HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

MEDICAID AND EXCHANGE ENROLLMENT UPDATE

This week, our *In Focus* section reviews updated reports issued by the Department of Health and Human Services (HHS) on Medicaid expansion enrollment from *"Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations, and Enrollment Report,"* published on February 29, 2016. Additionally, we review Exchange enrollment from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Issue Brief, *"Health Insurance Marketplace 2016 Open Enrollment Period: January 2016 Enrollment Report."* Combined, these reports present a picture of Medicaid and Exchange enrollment at the beginning of 2016.

Key Takeaways from Medicaid Enrollment Report

- Across 50 states and DC reporting Medicaid and CHIP monthly enrollment data, nearly 71.8 million individuals were enrolled as of December 2015.

- Medicaid and CHIP enrollment is up more than 14.6 million (more than 25 percent) from the "Pre-Open Enrollment" period, defined as July 2013 through September 2013.
- The top five states in percentage growth of Medicaid and CHIP enrollment under the Medicaid expansion are Kentucky (94.3 percent), Nevada (79.4 percent), Colorado (67.9 percent), Oregon (65.0 percent), and New Mexico (61.3 percent).
- The top five states in percentage growth of Medicaid and CHIP among states that did not expand Medicaid are Tennessee (25.4 percent), North Carolina (21.7 percent), Idaho (18.1 percent), Florida (15.2 percent), and Georgia (13.9 percent).
- The top five states in total enrollment growth of Medicaid and CHIP are California (4.03 million), New York (920,283), Washington (655,424), Ohio (590,520), and Kentucky (572,509).

Table 1 – Overall U.S. Medicaid/CHIP Enrollment Growth – Pre-Open Enrollment Monthly Average through December 2015

	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (Dec. 2015)	Dec. 2015 % Change	Dec. 2015 # Change
Expanded Medicaid				
State-Based Exchange	20,055,587	27,871,007	*39.0%*	*7,815,420*
Federally Facilitated	14,969,378	18,688,057	*24.8%*	*3,718,679*
Partnership	1,704,951	2,706,921	*58.8%*	*1,001,970*
Has Not Expanded Medicaid				
State-Based Exchange	238,150	281,309	*18.1%*	*43,159*
Federally Facilitated	20,191,903	22,230,464	*10.1%*	*2,038,561*
Partnership	0	0	*N/A*	*0*
Total	**57,159,969**	**71,777,758**	***25.6%***	***14,617,789***

Key Takeaways from Exchange Enrollment Report

- At the start of January 2016, nearly 11.3 million individuals enrolled in a qualified health plan (QHP) for plan year 2016 through the Exchanges.
- This equates to a 3.7 percent decline in QHP enrollment as compared to March 2015, but it is important to note that these data were reported prior to the conclusion of the open enrollment period.
- Among the 34 Federally Facilitated Marketplace (FFM) states and four states using the HealthCare.gov eligibility and enrollment platform:
    - 60 percent of active reenrollees switched QHPs from 2015 to 2016;
    - Nearly 820,000 applicants were determined Medicaid or CHIP eligible;
    - 83 percent of enrollees are receiving financial assistance in the form of a premium tax credit, with 57 percent receiving cost-sharing reductions;

- 36 percent of enrollees are younger than 35; and
- 71 percent of enrollees have selected a Silver plan, with 21 percent selecting a Bronze plan.

- Among the 13 State-Based Marketplace (SBM) states:
  - Nearly 2.3 million applicants were determined Medicaid or CHIP eligible;
  - 77 percent of enrollees are receiving financial assistance in the form of a premium tax credit;
  - 34 percent of enrollees are younger than 35; and
  - 60 percent of enrollees have selected a Silver plan, with 27 percent selecting a Bronze plan.

Table 2 – Overall U.S. Exchange Enrollment – Plan Year 2014, 2015, and 2016 (Through December 26, 2015)

	Selected Exchange QHP (2014)	Selected Exchange QHP (Mar. 2015)	Selected Exchange QHP (Jan. 2016)	QHP % Change	QHP # Change
Expanded Medicaid					
State-Based Exchange	2,451,295	2,740,079	2,636,586	*-3.8%*	*(103,493)*
Federally Facilitated	1,583,930	2,392,880	2,236,049	*-6.6%*	*(156,831)*
Partnership	154,352	250,603	265,733	*6.0%*	*15,130*
Has Not Expanded Medicaid					
State-Based Exchange	76,061	97,079	96,622	*-0.5%*	*(457)*
Federally Facilitated	3,754,125	6,207,433	6,023,153	*-3.0%*	*(184,280)*
Partnership	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
Total	**8,019,763**	**11,688,074**	**11,258,143**	***-3.7%***	***(429,931)***

The table on the following page (Table 3) provides state-level data on Medicaid and Exchange enrollment.

Medicaid and Exchange Enrollment Data Sources

Link to CMS Medicaid Expansion Enrollment Report:

"Medicaid & CHIP: December 2015 Monthly Applications, Eligibility Determinations, and Enrollment Report" (February 29, 2016)

Link to ASPE Health Insurance Marketplace Enrollment Report:

"Health Insurance Marketplaces 2016 Open Enrollment Period: January Enrollment Report" (January 7, 2016)

"Addendum to the Health Insurance Marketplaces 2016 Open Enrollment Period: January Enrollment Report" (January 7, 2016)

Table 3 – Medicaid/CHIP Enrollment Growth Across All States (December 2015) and 2016 Exchange Enrollment (End of December 2015)

State	Expanded Medicaid	State-Based/ FFM Exchange	Pre-Open Enrollment Monthly Avg. (Jul13-Sep13)	Medicaid/CHIP Enrollment (Dec. 2015)	Dec. 2015 % Change	Dec. 2015 # Change	Selected Exchange QHP (2014)	Selected Exchange QHP (Mar. 2015)	Selected Exchange QHP (Jan. 2016)	QHP % Change	QHP # Change
US Total			**57,159,969**	**71,777,758**	***25.6%***	***14,617,789***	**8,019,763**	**11,688,074**	**11,258,143**	***-3.7%***	***(429,931)***
Alabama	No	FFM	799,176	881,836	*10.3%*	*82,660*	97,870	171,641	174,708	*1.8%*	*3,067*
Alaska	Yes	FFM	122,334	131,334	*7.4%*	*9,000*	12,890	21,260	21,682	*2.0%*	*422*
Arizona	Yes	FFM	1,201,770	1,681,587	*39.9%*	*479,817*	120,071	205,666	169,110	*-17.8%*	*(36,556)*
Arkansas	Yes	FFM	556,851	839,277	*50.7%*	*282,426*	43,446	65,684	65,451	*-0.4%*	*(233)*
California	Yes	State-Based	7,637,273	11,670,308	*52.8%*	*4,033,035*	1,405,102	1,412,200	1,411,664	*0.0%*	*(536)*
Colorado	Yes	State-Based	783,420	1,315,144	*67.9%*	*531,724*	125,402	140,327	121,740	*-13.2%*	*(18,587)*
Connecticut	Yes	State-Based	618,700	746,047	*20.6%*	*127,347*	79,192	109,839	102,066	*-7.1%*	*(7,773)*
Delaware	Yes	FFM	223,324	241,704	*8.2%*	*18,380*	14,087	25,036	26,370	*5.3%*	*1,334*
District of Columbia	Yes	State-Based	235,786	263,296	*11.7%*	*27,510*	10,714	18,465	19,299	*4.5%*	*834*
Florida	No	FFM	3,104,996	3,576,023	*15.2%*	*471,027*	983,775	1,596,296	1,556,561	*-2.5%*	*(39,735)*
Georgia	No	FFM	1,535,090	1,749,136	*13.9%*	*214,046*	316,543	541,080	511,826	*-5.4%*	*(29,254)*
Hawaii	Yes	Partnership	288,357	338,656	*17.4%*	*50,299*	8,592	12,625	11,157	*-11.6%*	*(1,468)*
Idaho	No	State-Based	238,150	281,309	*18.1%*	*43,159*	76,061	97,079	96,622	*-0.5%*	*(457)*
Illinois	Yes	FFM	2,626,943	3,083,179	*17.4%*	*456,236*	217,492	349,487	346,869	*-0.7%*	*(2,618)*
Indiana	Yes	FFM	1,120,674	1,427,492	*27.4%*	*306,818*	132,423	219,185	181,995	*-17.0%*	*(37,190)*
Iowa	Yes	FFM	493,515	608,837	*23.4%*	*115,322*	29,163	45,162	49,428	*9.4%*	*4,266*
Kansas	No	FFM	378,160	402,055	*6.3%*	*23,895*	57,013	96,197	86,411	*-10.2%*	*(9,786)*
Kentucky	Yes	State-Based	606,805	1,179,314	*94.3%*	*572,509*	82,747	106,330	81,121	*-23.7%*	*(25,209)*
Louisiana	No	FFM	1,019,787	1,077,109	*5.6%*	*57,322*	101,778	186,277	185,215	*-0.6%*	*(1,062)*
Maine	No	FFM	266,900	279,000	*4.5%*	*12,100*	44,258	74,805	78,076	*4.4%*	*3,271*
Maryland	Yes	State-Based	856,297	1,139,441	*33.1%*	*283,144*	67,757	120,145	148,943	*24.0%*	*28,798*
Massachusetts	Yes	State-Based	1,296,359	1,668,206	*28.7%*	*371,847*	31,695	140,540	196,647	*39.9%*	*56,107*
Michigan	Yes	FFM	1,912,009	2,281,977	*19.3%*	*369,968*	272,539	341,183	323,430	*-5.2%*	*(17,753)*
Minnesota	Yes	State-Based	873,040	1,047,832	*20.0%*	*174,792*	48,495	59,704	56,135	*-6.0%*	*(3,569)*
Mississippi	No	FFM	637,229	691,293	*8.5%*	*54,064*	61,494	104,538	93,999	*-10.1%*	*(10,539)*
Missouri	No	FFM	846,084	948,576	*12.1%*	*102,492*	152,335	253,430	257,228	*1.5%*	*3,798*
Montana	Yes	FFM	148,974	182,132	*22.3%*	*33,158*	36,584	54,266	55,519	*2.3%*	*1,253*
Nebraska	No	FFM	244,600	231,596	*-5.3%*	*(13,004)*	42,975	74,152	78,927	*6.4%*	*4,775*
Nevada	Yes	Partnership	332,560	596,516	*79.4%*	*263,956*	45,390	73,596	75,367	*2.4%*	*1,771*
New Hampshire	Yes	FFM	127,082	185,958	*46.3%*	*58,876*	40,262	53,005	50,737	*-4.3%*	*(2,268)*
New Jersey	Yes	FFM	1,283,851	1,710,928	*33.3%*	*427,077*	161,775	254,316	258,993	*1.8%*	*4,677*
New Mexico	Yes	Partnership	457,678	738,231	*61.3%*	*280,553*	32,062	52,358	46,816	*-10.6%*	*(5,542)*
New York	Yes	State-Based	5,678,417	6,598,700	*16.2%*	*920,283*	370,451	408,841	265,772	*-35.0%*	*(143,069)*
North Carolina	No	FFM	1,595,952	1,941,561	*21.7%*	*345,609*	357,584	560,357	553,729	*-1.2%*	*(6,628)*
North Dakota	Yes	FFM	69,980	89,240	*27.5%*	*19,260*	10,597	18,171	19,729	*8.6%*	*1,558*
Ohio	Yes	FFM	2,341,481	2,932,001	*25.2%*	*590,520*	154,668	234,341	224,139	*-4.4%*	*(10,202)*
Oklahoma	No	FFM	790,051	781,927	*-1.0%*	*(8,124)*	69,221	126,115	128,758	*2.1%*	*2,643*
Oregon	Yes	Partnership	626,356	1,033,518	*65.0%*	*407,162*	68,308	112,024	132,393	*18.2%*	*20,369*
Pennsylvania	Yes	FFM	2,386,046	2,744,031	*15.0%*	*357,985*	318,077	472,697	408,147	*-13.7%*	*(64,550)*
Rhode Island	Yes	State-Based	190,833	279,321	*46.4%*	*88,488*	28,485	31,337	33,896	*8.2%*	*2,559*
South Carolina	No	FFM	889,744	936,141	*5.2%*	*46,397*	118,324	210,331	194,982	*-7.3%*	*(15,349)*
South Dakota	No	FFM	115,501	118,295	*2.4%*	*2,794*	13,104	21,393	22,697	*6.1%*	*1,304*
Tennessee	No	FFM	1,244,516	1,561,146	*25.4%*	*316,630*	151,352	231,440	232,623	*0.5%*	*1,183*
Texas	No	FFM	4,441,605	4,685,926	*5.5%*	*244,321*	733,757	1,205,174	1,096,868	*-9.0%*	*(108,306)*
Utah	No	FFM	294,029	303,990	*3.4%*	*9,961*	84,601	140,612	148,814	*5.8%*	*8,202*
Vermont	Yes	State-Based	161,081	190,398	*18.2%*	*29,317*	38,048	31,619	28,258	*-10.6%*	*(3,361)*
Virginia	No	FFM	935,434	955,868	*2.2%*	*20,434*	216,356	385,154	384,147	*-0.3%*	*(1,007)*
Washington	Yes	State-Based	1,117,576	1,773,000	*58.6%*	*655,424*	163,207	160,732	171,045	*6.4%*	*10,313*
West Virginia	Yes	FFM	354,544	548,380	*54.7%*	*193,836*	19,856	33,421	34,450	*3.1%*	*1,029*
Wisconsin	No	FFM	985,531	1,044,478	*6.0%*	*58,947*	139,815	207,349	216,877	*4.6%*	*9,528*
Wyoming	No	FFM	67,518	64,508	*-4.5%*	*(3,010)*	11,970	21,092	20,707	*-1.8%*	*(385)*

** Several states use the FFM marketplace for enrollment, despite being a state-based exchange; these states are HI, NV, NM, OR, listed in the above table as "Partnership."*

Note: Connecticut and Maine did not report Pre-Open Enrollment Period enrollment data to HHS for the report. HMA has substituted the December 2013 Medicaid enrollment total from the Kaiser Family Foundation, compiled by Health Management Associates (HMA) from state Medicaid enrollment reports for the Kaiser Commission on Medicaid and the Uninsured (KCMU). Data available at: http://kff.org/medicaid/state-indicator/monthly-medicaid-enrollment-in-thousands-december/

HMA Medicaid Roundup

Alabama

Alabama Senate Passes Budget without Plans to Reform Medicaid. On February 25, 2016, *The Anniston Star* reported that the Senate passed a $1.82 billion General Fund that would increase state spending by $60 million, none of which would go to Medicaid. Governor Robert Bentley had asked for a $100 million increase in Medicaid funds to set up non-profit regional organizations that would run the managed care program. Medicaid officials said they need increases just to keep providing basic services, such as hospice care and outpatient dialysis. The budget moves to the House for considerations. Read More

Alaska

Judge Dismisses Lawsuit to Halt Medicaid Expansion. On March 1, 2016, *Alaska Dispatch News* reported that Superior Court Judge Frank Pfiffner dismissed the Legislature's lawsuit to halt Governor Bill Walker's Medicaid expansion and concluded that the state acted within the law to expand Medicaid. The Legislature is likely to appeal. Read More

Arizona

AHCCS Announced Applications for 2016 DSH Payments are Due in April. On February 26, 2016, *Arizona Health Care Cost Containment System* (AHCCS) announced that applications for 2016 DSH payments are due by Thursday, April 14, 2016. Organizations have to file the required forms if they received Medicaid DSH funds in 2014, or if they are eligible and interested in receiving 2016 DSH payments. For 2016, DSH payments of $884,800 have been appropriated for Pools 1 and 2 (the pools for which the state match is provided by the General Fund) and approximately $18 million is expected to be available for Pool 5 (the pool for which the non-federal share is voluntarily provided by political subdivisions, tribal government, or Arizona public universities). Rural hospitals have the first priority for Pool 5. If all the funds are not used, the pool will be opened up for other eligible organizations. Read More

California

HMA Roundup – Don Novo (Email Don)

Governor Brown Approves MCO Tax, Which Now Requires CMS Review. On March 1, 2016, *The Sacramento Bee* reported that Governor Brown approved Managed Care Organization (MCO) tax legislation Tuesday, one day after lawmakers approved the package to preserve $1 billion in federal matching dollars as well as provide several hundred million dollars to services for the developmentally disabled, debt relief, and other programs. The vote ended a yearlong process of negotiations among lawmakers. The proposal will now go to CMS, which has to review the new tax before the current one sunsets on July 1st. Read More

Substance Abuse Treatment Facility Sues California Department of Managed Care for Untimely Reviews. On February 15, 2016, *KQED News* reported that a lawsuit filed by Evolve Growth Initiatives, an operator of substance abuse treatment facilities in California, accused California's Department of Managed Health Care of violating coverage review deadlines. Consumers who are denied coverage of services can appeal decisions to the Department, which can either uphold or overturn the health insurance company's decision. Under law, the agency has six days to do so. However, last year, the agency only handled 508 of 1,789 appeals on an expedited basis, leaving some consumers needing mental health care without a timely decision and in some cases no care at all since many cannot afford to pay out of pocket. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Lawmakers Agree on LIP Funding Formula to Help Mitigate Losses in Federal Funding. On March 1, 2016, *Health News Florida* reported that in light of a $400 million funding cut to the state's Low Income Pool (LIP), which helps pay for hospital care for the poor and uninsured, lawmakers have agreed to divide the funding according to a specific formula meant to mitigate the losses for hospitals providing a large portion of charity care. The four-tier formula will distribute the money based on the amounts of charity care that the hospitals provide. Read More

Lawmakers Agree to Fund KidCare Expansion to Include Legal Immigrants. On February 27, 2016, *Miami Herald* reported that House and Senate lawmakers agreed to include $28.8 million to pay for KidCare expansion, subject to approval of the expansion bills. If approved, KidCare would include legal immigrants. Currently, immigrant children must wait five years before being eligible for coverage. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Families MCO Award Protests Denied. The Georgia Department of Administrative Services announced that protests regarding the Georgia Families Care Management Organization RFP have been denied. AmeriHealth Caritas, Humana, and United all submitted protests. The apparent successful offerers, which were identified in a Notice of Intent to Award in September 2015, are

Anthem/Amerigroup, CareSource, Centene/Peach State, and Wellcare. Program implementation is scheduled to begin Jan. 1, 2017. The letter from the state is available here. Read More

House Voted For a Medicaid Budget Increase that Would Increase Pay for Doctors. On February 29, 2016, *Gwinnett Daily Post* reported that the House recently voted for a $26 million increase to the state's Medicaid budget in FY2017 for doctor pay raises. If the Senate and the Governor both agree with the House's actions, Medicaid rates for some primary care and OB/GYN services could see considerate rate hikes closer to Medicare rates. Currently, Medicaid pays doctors only about 65% of what Medicare pays for the same service. OB/GYNS and other physicians say that the rate increases, which have been few and far between in recent years, would help with access for Medicaid patients as well as help attract new young physicians to the state. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Policy to Limit Overtime for Home Health Aides is Delayed Again. On March 1, 2016, *The Chicago Tribune* reported that Illinois officials have once again delayed a policy that would limit overtime pay for home health aides due to concerns from the SEIU, the union that represents home care workers. The policy, which was supposed to go into effect March 1, would limit workers to a 40-hour work week and stems from a federal overtime law that took effect January 1. While Governor Rauner says that state cannot afford the extra pay in the midst of a state budget crisis, the SEIU has cited concerns about disruptions in care. Read More

Illinois Co-op Land of Lincoln Suffers Financial Trouble and Allegations of Fraud. On March 1, 2016, *Crain's* reported that the Affordable Care Act's (ACA) co-op Land of Lincoln Health plan continues to suffer from operating losses. Land of Lincoln was one of 23 co-ops nationwide created by ACA to create competition on health insurance exchanges. As of January 30, 12 of those 23 co-ops have closed. Although Land of Lincoln's $147.4 million in revenue in 2015 surpassed its 2014 revenue by 10 times, when the insurers announced it was capping enrollment in October and then dropped University of Chicago Medicine from its network March 1, two U of C patients sued the insurer for fraud and continues to suffer financial trouble. Read More

Louisiana

Louisiana's Credit Rating Downgraded Raising Concerns over Cost of Medicaid Program. On February 25, 2016, *ABC News* reported that Louisiana's credit rating was downgraded, raising concerns about the growing cost of the state's Medicaid program. The state was last downgraded in 2005 after Hurricane Katrina. The state faces a current shortfall ranging from $850 million to $950 million that must be closed by June 30 and a more than $2 billion gap in the financial year that begins July 1. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Governor Baker Plans to Introduce Medicaid ACOs and Increase LTSS Oversight. On February 23, 2016, *Sentinel & Enterprise* reported that Governor Charlie Baker's administration is working to move Medicaid toward population health and installing independent assessors for people in need of a range of services. The administration is looking to begin offering Medicaid coverage through accountable care organizations (ACOs). It is also seeking to increase oversight in long-term services and supports, where Medicaid funds home health visits, nursing-home care, and other long-term expenses. Long-term services makes up approximately $4.5 billion of all Medicaid spending. Read More

State Commission to Hold Hospital Mergers and Acquisitions Under Higher Scrutiny. On March 2, 2016, *Boston Business Journal* reported that the state will be taking an unprecedented look at hospital affiliations, mergers, and acquisitions through its Health Policy Commission, created to keep health care spending in check. The commission has already put two deals (MetroWest Medical Center and New England Baptist Hospital plans to become clinically affiliated with Beth Israel Deaconess Medical Center) on hold to better analyze the proposals and run cost and market impact reviews. Thus far, the commission found that the proposed deals may raise health care spending in the state. Read More

Mississippi

House Passes Bill Requiring Audits of Medicaid Recipients. On February 26, 2016, *The Washington Times* reported that the Mississippi House passed a bill requiring regular audits of Medicaid recipients' information, including income and other earnings, housing, Social Security information, immigration status and work status. Enrollees would be required to verify their records every three months by answering "knowledge-based quizzes" on their financial and personal information. Officials would maintain a computerized record of information and check it against federal databases. Recipients who fail to comply with those programs' rules would get three strikes before permanently losing aid, at the same time temporarily disqualifying anyone else in their household. Read More

New Hampshire

Initiatives Underway to Tackle New Hampshire Opioid Crisis. On February 20, 2016, the *New Hampshire Union Leader* reported that Sen. Jeanne Shaheen is seeking $600 million in funding to fight the opioid crisis. Following Shaheen's testimony, a number a bipartisan initiatives have gone underway, including:

- The Senate Judiciary Committee passed the Comprehensive Addiction and Recovery Act (CARA), which would invest approximately $70 million a year to enhance opioid abuse prevention and education nationwide.

- The FY 2016 Omnibus Funding Bill would provide an additional $159 million to federal programs to address the heroin and prescription drug abuse crisis.
- Shaheen's sponsored bill, the Opioid and Heroin Crisis Supplemental Appropriation bill, would add $600 million to existing anti-drug and rehabilitation programs at the Department of Justice and the Department of Health and Human Services. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Home Care Agencies Facing Financial Risk. The Home Care Association of New York State released a report that profiles the financial condition of New York's home care community, including a review of emerging cost and reimbursement challenges. The report indicates that 70 percent of home care providers had negative operating margins, and one-half have had to borrow money to pay for operating expenses over the past two years. They argue that the Medicaid rates do not account for many critical costs needed in service structure and delivery. They note that among home care agencies with a managed care rate below their fee-for-service rate, the managed care rate was on average 20 percent below the fee-for-service rate for nursing and home health services. The report also includes a discussion of the financial impact of new overtime rules resulting from the Federal Labor Standards Act (FLSA), as well as the potential impacts of an increase in the state minimum wage to $15 an hour, as proposed by Governor Cuomo., HCA estimates that implementing the minimum wage would cost the home care industry $1.7 billion/year when fully implemented. The report can be found on the HCA website.

Partnership Plan Annual Report. The Department of Health has posted the Partnership Plan Annual Report on the Medicaid Redesign website. New York State´s Medicaid Section 1115 Waiver, called the Partnership Plan, has operated since 1997. The waiver has allowed the state to implement a managed care program that provides comprehensive and coordinated health care to most Medicaid recipients. The annual report includes enrollment and disenrollment information; outreach activities (largely conducted by MAXIMUS, the enrollment broker for NY Medicaid Choice; operational issues relating to health plan certificates of authority; benefit and other program changes; consumer issues including a review of complaints received; and quality monitoring for both mainstream and managed long-term care plans. A profile of the Managed Long Term Care Program includes a review of grievances and appeals by plan, including total grievances, total appeals, and grievances and appeals per 1,000 enrollees. Rates of grievances ranged from four per thousand (United Healthcare) to 202 per 1,000 (ArchCare Community Life); appeals ranged from zero (Amerigroup, Elant, Fallon Health, I Circle, NSLIJ Health Plan, Prime Health Choice, Senior Whole Health) to 45 per 1,000 (VNS Choice).

Certified Community Behavioral Health Clinic Planning Grant. The New York State Office of Mental Health and Office of Alcoholism and Substance Abuse Services announced that New York has been awarded a SAMHSA federal planning grant of $982,373 (see here). The grant is intended to strengthen its community-based mental health care and substance use disorder programs through the development of new Certified Community Behavioral Health

Clinics (CCBHC) in pilot sites across the state. Through this grant, New York will establish multiple CCBHC pilot sites across the state, reflecting the regional diversity of the state's population and service delivery systems. The pilot sites will develop outpatient networks of primary care, mental health, and substance use disorder programs that will adopt a common set of tools, approaches, and organizational commitments to treat individuals in a seamless and integrated fashion.

The goals of New York's Certified Community Behavioral Health Clinics are to:

- Improve New Yorker's health outcomes by increasing access to quality care for all Medicaid eligible individuals;
- Reduce avoidable hospital use and complications through the development of intermediate levels of service;
- Foster better partnerships between primary care and mental health and substance use disorder providers through co-location; and
- Improve the fiscal outlook for mental health and substance use disorder care providers by improving Medicaid reimbursement.

The planning grants are the first phase of a two-phase process. When the planning grant phase ends in October 2016, New York will have an opportunity to apply for a two-year demonstration program that will begin January 2017. Under the demonstration program, up to eight states with certified community behavioral health clinics will provide mental health and substance use disorder services to individuals eligible for the program in their respective state.

New York State Department of Health Seeking Actuary. The Department of Health has released an RFP seeking a Rate and Fiscal Management Consultant. The RFP is to secure Medicaid rate, financial management and actuarial assistance for the Department and its sister agencies (the Office of Mental Health, the Office of Alcoholism and Substance Abuse Services and the Office of People with Developmental Disabilities) in support of all of the state's existing Medicaid service programs including mainstream Medicaid Managed Care, HIV/Special Need Plans, Health and Recovery Plans (HARPs), Managed Long Term Care (MLTC) Partial Capitation, Program All-Inclusive Care for the Elderly (PACE), Medicaid Advantage Plus (MAP), Fully Integrated Dual Advantage (FIDA), Medicaid Advantage (MA), Essential Plan (EP), Fully Integrated Dual Advantage for Individuals with Developmental Disabilities, and Development Disabilities Individual Support and Care Coordination Organization (DISCO). The state is also looking to secure fiscal management and consulting assistance with other topics such as service based payment programs, value based payments (VBP) and any new managed care programs or proposed initiatives during the term of the Agreement resulting from this RFP. The successful Contractor will provide rate, fiscal management, actuarial support and technical assistance, including certifying that premium rates developed by the State for existing and new programs are actuarially sound and managed care rates meet requirements of the Balanced Budget Act (BBA). The agreement will be for a period of five years, beginning August 1, 2016. Proposals are due April 20, 2016. The RFP can be found here. The current contract for actuarial services is held by Mercer Government Human Services Consulting.

EmblemHealth Downsizing. *Crain's HealthPulse* reports that EmblemHealth has announced another round of layoffs. The layoffs were a result of EmblemHealth's decision not to continue work on Medicare's Benefits

Coordination and Recovery Center, which work was inconsistent with EmblemHealth's desire to focus on value-based payment relationships rather than fee-for-service contracts. The layoffs, scheduled to occur in several phases between May and August, will result in job losses for 82 workers.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

More on the Initiated Statute to Cap Prices the State Pays for Prescription Drugs. In December, 2015, the Los Angeles based foundation, The AIDS Healthcare Foundation submitted petition signatures to put the Ohio Drug Price Relief Act before the General Assembly. The proposal would prohibit agencies and other state-funded entities from entering into agreements to purchase prescription drugs, either directly or indirectly, unless the net cost is the same or less than the lowest price paid by the U.S. Department of Veterans Affairs. Initiative supporters said consumers could see a 20-24% drop in drug prices. With 91,677 signatures needed to move the initiated statute to the General Assembly, 171,205 signatures in support of the initiated statute to the secretary of state's office.

In January, Secretary of State Jon Husted asked county election boards to take another look at petitions because of claims that some of the signatures may be invalid, due to improper redaction of voters' signatures on a majority of petitions and other discrepancies. Secretary Husted sent the statute to the General Assembly on February 4. Barring further court action on a separate lawsuit, four months after Feb. 4, the AIDS Healthcare Foundation group would be able to start collecting another round of signatures to put the matter on the ballot in November.

Now, on the last day of February, *Gongwer Ohio* is reporting that a lawsuit has been filed by three industry groups. PhRMA, the Ohio Manufacturers' Association and the Ohio Chamber of Commerce. The groups filed the challenge to the so-called "Ohio Drug Price Relief Act" with the Supreme Court of Ohio. The challenge asks for a review of the petitions circulated for the initiated statute. President of the AIDS Healthcare Foundation, Michael Weinstein, said the challenge is another attempt to keep Ohioans from voting on the issue. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Community HealthChoices RFP Released. The Departments of Human Services and Aging released a Request for Proposals (Solicitation RFP 12-15) for Community HealthChoices (CHC). CHC is a new initiative that will provide managed long-term services and supports (LTSS) to older persons, persons with physical disabilities, and physical health coverage to Pennsylvanians who are dually eligible for Medicare and Medicaid. The goals of CHC are to:

- Enhance opportunities for community-based services;
- Strengthen health care and LTSS delivery systems;
- Allow for new innovations;

- Promote the health, safety, and well-being of enrolled participants; and
- Ensure transparency, accountability, effectiveness, and efficiency of the program.

The official release of the RFP is the first step in the procurement process for the selection of managed care organizations (MCOs). The commonwealth plans to coordinate health and LTSS through MCOs. Participants will have a choice of two to five MCOs in each region. Responses to the RFP by the managed care organizations are due on May 2, 2016. A copy of the RFP can be found here.

DHSM Monthly Medical Assistance Advisory Council (MACC) Meeting – February 25, 2016. Office of Long-Term Living Updates. Jennifer Burnett, DHS Deputy Secretary for the Office of Long Term Living (OLTL), began the presentations on the Governor's proposed budget with a review of OLTL program budgets. Burnett said the Governor's proposed budget includes:

- $23 million for home- and-community-based services provided to an additional 2,040 individuals with disabilities. This funding flows to four waiver programs for persons with disabilities.
- $25.3 million to provide home- and community-based services to 2,904 additional older Pennsylvanians.

Burnett highlighted "Community HealthChoices" (CHC) that adds $43.1 million to the budget. This program would roll out in three phases over three years -- beginning in southwest Pennsylvania in January 2017. The CHC rate model will include value-based incentives to increase the use of home-and community-based services and meet other program goals Burnett summarized the CHC proposed budget of $43.1 from the General Fund by line items:

- Long term care: CHC services $20,716,000
- Human services support: Information systems $7,875,000
- Long term care: CHC administration: $7,351,000
- Services to persons with disabilities: CHC $3,239,000
- Home-and community-based services: CHC $2,452,000
- Income maintenance: County administration $832,000
- Attendant care: CHC services $682,000

Office of Medical Assistance Programs Updates. Lucia Roberto, Chief of Staff in the DHS Office of Medical Assistance Programs (OMAP) to present details about the proposed OMAP budget. Roberto reported on initiatives in the 2016-17 budget, including the Substance Use Disorder-Health Homes program, which will be an OMAP and Office of Mental Health and Substance Abuse Services (OMHSAS) joint effort. This initiative will include 50 "Health Home-like" facilities and treat 11,250 individuals. The department emphasized that a "Health Home" is not necessarily a single building or facility where a recipient would go for all prescribed services; it could also include a collaboration of providers at different locations. Roberto mentioned an upcoming Medicaid Management Information System (MMIS) procurement. No specific dates were mentioned, but it was pointed out that the Commonwealth's current contract with Hewlett Packard expires in October 2016. Roberto completed her presentation by listing priorities for OMAP:

- Complete physical health HealthChoices statewide procurement
- Shift from volume-based to value-based care
- Reform provider shared space and co-location enrollment policies
- Complete initial provider revalidation applications
- Develop and begin implementation of the new Medicaid Management Information System (MMIS)
- Continue modernization of operations for FQHCs, prior authorization, hospital cost reporting, and provider enrollment

You can review all materials from the February MAAC meeting.

Availability of Renewal of the Office of Long-Term Living's Home and Community-Based Waiver for Persons with Other Related Conditions, OBRA Waiver. The Department of Human Services (DHS) has made available for public review and comments the Office of Long-Term Living's proposed OBRA waiver renewal and the Centers for Medicare and Medicaid Services (CMS) final rule transition plan. DHS proposed the following substantive changes to the OBRA waiver effective July 1, 2016:

- A new entity to perform clinical eligibility determinations and redeterminations.
- Four new employment-related service definitions are replacing two existing employment service definitions.
- The transition of individuals from the OBRA waiver into a managed care delivery system.
- The implementation of a home modifications broker.
- Revised language to reflect the current practice under the new child abuse clearance laws.

The proposed OBRA waiver renewal and a summary of all revisions are available on DHS's website for review. The public comment period ends March 28, 2016. Read More

Medical Assistance Program Fee Schedule Updates. The Department of Human Services (DHS) announced changes to the Medical Assistance (MA) Program Fee Schedule, effective for dates of service on and after March 1, 2016. Read More

Payments for Nursing Facility Services Provided by County Nursing Facilities. The Department of Human Services announced its intent to modify payments to county nursing facilities by increasing Medical Assistance Day One Incentive (MDOI) payments, by eliminating the existing certified public expenditure (CPE) process. Read More

Reorganization of the Department of Human Services. The Executive Board approved a reorganization of the Department of Human Services effective February 5, 2016. An updated chart is contained in the *Pennsylvania Bulletin*. Read More

Rhode Island

"Reinvent Medicaid" Campaign to Exceed Projected Savings. On February 27, 2016, *Providence Journal* reported that according to Governor Raimondo, the "Reinvent Medicaid" initiative is expected to exceed the target $70 million in savings by $7 million and is projected to save an additional $40 million in fiscal 2017. The savings come from recommendations made by a working group of hospital and insurance executives, government regulators and social-service advocates. Read More

South Dakota

Governor to Delay Medicaid Expansion Discussions until Next Legislative Session or a Special Session. On February 29, 2016, *Chicago Tribune* reported that Governor Daugaard announced Monday that he will not pursue Medicaid expansion in South Dakota this legislative session because there is not enough time for consideration of a new plan. However Duagaard will continue to look into the possibility of an expansion plan in which the state's share of the cost is covered by other savings. He stated that the state would need to find $12 million in ongoing savings to fund the plan through FY2017 and $57 million to fund the plan through 2021. The Governor as well as lawmakers hope to convene a special session on the topic. Read More

Federal Officials Pledge to Reimburse 100 Percent for Indian Health Service Patients; Revives Medicaid Expansion Possibility. On February 27, 2016, *Rapid City Journal* reported that the federal government pledged to start reimbursing at 100 percent for services to Indian Health Service patients who are sent to receive additional care through non-IHS facilities. The change could provide the funding for Medicaid expansion, an effort which was previously declared dead. Governor Dennis Daugaard's office did not immediately make clear whether expansion would be pursued. Read More

National

Private Equity Interest in Substance Abuse Treatment Fuels $20 Million Massachusetts Facility, Among Others. On March 1, 2016, *Common Health* reported that the national opioid epidemic, as well as state and national legislative and insurance changes, are fueling private equity interest in the substance abuse treatment space, which is estimated to be a $35 billion a year business. One of the biggest projects and private equity investments is Recovery Centers of America's (RCA) $20 million project in Danvers, Massachusetts, where they are working to convert the former Hunt Hospital into a 210-bed substance abuse treatment center set to open August 1. The facility will provide both inpatient and outpatient care to privately insured patients and is modeled to look like a boutique hotel. Read More

CMS Releases Final Coverage Policies Rule. On February 29, 2016, *Modern Healthcare* reported that health insurers will not be required to have minimum quantitative standards when designing their 2017 networks of hospital and doctors, and will not have to offer standardized options for plans. CMS released the final rule for 2017 coverage policies Monday afternoon, which did not include the strict network adequacy provisions that were proposed in

November and would have required providers to be within a certain distance from members. Although the final rule relaxed some of the aggressive proposals for insurers, the rule does address issues such as premium rate transparency, surprise medical bills, and 2017 open enrollment. Read More

Supreme Court Rules State Officials Cannot Force Health Insurers to Turn Over Medical Claims Data. On March 1, 2016, *The New York Times* reported that the Supreme Court ruled state officials cannot force certain health insurers to turn over medical claims data and that efforts by at least 18 states to gather and analyze data conflicts with federal law. The case was brought by Liberty Mutual Insurance, which operates a self-insured health plan for its workers in Vermont. Justice Anthony Kennedy stated that different state regulations could impose major financial and administrative burdens on health care providers and subject them to wide-ranging liability. Read More

CMS Requests States to Report Monthly on Medicaid Enrollees. On February 24, 2016, *Modern Healthcare* reported that CMS is requesting the Office of Management and Budget to extend the agency's permission to continue the Transformed Medicaid Statistical Information System (T-MSIS) to 2019. States will need to fill out information on their Medicaid and CHIP members every month instead of quarterly. The T-MSIS will provide states with real-time feedback on problems, replacing manual reviews of the data and providing the opportunity to improve on efficiency and expense. The goal is to better identify inadequate care, fraud, waste, and abuse. Read More

Industry Research

ACAView Releases Third Report on the Affordable Care Act. On March 1, 2016, ACAView, a joint effort between the Robert Wood Johnson Foundation and athenahealth, released its third report on the Affordable Care Act. Some of the findings include:

- Medicaid expansion led to the formation of new physician-patient relationships and an increase in the number of Medicaid patients seen by primary care physicians.
- Commercially insured patients are paying only slightly more than in previous years for primary care costs, but costs for surgery are substantial and rising fast.
- Uninsured patients benefit from more free visits than commercial patients, but almost 60 percent of their visits cost over $40, and 20 percent cost over $100.
- Practice revenues for PCPs in 2014 increased despite a small drop in the number of visits. Read More

Industry News

Maximus Acquires Ascend, Provider of Health Assessment Services. On March 1, 2016, *Maximus* announced that it has acquired Ascend, a provider of specialized health assessments and data management tools to government agencies that allow them to determine the appropriate placement and service needs for beneficiaries. Ascend also provides states with tools for budgeting as well as compliance with state and federal regulations. The acquisition closed February 29, 2016. Read More

LHC Group Acquires Heartlite Hospice. On March 2, 2016, LHC Group announced that it has acquired Heartlite Hospice, a subsidiary of Hospice of America. Heartlite's service area covers eight counties in Alabama and 29 counties in Georgia. The estimated population of the service area is 5.7 million. Read More

Aetna CEO Mark Bertolini Supports Health Insurance Exchanges. On February 29, 2016, *Kaiser Health News* reported that in a conversation with Health and Human Services Secretary Sylvia Burwell, Aetna Chairman and CEO, Mark Bertolini, stated that he "likes" the health insurance exchange program but some changes need to be made. Bertolini will continue working with the Obama administration but wants officials to address some problems affecting enrollment. He stated that officials should allow more flexibility in rates and benefit design to attract younger and healthier consumers and suggested introducing lower-deductible plans for young consumers, focused on staying healthy. Bertolini is open to joining the California insurance exchange if the premiums can be agreed upon. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
March 1, 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
April 22, 2016	Minnesota SNBC	Contract Awards	45,600
April 29, 2016	Missouri (Statewide)	RFP Released	700,000
May 2, 2016	Pennsylvania MLTSS/Duals	Proposals Due	450,000
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; HAP 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:

- Public documents such as the **Pennsylvania** Community HealthChoices RFP and the **Georgia** Families CMO RFP Protest Decision
- **Texas** Acute Care Hospitals Medicaid Inpatient Days Average 21.2 Percent of Total Inpatient Days, 2014 Data
- Upcoming webinars on "*Value-Based Payment Readiness: A Self-Assessment Tool for Primary Care Providers, FQHCs, and Behavioral Health Providers*" and "*Launching a Successful Medicare Advantage Plan: Key Strategic, Product, and Operational Considerations*"

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

HMA and CohnReznick introduce a new Value-Based Payment Readiness Assessment Tool

HMA has introduced a new web-based, self-assessment to help primary care providers and behavioral health providers evaluate their readiness and implement the care delivery, financial, and operational changes necessary to prepare for value-based payment (VBP). The survey assesses multiple domains of readiness, identifies readiness elements that are essential for success under VBP models, and pinpoints implementation priorities.

Available now, the tool is designed for individual providers or groups of providers working together, including providers who are part of Integrated Delivery Systems, ACOs, IPAs, and associations. We offer two versions of the tool: one for primary care providers and one for behavioral health providers. Upon completing the assessment, each organization receives a custom report and a one-hour consultation with senior experts to help interpret the results and explore potential readiness strategies.

The tool was developed by HMA and CohnReznick, a global accounting, tax and financial advisory firm with expertise in publicly funded health care, in partnership with the DC Primary Care Association.

To learn more, register for our VBP Readiness Webinar on Thursday, March 3 (link to webinar registration) or visit the new HMA Blog.

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

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