HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 13, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

OHIO'S HEALTHY OHIO 1115 WAIVER AND ABD ELIGIBILITY CHANGES REVIEWED

This week, our *In Focus* section reviews two updates out of Ohio. The first is a Section 1115 Medicaid waiver, to be known as Healthy Ohio, which would implement a modified health savings account model for adult Medicaid beneficiaries in the state with the exception of individuals who are aged, blind, or have disabilities. Healthy Ohio also proposes a voluntary employment support program, as well as encourages transition to private insurance coverage, including a transitional spending account for enrollees shifting from Medicaid to the private market. Ohio's Medicaid agency estimates potential savings of nearly $1 billion from the program over a five year period. The second update relates to the planned transition to a single eligibility determination for individuals with

disabilities and mental illness, eliminating the need for both Supplemental Security Income (SSI) eligibility determinations and Medicaid eligibility determinations. The state estimates that as a result more than 400,000 Ohioans will convert to full Medicaid without spend down requirements in July 2016, pending State Plan Amendment approval.

The Healthy Ohio Program

The Healthy Ohio Program is designed to include a modified health savings account for each participant, known as the Buckeye Account. The state's summary document provides an overview of the Buckeye Account, as well as the employment supports and Bridge Account programs, and includes membership and estimated cost savings impacts. Additionally, and of note, the state indicates that implementation of Healthy Ohio includes a reprocurement of Medicaid managed care plans to serve the Healthy Ohio program. This RFP release could occur as early as July 1, 2016.

Healthy Ohio Program Eligibility. Non-disabled and non-aged adult Medicaid enrollees 18 and over, including foster youth to age 26, will be covered by the Healthy Ohio Program. Enrollment in Healthy Ohio for 2018 is estimated at nearly 1.29 million. The full list of eligibility categories is provided in the summary document.

The Buckeye Account. Under the Healthy Ohio Program, both the state and the individual will contribute to the member's Buckeye Account. Medicaid dollars will fund the Buckeye Account with $1,000 a year, and these funds are for use by participants in paying the Healthy Ohio annual deductible of $1,000. Mandatory member contributions to the Buckeye Account are intended for use by participants in paying copayments. Failure to make mandatory member contributions will result in loss of eligibility for the Health Ohio Program. Participants will be able to earn incentive dollars by meeting healthy behavior goals, such as completion of a smoking cessation program.

Employment Support. As has been proposed in other states – including Utah and Tennessee as part of Medicaid expansion proposals – the Healthy Ohio Program will implement a voluntary employment support program. All Healthy Ohio enrollees who work fewer than 20 hours per week will be offered a referral to a work force development agency.

Bridge Account. Another feature of the Healthy Ohio Program is the Bridge Account, which allows a member to take their Buckeye Account balance with them when transitioning to commercial insurance coverage. The Bridge Account may be used for premium payments and cost-sharing through individual or employer-based coverage.

Cost-Sharing. All members, with the exception of pregnant women, will be required to make upfront monthly contributions to their Buckeye Account. These monthly contributions will be set at 2 percent of income, not to exceed $8.25 on a monthly basis or $99 for a full year. The member contributed funds to the Buckeye Account are expected to be managed separately from Medicaid contributed funds. Member contributed funds are for use in paying copayments for services, ranging from $4.00 for outpatient and preferred pharmacy to $8.00 for non-preferred pharmacy and non-emergency ER use, and $75 for inpatient services. When the portion of the Buckeye Account funded by member contributions is zero, copayments will be waived.

Enrollment and Cost Projections. Based on a January 1, 2018, start date, the Healthy Ohio Program is estimated to cover nearly 1.29 million members in 2018, about 126,000 fewer than without the waiver. By 2022, the program is estimated to grow to more than 1.42 million, nearly 140,000 fewer than without the waiver. In 2018, the Healthy Ohio Program is estimated to save more than $169 million in annual Medicaid costs, rising to more than $231 million in 2022. Over the five-year waiver period, total estimated savings approach $1 billion, with more than $180 million in state share savings.

Next Steps and Timing. The state has posted the Healthy Ohio waiver proposal summary and will be posting the full 1115 waiver proposal for public comment on April 15, with public comments accepted through May 13, 2016. There will be two public hearings on the waiver proposal on April 21 and May 3, 2016.

Eligibility Transition

Ohio is also preparing to make a significant transition in the way eligibility is determined for Medicaid enrollees with disabilities in the state. The Executive Budget enacted last year authorizes the state to replace its two disability determination systems – one for Medicaid and one for SSI – with a single system as early as July 1, 2016. Historically, Ohio has used a more restrictive eligibility criteria for individuals with disabilities under 209(b) authority. Ohio has submitted a State Plan Amendment (SPA), which is currently under review by The Centers for Medicare & Medicaid Services (CMS), to transition to a single eligibility determination, in which SSI eligibility determinations will also apply to Medicaid, as is authorized under Section 1634 of the Social Security Act. Per the state's summary of the proposed redesign, 34 states let Social Security determine Medicaid eligibility using SSI criteria, and another seven states use the same income, asset, and disability criteria as SSI but make their own eligibility decision. Only ten states, including Ohio, currently use eligibility criteria for Medicaid that are more restrictive than SSI.

Current and Proposed Eligibility Comparison

	Current Medicaid	Current SSI	Proposed Medicaid/SSI
Disability Evaluation	Same as Social Security	Same as Social Security	Same as Social Security
Income Limit	$634 (~64% FPL)	$743 (75% FPL)	$743 (75% FPL)
Asset Limit	$1,500	$2,000	$2,000
Determinations	Ohio Dept. of Medicaid/CDJFS	Opportunities for Ohioans with Disabilities	Opportunities for Ohioans with Disabilities
State Authority	209(b)	N/A	Section 1634

Impact on Current Beneficiaries. Pending SPA approval, Ohio will convert all current Medicaid ABD beneficiaries from 209(b) based eligibility to 1634 based eligibility. These current beneficiaries, who will retain full Medicaid benefits, include:

- 206,480 individuals with monthly income below the 209(b) limit;
- 34,043 individuals who qualify for Medicaid through "spend down";
- 131,042 individuals needing LTSS with monthly income below $2,199; and
- 8,870 individuals with income above the limit, who qualify for Medicaid due to patient liability for long term care.

In addition, other individuals who can be identified within CRIS-E, the state's legacy eligibility system, as eligible for Medicaid, even if they are not in one of

the ABD categories described above, will convert to 1634 based Medicaid eligibility. This conversion will include:

- 11,804 SSI recipients not previously enrolled in Medicaid;
- 5,527 individuals with serious and persistent mental illness (SPMI) who qualify for a new Specialized Recovery Services (SRS) program; and
- 3,943 adults who do not otherwise qualify for Medicaid ABD or Medicare but have monthly income below $1,367 (the expansion group limit).

The state's summary document also identifies those individuals who could have qualified for Medicaid under spend down who will not qualify under the new criteria. These include:

- 2,813 individuals on Medicare with monthly income between $743 and $1,337 who will qualify for the Medicaid-funded Medicare Premium Assistance Program (Ohio Medicaid will automatically enroll these individuals in MPAP);
- 12,483 individuals who will qualify for Medicare only;
- 18,285 individuals with monthly income below $3,960, who are otherwise not covered by any of the programs described above, and will qualify for federally subsidized private insurance on the Exchange; and
- 469 individuals under age 65 with monthly income greater than $3,960 who will need to seek private health insurance.

Additionally, once the eligibility conversion is complete, individuals requiring LTSS with income over the $2,199 monthly limit, will need to establish a Qualified Income Trust (QIT) for Medicaid. A QIT or "Miller Trust" is a legal structure that allows income in excess of the eligibility limit for Medicaid institutional and home and community based services (HCBS) waivers to be disregarded. An individual must place the portion of his or her monthly income greater than $2,199 into the trust. Funds deposited into the trust can be used to pay patient liability, incurred medical expenses, monthly personal allowance, and monthly bank fees associated with the trust. Any funds remaining in the trust upon the recipient's death, up to the total cost of care, are paid to Medicaid. Ohio Medicaid has contracted with Automated Health Systems (AHS) to contact all current members who may need to establish a QIT and will provide free assistance in setting up a trust by the implementation date.

For More Information

Healthy Ohio Program 1115 Demonstration Waiver Summary, Full Waiver Proposal, and Public Hearing Information:
http://medicaid.ohio.gov/RESOURCES/PublicNotices/HealthyOhioHSA.aspx

Ohio's Disability Determination Redesign:
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=nwrdhnOoQqo%3d&tabid=117

HMA Medicaid Roundup

Alabama

Budget Hearings Continue; Medicaid Agency to Consider Cuts. *Al.com* reported on April 6, 2016, that Governor Robert Bentley is directing the Alabama Medicaid Agency to examine possibilities for program cuts before he considers calling a special session regarding the state budget. Lawmakers appropriated $700 million from the General Fund for Medicaid next year, $85 million short of the Governor's request. Potential areas for cuts include prescription drug coverage for adults, eyeglasses, outpatient dialysis, prosthetics and orthotics, PACE, health home, physician case management, and reducing reimbursement rates for some providers. These budget issues could also slow the state's planned transition to regional care organizations. Budget committee hearings will be held next week. Read More

Arizona

Advocates Rally to Restart KidsCare. *The New York Times* reported on April 11, 2016, that advocates rallied in Phoenix for KidsCare after state Senate leader Andy Biggs blocked a measure to restart the program. Under a proposal that had already passed in the Arizona House, KidsCare would have been restarted with federal funds paying 100 percent of the cost through 2017. KidsCare provides health insurance to children of families who do not qualify for Medicaid and cannot afford subsidized health insurance on the federal marketplaces. Arizona froze the KidsCare program in 2010.. Read More

Arkansas

Programs Could be Cut if Lawmakers Do Not Pass Expansion Funding. *The Associated Press/KTHV* reported on April 11, 2016, that state programs could face cuts if lawmakers don't pass legislation to fund the state's hybrid Medicaid expansion. House Speaker Jeremy Gillam released an alternate budget detailing the cuts needed if the expansion funding legislation does not receive the three-fourths majority it needs to pass. Most state agencies would see a cut of about 3 percent if it fails. Read More

Governor Signs Legislation to Continue Medicaid Expansion. *Arkansas Online* reported on April 9, 2016, that Governor Asa Hutchinson signed legislation to preserve the state's hybrid Medicaid expansion program for 267,000 low income residents. The legislation also encourages participants to remain employed and take responsibility for their health care. However, the budget appropriation for the expansion program still requires a three-fourths majority approval in the upcoming fiscal session if the program is to continue

beyond June 30. The Republican-controlled Legislature approved the Medicaid expansion in 2013, and the waiver authorizing the private option expires at the end of this year. If the Legislature ends the fiscal session without approving a Medical Services Division appropriation, legislators would have to determine how to fund the program before the new fiscal year starts on July 1. Read More

California

HMA Roundup – Don Novo (Email Don)

Covered California to Require Health Plans to Incentivize Providers for Quality, Cost. *Kaiser Health News* reported on April 8, 2016, that Covered California, the state's healthcare Marketplace, will now require exchange plans to incentive providers for quality and cost. Plans must reduce reimbursement rates by at least 6 percent if hospitals do not meet certain quality standards and award bonuses if hospitals exceed them. Providers that perform poorly are expected to be dropped from plan networks by 2019. Additionally, transparency provisions will require plans to disclose the rates they negotiate with providers. The incentives will be implemented over the course of seven years. Read More

State Scraps MMIS Modernization. *California Healthline* reported on April 12, 2016, that California will not continue with its $179 million MMIS modernization project with Xerox. According to the settlement, Xerox will continue to run the old platform for the state until 2019, pay $103 million in cash, provide computer hardware and software worth $15 million, and abandon requests for payments worth roughly $5 million. Read More

Senate Votes on Bill Overseeing Doctors Prescribing Antipsychotics. *The Mercury News* reported on April 11, 2016, that a bill to investigate California doctors who overprescribe psychiatric drugs to children in the foster care system received approval from a state Senate committee and will move to the floor next week. The bill would allow the California Medical Board to monitor physicians through quarterly prescription claims reports. Prescribing to very young children or extremely high dosages would be grounds for investigation. While a series of bills last year created new measures to prevent overuse of antipsychotics in teens, none dealt with overseeing the doctors who prescribe them. State provider associations are opposing the bill, arguing that increased oversight adds administrative burdens for doctors. Read More

Phone Line for Individuals with Terminal Illness Moves Forward. *CaliforniaHealthline* reported on March 31, 2016, that a California Senate committee approved legislation that would require the state to offer a toll-free phone number for terminally ill patients, families, and doctors with questions about end-of-life options. The number would be available on the state Department of Public Health's website. California's End of Life Option Act takes effect June 9 and allows patients to receive life-ending drugs if two doctors determine they have six months or less to live and the patient submits two oral requests 15 days apart. The patient must also be able to take the medication themselves. Religious groups oppose the law. The help line bill now heads to the state Senate Appropriations Committee. Read More

On Lok Names Grace Li as New CEO. On Lok, a not-for-profit provider of the Program of All-Inclusive Care for the Elderly (PACE) services, announced that it has named Grace Li as the chief executive officer, effective April 1, 2016. Li will

replace Robert Edmondson, who recently announced his retirement. She previously served as chief operating officer for On Lok Lifeways. Read More

Colusa Regional Medical Center Closing. Colusa Regional Medical Center announced that it will close its hospital and three clinics on April 22 due to financial difficulties. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Judge Rejects Challenge to No-Bid Prison Healthcare Award. *Health News Florida* reported on April 13, 2016, that a Florida judge rejected Wexford Health Sources' challenge to a Florida Department of Corrections decision to award Centurion of Florida a $268 million no-bid contract to provide health services to state prisons. The Department chose Centurion after Corizon Health terminated its contract in January. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

State Ordered to Provide In-Home Care to Children with Disabilities and Severe Medical Conditions. The *AP/Baltimore Sun* reported on April 7, 2016, that a federal judge has issued a preliminary injunction ordering Illinois to provide in-home nursing care to over 1,200 children with disabilities and severe medical conditions. The lawsuit alleges that the state failed to fulfill its Medicaid obligations and did not provide home care to children who were approved and promised services. Illinois is planning to appeal the decision and ask that the order be stayed until the lawsuit is resolved. Read More

Iowa

House Republicans Propose Medicaid Privatization Accountability Plan. *The Des Moines Register* reported on April 7, 2016, that the Iowa House proposed a plan to provide oversight of the state's transition to Medicaid managed care. The proposal adds consumer protections and accountability measures to prevent fraud and taxpayer waste, and to ensure high quality care. This includes:

- Requiring specific reporting on vulnerable residents, including those with special needs, behavioral problems and older persons
- Providing reports on levels of fraud, waste and abuse, program integrity, and adherence to insurance licensing, certifications, accreditation and financial accounting
- Examining access to care, plus information about grievances and appeals
- Providing call center performance information, as well as data regarding timeliness and process of previous authorization for services approval, denial and modifications
- Examining annual health care effectiveness data, quality measures, utilization of hospital admissions and emergency room visits

- Researching medical loss ratio

The proposal will be included in a state health and human services spending bill. The Senate also voted for a Medicaid accountability bill in March. Read More

Kentucky

Legislation to Save Kynect, Expansion Falters in State Senate. The *Courier Journal* reported on April 11, 2016, that legislation to save Kentucky's Kynect health insurance exchange and Medicaid expansion died in a state Senate committee meeting. Governor Matt Bevin has said the programs are too costly and unsustainable. He wants to transition Kentuckians from Kynect to the federal Exchange platform, Healthcare.gov. While the votes followed testimony about Kynect and expansion, much of the discussion also focused on issues with the state's new public benefit system Benefind, which is said to have disrupted services by erroneously notifying people of lost Medicaid coverage. Read More

Louisiana

Bill Would Create a Provider Tax on Hospitals to Support Medicaid Expansion. *The Times-Picayune* reported on April 6, 2016, that Louisiana House Speaker Taylor Barras has filed legislation to implement a hospital assessment program to help the state pay for the cost of Medicaid expansion. The bill caps several years of legislative work that began under former Governor Bobby Jindal, a vocal opponent of Medicaid expansion. The Louisiana Hospital Association, in favor of expanding Medicaid, supports efforts to levy a fee on hospitals. According to the Hospital Association, hospitals will pay up to 40 percent of the cost of the cost of Medicaid expansion. Read More

State Legislators Wary of Bills Requiring Medicaid Copays. *The Times-Picayune* reported on April 7, 2016, that legislative support to charge Medicaid beneficiaries copays for health care services is waning. Governor John Bel Edwards has backed copays. However, some lawmakers doubt whether there is enough support to get a bill out of committee, especially after health care providers began to lobby against the plan. The Louisiana House Health and Welfare Committee is scheduled to hear Medicaid copay bills this month, which would typically require Medicaid recipients to pay about $8 per visit for the health care services they're provided. Read More

DHH to Rework Medicaid Expansion Hiring Plan. The *AP/The Advocate* reported on April 11, 2016, that the Louisiana Department of Health and Hospitals is reworking its plan to hire additional staff to help implement the state's Medicaid expansion. Initially, the department proposed adding 250 employees, but Republican lawmakers put the plan on hold in January. Under a new plan, the state would contract with the University of New Orleans to augment agency staff. The university has as many as 200 short-term employees who would handle eligibility review. The staffing contract would cost about $9 million to $10 million, with the state's $2.9 million share expected to be paid by hospitals and managed care plans. Read More

Maine

Alternative Medicaid Expansion Bill Passes State Senate. The *Portland Press Herald* reported on April 12, 2016, that the state Senate passed an alternative Medicaid expansion bill. The proposal, passed by a one vote margin, calls for expansion beneficiaries to obtain coverage through the federal Marketplace and to contribute a small premium. The state Office of Fiscal and Program estimates that the expansion would cost $93 million in state tax dollars through fiscal 2018-19, while the Department of Health and Human Services put the cost at $315 million over five years. The bill is expected to pass the state House; however, Governor Paul LePage has shut down previous efforts to expand Medicaid. Read More

Massachusetts

MassHealth Restrictions on Hepatitis C Drugs Leaving Many Without Care. *The Boston Globe* reported on April 9, 2016, that MassHealth, along with Medicaid programs in other states, are putting restrictions on Hepatitis C medications to control high costs. Due to the high cost of new Hepatitis C drugs, such as Sovaldi and Harvoni, Massachusetts and other states have implemented requirements for alcohol and drug use cessation, or delayed approving the drugs until a patient's liver damage worsens. Advocates are pressing the state to collaborate on revised conditions for prescription approval. MassHealth spent $318.5 million in combined federal and state dollars on Hepatitis C drugs from December 2013 through January 2016. Read More

Michigan

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

Henry Ford Health System Finalizes Deal to Absorb Allegiance Health. The *Detroit Free Press* reported on April 5, 2016, that Henry Ford Health System has finalized a deal to absorb Allegiance Health of Jackson, including a 475-bed hospital and more than 30 outpatient centers. The deal marks the Detroit-based system's first significant expansion outside of southeast Michigan. Henry Ford also intends to begin offering its Health Alliance Plan insurance products to businesses in the Jackson, Michigan area. Read More

Missouri

Senate Budget Avoids Large Cuts to Medicaid. The *Kansas City Star* reported on April 9, 2016, that the Missouri state Senate cut just $57 million from the Governor's proposed $7.9 billion budget for Medicaid. Senate Appropriations Chairman Kurt Schaefer spoke about making big changes to cut costs, but the Senate-approved budget for the Department of Social Services was largely left intact. Last year, Senator Schaefer added a provision to the budget to transition 200,000 Medicaid recipients to managed care, which is currently contracted to Centene, Aetna, and WellCare. The contracts will go out to bid shortly, with managed care set to expand statewide, excluding individuals who are elderly, blind, or disabled. In fiscal 2016, the state budgeted around $1.8 billion for Medicaid managed care. Read More

New Hampshire

Medicaid Expansion Work Requirement Unlikely to be Approved. *The New Hampshire Union Leader* reported on April 7, 2016, that a 30-hour work requirement for Medicaid expansion beneficiaries in the Health Protection Program reauthorization is unlikely to receive federal approval. CMS has denied similar work requirements in Medicaid expansions in other states. Governor Maggie Hassan signed the bill extending the state's Medicaid expansion for two years through December 31, 2018. Opponents of expansion say the work requirement was a ploy to appeal to conservatives and move the bill through both chambers. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

CMS Approves State Plan Amendment for Children's Health Homes. The State Plan Amendment (SPA) regarding children's Health Homes was approved on April 7, 2016. The state conducted a webinar that outlined the conditions of the SPA as well as providing an update on children's health home implementation and the transition of children's behavioral health services into Medicaid managed care. Slides from the webinar can be found here. The implementation date for children's Health Homes has been postponed again from September 1, 2016, to October 1, 2016. CMS approved a rate structure for children's health homes that will be in place providers for two years; after two years, CMS will review the rate structure again. For now, Health Home implementation will exclude the Early Intervention program. This program was originally slated to convert service coordination into Health Home care management but that will be delayed. The State received approval to include serious emotional disturbance (SED) and complex trauma as eligibility criteria for health home participation. The issue around Health Home conflict free case management has not been resolved; the state will address this once they have clarification from CMS.

Health Homes must provide six core services:

1. Comprehensive Care Management
2. Care Coordination & Health Promotion
3. Comprehensive Transitional Care
4. Patient and Family Support
5. Referral to Community Supports
6. Use of HIT

New York State is asking Health Homes and Care Management Agencies to prioritize certain groups of children who meet Health Home chronic condition eligibility and enrollment criteria for enrollment into Health Homes serving children and families as of October 1, 2016.

- Children enrolled in OMH TCM care management programs that are converting

- Medicaid eligible children on the OMH Waiver waiting list within 30 days of discharge from inpatient/residential/day treatment settings, in order to participate in discharge planning
- Children on waiting lists for TCM
- Children on the Bridges to Health waiting list
- Children living in licensed congregate care
- Children who are within three months of discharge from foster care
- Children enrolled in LDSS prevention services for whom foster care placement is imminent
- Children prescribed three or more psychotropic medications
- Children who are within thirty days of discharge from an inpatient, residential or detox setting
- Children with multiple chronic conditions who are medically fragile and have had an inpatient stay within the past thirty days
- Children who have an ER referral, but were not admitted for inpatient services; or have been discharged with a recommendation for community follow up
- Children who are involved in multiple service systems (i.e. child welfare and juvenile justice)

Minimum Wage and Health Care Costs. *Crain's HealthPulse* reports that the state has met with health care providers to discuss how they plan to cover the cost to providers from the increase in the state's minimum wage. According to *Crain's*, the state will distribute up to $218 million over the next two years. The fiscal 2017 budget includes $13 million in cash to cover providers' costs, with up to $58 million available to be appropriated if necessary. In fiscal 2018, the state will set aside about $88 million in cash, with the authority to appropriate up to $160 million. The bulk of the funding will be distributed to home care providers, followed by nursing homes, outpatient care, and inpatient care. No details have been provided on how compensation will be determined. Read More

MVP Health Care's Operating Margin Improves in 2015. MVP Health Care (MVP) ended 2015 with a significant increase in operating margin over 2014, due in large part to the successful realignment of its product portfolio, the synergies realized as part of its acquisition of Hudson Health Plan, and controlled administrative costs. MVP reported gross revenue of $2.92 billion in 2015 and net income of $42.3 million, up from an operating loss of nearly $12.4 million in 2014, enabling it to close out the year with a solid operating margin of 1.4 percent. Read More

Kaleida Health, Eastern Niagara Announce Affiliation. Kaleida Health is again expanding as Eastern Niagara Health (ENH) System announced they have entered into a new affiliation agreement. The board of directors at the respective health systems recently approved the agreement. This comes on the heels of last month's announcement that Lake Shore Health Care Center and Brooks Memorial Hospital intend to affiliate with Kaleida Health. The Eastern Niagara Health System (ENHS) consists of Eastern Niagara Hospital's acute care site, outpatient service facilities, and the Niagara Regional Surgery Center. Kaleida Health includes Buffalo General Medical Center, DeGraff Memorial Hospital,

Millard Fillmore Suburban Hospital, and Women & Children's Hospital of Buffalo. By affiliating with Kaleida Health, Eastern Niagara will be better equipped to coordinate care and to have patients seamlessly transitioned to the tertiary network. The two health systems will now develop a full vision, plan, and strategy for the eastern Niagara County community. Read More

North Carolina

Audit On Medicaid Overpayments Is Questioned. The *Winston Salem Journal* reported on April 13, 2016, that North Carolina officials are questioning the accuracy of an audit that tallied the level of overpayments or claims payment errors made by the Department of Health and Human Services (DHHS) to Medicaid providers. The audit, from the State Auditor's Office, puts overpayments at $835 million in 2015. DHHS, meanwhile, puts the number at $690 million, which would represent a 7.8% claims payment error rate. State Auditor Beth Wood and Health Secretary Rick Brajer acknowledged differences in the audtior's annual determination and DHHS' three-year determination. Either way, DHHS expects the Medicaid program to end fiscal 2015-16 with a $250 million cash surplus. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

The Governor Called for Speeding up a Personal Income Tax Cut; Underspending in Medicaid May Create FY 2016 Year End Balance between $400 and $500 million. *Gongwer Ohio* is reporting on information from Ohio's Office of Budget and Management that tax receipts are tracking to estimates, and personal income tax intake is better than expected for March, helping push year-to-date tax receipts just above projections for the first eight months of FY 2016, to almost $16 billion. The commercial activity tax and the financial intuitions tax also came in above projections, according to the Office of Budget and Management. Ohio officials expect the FY 2016 year-end balance will be between $400 million and $500 million, due mostly, if not entirely, to the underspending in Medicaid. Read More

House Finance Committee to hold first hearing on Mid-Biannual Review Bill. HB 483, the MBR bill for the Department of Developmental Disabilities may see hearings this week, according to *Gongwer Ohio*. The bill adds to the kinds of medicine and treatment that a caretaker can administer and places early intervention services solely under the Department of Developmental Disabilities rather than splitting responsibilities between DODD and the Department of Health. Read More

Oregon

HMA Roundup – Nora Leibowitz (Email Nora)

Oregon, Medicaid Plan May be Closer to Resolving Rates Dispute. The past six months has seen a lot of activity in the ongoing dispute between the Oregon Health Authority (OHA; Oregon's Medicaid agency) and one of the Portland-area Coordinated Care Organizations (CCO) with which it contracts for Medicaid coverage in the state. The CCO, FamilyCare, covers approximately

134,000 Oregon Health Plan members in Clackamas, Multnomah, Marion and Washington counties. OHA and FamilyCare have been in conflict about the 2015 Medicaid capitation rates, which were recalculated when the Centers for Medicare and Medicaid Services (CMS) objected to the methodology Oregon had used to develop its contracted rates. The new methodology led to a 19 percent rate reduction for FamilyCare, and negatively impacted the rates of several other CCOs.

OHA publicly stated that if the two sides could not come to an agreement, the Department would consider FamilyCare in breach of contract. Late last November, OHA's director Lynn Saxton invited the other 15 CCOs to declare their interest in covering FamilyCare's members, should the contract with FamilyCare end. Six plans submitted binding letters of intent (Columbia Pacific CCO, Eastern Oregon CCO, HealthShare of Oregon, Pacific Source Community Solutions, Trillium Community Health Plan, and Willamette Valley Community Health). In December, in response to a legislator request, the Oregon Legislative Counsel issued a non-binding opinion that OHA cannot reclaim funds paid to CCOs for past periods.

During the February 2016 Oregon legislative session, the legislature approved HB 4107, which prohibits OHA from retroactively changing Medicaid CCO contracts in ways that result in the recovery of money paid to a CCO. The new law applies to plan years starting in 2016, and has an exception for funds recovery mandated by CMS.

Following the legislative session, in mid-March OHA announced a plan to settle with FamilyCare regarding the 2015 rates. OHA's proposal would settle FamilyCare's lawsuit against the Department by providing the plan with $12 million dollars and giving the plan until 2018 to repay the $55 million OHA says it was overpaid. FamilyCare countered with an offer to repay $47.3 million for 2015 and make changes to its budget for the population that became eligible due to the Affordable Care Act. OHA's counter accepted the 2015 rates but noted that agreeing to FamilyCare's 2016 proposal would increase the Medicaid budget by $28 million, putting the state over the 3.4 percent growth cap for the program and thus put the state at risk for $60 million in repayment to the federal government. OHA put an April deadline on FamilyCare's response. In late March, FamilyCare filed a complaint and motion for a temporary restraining order that would bar OHA from terminating the FamilyCare contract until a court reviews OHA's claim that FamilyCare has breached its 2015 contract. A Multnomah County judge issued a restraining order against OHA on April 5, allowing FamilyCare to continue serving its Medicaid members until the preliminary injunction hearing requested by FamilyCare is held or a further court order issued. A few hours prior to the hearing, OHA filed papers regarding its intent to hold a contested case administrative hearing in the FamilyCare matter.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Nursing Homes Sign New Union Contracts. The *Philadelphia Business Journal* reported on April 6, 2016, that three national nursing home operators signed new union contracts with SEIU Healthcare for 42 facilities in Pennsylvania. The agreements create a pathway for certified nurse assistants to

earn $15 per hour and for workers in non-nursing departments to earn $13 to $14. Contracts were negotiated with Genesis Healthcare of Kennett Square, Golden Living Centers, and Oaks Health of Florida. Read More

Pennsylvania Patient Safety Authority Appoints New Executive Director. The Pennsylvania Patient Safety Authority, a state agency focused on reducing medical errors and improving patient safety, announced on April 7, 2016, that it had named Regina Hoffman executive director. She replaces Michael Doering, who had been executive director since 2007. Hoffman previously led the state's Patient Safety Liaison program, which consults with providers across the state to ensure they are equipped with patient safety materials. Read More

Rhode Island

State Approves Texas Company's Freestanding Emergency Departments. *The Providence Journal* reported on April 4, 2016, that Neighbors Health Center, a company that runs freestanding emergency departments in Texas, received preliminary state approval to open two facilities in Rhode Island. Despite concerns that the facilities would drive business away from local hospitals, Rhode Island state health director Nicole Alexander-Scott approved the company's application. The decision followed a review of the proposals by the State Health Services Council and includes four pages of conditions that Neighbors must follow, such as no balance billing of patients. Read More

South Dakota

Coalition Working With Obama Administration to Expand Medicaid. The *Argus Leader* reported on April 6, 2016, that the South Dakota Health Care Solutions Coalition is rushing to prepare the infrastructure for Medicaid expansion before the new presidential election. The coalition has been working with the Obama Administration for years to reinterpret the federal policy on funding for Medicaid-eligible American Indians. In February 2016, the federal government informed the state they would accept the terms of a compromise if the state expands Medicaid. The coalition members need to determine whether the state's savings from the federal policy change are enough to foot the bill for an estimated 50,000 additional expansion enrollees. Read More

Tennessee

Governor Announces New Director of TennCare. The *Memphis Business Journal* reported on April 6, 2016, that Tennessee Governor Bill Haslam announced that Wendy Long will replace Darin Gordon as head of TennCare. Long was deputy director and chief of staff of the Health Care Finance and Administration division and was Chief Medical Officer for TennCare from 2004 to 2012. Read More

State House to Form Task Force on Insure Tennessee. *WKRN* reported on April 12, 2016, that Tennessee House Speaker Beth Harwell announced a new task force to study costs, access, and personal responsibility requirements related to Insure Tennessee. The task force will come up with recommendations by June. Democrats and supporters of the Insure Tennessee program oppose the creation

of the task force. Insure Tennessee is the state's alternative Medicaid expansion program. Read More

Texas

Lawsuit over Acute Therapy Rate Cuts Set for Trial April 25. *My Statesman* reported on April 12, 2016, that a lawsuit seeking a permanent injunction blocking cuts in Texas Medicaid payment rates to acute therapy providers is set to go to trial April 25. Last year, the Texas legislature approved $350 million in cuts to therapists serving 60,000 children with disabilities in the state. About $150 million of the reduction would be from state funds, and $200 million would be from federal matching funds. Republican lawmakers argue that Texas Medicaid therapy rates are higher than in other states and that the number of providers has risen 30% over five years. A group of providers and parents sued the state last year and received a temporary injunction to delay the cuts. Read More

State Regulators Unable to Prove Medicaid Fraud Against Orthodontists. The *Austin American-Statesman* reported on April 7, 2016, that Texas Medicaid regulators have yet to win a contested court case against orthodontic fraud. In the latest case, regulators alleged that a dental center billed for orthodontic services not covered by Medicaid, but a judge deemed that the Health and Human Services Commission failed to prove this and would need to pay out millions of dollars in reimbursements withheld from the center. In 2014, the Sunset Advisory Commission issued an audit that found that the investigators' failings in handling fraud cases harmed both providers and taxpayers. Read More

Vermont

Vermont Issues Medicaid ACO RFP. *Vermont Business Magazine* reported on April 7, 2016, that Vermont has issued a Request for Proposal (RFP) to contract with one or more Accountable Care Organizations (ACOs) to provide certain state Medicaid services. Under the model, ACOs would take risk-based capitation payments and assume responsibility for paying their contracted network providers for Medicaid services. The Department of Vermont Health Access said that the goal of the RFP is to further the state's transition to an integrated care system based on quality and access. The state has also been working with the Green Mountain Care Board around the idea of aligning Medicaid, Medicare, and commercial payers. Proposals are due June 8, 2016, with a targeted contract start date of January 1, 2017. Read More

Washington

HMA Roundup – Ian Randall (Email Ian)

Recent Washington Budget Deal Increases Funding for Mental Health, Makes Other Key Changes in Health Care Funding. After failing to reach agreement on a budget during the regular session, the Washington State Legislature reached agreement on a supplemental budget. The budget increases funding for mental health services, health systems, and hospitals. The supplemental budget also moved a number of functions from the Washington Health Care Authority to the Office of Financial Management or the legislature, including Medicaid

caseload forecasting and managed care actuarial rate setting, and set limits on spending on the Healthier Washington State Innovation Plan beyond specific legislative appropriations.

The budget deal included several new investments in mental health services and specifically provided financing for the state's psychiatric hospitals. Total funding increases in the supplemental budget total about $40M and include:

- Community mental health treatment: Funds expansion of mobile crisis teams, new housing and recovery services to support transitions out of inpatient settings, and pilots a telephone-based consultation service for rural areas to support primary care treatment of children's mental health needs.
- Appropriate rate-setting at new hospital psychiatric units: The budget directs the HCA to set psychiatric rates for new facilities using the same method that is used for existing facilities, ending a practice that paid new facilities lower rates.
- Community Diversion Innovation Fund: The budget creates a new fund to develop strategies to avoid long-term care and allow contracting from a Behavioral Health Organization (BHO) to put inpatient long-term beds in community settings.

Other key changes in funding health care initiatives include:

- Holds 2017 Medicaid managed care rates to 2016 levels.
- Assumes $4.2 million in state savings and $8.5 million in total savings in "inpatient cost avoidance."
- Funds new Department of Health initiatives including hospital pharmacy licensing, prescription monitoring program, maternal mortality, vapor/e-cigarette regulation, and vaccine reporting for schools, among others.
- Provides $3.9 million in state funding to expand Health Homes services for dual-eligible enrollees.

Read More

National

Rockefeller Institute Projects Flat State Income Tax Revenues. A "By the Numbers Brief" from the Rockefeller Institute indicates that April state income tax returns may be weak, causing an unexpected lack of revenue for states during the final stages of budget negotiations. States that heavily rely on oil revenues and those with legislative changes to reduce taxes could see declines. Read More

Hospitals Turn to Community Health Workers to Improve Care. *Kaiser Health News* reported on April 11, 2016, that hospitals across the country are increasingly using community health workers to improve patient care. Hospitals are using non-medical workers to strengthen relationships, not just with their patients, but with surrounding neighborhoods as well, in order to improve local population health. Some hospitals are able to fund such programs through grants from private foundations or the federal government, and states are

increasingly rewarding hospitals through Medicaid payments for keeping patients healthy and reducing readmissions. However, while more than 20 states have instituted regulations or created oversight committees, there are still some questions around the best level of scrutiny for community health workers. Read More

Self-Insured Plans Begin to Drop Out of All-Claims Databases. *CQ Roll Call* reported on April 12, 2016, that self-insured employer health plans have begun to stop providing data to all-claims databases in at least five states, after the U.S. Supreme Court ruled that ERISA takes precedence over state law. Colorado, Utah, Maryland, Minnesota, and Oregon are among the 12 states with all-payer claims databases. Self-insured employers do not oppose the databases, but rather do not want to pay the administrative costs associated with submitting the data. Read More

Funding Debate Stalls Mental Health Reform, Opioid Programs. *Modern Healthcare* reported on April 11, 2016, that although Democrats and Republicans have agreed on many aspects of mental health reform legislation, the issue of funding is preventing bills from passing. Time is limited and the remaining obstacles will be difficult to overcome before Congress breaks in July. After the break, most efforts will be dedicated to appropriation bills. The Mental Health Reform Act, which would create state grants focusing on improving access to evidence-based treatment, is heading to the Senate, but still has no funding attached. In March, the Senate passed the Comprehensive Addiction and Recovery Act, but an amendment to provide emergency funding was defeated. An identical bill may be brought up in the House, but it too, requires funding. Read More

Industry News

United to Exit Georgia, Arkansas Exchanges. *The Blade/Bloomberg News* reported on April 9, 2016, that UnitedHealth announced that it will no longer sell plans on the Georgia and Arkansas insurance Marketplaces starting next year. UnitedHealth, along with Aetna and several large Blue Cross Blue Shield plans, reported losses on their Qualified Health Plan (QHP) products last year. As of December 31, 2015, United had around 650,000 QHP members. Read More

Mississippi Department of Corrections Awards Centurion Correctional Healthcare Contract. Centene announced on April 7, 2016, that Centurion, a joint venture between Centene and MHM Services, was selected by the Mississippi Department of Corrections to provide healthcare services to over 17,000 inmates. The contract is effective July 2016 and extends for three years. Centurion also provides services in Massachusetts, Minnesota, Tennessee, Vermont, and, beginning in the second quarter of 2016, Florida. Read More

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

HMA Information Services 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.

HMA Upcoming Webinars

"Empowered Leadership Can Transform Care for Vulnerable Populations"

April 19, 2016
Learn more
Register Now

"Trauma-Informed Care: Overview and Best Practices in Patient Screening"

April 26, 2016
Learn More
Register Now

"'Business Associates' Redefined: What Healthcare Organizations Need to Know to Comply with Strengthened HIPAA Regulations"

April 26, 2016
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