HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

CMS RELEASES INITIAL FINDINGS ON WASHINGTON DUALS DEMONSTRATION

This week, our *In Focus* section follows last week's Centers for Medicare & Medicaid Services (CMS) report on initial findings across the Medicare-Medicaid Financial Alignment Initiatives with a look at the initial findings on the Washington managed fee-for-service (MFFS) demonstration. CMS has published a January 4, 2016, report, "*Measurement, Monitoring, and Evaluation of the Financial Alignment Initiative for Medicare-Medicaid Enrollees Preliminary Findings from the Washington MFFS Demonstration,*" also prepared by RTI International. The report presents preliminary findings from the Washington MFFS demonstration, which, a year-and-a-half after launching, has enrolled more than 10,000 dual eligible beneficiaries and generated Medicare savings in excess of $21 million.

MFFS Demonstration Model

The Washington Health Home Program is one of only two active MFFS demonstration under the CMS Medicare-Medicaid Financial Alignment Initiative program (the other MFFS state being Colorado). Under the MFFS model, Washington and CMS have entered into an agreement making the state eligible to receive performance payments based on achieving savings and quality measures. Washington has targeted its Health Homes MFFS demonstration to high-cost, high-risk Medicare-Medicaid enrollees based on the principle that focusing intensive care coordination on those with the greatest need provides the greatest potential for improved health outcomes and cost savings. In the Washington MFFS demonstration, health homes are responsible for organizing enhanced integration of primary, acute, behavioral, and LTSS services for Medicare-Medicaid beneficiaries.

Eligible and Enrolled by Demonstration Quarter

Washington launched the MFFS demonstration on July 1, 2013, expanding to all but two counties (King, Snohomish) on October 1, 2013. To be eligible for the demonstration, individuals must meet health home eligibility criteria, with one chronic condition and determined to be at risk for a second. Medicare Advantage and PACE enrollees are excluded from the demonstration.

As of the end of December 2014, more than 10,600 out of nearly 19,700 eligible duals were enrolled in the MFFS demonstration.

	DQ1 Jul.-Sept. 13	DQ2 Oct.-Dec. 13	DQ3 Jan.-Mar. 14	DQ4 Apr.-Jun. 14	DQ5 Jul.-Sept. 14	DQ6 Oct.-Dec. 14
Eligible for Demo	7,538	16,176	17,647	18,133	19,122	19,667
Enrolled in Demo	178	2,045	4,136	5,767	7,801	10,632
% Enrolled	2.4%	12.6%	23.4%	31.8%	40.8%	54.1%

Of the enrolled population, around 54 percent were ages 65 or older, with 46 percent ages 18 through 64. Diabetes was the highest occuring chronic condition (57.4 percent), followed by congestive heart failure (43.9 percent), COPD (39.7 percent), severe and persistent mental illness (26.4 percent), and substance use disorder (19.8 percent).

Medicare Savings Achieved

Nearly all of the demonstration enrollees in the Medicare savings calculations (more than 96 percent) are included in Cohort 1 in the table below, which includes those beneficiaries first eligible for enrollment between July 2013 and the end of December 2013. Cohort 1 enrollees were found to have average per-member- per- month (PMPM) savings of $121, a 7.2 percent savings, and generated nearly $23 million in total savings under the demonstration. These savings were offset slightly by the Cohort 2 and Cohort 3 enrollees who became eligible in 2014. Overall, in the initial six Demonstration Quarters, the Washington demonstration has generated $21.6 million in total savings, a 6.1 percent reduction in target costs.

Cohort (First Eligible Dates)	Eligible Months	Target PMPM	Actual PMPM	PMPM Savings	Total Savings	% Savings
1 (July 2013 - Dec. 2013)	190,719	$1,793	$1,672	$121	$22,981,640	7.2%
2 (Jan. 2014)	1,204	$1,520	$1,739	($219)	($263,925)	-12.6%
3 (Feb. 2014 - Dec. 2014)	5,077	N/A	N/A	($219)	($1,112,726)	N/A
Total Demonstration	**197,000**				**$21,604,989**	**6.1%**

The majority of savings for Cohort 1 ($14.4 million, 19.1 percent savings) came from the professional service category, which includes noninstitutional providers such as physicians, physician assistants, clinical social workers, and nurse practitioners as well as claims for free-standing facilities such as independent clinical laboratories, ambulance providers, and ambulatory surgical centers. In terms of percentage savings, hospice costs were down 57.2 percent ($4.2 million), home health costs were down 37.5 percent ($7.8 million), and durable medical equipment costs were down 19.2 percent ($3.4 million).

Early figures for Cohort 2 showed similar percentage savings in home health and hospice costs, but an overall increase in professional services. However, Corhort 2 did show a nearly 25 percent reduction in skilled nursing facility (SNF) costs.

Link to Washington MFFS Report

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

HMA Medicaid Roundup

Arkansas

Governor Hutchinson to Negotiate Changes to Medicaid Expansion Program as Waiver Set to Expire in 2016. On February 1, 2016, *Kaiser Health News* reported that as the Arkansas Medicaid expansion waiver is set to expire at the end of 2016, Governor Hutchinson is seeking to negotiate alterations to the program with CMS. Hutchinson is looking for additional GOP-friendly changes to the state's "private option." His proposed new policy is called "Arkansas Works." Read More

California

HMA Roundup – Don Novo (Email Don)

Regional Centers' Privatization Could Force Families of Autistic Children to Find New Providers. On February 24, 2016, *California Healthline* reported that the Department of Health Care Services will begin the transition of 21 regional centers that provide services for people with developmental disabilities to managed care on March 1. State officials say the centers will continue to serve children and children will not experience a disruption in service – no one will lose a provider without another one lined up. However, children's health advocates say half of the providers who work with the 9,000 children with autism at the state's regional centers could be excluded from seeing those kids. The state's new rules seem to exclude longtime providers from payment unless they are supervised by people with newer credentials. Read More

Tax on Health Care Plans Close to Final Vote. On February 22, 2016, *The Sacramento Bee* reported that Democrats are optimistic that the health care plan tax is close to approval. The bill would broaden an existing tax on health plans to help pay for health care for the poor, netting the state an estimated $1.3 billion in federal matching money. Additionally, the tax would allocate $287 million on services for the developmentally disabled and forgive a debt to the state by hospital-based, skilled-nursing facilities. The $287 million would pay for a 7.5 percent compensation increase for employees, as well as a 2.5 percent rate increase for regional center administrative costs, among other rate hikes. The bill needs a two-thirds approval in both houses to pass. Read More

Covered California May Tighten Rules on Special Enrollment Periods. On February 19, 2016, *California Healthline* reported that Covered California officials proposed new rules to tighten special enrollment periods by making consumers provide documentation proving they're eligible. Insurers said that currently, consumers are abusing the process since no documentation is necessary of a

"qualifying life event," such as marriage, divorce, loss of health insurance, etc. The Covered California board of directors is expected to vote on the proposal in April. If approved, it is expected to take effect in June. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Hospitals Oppose Introduced Legislation That Would Replace Hospital CONs With Permits. On February 21, 2016, *Georgia Health News* reported that a bill introduced in the General Assembly would eliminate the state's current certification of need, or CON, which plays a role in health care facility construction in the state. House Bill 1055 would eliminate CON and set up a system under which health care facilities could apply for a permit if they make a pledge to provide care for the state's Medicaid and uninsured populations. Passage of the bill would allow hospitals to build new facilities as long as they have a state permit and allow physicians to run multi-specialty surgery centers, which they are currently banned from doing. However, it is late in the General Assembly session for a bill such as this to start through the legislative process, and opponents in the Georgia hospital industry have mobilized against the proposal. Read More

Persons with Disabilities Bill Passes House. On February 23, 2016, *Georgia Health News* reported that a bill to allow tax-exempt saving accounts for people with disabilities passed the state House unanimously. The ABLE (Achieving a Better Life Experience) Act will help people with disabilities to live independently and not lose their Medicaid health insurance or Supplemental Security Income (SSI) benefits. Currently, disabled individuals can only have $2,000 or less in assets in order to retain Medicaid and SSI. An ABLE account will allow contributions up to $14,000. The bill now heads to the Senate. Read More

Senate Committee Holds Hearing on Medicaid Expansion Proposal. On February 17, 2016, *Georgia Health News* reported that the Senate Health and Human Services Committee held a legislative hearing on a proposal for a Medicaid expansion alternative. Experts say this this is the first time an expansion bill gained a hearing at the General Assembly since the Affordable Care Act was passed in 2010. The bill did not use the term "Medicaid expansion" but rather called for a premium assistance program for people who earn 138 percent of the federal poverty level or less. Read More

Idaho

State Dentists Not Seeing Medicaid Patients Due to Low Reimbursements. On February 17, 2016, *Idaho Statesman* reported that Idaho dentists are pushing for higher Medicaid reimbursement rates. Over the past 10 years, rates have dropped by 25 percent. The low pay is driving down the number of dentists willing to accept Medicaid patients. Currently, there are 500 dentists in the state who accept Medicaid patients and nearly 200 of them are no longer accepting new Medicaid patients. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Two ACEs to Transition nearly 140,000 Members to Meridian Health Plan. On February 18, 2016, Advocate Health Care and Meridian Health Plan announced an agreement to transition Advocate's 96,000 Medicaid Accountable Care Entity (ACE) members to Meridian, beginning April 1, 2016. Advocate had previously announced its intentions to transition to a full-risk Managed Care Community Network (MCCN). Read More. On February 23, 2016, Community Care Partners (CCP) and Meridian announced an agreement to transition 41,000 CCP members in northern Cook and Lake Counties to Meridian, beginning May 1, 2016. CCP is comprised of NorthShore University Health System, Erie Family Health Center, Lake County Health Department and Community Health Center and Vista Health System. Read More

NextLevel Health Completes MCCN Transition. On February 23, 2016, NextLevel Health announced that it has completed all state requirements and successfully transitioned to a Managed Care Community Network (MCCN). NextLevel Health will continue to be available to newly eligible ACA adults and non-dual seniors and persons with disabilities (SPDs) as a full-risk Medicaid health plan, and will begin serving the traditional Family Health Plans (mothers and children) population on March 1, 2016. As of January 2016, NextLevel Health enrolled just over 4,200 SPD members and more than 15,000 ACA adults in Cook County. Read More

Iowa

CMS Approves Medicaid Privatization Plan; Sets Implementation Date. On February 23, 2016, Governor Terry Branstad announced that CMS approved the state's plan to shift Medicaid to managed care. CMS and Iowa agreed on an implementation date of April 1, 2016. The CMS letter to the state can be found here. Read More

Louisiana

Baton Rouge Area Foundation and HMA Unveil Mental Health Strategy. On February 22, 2016, *Business Report* reported that the Baton Rouge Area Foundation, in conjunction with Health Management Associates, unveiled a mental health strategy to save the city-parish money and reduce the population of the East Baton Rouge Parish Prison. The report, titled "Initiative to Decriminalize Mental Illness: Recommendations for a Treatment Center and Continuum of Care," calls to fix the issue of inadequate mental health services by creating a nonprofit organization to operate a diversion center where law enforcement could bring the mentally ill as opposed to emergency rooms or East Baton Rouge Parish Prison. The center would be funded by Medicaid expansion dollars and other funding streams. Read More

Louisiana's Safety Net Hospitals Consider Ending Contracts with the State due to Budget Cuts. On February 17, 2016, *The Times-Picayune* reported that several of Louisiana's privatized safety net hospitals are considering abandoning their contracts with the state. Seven of the hospital CEOs told Senate Finance members that the $137.8 million proposed cuts being discussed

in the legislature would hinder the hospitals' ability to deliver care to the poor and uninsured. The threat of canceling contracts could create issues for Legislators looking for a way to close the state's $940 million budget gap if the contracts are canceled and complaints about layoffs and access to care arise. Read More

Maine

Maine Begins Sixth Effort to Expand Medicaid. On February 23, 2016, *Bangor Daily News* reported that Senator Tom Saviello proposed to expand Medicaid in order to increase access to mental health counseling, drug addiction treatment, and preventative health care. This will be the sixth effort since 2013 to expand Medicaid. The state is currently dealing with an opioid addiction crisis and an increase in drug-related crime. Approximately 60 percent of inmates in county jails were incarcerated for addiction-related crimes, and 40 percent suffered from mental illnesses. Read More

Maryland

Carroll County to Begin New Funding Plan for Substance Abuse Services in July. On February 22, 2016, *The Washington Post* reported that Carroll County will pilot a new funding model to treat substance abuse in the state. The change calls for the involvement of private health care providers, who are then reimbursed by the state. Currently, funding is at the county level, using a fee-for-service model. The rest of the state is scheduled to make the switch in January 2017, although local health departments have requested an extension. The switch was originally scheduled to take place in July 2015. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Update on the transportation broker RFP, Proposal Number 17-X-23318. On February 24, 2015, the Department of Treasury, Division of Purchase and Property issued an Addendum to the Transportation Broker Services RFP with a revised proposal submission due date. Proposals were previously due on February 24, 2016 and are now due on March 8, 2016. The Addendum also provided responses to 49 questions received about the RFP. Additional RFP Exhibits were released with the Addendum and include:

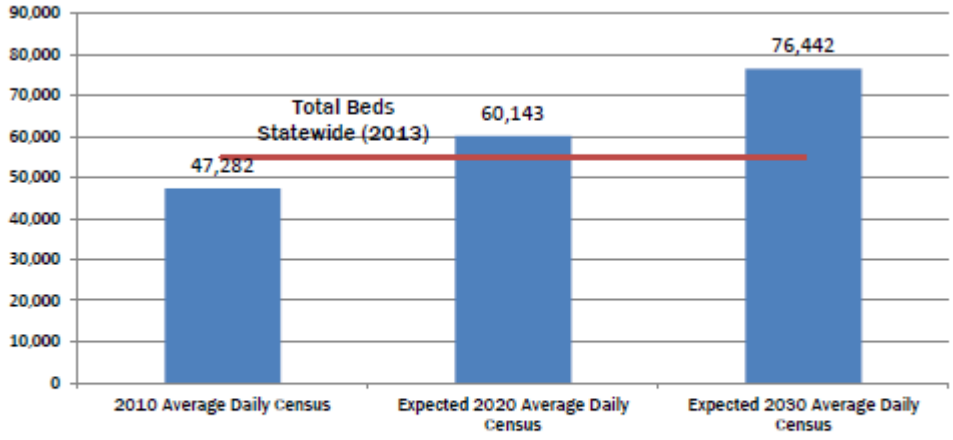
- Exhibit E: Verified Paid Trips by County by Level of Service
- Exhibit F: Number of Complaints in 2015
- Exhibit G: Population by Month from September 2014 – November 2015
- Exhibit H: Call Center Statistics in 2015
- Exhibit I: Out of State Trips from July 2011 – December 2015

New Jersey Hospital Association releases report on economic impact of nursing homes. On February 17, 2016 NJHA reported that the state's nursing homes account for $5.4 billion in expenditures throughout the state, employ nearly 56,000 people, contribute at least $116 million in state income taxes and provide $2.1 billion in salaries, according to 2013 financial data from the Centers for Medicare and Medicaid Services (CMS). It found that 59 percent of nursing home reimbursements come from Medicaid and about 16 percent come from

Medicare. The report was conducted to underscore the economic impact the nursing home industry has on the state.

It notes that while the state is working to reduce reliance on institutional long term care under Medicaid's managed long term services and supports program, demographic trends suggest that nursing home bed capacity should remain stable to care for the most senior and frail state residents (see chart).

COMMUNITY NEED



The need for nursing home services statewide will continue to increase as the Baby-Boom generation ages.

A copy of the report can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

PACE Request for Information. In response to federal changes in the Program of All-inclusive Care for the Elderly (PACE), New York State (NYS) has released a Request for Information. The PACE Innovation Act allows providers who are not currently PACE providers to consider adapting the model to serve new populations in innovative ways, consistent with the Balancing Incentive Program, MRT initiatives, and the Olmstead Act, all of which encourage the provision of long term services and supports in the least restrictive setting possible. The RFI is intended to help the Department of Health (DoH) develop a comprehensive analysis of PACE and its current role in the provision of LTSS, as well as develop strategies to expand the current PACE model. The RFI seeks input from all interested parties, including current PACE providers, organizations interested in becoming PACE providers, individuals or family members of individuals currently enrolled in PACE, and DSRIP Performing Provider Systems. The RFI can be found on the MRT website, here.

Enrollment through the NY Health Exchange. NY State of Health, the state's official health exchange, announced that more than 2.8 million people had signed up for health insurance as of January 31, 2016, the end of the 2016 open enrollment period. This includes almost 380,000 people enrolling in the Essential Plan, New York's new Basic Health Program. Since the Marketplace opened in 2013, the number of uninsured New Yorkers has declined by nearly 850,000. The

press release notes that, per CDC statistics, the rate of uninsured in NYS declined from 10 percent to 5 percent between 2013 and September 2015 and is at its lowest level in decades.

The breakdown of NY State of Health enrollees as of January 31, 2016, the end of open enrollment, is as follows:

- Total enrollment: 2,833,823
- Total Medicaid enrollment: 1,966,920
- Total non-Medicaid enrollment: 866,903
    - Essential Plan: 379,559
    - Qualified Health Plan: 271,964
    - Child Health Plus: 215,380

SUNY Procurement. The State University of New York (SUNY) has announced its intentions to procure the services of a consulting firm with expertise in healthcare financial advisement and analysis, financial modeling, and experience with current NYS initiatives, including: DSRIP. The firm will be responsible for creating a predictive financial model to analyze the financial effects of changes in state and federal reimbursement, especially focused on, but not limited to, possible changes in Medicaid Disproportionate Share Hospital (DSH) funding, the Accountable Care Act, Health Homes, DSRIP and Medicaid redesign. SUNY operates three hospitals in NYS which are all part of the larger State University Health Science Centers at Brooklyn, Stony Brook and Syracuse. Information about the procurement can be found here. Proposals are due by March 9, 2016.

DSRIP Mid-Point Assessment. As part of the Delivery System Reform Incentive Payment program (DSRIP), NYS is required to conduct a Mid-Point Assessment. The Mid-Point Assessment is intended to evaluate Performing Provider Systems' (PPS) compliance with the approved DSRIP Project Plan and to assess PPS progress towards meeting DSRIP milestones and measures. The state has released a document outlining an overview of the process it anticipates using to complete the Mid-Point Assessment, which is scheduled to begin with the PPS submission of the DSRIP Year 2, Quarter 1 PPS Quarterly Report by July 31. The expectation is that any Project Plan modifications that result from the Mid-Point Assessment can be implemented by March 31, 2017 for the start of DSRIP Year 3. The state has opened a 30 day public comment period on its proposed Mid-Point Assessment. The assessment will review each of the projects undertaken by the 25 Performing Provider Systems. It will focus on the progress the PPS has made towards the completion of project milestones and measures. While it is not expected that PPS will have completed all of the project requirements at the Mid-Point Assessment, it is important that the PPS demonstrate progress towards the completion of the project requirements associated with each project. The assessment will also focus on PPS progress towards meeting those project requirements that cross multiple projects including, but not limited to, milestones associated with the attainment of Patient Centered Medical Home (PCMH) Level 3 certification and the implementation and use of electronic health records (EHRs) to share data and track patient engagement across the PPS. The state is seeking public comment on the proposed Mid-Point Assessment process during a 30 day public comment period. Comments are due by March 17. More information can be found on the DSRIP website.

DSRIP Data Sharing Opt-Out. CMS has determined that Performing Provider Systems operating within the state's DSRIP program need beneficiary approval before they share individual health and utilization data. PPSs want to share such protected health data across providers within the PPS network to improve communication and collaboration. Medicaid beneficiaries are being given the opportunity to opt out of data sharing; the default is that data will be shared. As part of the opt-out data sharing process, the Department of Health will be mailing approximately 5 million opt-out letters to Medicaid members. The letter explains the DSRIP program and data sharing with PPSs. Individuals wishing to opt out of data sharing will have to notify DoH either by phone or by mail. Beneficiaries can choose to opt out at any time. The opt-out mailing and the opt-out form have been posted on the DSRIP web site in English, Spanish and 18 point font.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

A Good First Year for Indiana's Healthy Indiana Program 2.0. Are there lessons for Healthy Ohio? *nwi.com* is reporting that after one year, Indiana's HIP 2.0 is a success, significantly expanding access to coverage with more than 370,000 low-income Hoosiers enrolled. HIP 2.0 is a consumer driven program available to Hoosiers with incomes below 138% of the federal poverty level. Enrollees put funds into a health savings account monthly and are enrolled into HIP Plus. HIP Plus covers medical, dental and vision benefits. If people don't contribute, they receive HIP Basic, which only has medical coverage and requires a copay for services. Monthly payments average $11, with 60 percent of people paying only $1.

But while the program names may be similar, there are some significant differences between Indiana's program and the program Ohio's legislators called for in the 2016-2017 state budget bill passed last summer. Ohio's budget language requires the Ohio Department of Medicaid to apply for a new waiver that would require all non-disabled adults on Medicaid who already qualify for Medicaid based on income (between 0 and 138% of poverty) to pay premiums into a modified health savings account. This does not expand coverage in Ohio. The premium requirement is estimated to apply to over one million adult Ohioans who are currently enrolled in Medicaid. Premium payments for Healthy Ohio participants would be equal to the lesser of 2 percent of annual family income or $99, annually, also not following Indiana's lead where 60 percent of people pay $1 and monthly premiums average $11. Healthy Ohio payments would be made in monthly installments. If premiums and/or documentation are 60 or more days late, Healthy Ohio participants would be locked out of Medicaid completely, unlike Indiana where they are moved to basic coverage and charged a copay until premiums are paid. For more on Indiana's HIP 2.0, see here. For more on Healthy Ohio, see here.

The Health Policy Institute of Ohio releases 'Healthcare Data Transparency Basics': In A new brief released by the Health Policy of Ohio (HPIO) discusses the rationale for healthcare price transparency, the challenges it presents and potential policies for increasing transparency. This is a follow up to HPIO's 2012 first Transparency Basics publication. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Reduces Psychotropic Medication Use Among Medicaid-Enrolled Foster Children. The Department of Human Services (DHS) and PolicyLab at The Children's Hospital of Philadelphia (CHOP) announced several new initiatives that will further reduce the use of psychotropic medication among Medicaid-enrolled Pennsylvania children. Over two years, DHS was able to realize a 75 percent reduction in psychotropic medication use for children served through the Medicaid fee-for-service program administered by DHS. A state-commissioned PolicyLab study found that in 2012, the use of psychotropic medications was nearly three times higher among 6-18 year olds in foster care than among youth in Medicaid overall (prescribed at 43 percent versus 16 percent). In response to PolicyLab's research and analysis, DHS and the Administrative Office of Pennsylvania Courts convened workgroups that offered a series of recommendations to DHS in June 2015. DHS announced the following additional steps to further reduce the use of psychotropic drugs among children in the foster care system:

- Implemented prior authorization for all physical-health managed care organizations (PH-MCOs).
- Developed best practices guidelines for primary care physicians and psychiatrists.
- Deployed an electronic dashboard to improve care coordination for foster care children.

DHS also announced the following initiatives, which will be implemented in the next few months:

- Creating a telephonic child psychiatric consultative service in April 2016.
- Adopting a new psychotropic training module in July 2016.

Read More

Highmark to Cut Physician Payments in Exchange Plans. Citing an estimated $500 million loss last year on health insurance plans sold on the Affordable Care Act marketplace, Highmark Inc. said Friday it plans to reduce what it pays doctors who treat patients enrolled in the plans. Highmark plans to reduce payments to the physicians by 4.5 percent starting April 1 as part of a broad effort to stem losses related to the federal marketplace, said Alexis Miller, Highmark's special vice president of individual and small group markets. Miller said decreasing payments to doctors would help Highmark continue to participate in the federal marketplace, ultimately helping to keep the marketplace sustainable. The insurer raised premiums by an average of 20 percent for its 2016 marketplace plans, changed its networks, reduced commissions to brokers selling the plans and has taken steps to aggressively manage the care of patients with the plans, Miller said. The insurer made the change Monday in an online system through which it interfaces with physicians, and began sending letters to physicians Friday, Miller said. In 2015, 280,000 Pennsylvanians were enrolled in Highmark plans purchased through the federal marketplace. Highmark has said it will announce the latest number in the coming weeks, including signups during the open enrollment period that ended

Jan. 31. The change affects all Pennsylvania physicians treating patients with marketplace plans from Highmark, including physicians employed by Highmark-owned Allegheny Health Network. Read More

Puerto Rico

HHS Pushes to Expand Medicaid Eligibility In Puerto Rico and Increase Contributions to the Program. On February 18, 2016, *Congressional Quarterly (CQ)* reported that HHS is pressuring Congress to support Puerto Rico's Medicaid program. HHS wants to gradually expand eligibility for Medicaid to 100% of the federal poverty limit in Puerto Rico and lift the annual cap on federal Medicaid contributions, which was $329 million in 2015. The White House is urging lawmakers to raise the federal matching rate in Medicaid from 55 percent to 60 percent, as the rates for U.S. territories are statutorily set at 55 percent.

Texas

HMA Roundup – Dianne Longley (Email Dianne)

Texas Health and Human Service Commission Continues with Agency Transformation. The Texas Health and Human Services Commission (HHSC) provided an update on agency reorganization activities at the first meeting of the Transition Legislative Oversight Committee (TLOC) on January 25th. The Committee was created as part of the 2015 Health and Human Services "Sunset" legislation that enacted comprehensive reorganization and consolidation of the health and human services agencies. Key requirements of the legislation include:

- Consolidation of the functions of the Department of Assistive and Rehabilitative Services (DARS) and the Department of Aging and Disability Services (DADS) under the Health and Human Services Commission in a phased, two year process that is to be completed by September 2017
- Realignment of certain functions of the Department of State Health Services (DSHS) and Department of Family and Protective Services (DFPS) to strengthen their focus on public health and protective services
- Consolidation of client services across the HHSC system
- Evaluation and consolidation of regulatory and administrative services where possible.

Goals of the transformation are to improve services to clients and organize agency functions in a way that increases accountability, reduces fragmentation, and streamlines operations across the system of services.

At this initial meeting, HHSC Executive Commissioner Chris Traylor provided an overview and timeline of the transformation planning activities that included a discussion of the complex financial, organizational and contracting issues the agency is beginning to address. He stressed that he will strive to balance the varying needs of their clients and other stakeholders in implementing the many program changes that are part of the transformation process.

Traylor reported the agency has established a newly created Transformation, Policy & Performance division, an internal think tank designed to assist in the

development and oversight of the transition plan. Seven HHS staff workgroups will work with the Division to provide input on the organizational structure for core functions of the HHS system, including:

- Eligibility and Enrollment
- Direct Delivery and Contracted Services
- Clinical Services and Quality Initiatives
- Regulatory Services
- State-operated Facilities
- DSHS – Public Health
- DFPS – Protective Services

Six additional workgroups have been created to identify ways to structure and improve administrative support services for the core functions.

Traylor also provided a timeline for key activities that are intended to meet the legislative deadlines included in SB 200. Several initial requirements have already been met, but Traylor noted that the aggressive deadlines create challenges that the agency is working to address to ensure legislative expectations are met. Activities already completed include:

- Creation of cross-agency transition steering committee
- Functional analyses of all HHS operational areas
- A review and evaluation of all HHS advisory committees and publication of proposed rules that reduce and consolidate the number of committees from 133 to 27
- Regional statewide stakeholder meetings and a stakeholder input questionnaire

Traylor reported the agency will submit a draft transition plan to the TLOC by March 1, 2016 as required. The transition plan must outline HHSC's reorganized structure and will include timelines for when each function will move, any entity that will be abolished and when each division is created; division structure for each group of functions (client services, regulatory, public health, etc.); and administrative support services to be consolidated and measures for ensuring IT and contracting services operate effectively. The TLOC will provide comments and recommendations to the draft plan, and a final plan must be approved by Traylor by May 1, 2016. Other key deadlines include:

- Complete all organizational, funding and staffing transfers for medical and client services consolidations by September 1, 2016
- Complete transfer of all NorthSTAR behavioral health non-Medicaid services into two new service systems and Medicaid services into managed care in the Dallas area by January 1, 2017
- Begin regulatory program consolidation and state-operated facility consolidation at HHSC by September 1, 2016 and complete no later than September 1, 2017.

Legislators attending the meeting were supportive of the HHSC progress to date and emphasized expectations for both improved client services and savings.

Several members expressed concern with federal requirements and the complexity of the reorganization and how the agency will managed the reforms while carrying out their routine duties. In response to questions, Traylor agreed the process is daunting, and confirmed the agency is in the process of selecting outside consultant/s to assist with the transformation planning.

Additional hearings are scheduled for March, May, and early fall.

HHSC Proposes Rules for New Nursing Facilities Quality Incentive Payment Program. HHSC published its proposed rules for the Quality Incentive Payment Program (QIPP), which is designed to incentivize nursing facilities to improve quality and innovation in the delivery of services. The rules are in response to legislation enacted in 2015 instructing HHSC to transition the existing Nursing Facility Minimum Payment Amounts Program (MPAP) to a Quality Incentive Payment Program for all nursing facilities that have a source of public funding for the non-federal share, regardless of whether the facilities are publically or privately owned. MPAP was established in 2014 following the nursing facility carve-in for the STAR+PLUS managed care program. MPAP allows participating nursing facilities to receive additional funding equal to the difference between the normal Medicaid rates and the amount the facility would have received if the residents had been covered by Medicare Part A. Participating nursing facilities must be a non-state governmental entity with a source of Intergovernmental Transfer (IGT) and must actively enroll to participate in the program.

MPAP was always intended to be a temporary program that would transition to a performance-based initiative. HHSC has been working with stakeholders to develop the new QIPP, which will provide additional payments to nursing facilities that meet predetermined goals and performance targets which facilities will establish with contracted Managed Care Organizations (MCO)s participating in STAR+PLUS. HHSC has proposed a predetermined menu of performance projects but also will allow facilities to submit their own unique proposals for consideration.

Once a project is approved, HHSC will calculate the addition to an MCO's PMPM payment associated with the QIPP project. MCOs must them make subsequent payments to the nursing facility when the facility meets the targeted proposal metrics. If a facility fails to achieve its proposed metrics, HHSC will recoup from the MCO the PMPM capitation funds associated with the metric.

HHSC held a public hearing on the rule on January 15 but received no public comments. The rule is scheduled to be effective March 1, 2016. Under the first year of the transition from MPAP to QIPP, current MPAP participants will be allowed to continue receiving MPAP payments at approximately 50% of their current payment level. Additional funding may also be available for achievements under the QIPP. All MPAP payments will be eliminated after the first year of the QIPP.

Utah

Committee Sends Full Medicaid Expansion Bill to Senate. On February 23, 2016, *The Salt Lake Tribune* reported that the Senate Judiciary, Law Enforcement and Criminal Justice Committee approved a Medicaid expansion proposal. The bill, which was sent to the Senate, will likely face a tough battle as several members said they would not support it without changes. Senators have expressed concerns about the costs of expansion. Read More

Virginia

Republicans Oppose Virginia Governor's Latest Attempt for Medicaid Expansion. On February 21, 2016, *The Washington Post* reported that while the Virginia Hospital Association was open to revisiting expansion, Republicans refuted Governor Terry McAuliffe's latest attempt to expand Medicaid. The proposal that the Governor released in December would have required hospitals to pay an annual fee of no more than 3 percent of their net patient revenue, which would be used to draw down federal matching funds to cover the state's share of the cost for expansion. While 39 states currently charge hospitals provider taxes to help fund their Medicaid programs, only a few states have used the fees to cover expansion costs, as the Governor proposed. Read More

Washington

Lawsuit Seeks to Change Medicaid Policy That Limits Hepatitis C Drugs to Sickest Patients. On February 17, 2016, *The Seattle Times* reported that a class-action lawsuit filed by two Apple Health clients is seeking to force the Health Care Authority to change its Medicaid policy that limits hepatitis C drugs to the sickest patients. The lawsuit comes two weeks after private insurers were sued for improperly denying the drugs. Washington Medicaid Director MaryAnne Lindeblad estimated that it would cost $242 million just to provide drugs for high-risk hepatitis C patients in fiscal 2016. To pay for hepatitis C treatment for all Medicaid clients would cost $3 billion, three times the current pharmacy budget. Read More

Wisconsin

Milwaukee Health Systems See Rise in Profits from Medicaid Expansion. On February 22, 2016, *Journal Sentinel* reported that Milwaukee-area health systems saw a sharp increase in profits as a result of Medicaid expansion. Analysts say health systems were providing less charity care and incurring less debt, in addition to systems' ongoing efforts to control costs and become more efficient. Read More

Wyoming

Senate Passes Medicaid Expansion Alternative. On February 22, 2016, *Wyoming Public Radio* reported that the State Senate approved a Medicaid expansion alternative that would provide medical assistance to those who cannot afford health insurance. Senator Charles Scott, who proposed the bill, is a longtime opponent of expansion. He stated that he wants to design a program that achieves better health results than Medicaid. The bill now heads to the House for debate. Read More

Legislature Debates Bill That Would Block Expansion for Two Years. On February 23, 2016, *Casper Star Tribune* reported that the Legislature is debating a bill that would create a two-year state study of health coverage for low income residents. The study would look at the possibility of the Medicaid program rules changing under a new president, look at allowing the poorest of the uninsured to enter a state program, and consider requiring everyone who is not disabled to get a job to get coverage. However, the bill contains a provision prohibiting the state from expanding Medicaid while the study is underway. It has passed the Senate and moves on to the House for debate. Read More

National

OMB Receives CMS Final Rule to Overhaul Managed Medicaid. On February 19, 2016, *Modern Healthcare* reported that CMS sent its final rule to overhaul the managed Medicaid program to the Office of Management and Budget for review. The 653-page report includes the largest changes to Medicaid managed-care regulations in a decade, including caps on insurer profits, network adequacy requirements, a minimum medical-loss ratio, and more. The review can take up to 90 days, meaning the final rule is expected to be published in mid-May, a year after it was proposed. Read More

Autism Treatment Uneven Across States. On February 19, 2016, *The PEW Charitable Trusts* reported that coverage for Autism treatment varies across states. Applied Behavior Analysis (ABA) is considered the best known treatment for autism, however, due to varying rules between states, health insurance does not always cover it. Autism Speaks, a national nonprofit, estimates that 36 percent of Americans have access to autism coverage. Furthermore, the scope of coverage also varies. Some states only require coverage up to a set dollar amount per year, a set number of hours of treatment per week, or only require the coverage until a child reaches a certain age. The six states that do not require that insurers cover therapy are Alabama, Idaho, North Dakota, Oklahoma, Tennessee and Wyoming. Oklahoma and Alabama are considering bills that would mandate coverage. Read More

Industry News

WellCare to Acquire Advicare Corp. On February 23, 2016, WellCare announced that it will acquire certain assets of Advicare Corp, a South Carolina-based managed care organization serving 32,500 Medicaid members. The acquisition is expected to close in the second quarter of 2016. Financial terms were not disclosed. Read More

IBM to Acquire Truven Health Analytics for $2.6 Billion. On February 18, 2016, IBM announced that it will acquire Truven Health Analytics for $2.6 billion. IBM launched its Watson Health Unit in April 2015. Including the Truven deal, the company invested over $4 billion to acquire and build its healthcare capabilities. Read More

Kindred Partners with Inovalon to Create Data-Based Care Management Tools for Post-Acute Care. On February 18, 2016, Kindred Healthcare announced it will partner with Inovalon, and its subsidiary, Avalere Health, to create a set of "data-based care management tools designed to risk stratify patients, help determine the most appropriate post-acute sites of service, develop evidence-based care pathways and outcomes, and establish cost-effective pricing models" for the post-acute care marketplace. Read More

Inspira Health Network and Bayada Home Health Care Create Joint Venture. On February 19, 2016, *Philadelphia Business Journal* reported that Inspira Health Network is creating a home health care and hospice care joint venture with Bayada Home Health Care. The joint venture is set to be completed in mid-April and will provide services in Salem, Cumberland, and Gloucester counties. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
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
TBD Winter/Spring 2016	Virginia MLTSS	RFP Released	130,000
April 1, 2016	Iowa	Implementation	550,000
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
May, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
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:

- CMS approves **Iowa** Medicaid managed care transition, Feb. 2016
- Acute care hospitals Medicaid inpatient days average for **Texas, Pennsylvania, Illinois,** and **New York**
- Public documents such as the **Nebraska** Medicaid Integrated Managed Care RFP responses and scoring and governors' proposed budgets for **Michigan**, **Illinois**, **New Jersey**, and more
- 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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