HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 30, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

WISCONSIN ISSUES CONCEPT PAPER ON FAMILY CARE/IRIS LTSS REDESIGN

This week, our *In Focus* section reviews the Wisconsin Department of Health Services (DHS) concept paper on Family Care and IRIS (Include, Respect, I Self-direct) redesign published this month. Under the 2017-2017 State Budget Act, Act 55, DHS is directed to make changes to the Family Care and IRIS Medicaid long-term services and supports (LTSS) programs. Family Care is the state's existing MLTSS program, while IRIS allows members to self-direct their long term care services. Under the proposed design of Family Care/IRIS 2.0, integrated acute, behavioral, and LTSS services for more than 55,000 Medicaid beneficiaries with more than $3.4 billion in LTSS costs alone will be coordinated statewide through contracted integrated health agencies (IHAs).

Family Care/IRIS 2.0 Covered Populations, Services

Under Family Care/IRIS 2.0, the same populations will be covered as under the current programs. This includes adults with physical disabilities, adults with intellectual/developmental disabilities, and persons who are elderly. Dual eligibles will be eligible to enroll in Family Care/IRIS 2.0, or may remain in the Family Care Partnership program, which will continue to operate in its 14

existing counties, requiring enrollment in a Medicaid MCO and an affiliated D-SNP. Family Care/IRIS 2.0 will be statewide, including the seven counties currently excluded from Family Care.

DHS proposes a continuous open-enrollment process, in which members may make changes at any time to their IHA selection and self-direction of services. The concept paper notes that only 1.2 percent of Family Care members requested a health plan change during 2015.

The existing Family Care and IRIS LTSS services will continue to be provided by the IHAs, as well as integrated acute care and behavioral health services, which are currently fee-for-service for Family Care and IRIS members. Prescription drugs will continue to be paid fee-for-service under the statewide carve-out approach. Family Care/IRIS 2.0 members will have the option to self-direct many of their LTSS benefits. A full list of proposed benefits and self-direction options are included in the concept paper.

Integrated Health Agencies (IHAs)

DHS proposes dividing the state into three region, each to be served by three IHAs. The regions will be a mix of urban and rural counties. IHAs will be procured under a competitive RFP process and must be licensed insurers, per a decision by the Office of the Commissioner of Insurance. IHAs will be able to bid on any combination of the three regions, but must serve all counties within a region. IHAs will be paid a monthly actuarially sound capitation rate for Family Care/IRIS 2.0 members, and will account for self-directed LTSS. The concept paper proposes pay-for-performance measures in the capitation structure, and encourages IHAs to invest in home and community-based service options.

Role of Aging and Disability Resource Centers (ADRCs)

ADRCs will continue to play a role in the Medicaid LTSS structure under Family Care/IRIS 2.0, acting as the point of entry for members, and conducting eligibility screenings and assessments, as well as assisting with enrollment, appeals, and other functions as they do currently under Family Care and IRIS.

Existing Family Care, Family Care Partnership, IRIS Market

There are more than 55,000 members across the Family Care, Family Care Partnership, and IRIS programs. Family Care and Partnership enrollment figures below are from February 2016, with IRIS enrollment as of May 2015. Community Care and MyChoice are the two largest health plans in the Family Care and Partnership market.

	Family Care	Partnership	IRIS	All Programs
Community Care Family Care/Community Care Org. of Milwaukee Co.	9,524	683		10,207
My Choice Family Care	8,370			8,370
Care Wisconsin	5,938	1,478		7,416
Community Care Connections of WI/Community Care of Central WI	5,810			5,810
Continuus	5,146			5,146
Lakeland-fond Du Lac-manitowoc-winnebago	4,163			4,163
Western Wisconsin Cares	3,855			3,855
Independent Care (iCare)		827		827
Total Membership	**42,806**	**2,988**	**12,026**	**57,820**

Source: DHS Reported Enrollment Figures, February 2016 (Except IRIS)

Link to Concept Paper

https://www.dhs.wisconsin.gov/familycareiris2/index.htm

HMA Medicaid Roundup

Arizona

HMA Roundup – Don Novo (Email Don)

AHCCCS to Increase the Hospital Assessment by $15 Million in FY2017. On March 25, 2016, the Arizona Hospital and Healthcare Association reported that AHCCCS is increasing the hospital assessment from $250 million in FY2016 to $265 million in FY2017 due to population and expenditure projections. AHCCCS is planning on using the existing methodology to compute the amount each hospital will owe, and will provide that information to hospitals in May. The state agency updates the amount of the hospital assessment to be collected annually to ensure that funding is sufficient to cover the expected costs of the population funded by the assessment. The annual assessment amounts can be found here.

Governor Ducey Signs Law to Improve Access to Care for Foster Children. On March 25, 2016, a press release by AHCCCS reported that Governor Ducey signed HB2442, "Jacob's Law," to provide access to behavioral health care for nearly 19,000 Arizona foster children. Read More

Arkansas

Governor Called Special Session Starting April 6 to Discuss His Reform Options. On March 30, 2016, *SWTimes* reported that Governor Asa Hutchinson will call a special session beginning April 6, 2016, to ask lawmakers to consider his plan for modifying the state's Medicaid program and contracting with private companies to manage parts of the program. The managed care proposal, contained in a bill titled the Arkansas Medicaid Reform Act, would create a managed care system for the disabled, those receiving behavioral health services, and all dental services. Hutchinson also wants to modify the private option and rename it Arkansas Works. Although there are other proposals and discussions on the table, the Governor will only discuss Arkansas Works and the Medicaid Reform Act during the special session next week. Read More

Arkansas Governor Proposes Managed Care Reforms in Addition to a Hybrid Expansion. On March 25, 2016, *theeagle.com* reported that Arkansas Governor Hutchinson has said that he is trying to broaden the Medicaid reform debate by discussing not just hybrid expansion but also managed care reforms. His proposal would shift some Medicaid services for individuals with developmental disabilities and individuals with severe and persistent mental illness to management by private companies. It is intended to bring $1.4 billion in savings to reduce the state's waiting list for home and community-based services. However, state lawmakers are resisting the managed care proposal,

especially Democrats who have historically backed the state's hybrid expansion. Read More

Colorado

Colorado Attorney General Approves InnovAge's Transition to a For-Profit Provider. On March 25, 2016, *Denver Business Journal* reported that Colorado Attorney General gave senior care company InnovAge approval to convert from a nonprofit to a for-profit provider, with several stipulations. InnovAge has six senior centers and a daycare program in Colorado, as well as in New Mexico and California. The company is a PACE provider, serving those over 55 years, eligible for Medicaid and Medicare, and needing a nursing home level of care. Read More

Connecticut

Connecticut to Close Two Residential Care Facilities for People with Intellectual or Developmental Disabilities. On March 24, 2016, *The CT Mirror* reported that Connecticut will close two state-operated centers for people with intellectual or developmental disabilities. State-run facilities often cost more than independent providers. The Department of Developmental Services reports it costs, on average, $247,833 per resident at the state-run regional centers compared to $113,860 per resident at privately-run group homes. The department plans to expand services to a wider number of people who may not currently have access to them. The 40 residents who live at the two facilities will have the choice of relocating to one of the three other state-run centers or move into a community-based setting. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Governor Signs Dental Carve Out Bill. On March 24, 2016, *Politico Florida* reported that Governor Rick Scott signed a bill that carves dental services out of the mandated benefits that HMOs must provide to Medicaid patients and sets up a study on the effectiveness of dental care provided by the HMOs. Scott also sent a letter to the Secretary of State Ken Detzner regarding the accomplishments of Medicaid HMOs and said that if the study shows that care does not improve, he would expect the 2017 Legislature to amend the statute immediately. The Florida Association of Health Plans does not support the bill and believes "that the result of a valid study will show that coordinated, comprehensive care under managed care ultimately results in better health outcomes." Read More

Manatee County Leaders Search for New Funding Mechanism for the Uninsured with Help of HMA Colleagues. On March 29, 2016, *Herald Tribune* reported that Manatee County leaders are concerned about gaining public support to fund health care for the 7.1 percent of the county's population that do not qualify for Medicaid or for Affordable Care Act subsidies. The county is currently using reserves to provide subsidies but has not found a long-term solution, and county voters have already rejected a sales tax to fund the care. The County Commission is working with the Health Care Advisory Board and HMA colleagues to find a new funding source now that the trust fund used for

the last three decades is depleted. The county is currently using general fund reserves to partially restore the depleted fund. Read More

Idaho

Governor Rules Out Special Legislative Session, Creates Workgroup on Medicaid Expansion. The *Idaho Statesman* reported on March 28, 2016, that Idaho Governor Butch Otter has ruled out calling a special legislative session to expand Medicaid for 78,000 Idahoans. Instead the administration will work with an interim legislative committee to review Idaho's options for an alternate Medicaid expansion, likely through a federal waiver. The committee will consist of state House and Senate lawmakers, and the Governor said that he will not act with executive order for Medicaid expansion due to the implications of taking such action. Read More

Medicaid Expansion Proposal Fails in Legislative Session. On March 23, 2016, *The Charlotte Observer* reported that lawmakers have failed to finalize a proposal to expand Medicaid. Two minor bills were approved to further study the Medicaid gap population, consisting of approximately 78,000 Idaho residents. Read More

Illinois

Budget Impasse Continues Payment Delays to State Employee Group Insurance Program; Debt Nears $2.8 Billion. On March 25, 2016, *The News-Gazette* reported that Illinois is nearing its tenth month without a budget. As a result, along with years of underfunding, the state employee group insurance program is now averaging 15 months of payment delays and a total of $2.8 billion of unpaid claims – $1.4 billion owed for the state's self-insured plans and $1.5 billion for the fully insured plans. CMS and health plan administrators are working with health care providers around the state to help avoid billing impacts and service interruptions for state group insurance members. Presence Health recently announced plans to reduce 700 jobs throughout its system this year after posting a $186 million loss on operations for 2015. Health Alliance is managing the state payment delay by using Central Management Service's Vendor Support Initiative to keep claims paid on time. Read More

Iowa

Mayo Clinic Will No Longer Be a Provider for Iowa Medicaid After Privatization. On March 24, 2016, *The Des Moines Register* reported that none of the three managed care companies picked to run Iowa's Medicaid managed care program were able to negotiate a contract with Mayo Clinic. The companies said they will continue to try to persuade the hospital system to reconsider. The Iowa Department of Human Services said the situation could mean some Medicaid patients in northern Iowa would have to travel to Iowa City for specialty care at University of Iowa Hospitals. Read More

Kansas

Kansas Announces Program to Help Nursing Homes with Medicaid Eligibility Processing Delays. On March 25, 2016, *Kansas Health Institute* reported that the Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services announced that they will allow some nursing facilities to petition for half-payments for some residents whose Medicaid applications or renewals are still processing. The state's plan allows facilities to apply for advanced payments only for residents whose applications have been pending for 60 days or more, with priority to smaller facilities versus large, corporate-owned facilities. The processing delays began in July 2015 with a computer system switch and administrative changes in January 2016. Read More

Louisiana

Louisiana Medicaid Expansion Gateway for Additional Reforms. On March 29, 2016, *The Times-Picayune* reported that Louisiana's recent Medicaid expansion, set to begin July 1, 2016, is just the beginning of health care reforms planned by the Governor's administration. Other changes could include moving away from designating regional hospitals as "safety net" providers to treat individuals with lower incomes and moving away from using teaching hospitals to treat the uninsured and teach new doctors simultaneously. Read More

Maine

Mental Health Providers in Maine Face Rate Adjustments with a Net Negative Impact. On March 30, 2016, *Bangor Daily News* reported that mental health providers in Maine are facing major changes in how much they are paid for services for individuals covered by MaineCare, which providers say will have a net negative financial effect. Health and Human Services Commissioner Mary Mayhew said that the rate study is part of the legislature's June 2015 budget bill which called for examination of how Medicaid dollars are spent for services including those for children with cognitive impairments and behavioral health services. The study resulted in a report released last week. Providers have until early April to comment on the proposals, followed by DHHS releasing a formal rule and implementing new rates later this year. Read More

Massachusetts

HMA Roundup – Rob Buchanan (Email Rob)

Massachusetts Hospital Association Objects Governor Baker's New Hospital Tax Proposal. A recent press release by the *Massachusetts Hospital Association* included a letter to Massachusetts House leadership objecting to the Baker Administration's proposed new $250 million tax on acute care hospitals, but offered a series of required conditions needed to achieve the association's acceptance of the tax. The new hospital tax would generate federal matching funds used to support investments in Medicaid ACOs and community healthcare providers that are part of the new five-year Medicaid waiver being considered. However, the tax would be permanent. While supportive of the waiver, MHA raised concerns that the hospital tax does not have a five-year

sunset provision and that language must clearly state that the funds will not be diverted from hospitals for other state uses.

Massachusetts Community Hospitals are Losing Business to Larger Urban Teaching Hospitals. On March 21, 2016, *The Boston Globe* reported that Massachusetts community hospitals are losing business to larger urban teaching hospitals. The state's Health Policy Commission released its first report on the issue on Monday, saying that community hospitals are being squeezed by lower payments from insurers and patients choosing to be treated at big Boston hospitals, even for routine care. The state's five largest health system accounted for 61 percent of inpatient discharges for commercial patients in 2014, up 54 percent from 2012. Additionally, community hospitals are seeing competition from rapidly growing walk-in clinics and urgent care centers. Not only is volume an issue, but community hospitals are also paid less than urban teaching hospitals, leading to more closures and rising healthcare costs. Read More

Mississippi

Mississippi Senate Committee Passes Bill to Build Electronic Records System for Medicaid and Audit Recipients. On March 24, 2016, *The Baltimore Sun* reported that the Mississippi Senate committee passed HB 1116 that would contract with a company to build a computerized record of Medicaid recipient's information to conduct regular audits. The bill is intended to eliminate fraud and waste. It now moves to the Senate for debate. Read More

Nebraska

Nebraska Lawmakers Reject Another Attempt at Expansion. On March 29, 2016, *KSL.com* reported that Nebraska lawmakers have rejected another proposal to expand Medicaid. The proposal would have covered an estimated 97,000 uninsured whose incomes are too high to qualify for Medicaid but too low to receive federal subsidies to help pay for insurance by buying coverage for residents without access to an employer-sponsored plan or pay the worker's share of premiums for employers offering plans. Three other attempts to expand Medicaid have failed in the past three years. Read More

New Hampshire

Senate Finance Committee Endorses Continuation of Expansion with a Work Requirement. The *Washington Times* reported on March 28, 2016, that New Hampshire's Senate Finance Committee endorsed the continuation of the Medicaid expansion program. The expansion covers 48,000 eligible and would end this year if lawmakers do not pass the reauthorization bill. The bill makes changes to the program including a minimum work requirement of 30 hours per week. It has passed the state House and will go to the Republican-led Senate Thursday before going to Governor Hassan later this week. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Department of Banking and Insurance (DOBI) releases the annual New Jersey HMO & PPO Performance Report. This report uses the HEDIS measurement system to compare performance of five HMO and PPO carriers in 2015:

- Aetna-HMO/POS and PPO/EPO
- AmeriHealth-HMO/POS & PPO/EPO
- Cigna-HMO/POS & PPO
- Horizon-HMO & PPO/EPO
- United/Oxford-HMO/POS & PPO/EPO

The report does not review the performance of the state's Medicaid MCOs, which is reported separately by DMAHS. A copy of the report can be found here.

Medicaid agency releases FY2014 Drug Utilization Review Board annual report for public comment. On March 7, 2016 the Division of Medical Assistance and Health Services (DMAHS) issued a public notice to invite comments on the New Jersey Drug Utilization Review Board (DURB) annual report, which describes the activities for State fiscal year 2014 and its impact on the quality of care for Medicaid beneficiaries who receive pharmaceutical benefits. The report details Medicaid fee-for-service drug costs avoided by the state's Medical Exception Process through prospective drug utilization review, and administered by Molina Medicaid Solutions.

MCO contractors also maintain a drug utilization review program consistent with the standards established by the state's DURB. The DURB collaborates with the MCOs to address DUR concerns, achieve consistent utilization management strategies across all MCOs, advise the state regarding clinical criteria used by the MCOs to prior authorize drugs, recommend prospective DUR edits, develop educational strategies to guide drug product selection in disease management and recommend protocols specific to high-cost drugs.

Highlights from the DURB's actions and recommendations include:

- A "Long-acting beta agonists in Asthma and COPD" educational newsletter
- An "Acute Pain Treatment Options" educational newsletter
- Review and recommendations of the MCOs' prospective DUR protocols against the state's Medicaid FFS program
- Recommendations for a Sovaldi® (sofosbuvir) "universal" protocol
- Assessment of costs

Comments may be submitted by May 6, 2016.

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Costs and Budget Negotiations. New York State is required to pass its budget before the end of the fiscal year on March 31. While the deadline for enacting a new state budget has not yet passed, the three-day window required

between printing the bills and voting on them has. The New York State constitution requires lawmakers to allow three days to pass from the time a bill is introduced until it is voted on, allowing it to age, and allowing legislators to review budget details prior to voting. The governor can waive the three-day aging rule, however, if he determines that an issue requires an immediate vote. In order to pass an on-time budget, the Governor will have to issue this so-called message of necessity.

Reports indicate that one of the biggest issues causing the delay is the Governor's proposal to shift some Medicaid costs from the state to NYC. New York is the only state that requires localities to contribute significantly to Medicaid costs, which were split between federal, state and local shares at 50 - 25 - 25. That began to change in 2012, when the state accepted responsibility for any growth in Medicaid costs, reducing the local share over time. The Governor proposes shifting that responsibility back to NYC since, unlike other counties, the city does not operate under a property tax cap and therefore has the capacity to raise additional tax revenue to cover the cost.

A recent blog post from the Citizen's Budget Commission comments that New York's policy of requiring counties and New York City to pay a sizable share of Medicaid costs is out of step with other states and results in an inequitable distribution of Medicaid costs among New York taxpayers. Their analysis indicates that the per capita local share of Medicaid costs ranges from a high of $597 in NYC to a low of $96 in Putnam County, with a statewide average of $190.

Nursing Home Ownership and Quality of Care. *City and State* has published the first of a three-part series on quality of care in nursing homes in NYS. The first piece focuses on the growth of for-profit ownership, and the relationship between ownership and quality. They note that in 2006, half of all nursing homes in NY were owned by for-profit entities; that has increased to 60 percent as for-profits bought up 20 percent of all government and nonprofit nursing homes in the state. They go on to note that for-profit homes are more than twice as likely to hold the lowest federal rating (1-star) as those that are nonprofit or government run. In a related development, CenterLight Health System, a not-for-profit organization serving the elderly, chronically ill and disabled, and one of the largest long-term care providers in New York State, has announced the sale of two of its nursing facilities to Centers Health Care, a for-profit company.

Integrating Primary Care and Behavioral Health. The Department of Health has recently posted an update to its Frequently Asked Questions (FAQ) related to integrating primary care and behavioral health. The FAQ provides guidance on possible approaches that providers wishing to integrate primary care and mental health and/or substance use disorder (behavioral health) services might pursue: licensure thresholds, integrated outpatient services regulations, collaborative care and multiple licenses. A webinar on integrated services, as well as the updated Integrated Services and Billing Matrix, can be found on the DSRIP website under the Integrated Services section here.

Fidelis Planning Expansions. The *Albany Business Review* reports that FidelisCare, the largest Medicaid managed care plan in NYS, appears to be on the verge of expanding their Albany presence. Fidelis, which is headquartered in New York City, has doubled its Albany workforce to more than 260 employees over the past two years, and quadrupled the size of its Albany regional office since 2013. While Fidelis has not confirmed plans to expand its Albany

operations center, its landlord is engaged with local planning officials to construct a new building adjacent to the current Fidelis site. In addition, Fidelis is recruiting 50 information technology positions at its Buffalo operations center, and has posted 40 openings at its Colonie site, including analysts, project managers, an IT manager, a training specialist and a graphics designer. Fidelis officials have also said they currently are planning a new call center that will serve the entire state. Enrollment in FidelisCare has more than doubled over the last five years, from 675,000 to 1.4 million. FIdelisCare is the only Medicaid managed care plan operating in every county across the state. Fidelis, officially called the NYS Catholic Health Plan, is owned by Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic health care providers.

New York Assembly Proposes Medicaid Coverage For Inmates 30 Days Prior to Release. On March 26, 2016, *Washington Times* reported that New York's Assembly has proposed Medicaid coverage for high needs state prison and local jail inmates beginning 30 days prior to release. The plan is meant to ensure inmates can get medications and services necessary to prevent relapse. The proposal is part of the Assembly's budget plan for the fiscal year beginning April 1. Read More

HMA and CohnReznick Created a Survey Tool to Help Providers Assess Their Readiness to Transition to Value-Based Payments. On March 30, 2016, *Crain's* reported that a new survey tool created by HMA colleagues and consulting firm CohnReznick allows health care administrators to assess how prepared they are for transitioning to value-based payments and how they compare with other providers. Both primary care and behavioral health versions of the survey tool are available. The Community Health Care Association of New York State is sponsoring the use of the primary care version of the tool by 26 FQHCs, and Liberty Resources is piloting the use of the behavioral health version. Once the survey results are in, they will be compiled and shared anonymously.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio Department of Medicaid Spending More than a Billion Less than Projected in the First 18 months of Fiscal Year 2016: *Gownger Ohio* reports that staff from the Joint Medicaid Oversight Committee (JMOC) presented their review of Medicaid spending in the first 18 months of the fiscal year and found that the program has spent about $1.1 billion less than the projected $17.4 billion. The underspending represents about 6.5% of the program's budget in the current fiscal year. Some reasons noted include a delayed Hospital Care Assurance Program payment and that more newly eligible individuals are being enrolled sooner into managed care instead of being in the fee-for-service payment program. The JMOC presentation can be found here. Read More

Oklahoma

Oklahoma Medicaid Agency Cutting Reimbursement by 25 Percent for Many Providers Starting July 1. On March 29, 2016, *KOCO* reported that the Oklahoma Medicaid agency announced it is cutting reimbursement rates to over 46,000 Medicaid providers by 25 percent at the start of the upcoming fiscal year, which begins July 1, 2016. The cuts are a result of declining state revenue

collections and a $1.3 billion gap in next year's state budget. The cuts are expected to affect contracts with 46,129 providers including hospitals, physicians, pharmacies, durable medical equipment providers, and nursing facilities. Read More

Bill to Drop 110,000 from Medicaid Fails to Pass State Senate Committee. *News Channel 4* reported on March 28, 2016, that a controversial bill that would have dropped 111,000 Oklahomans from Medicaid failed to pass a state Senate committee this week despite being passed by the House earlier this year. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Governor Tom Wolf to Let Budget Lapse into Law. Pennsylvania Governor Tom Wolf announced that he will let the final pieces of a budget lapse into law instead of vetoing them as he had threatened to do. Governor Wolf's decision will release $6 billion in frozen tax money to school districts, prisons and Medicaid providers starting Monday to complete a roughly $30 billion budget for the 2015-16 fiscal year, which began July 1 and ends June 30. It ended a nine-month budget impasse that drew national attention. Wolf also announced he will veto the fiscal code, a separate budget document that dictates how some money will be spent for state programs and pet projects for lawmakers. Of the $6 billion to be released, roughly half is slated to go to school districts, including an additional $200 million to public schools. Read More

Pennsylvania Launches PA Link to Community Care. The Department of Human Services (DHS) and the Department of Aging (PDA) have collaborated to create PA Link to Community Care. This initiative will enhance Pennsylvanians' ability to learn about and access a wide variety of long-term supports and services available through federal, state, and county agencies for persons with disabilities and older Pennsylvanians. The first public phase of the project was launched March 12, with an online information referral tool (IRT) and improvements to DHS' COMPASS application. The next phase of the project will be to launch the PA Link to Community Care website, which will further enhance the commonwealth's efforts to help individuals locate aging, disability, and other long-term care services in their county. Read More

New Executive Housing Director at Pennsylvania Department of Human Services. The Department of Human Services welcomed Ben Laudermilch as Executive Housing Director starting April 4. With over 20 years of housing experience, Ben brings a vast knowledge and understanding of leveraging internal and external resources and collaboration with all levels of government to make housing resources more accessible and available. DHS is also in the process of launching a 5-year housing strategy to help connect people with housing opportunities, expand affordable housing, partner with local agencies, and pool resources. Read More

DHS Announces new Centers of Excellence Initiative. Department of Human Services Secretary Ted Dallas met with providers, stakeholders, and legislators to discuss DHS' Opioid Use Disorder Centers of Excellence. These centers, also referred to as health homes, will serve as a hub for imperative coordination of care services. Governor Wolf's proposed budget includes $34.2M to open 50 Centers of Excellence across the commonwealth. Read More

Rhode Island

Proposed Budget Calls for Continued Rate Cuts for Medicaid Hospitals. On March 24, 2016, *Rhode Island Public Radio* reported that hospitals in the state could see additional rate cuts under the proposed Medicaid budget. Last year, the state cut rates in the face of a large deficit. Today, stakeholders such as the Hospital Association and Nursing Association are opposing a continued two and a half percent cut, saying the state already spends less than they should. The cuts are part of the state budget proposal, which still has to be approved by lawmakers. Read More

Washington

HMA Roundup – Ian Randall (Email Ian)

Special-session Compromise Budget Increases Spending by $190M, Directs More Funding to Mental Health. On March 28, the WA House and Senate came to agreement on a 2016 supplemental budget after failing to finalize a budget when the regular session ended on March 11. Among other provisions, the agreement proposes to hold 2017 managed care rates at 2016 levels, and accounts for unrealized savings from the Healthier Washington SIM program caused by delays in integrating clinical models of physical and behavioral health care. The agreement also increases funding toward mental health care. Read More

State Budget Mandates Review of Public Employee Benefits Wellness Program. The Washington state budget requires the Health Care Authority to review the cost effectiveness of the Public Employee Benefits Board (PEBB) wellness program, and report to the legislature on the effectiveness of contractors' communication strategies, rates of employee engagement, and the identification and quarterly measurement of employee wellness outcome measures. . Read More

Statewide Public Health Report Shows Urban/Rural Disparities, Identifies Healthiest Counties. A County Health Rankings & Roadmaps study by the Robert Wood Johnson Foundation found that residents in rural areas are aging faster than their urban counterparts, and have higher rates of smoking, obesity, child poverty and teen pregnancy compared to urban residents. Urban areas also tend to have better access to health care and lower rates of premature death. The study found that San Juan County in northwest WA was the healthiest county, followed by King County. Read More

National

CBO Estimates ACA to Cost $136 Billion More Than Expected. On March 24, 2016, *Modern Healthcare* reported that according to the Congressional Budget Office, the Affordable Care Act will cost $136 billion more than expected, but still less than initial estimates from March 2010. This is largely due to the higher costs of Medicaid expansion. According to CBO's report, the federal government will spend $1.34 trillion on ACA provisions between 2016 and 2025. CBO also released updated budget projections from 2016 to 2026. Spending on Medicare, Medicaid, the ACA's exchanges, and the Children's Health Insurance Program will total $15.56 trillion over the next decade. Read More

HHS Report Argues Medicaid Expansion Could Aid Individuals with Substance Abuse, Mental Illness. *CQ Roll Call* reported on March 26, 2016, that the Department of Health and Human Services made a case Monday that people struggling with opioid addiction could benefit from Medicaid expansion, which would allow for treatment for those with severe disabilities. The HHS report states that there are 1.9 million people who have a substance use disorder or mental illness that could benefit from Medicaid expansion but who often earn too much to be eligible for the program. There are 19 states that have still not expanded Medicaid. Click here to view the report.

Blue Cross and Blue Shield Association Report Shows Newly Insured ACA Patients Are Sicker, More Expensive. On March 30, 2016, *The New York Times* reported that a new Blue Cross and Blue Shield Association study of its policyholders reveals that those newly insured under the Affordable Care Act are sicker, use more medical care, and have higher medical costs than those who already had coverage. The study is based on claims for 4.7 million people and examines the use of medical services by those who enrolled in Blues plans before and after major provisions of ACA took effect in 2014. Read the report here.

Industry News

Centene Completes Health Net Acquisition. On March 24, 2016, Centene announced that it has completed its acquisition of Health Net. Centene is now the largest Medicaid managed care organization in the country. The acquisition also expands Centene's business to include Medicare Advantage and contracts offered with the U.S. Departments of Defense and Veterans Affairs. The Company expects to provide full 2016 updated guidance with its first quarter 2016 earnings release on April 26, 2016. 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:

- **Arizona** Medicaid MCO net margin averages 1.8 percent, 2015 data
- Average acute care hospital Medicaid inpatient days for **Georgia**, **Indiana**, and more
- Public documents such as the 2015 **Virginia** Value-Based Payment Strategy RFI responses and the **California** Duals Demonstration performance dashboard
- Plus an upcoming webinar on *"Trauma-Informed Care: Overview and Best Practices in Patient Screening"*

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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