HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 8, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

NORTH CAROLINA SUBMITS 1115 DEMONSTRATION WAIVER APPLICATION

This week, our *In Focus* section reviews the Section 1115 waiver demonstration proposal submitted to the Centers for Medicare & Medicaid Services (CMS) on June 1, 2016, by North Carolina's Department of Health and Human Services (DHHS). The waiver process was initiated by a state law passed in 2015, directing DHHS to redesign the Medicaid program around goals of quality, budgetary stability, and efficiency, including the development of a two-model statewide Medicaid managed care program. Under the submitted waiver, DHHS will contract with three statewide Medicaid health plans to operate alongside local health care provider-led managed care entities, scheduled to begin serving more than 1.5 million Medicaid beneficiaries in the summer of 2019.

Overview of Managed Care Model Design

Overview. Under the proposed waiver, DHHS will contract with two types of prepaid health plans (PHPs) – provider-led entities (PLEs) led by local health

care providers and commercial Medicaid managed care organizations (MCOs), referred to the in waiver submission as Commercial Plans (CPs). DHHS is also working with the Eastern Band of Cherokee Indians to develop a Tribal managed care entity, potentially the first of its kind in the U.S. DHHS also intends to develop a statewide PHP for children in foster care.

Contract Awards, Terms. DHHS intends to contract with three statewide PHPs and at least one PLE in each region of the state, aiming for at least four PHP options in each region. DHHS intends to enter into long-term contracts of four to five years with each PHP.

Behavioral Health Integration. North Carolina has contracted with local management entity managed care organizations (LME-MCOs) for many years, providing managed behavioral health care to the state's Medicaid population. Under the waiver, DHHS intends to work with LME-MCOs and PHPs to develop policy and pilot programs to better incentivize integration of physical and behavioral health. The waiver specifically mentions the potential for LME-MCOs to take more responsibility for physical health services for individuals with severe mental illness, individual with substance use disorders, and individuals with intellectual or developmental disabilities. Under the waiver, LME-MCO services are explicitly carved-out from PHP contracts for four years, leaving the potential for behavioral health carve-in down the road.

Managed Long Term Services and Supports (MLTSS). The waiver proposes implementing MLTSS for Medicaid-only beneficiaries, including state plan LTSS services and the services authorized under two 1915(c) waivers – Community Alternatives Program for Children (CAP/C) and Community Alternatives Program for Disabled Adults (CAP/DA). Dual eligible beneficiaries are excluded from the initial demonstration under state law, but DHHS intends form a committee to develop a long-term strategy to cover duals through capitated PHP contracts.

Managed Care Implementation Timeline. DHHS estimates around 18 months for CMS to review and approve the waiver submission, during which time the draft RFP and contract development process would occur. With an estimated waiver approval date of January 1, 2018, DHHS intends to release a managed care RFP for PHPs in March of 2018, with proposals due in June, and contract awards in September. Implementation of the program would occur on July 1, 2019.

1115 Waiver/Managed Care Milestone	Date*
1115 Waiver Submission	June 1, 2016
Draft RFP/Contract Development	October 2016 - January 2018
CMS Approval of 1115	January 1, 2018
RFP Release	March, 2018
Proposals Due	June, 2018
Contract Awards	September, 2018
Implementation	July 1, 2019

**RFP, Implementation dates assume January 1, 2018 approval of 1115 wavier by CMS*

Managed Care Members, Cost Estimates. The waiver submission provides member month, expenditure, and savings estimates for five major eligibility groups for each of the five demonstration years. The table below summarizes this data, providing average annual enrollment and expenditures for the five-year waiver period, as well as average per member monthly spending and total five-year cost/savings estimates under the waiver. At a high level, the waiver

would shift between 1.5 and 1.6 million Medicaid beneficiaries into managed care, with average annual spending of more than $6.1 billion.

Eligibility Group	Average Annual Enrollment	Average Per Member Monthly Spending	Average Annual Expenditures	Total 5-Year Add'l Costs/Savings
Aged, Blind, and Disabled (ABD)	201,940	$959.69	$2,325,599,591	($353,968,799)
TANF & Related Children	996,784	$140.29	$1,678,112,461	($64,948,595)
TANF & Related Adults	376,368	$366.42	$1,654,913,300	($173,964,552)
Nursing Facility Level of Care	3,203	$6,462.05	$248,412,702	$61,552,533
CAP/C	2,371	$8,126.08	$231,245,393	$93,557,531
Total	**1,580,667**	**$323.61**	**$6,138,283,447**	**($437,771,882)**

Other Initiatives, More Info

The implementation of statewide Medicaid managed care is just one element of the 1115 waiver proposal, which also includes initiatives and proposals around the following areas:

- Person-centered health communities
- Improved rural health access, outcomes, equity
- Minimizing administrative burdens through uniform credentialing, standard preferred drug list, common performance measures and requirements for prompt payment
- Practice supports for quality improvement
- Statewide initiatives such as the North Carolina Health Transformation Center, the NC Health Information Exchange, and statewide informatics tools
- Extending coverage to parents of children in foster care
- Value-based payments
- Public and private safety net hospital payments
- Funding for DSRIP initiatives
- Workforce initiatives
- Uncompensated care payments to tribal authorities

A link to the 1115 waiver submission and related materials are available here: http://www.ncdhhs.gov/nc-medicaid-reform

HMA Medicaid Roundup

Alabama

Medicaid Agency to Hold Community Stakeholder Meetings on LTSS Changes. The Alabama Medicaid Agency announced on June 2, 2016, that it will hold nine 90-minute community stakeholder meetings over the next month on proposed changes to the delivery of Medicaid Long Term Services and Supports (LTSS) in the state. The state legislature passed legislation in 2015 to establish a competitively bid Integrated Care Network (ICN) program for the delivery of LTSS. The meetings will seek comments from consumers, family members, caregivers, and other stakeholders to aid the development of the ICN program, focusing on both institutional and community-based LTSS, and how service coordination can be improved for Alabama Medicaid members who are older or who have disabilities.

Arkansas

State Requests Authority to Shift from a Federal to State-Run Exchange. *Arkansas Online* reported on June 2, 2016, that Arkansas is seeking federal permission to shift from a federally facilitated to a state-run insurance Exchange beginning in 2017. The request was made in a letter from Arkansas Governor Asa Hutchinson to Health and Human Services Secretary Sylvia Burwell. Arkansas uses the federal Exchange to cover 270,000 individuals and partners with the federal government to help administer and regulate Qualified Health Plans. If the Exchange transitions to state-run, Arkansas would also be responsible for certifying plans, conducting outreach, and hiring navigators to enroll people. The change is also expected to reduce fees on insurers, helping to hold down premiums. In the federal exchange, plans pay a fee equal to 3.5 percent of premiums. Under the state exchange, Arkansas would be responsible for paying the federal government a fee equal to 1.5 percent of premiums; the state would recapture some or all of that by charging its own fee to plans. Arkansas would become one of 13 states with a state-run Exchange if approved. Read More

California

HMA Roundup – Don Novo (Email Don)

Minimum Wage Hike Means Some Will Lose Medi-Cal Coverage. *California Healthline* reported on June 7, 2016, that California's hourly minimum wage increase to $15 by 2022 will push some individuals out of Medi-Cal and likely into employer-based insurance, the state's Exchange, or the broader insurance market. Still, the benefits of higher pay will outweigh higher health care costs for

most, said Miranda Dietz of the University of California, Berkeley Labor Center. The state's Covered California Exchange projects that between 67,558 and 204,740 individuals will leave Medi-Cal for the Exchange by 2020. Health Access California projects that approximately 77 percent of workers earning $15 an hour will choose their employers' health insurance plan if available. Read More

Regulators Investigate Claims Dispute Between Health Net, Addiction Treatment Centers. *Kaiser Health News* reported on June 6, 2016, that California regulators are investigating whether Health Net improperly withheld certain payments from addiction treatment centers. The dispute began when Health Net notified several California facilities in January that it was reviewing potentially fraudulent claims for out-of-state individuals and investigating whether providers were paying kickbacks for referrals. The plan also sent letters to patients notifying them that their claims may not be processed until they provided proof that they paid deductibles and copays. Providers are saying that they can't afford to keep accepting patients without reimbursement. California's Department of Insurance and Department of Managed Health Care are handling the investigation. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Health Foundation Report Projects Continued Positive Economic Impact of Medicaid Expansion. The Colorado Health Foundation released a report on June 2, 2016, titled *"Assessing the Economic and Budgetary Impact of Medicaid Expansion in Colorado: FY2015-16 through FY2034-35,"* which finds that Colorado's Medicaid expansion will continue to have a strong positive effect on the state economy. Commissioned by the Colorado Health Foundation and prepared by the Colorado Futures Center at Colorado State University, the report projects that the state will add 43,018 new jobs, increase economic activity by $8.5 billion, and raise average annual earnings by $1,033 by fiscal year 2034-35. The Foundation supplemented the report with a document narrating three first-hand accounts of the positive impact of the Medicaid expansion on individuals. Read More

Legislature Orders Plan for Addressing Community Board Conflicts of Interest. *The Denver Post* reported on June 5, 2016, that the Colorado legislature has ordered the state Department of Health Care Policy and Financing to produce a plan by July 1, 2016, on how community boards serving people with disabilities will comply with federal conflict-of-interest rules. The same community boards that manage funding and eligibility for individuals with disabilities often own the group homes serving their clients. Community boards also often create and control separate enterprises that provide therapy, house cleaning, community outings, and other services. Eighteen of Colorado's 20 community boards have joined forces to hire a legal firm to lobby federal authorities to slow the transition to a conflict-free system. Read More

Delaware

State to Extend Hepatitis C Treatment to All Medicaid Patients by 2018. *The Inquirer* reported on June 7, 2016, that Delaware will begin phasing in a new policy to provide treatment to all Medicaid beneficiaries with a Hepatitis C diagnosis. Beginning in July, restrictions limiting treatment to patients with

significant liver damage will be lifted. In addition, patients who abuse drugs will also have access to treatment. By 2018, all Medicaid beneficiaries with Hepatitis C are expected to have access. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Requires Medicaid Plans To Provide Hepatitis C Drugs Earlier. *The Ledger/AP* reported on June 1, 2016, that Florida will require Medicaid health plans to provide Hepatitis C treatment to patients at an earlier stage of the disease. Currently, patients become eligible when their fibrosis level is at a stage three or four, at which point a liver transplant is often required. Under the new criteria, the fibrosis metric is no longer a requirement. The policy change is effective June 1, but plans will have until June 17 to comply. Read More

Indiana

FSSA to Cut Medicaid Home Health Rates. *Indianapolis Business Journal* reported on June 4, 2016, that the Indiana Family and Social Services Administration (FSSA) will reduce Medicaid home health agency reimbursement rates effective July 1, 2016. Licensed practical nurses will see cuts of 5 percent; registered nurses 8.4 percent, home health aides 7.9 percent; and therapists and pathologists up to 6 percent. The cuts would save the state $17 million a year, while more than 200 home health agencies in Indiana will see revenues drop an average of 6 percent. FSSA stated that the cuts are the result of lower provider costs. Read More

Iowa

MCOs, Horizons Meals on Wheels Attempt to Address Billing Issues. *The Gazette* reported on June 5, 2016, that Horizons, which operates a not-for-profit Meals on Wheels program in Iowa, is working with the state's three Medicaid managed care organizations (MCOs) to sort out problems related to claims and billing. Horizons is reporting that claims have been mostly declined or unanswered since the state transitioned 560,000 beneficiaries to MCO coverage beginning April 1, 2016. The three Medicaid MCOs have said that the meals could be reimbursed retroactively once Horizons sorts out its billing issues; meanwhile, Horizons plans to continue delivering food without reimbursement. Horizons, which provides transportation, nutritional, and mental health services to underserved populations, delivers around 1,100 meals a day to seniors and adults with disabilities. Read More

Kansas

Budget Cuts Result in Waiting Lists for In-Home Services for Seniors. *Kaiser Health Institute* reported on June 6, 2016, that budget cuts in Kansas are forcing some home health agencies to create waiting lists for certain in-home services for seniors. Governor Sam Brownback's budget cuts last month reduced funding for the state's Senior Care Act programs by $2.1 million, which is projected to impact 1,300 of the 4,500 Kansas seniors served by the Act. Senior Care Act programs are administered by the Kansas Department for Aging and Disability

Services with the help of Area Agencies on Aging and provide attendant care, respite care, housekeeping, chore services, and adult day care to individuals over 60 who do not qualify for the state's Medicaid frail/elderly waiver. The Jayhawk Area Agency on Aging says the cuts represent about 30 percent of the total program budget, forcing some agencies to wait-list individuals for housekeeping and attendant care services. Read More

State May See Further Medicaid Cuts Following Another Month of Lower than Expected Tax Revenues. *Kansas Health Institute* reported on June 1, 2016, that Kansas legislators fear further Medicaid cuts in the wake of a $74 million tax revenue shortfall in May. The shortfall comes even after the state had revised revenue projections downward three consecutive times and wipes out the impact of savings the state had achieved through Medicaid cuts made just two weeks ago by Governor Sam Brownback. Providers are reportedly already dropping out of the Kansas Medicaid program or providing services without reimbursement. Read More

Louisiana

Providers Welcome Medicaid Expansion; Budget Shortfall Still Threatens Safety Net Hospitals. *Modern Healthcare* reported on June 1, 2016, that Louisiana hospitals and other health care providers are welcoming the state's new Medicaid expansion, which took effect June 1. While the expansion will bring in additional federal funds, Louisiana still faces a budget shortfall that threatens the viability of the state's nine safety net hospitals, which were recently privatized. The state is hoping to sign up an estimated 375,000 Medicaid expansion members. The enrollment push will be aided by recent federal approval for Louisiana to use SNAP eligibility data to qualify individuals for Medicaid. Read More

Maryland

Hospitals Seeking Higher Rate Increase than State Proposal. *The Baltimore Sun* reported on June 7, 2016, that Maryland hospitals are seeking a larger rate increase than the one proposed by the state Health Services Cost Review Commission for the upcoming fiscal year. The commission originally proposed a 2.16 percent increase beginning July 1, 2017. Hospitals are saying they need 3.27 percent to cover the cost of care for new patients and to account for delivery system improvements. Since 2014, hospital rates in the state have been tightly managed as part of a five-year agreement with the Centers for Medicare and Medicaid Services (CMS) aimed at controlling overall healthcare cost trends. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Medicaid Releases the Latest CMS Approved Medicaid MCO Contract Amendments. New Jersey's Division of Medical Assistance and Health Services (DMAHS) posted the latest publicly available Medicaid MCO contract with amendments on its website. This version, effective July 1, 2015, includes amendments to the January 1, 2015 contract. Highlights of the amendments are

provided and represent changes in policy and procedure for the following subjects:

Enrollment and Coverage

1. The contract clarifies when incarcerated individuals qualify for Medicaid Fee for Service, and that medical coverage for inmates in correctional facilities are not the financial responsibility of the MCO or DMAHS.

MLTSS

1. The state launched a nursing facility performance-based incentive program to run from July 1, 2015 – June 30, 2016. It set aside $10 million dollars to incentivize the transition of individuals from institutions to the community. The contract includes a description of enrollees who would be eligible for this program. MCOs may receive $20,000 per successful transition on a monthly basis until the set aside is exhausted.
2. MCOs cannot exceed a 7 percent "Not Authorized" rate for members who have been assessed for MLTSS clinical eligibility
3. MLTSS enrollees may withdraw from MLTSS and the MCO must counsel them on the consequences, depending on their eligibility terms, of withdrawal including the risk of loss in eligibility for Medicaid State Plan services, loss of NJ FamilyCare eligibility, other services for which they may qualify, and how to access MLTSS in the future. The MCO is responsible for following MLTSS care management case closure processes for members who voluntarily withdraw. Voluntary disenrollment would still leave the member enrolled with their MCO for regular medical benefits subject to eligibility for Medicaid.
4. A provision that limited service capacity for Medical Day Care (Adult Day Health Services) providers was removed from the contract. It previously stated that these providers could not serve more than "licensed capacity or no more than 200 participants per day, whichever is lower." Note — New Jersey Administrative Code, N.J.A.C. 8:43F-2.6 (2016) that cites a facility shall not exceed its licensed capacity still applies.

Behavioral Health

1. The state added a definition for "Mental Health/Substance Abuse Services"
2. The contract now makes several references to the state's newly designated Interim Managing Entity (IME) for substance abuse services and the MCO's responsibilities for collaborating with it to coordinate member services.
3. The MCO cannot duplicate the care management provided to MCO enrollees who are active with a Behavioral Health Home (BHH) provider; the MCO must coordinate care with the BHH.
4. The state expanded the qualifications of an MCO's Behavioral Health administrator to include social workers (LSW), clinical nurse specialists (CNS), and licensed advanced practice nurse (APN) with experience serving chronically ill populations with mental health and substance abuse disorders.

5. Medicaid managed care specialty codes have been added to the Provider Network File submission requirements, Attachment C for behavioral health provider types with institutional classifications. These include:

    - 866 I Acute and/or Partial Hospitalization (Mental Health)
    - 867 I Inpatient Psychiatric Hospitalization (Private Hosp)
    - 869 Inpatient Psychiatric Hospital Care
    - 909 I Adult Mental Health Rehabilitation (AMHR)
    - 921 I Nonmedical Detox Facility
    - 922 I Opioid Treatment Services
    - 923 Intensive Out Patient Substance Abuse (SUD)
    - 924 I Substance Abuse Outpatient (Outpatient SUD)
    - 925 I Partial Care Substance Abuse
    - 926 I Short Term Residential – Substance Abuse
    - 942 I Behavioral Health Home
    - 943 I Community Support Services
    - 944 I Partial Care (Mental Health)
    - 925 I Partial Care Substance Abuse
    - 926 I Short Term Residential – Substance Abuse
    - 942 I Behavioral Health Home
    - 943 I Community Support Services

Quality

1. MCOs will be required to obtain and maintain NCQA accreditation with a minimum Commendable status beginning June 1, 2018.
2. The state added the HEDIS measure "Annual Dental Visit" to the contract.
3. MLTSS enrollees have been added to the client set for which performance is measured for the following HEDIS measure: Follow-Up After Hospitalization for Mental Illness.

Performance-Based Incentives

1. The state set aside $20 million in State fiscal year 2016 for performance-based incentives for MCOs in good standing with DMAHS. Updates to five existing metric scores have been made.

Medical Loss Ratio

1. The contract revised the term "Medical Cost Ratio" to "Medical Loss Ratio."
2. The MLR for acute care services has been changed from 80 percent to 85 percent, and now also applies to Medicaid Expansion groups and the HCBS premium groups portion of MLTSS.
3. A 90 percent MLR now applies to the Nursing Facility premium groups portion of MLTSS.

Finance and Reimbursements

1. The state discontinued separate reimbursement to MCOs for AIDS/HIV drugs under a pass-through payment. The cost for these drugs is now included in the capitation payments.

2. MCOs must now notify DMAHS, in writing of plans to modify reimbursement rates or the methodology applicable to personal care assistance providers at least 90 days before the effective date of such changes. Previously the state required at least 30 days of notice.
3. Costs for health care quality improvement may be considered direct medical expenditures.
4. Capitation rates have been updated in Section C of the contract.

Fraud, Waste, and Abuse

1. Provisions have been added to require Provider Auditing and Monitoring of claims payments, vendor contracts, credentialing and quality concerns that may indicate fraud, waste or abuse.
2. A number of updates have been made throughout the contract to strengthen the responsibilities of the MCO's Special Investigative Unit (SIU), and its relationship with the state's Medicaid Fraud Division.

New Jersey Medicaid Agency Issues Public Notice of Intent to Submit Application to Renew 1115 Waiver. On June 6, 2016, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) sent out a public notice (see data package below) of intent to apply to the Centers for Medicare and Medicaid Services (CMS) for a renewal of its Section 1115 Demonstration "Comprehensive Waiver." The renewal effective dates would be July 1, 2017 through June 30, 2022. The agency seeks authority to continue its current programs under the existing 1115 waiver authority, and to:

- Move to an at-risk managed behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit;
- Redefine the scope and duration of support services for individuals with intellectual and developmental disabilities;
- Streamline NJ FamilyCare eligibility and enrollment;
- Increase care coordination for individuals who are dual eligible through a seamless enrollment option;
- Develop an uninterrupted reentry system for incarcerated individuals;
- Include reinvestment dollars targeting housing support services for homeless or at-risk of being homeless individuals;
- Expand and enhance the current value-based purchasing strategies to include additional target populations and data-driven performance metrics;
- Enhance access to critical providers and underserved areas through alternative provider development initiatives; and
- Continue DSRIP funding for health care delivery system innovations.

DMAHS leadership will present on the proposed renewal terms at its Medical Assistance Advisory Council meeting on June 15, 2016. DMAHS is accepting comments on the notice for 30 days at DMAHS.CMWcomments@dhs.state.nj.us.

Appeals Court Upholds State Approval of Horizon's Two-Tiered Network Product, OMNIA Plan. On June 7, 2016 the Appellate Division of the Superior Court of New Jersey issued an opinion in favor of the Department of Banking and Insurance final decision to approve Horizon Blue Cross and Blue Shield's OMNIA Health Alliance network. The plan has a two-tiered network of hospitals and physicians, and cost advantages for members who elect to use providers in Tier 1. Ten hospitals in Tier 2 appealed the Department's final decision last September. The group of hospitals argued that the tiered network did not comply with time and distance standards to provide access to care, and that the Department's analysis of the hospital network was inadequate. Read More

Medicaid ACO Demonstration Report Provides Lessons from the Initial Implementation. In May 2016, the Rutgers Center for State Health Policy released a report, *The New Jersey Medicaid Accountable Care Organization Demonstration: Lessons from the Implementation Process*. The report covers the issues and challenges that were found over the four-year period from legislating the ACO demonstration to their certification. It cites five challenges of the implementation: 1) securing sufficient provider participation to satisfy the 75% primary care provider requirement; 2) engaging major Medicaid MCOs; 3) lack of state funding to support start-up costs; 4) protracted legal process to promulgate ACO regulations; and 5) reaching consensus about quality metrics and reporting. Five key lessons are cited in the Executive Summary and have been provided here:

- "Lesson 1: The detailed, prescriptive character of the founding legislation in New Jersey created implementation challenges and may have undercut the ability of the demonstration to reach its full potential.
- Lesson 2: Demanding, numerical targets for ACO participation by primary care providers coupled with limitations in data that the state could share created formidable implementation challenges and weakened the ability of the ACO demonstration to achieve its full potential.
- Lesson 3: Launching Medicaid ACOs without additional state funding impeded implementation and necessitated alternative support from private sources to sustain the initiative.
- Lesson 4: The voluntary participation of Medicaid managed care organizations envisioned by the founding ACO legislation heightened the transaction costs for applicants and may weaken the ability of the ACOs to achieve their full potential.
- Lesson 5: Assuring the timeliness and validity of quality metrics, promoting greater congruence among the measures used by Medicaid ACOs and other payers, and paring the reporting costs associated with the metrics may well increase prospects for the diffusion of successful ACOs."

Lawmakers Look to Extend Medication Therapy Management Covered by Medicare to FamilyCare Enrollees. *NJ Spotlight* reported on June 3, 2016, on an Assembly bill, A-1443, that would require coverage of medication therapy management (MTM) in Medicaid and NJ FamilyCare to lower the risk for adverse drug events. The proposal would enable certain providers including advanced practice nurses to provide MTM, in addition to pharmacists. The New

Jersey Association of Health Plans seeks alignment between the proposal and Medicare requirements. Read More

North Carolina

Senate Budget Proposal Reduces Health and Human Services Spending. *North Carolina Health News* reported on June 2, 2016, that the state Senate's budget proposal would reduce health and human services spending, while increasing pay for teachers. The Senate's plan includes 3.4 percent less spending on health care, mostly because Medicaid operated under budget last fiscal year. The plan proposes eliminating $2.1 million in funding for a school serving children with emotional and behavioral health needs. It allots $10 million to a reserve to pay for mental health services, but that's $20 million lower than recommended by Governor Pat McCrory's Task Force on Mental Health and Substance Use. The proposed budget also creates a legislative subcommittee on behavioral health, as well as provides pay increases and performance bonuses for teachers and state employees, adds to the state's rainy day fund, and cuts taxes by $350 million. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Receives Initial Approval of Statewide HCBS Transition Plan. The Ohio Office of Health Transformation announced CMS approval of Ohio's Statewide Home and Community-Based Services (HCBS) Transition Plan. All states are required to submit an HCBS Statewide Transition Plan in order to come into compliance with March 2014 federal regulations. Ohio is the third state with a federally approved plan, along with Tennessee and Kentucky. Read More

Ohio Launches ABLE Account Program. The Ohio State Treasurer's Office has launched the first Achieving a Better Life Experience (ABLE) account program in the nation. The ABLE Act of 2014 is federal legislation that authorizes states to establish accounts for people with disabilities that are tax exempt and are not counted when determining eligibility for means-tested federal programs. Ohio is calling its program the State Treasury Achieving a Better Life Experience (STABLE) program. The accounts will allow people with disabilities to save and invest without losing eligibility. The STABLE program is open to anyone across the country who meets eligibility requirements, though the fees are higher for people who live out-of-state. Ohio residents will pay $2.50 per month to maintain the accounts, while residents of other states will pay $5 per month. Ohio residents will pay an asset-based fee of between 0.19-0.34%, depending on investment options, while out-of-state residents will pay a fee between 0.45-0.60%. Participants can use the money from the account for qualified expenses, including education, health care, housing and transportation. Participants will be able to choose between five different investment strategies that range in risk levels, including a banking approach that offers no risk and is backed by the Federal Deposit Insurance Corporation. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Secretary Dallas Introduces "Centers of Excellence." Department of Human Services Secretary Ted Dallas provided more detail on the new "Centers of Excellence" (COE) approach to assist Medicaid recipients who have an opioid use disorder. COEs, sometimes called "health homes for opiate addiction," are a comprehensive approach funded in Governor Tom Wolf's 2016-2017 proposed budget. The budget allocates $34.2 million to build 50 COEs across Pennsylvania in the span of a year, expanding off a few centers of excellence already in operation for pregnant women with substance use disorders. Even without additional funding from state and federal sources, Sec. Dallas indicated that DHS's current budget will allow the department to work on the creation of twenty health homes over the next year. Sec. Dallas also clarified that a "center of excellence" does not necessarily have to be one specific location, and instead describes an increased focus on holistic care. Read More

Texas

Texas Proposes More Medicaid Home Health Therapy Cuts. *The Dallas Morning News* reported on June 3, 2016, that the Texas Medicaid program has again proposed to cut home health therapy rates for certain services, after an April court ruling dismissed challenges to the last round of proposed reductions. The Texas Association for Home Care & Hospice said the rate cuts would approach 26 percent in some cases. The reimbursement cuts would take effect July 15 and would impact more than 250,000 children with disabilities and Texans who are elderly. The rate reductions still require federal approval and are expected save the state an estimated $135 million. The public notice from the Texas Health and Human Services Commission is available here. Read More

Vermont

Joint Fiscal Office Says One Third of State's Medicaid Enrollees May Be Ineligible. *Times Argus* reported on June 3, 2016, that Vermont Legislature's Joint Fiscal Office has estimated that one-third of the state's Medicaid enrollees may be ineligible for the program. Vermont Health Connect reportedly lacked the requisite technology needed to make redeterminations for individuals who were once enrolled in the Vermont Health Assistance Program and the Catamount Health Premium Assistance Program, which were phased out when the Affordable Care Act went into effect. As a result, as many as 11,700 people may have been enrolled into Medicaid under old eligibility rules. Governor Shumlin's administration says the number of ineligible individuals who were enrolled is smaller. Either way, Medicaid enrollment is the state came in higher than expected. In 2014, about 47,000 adults were projected to be enrolled in Medicaid during the 2015 state fiscal year and another 43,000 were expected to be eligible for qualified health plans with subsidies on the state's health care exchange. However, 72,534 were actually enrolled in Medicaid and only 16,906 in qualified health plans. Read More

National

CMS Informs States of Medicaid Services Available to Combat Zika. *Modern Healthcare* reported on June 1, 2016, that the Centers for Medicare & Medicaid Services (CMS) issued a bulletin to state Medicaid directors and interested stakeholders, outlining how Medicaid funding can be tapped to fight the spread of the Zika virus. The bulletin provides states with a list of available Medicaid services that can prevent the spread of Zika and reduce the risks for newborns. These include prescribed mosquito repellent, diagnostic services to detect signs of the disease, and family planning and counseling for contraception to reduce the risk of sexually-transmitted cases of the virus. In addition, the U.S. Senate has proposed $1.1 billion in funding to fight Zika, while the House has approved a bill to provide $622 million for the effort. According to the Centers for Disease Control and Prevention, there have been over 300 cases of Zika in the U.S. as of May 19. Read More

Industry News

LHC Group Acquires Two Home Health, Hospice Companies. The LHC Group announced on June 7, 2016, that it has signed definitive agreements to purchase Professional HealthCare Resources (PHR) and East Arkansas Health Holdings (EAHH). PHR, which provides home health care services, operates in Washington, DC, Virginia, and Maryland. The acquisition is expected to close August 1, 2016. EAHH has four home health locations, two hospice locations, and a community-based services location in Arkansas. The acquisition is expected to close by July 1, 2016. Combined, the two companies have total annualized revenues of $44 million. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
TBD	Minnesota SNBC	Contract Awards	45,600
June 24, 2016	Massachusetts MassHealth ACO - Pilot	Responses Due	TBD
June 30, 2016	Virginia MLTSS	Proposals Due	212,000
June, 2016	Nevada	RFP Release	420,000
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-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
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November, 2016	Oklahoma ABD	RFP Release	177,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
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
January, 2017	Oklahoma ABD	Proposals Due	177,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Implementation	177,000
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
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

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.

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