HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 23, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

CALIFORNIA PUBLISHES DUALS DEMONSTRATION PERFORMANCE DASHBOARD

This week, our *In Focus* section reviews the March 2016 release of the Cal MediConnect Performance Dashboard, published by the California Department of Health Care Services (DHCS). Cal MediConnect is the state's dual eligible financial alignment demonstration, which began phasing in enrollment in April 2014. As of February 1, 2016, Cal MediConnect had enrolled more than 124,000 dual eligible members in 10 Medicare-Medicaid plans (MMPs) across seven counties. The Cal MediConnect Performance Dashboard provides cumulative and quarterly data on long term services and supports (LTSS) use, health risk assessment (HRA) completion rates, case management/care team contact, hospital discharges and emergency utilization, and member appeals. Data is provided both in aggregate and by health plan.

LTSS Utilization

As of the third quarter of 2015 (Q3 2015), there were 33,743 Cal MediConnect members receiving LTSS. The majority of members were receiving LTSS through the In-home Supportive Services (IHSS) program, with a limited number of members in the Community-based Adult Services (CBAS) program and Multipurpose Senior Services Program (MSSP). There were 4,690 members in a nursing facility.

	Q4 2014	Q1 2015	Q2 2015	Q3 2015
IHSS	17,537	32,070	29,410	27,252
CBAS	1,068	2,236	1,669	1,262
MSSP	363	562	526	539
Nursing Facility	2,865	5,182	4,866	4,690
Total LTSS Members	**21,833**	**40,050**	**36,471**	**33,743**

Health Risk Assessment Completion Rates

Since its launch in April 2014, 88 percent of members had a HRA completed within 90 days of enrollment. The report breaks down quarterly HRA completion numbers, as well as the reasons for non-completion.

	Q4 2014	Q1 2015	Q2 2015	Q3 2015
Completed	5,479	33,610	9,024	5,121
Unwilling	2,497	7,422	1,754	774
Unreachable	8,182	26,915	7,119	4,069
Not Completed	949	2,884	864	1,301

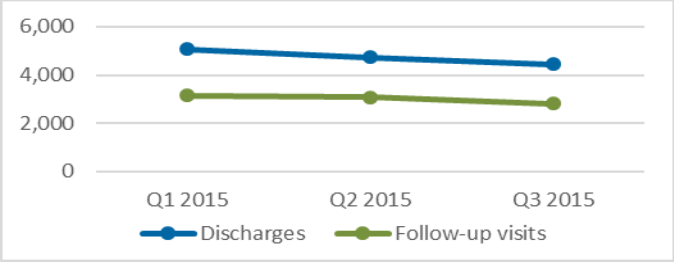
Note: The Dashboard notes that the spike in HRA completion data in Q1 2015 was due to the passive enrollment of a large number of Dual Special Needs Plan (DSNP) and Low income subsidy (LIS) members with effective dates of January 1, 2015.

Case Management Contact Rates

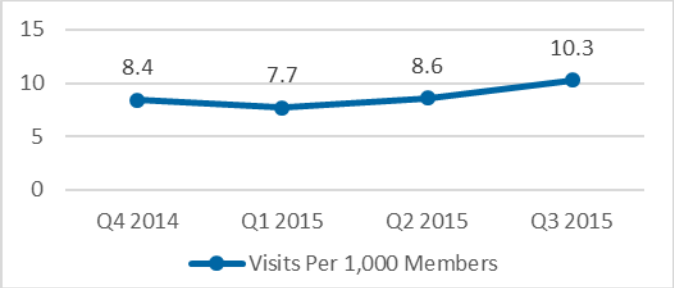
Case manager and care team contact rates are reported annually to the state. For 2014, an average of 85 percent of all Cal MediConnect members had been contacted by their case manager or care team. Five of the eight plans reporting had contact rates of 94 percent or higher, with two plans at 100 percent. The Dashboard provides actions taken by the two plans with the lowest contact rates to improve their performance.

Hospital Discharge Follow-Ups and Behavioral Health ED Utilization

MMPs began reporting on hospital discharge and ambulatory follow-up visits in Q1 2015. As of Q3, an average of 63 percent of members discharged from a hospital resulted in an ambulatory follow-up visit within 30 days. Three out of ten plans had Q3 follow-up rates of 72 percent or higher, with two other plans coming in above the 63 percent average. The Dashboard provides actions taken by the two plans with the lowest follow-up rates to improve their performance.



For Q3 2015, there were 10.3 behavioral health-related emergency visits per 1,000 members, up from 8.6 in Q2 and 7.7 in Q1. Health plan-specific rates per 1,000 members varied significantly, ranging from as low as 0.4 to as high as 16.1, with four plans at 10.6 visits per 1,000 or more.



Appeals Determinations

In Q3 2015, there were 9.7 appeal determinations per 10,000 members, up from 4.4 in Q2 and 4.2 in Q1. Appeals are categorized in three outcomes:

- A "Fully Favorable" decision is defined as an item or service covered in whole.
- A "Partially Favorable" decision is defined as an item or service partially covered.
- An "Adverse" decision is defined as an item or service denied in whole. Initial denials were issued due to a lack of records or medical necessity.

Across all plans, 86 percent of appeal determinations were Fully Favorable, with another 9 percent Partially Favorable. Only 5 percent of appeal determinations in Q3 2015 were categorized as Adverse.

Current Cal MediConnect Enrollment by Plan

As of February 1, 2016, Inland Empire and Health Net were the two largest health plans in the Cal MediConnect program, with more than 20,000 members each. CalOptima, Molina, and LA Care each hold more than 10 percent market share. Enrollment in Cal MediConnect was roughly flat over the past year.

Cal MediConnect Enrollment by Plan, February 2016	Enrollment	Market Share
Inland Empire Health Plan	21,620	17.4%
Health Net	20,325	16.4%
CalOptima	16,973	13.7%
Molina	13,484	10.8%
LA Care	12,996	10.5%
HP of San Mateo	9,573	7.7%
Santa Clara Family Health Plan	8,584	6.9%
Anthem/CareMore	8,010	6.4%
Care 1st	7,728	6.2%
Community Health Group Partner	4,999	4.0%
Totals	**124,292**	

Source: California DHCS

Link to Cal MediConnect Dashboard

http://www.calduals.org/enrollment-information/enrollment-data/cal-mediconnect-performance-dashboard/

HMA Medicaid Roundup

Alabama

Alabama Governor and Legislators Disagree Over Medicaid Funding, Putting The New Managed Care Model at Risk. On March 22, 2016, *AJMC* reported that Gov. Robert Bentley told legislators that he will veto any budget that does not fund Medicaid with the $785 million it needs. A $785 million Medicaid budget would represent an increase of $100 million and allow the state to transition to a managed care-type model under regional care organizations. However, the Senate is currently looking to pass a budget $85 million short of the governor's request, which would undermine the managed care model. The governor believes that a state lottery, which requires a three-fifths vote in both houses of the legislature and voter approval, may be the only option if the legislature refuses to pass a budget with enough funding for the proposed Medicaid transition. Read More

Legislature Discussing Not Granting Medicaid Full Amount of Funding Requested. On March 18, 2016, *Montgomery Advertiser* reported that legislators may not grant the Alabama Medicaid Agency the full amount of funding that it requested. Medicaid and health care groups are concerned that the move will have negative consequences on the state health care system, including the loss of matching federal funding needed to implement regional care organizations (RCOs). Legislators say that they want to stop Medicaid from continuing to divert needed funding from other state agencies. The Legislature's proposed 2017 General Fund budget moves Medicaid from $685 million to $700 million. The agency says it needs $785 million to keep services. Read More

Arizona

HMA Roundup – Don Novo (Email Don)

Arizona Hospital and Healthcare Association Reports on Health Care Bills. On March 18, 2016, AzHHA's latest newsletter covered the health care bills.

- SB 1327 - Hospitals; Dietitians; Prescriptions; Diet Orders passed out of the House Health committee and now moves for debate to the House.
- HB 2502 – Medical Licensure Compact passed out of the Senate Health and Human Services Committee. Compact bills for nurses, psychologists and physical therapists passed out of committee as well.
- SB 1283 – Controlled Substance Monitoring Program passed out of the House Health Committee and now heads to the House for debate. The bill would require physicians to check the controlled substances prescription monitoring program before prescribing certain drugs. Read More

Arkansas

Governor Hutchinson Proposes Work Incentives for Expansion, Managed Care for Individuals with Disabilities, Mental Illness. On March 23, 2016, *Arkansas Online* reported that Gov. Asa Hutchinson is proposing changes to the state's Medicaid expansion program which include encouraging work and personal responsibility. The Arkansas Legislature will meet in a special session beginning April 6 to consider changes to the expanded program, which currently covers 267,000 Arkansans. The expansion originally extended coverage to those with incomes of up to 138 percent of the FPL, and most are covered by private plans purchased with Medicaid funds under the private option. The governor says he wants to make changes to the private option to encourage beneficiaries to stay employed, including charging premiums, referring the unemployed to job-training programs, and subsidizing job-based coverage for those who are employed. Under a separate bill, Hutchinson will propose a Medicaid managed care program for individuals with disabilities and mental illness as part of a plan to curb the growth of spending in the traditional Medicaid program. Read More

California

HMA Roundup – Don Novo (Email Don)

California Health Insurance Exchange Threatens to Cut Hospitals with Poor Performance or High Costs. On March 18, 2016, *California Healthline* reported that California's health insurance exchange, Covered California, is threatening to cut hospitals that have poor performance or high costs. If the proposal is approved, insurers would need to identify hospital "outliers" on cost and quality starting in 2018. Medical groups and doctors would be rated after that. Health plans would be expected to expel poor performers from their exchange networks by 2019. Both providers and health plans strongly oppose the plan. Read More

Phase One of Fragile Kids Transition to Managed Care on Hold. On March 17, 2016, *California Healthline* reported that the first phase of transitioning the California Children's Services to managed care has been put on hold by the state Assembly's budget subcommittee, with the Senate's budget subcommittee expected to endorse the ruling. The first phase was originally set to begin next January and move approximately 20 percent of the 180,000 children and young adults in the program. The director of the California Department of Health Care Services, Jennifer Kent, testified to the subcommittee that the transition into managed care plans would provide better, but not cheaper, care. Read More

Safety Net Hospitals Launching Marketing Campaigns to Remain Competitive. On March 16, 2016, *HealthLeaders Media* reported that safety net providers are launching marketing campaigns to retain traditional patient populations and capture the newly insured. As more patients become insured under the ACA and have more choice on where to go, some are seeking other hospitals because safety net hospitals were never associated with quality of care. Read More

Connecticut

Connecticut Medicaid Touts Success of Move Away from Managed Care. On March 18, 2016, *The Wall Street Journal* reported on Connecticut's shift away from using private insurers to manage its Medicaid system, Husky. In 2012, the state returned to a more traditional fee-for-service system, reimbursing providers directly. As a result, the average cost per enrollee per month, went down from $718 in mid-2012 to $670 last year. Additionally, the number of doctors willing to treat Medicaid patients went up 7 percent. Connecticut calls its new system "managed fee-for-service." A nonprofit administrator processes medical claims, but the state carries the financial risk, with reimbursement rates the same across the state. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Wexford Health Services is Challenging the State's Award to Centurion to Provide Prison Health Care. On March 22, 2016, *Health News Florida* reported that prison health care company Wexford Health Sources is asking a judge to allow it to challenge the Florida Department of Correction's decision in January to award a contract to competing firm Centurion to provide prison services. Although the state is saying that the contract with Centurion was authorized by statute, Wexford argued that it has grounds to protest the contract award. Read More

Idaho

Legislative Leaders Developing Proposal to Address Medicaid Gap. On March 18, 2016, *magicvalley.com* reported that legislative leaders are working on a proposal to address the 78,000 residents who don't qualify for Medicaid or health insurance subsidies. The House Health and Welfare Committee was originally scheduled to introduce two health care-related bills: one to create an interim committee, and one to give a grant to the state's community health centers and gather data on the gap population. However, the committee chose to wait until leadership introduces its plan. One possibility could be seeking a Medicaid expansion waiver. Read More

Kansas

Senate Advances Bill to Stop Medicaid Payments for Early Elective Births. On March 17, 2016, *Kansas Health Institute* reported that a Senate subcommittee advanced Senate Bill 495, which would ban Medicaid from covering elective births prior to the 39th week of pregnancy. Reducing Medicaid funding for early elective births can save up to $20 million over five years, according to a statewide efficiency report. However, the State Office of the Budget could not estimate how much the state would save because of the uncertainty about the number of early births that were medically necessary. Read More

Louisiana

Gov. Edwards Wants Co-Pays, Work Referrals, and Healthy Behaviors for Medicaid Expansion. On March 15, 2016, *The Advocate* reported that Gov. John Bel Edwards stated during his State of the State address that he is seeking a Medicaid expansion to "require personal responsibility for health by charging copays, providing premium assistance, requiring work referrals and promoting healthy behaviors." Edwards signed an executive order expanding Medicaid right after taking office in January. Expansion is set to rollout on July 1. However, some legislators have already filed bills looking to block expansion or create significant hurdles. Read More

Montana

Montana Medicaid Expansion Receives First Progress Report, with Enrollment Better than Expected. On March 23, 2016, *Kaiser Health News* reported that Montana's Medicaid expansion is currently exceeding expectations according to its first progress report. The state initially projected that it would add 23,000 of the state's 70,000 Medicaid-eligible in the first year, however enrollment is currently at 38,298 since the January 1 rollout. The report was issued by a Medicaid expansion oversight committee created by the legislature when the state approved expansion last year. The expansion, a compromise to win support from enough Republicans, included co-pays and premiums for recipients above 50 percent of the federal poverty level (FPL).

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Home Health Aides in Jeopardy Due to Low Wages, Employee Shortage, and Unfunded Regulations. On March 21, 2016, *Courier-Post* reported that home health care agencies are warning that personal assistance services in the state are in jeopardy due to low wages tied to low reimbursement rates paid by managed care companies, employee shortages, and unfunded regulations. A state bill to raise the minimum wage to $15 an hour could both help and hurt firms. Since most home care companies are operating on very thin margins, the changes could force agencies to either fold or merge with other companies. Read More

New Jersey Medicaid Selected to Receive Technical Assistance from CMS Innovation Accelerator Program. On March 22, 2016, Gov. Chris Christie's Administration announced that the Centers for Medicare and Medicaid Services (CMS) chose New Jersey Medicaid for a six-month program to build state capacity and support innovation in four areas: 1) substance use disorders; 2) Medicaid beneficiaries with complex needs and high costs; 3) community integration and long term services and supports; and 4) physical/mental health integration. Acting Commissioner for the state's Department of Human Services, Elizabeth Connolly, sees the program as an opportunity to expand the state's work to improve housing options, since it will be undertaken in collaboration with several housing and development agencies. Read more

Governor Supports a Two-Year Moratorium on Nonprofit Hospital Property Taxes; Creates a Commission to Review the Tax Exemption Law. On March 18, 2016, *NJBIZ* reported that Gov. Christie is in support of the temporary suspension of property taxes on the state's 62 nonprofit hospitals, and established a nine-member review commission to consider solutions to address both the hospitals' and municipalities' concerns. Read more

Department of Health Awards $5.5 Million in Grants to Improve Health Care for Veterans. The New Jersey Department of Health's March 2016 newsletter identified 14 organizations that will share in the total grant award to respond to unmet veteran health care needs across the state. The following grants will be made:

ORGANIZATION	GRANT AWARD
Cooper Health System	$2.05 million
Rutgers University-Behavioral Healthcare	$1.55 million
Kennedy University Hospital	$1.4 million
Zufall Health Center	$50,000
Robert Wood Johnson University Hospital – New Brunswick	$50,000
Catholic Family and Community Services	$50,000
Deborah Hospital Foundation	$50,000
Ocean Health Initiatives, Inc.	$50,000
Trinitas Regional Medical Center	$50,000
Catholic Charities Archdiocese of Newark	$50,000
Visiting Nurses Association of Central Jersey	$45,000
Veterans Foundation of America	$39,000
Servicio Latinos de Burlington County	$33,500
Rowan University	$33,300

New Mexico

New Mexico Stands to Lose $417 Million in Medicaid Funding. On March 22, 2016, *Santa Fe New Mexican* reported that if New Mexico cannot find $87 million through cuts or new revenue for Medicaid, it stands to lose another $330 million in matching federal funds. The state budget requires the Human Services Department to reduce reimbursement rates paid to Medicaid providers, including rescinding a rate increase in the Affordable Care Act to primary care physicians and reducing rates paid to hospitals. Additionally, the budget reduces administrative costs for the four Medicaid managed care companies. A Medicaid committee is expected to make recommendations by the second week in April on how much to cut rates paid to health care providers for treating Medicaid patients. Read More

Proposed Bill to Create Safeguards for Medicaid Consumers and Providers Against Fraud. On March 20, 2016, *Albuquerque Journal* reported that Democratic legislators are proposing a bill, the Medicaid Due Process Integrity Act, to create safeguards for Medicaid providers and consumers when fraud is alleged. In June 2013, Medicaid funding was halted to 15 providers who were accused of committing fraud. Thirteen of the providers have been cleared of any wrongdoing. The newly proposed bill would require the Medicaid agency to consult with the state attorney general on the credibility of allegations before suspending payments and require the state, before withholding payments, to consider how access to care would be affected. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

E-Prescribing Mandate. NYS enacted legislation in 2012 that included an e-prescribing mandate as part of the I-Stop (Internet System for Tracking Over-Prescribing) legislation. I-Stop required that, effective March 2015, all prescriptions for controlled substances must be submitted electronically, in an effort to eliminate the problem of forged or stolen prescriptions. Due to concerns raised by the provider community, the implementation was delayed by one year. The concern was that many electronic health record (EHR) vendors are not yet certified for e-prescribing controlled substances, and necessary system testing has not yet occurred. Software used in e-prescribing must be certified by the Drug Enforcement Administration (DEA). A letter from the Medical Society of the State of New York, last February, noted that at least half of the state's nursing facilities do not yet have an EHR system, and assisted living facilities are even less likely to have systems that allow communication between the pharmacy and prescriber. With the implementation date looming, Health Commissioner Zucker issued a blanket waiver with respect to the electronic prescribing requirements that go into effect on March 27, 2016, for "exceptional circumstances in which electronic prescribing cannot be performed due to limitations in software functionality." The exceptional circumstances for which this waiver applies are described in a March 16 letter. Among the 12 exceptions are prescriptions for compound drugs, and medications issued to patients in nursing homes and residential health care facilities. According to the Associate Press, about 8 percent of New York's 124,000 doctors, dentists, nurse practitioners and other prescribers have gotten extensions on the March 27 deadline. The New York Senate has passed legislation that would exempt from the mandate, providers who write a small number of prescriptions.

Value-based Payment Roadmap Updated. The Department of Health has released an update to its value-based payment (VBP) roadmap, "A Path toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform." New York has committed to achieving 80 percent of reimbursements by VBP by the end of the 5-year DSRIP waiver period. To achieve success, all components of the Medicaid program must understand the fundamental shift that DSRIP and VBP represent. The state developed a sizable stakeholder engagement process that resulted in over 500 stakeholders across the state participating. Five subcommittees were established to address a number of dimensions:

- Technical Design I: addressed remaining financial and methodological policy questions
- Technical Design II: addressed remaining quality, support and design policy questions
- Regulatory Impact: addressed remaining regulatory policy questions
- Social Determinants of Health & Community-based Organizations: formulated and provided specific recommendations that drive VBP by addressing social determinants of health, addressed the training needs for CBOs, and ensured all pertinent organizations were involved
- Advocacy and Engagement: assisted in the design of member incentives to promote lifestyle choices proven to improve health and reduce

downstream costs, and discussed the members' right to know about the incentives that affect their care.

In addition to the subcommittees, Clinical Advisory Groups (CAGs) were created to review the care bundle design and subpopulation definitions most relevant to New York State Medicaid. The CAGs made recommendations on quality measures, data and support required for providers to be successful, and addressed other implementation details related to specific VBP arrangements. Eight CAGs met during 2015, including: Maternity, Chronic Heart Conditions, Diabetes, Chronic Pulmonary Conditions, Behavioral Health, Substance Use Disorder, HIV/AIDS, Managed Long-Term Care, and Health and Recovery Plans. The updated roadmap has been posted to the DSRIP website in draft form and is open for public comment through April 18, 2016. Both the draft of the roadmap and the complete set of recommendations made by the subcommittees can be found here.

Hospital Consolidations Continue. Rome Memorial Hospital and St. Joseph's Health have announced that they are entering into a "collaborative relationship in pursuit of mutual goals to expand patient access to needed services and technology in the community." Over the next several months, Rome Memorial and St. Joseph's will be working through the details to finalize the affiliation agreement and obtain the necessary regulatory approvals. Rome Memorial will continue to operate as an independent, separately licensed hospital. Rome Memorial is a not-for-profit community hospital with 130 licensed acute care beds, an 80-bed skilled nursing facility, a broad array of outpatient services, and three Article 28 primary care practices. St. Joseph's Health is a non-profit regional health care system based in Syracuse, providing services throughout central New York and northern Pennsylvania. St. Joseph's Health is affiliated with Franciscan Companies and St. Joseph's Physicians and is a part of Trinity Health. More here.

In a separate announcement, Northwell Health (formerly North Shore-LIJ Health System) announced that it had received state approval to join Forest Hills Hospital and Franklin Hospital, in Valley Stream, with Long Island Jewish (LIJ) Medical Center (More here). Both community hospitals are now under the operating license of LIJ Medical Center, based in New Hyde Park, and are divisions of LIJ Medical Center. They have been renamed Long Island Jewish Forest Hills and Long Island Jewish Valley Stream. Long Island Jewish Forest Hills is a 312-bed community teaching hospital that provides inpatient medical and surgical care, intensive care, and obstetrics and gynecology services. Long Island Jewish Valley Stream is a 305-bed community hospital offering a comprehensive array of medical and surgical programs and services, and is also home to the 120-bed Orzac Center for Rehabilitation, which houses the hospital's long-term care and rehabilitative medicine department and the medically oriented Adult Day Health Care Program.

Encouraging Health Care Competition. In light of the on-going trend toward hospital consolidation and the efforts under DSRIP to build large provider networks, the Manhattan Institute has released a paper arguing that hospital mergers typically result in higher prices with little improvement in quality, particularly in markets that have already experienced a significant degree of hospital consolidation. The report notes that while competitive markets are thought to produce the optimal allocation of resources through their use of pricing signals, hospitals have successfully argued that competition is antithetical to their successful operation, given the unique characteristics of

hospital markets, which include natural barriers to entry and hospitals' safety net and medical-teaching roles. The Institute recommends the following reforms to foster greater competition in hospital markets:

- Encourage greater pricing and quality transparency for hospitals, beginning with the full implementation of the state's all-payer claims database (APCD).
- Prohibit anticompetitive contracts between providers and health care plans that either restrict transparency or prohibit steering patients to high-value providers.
- Repeal barriers to entry in health care markets—including certificate-of-need (CON) laws, the prohibition on the corporate practice of medicine, and the certificate of public advantage (which immunizes certain providers from antitrust challenges)—to remove unnecessary restrictions on the supply of firms offering health care services.
- Establish a New York State Health Cost Commission, modeled after the Massachusetts Health Policy Commission, mandated to produce annual reports on health care cost and consolidation trends in New York State, including barriers to entry faced by new firms and business models.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Infant Mortality Commission Issues Recommendations. According to *Gongwer Ohio,* the Ohio Commission on Infant Mortality has issued a report to the General Assembly after eight months of public meetings focused on how to best improve the state's infant mortality rates. A key recommendation is more extensive screening of potential mothers to identify risks associated social determinants of health. The report also recommends that the General Assembly contract with an outside entity to lead a stakeholder group to review state policies and programs that impact infants and women of childbearing age. The full Ohio Commission on Infant Mortality Report is available here. Read More

***Watchdog.org* Claims Ohio's Medicaid Expansion is On Track to Run Nearly $8 Billion Over Budget by the End of Next Year:** On March 21, 2016, *Watchdog.org,* citing Jonathan Ingram, research director at the free-market Foundation for Government Accountability, reported that Ohio's Medicaid expansion has run $3.1 billion over budget and is on track to run nearly $8 billion over budget by the end of the year.

Ohio Counties' Health Rankings: *Crains's Cleveland Business* is reporting that Cuyahoga and Summit counties rank in the bottom half of Ohio county health rankings according to the 2016 County Health Rankings, a Robert Wood Johnson Foundation project released March 16. Cuyahoga County's rank was 64th of 88 counties in the state. Summit County was ranked 52nd in the state. The rankings occur annually and look at a variety of factors that influence health. The University of Wisconsin partners with Robert Wood Johnson on the project. Read More

Oregon

FamilyCare to Settle With Oregon Health Authority. On March 21, 2016, *The Oregonian* reported that FamilyCare announced that it is ready to settle with the Oregon Health Authority. The organization said it's prepared to give the state $47.3 million in overpayments after the Oregon Health Care Authority demanded $55 million and threatened to end the contract otherwise. The Oregon Health Care Authority is reviewing the proposal. Read More On March 17, 2016, *The Oregonian* reported that the Oregon Health Authority offered FamilyCare, a Medicaid managed care organization, to either pay a settlement or risk losing their contract. In 2015, Oregon retroactively reset Medicaid rates, which left FamilyCare with $55 million in overpayments. The company sued the state as a result. Oregon is offering FamilyCare the option to pay an unspecified amount by December 2018 for the money owed, or the state will end the contract. FamilyCare issued a statement indicating it wasn't backing down. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

SEIU Healthcare PA Discusses Nursing Home Worker Contracts. SEIU Healthcare Pennsylvania hosted a conference call to discuss the 7,000 nursing home workers from 50 facilities who are now engaged in negotiations for new union contracts set to expire at the end of March. The caregivers are calling for minimum wages of at least $15 an hour and fair wages for all workers, affordable health care, and improved staffing. Matt Yarnell, Vice President of Long Term Care for SEIU Healthcare Pennsylvania, explained the difficulty of the work nursing home caregivers perform and emphasized that many are underpaid: "…workers depend on public assistance and the workforce experiences very high turnover which is bad for the continuity of resident care." Yarnell's statement reflects the union's concerns as the state moves toward Managed Long Term Care. Stephen Herzenberg, executive director of the Keystone Research Center, explained that the center released two reports on the nursing home workforce which highlighted "the fact that this is a taxpayer funded industry that also profits from the taxpayer funded safety net for its workforce who could otherwise not afford to stay in this industry." Read More

Rhode Island

Auditor's Report Indicates Rhode Island Overpaid MCOs for Medicaid Expansion. On March 17, 2016, the Rhode Island Office of the Auditor General released its report on state fiscal year ending June 30, 2015. The audit reveals that Medicaid MCOs were overpaid by more than $200 million due to overstated capitation rates for the Medicaid expansion population. The report notes that due to contract provisions around gain sharing, the MCOs will retain a portion of the excess capitation payments. According to the report, the state will be recouping most of the outstanding gain share balance in the first half of 2016. Additionally, the state is continuing to reexamine the underlying assumptions in the Medicaid expansion capitation rates. Read More

Vermont

Medicaid Patients with Disabilities or in Long-Term Care Are Most Expensive Patients. On March 20, 2016, *VTDigger.org* reported that according to an analysis of enrollment and expenditure data from the Department of Vermont Health and other departments within the Agency of Human Services, Medicaid patients with disabilities or those in long-term care use more health care resources and cost more. A high number of low-income people, and a slowly increasing number of people who rely on Medicaid for treatment of long-term health problems has increased Medicaid spending. Read More

Shumlin Administration Proposes to Postpone Medicaid Management Information System. On March 16, 2016, *VTDigger.org* reported that the Shumlin administration is proposing to postpone the Medicaid billing system project, MMIS core, in order to focus on building a smaller integrated eligibility platform than previously planned. The current MMIS core contract is set to expire on Dec. 31. The administration will spend $51 million in state and federal funding over the next 18 months to build out "Phase 1" of integrated eligibility, which focuses on the foundation of the system. Vermont would pay for around $5 million of the total. Phase 2 would expand the system to include about a dozen total programs, such as heating assistance and supplemental nutritional assistance. Read More

National

House Budget Committee's Spending Plan to Eliminate Health Care Subsidies, Cut Medicaid, and Transform Medicare to Voucher Program. On March 16, 2016, *Modern Healthcare* reported that the House Budget Committee is moving forward with a 10-year spending plan that would eliminate health care subsidies, cut Medicaid, and transform Medicare to a voucher-like program. It also proposes work requirements for benefit programs, raising the Medicare eligibility age to 67, and eliminating the Social Services Block Grant. The Center on Budget and Policy Priorities calculated that programs for the poor would bear about 60 percent of the cuts in the House budget. Read More

Republican Expansion States Push For Job Mandates in Medicaid Expansion. On March 18, 2016, *CQ Roll Call* reported that Republican-led states that are expanding Medicaid continue to push for job requirement waivers. Thus far, CMS has yet to approve any waiver requiring beneficiaries to have a job or be enrolled in job-search or training programs. Arkansas is one of the latest states seeking such a waiver. Indiana, Montana and New Hampshire, whose waivers were rejected, have connected voluntary work referral programs to their Medicaid expansion plans, advertising them as a perk for new enrollees. Montana's HELP-Link program provides services such as résumé assistance and job matching for Medicaid recipients.

Industry News

Centene and Health Net Receive CDI Approval for Merger. On March 23, 2016, a Centene Corporation press release reported approval from the California Department of Insurance of the company's merger with Health Net. Centene and Health Net announced a merger agreement in July 2015, and are expected to close the transaction in the coming days. Read More

Capella Healthcare and RegionalCare Hospital Partners to Merge to Own Eighteen Total Hospitals. On March 22, 2016, *The Tennessean* reported that Capella Healthcare and RegionalCare Hospital Partners will merge to create a hospital portfolio in a dozen states. The two companies plan to use the merger to expand their scale as well as find new ways to reach patients in their existing markets. Together they own 18 hospitals. RegionalCare is backed by Apollo Global Management and Capella has received investment from Medical Properties Trust. The deal is expected to close in the second quarter. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
March 29, 2016	Minnesota SNBC	Proposals Due	45,600
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 1, 2016	Massachusetts MassHealth ACO - Pilot	RFA Released	TBD
May 2, 2016	Pennsylvania MLTSS/Duals	Proposals Due	420,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
May, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
TBD Spring/Summer 2016	Virginia MLTSS	RFP Released	130,000
June 1, 2016	Massachusetts MassHealth ACO - Full-Scale	RFA Released	TBD
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)	100,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 1, 2017	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
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
June 1, 2017	Massachusetts MassHealth ACO - Full-Scale	RFA Released	TBD
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)	145,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000

Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of the progression of states toward implementing a 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	126,100	29.3%	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	48,143	32.5%	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	12,524	13.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	34,162	32.5%	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	5,801	4.7%	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	62,155	65.4%	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	1,824	3.4%	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	48,010	28.6%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	27,259	38.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,319,100**	**365,978**	**27.7%**	

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:

- Updated Medicaid managed care plan financials for **South Carolina**, **Texas**, **Tennessee**, and more
- **Rhode Island** Medicaid managed care membership rises 10%, 2015 Data
- Public documents such as **Virginia** Public Comments on the MLTSS Model of Care and the **Oregon** Health Plan 1115 Waiver Documents
- An upcoming webinar on *"Targeting Readmissions: A Collaborative Strategy for Hospitals, Health Plans, and Communities"*

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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