HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 25, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

AHCA REPORT HIGHLIGHTS NURSING CENTER MEDICAID FUNDING GAP

This week, our *In Focus* section reviews *"A Report on Shortfalls in Medicaid Funding for Nursing Center Care,"* published by the American Health Care Association (AHCA) in April 2016. The report, prepared for AHCA by Eljay, LLC, and Hansen Hunter & Company, PC, reviews Medicaid nursing center rates and average costs in 33 states. The report finds that the average shortfall per Medicaid patient day has grown from $9.05 in 1999 to $22.46 in 2015 (projected). When extrapolated to all 50 states, this equates to an estimated Medicaid funding shortfall of more than $7 billion annually. The report provides a state-by-state breakdown of average Medicaid funding shortfalls, as well as a broader overview of and outlook on the nursing center sector.

Medicaid Funding Shortfall

As noted above, the report projects an annual shortfall across all 50 states of more than $7 billion in Medicaid reimbursement. For illustrative purposes, the report explains that a typical nursing center or other facility with an average daily of census of 100 residents, of which 63 are funded by Medicaid, would lose an average of $1,415 dollars per day, and more than $516,000 annually, due to Medicaid reimbursements that fall short of patient costs.

A look at individual state data provided for 33 states (see **Table 1**) shows significant variation from state to state.

- Five states have projected 2015 Medicaid funding shortfalls of more than $30 per Medicaid day: Wisconsin, New York, New Jersey, Massachusetts, and Minnesota.
- On the other end of the spectrum, five states have projected 2015 Medicaid funding shortfalls of less than $10 per Medicaid day: Arizona, Georgia, Colorado, Florida, and Delaware. Virginia and North Dakota show net positive differences between average rates and cost of $0.32 and $2.42, respectively.
- Looking at changes in shortfalls from 2013 to 2015, there is some positive movement, although significant shortfalls remain. A total of 13 states saw a decrease in the average Medicaid shortfall from 2013 to 2015.
- On the other end of the spectrum, four states – Maryland, Hawaii, Wyoming, and Ohio – saw their average Medicaid shortfall increase by more than $5 during the same time period.

Table 1 – 2013 Estimated and 2015 Projected Medicaid Funding Shortfalls by State (33 States)

State	2013 Rate	2013 Cost	2013 Difference	2015 Rate	2015 Cost	2015 Difference	Change in Difference 2013 to 2015
Arizona	$198.53	$206.93	($8.40)	$208.12	$217.10	($8.99)	($0.59)
California	$180.97	$199.03	($18.06)	$191.33	$205.50	($14.17)	$3.89
Colorado	$220.55	$226.96	($6.41)	$225.23	$232.05	($6.82)	($0.41)
Connecticut	$229.84	$250.75	($20.91)	$230.06	$255.04	($24.98)	($4.07)
Delaware	$249.72	$250.80	($1.09)	$256.69	$258.34	($1.65)	($0.56)
Florida	$218.64	$226.40	($7.75)	$225.14	$231.81	($6.67)	$1.08
Georgia	$157.33	$163.76	($6.43)	$164.02	$171.81	($7.79)	($1.36)
Hawaii	$259.34	$272.85	($13.50)	$260.77	$281.85	($21.08)	($7.58)
Illinois	$132.82	$165.87	($33.05)	$145.99	$171.08	($25.09)	$7.96
Iowa	$158.85	$171.51	($12.65)	$165.39	$177.64	($12.25)	$0.40
Kansas	$152.67	$164.00	($11.34)	$158.70	$169.14	($10.45)	$0.89
Maine	$183.72	$206.44	($22.72)	$200.58	$213.50	($12.92)	$9.80
Maryland	$242.44	$252.36	($9.92)	$239.37	$257.99	($18.62)	($8.70)
Massachusetts	$196.46	$230.22	($33.76)	$201.44	$236.70	($35.26)	($1.50)
Minnesota	$170.84	$205.40	($34.56)	$179.96	$214.00	($34.04)	$0.52
Missouri	$149.01	$162.50	($13.49)	$152.66	$167.57	($14.90)	($1.41)
Montana	$178.88	$192.79	($13.91)	$183.34	$200.48	($17.14)	($3.23)
Nebraska	$157.86	$182.69	($24.82)	$161.87	$186.93	($25.06)	($0.24)
Nevada	$197.96	$220.84	($22.88)	$201.41	$224.12	($22.71)	$0.17
New Jersey	$204.37	$235.76	($31.38)	$207.35	$242.67	($35.32)	($3.94)
New Mexico	$165.10	$190.26	($25.15)	$168.00	$192.73	($24.73)	$0.42
New York	$226.03	$270.53	($44.50)	$234.16	$282.59	($48.43)	($3.93)
North Dakota	$232.78	$240.86	($8.08)	$250.51	$248.08	$2.42	$10.50
Ohio	$174.52	$190.88	($16.36)	$175.10	$196.79	($21.69)	($5.33)
Oklahoma	$144.26	$155.38	($11.12)	$144.08	$158.89	($14.81)	($3.69)
Pennsylvania	$211.16	$234.03	($22.87)	$216.75	$242.18	($25.43)	($2.56)
Texas	$132.41	$149.29	($16.87)	$141.64	$154.18	($12.55)	$4.32
Utah	$184.74	$200.00	($15.25)	$188.70	$205.21	($16.51)	($1.26)
Vermont	$214.79	$231.68	($16.89)	$217.23	$234.98	($17.76)	($0.87)
Virginia	$160.56	$167.93	($7.37)	$173.81	$173.49	$0.32	$7.69
Washington	$190.75	$219.93	($29.18)	$197.32	$225.15	($27.83)	$1.35
Wisconsin	$163.29	$214.09	($50.80)	$167.85	$220.68	($52.84)	($2.04)
Wyoming	$219.69	$237.96	($18.28)	$224.12	$249.04	($24.92)	($6.64)

Source: Eljay, LLC, & Hansen Hunter & Co. P.C. (For AHCA). "A Report on Shortfalls in Medicaid Funding for Nursing Center Care." April 2016.

Role of Provider Taxes

As of fiscal year (FY) 2015, 43 states and the District of Columbia have implemented nursing center provider tax programs, up from just 20 states in FY 2004, with total tax collections estimated at $5 billion annually. While the taxes are funding rate increases, and tax collections are raised annually in many states, the report states that many states "have used the tax proceeds to fund rate increases in lieu of state funded inflationary increases, to 'back-fill' rate reductions or rate freezes from prior years, and/or to fund other areas of the Medicaid program."

Additionally, as more states implement Medicaid managed long term services and supports (MLTSS) programs, the provider tax structure must adapt. Where states are funding supplemental payments through the provider tax program, these funds will have to either:

- Incorporate these payments into the daily rate structure, requiring greater estimation around patient census figures, tax collections, and Medicaid payments, or;
- Accept risk associated with managed care plans allocating the supplemental payments.

Finally, the report notes that reductions in allowable provider tax amounts have been discussed at the federal level, and a reduction in the provider tax safe harbor threshold from the current 6 percent of provider revenues could have significant implications for Medicaid nursing center funding.

Other Report Elements and Nursing Center Outlook

In addition to the Medicaid shortfall analysis and provider tax implications, the AHCA report addresses the following topics:

- Financing factors related to capacity
- The role of Medicare in subsidizing Medicaid shortfalls
- State budget and Medicaid programmatic trends
- Trends in LTSS impacting nursing centers, including MLTSS and value-based purchasing.

Finally, the AHCA report provides an outlook on the nursing center environment.

- States are tightening LTSS budgets and expanding home and community based services (HCBS) and MLTSS. Despite overall economic improvement, state economic outlooks are uneven and nursing center rates are not keeping up with inflation.
- Federal Medicare reimbursement has been impacted by sequestration and future changes to nursing center Medicare prospective payment system (PPS) could reduce payments.
- As mentioned above, congressional action on bad debt, provider taxes, and supplemental payments could add to Medicaid funding shortfalls.
- The provider community may face continued pressure to reduce overall spending under expansion of Medicare and Medicaid Accountable Care Organization (ACO) models, dual eligible demonstrations and other integration efforts, and bundled payment methodologies.

- Overall, the AHCA report sees a difficult environment for the nursing center sector, in light of current financial challenges and future uncertainties. The report concludes that "the ability to meet the needs and expectations of the growing elderly and disabled populations without major overhauls in how the services are funded is major cause for concern."

Link to AHCA Report

https://www.ahcancal.org/research_data/funding/Pages/2015-Medicaid-Shortfall-Report.aspx

HMA Medicaid Roundup

Arizona

HMA Roundup – Jeff Smith (Email Jeff)

Arizona Supreme Court Rules in Banner Health's Favor to Balance Bill Medicaid Patients. The Arizona Supreme Court unanimously ruled Banner Health Network did nothing wrong in negotiating a settlement with a group of AHCCCS (Arizona's Medicaid program) patients. Banner Health accepted AHCCCS's payments for services but then billed patients for the balance of charges unpaid, a practice known as "balance billing". Federal Medicaid laws prohibits balance billing over and above what Medicaid pays. However, Arizona law allows providers to seek higher payments. Banner put liens on patients in an attempt to recover these higher charges. The patients agreed to a settlement but then challenged it in court saying that federal law prohibits balance billing. The Arizona justices agreed that the settlement does violate federal law but let it stand nonetheless because both parties made the settlement in good faith. The justices did not issue a ruling on whether Arizona's law should remain in effect in light of contradicting federal law.

Department of Corrections Slow to Improve Prison Healthcare After Lawsuit Settlement. *KTAR News* reported on May 21, 2016, that U.S. Judge David Duncan has ordered the state of Arizona to develop a plan to improve medical and mental health care services for inmates. The order comes in response to claims that the Arizona Department of Corrections is not making improvements in line with an October 2014 settlement to a class action lawsuit. Attorneys representing the 33,000 prisoners have alleged inflated compliance figures and a failure to meet many requirements of the settlement. As a part of the 2014 settlement, the Department of Corrections received an additional $6.6 million from the legislature to increase staffing, offer cancer screenings, and help treat inmates with chronic diseases. Prison officials denied the allegations, and the Arizona Department of Corrections had not responded to a request for comment at the time of publication. Read More

Arkansas

Draft Arkansas Works Plan and Waiver Renewal Posted for Public Comment. *Arkansas Online* reported on May 19, 2016, that the Arkansas Department of Human Services released for public comment a draft of its request to make changes to the state's private option Medicaid expansion, including renaming it as Arkansas Works, and extending the waiver that authorizes the program until 2021. Under the private option, the state uses Medicaid funds to buy coverage for low-income Arkansans through the Exchange, which had enrolled 268,000 as of January 31, 2016. Changes to the private option would include charging

enrollees above the poverty level premiums of $19 month, offering some subsidized employer plans with extra benefits as an incentive to pay premiums, and eliminating a provision that allows retroactive coverage for enrollees. If approved, the changes would take effect January 1, 2017. The application estimates that Arkansas Works will cost $9 billion over the next five years, roughly $328 million less than what coverage would cost under the traditional Medicaid program. The state plans to submit the waiver to CMS for approval after the public comment period ends on June 17. Read More

Arkansas Health Care Association Agrees to Help State Generate Savings Through Increased Home and Community-Based Care. *Arkansas Online* reported on May 21, 2016, that Governor Asa Hutchinson signed a memorandum of understanding with the Arkansas Health Care Association, which represents nursing homes, to curb spending while improving home and community-based services and helping to keep individuals out of nursing homes. The plan includes capping nursing home beds at their current level for 10 years, providing preventive home and community-based services to some recipients, conducting patient assessments, and reforming some nursing home payments for quality. All measures are considered part of the state's larger effort to reduce Medicaid spending growth by $835 million over five years to help pay for expansion. Hutchinson proposed last month that nursing home providers be required to generate at least $50 million a year in savings between July 1, 2017, and the end of 2019, and that managed care plans be prohibited from providing such services, savings that the Governor hopes the new agreement will achieve or exceed. External consultants to the state estimate it could save $504 million from 2017 to 2021 through shifting services from high cost nursing home care to lower cost community-based care. Read More

California

HMA Roundup – Don Novo (Email Don)

Medi-Cal Commission to Seek Revised Pharmacy Bids for Gold Coast Plan. *Ventura County Star* reported on May 23, 2016, that California's Medi-Cal Managed Care Commission rejected bids submitted by Magellan Rx Management and Script Care to manage pharmacy benefits for Gold Coast Health Plan, which covers 200,000 Ventura County residents. The commission, which cited conflict of interest concerns, will submit a revised request for bids from Magellan, Gold Coast, and one other finalist, OptumRx. Script Care currently manages the Gold Coast pharmacy program in a five-year contract that is nearing expiration. In the final fiscal year of the contract, Script Care will receive $4.35 million plus $96 million for the cost of medications. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Colorado to Expand Chronic Pain Management Program. Colorado's Medicaid agency is expanding a chronic pain management program that connects primary care providers with specialists to guide treatment of clients with pain issues as well as those struggling with opioid addiction. The Colorado Department of Health Care Policy and Financing announced the expansion in a news release on Tuesday. The second phase of the program will connect primary care providers who are licensed to prescribe buprenorphine combination products, such as

Suboxone, with specialists. The original pain management program was launched in March 2015 and is modeled after a University of New Mexico program. In the first year, 84 providers across Colorado participated. Primary care providers can participate in the programs at no cost to them. The state hopes to increase the number of providers trained in treating chronic pain and/or opioid addiction.

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida to Spend Additional $58 Million on Mental Health Care. *The Sarasota Herald-Tribune* reported on May 20, 2016, that spending on mental health care by the state of Florida will rise 6 percent, or $58 million, in the fiscal year ending June 30, 2017, due to a measure was signed by Governor Rick Scott in April. State mental health facilities will receive $16 million to address staffing and safety deficits, while another $6 million will go toward a "reinvestment grants" program to fund community partnerships aimed at diverting individuals with mental illness from the criminal justice system. Additionally, $10 million will help fund the creation of central receiving facilities to triage patients to appropriate services when they enter the mental health system. The remaining funds will go to providers with existing state contracts, additional beds for patients leaving state hospitals, and teams working with children and families. Read More

AHCA Halts Medicaid Broker Contract Bid Process after Challenge. *Politico* reported on May 23, 2016, that Florida has halted its Medicaid broker contract bid process after Maximus announced its intent to challenge the bid criteria. Maximus said that the Florida Agency for Health Care Administration's invitation to negotiate a three-year Medicaid enrollment broker and recipient support services contract included specific terms intended to help the current contract holder, Automated Health Systems, win the bid. Specifically, Maximus pointed to requirements that the winning vendor must have offices within five miles of the AHCA's headquarters in Tallahassee and must set up office space within 15 business days of the contract being signed. Maximus stated that even if another vendor had a location and was prepared to sign a lease immediately upon receiving the award, the minimum time to permit, renovate, wire, and equip a facility would take 60 to 90 days and prevent any vendor from meeting the 15-day requirement. The current contract is worth $123.6 million. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Georgia Extends Federal Settlement Agreement to Move Individuals with I/DD Out of State Hospitals. *Georgia Health News* reported on May 18, 2016, that the state of Georgia signed an extension agreement to a five-year settlement from 2010, responding to a lawsuit brought by the Department of Justice against the state regarding the state's provision of services for individuals with intellectual and developmental disabilities (I/DD). Under the settlement, the state agreed to stop admitting people with I/DD to state psychiatric hospitals and move those already institutionalized to more appropriate community settings. However, when a September 2015 report by an independent reviewer showed Georgia's lack of progress in its efforts, U.S District Court Judge Charles

Pannell informed the state in a December hearing that they needed to speed up the process. Under the extended agreement, signed May 18, 2016, the state will be required to maintain a "high-risk surveillance list" for individuals who have moved out of state hospitals since 2010 to ensure community support as well as investigate the number of deaths of individuals with I/DD since 2010. The renewed agreement extends until June 30, 2018. Read More

Georgia Renews Temporary Medicaid Rate Increases; Looks at Medicaid Expansion. *Modern Healthcare* reported on May 18, 2016, that Georgia lawmakers are renewing temporary Medicaid payment increases for primary care doctors and are looking at expanding Medicaid to help balance the state's budget and address a growing population. Georgia Senate Health and Human Services committee chairwoman, Renee Unterman, believes there could be enough support in the Senate to pass a conservative expansion model, replicating the Arkansas private option expansion, which requires some beneficiaries to pay up to 2 percent of their income in premiums. About 400,000 people would be eligible for expansion. The Chamber of Commerce is expected to present expansion ideas when it reconvenes in January 2017. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Lawmakers Propose Bill to Audit Medicaid MCOs. *Crain's Chicago Business* reported on May 19, 2016, that a proposed bipartisan bill, House Resolution 1123, would require audits by the Illinois auditor general of Medicaid managed care organizations operating in the state. The audits would evaluate the appropriateness of the capitated rates paid to insurers and examine the health care outcomes of Medicaid enrollees. The article quotes Democratic State Representative Fred Crespo, who filed the bill with Republican Representative Ron Sandack, as stating that the purpose of the bill is to take a "close look" at the progress of the $17 billion Medicaid program. The bill has 60 co-sponsors. Read More

Governor Rauner Hopeful of Progress on Budget Deal as Legislative Deadline Looms. *Bloomberg Markets* reported on May 25, 2016, that Illinois Governor Bruce Rauner is "cautiously optimistic" that lawmakers are making progress on a budget deal as the state nears one full year without a budget in place. Absent a current fiscal year budget, Illinois has amassed a budget shortfall of $6.2 billion, with $7 billion in unpaid bills. The legislature has made progress on partial fixes, including a recent $700 million human services funding bill, which the Governor has yet to sign. The state legislature has until May 31 to approve a budget deal by a majority vote, with any vote beyond May requiring a three-fifths majority to pass. Read More

Kansas

Budget to Cut Medicaid Reimbursements by 4 Percent. *The Wichita Eagle* reported on May 18, 2016, that Kansas Governor Sam Brownback has signed a budget that includes $97 million in state spending cuts, equaling a total of $120 million when accounting for federal matching dollars. The Kansas Department of Health and Environment and the Kansas Department for Aging and Disability Services will see combined cuts of $57.4 million, most of which will come from Medicaid. Including federal funding, the total loss is $72 million,

with Medicaid provider reimbursement rates scheduled to drop 4 percent beginning July 2016. Home-based services for individuals with disabilities, as well as payments for 95 critical-access hospitals in rural Kansas are exempt. The planned rate cuts still require CMS approval. Read More

KDHE Proposes Medicaid Value-Based Payments, Preferred Networks. *The Topeka Capital-Journal* reported on May 24, 2016, that Kansas is proposing to shift Medicaid providers to value-based payments and to narrow provider networks in certain areas of the state. The Kansas Department of Health and Environment (KDHE) unveiled the proposed changes to the state's Medicaid program, KanCare, in a public meeting. However, several speakers attending the meeting noted that the state is failing to focus on more immediate problems facing KanCare, including a claims processing backlog and long wait times for the state Medicaid hotline. Kansas is hoping to obtain federal approval to renew the KanCare 1115 waiver next year. Read More

Kentucky

Kentucky Expands Efforts to Enroll Ex-Inmates in Medicaid Through Kynect. *Modern Healthcare* reported on May 21, 2016, that Kentucky officials have begun new initiatives to enroll former inmates in Medicaid through the state's insurance Exchange, Kynect. After the state expanded Medicaid in 2014, Louisville Metro Corrections Director Mark Bolton hired a full-time enrollment staffer to sign up uninsured inmates for Medicaid as part of the jail intake process. Bolton also launched a program that supplies inmates a backpack with medications and basic supplies and provides transportation to a shelter upon their release. So far, the program has enrolled just 2,000 of the 30,000 admitted to the jail in the last year. There is also is concern that if the state's new Republican Governor, Mett Bevin, shuts down Kynect, the program will face challenges going forward. Read More

Massachusetts

Health Policy Commission Chairman Concerned Over Proposed Change in Hospital Payments. *The Boston Globe* reported on May 20, 2016, that Massachusetts Health Policy Commission Chairman Stuart Altman is concerned about proposed payment changes to Massachusetts hospitals despite the ongoing issue of how price variation in the state is squeezing smaller facilities. Altman says a proposed ballot initiative, which would prohibit hospitals from being paid more than 20% above average for a particular service and redirect $440 million from Partners HealthCare to other hospitals, is too much too quickly. He believes that any policy changes should be phased in over time. Similarly, Partners executives say they would have to cut thousands of jobs if the changes are made; however, they are working with the Service Employees International Union, Local 1199, which supports the proposed initiative, to find an alternative. Read More

MassHealth Personal Care Attendants to Receive $15 per Hour by 2018. *MassLive* reported on May 16, 2016, that 35,000 personal care attendants who work for the state of Massachusetts through the MassHealth Medicaid program will be paid $15 an hour by 2018 under a new contract with 1199SEIU United Healthcare Workers East. Attendants' wages will increase from $13.68 an hour to $14.12 an hour in July 2016, to $14.56 an hour in 2017, and finally to $15 an

hour in 2018. The state and SEIU had agreed in principal to the increases last year. The newly signed contract also includes an extra $200,000 for education and training. Read More

New Hampshire

New Hampshire Receives Approval for $150 Million Grant to Rebuild Its Mental Health System. *PerfScience* reported on May 16, 2016, that New Hampshire received approval for a $150 million federal grant to rebuild its mental health system. Funds will go toward the creation of regional integrated networks, improved communication between providers, and a transformation in how the state delivers behavioral health services. The state was awarded the grant in January and will receive the funds in increments of $30 million annually over five years. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Quality and Innovation Institutes Partner to Develop an 11,000 Physician Practice Transformation Network. On May 18, 2016, *NJ Spotlight* reported that a 3.5 year peer-network program will support providers' adaptation to Medicare payment system changes that will replace the existing fee-for-service model with one based on quality benchmarks and improved patient outcomes. The New Jersey Health Care Quality Institute (NJHCQI) will team up with the New Jersey Innovation Institute (NJII) to develop a "one stop shop" for primary care and specialty providers to determine how to share clinical information and meet new quality metrics. The network will also learn from similar experiences of the state's Accountable Care Organizations (ACOs) and health plans. The New Jersey Academy of Family Physicians will take the lead in working with providers. This work is supported by a $50 million federal grant to the New Jersey Institute of Technology (to which NJII is connected). Read more

Weak state tax collections lead to proposal for additional funding cuts to New Jersey hospitals. On May 24, 2016 *NJ Spotlight* reported that a number of reductions to the state's proposed FY17 budget could cut hospital charity care funds by a total of $50 million ($25 million state share). The reductions are part of a strategy to balance the proposed budget, which has a $600 million gap. Acting Treasurer Ford Scudder reports that the reductions would be offset in part by the increase in Medicaid funds hospitals are receiving for newly enrolled beneficiaries. The hospital industry is concerned that further cuts to charity care will affect treatment for the uninsured, in particular for safety-net hospitals that serve low-income and immigrant populations. Read more

New Jersey State Commission Opposes Bills on Tiered Network. On May 20, 2016, *NJBiz* reported that the state's Pension and Health Benefits Review Commission opposed two bills on tiered networks. The first bill, S1934, would implement a freeze on future enrollment in tiered network health benefits plans until new legislation and regulations are established to govern these types of plans, while the second bill, S296, would establish standards for these plans. The bills were a result of Horizon's controversial OMNIA tiered network plan, which divided all of New Jersey's hospitals into two tiers. David Pointer, Assistant Director of the Division of State Health Benefits Program (SHBP), is

skeptical that these bills will have a large impact on the SHBP since only 0.13% of SHBP covered lives are in a tiered network plan. In addition, members of the review committee expressed that S296's provision to include University Hospital diminished the concept of a tiered network. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Redesign Team Initiatives and their Impact on New York Medicaid Spending. The Citizen's Budget Commission released a report on the impact of Medicaid Redesign Team (MRT) strategies on New York's Medicaid spending. It finds that the strategies have yielded significant savings and quality improvements, but realization of their full potential faces serious implementation challenges. The report finds that the MRT initiatives have been successful in containing total program costs despite a one-third increase in enrollment; average cost per enrollee between 2010 and 2014 declined 17 percent from $10,432 to $8,620, including declines in the more expensive categories of enrollees, the aged and disabled, as well as for other adults. The report discusses MRT strategies in three buckets: greater reliance on managed care, promotion of delivery models of Health Homes and Performing Provider Systems (PPSs) with greater coordination of care, and use of value-based payments that create incentives for better outcomes rather than greater volume of care. Continued implementation and refinement of these strategies is expected to yield additional substantial recurring savings. The annual savings target for state fiscal year 2020 is between $1.3 billion and $1.9 billion, or about 2 to 3 percent of the estimated baseline. The report also notes several significant challenges that the state is already facing in moving forward with further reform. The greatest barrier is federal limitations on the state's ability to mandate enrollment in managed care plans and Health Homes. Many of those with the most severe medical care needs and who are most likely to benefit from these arrangements are not yet participating. New PPSs have been created, but have not yet demonstrated their ability to meet performance goals in terms of new patterns of care and constraints on expenditure growth. Another uncertainty is whether PPSs will be sustainable after the substantial federal incentive payments end. The design of value-based payments is in an early stage, and many technical and policy issues remain to be resolved.

The report concludes by noting that New York has made significant progress in imposing fiscal discipline on New York's Medicaid program, has reduced per enrollee spending, and has identified longer term strategies for improving the quality of care and restraining growth in future cost per enrollee. If obstacles to implementation can be overcome, the MRT strategies should serve the triple aim of expanding access, improving quality, and reducing costs. The strategies warrant support and have the potential to yield substantial savings. Read More

Supportive Housing Funds at Risk. As part of this year's state budget, Governor Andrew Cuomo announced a major initiative to expand supportive housing across the state. Estimated at $20 billion over the next 15 years, this year's state budget included $2 billion toward that initiative, although the budget did not make explicit how the money was to be spent. With less than one month left in the legislative session, a coalition of groups that fought for the funding is raising concerns. The Campaign 4 NY/NY Housing is calling on the

governor to arrive at an agreement with the Legislature before the legislative session ends on June 16. Read More

Medicaid Funding for Criminal Diversion Program. A Performing Provider System serving the Albany area has decided to use DSRIP (Delivery System Reform Incentive Payment) funds to help support a new diversion program that aims to find new support systems for nonviolent, low-level offenders caught in the criminal justice system. The Law Enforcement Assisted Diversion (LEAD) program, developed in Seattle and begun in Albany on April 1, is unique among diversion programs. While most rely on judges to divert people from the criminal justice system after they've been arrested, the LEAD program lets police officers divert them before arresting them, and sends them instead to case managers. The LEAD program can save money by avoiding arrests and their concomitant costs, and by reducing the likelihood of repeat ED visits among the substance use population. At its heart, however, is finding ways to link those who have been diverted into new support systems, including enrollment in Medicaid. The program is operated by the Albany Medical Center PPS, funded in part by Medicaid incentive payments through the DSRIP program. One of the principle goals of New York's DSRIP program is to reduce avoidable hospital use among the Medicaid population. Read More

Behavioral Health Managed Care Consumer Forums. In preparation for the carve-in of behavioral health services for Medicaid managed care members who reside outside New York City, the New York State Department of Health, Office of Mental Health, Office of Alcoholism and Substance Abuse Services, and Local Government Units are hosting a series of consumer education forums. The intent is to inform Medicaid members about the upcoming transition of adult behavioral health services into Medicaid managed care. Questions that will be addressed include:

- How will these changes impact me?
- What are the new benefits?
- What is a Health and Recovery Plan (HARP)?
- What should a person do if they get a letter about enrollment?

The events will be held during the month of June. A schedule of the sessions as well as registration information can be found here.

Further Payment Reductions on Elective Delivery. In April, 2015, New York Medicaid reduced payment for elective deliveries, both caesarean sections and induced labor, for deliveries under 39 weeks gestation without an acceptable medical indication. Beginning April, 2016 for Medicaid fee-for-service and July 1, 2016 for Medicaid managed care, hose rates will be further reduced by an additional fifty percent. The increased penalty reflects the Medicaid program's commitment to providing high quality prenatal care by ensuring appropriate delivery for both mothers and babies. Read More

Exchange Plans Request Double-Digit Rate Hikes. *Crain's New York* reported on May 18, 2016, that New York health insurance Exchange plans are requesting double-digit rate hikes. The New York Health Plan Association said the requests are tied to increases in "the underlying cost of care and marketplace changes that continue to impact health plans' operations." Insurers selling individual plans requested an average 17.3% increase, while those selling small group plans asked for an average 12% increase. United Healthcare, which only enrolled 2% of those who signed up through the Exchange last year, requested a 45.6% increase. Newer insurer Oscar asked for an 18.4% increase after losing $120

million last year. CareConnect and MetroPlus requested 29.2% and 20.3%, respectively. The state Department of Financial Services (DFS) has to approve all rate requests. Last year, insurers requested an average increase of 10.4%, but DFS only approved an average increase of 7.1%. Read More

WellCare Exiting New York State of Health Marketplace. *Crain's* reports that WellCare will be exiting New York State of Health, the New York marketplace established under the Affordable Care Act. WellCare had fewer than 1,000 enrollees in its marketplace plan; it has 95,000 enrollees in its Medicaid managed care plan. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Health Care Providers Push Case for Shorter Pre-Authorization. *Gongwer Ohio* reports that a bill (SB 129) has been introduced that would establish a timeline for companies to respond to prior authorization requests and would create a web-based system to foster communication between insurers and physicians. Passed in the Senate in December 2015, hearings are now taking place in the House Insurance Committee. Testimony was heard on May 17, 2016, but no decision was made at the hearing. Read More

Ohio MHAS Selects CareSource for the Community Transition Program. The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has awarded CareSource the Community Transition Program (CTP) contract to provide treatment and recovery supports for individuals with substance use disorders (SUD) returning to the community upon their release from Ohio's adult prison system. The program, which is expected to launch July 1, will provide continued treatment and recovery supports to individuals upon release from prison. A seamless transition to services will promote recovery and increase stability for individuals. In addition, supports such as housing and employment will improve the quality of life for these individuals further reducing the risk of future relapse and recidivism.

Bill Introduced To License Dental Therapists, Dental Groups Skeptical. *Gongwer Ohio* reports a bill (SB330) was introduced on May 17th that would allow dental therapists to perform many of the tasks of dentists, such as surgical procedures including drilling, extractions and restorations. Advocates say it will improve oral health for those who need it, but it was panned by industry groups that maintain the plan won't be effective and could be dangerous for Ohioans. Read More

Oklahoma

Oklahoma Health Care Authority Postpones Vote on Rate Cut, Awaiting Legislative Budget Action. *The Oklahoman* reported on May 23, 2016, that Oklahoma's state Medicaid agency board postponed its vote on a 25% provider rate cut as the state waits for the Legislature to adopt a budget. The Oklahoma Legislature is in the final week of its session and the Legislature will have to agree on a budget this week. Nico Gomez, CEO of the Oklahoma Health Care Authority, advised the board to wait to make such a big decision. The Medicaid Rebalancing Act proposal, that would have expanded Medicaid through the state's existing Insure Oklahoma program, appears to have stalled in the

Legislature with the House of Representatives not passing the cigarette tax increase which would have provided the state funding for the expansion proposal. Gomez has said that the cigarette tax likely will not be the funding mechanism for stabilizing provider rates, and the other parts of the Medicaid Rebalancing Act are "effectively dead" this session. Read More

Oregon

HMA Roundup – Nora Leibowitz (Email Nora)

Oregon Hospitals are Increasing Cost Transparency. Oregon hospitals are improving transparency on cost, pledging to provide cost estimates for scheduled procedures. The change, which occurred in March, is intended to help the 5% of Oregonians who are uninsured. Consumers with insurance using a participating provider can still get estimates of their costs from their insurers. The Oregon Association of Hospitals & Health Systems (OAHHS) now provides cost estimate information on its website, OregonHospitalGuide.org and includes hospital billing department contact information for each hospital in the state. The site also provides data on hospital performance from the federal Centers for Medicare and Medicaid Services. Oregon's 62 hospitals have promised to provide information to consumers within three days of a request, though some are responding more quickly. Andy VanPelt, OAHHS Executive Vice President, notes that in addition to getting information, consumers who call hospital billing departments are more likely to get connected to financial assistance and charity care assistance. Beginning in July, the website of the state's health care agency (the Oregon Health Authority) will report median prices for the 50 top inpatient procedures and the 100 most common outpatient procedures.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Releases Five-Year Housing Strategy. Pennsylvania's Department of Human Services (DHS) released a five-year comprehensive housing strategy plan called Supporting Pennsylvanians through Housing. The strategy was created in partnership with the Pennsylvania Housing and Finance Agency and the Pennsylvania Department of Community and Economic Development, as well as other local, state, and federal agencies. DHS's goal is to leverage internal and external resources to connect Pennsylvanians to affordable, integrated and supportive housing. The plan identifies four strategies with multiple goals stated under each. Under Strategy No. 2: Strengthen and Expand Housing and Housing-Related Services and Supports, the department declares a goal of maximizing Medicaid funding for housing-related services and supports and outlines action steps by year as follows:

2015-2016:

- Convene the DHS Medicaid (also known as Medical Assistance or "MA") Supportive Services Work Group.
- Participate in the CMS Innovation Accelerator Program (IAP) supporting housing tenancy.

- Complete a Medicaid crosswalk exercise to identify options for improving and expanding Medicaid coverage of housing-related services and supports.

2017-2020:

- Evaluate and update policy as documented in the Pennsylvania state plan, medical assistance waivers, and vendor agreements through the MA Supportive Services Work Group.
- Use a structured, outcomes measurement approach to evaluate policy reform.
- Work with managed care organization provider networks to expand housing-related services and supports across Pennsylvania's MA Program.
- Build a schedule to enact policy changes.

Read More

Pennsylvania Health Information Exchange Awards $3.8M in Grants. The Pennsylvania eHealth Partnership Authority has awarded nearly $3.8 million in grant money to bring more healthcare providers onto the eHealth network. The Pennsylvania Patient and Provider Network (P3N) enables electronic health information exchange (eHIE) across the state through the connection of healthcare providers to health information organizations (HIO), and the connection of HIOs to the P3N. The funding for these programs was made available through a grant from the federal Centers for Medicare & Medicaid Services (CMS), and is being administered in partnership with the Pennsylvania Department of Human Services (DHS). The awardees include: HealthShare Exchange of Southeastern Pennsylvania, Clinical Connect HIE, and Mt. Nittany Medical Center. Read More

Utah

Utah Hears from Those Left Out of Medicaid Expansion Plan. *Deseret News* reported on May 19, 2016, that Utah residents left out by the state's pared down Medicaid expansion are the most vocal in speaking out about the plan during the public comment period. Lawmakers voted in favor of an expansion plan, which would cover up to 11,000 out of 53,000 uninsured individuals. Attempts to approve a full expansion plans were unsuccessful in the state House and Senate. Utah Department of Health deputy director Nat Checketts said that the expansion plan is limited because the funding is limited. Those eligible are expected to be high users of costly medical services. Read More

Virginia

Governor McAuliffe Vetoes Budget Language Preventing Medicaid Expansion. The Washington Post reported on May 20, 2016, that Virginia Governor Terry McAuliffe has vetoed language the Virginia Legislature inserted into the state budget to attempt to prevent Medicaid expansion. Although Governor McAuliffe has no imminent plans to expand the program, he hopes to keep the option open for a possible compromise. Republican legislators stated that he can't veto conditions attached to appropriations without removing the

budget item in its entirety, which would result in him removing the entire Medicaid budget line. Governor McAuliffe defended the veto, saying that the anti-expansion language applies to the entire budget, not just the Medicaid program. Read More

National

Physicians Tell CMS that States Are Cutting Medicaid Rates in Anticipation of Equal Access Rule. *Fierce Practice Management* reported on May 19, 2016, that four large physician associations argued in a letter to the Centers for Medicare & Medicaid Services (CMS) that there is a trend of states cutting Medicaid reimbursement rates prior to the October 1, 2016, implementation of the Equal Access rule. The Equal Access rule will require states to assess how changes in Medicaid reimbursements impacts access to care. The letter is signed by the American Academy of Pediatrics, the American College of Physicians, the American Medical Association, and the American Osteopathic Organization. The letter expresses concerns that states have incentives to reduce rates now to lower the baseline for analyzing the impact of later changes. The letter urges CMS to require states to use 2014 rates as the baseline. In the last two months, Oklahoma proposed cutting rates by 25% and North Dakota by 47%. North Carolina cut rates by 23% in 2015. Read More

Industry News

Maryland Physicians Care Awards Management Services Contract to Centene. Centene Corporation announced on May 25, 2016, that its specialty solutions division, Envolve, Inc., was selected to provide health plan management services to Maryland Physicians Care MCO beginning July 1, 2017. Maryland Physicians Care covers 190,000 Maryland residents enrolled in the state's Medicaid program, Maryland HealthChoice. Read More

Aetna Applies to Operate as Medicaid MCO in Maryland. Aetna announced on May 25, 2016, that it has applied to operate a Medicaid managed care plan in Maryland called Aetna Better Health of Maryland. The application is pending review and approval by the Maryland Department of Health and Mental Hygiene. Aetna currently has 36 Medicaid contracts in 17 states. Read More

New Mexico Awards Correctional Healthcare Contracts to Centurion. Centene Corporation announced on May 24, 2016, that the New Mexico Corrections Department has awarded two separate contracts to Centurion for correctional medical health care services and pharmacy services. Each contract is for an initial one-year term with three additional one year renewal options. Centurion is expected to begin providing services June 1, 2016. Centurion, which is a joint venture of Centene and MHM Services, also operates in Florida, Massachusetts, Minnesota, Mississippi, Tennessee, and Vermont. Read More

Correctional Medical Group Completes Strategic Investment in TransformHealthCS. Correctional Medical Group Companies (CMGC) announced on May 23, 2016, that it has completed an investment in TransformHealthCS, a Georgia-based provider of correctional healthcare services to county jails in Georgia and North Carolina. Through the partnership, CMGC and Transform will provide correctional health care services across the Western, Southwestern, Midwestern, and Southeastern United States. Transform will be re-branded as Southeast Correctional Medical Group. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
May, 2016	Minnesota SNBC	Contract Awards	45,600
May, 2016	Massachusetts MassHealth ACO - Pilot	Applications Open	TBD
May, 2016	Oklahoma ABD	DRAFT RFP Release	177,000
June, 2016	Indiana	Contract Awards	900,000
June 30, 2016	Virginia MLTSS	Proposals Due	212,000
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
August, 2016	Oklahoma ABD	RFP Release	177,000
July-August, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
September 1, 2016	Texas STAR Kids	Implementation	200,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
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 Release	30,000
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December, 2016	Massachusetts MassHealth ACO - Full	Selection	TBD
January 1, 2017	Georgia	Implementation	1,300,000
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 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
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 (April 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	431,000	123,981	28.8%	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	48,272	32.6%	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	12,307	13.1%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	31,766	30.3%	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	5,617	4.5%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
Ohio	Capitated	5/1/2014	1/1/2015	95,000	61,535	64.8%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	5/1/2016	7/1/2016	30,000			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,954	11.1%	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	45,219	26.9%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	27,116	38.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,319,100**	**361,767**	**27.4%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA News

HMA's Strugar-Fritsch, Follenweider Author "A Call for New Models of Care in Correctional Health"

The Spring 2016 issue of *CorrectCare*, the quarterly publication of the National Commission on Correctional Health Care, features a piece by HMA Managing Principal Donna Strugar-Fritsch, MPA, BSN, CCHP, and HMA Principal Linda Follenweider, MS, CNP. "A Call for New Models of Care in Correctional Health" explores components of new primary care models, how they have advanced community care and the Triple Aim, and how they can be used in correctional settings. They offer important advantages to correctional health, including the following:

- Early identification of patients at risk for poor outcomes
- Proactive interventions designed to mitigate risk
- Use of health information technology and population health science to drive and inform care
- Optimized actions of licensed professionals so that each discipline is working at the "top of its license"
- Reduced redundancy
- More timely access and fewer missed opportunities for appropriate care

The article is based on a presentation at NCCHC's 2015 Leadership Institutes and is the first in a series on innovation in correctional health practice. The Spring 2016 *CorrectCare* is available here. For questions on the article or more information on HMA's correctional health expertise, contact Donna Strugar-Fritsch (dstrugarfritsch@healthmanagement.com) or Linda Follenweider (lfollenweider@healthmanagement.com).

HMA Blog Post: "MACRA: Will these carrots and sticks work?"

From HMA's Greg Vachon, MD, MPH: "The comment period for MACRA proposed rules started a couple of weeks ago and ends June 26, 2016. CMS is to be commended for valiantly translating MACRA legislation into specific rules that will apply at the start of the first performance period scheduled to be January 1, 2017 (wow!). However commendable though, we should all be clear about the inherent problems, of which there are a number. I'll briefly outline one central problem: behavioral economics." Read More and Sign Up for HMA Blog Updates

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. For more information about the Daily Roundup please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Upcoming Webinars

"Trauma Informed Care: The Benefits of Clinical Integration and Organizational Buy-In"

June 8, 2016

Learn More
Register Now

"Community-Based Participatory Research: How to Identify Social Determinants of Health and Engage Hard-to-Reach Populations in Your Community"

June 28, 2016

Learn More
Register Now

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

http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.