016, by the Centers for Medicare & Medicaid Services (CMS) entitled *"Report on Early Implementation of Demonstrations under the Financial Alignment Initiative."* The report, which was prepared for CMS by RTI International, provides a preliminary update on the implementation status for the seven CMS Financial Alignment Initiative (FAI) demonstrations for Medicare-Medicaid enrollees (dual eligibles) implemented as of May 1, 2014. The report describes activities and experiences in implementing these demonstrations during the first six months of operations in each demonstration state, including successes and challenges encountered by states in aligning Medicare and Medicaid systems and policies. The report found several notable similarities among demonstrations:

- States reported that the upfront time and resource commitments required to implement the demonstrations were higher than expected.

Officials cited alignment of Medicaid eligibility, enrollment and data systems with those of Medicare as a significant barrier to implementation. State officials indicated they were unaware of the many applicable Medicare requirements, including IT system requirements and quality compliance rules.

- In capitated model demonstrations, joint State and CMS Contract Management Teams (CMTs) have been established and convene regularly to oversee and address administrative and operational issues in addition to care delivery and enrollee-specific concerns.
- States had to overcome challenges in identifying dual eligible beneficiaries and persuading enrollees and stakeholders of the benefits of an integrated service model.
- States have made significant investments in training care coordinators, providers, and Medicaid-Medicaid Plans (MMPs) on the special needs of dual eligibles.
- States have used CMS funds to establish or improve enrollment assistance and ombudsman programs to advocate for and support beneficiaries.
- Stakeholders are actively engaged and committed to ensuring that the demonstrations are transparent and address the needs of beneficiaries.

Background

Under the Financial Alignment Initiative, CMS made two financial alignment models available to States: (1) a capitated model in which health plans coordinate the full range of health care services, and (2) a managed fee-for-service (MFFS) model in which States are eligible to benefit financially from savings resulting from initiatives that improve quality and reduce costs. States covered in the report include:

- **Capitated model:** California, Illinois, Massachusetts, Ohio, Virginia
- **MFFS model:** Washington
- **Other model:** Minnesota

Integrating Medicare and Medicaid Systems

As of August 2014, 29 Medicare-Medicaid Plans (MMPs) had entered into three-way contracts with States and CMS. Three-quarters of the MMPs had previous Medicaid managed care experience, and nearly all had experience operating Dual Eligible Special Needs Plans (D-SNP) or another type of Medicare Advantage plan. However, MMPs varied in their experience with long term services and supports (LTSS) and with LTSS providers, creating challenges to integrating services and to administering LTSS benefits.

In several states, some providers – such as nursing facilities – were reluctant to partner with MMPs due to limited experience with managed care, citing prior authorization and billing procedures as obstacles.

In some States, MMPs decided to work together to address problems related to LTSS contracting and to share solutions. In Virginia, the three MMPs hired an attorney to work through antitrust issues; created common responses to providers on questions related to managed care; designed similar authorization

forms; and met with providers and beneficiaries to explain differences among MMPs.

State officials said addressing alignment of Medicare and Medicaid program policies, procedures, and systems has been more time consuming and required more financial investment than they expected, particularly related to modifications to management information systems required to conform to CMS requirements. Interviewees noted the importance of the role of the joint CMS-State Contract Management Team (CMT) in addressing issues related to the integration of Medicare and Medicaid policies and processes.

Enrollment and Opt-Out Observations

The six demonstrations covered in the report (enrollment data for Minnesota is not included) enrolled fewer beneficiaries than initially anticipated in the first 6 months of operations. In some areas, fewer MMPs participated in the demonstration than anticipated, limiting States' ability to implement passive enrollment, which requires at least two plans available to each beneficiary.

- States reported several reasons that beneficiaries opted out, including: satisfaction with their current care, providers not having contracted with the MMPs or encouraging beneficiaries not to enroll, and confusion about the demonstration.
- Additional reasons cited for low enrollment included: incorrect or outdated contact information for beneficiaries; and technological enrollment challenges, such as a lack of a platform for end-to-end testing, and challenges in reconciling their enrollment systems with those of CMS.

The most recent demonstration enrollments in the nine active capitated demonstration states include an estimated 370,000 total enrollees. These data, compiled by HMA, are presented in the following table.

State	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
California	117,307	117,179	116,538	115,743	125,257	127,084
Illinois	49,586	48,779	53,136	54,770	47,340	49,294
Massachusetts	17,179	12,657	12,366	12,285	13,146	12,787
Michigan	42,728	37,072	36,335	34,858	34,297	34,833
New York	8,028	9,942	8,005	6,811	6,242	6,029
Ohio	59,697	61,428	61,333	59,887	60,622	61,246
South Carolina	1,530	1,355	1,359	1,331	1,357	1,364
Texas	45,949	56,737	52,232	48,085	55,671	50,296
Virginia	29,176	27,138	28,644	27,103	28,844	27,298
Total Duals Demo Enrollment	**371,180**	**372,287**	**369,948**	**360,873**	**372,776**	**370,231**

Source: HMA Duals Demonstration Enrollment Tracking (State Reporting, CMS)

The CMS report provided the following observations on MMP enrollment by capitated model demonstration at the end of the first 6 months:

- Of eight operational MMPs in California, three plans each enrolled between 17 percent and 20 percent of demonstration enrollees.
- Of Illinois' eight MMPs, one plan enrolled slightly more than 20 percent of enrollees, and five plans each enrolled from 10 percent to 17 percent. HCSC led with 21 percent of enrollees, followed by HealthSpring and Humana at 17 percent and 16 percent, respectively.
- Two of the three MMPs enrolled 66 percent and 26 percent of demonstration enrollees in Massachusetts.

- One MMP of five in Ohio dominated the market with 44 percent of beneficiaries enrolled.
- In Virginia, three MMPs each had enrollment ranging from 20 percent to 42 percent. (HealthKeepers: 39 percent, Humana: 38 percent, Virginia Premier Health Plan: 23 percent.)

Variation in enrollment across plans reflects factors including covered geographic area, intelligent assignment algorithms, MMP capacity, and plans' existing Medicaid managed care enrollment.

Care Coordination

Several States identified the need to provide specialized training for care coordinators on beneficiary needs and their enhanced roles and responsibilities.

- Washington provided extensive statewide training for care coordinators.
- Massachusetts developed a training video for care coordinators and the LTS coordinators on the distinct roles and responsibilities of the LTS coordinator.
- California used grant funds from the Administration for Community Living to develop a training program for care coordinators focused on Alzheimer's disease.

The lack of trained care coordinators was also a common challenge during the early implementation phase, particularly in Ohio, Illinois, and Massachusetts.

Plans reported difficulty staffing to meet the demands of peak enrollment periods; as a result, many MMPs and health homes were not able to adhere to required timelines for assessment and care plan completion.

Beneficiary Safeguards and Protections

Enrollment Assistance. All demonstrations developed programs to help beneficiaries make enrollment decisions, with varying success.

- All capitated model demonstrations used an outside enrollment broker. Four states used the same enrollment broker as for their traditional Medicaid Managed Care program.

Ombudsman Program. All demonstrations, except for Minnesota, received Federal funding to develop an ombudsman program for the demonstration.

- Several states required the ombudsman program to be an independent entity, while other states augmented the scope of existing State ombudsman programs.
- Activities conducted by the ombudsman program varied but generally included outreach, advocacy, complaint resolution, and options counseling.

Continuity of Care. Under the demonstration, enrollees may, for a period of time, continue to see providers (including out-of-network providers) and receive services that were authorized before enrollment. California and Virginia have the longest continuity of care provision at 6 months (in California, for Medicare-only services); there is also a 12-month continuity of care for Medicaid services in California. The continuity of care provision in Illinois and Massachusetts extends until assessments and plans of care are completed.

Complaints, Grievances, and Appeals. Under capitated demonstrations, complaints must be tracked and entered into the CMS Complaint Tracking Module (CTM).

- There were limited appeals during the first 6 months, presumably because continuity of care provisions remained in effect for many beneficiaries during the first 6 months.
- There were a few variations in how States operate their appeals process, primarily pertaining to the path for resolving an appeal.

Beneficiary Focus Groups and Surveys. All demonstrations presented in this report have conducted or plan to conduct focus groups or surveys with enrolled beneficiaries.

Accountability and Transparency. States have established councils, committees, work groups, and websites to ensure transparency.

Next Steps for the Evaluation

RTI will produce three annual reports for each demonstration, and an annual cross-State report. These reports will contain greater detail about the demonstrations and their experiences and will be posted on the CMS website. RTI will also examine the experiences of beneficiaries, their families, and caregivers.

A detailed quantitative evaluation of quality of care, utilization and access, and cost will also be conducted as data become available. RTI will work with CMS to identify high-priority, policy-relevant populations to analyze for each demonstration.

Link to CMS/RTI International Report

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/MultistateIssueBriefFAI.pdf

HMA Medicaid Roundup

Alabama

Alabama's New Medicaid Managed Care Program Run by Hospitals and Local Providers. On February 17, 2016, *Kaiser Health News* reported that Alabama recently won federal approval to shift most of its Medicaid program to managed care. The state will not rely on insurance companies to run the program, but rather is handing the control to state hospitals and other local providers. The shift will bring the state an additional $328 million in federal funding over three years. Hospitals say the money they receive through managing the regional care collaborations will give them incentives to keep people healthy. Read More

Arizona

House Committee Passes KidsCare Bill. On February 10, 2016, *The Arizona Republic* reported that the Arizona House Health Committee passed a bill that would resume KidsCare enrollment and restore eligibility for families earning between 138 and 200 percent of the federal poverty level. The Committee added an amendment allowing administrators in the Arizona Health Care Cost Containment System to halt new applications if Medicaid officials learned that there was not enough funding to cover costs of the program. Enrollment for KidsCare was originally halted in 2010 and the program was ended in 2014. Arizona is the only state without a version of the Children's Health Insurance Program. Read More

California

HMA Roundup – Don Novo (Email Don)

Legislature Likely to Approve Health Care Plan Tax. On February 14, 2016, *San Jose Mercury News* reported that the California Legislature will vote on the health care plan tax this week; the tax would generate $1.27 billion annually. If approved, it would replace an existing tax on plans set to expire in July. The new tax would use $250 million of the revenue raised to restore funding for the In-Home Supportive Services program that was cut several years ago during the state's budget crisis. The tax would apply to 35 plans, including nine that do not accept Medi-Cal patients. Read More

California Shifts Health Plan Regulation From Department of Insurance To Department Of Managed Care. On February 8, 2016, *California Healthline* reported that the role of the California Department of Insurance in regulating health plans is shrinking; while it was responsible for regulating 71% of the

individual market in 2012, that number dropped to 18% in 2014. California is the only state in the U.S. with two health insurance regulators, with the Department of Insurance typically overseeing indemnity plans and PPOs and the Department of Managed Care monitoring HMOs and some PPOs. Critics say the dual system creates a diluted and inefficient regulatory authority in the state and can cause underpayments by plans. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Revised Timeline for Accountable Care Collaborative Phase 2.0. The Department of Health Care Policy and Financing has revised the timeline for implementation of Phase 2.0 of the Accountable Care Collaborative (ACC) by one year. Phase II of the ACC seeks to leverage the proven successes of Colorado Medicaid's programs to enhance the Medicaid client and provider experience. Phase II is based on three key principles:

- Person- and family-centeredness
- Delivery of outcomes and value
- Accountability at every level

A few of the key concepts of the ACC Phase II model include:

- Integrate physical and behavioral health care by contracting with one regional entity (the Regional Accountable Entity, or RAE --now known as the Regional Care Collaborative Organization or RCCO) that focuses on whole person care,
- Further advance coordinated care by supporting a system of multidisciplinary Health Teams that, based on a client's needs, can include specialty behavioral health providers, long-term services and supports case management agencies and certain specialists,
- Automatically enroll full-benefit Medicaid clients in the ACC, and
- Increase the use of value-based payment for both RAEs and providers.

Read More

Connecticut

Access Health CT Signs Up Over 116,000. On February 8, 2016, *Hartford Courant* reported that the state's exchange, Access Health CT, signed up over 116,000 residents in the most recent quarter. This figure includes 20,000 new customers, making this the most successful three-month period the state has ever had. State officials targeted certain ZIP codes to find uninsured residents. Efforts in these areas included meeting with community leaders and asking them to spread the word about how to sign up. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

House and Senate Budgets Show $400 Million Difference in Medicaid Funding. On February 10, 2016, *Naples Daily News* reported that the House and Senate began discussing their separate budgets, which show a $400 million gap in Medicaid funding, consisting of both state and federal dollars. The Senate provided an additional $200 million to increase hospital rates, meant to offset the Low Income Pool Fund. The House, however, chose to target the funds to smaller hospitals than directly support the pool fund. Read More

Lawmakers Express Concerns Over The State's Prison Health Care Contracts. On February 11, 2016, *Tallahassee Democrat* reported that Florida lawmakers are expressing concerns over the recent Department of Corrections deal with Centurion of Florida to provide health care in its prisons, noting that the deal was not properly vetted and includes provisions that could drive cost increases. Centurion replaced the agency's old vendor, Corizon Healthcare, and will be paid a maximum of $267.9 million a year to provide care to 82% of the state's inmates. Due to the "cost-plus" nature of the contract, Centurion will be paid for its actual costs such as salaries and benefits as well as for overhead and could end up making more than $30 million a year in profits. Although another prison health care vendor, Wexford Health Services, challenged the agency's selection and filed a bid protest, the Department of Corrections dismissed the protest, saying that the agency did not have to follow a competitive process under state procurement laws because the contract involved health services. Read More

Florida Healthy Kids Corporation Awards 2-Year Contracts To Argus Dental, DentaQuest, and MCNA Dental. On February 4, 2016, *Health Kids* reported that the Florida Healthy Kids Corporation's Board of Directors awarded 2-year contracts to 3 dental subcontractors: Argus Dental, DentaQuest, and MCNA Dental. The contracts will begin effective July 1, 2016 and will allow for two 1-year renewals at the end of the initial contract period. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia House Health Panel Passes Dental Hygienist Bill. On February 16, 2016, *Georgia Health News* reported that the House Health and Human Services Committee passed the bill allowing dental hygienists to practice in safety-net settings without a dentist present. It was previously reported that the bill had been tabled by the committee.

Idaho

Idaho Governor's Alternative to Medicaid Expansion Up For Review by Both Chambers. On February 11, 2016, *Idaho Statesman* reported that Governor Otter's proposed alternative to Medicaid expansion was introduced by the House Health and Welfare Committee Thursday. The $30 million plan, called the Idaho Primary Care Access Program, would cover primary care services by providing primary care clinics with $32 per month for each uninsured patient they treat. The proposal would not cover expensive treatments such as hospitalization and prescription medications. The plan would likely cost the state $19.3 million

during the first year, and $30 million annually thereafter. It must now clear both chambers before being sent to the Governor for approval. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Governor Rauner Presents FY 2017 Budget Proposal. On February 17, 2016, Illinois Governor Bruce Rauner made his FY 2017 budget address and released his budget proposal for the upcoming fiscal year. Governor Rauner has proposed a $91.7 billion budget for FY 2017, with more than $22.1 billion in funding to the Department of Healthcare and Family Services (HFS), which oversees the Medicaid program. A few key Medicaid-related budget items are detailed below.

- Governor Rauner's budget preserves all current eligibility levels and covered services.
- The proposed budget would shift $299 million in current long-term services and supports (LTSS) and other fee-for-service spending into managed care by the end of FY 2017.
- The proposed budget assumes a continued growth in managed care, with an estimated 68 percent of the population in managed care by the end of FY 2017, up from around 60 percent currently.
- HFS also seeks to expand community-based programs and integrate physical and mental health care coordination into community-based service delivery during fiscal year 2017.
- Under the Department on Aging, the Governor proposes $608.7 million in funding for the Community Care Program (CCP), which provides adult day and in-home services to Medicaid and non-Medicaid individuals who are 60 years or older. Additionally, the budget would create the Community Reinvestment Program (CRP) to provide a modified service package to non-Medicaid individuals meeting CCP level of eligibility.

The Governor's Budget and related materials are available here.

Iowa

Judge Rules State Had Right to Remove WellCare's Contract. On February 15, 2016, *The Des Moines Register* reported that a judge ruled WellCare failed to show the state acted improperly by terminating their Medicaid contract. The ruling allows Iowa to proceed with plans to privatize the Medicaid program. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Massachusetts Moves to Strengthen Oversight of Nursing Homes. On February 11, 2016, *Boston Globe* reported that state health regulators are moving to strengthen the oversight of nursing homes. Officials will create a unit that will conduct unannounced inspections and fine facilities experiencing problems. The

state will start imposing fines in March. Additionally, those seeking licensure to run nursing homes will be subject to stricter scrutiny. Meanwhile, consumers will have access to a new online system to file complaints and find more detailed information about nursing homes. Read More

Michigan

From the HMA Michigan Update: A Special Michigan Budget Update. On February 10, 2016, Governor Snyder released his budget for the coming fiscal year. The Executive Budget for fiscal year 2017 is $54.9 billion which reflects an increase of 0.9 percent ($438 million) in total funding and an increase of 1.5 percent ($145 million) in state general funds. The Governor's budget message identifies four challenges currently being faced by Michigan: Flint water crisis, statewide infrastructure, Detroit Public Schools, and specialty medications. The last of these four issues relates primarily to Medicaid, and is described below along with other key Medicaid issues addressed in the budget.

Funding for Specialty Drugs. With respect to specialty medications the budget indicates that the State's Pharmacy and Therapeutics Committee recently recommended coverage of additional drugs to treat Cystic Fibrosis and Hepatitis C. A recent legislative transfer authorized coverage of these drugs in the current fiscal year. The budget for FY 2017 includes the full year costs to cover Hepatitis C drugs for nearly 7,000 Medicaid enrollees ($91.5 million in state general funds) and 340 prisoners ($17.3 million in state general funds). Coverage of Orkambi for Cystic Fibrosis for approximately 320 children enrolled in Medicaid and/or Children's Special Health Care Services is budgeted at $43.7 million in state general funds.

The budget also adds a one-time cost to create a pharmacy reserve fund ($86.1 million total, with a state share of $30 million.) This reserve fund is for unanticipated needs that could occur during FY 2017 as new high-cost specialty drugs come to the market. More detail on specialty drugs is included in one of the FY 2017 Executive Budget Issue Papers.

Integration of Mental Health Services with Physical Health Services. The book that accompanies the Executive Budget includes a single paragraph on page B-30 related to "service integration". That document states the following:

"*The governor recommends that the state begin the process to better integrate mental and behavioral health services with a patient's physical health treatments. The governor expects to see improved coordination of care and a stronger focus on the needs of an individual patient by initiating a process by which all patient services are closely integrated. The budget recommendation asks the legislature and the health provider community to engage in an important conversation about integrating physical and behavioral health services into the larger consideration of patient need.*"

The language in the proposed budget is much more detailed and much stronger, beginning with the following statement: "Sec.8-298. (1) The department (of Health and Human Services) shall transfer the service funds appropriated in part 1 currently provided to PIHPs through the Medicaid mental health services, Medicaid substance use disorder services, Healthy Michigan plan - behavioral health and Autism services lines to the Health plan services line by September 30, 2017."

Section 8-298 indicates among other things that the department is to amend the contracts with the Medicaid Health Plans to include responsibility for the full array of behavioral health services, engage external stakeholders in the development of the integration plan, and contract with an administrative service organization to provide oversight and ensure continuity of care.

The budget requires that the HMOs contract with the existing Community Mental Health Service Providers (CMHSPs) for the provision of the behavioral health services. This proposed action would appear to eliminate the role of the Prepaid Inpatient Health Plans (PIHPs) that previously received the Medicaid funding for behavioral health services and contracted with the CMSHPs for the delivery of these services.

Healthy Kids Dental. The Governor's budget completes the expansion of the Healthy Kids Dental program to eligible children in all Michigan counties at a cost of $25.6 million (state share of $8.9 million). The final expansion group is children between the ages of 13 and 20 in Kent, Oakland and Wayne Counties.

Other Medicaid Changes. The total budget for physical health care for Medicaid enrollees is $14.27 billion, of which the state general fund share is $1.82 billion. Most changes in the Medicaid budget are technical adjustments, including the following:

- Both traditional Medicaid and the Healthy Michigan Plan have enrollment in the current fiscal year that is below budgeted levels.
- The federal share of Medicaid is reduced from 65.60 percent to 65.15 percent for FY 2017. The federal share of the Healthy Michigan Plan is reduced from 100 percent to 95 percent as of January 1, 2017, resulting in an approximate federal share of 96.25 percent for the fiscal year from October 1, 2016 to September 30, 2017.
- Fewer individuals dually enrolled in Medicaid and Medicare are choosing the Integrated Care Organizations (ICO) as part of the "duals demonstration" than was anticipated by the FY 2016 budget. As a result, $239.8 million is removed from the ICO line and the long term care services line is similarly increased.
- The federal requirement to eliminate the Use Tax on Medicaid HMOs and the PIHPs as of January 1, 2017 has a revenue implication for the state, but also reduces Medicaid and Healthy Michigan HMO costs by about $490 million (state share of $101 million) for the nine months from January to September of 2017.
- The budget assumes a 2 percent rate increase for HMOs for Medicaid and the Healthy Michigan Plan. However, the cost in FY 2017 is only 1.5 percent since those rates were rebased as of January 1, 2016.

One other programmatic change is that the Governor's budget expands funding for the Program of All-inclusive Care for the Elderly (PACE) from $66 million to $92.5 million. This proposed expansion allows for additional slots at current Michigan PACE sites and new slots in Jackson and Traverse City.

The Executive Budget and Issue Papers are available online from the State Budget Office.

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Governor Christie delivers FY17 budget address. On February 16, 2016 Governor Chris Christie delivered the budget address for Fiscal Year 2017. The budget calls for $34.8 billion in State appropriations. Of that more than a third or $13.3 billion will provide aid to schools, and to pension and health benefits payments. Here are some of the highlights:

- **Pension fund.** The budget includes a $1.9 billion contribution to the State's pension funds, an increase of $550 million from FY16. The Governor continues to advocate for lowering state taxes. To allow for this increase, the budget calls for $250 million in savings from state employee and retiree health care costs.
- **State employee health benefits.** The FY17 budget calls for reforms to provide for $450 million in state and local government savings.
- **Property tax relief, school and municipal aid.** It includes over $16 billion in direct and indirect property tax relief, including $13.3 billion in school aid, $1.5 billion in municipal aid, and $1 billion in direct property taxpayer relief programs.
- **Homestead Benefit.** The budget will provide over 440,000 seniors and individuals with disabilities with an average Homestead Benefit of $515, and more than 160,000 will receive an average Property Tax Freeze benefit of more than $1,200. More than 200,000 other homeowners earning up to $75,000 will receive an average of more than $400 in Homestead Benefits.
- **Homeless Program.** More than $17 million in State and Federal funding will be provided for the Division of Family Development's Social Services for the Homeless Program. The budget also commits $42 million for the State Rental Assistance Program, and over $14 million for homelessness prevention and emergency shelters. The Governor attributes these initiatives to lowering the number of homeless citizens by close to 14 percent between 2014 and 2015.
- **Mental health and substance use treatment.** It invests over $100 million in State and Federal funds to extend access to behavioral health care. The Drug Court Program will be funded at close to $64 million. And $25.8 million will support children with behavioral health and substance use needs.
- **Individuals with developmental disabilities (DD).** This group will receive an additional $48.8 million to create community placement and services to advance the State's commitment to transitioning individuals with DD out of institutional settings.
- **Women's services and domestic violence reduction.** The budget includes over $20 million to support these programs; $15 million will cover the Home Visitation Program for pregnant women and children.
- **GME in teaching hospitals.** Graduate medical education (GME) will receive $60 million.

- **Education.** Close to $9 billion is in place in aid to K-12 school districts, an increase of nearly $100 million. This will include funding to support Charter Schools including the opening of up to six new charter schools in FY17. Higher education will receive over $2.2 billion.

A complete copy of the budget address can be found here.

Governor Christie Proposes Hospital Cuts. On February 16, 2016, *Nasdaq* reported that Governor Chris Christie's proposed $34.8 billion budget plan includes steep cuts to state hospitals to fund charity-care cases. Hospital Alliance of New Jersey President, Suzanne Ianni, said the reductions will put hospitals serving the poor at risk. Read More

Bill A762 would establish a Prescription Drug Review Commission. On January 27, 2016 Assemblyman Paul Moriarty introduced A762 to establish a Prescription Drug Review Commission under the Division of Consumer Affairs that would develop a list of critical drugs for which drug manufacturers would "be required to report certain information concerning development, production, and marketing costs." If the Commission determines that a drug has an unnecessarily high cost, it would have the authority to establish a maximum price in New Jersey. The bill was referred to the Assembly Health and Senior Services Committee.

New York

HMA Roundup – Denise Soffel (Email Denise)

FIDA Rate Increase. CMS recently approved shared risk adjustment rate increases for FIDA plans. Historical under-prediction of what it costs to manage care for dually eligible individuals led CMS to adjust Medicare Part A and B rates. In Manhattan and the Bronx, the Medicare rate will increase by about 5.7 percent, and other areas throughout the FIDA region will see an increase of up to 10.5 percent. The rate increases will be retroactive to January 1, 2016.

Behavioral Health Carve-In Outside New York City. The Office of Mental Health has announced preliminary plan designation in response to the rest-of-state Request for Qualifications. As NY moves to carve all behavioral health benefits into the Medicaid managed care benefit package, every plan in the state has had to demonstrate its capacity to meet the behavioral health needs of all their members. In addition, plans have had the option of establishing a Health and Recovery Plan for their members with serious mental illness and/or substance use disorder. These designations were announced in New York City last fall; the current announcement addresses plans that do not operate in the city as well as plans that had been approved in the city that are seeking approval to operate in non-NYC counties. The table below provides information about each Medicaid managed care plan in the state, the type of designation it is seeking, and whether they are working with the support of a behavioral health organization. On-site readiness review is scheduled to begin in March 2016, with an anticipated start date of July 1.

Region	Plan Name	Designation Status	BHO
NYC and Upstate	Affinity Health Plan Inc	Conditional HARP	Beacon
NYC and Upstate	Empire Blue Cross Blue Shield HealthPlus (Formerly Amerigroup)	HARP	None
NYC and Upstate	Health Insurance Plan of Greater New York (Emblem)	HARP	Beacon
NYC and Upstate	HealthFirst PHSP Inc	HARP	
NYC and Upstate	NYS Catholic Health Plan Inc (Fidelis)	HARP	None
NYC and Upstate	United Healthcare Of NY Inc.	HARP	Optum
NYC and Upstate	WellCare of New York	Mainstream	None
NYC Only	AmidaCare Inc	HIV-SNP	Beacon
NYC Only	MetroPlus	HIV-SNP and HARP	Beacon
NYC Only	VNS Choice Select Health SNP	HIV-SNP	Beacon
Upstate Only	Capital District Physicians Health Plan	Conditional HARP	None
Upstate Only	Crystal Run	Conditional Mainstream	Beacon
Upstate Only	Excellus	Conditional HARP	Centene
Upstate Only	HealthNow	Conditional Mainstream	Health Integrated
Upstate Only	Independent Health Association	Conditional HARP	Beacon
Upstate Only	MVP	Conditional HARP	Beacon
Upstate Only	TotalCare(A Today's Option)	Conditional HARP	Beacon
Upstate Only	YourCare (Fomerly Univera)	Conditional HARP	Beacon

FLSA Funding. In response to Federal Labor Standards Act (FLSA) changes in rules addressing compensation requirements for overtime, travel time, and live-in services for home care workers, the Department of Health announced last fall that it would increase MLTC rates by 34 cents per personal care hour. At a recent meeting with health plans DoH explained that the FLSA adjustment is being made as an adjustment to MLTC base rates, based on a unit cost of 34 cents per hour, risk adjusted for each plan. DoH expects that funds issued to plans will be passed directly to providers in entirety. According to a summary prepared by LeadingAge NY, DoH noted that the initial FLSA adjustment will include the State share only, reflecting a six-month adjustment. Once the federal share is approved, DOH will recoup the State share advance and pay out the full amount. For providers delivering personal care on a fee-for-service basis (i.e., not through a managed care contract), the per-hour amount will be factored into rate adjustments, effective Oct. 13, 2015.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Comprehensive 1634 Program Overview Posted. The Department of Medicaid has posted a slide deck that walks readers through the upcoming change of Medicaid state status associated with the State's move to a single disability determination process. The deck includes anticipated policy changes and provides information on the Qualified Income Trust process that will enable many individuals to gain or maintain Medicaid eligibility. Read More

Ohio's PCMH model will be implemented statewide beginning in 2016, two years ahead of schedule. The Governor's Office of Health Transformation (OHT) announced January 14, 2016 that the Ohio Department of Medicaid will implement a Patient-Centered Medical Home (PCMH) model of care statewide in 2016. In the spring of 2015, OHT convened a PCMH design team to develop a payment model that financially rewards primary care practices that hold down the total cost of care by preventing disease and managing chronic conditions. OHT engaged an active stakeholder process that includes Medicaid and commercial health insurance representatives, including patients, primary care

practices and health plans. Stakeholder feedback that the model should be implemented statewide as soon as possible prompted the announcement that the PCMH model will be implemented statewide beginning 2016, two years ahead of schedule. Read More

Oklahoma

Governor Fallin Rejects Mental Health Proposal That Would End Medicaid Payments for Private Counselors. On February 16, 2016, *KFOR* reported that the Oklahoma Department of Mental Health and Substance Abuse Services' proposal to end Medicaid payments for private counselors was rejected by Governor Mary Fallin. The Oklahoma Health Care Authority stated the cuts were necessary to balance its budget. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Governor Wolf announces proposed 2016-2017 Budget. Governor Wolf was in the unusual position of announcing his proposed 2016-2017 budget while the Commonwealth still has an incomplete 2015-1016 budget. Ahead of Governor Tom Wolf's 2016-17 budget address, Budget Secretary Randy Albright briefed reporters on the contents of the governor's proposal, which calls for a $32.7 billion total spend in the upcoming fiscal year, not including more than $560 million set aside for the Public School Employees Retirement System (PSERS). Outlining the broad strokes of the governor's proposal, Sec. Albright said the $32.7 billion total spending figure is driven by $1.6 billion in mandated spending increases, including $100 million in debt obligations, $178 million for corrections spending, $800 million for human services and $500 million in rising pension costs. To the human services increases, Sec. Albright explained the $800 million total includes a required increase in state spending as a resulting of larger federal reimbursements for Medicare and Medicaid. Following Governor Tom Wolf's budget address today, Department of Human Services (DHS) Secretary Theodore Dallas briefed reporters on the department's 2016-17 executive budget. Sec. Dallas then outlined some of the major initiatives included in the department's proposed budget. He said that one of the major initiatives is $43.1 million to develop Community HealthChoices, the Governor's plan to increase opportunities for older Pennsylvanians and individuals with physical disabilities to remain in their home and $48.3 million to provide home-and community-based services. To combat the Commonwealth's heroin epidemic, the budget includes $34.2 million to implement 50 Health Homes to treat more than 11,250 individuals with opioid-related substance use disorder. Sec. Dallas explained that the plan is to have 25 Health Homes licensed by July 1 of this year and the remaining 25 licensed by January 1, 2017. Other initiatives include:

- Restoring $27.9 million to human services appropriations originally subject to a ten percent reduction in Fiscal Year 2012-13
- $12.3 million to provide home- and community-based services for an additional 850 individuals with intellectual disabilities and autism
- $10 million to increase support to families through evidence-based home visiting services

- $12 million to provide access to an additional 2,247 children to safe and reliable child care.

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PA Medical Assistance Advisory Committee (MAAC): Subcommittee Meetings. Community HealthChoices Update: On February 9, 2016 the Long Term Care Subcommittee of the MAAC met. A brief update on the upcoming managed long term services and supports procurement was provided. The current tentative release date for the Community HealthChoices RFP is February 22, 2016. The RFP will be open for 60 days and the current timeline calls for awards to be made in late May.

Integrated Care Program Update: On February 11, 2016, the Managed Care Delivery System Subcommittee of the MAAC met. A large portion of the meeting was spent on discussing the transmission of data for the Integrated Care Plan (ICP) initiative. Data transmissions from the physical health managed care plans have been on hold since April 2015 for the program. There is concern for the high degree of scrutiny and confidence level in assuring that confidential and protected SUD and HIV information has been removed from all applicable records in which consent forms have not been collected. Data could appear in many forms, some apparent, and therefore easier to remove, such as diagnosis. Other data could require manual effort, such as discharge notes, and are more likely to remain in a record in error. The behavioral health and physical health plans have agreed to meet together with legal representatives to discuss how to move forward. The Managed Care Delivery System (MCDS) Subcommittee will also be making a recommendation to the MAAC to collect the information at the point of application for Medicaid benefits to minimize instances of absence of signed consent, when consent is amendable to the consumer.

Pennsylvania Launches Electronic Portal for Faster, More Efficient Provider Enrollment. Governor Wolf's Office of Transformation, Innovation, Management, and Efficiency (GO-TIME) and the Department of Human Services (DHS) have launched an electronic provider enrollment application, improving customer service for health care providers in Pennsylvania's Medical Assistance (MA) program. According to DHS, improvement in the process will lead to more options for Medicaid recipients. The electronic portal will automate enrollment and allow MA providers to complete new applications and submit federally mandated revalidation and reactivations through a secure online portal. Other key improvements include:

- Allowing documents that previously had to be mailed or faxed to be uploaded directly to the portal
- Permitting providers see the status of their submission
- Decreasing DHS' time to review applications

New practitioners and providers need to be enrolled in the MA program before they can deliver services to recipients. To access the electronic provider enrollment application, click here. Read More

Utah

Lawmakers Review Four Medicaid Expansion Plans. On February 15, 2015, *The Washington Times* reported that lawmakers are looking at various Medicaid expansion plans, but have yet to vote. Representative Jim Dunnigan's proposal would cover 16,000 people, who are mostly childless adults who are homeless or on the verge of homelessness. Representative Ray Ward's proposal would cover 125,000 people earning up to 138 percent of the federal poverty level, providing them with private insurance by hospital and e-cigarette taxes. Senator Brian Shiozawa's plan would cover those up to the poverty line. Senator Gene Davis' proposal would expand traditional Medicaid to everyone earning up to 138 percent of the poverty level. Read More

National

Insurers Under Pressure to Improve ACA Plan Margins After Losses in 2014, 2015. On February 10, 2016, *The Wall Street Journal* reported that although the Affordable Care Act added many new enrollees for insurers, much of the growth has been unprofitable leaving insurers under pressure to improve margins. In 2014, 70 percent of insurers lost money on individual plans. Over the first three quarters of 2015, nonprofit Blue Cross and Blue Shield insurers had approximately $20.4 billion in individual plan premiums, but incurred $20.7 billion in medical claims. UnitedHealth is considering withdrawing from the exchanges; it reported losses of $475 million on 2015 ACA plans, and is projecting losses of $245 million in 2016. Read More

CMS Will Pay Exchange Plans $7.7 Billion In Reinsurance. On February 12, 2016, *Modern Healthcare* reported that CMS released a memo Friday stating that it expects to pay out $7.7 billion in reinsurance for insurers that sold plans on the exchanges in 2015. The Affordable Care Act created the temporary, three-year reinsurance program to protect insurers during their initial years on the exchanges. Insurers pay into the reinsurance pool and those funds are paid out to health plans with exceptionally high medical claims. Last year, CMS increase the program's payout rate because it received more money than payment requests. This year, using newly collected reinsurance funds and $1.7 billion in unused funds from last year, CMS plans to pay out a total of $7.7 billion. Read More

Industry News

Pfizer Settles Unpaid Medicaid Rebates Claim for $784.6 Million. On February 16, 2016, *USA Today* reported that Pfizer settled the long-running case involving Wyeth's, acquired in 2009, calculations for Medicaid rebates for its drug Protonix, between 2001 and 2006. Pfizer will pay $784.6 million to resolve the unpaid rebates. The lawsuit claimed Wyeth violated the law by not offering to Medicaid the discounts it had given to hospitals on its heartburn drug Protonix. The Justice Department estimated total damages could be over $2 billion. Read More

Community Health System's Shares Plummet as Revenue Falls in 4Q. On February 16, 2016, *The Wall Street Journal* reported that Community Health System's shares fell 22 percent and are down over 75 percent since a June 2015 high. Revenue in the last quarter of 2015 fell 2.4 percent compared to the same period in 2014. Tenet Healthcare also saw shares plummet in recent months to its lowest levels since 2012. "Analysts say hospital stocks' recent declines are propelled by concerns about corporate debt in an industry that has seen a recent flurry of merger-and-acquisition activity, dwindling benefits from the health law, and new questions about the strength of the economy." Read More

Amedisys Acquires Associated Home Care. On February 11, 2016, *Modern Healthcare* reported that the home health and hospice company Amedisys has agreed to acquire Associated Home Care for up to $38 million, with a close date of March 1. Associated Home Care is based in North Andover, Massachusetts and cares for 5,000 elderly clients in the state. The Company's CEO, Michael Trigilio, could be eligible for up to $10 million of the acquisition amount in additional payments based on the company's earnings during the first 5 years of the deal and is contingent on his employment. Such additional payments are uncommon in deals made by healthcare service companies due to the risk that they may violate fraud and abuse laws, however are sometimes used to encourage growth through acquisitions. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
March 1, 2016	Iowa	Implementation	550,000
March 3, 2016	West Virginia	Proposals Due	450,000
March 15, 2016	Nebraska	Contract Awards	239,000
March 29, 2016	Minnesota SNBC	Proposals Due	45,600
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
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
April 22, 2016	Minnesota SNBC	Contract Awards	45,600
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
July 1, 2016	Missouri (Statewide)	Proposals Due	700,000
July 1, 2016	West Virginia	Implementation	450,000
July 1, 2016	Minnesota SNBC	Impementation (Northern Counties)	45,600
July, 2016	Georgia	Implementation	1,300,000
August, 2016	Oklahoma ABD	RFP Released	177,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Oklahoma ABD	Proposals Due	177,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Released	30,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
March 1, 2017	Virginia MLTSS	Implementation	130,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
TBD 2017/2018	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 IMPLEMENTATION STATUS

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Feb. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	431,000	127,084	29.5%	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)
Illinois	Capitated	4/1/2014	6/1/2014	148,000	49,294	33.3%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	94,000	12,787	13.6%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	34,833	33.2%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	6,029	4.9%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
Ohio	Capitated	5/1/2014	1/1/2015	95,000	61,246	64.5%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island*	Capitated	12/1/2015	2/1/2016	30,000			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	1,364	2.5%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	50,296	29.9%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	27,298	38.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,319,100**	**370,231**	**28.1%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA NEWS

New this week on the HMA Information Services website:

- **Arizona** Medicaid Managed Care Enrollment is Flat, Feb. 2016
- **Colorado** Medicaid RCCO Enrollment Share by Plan, 2015 Data
- Public documents such as the **Virginia** Delivery System Transformation 1115 Waiver Application and the **Washington** Apple Health Southwest Region RFP Data Book
- Plus upcoming webinars on "*Value-Based End-of-Life Care: Having the Conversation Nobody Wants to Have Benefits Everybody*" and "*MLTSS Network Adequacy: Meeting the Access Requirements of an Emerging Market*"

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.

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