

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... June 22, 2016



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THIS WEEK

- **IN FOCUS: MASSACHUSETTS 1115 WAIVER RENEWAL, AMENDMENTS**
- KENTUCKY MEDICAID REFORM PLAN, WAIVER APPLICATION POSTED FOR PUBLIC COMMENT
- ALASKA GOV. SIGNS MEDICAID REFORM BILL
- KANSAS ELIGIBILITY DETERMINATION BACKLOG LARGER THAN PREVIOUSLY ESTIMATED
- MARYLAND TO OFFER SAVINGS ACCOUNTS FOR INDIVIDUALS WITH DISABILITIES
- NEW JERSEY PRESENTS 1115 WAIVER RENEWAL DETAILS
- WISCONSIN HEALTH SECRETARY PASSES AWAY
- ASPE FINDS MEDICAID EXPANSION INCREASES ACCESS TO CARE
- HOUSE REPUBLICANS PROPOSE PLAN TO REPLACE ACA
- 30-PLUS SPEAKERS SLATED FOR HMA CONFERENCE ON INTEGRATED CARE DELIVERY

IN FOCUS

MASSACHUSETTS ANNOUNCES PLANS FOR 1115 WAIVER RENEWAL AND AMENDMENTS

This week, our *In Focus* section reviews the Massachusetts Executive Office of Health and Human Services (EOHHS) announcement and call for public comments on a proposal to renew and amend the state's existing Section 1115 Demonstration waiver. Massachusetts' current Delivery System Reform Investment Program (DSRIP) waiver is authorized through June 30, 2019, but a key portion of the 1115 demonstration, the Safety Net Care Pool (SNCP), is authorized only through June 30, 2017. Massachusetts proposes to begin the five-year extension of the entire demonstration starting July 1, 2017. The proposed waiver implementation process includes the implementation of Medicaid Accountable Care Organizations (ACOs), a procurement of existing

Medicaid managed care organizations (MCOs), and greater integration of physical health, behavioral health, and long-term services and supports (LTSS). Public comments on the waiver renewal will be accepted through July 17, 2016.

Overview

The demonstration renewal goals are to (1) enact payment and delivery system reforms that promote coordinated care that is member driven and that holds providers accountable for the quality and cost of care; (2) improve integration of physical health, behavioral health, long-term services and supports, and social services that are health related; (3) maintain coverage of over 96 percent of population; (4) support safety net providers and continue supporting access to care for Medicaid and low-income uninsured individuals; (5) and expand access to substance use disorder services in order to address the burgeoning opioid crisis.

Accountable Care Approach

In preparation for the full launch of ACO models in 2017, MassHealth will conduct an ACO pilot with a small set of ACOs in 2016. The pilot will not change the payment model for any members that receive care and are currently enrolled in MCOs. Additionally, the pilot will utilize a retrospective shared savings and risk model for Primary Care Clinician (PCC) Plan members. The demonstration renewal plan offers flexibility for providers with three possible ACO models to choose from. The three models cater to a spectrum of provider capabilities.

Model A: Integrated ACO/MCO model	Model B: Direct to ACO model	Model C: MCO-administered ACO model
<p>Fully integrated: an ACO joins with an MCO to provide full range of services</p> <p>Risk-adjusted, prospective capitation rate</p> <p>ACO/MCO entity takes on full insurance risk</p>	<p>ACO provider contracts directly with MassHealth for overall cost/ quality</p> <p>Based on MassHealth/ MBHP provider network</p> <p>ACO may have provider partnerships for referrals and care coordination</p> <p>Advanced model with two-sided performance (not insurance) risk</p>	<p>ACOs contract and work with MCOs</p> <p>MCOs play larger role to support population health management</p> <p>Various levels of risk; all include two-sided performance (not insurance) risk</p>

In this new model, MCOs will be expected to take on additional roles. The expanded responsibility will include delivery and coordination of LTSS, facilitation of analytics and reports for population management, assisting ACOs in the integration Behavioral Health Community Partners (BH CPs) and LTSS Community Partners.

Community Partners and Integration Of Behavioral Health, Long-Term Services and Supports and Health-Related Social Services

To support the demonstration renewal’s goal of improving the integration of behavioral health services and LTSS, MassHealth will certify two types of Community Partners to partner with ACOs, Behavioral Health Community

Partners (BH CPs) and LTSS Community Partners. This partnership between ACOs and their CPs will abide by minimum expectations that are established by MassHealth.

Delivery System Reform Investment Program (DSRIP) Investments

Massachusetts is taking a unique approach to DSRIP programs by investing in ACOs and certified CPs that have extensive knowledge of BH and LTSS needs rather than focusing on traditional medical providers. Massachusetts has a goal of improving coordination across traditionally siloed health systems. The partnership between CPs and ACOs is integral to the DSRIP program. To formally support increased coordination, medical providers must participate as an ACO or CP in order to receive DSRIP funding. Additionally, participating ACOs must establish a formal relationship with a BH CP or LTSS BP.

MassHealth is proposing a maximum DSRIP allocation of \$1.8 billion for participating providers. Massachusetts has proposed the following funding allocation for 3 objectives:

- Support development of MassHealth ACOs (~65-70 percent of funding),
- Support development of certified Community Partners (~20-25 percent of funding), and
- Support development of statewide infrastructure (~6 percent of funding).
- A small amount of funding (~4 percent) will be used for state operations/implementation of DSRIP.

Safety Net Care Pool (SNCP) Redesign

MassHealth has presented five streams of funding to align the Safety Net Care Pool redesign with the Commonwealth's ACO reforms. The combined funding streams total \$1.593 billion per year, or \$7,965 billion over the 5 year DSRIP demonstration:

1. Delivery System Reform Incentive Program (DSRIP)
2. Public Hospital Transformation and Incentive Initiative (PHTII)
3. Disproportionate Share Hospital allotment pool (DSH)
4. Uncompensated Care Pool (UCC)
5. ConnectorCare affordability wrap

Expansion of Substance Use Disorder (SUD) Treatment Services

In order to address the opioid crisis in Massachusetts, the demonstration renewal includes specific provisions to strengthen substance abuse disorder (SUD) treatment services. The demonstration proposes to expand access to 24 hour community-based services (including services for members dually diagnosed with SYD and mental health disorders) and to Medication Assisted Treatment, cover community-based SUD services at American Society of Addiction Medicine (ASAM) Levels 3.1 and 3.3 as a MassHealth benefit, increase care management access, and support the development of SUD workforce across the health care system.

Link to 1115 Waiver Renewal Proposal

<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/1115-waiver-proposal-information.html>



HMA MEDICAID ROUNDUP

Alaska

Governor Walker Signs Medicaid Reform Bill. Alaska Governor Bill Walker signed Senate Bill 74, the Medicaid reform bill passed by the Legislature in April, on June 21, 2016. The reforms, which followed many of the recommendations of the Medicaid redesign report released in January, includes expanded use of primary care case management, accountable care demonstration projects, and telemedicine. It also bolsters the state's Prescription Drug Monitoring Program, includes fraud, waste, and abuse provisions, and supports a private-public partnership to help hospital emergency departments identify overutilization and connect visitors to primary care and behavioral health services. The fiscal analysis of the bill's provisions projects savings of over \$365 million over six years, a key factor in a state facing a \$3 billion shortfall for fiscal year 2017. In response to the budget problems, the State's Medicaid program recently delayed some payments to providers until the new fiscal year in July. [Read More](#)

California

Medi-Cal Plans to Receive \$1 Billion in Additional Payments to Cover Hepatitis C Drugs. *California Healthline* reported on June 21, 2016, that California health officials have budgeted \$1 billion in additional payments to Medi-Cal managed care plans next year to cover hepatitis C drugs for approximately 14,300 members. About 30 percent of the additional funds will come from the state, with federal matching dollars making up the remaining 70 percent. The California Association of Health Plans has expressed concerns about the high cost of the drugs, which for Sovaldi can range from \$54,000 to \$84,000 per treatment regimen. The state added that the number of patients taking hepatitis C medications has nearly quadrupled over the last two years. Meanwhile, the state Assembly is working on legislation that would require drug makers to be more transparent about price increases and also require Medicaid managed care plans to report how much of premiums is spent on prescription drugs. [Read More](#)

Approved Budget Includes Funding for Medi-Cal Interpreters, Dental Care for School Children, and Primary Care Training for Physicians; Limits Medi-Cal Estate Recovery Program. *California Healthline* reported on June 20, 2016, that the recently approved California state budget will fund health efforts including medical interpreters for non-English-speaking Medi-Cal recipients, dental care for school children, primary care training for physicians, and a rollback of a policy to recover assets of deceased Medi-Cal recipients. However, proposals to increase Medi-Cal provider rates and expand Medi-Cal coverage to

undocumented adults did not make the final budget. Meanwhile, the California Medical Association is sponsoring a ballot proposal initiative to increase cigarette taxes and raise up to \$1.6 billion to fund payments to health care providers. [Read More](#) Previously, *KQED News* reported on June 16, 2016, that California's \$122 billion General Fund budget includes \$30 million to limit to the state's estate recovery program, which allows the seizure of assets of deceased Medicaid beneficiaries who received health coverage through Medi-Cal. The federal government requires that states recover state money used to pay for nursing home care and allows states the option of whether to recover the costs of medical care for Medicaid individuals over 55. Most states do not participate in the optional recovery program, but California opted in. A new California law effective January 1, 2017, will limit Medi-Cal's recovery of assets for nursing home care paid for by the state and eliminate recovery of medical costs, a move advocates are praising. [Read More](#)

Gold Coast Health Plan Launches Program to Provide Food, Opioid Help to Low Income Residents. *Ventura County Star* reported on June 15, 2016, that Gold Coast Health Plan has launched a program to deliver food to seniors and to provide naloxone kits, which can save lives in cases of opioid overdose. Gold Coast, which has more than 200,000 Medi-Cal members in Ventura County, will spend about \$12.1 million to fund the Alternative Resources for Community Health program. Separately, the National Health Foundation is working to launch a program that allows hospitals to discharge individuals who are homeless to a recuperative care program at the Ventura Salvation Army. The program is aimed at preventing additional emergency room visits and keeping individuals from ending up back on the streets. [Read More](#)

Colorado

HMA Roundup – Lee Repasch ([Email Lee](#))

UCHealth Begins \$85 Million Addition Project. University of Colorado Health (UCHealth) Memorial Hospital, located in Colorado's Pikes Peak region, began construction of an addition to its hospital that will contain 21 inpatient beds, eight exam rooms in the emergency department, and two operating rooms in an \$85 million project. The addition will house primarily women's and oncology to accommodate a 43 percent increase in admissions in the past two years and a fourfold increase in outpatient visits. The addition will be on the same campus as a \$100 million full-service pediatric hospital planned by Children's Hospital Colorado. University of Colorado Health has spent more than \$130 million in capital improvements, investments, and additional services at UCHealth Memorial's two campuses since leasing the Memorial Hospital system from the City of Colorado Springs in 2012. The investments include six new primary-care locations and installing advanced imaging and other equipment on both campuses. UCHealth Memorial also is planning to spend up to \$4 million on a catheterization lab for neurological imaging on its central campus. A partnership of UCHealth Memorial and Adeptus Health Inc., also plans to open Grandview Hospital, a 22-bed facility at North Nevada Avenue and Interstate 25, in August with three operating rooms, three intensive care units, an emergency department and other services that will be announced closer to the opening. Adeptus will manage the new hospital. The UCHealth Memorial projects, along with construction of Grandview Hospital, Children's Hospital Colorado's facility on Memorial's north campus, an expansion of St. Francis Medical Center,

and a new 300-bed hospital planned by Penrose-St. Francis Health Services in northwest Colorado Springs are part of a more than \$1 billion health-care industry building boom in the Colorado Springs area planned during the next few years. [Read More](#)

Florida

HMA Roundup - Elaine Peters ([Email Elaine](#))

AHCA Submits 1115 MMA Waiver Amendment for Housing Assistance. The Agency for Health Care Administration (AHCA) will host two public meetings on July 5, 2016 (Largo) and July 6, 2016 (Orlando) to solicit public input on an upcoming amendment request for Florida's 1115 Managed Medical Assistance (MMA) Waiver. AHCA is seeking federal authority to amend the waiver as a result of changes in the law passed during the 2016 Legislative session. The state was directed to seek federal approval to pay for flexible services for persons with severe mental illness or substance use disorders, including, but not limited to, temporary housing assistance. Payments may be made as enhanced capitation rates or incentive payments to managed care plans that meet the requirements of section 409.968(4), Florida Statutes. The state is submitting this amendment to implement a pilot program for housing assistance in the Agency's region 5 and 7 of the state. The pilot program would provide additional behavioral health services and supportive housing assistance services for persons aged 21 and older with serious mental illness (SMI), substance use disorder (SUD) or SMI with co-occurring SUD, who are homeless or at risk of homelessness due to their disability. The 30-day public notice and public comment period will be held June 22, 2016, through July 22, 2016. [Read More](#)

Florida Healthy Kids Board Approves Subsidized Plan Premiums and Full-Pay Plan Changes. The Florida Healthy Kids Corporation Board of Directors, on June 9, 2016, approved contracts for four health plans to continue to provide subsidized CHIP coverage to nearly 165,000 low-income children, effective October 1, 2016: Amerigroup Florida, Inc., Coventry Healthcare of Florida, Inc., United Healthcare of Florida, Inc., and Wellcare Healthplans, Inc. d/b/a/ Staywell Kids. At least two CHIP plan options will continue to be available in every Florida county. The Board also approved Sunshine Health, the current statewide full-pay provider for more than 12,000 children, to continue to offer full-pay coverage for families with household income above 200 percent of FPL not eligible for subsidized CHIP coverage. The "Stars" option will continue to be offered with no premium increase per month through at least December 31, 2017. The "Stars Plus" option will be offered with no premium increase until that option is retired on December 31, 2016. Sunshine Health will offer the "Stars Plus" option for an additional three months to allow time for families to shop the Federal Marketplace, to ensure they experience no gaps in health insurance coverage. In the next few weeks, Florida Healthy Kids will begin notifying families affected by the full-pay plan changes and assist these families with transitioning their coverage. [Read More](#)

BCBS of Florida Reports \$471M Gross Profit on Exchange Plans in 2015. *Modern Healthcare* reported on June 15, 2016, that Blue Cross Blue Shield of Florida posted a \$471 million gross profit on individual Florida Blue plans offered through the Exchange in 2015, up from \$124 million in 2014. A spokesman for the company attributed the profits in part to Florida Blue's high deductible plans. Approximately 500,000 members were enrolled in Florida Blue

Exchange plans at the end of 2015. For the 2017 plan year, Florida Blue has requested a 9.8 percent rate hike for individual plans and 8.7 percent for small-group plans. [Read More](#)

Georgia

HMA Roundup - Kathy Ryland ([Email Kathy](#))

Task Force to Finalize Alternate Medicaid Expansion Plan. *Georgia Health News* reported on June 21, 2016, that a Georgia health care task force is working to finalize recommendations for an alternative Medicaid expansion model by July in order to begin discussions with Governor Nathan Deal and legislators ahead of the next legislative session in January 2017. The task force was formed by the Georgia Chamber of Commerce and includes hospital industry officials, physicians, and insurance company representatives. Brian Robinson, a former aide to Governor Deal who is working on the project, said the recommendations will include “market-based reforms” and “personal responsibility” for people who gain coverage. He says the task force is coming up with three options and is leaning towards one that would cover as many as 565,000 individuals up to 100 percent of the poverty level, lower than the 138 percent level under the Affordable Care Act. Governor Deal’s administration has said that the decision is in the hands of the legislature and that the Governor has not had any meetings on the proposals yet. [Read More](#)

Hawaii

Kaiser to Freeze Medicaid Enrollment Amid Provider Shortages. *News of Hawaii* reported on June 20, 2016, that Kaiser Permanente of Hawaii is freezing enrollment of new Medicaid members amid concerns of provider shortages across the state’s Medicaid program. Kaiser currently serves around 31,500 Medicaid members in Hawaii’s Quest Medicaid program. The article noted that Hawaii’s medical providers rely on higher-paying privately insured patients to offset lower Medicaid reimbursements, which can limit access for Medicaid patients. [Read More](#)

Iowa

Medicaid Therapy Providers Experience Billing Issues, Unpaid Claims Under Managed Care. *The Gazette* reported on June 16, 2016, that Medicaid occupational, physical, and speech therapy providers in Iowa have experienced billing issues, including unpaid or incorrectly paid claims, since the state’s transition to Medicaid managed care in April. Providers say the issue stems from incorrect billing codes and fee schedules being applied. UnitedHealthcare said that it has corrected the problem, while Amerigroup is working to correct the issue. [Read More](#)

Kansas

Providers Express Concerns Ahead of Medicaid Rate Cuts. *The News & Observer/AP* reported on June 15, 2015, that Kansas hospitals and providers are concerned over Medicaid reimbursement cuts of 4 percent, or \$38 million, which take effect on July 1. Hospitals, physicians, dentists, and pharmacies in urban areas will see the greatest impact of the rate reductions, while rural hospitals and home and community-based services for people with disabilities are exempt. The state's largest hospital system, Via Christi Health, said the cuts will cost the system more than \$4.3 million annually. [Read More](#)

Medicaid Waiting List Grows Due to Eligibility Determination Error. *The Hutchinson News* reported on June 18, 2016, that the Kansas Department of Health and Environment incorrectly reported the backlog of applications for Medicaid eligibility by 12,000 people, increasing the waiting list for Medicaid services from 3,500 to 15,400. State Medicaid Director Susan Mosier sent a letter to federal officials in early June stating that the change in the backlog number is due to an error in the method used by the state's contractor, Accenture. Governor Sam Brownback's administration introduced a new eligibility determination system in 2015, the Kansas Eligibility Enforcement System (KEES), and processing backlogs have been an issue throughout the implementation process. [Read More](#)

Kentucky

Medicaid Reform Plan, 1115 Waiver Application Posted for Public Comment. *The Huffington Post* reported on June 22, 2016, that Kentucky Governor Matt Bevin announced a plan to transform the state's Medicaid program, shifting most of the state's 1.2 million Medicaid beneficiaries into a new program called Helping to Engage and Achieve Long Term Health (HEALTH) and requiring most adult beneficiaries to pay premiums of \$1 to \$15 a month. Additionally, the proposal requires many members to engage in community service, job training, or other activities to gain access to additional benefits. The waiver also includes delivery system reforms targeting substance use disorder, chronic disease management, and improved quality and outcomes. The 30-day comment period for the proposal will run until July 22, and the state plans to hold public hearings on June 28, June 29, and July 6. After the public comment period has closed, the state will make revisions to the waiver application before submitting it to the Centers for Medicare and Medicaid Services (CMS). Governor Bevin has discussed phasing out the state's Medicaid expansion if CMS does not approve a redesign plan, threatening coverage of roughly 400,000 members. [Read More](#)

Maryland

New Law Allows ABLE Savings Accounts for Individuals with Disabilities. *The Baltimore Sun* reported on June 21, 2016, that Maryland will begin offering Achieving a Better Life Experience (ABLE) savings accounts in the fall of 2017, allowing individuals with disabilities and their families to set aside up to \$14,000 annually (\$350,000 total) without losing eligibility for Supplemental Security Income (SSI) or Medicaid. An estimated 30,000 to 50,000 Maryland residents may be eligible for ABLE accounts, which can be used to pay long-term services and supports expenses like housing, transportation, and

technology. To be eligible, individuals must have a qualified intellectual, developmental, or physical disability that began before age 26. ABLE accounts were created in 2014 under federal legislation that modified the tax code and allowed states to establish the accounts. Dozens of other states have taken steps to implement ABLE accounts. [Read More](#)

Nebraska

Medicaid MCO Awards Challenged in Court by Aetna. *The Lincoln Journal Star* reported on June 16, 2016, that Aetna Better Health of Nebraska has filed a complaint in a Nebraska county court after the state reversed a decision to award Aetna a contract under the new Heritage Health program. Heritage Health will combine managed physical and behavioral health, serving an estimated 230,000 members with \$1 billion in annual spending. Six managed care organizations applied, with three initial awards announced, including Aetna. However, after the awards were challenged and proposals rescored, Aetna's award was rescinded. Aetna claims the state's re-scoring process was flawed, ignored standard procedures, and was in violation of state law. Aetna has operated in the state for five years and serves over 100,000 Medicaid members. [Read More](#)

New Hampshire

New Hampshire Certificate of Need (CON) Board to Disband. *New Hampshire Business Review* reported on June 15, 2016, that the New Hampshire Certificate of Need (CON) board, which governs health care facility expansion, will be disbanded at the end of the month. However, some limits on new facility construction will remain. Effective July 1, 2016, Senate Bill 481, signed last week by Governor Maggie Hassan, will allow the state Department of Health and Human Services to maintain some authority over new construction, as opposed to the CON board. The CON board was first adopted in New Hampshire in 1979. Currently, 32 states still have a CON board. [Read More](#)

New Jersey

HMA Roundup - Karen Brodsky ([Email Karen](#))

New Jersey Extends Comment Period on 1115 Waiver Renewal Application. On June 22, 2016, New Jersey Department of Human Services Acting Commissioner Elizabeth Connolly informed stakeholders that she had requested and received approval from the Centers for Medicare & Medicaid Services (CMS) to extend the public comment period for the state's Medicaid 1115 waiver renewal application by 30 days to August 12, 2016.

DMAHS Presents 1115 Demonstration Waiver Renewal Application Plans at MAAC Meeting. On June 15, 2016 the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) presented its plans to strengthen the state's Medicaid program under an [1115 waiver renewal](#) with alignment and redesign through care integration. Allison Hamblin from the Center for Health Care Strategies, which has been working with New Jersey Medicaid on the draft 1115 waiver application, gave an overview of its goals.

The waiver renewal vision is to achieve a “fully integrated continuum of care that seamlessly addresses physical, behavioral and long term care needs.” The application is seeking authority to continue the current 1115 waiver programs and to enhance them by taking the following additional steps:

1. Maintain its Managed Long-term Services and Supports (MLTSS) program;
2. Move to an integrated and managed behavioral health delivery system, that includes a flexible and comprehensive substance use disorder (SUD) benefit;
3. Increase access to services and supports for individuals with intellectual and developmental disabilities;
4. Further streamline NJ FamilyCare eligibility and enrollment;
5. Increase care coordination options for individuals who are dually eligible;
6. Develop an uninterrupted reentry system for incarcerated individuals;
7. Target housing support services for individuals who are homeless or at-risk of being homeless;
8. Expand and enhance the current value-based purchasing strategies;
9. Enhance access to critical providers and underserved areas through alternative provider development initiatives;
10. Continue DSRIP funding to promote and foster health care delivery system innovations, and
11. Expand and enhance population health partnerships with community and faith-based organizations, public health organizations, healthcare providers, employers, and other stakeholders to improve health outcomes for Medicaid-eligible individuals.

DMAHS has approached the 1115 waiver under three phases:

PHASE	GOALS	STATUS
I	MLTSS and Health Homes	Done
II	Building system capacity (BH IME, enabling BH providers to do presumptive eligibility; SUD “true-up” to match Medicaid Expansion benefits to the Plan A enrollees)	In progress
III	Fully integrated care	To occur under waiver renewal

Additional information was offered for each of these steps.

1. **MLTSS.** As of April 2016 the state has 25,750 MLTSS enrollees of which 66 percent receive home and community based services (HCBS) and the rest are nursing facility based. There are no major reforms to MLTSS planned under the waiver renewal.
2. **Move to an integrated and managed behavioral health delivery system, that includes a flexible and comprehensive substance use disorder (SUD) benefit.** This step will:

- a. Create a comprehensive continuum of Substance Use Disorder (SUD) care
- b. Integrate BH benefits into a coordinated integrated health delivery system. This will entail extensive stakeholder input to determine system design specifications.
- c. Implement aligned financial incentives with value-based payments to reward quality and integrated care delivery
- d. Address regulatory barriers

The BH integration aims to promote goals at all three system levels: 1) payer, 2) provider, and 3) regulatory.

3. **Increase access to services and supports for individuals with intellectual and developmental disabilities.** The waiver renewal would move the Community Care Waiver (CCW) under the 1115 waiver. CCW is the last remaining 1915c waiver in the state and relocating it under the 1115 waiver would provide for efficiencies for state agencies. It would also build a comprehensive package of services for children with autism spectrum disorder (ASD) under the Medicaid State Plan. During the comment session an attendee asked if CCW would become the responsibility of the MCOs and Director Davey said no, that was not the state's intent.
4. **Further streamline NJ FamilyCare eligibility and enrollment.**
 - a. Build on current waiver authority that allows individuals under 100 percent of the Federal Poverty Level (FPL) to apply for MLTSS through self-attestation of the transfer of assets. Under the waiver renewal individuals under 300 percent of the Federal Benefit Rate could self-attest. The state is actively pursuing an Asset Verification System.
 - b. Require new managed care enrollees to choose a Medicaid MCO upon application or be auto assigned. Members will be allowed a 90-day period after MCO enrollment to change MCOs without cause. After the 90-day period, plan changes only for cause would be permitted.
 - c. Require individuals who could (but choose not to) enroll in Medicare to do so; New Jersey will be requesting a State Plan Amendment that will require that individuals enroll in Medicare parts A, B, and D in order to be Medicaid eligible. As part of this requirement, the individuals' Medicare premiums, cost-shares, and co-pays will be paid by Medicaid. The state anticipates realized savings through lower capitation payments to MCOs because most of the health care costs would be covered by Medicare.
5. **Increase care coordination options for individuals who are dually eligible.** Building on the state's contracts with Fully Integrated Dual Eligible Special Needs Plans (FIDE-SNP), the state would pursue seamless conversion of Medicaid enrollees who are newly eligible for Medicare into the D-SNP operated by their Medicaid plan. It will also seek authority to auto-assign new dual Medicaid enrollees to a FIDE D-SNP. These actions would further the states goals for ensuring alignment of Medicare and Medicaid coverage, and for providing care coordination.

6. Develop an uninterrupted reentry system for incarcerated individuals.
 - a. The state will seek authority to allow formerly incarcerated individuals re-entering the community to retain Medicaid eligibility for 18 to 24 months before redetermination to ensure continuity of services.
 - b. It will also request to auto-assign these individuals into an MCO to ensure that their care is managed beginning at the time of release.
 - c. These individuals would be eligible to receive SUD program services, including recovery based supports.
 - d. The state is also considering a Behavioral Health Home under Section 2703 of the Affordable Care Act for these individuals.
7. Provide housing support services for individuals who are homeless or at-risk of being homeless.
 - a. New Jersey will seek expansion of the High-Fidelity Housing First (HFHF) model to meet the needs of individuals who are at-risk for homelessness or who are considered to be chronically homeless. HFHF is a SAMHSA supported, evidence-based approach to end homelessness.
 - b. New Jersey is proposing to provide housing-related services to all Medicaid recipients to
 - c. identify, attain and keep housing. They will target individuals who are transitioning from, for example, institutional settings, hospitals, nursing homes, residential treatment centers, assisted living facilities, homelessness or chronic homelessness, correctional facilities, and foster care.
 - d. Housing services will fall into three broad categories:
 - i. Housing screening services
 - ii. Housing transition services, and
 - iii. Housing tenancy sustaining services.
8. **Expand and enhance the current value-based purchasing (VBP) strategies.** This step will continue DSRIP for two years with an option to extend it for an additional three years. The state will also further develop their existing VBP strategies and increase the percentage of VBP occurring between MCOs and providers. The state is open to various payment models and seeks stakeholder engagement from which it will develop a VBP strategic plan.
9. **Enhance access to critical providers and underserved areas through alternative provider development initiatives.** Under this goal the state will seek to increase the use of evidence-based telehealth options for Medicaid beneficiaries in geographic areas of the state for which financial incentives would not effectively improve cost-effective access to care.
10. **Continue DSRIP funding to promote and foster health care delivery system innovations.** The state will propose a DSRIP demonstration program expansion by June 30, 2018 to begin on July 1, 2019 and extend through June 30, 2022 with an option for renewal term of an additional two years. The new state DSRIP demonstration program would incorporate enhancements leading to more targeted performance improvement and a return on investment.

11. **Expand and enhance population health partnerships with community and faith-based organizations, public health organizations, healthcare providers, employers, and other stakeholders to improve health outcomes for Medicaid-eligible individuals.** This step will partner with the New Jersey Department of Health, which promotes stronger collaborations among hospitals, local health officials, healthcare providers, government, employers, and schools. The Department will help its partners deliver desired outcomes targeted in the state health improvement plan, Healthy New Jersey (NJ) 2020 which sets a vision for public health, desired outcomes and the indicators that will help the state to understand how well public health is being improved and protected. Healthy NJ 2020 covers numerous issues, including chronic disease, immunization and improved birth outcomes.

The state is accepting comments on the draft 1115 waiver renewal through July 10, 2016.

Medicaid Agency Plans to Terminate Medicaid Fee-for-Service Providers Who Have Not Completed Re-enrollment Application. The Division of Medical Assistance and Health Services (DMAHS) released a notice to all Medicaid providers on June 16, 2016, to alert them to the state's plans to terminate their enrollment as a Medicaid provider, effective on or about July 1, 2016, if they have not submitted or completed an enrollment packet to reactivate their NJ FamilyCare provider number. This could affect a provider's ability to access the state's recipient eligibility verification system (REVS). [Read More](#)

Advocates Release Out-of-Network Bills Study. The New Jersey Policy Perspective and NJ for Health Care teamed up to examine the degree to which state residents received out-of-network medical bills. On June 16, 2016, it released a report that concluded that each year more than 168,000 residents receive out-of-network medical bills. Of those, they say 71 percent did not know that the provider who treated them was not in their network. The report came out a few days before the New Jersey Assembly Financial Institutions and Insurance Committee met on June 20, 2016, to discuss the bill A-1952, "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act," which appears in the data package below. The study found that surprise bills are contributing to higher deductible and premium costs. The researchers estimate that New Jersey consumers owe \$420 million in unexpected medical bills annually. The full report is produced in a slide deck format and can be found [here](#).

New York

HMA Roundup - Denise Soffel ([Email Denise](#))

2016 Legislative Session Ends. The New York State Legislature ended its 2016 session this week. A number of health care bills passed both houses of the legislature. They require the Governor's signature to become law. Some of the bills that passed both houses are described below.

- *Enhanced Medicaid Funding for Safety Net Hospitals:* creates a supplemental Medicaid rate adjustment for "enhanced safety net hospitals," including public hospitals and federally designated critical access and sole community hospitals that serve a high number of Medicaid and uninsured patients. As the bill was not included in the

budget that was passed in April, the bill comes with no new funding. It appears to be a zero-sum game, implying that it would be paid for by reducing Medicaid rates at those hospitals that are not in this category.

- *Opioid Package*: Three bills were introduced in response to the state's heroin and opioid crisis that would require hospitals to have discharge materials for people at risk of addiction, increase the involuntary hold for incapacitated individuals from 48 to 72 hours, and require insurers to provide inpatient coverage for those suffering from substance use disorders without prior authorization.
- *Certifying Advanced Home Health Aides*: Creates a mechanism for a new category of health care worker – advanced home health aides – who can provide a higher level of care to patients receiving home care services than currently permitted under state law and regulations.
- *Prescription Drug Step Therapy Override*: Establishes a protocol that would override step therapy, the practice of insurers requiring patients to try less expensive drugs before approving the one recommended by their provider. The protocol affects commercial insurers, not just Medicaid.

One very controversial bill addressed the question of mandating nurse staffing ratios. Supported by the New York State Nurses Association and many consumer and labor groups, the Safe Staffing for Quality Care Act would have required that all acute care hospitals and nursing facilities establish staffing ratios of nursing and unlicensed direct care staff. The bill was strongly opposed by the hospital industry. The bill passed the Assembly but did not pass the Senate.

Superintendent of Financial Services Confirmed. The New York State Senate confirmed Governor Andrew Cuomo's nomination of Maria Vullo as Superintendent of the New York State Department of Financial Services (DFS). As Superintendent, Ms. Vullo is responsible for regulating more than 1,500 insurance companies, as well as nearly 1,600 banking and other financial institutions. DFS oversees the prior authorization requirements for health insurance premium increases. Ms. Vullo has served as Acting Superintendent since February, when she was nominated by Governor Cuomo to lead DFS.

Ohio

HMA Roundup – Jim Downie ([Email Jim](#))

Joint Medicaid Oversight Committee Fields Testimony on Value-Based Payment Systems for Medical Services. *Gongwer-Ohio* reports the Joint Medicaid Oversight Committee (JMOC) heard from analysts and providers on moving from fee-based payments to outcome-based methodologies. "Sukey Barnum, with Health Management Associates, outlined some trends in value-based payments, in which providers are paid based on the patient's outcomes, not what services were provided, and contrasted it with the fee-for-service system. Fee-for-service payments are one of many drivers of rising health care costs," according to the article. Members of the Committee shared personal stories of the difficulties encountered due to the lack of health care literacy and health care financing literacy. Committee members also voiced concerns with the inability of providers to share health records. [Read More](#)

Governor Kasich Signs Bill Expediting Prior Authorizations. *The Bowling Green Sentinel-Tribune* reported on June 15, 2016, that Governor Kasich has signed Senate Bill 129. The legislation identifies a timeline for response from insurers on requests for prior authorization. Urgent requests must have a response in 48 hours. Routine requests must have a response in 10 calendar days. The bill further requires a web-based system for communicating requests and responses. In addition, the bill bans insurers from retroactively denying payment for previously approved services. [Read More](#)

Office of Health Transformation Announces the Release of New Behavioral Health Billing Codes. The Ohio Departments of Medicaid and Mental Health and Addiction Services has released new Medicaid billing codes and prices for behavioral health services. The new codes are estimated to generate an additional \$38 million annually in payments to behavioral health providers. The new codes align with national health care payment standards that support coordination of benefits and integrate behavioral and physical health care. Provider agencies may voluntarily transition to the new code set beginning January 1, 2017, and all providers must use the new code set after June 30, 2017. [Read More](#)

Pennsylvania

HMA Roundup - Julie George ([Email Julie](#))

Health Information Exchange Continues New Member Growth. The Pennsylvania Patient & Provider Network (P3N), a part of the Pennsylvania eHealth Partnership Authority, has added Keystone Health Information Exchange (HIE) to its health data repository. Authority Acting Executive Director Kelly Hoover Thompson said that, including KeyHIE, five health information organizations from across the state are expected to be connected to the P3N network this summer, contributing to substantial health IT interoperability growth throughout Pennsylvania. The Pennsylvania eHealth Partnership Authority is a state agency that seeks to boost healthcare through health information exchange and health data interoperability. [Read More](#)

South Dakota

Governor Courts Votes for Medicaid Expansion Plan. *The Argus Leader* reported on June 18, 2016, that South Dakota Governor Dennis Daugaard is working to court the necessary 36 votes in the state House and 18 in the state Senate to pass his administration's Medicaid expansion proposal. Governor Daugaard has a solid block of Democrats favoring expansion as well as a group of moderate Republicans, but key Republicans like House Majority Leader Brian Gosch remain opposed to the plan. [Read More](#)

Texas

Texas Families Push for Medicaid Coverage of Applied Behavioral Analysis for Children with Autism. *The Texas Tribune* reported on June 17, 2016 that Texas families are pushing the state Medicaid program to cover Applied Behavioral Analysis (ABA), a treatment for children with autism. In 2014, the Centers for Medicare & Medicaid Services (CMS) advised states that they must cover medically necessary care for Medicaid children up to age 21 with autism;

however, Texas is one of several states that has responded slowly to CMS' guidance. Texas Medicaid covers medically necessary services to children with autism such as physical, occupational, and speech therapy, but not ABA, forcing families to forgo therapy or turn to individual insurance plans to help with the cost. Furthermore, upcoming cuts to children's home-based therapy reimbursements are exacerbating the issue for some families. The national Autism Speaks advocacy group says that Texas families may take legal action if federal officials do not weigh in on state denials of ABA coverage. The Texas Health and Human Services Commission said that it is reviewing guidance from CMS on the issue. [Read More](#)

Wisconsin

Department of Health Services Secretary Passes Away. *The Milwaukee Journal Sentinel* reported on June 18, 2016, that Wisconsin Department of Health Services (DHS) Secretary Kitty Rhoades has passed away. Rhoades began as deputy before being promoted to secretary in February 2013. Previously, she served in the state Assembly from 1999 to 2010 and was co-chairwoman of the Joint Finance Committee from 2007 to 2008. [Read More](#)

National

ASPE Finds Medicaid Expansion Increases Access to Care, Decreases Number of Uninsured. The U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) reported in an Issue Brief on June 20, 2016, that Medicaid expansion increased access to primary care, expanded use of prescription medications, and increased rates of diagnosis of chronic conditions for new enrollees. The brief, titled *Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care,* and is based on a literature review covering 2014 and 2015, also said that expansion decreased the uninsured rate in both expansion and non-expansion states, improved affordability, and provided quality care to new enrollees. [Read More](#)

House Republicans Propose Plan to Replace ACA. *Kaiser Health News* reported on June 22, 2016, that House Republicans have proposed a plan, called "A Better Way," to replace the Affordable Care Act (ACA). The framework is built on five major principles: repeal the ACA; provide more choices, lower costs, and greater flexibility; protect the nation's most vulnerable; spur innovation; and protect and preserve Medicare. The plan calls for high-risk pools for people with high medical expenses, ending open-ended funding for Medicaid, and encouraging small private businesses to form "Association Health Plans." It would dismantle the current Exchanges and instead provide tax credits to people buying policies in the individual market. The plan also encourages moving Medicare patients from fee-for-service to Medicare Advantage managed care plans. [Read More](#)



INDUSTRY
NEWS

No Industry News to Report This Week.

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
June 24, 2016	Massachusetts MassHealth ACO - Pilot	Responses Due	TBD
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	Implementation (Northern Counties)	45,600
July, 2016	Nevada	RFP Release	420,000
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
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	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	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
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.

HMA NEWS

30-Plus Speakers Slated for HMA Conference on Integrated Care Delivery

HMA's inaugural conference "*The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*" is slated for October 10-12 in Chicago. This premier event, presented by HMA and HMA's Accountable Care Institute, will address key issues facing health systems, hospitals, clinics and provider practices seeking to integrate care in an environment of rising quality and cost expectations. More than 30 speakers have been confirmed to date. Early Bird registration is now open. Click [here](#) for complete conference details or contact Carl Mercurio at (212) 575-5929 or cmercurio@healthmanagement.com.

HMA Upcoming Webinars

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

June 28, 2016

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