HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 6, 2016

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THIS WEEK

HMA IS LAUNCHES DAILY ROUNDUP

HMA Information Services is pleased to announce the launch of the ***Daily Roundup***, which includes breaking industry news and state-by-state updates from HMA consultants in the field. The Daily Roundup will be available only to HMAIS subscribers and will include advance content from the HMA Weekly Roundup, which will otherwise remain unchanged and continue to be distributed to readers every Wednesday evening. In other words, HMAIS subscribers will have a leg up on the competition by getting breaking news and analysis first.

The launch of the Daily Roundup is part of a broader expansion and redesign of the HMAIS healthcare information website, which is dramatically expanding its industry-leading database of information on government-sponsored healthcare. Additional details on the relaunch and expansion will be forthcoming. For more information about the Daily Roundup please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

IN FOCUS

CDC ISSUES GUIDELINES FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

This week, our *In Focus* section comes from HMA Principal Mary Hsieh, PharmD, MPH, of our Atlanta, Georgia office. On March 15, 2016, the Centers for Disease Control and Prevention (CDC) issued guidelines to limit opioid pain medication prescriptions as a result of increased opioid prescribing across the nation. The voluntary recommendations provide guidance to primary care clinicians who prescribe opioids for chronic pain. Opioid prescriptions per capita in the U.S. increased 7.3 percent from 2007 to 2012, with the opioid prescribing rate increasing more for family practice, general practice, and internal medicine compared to other specialties.[1]

In 2010, Medicaid enrollees with opioid prescriptions obtained an average 6.3 opioid prescriptions, and 40 percent had at least one indicator for potential inappropriate use or prescribing.[2] In addition, more than a third of reproductive-aged women who enrolled in Medicaid (in contrast with more than a quarter with private insurance) filled a prescription for opioid pain medication each year from 2008 to 2012.[3]

Condition and Patient Population

The guidelines are intended to provide primary care clinicians (e.g., family physicians, internists) with recommendations for prescribing opioids for patients aged 18 years and older with chronic pain in an outpatient setting. Chronic pain is defined as pain that typically lasts more than 3 months or past the time of normal tissue healing. The recommendations address the use of opioid pain medication in older adults, pregnant women, and in populations at higher risk for misuse (e.g., a history of substance use disorder).

The guidelines are not intended for patients undergoing active cancer treatment, palliative care, or end-of-life care and do not address the use of opioid pain medications in children or adolescents under age 18.

Process of Soliciting Feedback

A "Core Expert Group" of subject matter experts, including representatives of primary care professional societies, state agencies, and an expert in the development of clinical practice guidelines, assisted in reviewing evidence and providing feedback to the CDC on the recommendations. Where there was disagreement, however, the CDC had final decision-making authority on the recommendations. The CDC indicated that the Core Expert Group has not yet reviewed the final version of the guidelines.

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[1] Levy B, Paulozzi L, Mack KA, Jones CM. Trends in opioid analgesic prescribing rates by specialty, U.S., 2007-2012. Am J Prev Med 2015;49:409-13.

[2] Mack KA, Zhang K, Paulozzi L, Jones C. Prescription Practices involving Opioid Analgesics among Americans with Medicaid, 2010. Journal of health care for the poor and underserved. 2015;26(1):182-198. doi:10.1353/hpu.2015.0009.

[3] http://www.cdc.gov/media/releases/2015/p0122-pregnancy-opioids.html

Several federal entities participated in meetings, reviewed the guidelines, and provided written feedback. Participants included:

- National Institute of Occupational Safety and Health (NIOSH)
- Substance Abuse and Mental Health Service Administration (SAMHSA)
- National Institute on Drug Abuse (NIDA)
- U.S. Food and Drug Administration (FDA)
- Centers for Medicare & Medicaid Services (CMS)
- Others: Office of the National Coordinator for Health Information Technology (HealthIT), U.S. Department of Veterans Affairs (VA), U.S. Department of Defense (DoD), Health Resources and Services Administration (HRSA), Agency for Healthcare Research and Quality (AHRQ), and the Office of National Drug Control Policy.

The CDC solicited stakeholder comments from professional organizations with an interest in this area, including specialties that commonly prescribe opioids, health care delivery systems, and community organizations. The CDC also used three experts to independently peer-review the guidelines. The CDC received more than 4,000 public comments from patients with chronic pain, clinicians, families who have lost members to overdose, medical associations, professional organizations, academic institutions, states, local governments, and the health care industry.

The CDC also sought advice from the National Center for Injury Prevention and Control (NCIPC) Board of Scientific Counselors (BSC). The BSC is a federal advisory committee that makes recommendations regarding feasible goals for the prevention and control of injury. The CDC formed an Opioid Guideline Workgroup (OGW), which provided observations on the draft guidelines to BSC. In 2016, BSC voted unanimously for the CDC to adopt the guideline recommendations.

Guideline Development Methods

The CDC used the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) method to develop the guidelines. The GRADE method applies a hierarchy to the body of evidence that reflects the degree of confidence in the effect of a clinical action on health outcomes. Each recommendation is given two designations: a recommendation category and evidence type.

The recommendations are divided into two categories. Category A recommendations apply to all persons in a specified group and indicate that most patients should receive the recommended course of action. Category B recommendations indicate that decision-making should be driven by the individual patient, with the clinician helping the patient make decisions that are consistent with the patient's values and preferences, and the specific clinical situation.

The recommendations are also placed in one of four evidence types. Type 1 evidence represents high confidence that the true effect is close to the estimate of the effect. Type 2 evidence means that the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different. Type 3 evidence means that the confidence in the effect is limited and the true

effect might be substantially different from the estimate. Type 4 evidence represents very little confidence in the estimated effect.

Evidence Type and Clinical Data Support

Type 1 evidence: Randomized clinical trials or overwhelming evidence from observational studies.

Type 2 evidence: Randomized clinical trials with important limitations, or exceptionally strong evidence from observational studies.

Type 3 evidence: Observational studies or randomized clinical trials with notable limitations.

Type 4 evidence: Clinical experience and observations, observational studies with important limitations, or randomized clinical trials with several major limitations.

Recommendations

The 12 recommendations are grouped into three areas:

1. Determining when to initiate or continue opioids for chronic pain
2. Opioid selection, dosage, duration, follow-up, and discontinuation
3. Assessing risk and addressing harms of opioid use.

Area 1: Determining When to Initiate or Continue Opioids for Chronic Pain

Recommendation 1: Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patients. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate. (Recommendation category: A, evidence type: 3)

Recommendation 2: Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety. (Recommendation category: A, evidence type: 4)

Recommendation 3: Before starting and periodically during the opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy. (Recommendation category: A, evidence type: 3)

Area 2: Opioid Selection, Dosage, Duration, Follow-Up, and Discontinuation

Recommendation 4: When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids. (Recommendation category: A, evidence type: 4)

Recommendation 5: When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when increasing dosage to ≥50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥90 MME/day or carefully justify a decision to titrate dosage to ≥90 MME/day. (Recommendation category: A, evidence type: 3)

Recommendation 6: Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the

lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less is often sufficient; more than seven days is rarely needed. (Recommendation category: A, evidence type: 4)

Recommendation 7: Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids. (Recommendation category: A, evidence type: 4)

Area 3: Assessing Risk and Addressing Harms of Opioid Use

Recommendation 8: Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥50 MME/day), or concurrent benzodiazepine use, are present. (Recommendation category: A, evidence type: 4)

Recommendation 9: Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months. (Recommendation category: A, evidence type: 4)

Recommendation 10: When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs. (Recommendation category: B, evidence type: 4)

Recommendation 11: Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible. (Recommendation category: A, evidence type: 3)

Recommendation 12: Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder. (Recommendation category: A, evidence type: 2)

For More Information…

Complete CDC Guideline can be found here.

Questions? Please contact Mary Hsieh at MHsieh@healthmanagement.com

HMA Medicaid Roundup

Arkansas

Special Session Begins without Governor's Managed Care Proposal. *ArkansasOnline* reported on April 6, 2016, the start of a special legislative session, which among other things will review Governor Asa Hutchinson's proposal to continue the state's Medicaid expansion program. However, the session will not take up Hutchinson's managed care proposal, at the request of House Speaker Jeremy Gillam and Senate President Pro Tempore Jonathan Dismang, who asked for more time to consider the proposal. Separately, a bi-partisan group of legislators who back a proposal called DiamondCare, an alternative to Hutchinson's Medicaid managed care plan, have not decided whether they will try to introduce the plan during the session. Read More

State Legislators Proposed Medicaid Managed Care Alternative, Urge Governor to Drop Proposal. *ArkansasMatters.com* reported on April 4, 2016, that a bi-partisan group of legislators released a proposal for DiamondCare, an alternative to Governor Asa Hutchinson's Medicaid managed care plan. DiamondCare would utilize Administrative Services Organizations (ASOs) instead of capitated managed care organizations (MCOs), and would reduce the state's Medicaid budget by an estimated $1.057 billion over the next five years. DiamondCare would utilize the existing network of Medicaid providers and include funding to reduce the waiting list for individuals with developmental disabilities. Read More. Meanwhile, the *Arkansas Democrat-Gazette* reported that Governor Hutchinson's formal call for a special legislative session on Medicaid includes a plan to hire managed care companies to provide care for the individuals with developmental disabilities and individuals with severe mental illness, as well as a bill to make changes in the state's private option expanded Medicaid program through an initiative called Arkansas Works. Legislators are calling on the Governor to drop the managed care proposal from the special session. Read More

California

HMA Roundup – Don Novo (Email Don)

Denti-Cal Criticized by Independent Oversight Committee. *California Healthline* reported on April 1, 2016, that the Little Hoover Commission, an independent oversight agency, released a report titled, "Fixing Denti-Cal." The report stated that Denti-Cal falls "short in providing dental care to a third of California's population and more than half of its children." There are entire counties with no Denti-Cal providers and families who do not understand basic preventative care, the report stated. Additionally, reimbursement rates are

among the lowest in the nation, the report said, causing a dentist shortage. The report called for a reboot of the program. Read More

Medi-Cal to Cover All Low-Income Children, Regardless of Immigration Status. *Kaiser Health News* reported on April 4, 2016, that beginning May 16, all low-income children, regardless of immigration status, will qualify for Medi-Cal coverage. The Department of Health Care Services stated that implementation may be delayed due to complex programming changes required for state and county computer systems; however, coverage will be retroactive to May 1. An estimated 170,000 to 250,000 children will be newly eligible. The state estimates that there are already about 115,000 children who are living in or immigrated to California illegally with restricted Medi-Cal coverage. Mark Diel, CEO of California Coverage & Health Initiatives (CCHI), a statewide outreach and enrollment network, urges families to enroll their children even if they receive coverage through another existing program. Read More

SNFs See Rise in Number of Young Residents with Behavioral Health Needs. The *Sacramento Bee* reported on April 3, 2016, that a growing portion of the residents of skilled nursing facilities (SNFs) are younger, more able-bodied, and often diagnosed with mental illness or drug abuse problems. Facilities are also serving as long-term housing for the homeless and those newly released from prison. Between 1994 and 2014, the population of California nursing home residents under age 65 grew by nearly 40 percent. In 2014, California ranked fourth in the nation for the percentage of nursing home residents diagnosed with schizophrenia or bipolar disorder. A *Sacramento Bee* analysis of California facilities found that nursing homes with a relatively high proportion of younger patients tend to have lower patient-staffing ratios, lower quality ratings, and deficiencies including medication errors and care plans that are neglected or ignored. Read More

Colorado

Families Question Overhead Costs of Community-Centered Boards Serving Individuals with Disabilities. *The Denver Post* reported on April 1, 2016, that Colorado families are questioning the overhead costs of community-centered boards, which serve as case managers for individuals with disabilities. The Denver Post examined the difference between what service agencies bill the state Medicaid department compared to what they pay their caregivers and therapists, determining caregivers receive less than half of the funding. The state's 20 community-centered boards receive $325 million in funds each year, largely from taxpayers. Currently, the state Medicaid department does not require community-centered boards or the service agencies they use to report their overhead costs. Read More

Denver Health Medical Plan CEO to Step Down. Denver Health Medical Plan chief executive LeAnn Donovan announced that she is leaving the plan at the end of April. Donovan has been CEO of the plan since 2007.

Florida

HMA Roundup – Elaine Peters (Email Elaine)

State Settles Lawsuit Regarding Access to Pediatric Medicaid Services. *TCPalm* reported on April 5, 2016, that Florida health officials have reached a settlement ending a decades-long class action lawsuit that alleged the state is violating federal mandates by failing to deliver certain medical and dental health services to children on Medicaid. The 2005 lawsuit against three state agencies alleged that 390,000 children did not get medical checkups and 750,000 did not receive dental care in 2007. The agreement requires health plans to provide an opportunity for pediatricians to earn Medicaid reimbursement rates closer to Medicare, in an attempt to increase access to care. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia to Hold Medicaid Managed Care Plan Protest Hearing May 4. Georgia Governor Nathan Deal announced on April 4, 2016, that the state Department of Administrative Services will hold a hearing on May 4, 2016, related to health plan protests of the state's recent Medicaid managed care awards. In September 2015, Georgia announced it would award four health plans contracts to serve the state's 1.3 million Georgia Families members. The three incumbent plans were among the winners: Anthem/Amerigroup, Centene/Peach State, and WellCare. The fourth winner, CareSource, is a new entrant to the Georgia Medicaid market. AmeriHealth Caritas, AmeriChoice (United), and Humana submitted protests in response.

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Advocate-NorthShore Merger Hearings to Begin in Federal Court. *Modern Healthcare* reported on April 4, 2016, that two Chicago-area health systems may have a difficult time persuading a federal judge this week to allow their merger to proceed. Advocate Health Care and NorthShore University Health System will face the Federal Trade Commission (FTC) in federal court hearings in Chicago beginning April 6. The FTC has requested a preliminary injunction to delay the merger while it holds administrative hearings to address concerns that the merged system would control 55 percent of inpatient hospital services in Chicago's northern suburbs. The systems argue, however, that their combined market share is closer to 28 percent, and value-based payments would allow them to better manage care. Read More

Indiana

Medicaid Expansion Raises CMS Concerns over Access to Care. *Modern Healthcare* reported on April 1, 2016, that the federal Office of Management and Budget has approved an emergency request by CMS to examine whether Indiana's alternative Medicaid expansion has negatively impacted access to care. When CMS approved the waiver to expand Medicaid last year, it gave the state permission to not cover non-emergency transportation services until December

2016, which patient advocates said would prevent beneficiaries from accessing care. CMS has to decide whether to let the state to continue to forego the transportation benefit. The state has argued that a February 2016 report showed that only 11 percent of beneficiaries cited lack of transportation as their reason for missing appointments. Read More

Idaho

State Approves 15-Month Contract Extension with Optum. The *AP/Baltimore Sun* reported on April 5, 2016, that the Idaho Department of Health and Welfare approved a 15-month, $186 million contract extension with Optum Idaho, effective through June 2017. Optum has been administering Medicaid outpatient behavioral health services for the state since 2013. Read More

Iowa

Governor Says Medicaid Managed Care Transition is Going Smoothly. *The Des Moines Register* reported on April 4, 2016, that Governor Terry Branstad announced that the shift of 560,000 Iowans to private Medicaid managed care plans under IA Health Link effective April 1 has been smooth so far. The managed care plans took over the state's $4 billion Medicaid program after months of controversy. The state legislature continues to push for additional government oversight of the program, including access, quality, and patient outcomes requirements. Read More

Kansas

Not-for-Profit Groups to Launch Registry for Medicaid Personal Care Workers. The *Kansas Health Institute* reported on April 4, 2016, that several Kansas not-for-profit organizations are working to create a statewide registry to make it easier for Medicaid patients to find qualified and reliable personal care workers. According to the Kansas Department of Labor, about 18,190 people were employed in 2014 as personal care workers in Kansas; however, low Medicaid rates make it hard to attract new workers. The system will allow Medicaid patients to create profiles and search for matches, as well as send regular reminders to workers on the registry to update their information. The not-for-profits hope to have the registry live within a year. Read More

Louisiana

Louisiana to Tighten Regulations on Program for Medically Fragile Children. The *Daily Journal* reported that the Louisiana Department of Health and Hospitals (DHH) will tighten regulations on the Pediatric Day Health Care program, which offers specialized health services to 700 children with disabilities on Medicaid. Spending on the program has risen by $30 million in the past year. DHH plans to tighten admissions criteria and assign nurses to review cases of the children currently enrolled. Read More

Michigan

HMA Roundup – Eileen Ellis & Esther Reagan (Email Eileen / Email Esther)

From *The Michigan Update*: Integration of Behavioral Health and Physical Health Services. As we reported in last month's edition of *The Michigan Update* and the *Special Michigan Budget Update* also published in February, Governor Rick Snyder's Executive Budget Recommendation included language (Section 298) that would transfer funds currently appropriated to the state's ten Prepaid Inpatient Health Plans (PIHPs) for the provision of behavioral health services to the Medicaid-contracted Medicaid Health Plans (HMOs) that provide physical health services.

As a result of the immediate reaction to the language, Lieutenant Governor Brian Calley announced that he and the Michigan Department of Health and Human Services (MDHHS) have convened a group of stakeholders that will meet over the next two months to develop a framework to better coordinate physical and behavioral health care while improving access to and funding for direct services.

The workgroup established has more than 120 members and first met on March 30th. A fact-finding subcommittee of approximately 15 members of the larger group had already met twice prior to the workgroup meeting and has been charged with developing a set of consensus facts on the performance of the PIHPs and HMOs by mid-May. This report will be used to aid the entire workgroup in developing core values, principles and goals around the issue. The goals stated by MDHHS staff during the workgroup meeting are to develop concepts to be suggested as boilerplate replacement for Section 298 before the appropriations process for the next fiscal year is finalized, create a consensus outline, and establish a framework for further deliberations. This framework will likely include at a minimum identifying the target population, obtaining feedback on core values, and developing a better understanding of what works and doesn't work today. At this time there has been no end date identified for the entire process.

To aid in the workgroup discussions, the Michigan Association of Community Mental Health Boards commissioned and has released a report that surveys various ways states manage, finance and deliver behavioral health care to their residents. The report, entitled *Beyond Appearances: Behavioral Health Financing Models and the Point of Care*, concludes there is no dominant model to manage payments for behavioral health services but provides information about approaches and experiences in 19 states. Link to *The Michigan Update*

From *The Michigan Update*: Health Insurance Claims Assessment. In previous editions of *The Michigan Update*, most recently last month, we have reported that the State of Michigan is facing a loss of revenue because the Medicaid Managed Care Use Tax (that has generated almost $600 million annually) will no longer be allowed by the federal government after December 2016. Under current state law, the Health Insurance Claims Assessment (HICA), which was enacted to fill a small fraction of the lost revenue (about $80 million annually), will increase from 0.75 percent to 1.0 percent on January 1, 2017 when the Use Tax is eliminated, but with a sunset date of January 1, 2018. On March 15, 2016, Governor Rick Snyder signed a bill into law (Public Act 50 of 2016) to extend the HICA through December 2020. Link to *The Michigan Update*

Minnesota

Fairview Health to Acquire UCare. *Modern Healthcare* reported on April 5, 2016, that Minneapolis-based Fairview Health Services is expanding its presence in the health insurance business by acquiring UCare. The deal is expected to receive final approval by summer. UCare had once served more than 350,000 Medicaid beneficiaries in Minnesota; however, the company lost its Medicaid contract in all but one county following a competitive bid of the state's Medical Assistance program in 2015. As of March 2016, UCare had about 48,000 Medical Assistance members in Minnesota. Fairview also recently took ownership of health plan PreferredOne. Read More

Missouri

Senate Budget Director Seeks Ways to Cut Medicaid Pharmacy Spending. *Missourinet.com* reported on April 1, 2016, that Missouri Senate Budget Director Kurt Schaefer is asking the state Department of Health to provide more suggestions on how to reduce Medicaid pharmaceutical spending before the budget committee makes its spending recommendations for next year. Missouri Medicaid pharmaceutical spending has doubled in the last five years to $1.8 billion. The Department has been developing programs to look for savings, including one that would have clinical pharmacists review the needs of Medicaid recipients who are on 12 or more long-term medications to see if they can be treated with fewer. Read More

New Hampshire

State Senate Approves Bill to Continue Medicaid Expansion for Two More Years. The *New Hampshire Union Leader* reported on March 31, 2016, that the state Senate has approved and Governor Maggie Hassan has agreed to sign a bill to continue the state's Medicaid expansion program for two more years. Under the plan, hospitals and health plans will pay the state's $40 million share of the costs over the next two years when the federal government no longer pays 100 percent. If the program was not reauthorized, it would have ended January 1, 2017. Read More

Elliot Health Chooses Lahey Health, HCA as Bidding Finalists to Acquire the Company. *The Boston Business Journal* reported on March 31, 2016 that Massachusetts' Lahey Health and Hospital Corporation of America (HCA) were chosen as the bidding finalists to acquire Eliot Health System, a 238-bed hospital in Manchester, NH. Elliot could be acquired by one of the organizations, or could potentially be purchased by a joint venture involving both Lahey and HCA. Both companies have declined to comment on details of the deal. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Two hospital transitions move forward. A merger of The Robert Wood Johnson Health System and Barnabas Health has been approved to establish RWJBarnabas Health, the largest health system in the state. The new system will have 11 hospitals and care for over half of the residents in the state. At the same time, a Superior Court judge has approved the transfer of ownership of Hackettstown Regional Medical Center from Adventist HealthCare to the Atlantic Health System. The facility has been renamed the Hackettstown Medical Center. Read More

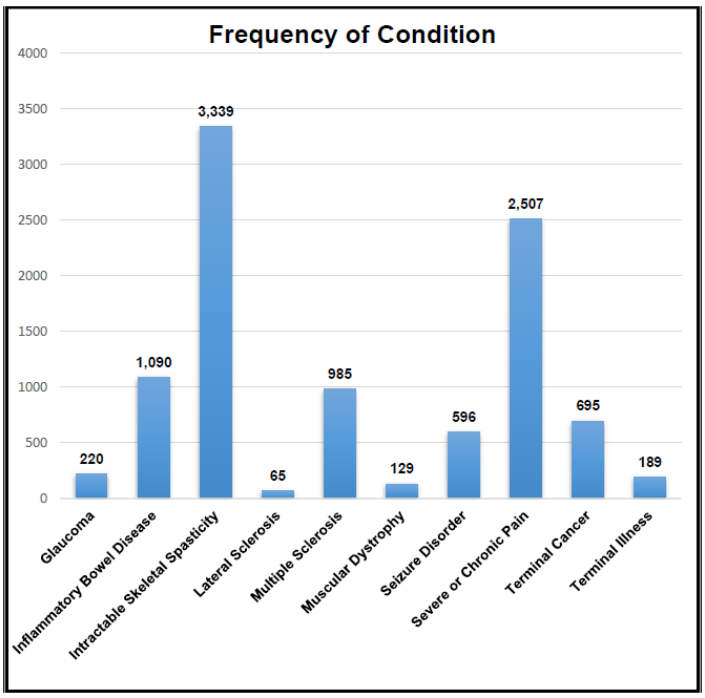
Report cites licensing and reimbursement barriers to integrating behavioral and physical health in New Jersey. On March 31, 2016, *NJSpotlight* reported that Seton Hall Law, Center for Health & Pharmaceutical Law & Policy released a study that found legal barriers are frustrating innovative efforts of clinicians in New Jersey to integrate behavioral health services with physical health care. It offers recommendations for modifying regulations that govern reimbursement and licensure. In particular, it observes that "a major sticking point with many facilities striving to provide integrated care has been the State's position that licensure provisions prohibited providing behavioral and primary care in the same clinical space." The state just recently responded to this barrier with a Shared Space Waiver memorandum, which relaxed this standard for ambulatory care facilities. Read more.

***I Choose Home NJ* program celebrates milestone moving 1,675 people from nursing home back into community settings.** On April 1, 2016, *NJSpotlight* reported on New Jersey's efforts to transition nursing home residents back to a community-based setting. "I Choose Home NJ" is a Money Follows the Person (MFP) demonstration grant administered by the Department of Human Services, Division of Developmental Disabilities, and is funded through Medicaid with an enhanced 75 percent federal matching rate. MFP demonstrations are in effect in 42 other states. New Jersey's surveyed participants give the program a 94 percent satisfaction rating which compares favorably to the nationwide rate of 81 percent. The program is for individuals age 65 and over, individuals over age 18 with physical disabilities, and those age 21 and over with intellectual or developmental disabilities. New Jersey was approved by CMS for an extension, enabling the MFP demonstration to continue through the 2020 fiscal year. The state's FamilyCare MCOs that provide long term services and supports can refer members who reside in nursing homes and who have been assessed for transition back into the community to the I Choose Home NJ program. Read more.

Governor Christie announces new statewide Housing First initiative for chronically homeless population. On March 30, 2016, the Christie administration issued a press release announcing that the Department of Community Affairs will issue 500 State Rental Assistance Program vouchers under the new Housing First program. The vouchers will be made available to individuals who have experienced chronic homelessness and who frequently rely on public systems. The state succeeded in reducing homelessness by 25 percent in 2015. Approximately $5.4 million in vouchers and an additional $250,000 in Community Services Block Grants for coordinated services will be available. Housing First has been associated with stabilizing housing for the

homeless, reducing unnecessary hospitalizations, use of the emergency room, and incarcerations. The state plans to issue an RFP to identify local partnerships that will stimulate best practices in housing and related services for the target population.

Department of Health issues annual and biennial Medicinal Marijuana Report. Last month, New Jersey's Department of Health reported on the current status of its Medicinal Marijuana Program (MMP). MMP was established in 2010 under the Compassionate Use Medical Marijuana Act (N.J.S.A. 24:61-1 et seq.) The report includes the status of the Alternative Treatment Centers (ATC), medicinal marijuana cultivation, ATC examinations, patient/caregiver/ physician registries, outreach and communication, education, marijuana testing, the regulatory process, and CY 2015 statistics. Six ATCs have permits or are in development. In 2015, the registries documented 2,557 patients and 79 caregivers. There are 362 active physicians in the registry. Physicians can access a Medicinal Marijuana Strain Library made available by the state. The MMP budget for FY 2016 is $1.6 million with carryover from FY 2015 of close to $440,000. The following medical conditions qualify for MMP participation, and present with this frequency:



An evaluation of utilization has found that "patients' medical needs are being met by the two-ounce limit" and have not been subject to excessive pricing by ATCs. A full copy of the report can be found here.

New Mexico

State's Attorney General Suing Nursing Homes for Fraud. *NPR* reported on March 31, 2016, that the New Mexico Attorney General will be suing seven nursing home facilities for billing Medicaid and private insurance for services they could not have delivered given their severe under-staffing levels. Hector Balderas, the attorney general, stated that the companies profited by hundreds of millions of dollars, 80 percent of which came from the state. Furthermore, the

lawsuit claims the residents of the nursing homes had poor treatment, including bed sores and deaths due to lack of care. Read More

State Attorney General Clears Remaining Mental Health Providers of Fraud. The *AP/Chicago Tribune* reported on April 6, 2016, that New Mexico's Attorney General Hector Balderas cleared Pathways and TeamBuilders of Medicaid fraud, the last of a dozen not-for-profit mental health providers investigated and cleared by the state. The investigations arose in 2013 after an independent audit led Governor Susana Martinez to freeze payments to the providers. Several providers have since filed lawsuits against the Human Services Department and some have exited the market. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Agreement Reached on 2016-2017 State Budget. A budget agreement was announced hours before the fiscal year ended, and was approved by both houses of the legislature on the first day of the new fiscal year. The budget holds the growth in state spending to 2 percent for the sixth consecutive year. The budget agreement includes $18.5 billion in state Medicaid spending, up from the Governor's originally proposed $17.7 billion, but still within the Medicaid Global Cap, which limits spending to the 10 year average of the medical care consumer price index of 3.4 percent.

- The budget includes $200 million in capital funding for health care providers to facilitate health system restructuring; $30 million is set aside for community-based programs, including licensed diagnostic and treatment centers, mental health clinics, substance abuse treatment centers, and home care providers. These funds will be awarded without a competitive bid or RFP process, but according to a series of criteria including alignment with DSRIP goals and incentives; the integration of health care services; furthering the development of primary care and other outpatient services; and community engagement in the project.
- Both houses rejected the Governor's proposal to remove transportation costs from Medicaid managed long term care premiums and institute a state broker; it was not included in the final budget.
- Both houses rejected the Governor's proposal restricting eligibility for managed long-term care to those who are nursing home-eligible, rather than the current requirement of needing at least 120 days of community-based long term care services; it was not included in the final budget.
- Governor Cuomo's proposal to shift the growth of New York City's Medicaid program back to the city government, which would have cost NYC $180 million dollars in the coming fiscal year, was dropped.
- The executive budget had also included a number of changes in pharmacy, recognizing that it is the fastest-growing component of Medicaid spending. The elimination of the "provider prevails" policy, except for behavioral health drugs, was not included in the final budget. Plans to impose a maximum price on generic drugs, and establish a price ceiling on "blockbuster" drugs such as those for hepatitis C, high cholesterol or cystic fibrosis, were not included.

- The budget requires prior authorization for anyone seeking more than four opioid prescriptions in a 30-day period, except for patients in hospice, or those with cancer, sickle cell or any other disease designated by the health commissioner.
- The budget amends the new e-prescribing law, which took effect this week, so that physicians who write fewer than 25 prescriptions in a year may still use paper and pen.
- The carve-out from Medicaid managed care for school-based health centers (SBHCs) was extended through July 1, 2017. Further, family planning services will remain carved out.
- The transition for Traumatic Brain Injury and Nursing Home Transition and Diversion waiver benefits into managed care will be delayed until January 1, 2018.
- Following the collapse of Health Republic Insurance of New York, hospitals and other health care providers had requested that the state create a guarantee fund that would levy a one-time assessment on health insurers. The final budget includes a new fund that can reimburse providers for losses related to Health Republic, but because Health Republic has not yet gone through the liquidation process, details regarding appropriations will be subject to a future law.
- The budget authorizes the provision of Medicaid benefits for incarcerated individuals for the 30 days prior to release, to pay for transitional services including medical, prescription and care coordination services, contingent on CMS approval and agreement to cover the federal share of such services.

Minimum Wage Increase Approved. The budget that has been enacted for SFY 2017 includes an increase in the state's minimum wage. The increase varies based on the size of a business as well as geography, and will be phased in over time.

- For workers in New York City employed by large businesses (those with at least 11 employees), the minimum wage will rise to $11 at the end of 2016, then another $2 each year after, reaching $15 on December 31, 2018.
- For workers in New York City employed by small businesses (those with 10 employees or fewer), the minimum wage will rise to $10.50 by the end of 2016, then another $1.50 each year after, reaching $15 on December 31, 2019.
- For workers in Nassau, Suffolk and Westchester Counties, the minimum wage will increase to $10 at the end of 2016, then $1 each year after, reaching $15 on December 31, 2021.
- For workers in the rest of the state, the minimum wage will increase to $9.70 at the end of 2016, then another $0.70 each year after until reaching $12.50 on December 31, 2020. After 2020, the minimum wage will continue to increase to $15 on an indexed schedule to be set by the Director of the Division of Budget in consultation with the Department of Labor.

In response to concerns about the impact of an increased minimum wage on the economy, the bill provides a safety valve to the increases. Beginning in 2019, the Director of the Division of Budget will conduct an annual analysis of the economy in each region and the effect of the minimum wage increases statewide to determine whether a temporary suspension of the scheduled increases is necessary, and alter the phase-in depending on economic conditions.

The increase in the minimum wage has a significant impact on the Medicaid program. Sizeable parts of the Medicaid program, particularly home and community based services, rely on low-wage workers, and increases in the minimum wage will have a direct effect on the Medicaid budget. The Health Care Association of New York State (HANYS) has concluded that the proposal would cost the hospital sector between $50 and $100 million in the first year, and will cost $570 million annually once fully implemented. Their analysis indicates that other sectors of the health care delivery system would experience an even greater impact, with nursing home costs up $600 million and home care agency costs up $1.7 billion annually, for a total impact of $2.9 billion annually upon full implementation in 2022. According to a GNYHA Member Letter, "The Governor will direct the Medicaid Director to include minimum wage funding for affected providers through Medicaid rate increases starting in the final quarter of the coming fiscal year," although no details have been provided.

In response to provider concerns that increases in the minimum wage, and the resulting increase in Medicaid costs, would cause the state to bump into the Medicaid Global Spending Cap, the Governor has committed that these increases will not trigger the Commissioner of Health's unilateral authority to enact spending cuts in the program.

1115 Medicaid Waiver Public Comment Days. The Department of Health has announced the dates for both downstate and upstate Public Comment Days on New York's 1115 Waiver programs. The 1115 waiver is designed to permit New York to use a managed care delivery system to deliver benefits to Medicaid recipients, create efficiencies in the Medicaid program, and enable the extension of coverage to certain individuals who would otherwise be without health insurance. The Delivery System Reform Incentive Payment (DSRIP) program is a significant waiver initiative, and members of the DSRIP Project Approval and Oversight Panel will join DOH staff in listening to the feedback provided by members of the public and stakeholders on these Public Comment Days. Feedback on all waiver programs is welcomed.

The downstate Public Comment Day will be held on May 4th in New York City, at the NYU Kimmel Center (60 Washington Square Park South), from 9:30am – 2:30pm. The upstate Public Comment Day will be held on June 10th in Albany at the Empire State Plaza, Meeting Room #6, from 10:30am – 3:30pm. Both meetings are open to the public, and will be webcast. No pre-registration is required. Individuals who wish to provide comment will be asked to register on site.

North Carolina

North Carolina Holds Formal Public Hearing on Medicaid Overhaul. *The News & Observer* reported on March 30, 2016, that speakers at the first formal public hearing on North Carolina's planned Medicaid overhaul said that they wanted the state to expand Medicaid and expressed concerns that additional paperwork might drive away physicians. The state Department of Health and Human Services is preparing to ask the federal government to approve a Medicaid privatization plan in which most beneficiaries would receive coverage through health plans run by insurance companies, hospitals, or other providers. North Carolina has about 1.9 million Medicaid beneficiaries at a total cost of about $14 billion, with about two-thirds paid by the federal government. Expansion would add another 300,000 to 500,000 eligibles. Read More

Audit Finds $836 Million in Improper Medicaid Reimbursements; DHHS Says Figure is Too High. *The Charlotte Observer* reported on April 4, 2016, that a state audit of Medicaid payments found errant claims worth approximately $836 million. The Department of Health and Human Services (DHHS) processed about 127 million claims for payments totaling $11 billion last year. The audit analyzed a sample of 296 payments and found errors in 50. Of these, 19 payments did not have the correct paperwork, 15 were to providers who were not eligible to render services, and 11 did not reflect a retroactive Medicaid rate cut. DHHS only agreed with 31 of the 50 claims identified, closer to $690 million. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Waiver Would Require Medicaid Beneficiaries to Contribute to HSAs. *Ohio.com* reported on March 30, 2016 that Governor John Kasich's administration will be moving forward with plans to require as many as 1 million Ohioans on Medicaid to make a monthly contribution to a health savings account or potentially lose coverage. Beneficiaries, aside from pregnant women, could be disenrolled from Medicaid if they don't contribute 2 percent of their family income, or $99, whichever is less, on an annual basis. The provision was added to the state budget last year, but still would require federal approval. The administration plans to make a draft of the waiver available for public comment by April 15, and send the application to CMS for approval mid-June. If approved, the program changes would take effect in January 2018. Read More

Ohio Sued Over Access to Non-institutional Care Settings. *The Columbus Dispatch* is reporting that Disability Rights Ohio and other advocates filed a class action lawsuit March 31 over how and where adults with developmental disabilities live. The allegation is that the current system fails to provide the support people need to live and work in their communities. The suit was filed in federal court. The Department of Developmental Disabilities, the Department of Medicaid and Opportunities for Ohioans With Disabilities and the Governor (in his official capacity) are named, accused by plaintiffs of violating both the American With Disabilities Act, Section 504 of the Rehabilitation Act, the Social Security Act and the U.S. Supreme Court's ruling in the *Olmstead* case against unnecessary segregation of people with disabilities. There are six named plaintiffs, along with the Ability Center of Greater Toledo. A copy of the filing is available here. Read More

Moving Telehealth Forward in Ohio. *Gongwer* is reporting on several recent events aimed at moving telehealth forward in Ohio. Charles Moses, president of the Ohio Telecom Association is reported to have participated in a White House forum this week to discuss how telehealth could help rural areas, citing the importance of health care providers and telecommunications companies working together. He also helped lead a panel discussing evidence based practices, highlighting work underway in Cleveland. Specifically, he stressed that implementing telehealth in rural areas is a two pronged approach. Health care providers develop the technology to deliver health care services and work with patients remotely. Telecom companies continue to improve internet connectivity in rural areas. Mr. Moses also pointed to Cleveland Clinic's current practice of letting patients access their records online as an example of how Ohio may be a little ahead of the curve. Read More

Ohio has a new task force to investigate accusations of improper nursing home care of seniors. *The Columbus Dispatch* is reporting that Ohio is one of 10 states where the Justice Department has partnered with state and local officials to create task forces to investigate accusations of improper nursing home care of seniors. Ohio Attorney General Mike DeWine hailed Wednesday's announcement, saying, "It is essential that state, local and federal agencies work together to look after elderly residents' best interests and hold accountable those who failed in their duty to protect these vulnerable citizens." Keesha Mitchell, director of the Ohio Medicaid Fraud Control Unit and president of the National Association of Medicaid Fraud Control Units, said at the news conference that the task forces will allow the state and federal governments to better coordinate the investigations to protect seniors in nursing homes. Ohio's new task force will be established in the federal court system's southern district of Ohio, which includes Columbus, Dayton and Cincinnati. Read More

Oklahoma

Oklahoma Health Care Authority Proposes Medicaid Rebalancing Act of 2020. The *AP/Washington Times* reported on March 31, 2016, that Oklahoma Health Care Authority CEO Nico Gomez unveiled a four-year rebalancing program that would create a new Insure Oklahoma program option, expanding coverage to 175,000 uninsured adults with incomes under 133 percent of the federal poverty level. Additionally, the proposed plan would move 175,000 SoonerCare members, many pregnant women and children, into the commercial market reducing Medicaid enrollment by 17 percent. Medicaid rates would also be restored to at least 86.5 percent of Medicare under the proposal. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS releases Q&A Log, Revised Draft Agreement for MLTSS Procurement. The Department of Human Services has issued Addendum #5, along with a revised Draft Agreement for the Community HealthChoices (CHC) RFP. DHS also released a Q&A Log following their Pre-Proposal Conference on March 16. Jennifer Burnett, DHS Deputy Secretary for the Office of Long Term Living (OLTL) reported to the Medical Assistance Advisory Committee that OLTL is working on memoranda of understanding (MOUs) for coordination among CHC MCOs, behavioral health organizations and HealthChoices MCOs. The

MOUs would address such things as plans of communication and data exchanges. Read More

March 31 Meeting of Pennsylvania Medical Assistance Advisory Committee. Office of Medical Assistance Progams (OMAP) Updates. Leesa Allen, Deputy Secretary of OMAP said that the Department of Human Services is still working to finalize its analysis and evaluation of the HealthChoices physical health procurement. Allen indicated that they hope to finalize the procurement recommendations by the end of April.

Community HealthChoices Waivers Update. Virginia Brown, Director of OLTL Bureau of Policy and Regulatory Management, discussed the status of the Community HealthChoices (CHC) waivers and the current Long Term Services and Supports (LTSS) system.

Amendments for OLTL's Aging, Attendant Care and Independence Waivers. The Department of Human Services is making available for public review and comment the Office of Long-Term Living's proposed Aging, Attendant Care and Independence waiver amendments and the Centers for Medicare & Medicaid Services final rule transition plan. The proposed waiver amendments and a summary of all revisions are available for review. These amendments are a part of the Community HealthChoices transition process. Read More

Public Comment Sought on State Plan on Aging. Under the Older Americans Act, the Pennsylvania Department of Aging is required to develop and implement a State Plan on Aging. Pennsylvania's next State Plan will cover the time period of October 1, 2016 through September 30, 2020. The Department of Aging will host seven Community Listening Forums in regions throughout the Commonwealth. Following the Community Listening Forums, a Draft State Plan for final review and feedback will be released. Public comment on the Draft State Plan will be received during three Public Hearings to be held in May. Read More

Department of Human Services Announces Selection of Community Behavioral Health Clinics. The Department of Human Services (DHS) has announced the selection of 16 locations to participate in the Certified Community Behavioral Health Clinic (CCBHC) planning grant. The federal grant encourages states to adopt innovative approaches to community-based behavioral health services. The 16 locations are comprised of both rural and urban locations throughout the state. The CCBHC grant has two phases. Pennsylvania was one of 24 states who received the Phase I planning grant. The selected locations will continue working with the Commonwealth as DHS prepares to apply to participate in a two-year demonstration program that will begin January 2017. The following clinics were selected:

- Berks Counseling Center, Berks
- Cen Clear Child Services, Clearfield
- Cen Clear Child Services, Jefferson
- Cen Clear Child Services, Blair
- Community Council Mental Health and Mental Retardation, Philadelphia
- Community Counseling Center of Mercer County, Mercer
- Community Guidance Center, Clearfield
- Creative Health Services, Montgomery
- Kidspeace, Monroe

- NHS Delaware County, Delaware
- Northeast Treatment Centers, Philadelphia
- Pittsburgh Mercy, Allegheny
- Public Health Management Corporation, Philadelphia
- Resources for Human Development, Philadelphia
- Safe Harbor, Erie
- The Guidance Center, McKean

Read More

DHS Receives $91 Million Federal MFP Grant. Pennsylvania Department of Human Services (DHS) Secretary Ted Dallas announced today that the department has received a $91 million "Money Follows the Person" (MFP) Rebalancing Demonstration grant. This funding comes from the Centers for Medicare & Medicaid Services and will work to transition older Pennsylvanians and those with a disability from an institutional setting back into the community. The grant, which runs through 2020, includes an additional $7.3 million reimbursement grant to create new initiatives to aid in the department's priority of serving more people in the community. Pennsylvania has participated in MFP since 2008, transitioning 2,333 people from institutional settings to where they want to live -- their communities. DHS plans to transition another 1,172 individuals through the end of 2018. Read More

Tennessee

TennCare Director Darin Gordon to Step Down. *The Tennessean* reported on March 30, 2016 that TennCare Director Darin Gordon will leave his position effective June 30, 2016, to join the private sector. Gordon is the longest serving Medicaid director in the nation and has run programs under both Democratic and Republican governors. Gordon pushed for the adoption of the Insure Tennessee Medicaid expansion, but lawmakers have rejected it. Governor Bill Haslam hopes to announce his successor before the legislative session ends. Read More

Virginia

Virginia to Reprocure Medicaid Managed Care Contracts. Virginia will reprocure its statewide Medicaid managed care program, Medallion 3.0, in late 2016, with contracts effective January 2018, the state said in a newsletter to stakeholders. Medallion 3.0 has about 740,000 members. Medallion currently covers children, pregnant women, parents up to 52 percent of the federal poverty level, acute care for waiver recipients, and the aged, blind and disabled (ABD) population. However, under the new procurement, managed care services for the ABD population would be transitioned to Virginia's proposed managed long-term services and supports (MLTSS) program. Seven managed care plans compete in the Medallion 3.0 program. Historically, there has not been a formal RFP process; the state had determined whether it will allow additional interested plans to enter the market.

Washington

HMA Roundup – Ian Randall (Email Ian)

State Begins Integration of Medicaid Medical, Behavioral Health. *The Columbian* reported on April 3, 2016, that southwest Washington's Clark and Skamania counties became the first in the state to fully integrate Medicaid physical health, mental health and chemical dependency services. State-wide integration is expected by January 2020. In southwest Washington, Medicaid managed care plans Molina and Community Health Plan of Washington have been preparing for the changes and focusing on community outreach. Read More

Washington state budget deal includes provisions impacting population health and environment. The final FY 2016 supplemental budget, which includes $191 million in increased spending and borrows from the Budget Stabilization Fund, includes several funding changes impacting public health. These include $41 million in additional funding for mental health that will provide additional resources for Western State Hospital, a state psychiatric facility, to expand medical staff and increase community-level services. The increased funding comes after the facility has struggled with clinician recruiting, and after federal investigators looked into abuse of a restrained patient and threatened to withhold federal funding until the facility complied with federal guidelines. Read More

Washington counties will start work requirements for food stamp recipients. A number of counties in Washington, including King and Snohomish Counties, and parts of Pierce County, renewed work requirements for recipients of food stamps. Under the new requirements, non-disabled individuals ages 18-49 without dependents are limited to three months of food stamps in a three-year period unless they work 80 hours a month or participate in a specified number of training and volunteer programs. These requirements have been inactive since the 2009 financial crisis. Federal waivers have been granted for areas with higher unemployment numbers, which is why only certain parts of Washington are affected. Washington joins 21 other states that have implemented similar work requirements. Read More

Community Health Plan of Washington CEO to Step Down. Community Health Plan of Washington chief executive Lance Hunsinger announced that he will leave the plan at the end of August. Hunsinger is also the CEO of Community Health Network of Washington.

National

CMS Finalizes Medicaid/CHIP Mental Health Parity Rule. *Modern Healthcare* reported on March 29, 2016 that CMS has finalized a rule applying the provisions of the Mental Health Parity and Addiction Equity Act of 2008 to Medicaid and CHIP enrollees. States will need to ensure beneficiaries have access to mental health and substance abuse services regardless of whether the care is provided through managed care organizations or other delivery systems. A 2015 report by the National Alliance on Mental Illness found that private insurers were twice as likely to deny coverage for mental health services as medical services. The final rule is expected to impact 22.3 million Medicaid and

880,000 CHIP beneficiaries in 2016 and cost $1 billion from 2016 to 2020. Read More

CMS to Delay Medicaid Drug Rule Enforcement Until July. *Modern Healthcare* reported on April 5, 2016, that the Centers for Medicare & Medicaid Services (CMS) will delay enforcement of a rule to change the way state Medicaid agencies reimburse pharmacies for prescription drugs until July. Pharmaceutical companies were asking for enforcement to be pushed back to October in order to allow for more time to determine the average manufacturer price for inhalation, infusion, instilled, implanted or injectable drugs that are not generally dispensed through retail community pharmacies. The final rule, released in January, changes reimbursement to be based on acquisition costs of the drug. Currently, pharmacies are reimbursed based on the cost of the ingredients plus a dispensing fee for filling the prescription. Read More

One Third Of Exchange Enrollees Picked the Same Plan in 2016. According to a report published by Avalere on March 31, 2016, which examined ASPE Exchange enrollment data, only 33 percent of Exchange enrollees kept the same plan in 2016 from the previous year. Approximately 25 percent selected a different plan from 2015, while the remaining individuals were new to the market. The report notes that it is likely some enrollees are leaving the market for other sources of insurance, including Medicaid. Read More

Industry News

Kindred Healthcare to Sell 12 Long-Term Acute Care Hospitals to Curahealth. Kindred Healthcare announced on April 4, 2016, that it has signed a definitive agreement to sell 12 acute-care hospitals to Curahealth, an affiliate of a private investment fund sponsored by Nautic Partners, for $27.5 million. The hospitals have 783 licensed beds in Arizona, Louisiana, Massachusetts, Oklahoma, Pennsylvania, and Tennessee. Read More

LHC Group Partners with Arizona Home Health, Hospice Provider. *Home Health Care News* reported on April 4, 2016 that Louisiana-based non-acute care provider LHC Group has partnered with Northern Arizona Healthcare (NAH) to expand home health and hospice care services in Northern Arizona. LHC will operate NAH's two home health agencies and one hospice agency. LHC Group operates 283 home health locations, 56 hospice locations, 13 community-based service locations, and six long-term acute care hospitals. Read More

Community Health Systems Acquires Physicians Specialty Hospitals in Arkansas. Community Health Systems announced on April 1, 2016, that a subsidiary of the company has acquired an 80 percent stake in Physicians Specialty Hospital, a 20-bed specialty hospital in Fayetteville, Arkansas. Read More

Summit BHC Acquires Three Pennsylvania Treatment Centers. Summit BHC announced that it has completed the acquisitions of Turning Point; Mountain Laurel Recovery Center; and St. Joseph Institute. The three treatment centers are located in Pennsylvania.

RFP Calendar

Date	State/Program	Event	Beneficiaries
April 22, 2016	Minnesota SNBC	Contract Awards	45,600
April 29, 2016	Missouri (Statewide)	RFP Released	700,000
April, 2016	Virginia MLTSS	RFP Released	130,000
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
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

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