HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

OKLAHOMA DECIDES ON ABD MANAGED CARE MODEL

This week, our *In Focus* section reviews the decision announced this week by the Oklahoma Health Care Authority (OHCA) on the care coordination model selected to serve the aged, blind, and disabled (ABD) Medicaid population. OHCA has selected a fully capitated statewide model, rather than a managed fee-for-service arrangement. We previously reviewed the request for information (RFI) issued by OHCA to solicit input on the model design in our July 1, 2015 Weekly Roundup. OHCA has entered a quiet period around the development of a request for proposals (RFP), which will be released in June 2016. A draft RFP is set to be publicized in March 2016. Depending on final RFP and contract design, the statewide ABD managed care program could cover

more than 177,000 beneficiaries with annual Medicaid spending of up to $2.5 billion.

Background

In early May, 2015, Governor Mary Fallin signed into law HB 1566, which directed OHCA to issue a request for proposals (RFP) for ABD care coordination. HB 1566 allows for a phased in approach, delaying implementation for individuals receiving institutional care by two years. Oklahoma does not currently operate a fully capitated managed care program. OHCA does operate SoonerCare Choice, the state's primary care case management (PCCM) program, which covers nearly 70 percent of Medicaid enrollees, including more than 25 percent of the ABD population. .

Target Population

In state fiscal year 2014 (SFY 2014), there were nearly 177,000 ABD Medicaid members in the state, with more than 70 percent in the blind/disabled category of aid. More than 55 percent are dually eligible for Medicaid and Medicare. According to the RFI issued this summer, the ABD population accounts for just over 16 percent of total enrollment, but more than 46 percent of annual Medicaid spending. In SFY 2014, total Medicaid expenditures for the ABD population exceeded $2.4 billion. Total potential spending under a managed care model will be highly dependent on the timing, design and scope of the long-term supports and services (LTSS) benefits that will be included in the capitated model.

The state has determined that to achieve meaningful results under this model, it is essential that members residing in nursing facilities ultimately be enrolled. OHCA insists that delaying their enrollment by two years already has reduced the model's potential short term impact.

Care Coordination Model Conclusions

OHCA, in its press release announcing the fully capitated statewide model decision, indicated that this model best meets the intent of HB 1566 and provides "the highest quality of care for the ABD populations, while helping to control costs and improve health outcomes." Based on the comparison between the capitated and the Managed Fee-For-Service/Administrative Services Organization (MFFS/ASO) models, the capitated model won out due to the reduced financial risk to the state, the ability to advance Pay for Performance (P4P) and Value Based Purchasing (VBP) initiatives through contract design, and the preservation and integration of the Health Access Network (HAN) initiative, a Medicaid patient-centered medical home (PCMH) program.

Capitated Health Plan Option	MFFS/ASO Option
• Improves care coordination • Shifts financial risk for service delivery to the plans • Has the ability to use the RFP process to advance other stakeholder/state objectives: ○ Selecting plans with strategies for addressing provider shortages over time, and favoring these plans when making awards	• Improves care coordination • Does not address provider shortages or advance P4P and VBP, as the organization would not be capitated for service delivery • Exposes the state to greater financial risk, as service costs remain the responsibility of the OHCA. If costs are over budget, the agency will have to resort to provider rate cuts and

○ Selecting plans with strategies for advancing quality through contracts with providers that employ P4P ○ Selecting plans that form partnerships with existing initiatives, such as HANs, and with regional provider organizations	benefit cuts to address • Would supplant some existing initiatives, such as the HAN. These initiatives would be discontinued for ABD members, to avoid paying twice for care coordination of the same individuals

Health Plan Respondents to RFI

A total of eleven health plans responded to the RFI, with most of the major national Medicaid plans represented. Local insurers BCBS of Oklahoma and GlobalHealth also responded to the state's RFI. Responding to the RFI was not mandatory for eventual bidders on the RFP.

- Aetna
- AmeriHealth Caritas
- Anthem (Amerigroup)
- Blue Cross Blue Shield of Oklahoma
- Centene
- GlobalHealth Holdings, LLC
- Magellan Healthcare
- Meridian Health Plan
- Molina Healthcare
- United Healthcare
- WellCare

Proposed Timeline

OHCA's proposed timeline for the care coordination RFP is detailed below, with the state in a quiet period for RFP development. Per the current timeline, a draft RFP will be released in March 2016, with a final RFP to follow in June 2016. OHCA's website indicates that proposals would be due in August 2016. The implementation dates below are based on OHCA presentations indicating that no RFI respondents saw an issue with a targeted implementation in 2017.

Timeline	Date
Draft RFP Publicized	March, 2016
RFP Released	June, 2016
Proposals Due	August, 2016
Implementation	TBD 2017
Implementation (Institutional)	TBD 2019

Link to OHCA ABD Care Coordination:

http://okhca.org/about.aspx?id=17366

HMA Medicaid Roundup

Alabama

Alabama Health Care Improvement Task Force Votes for Medicaid Expansion. On November 18, 2015, the *Montgomery Adviser* reported that Governor Bentley's Alabama Health Care Improvement Task Forces voted in favor of Medicaid expansion. The task force cited the potential public health and economic benefits and the need to keep state hospitals open. It did not use the phrase "Medicaid expansion," however, but recommended for the governor and Legislature to "move forward at the earliest opportunity to close Alabama's health coverage gap with an Alabama-driven solution." Read More

Arizona

Arizona Health Insurance Co-op, Meritus Health Partners, to Close Dec. 31. On November 24, 2015, *AP News* reported that Meritus Health Partners, the state's nonprofit health insurance co-op, will close Dec. 31. The insurance department said Meritus would fail midway through 2016 and the plan's executives stated that they could not come up with additional financial backing. The 59,000 people the plan currently serves will need to find a new insurer by Dec. 15 to have uninterrupted coverage. Read More

Arkansas

Legislative Task Force on the Hybrid Medicaid Program Nears Deadline. On November 24, 2015, *Arkansas Business* reported that the Health Reform Legislative Task Force is nearing a deadline for recommendations. Chairman Rep. Charlie Collins stated the group will make a decision regarding changes to the Private Option program and to overall Medicaid in the state at the December meeting. Department of Human Services Director John Selig said Arkansas has to file notice with CMS that it plans to amend the existing waiver. Selig stated that making amendments to the existing waiver will be more beneficial than getting rid of the waiver and starting anew. Read More

California

HMA Roundup – Don Novo (Email Don)

Katz Selected to Head New L.A. County Health Agency. On November 25, 2015, *The Los Angeles Times* reported that Dr. Mitch Katz will head the new health agency containing the hospital system and the departments of mental health and public health. In September of this year, the Los Angeles County

board voted to form a single health agency to better integrate care and a more efficient administration. Opponents are pushing back on the consolidation, arguing that mental health services and public health programs will suffer. Read More

Lawmakers Worry Budget Surplus Would End Effort to Revise MCO Tax. On December 1, 2015, *The Los Angeles Times* reported that the Legislature's independent analyst projection of a $4 billion budget surplus could weaken the effort to revise a tax that helps fund health care for low-income residents. The tax on managed care organizations is set to expire next summer. Many legislators and healthcare industry officials are now questioning whether the tax is now necessary. Read More

33,000 Adults Sign Up for Dental Coverage Offered for First Time on California Exchange. On November 19, 2015, *Kaiser Health News* reported that approximately 33,000 adults signed up for dental plans offered for the first time on California's health insurance exchange. The new dental plans are offered by Access Dental Plan, Anthem Blue Cross of California, Delta Dental of California, Dental Health Services and Premier Access, and have monthly premiums ranging from $11 to $65. Washington is only remaining state that does not offer dental coverage on the exchange. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Governor Rick Scott's Florida First Budget FY 2016-17 – On November 23, 2015, Governor Rick Scott proposed a $79.3 billion budget for the next fiscal year. The general revenue portion is $29.3 billion, an increase of $1.3 billion over the prior fiscal year (a five percent increase). The budget cuts taxes by $1 billion, provides increased funding to schools, invests in jobs and eliminates nearly 1,000 more full-time jobs from the state workforce. The budget funds the Medicaid program at $24.8 billion to serve an estimated 4.2 million Medicaid beneficiaries. The KidCare program is funded at $434 million to serve an estimated 221,231 children. Below are the key issues affecting the Medicaid program. Click here to view the Florida First complete budget.

Major Issues

- **Low Income Pool –** LIP funding was reduced by federal CMS from $1 billion to $608 million. Funding will be reallocated to hospitals using on a three-tiered reimbursement methodology based on hospitals charity care costs as a percentage of privately insured patient costs.
- **Disproportionate Share Hospital –** The DSH funding model is revised to minimize LIP reductions and allocates funds to safety net hospitals determined by their levels of Medicaid inpatient care and graduate medical education.
- **Supplemental Medicare Insurance Premium Increase –** $100 million is provided to increase Medicare Part B premiums and deductibles for dually-eligible enrollees.
- **Faculty Physician Supplemental Payments –** $92.4 million is provided for a differential fee schedule for payments for services provided by doctors of medicine and osteopathy as well as other licensed health care practitioners acting under the supervision of the doctors. (This will help minimize the loss of LIP funding).

- **Graduate Medical Education** - $26.6 million is provided for Graduate Medical Education.
- **Florida Medicaid Management Information System (FMMIS)** – $17.4 million is provided for the FMMIS/Decision Support Fiscal Agent procurement project.
- **All-Payer Claims Database** (ACPD) – $5 million is provided for an APCD, a transparent, centralized database that can be accessed by consumers to compare prices and will assist in updating the FloridaHealthFinder.gov website.
- **Advanced Data Analytics and Detection Services** – $2.9 million is provided for the purchase of analytical subscription services in order to detect and deter fraud, waste and abuse in the Medicaid Program and other public benefit programs within the state.
- **Evaluation of Medicaid Waivers** – $751,000 is provided for an independent evaluation of two Medicaid waiver programs, MEDS-AD 1115 and Long Term Care.
- **Nursing Home Prospective Payment System** – $500,000 is provided to contract with an independent consultant to develop a plan to convert nursing home reimbursement to a prospective payment system.
- **Managed Care Plan Contract Compliance** – $480,000 is provided to hire an independent consultant to assist with the development of a contract compliance tracking system for Statewide Medicaid Managed Care oversight activities.
- **Hospital Readmissions and Complications Study** – $400,000 is provided to update the Comprehensive Health Information System's existing methodology for calculating rates of potentially preventable readmissions and to establish a methodology for calculating rates of potentially preventable complications for hospitals.

Reductions

- **Hospital Add-on Reduction** – Reduces $202.3 million for automatic add-on payments that exist on top of the established DRG methodology for hospital inpatient services. Reduction distribution is based on hospital profitability.
- **Offset Hospital Rate Inflation** – Reduces $82.6 million that offsets the 2% inflation rate for hospital inpatient and hospital outpatient services that is included in Medicaid Services estimated expenditures.
- **Management and Efficiencies** - Reduces $837,024 and eliminates 20 FTEs and 25 OPS staff for management and efficiencies due to implementation of Statewide Medicaid Managed Care, streamlined processes and administrative efficiencies.
- **Contract Savings** – Reduces $2.1 million due to the implementation of the Statewide Medicaid Managed Care, streamlined processes related to Enrollment Broker Services and Quality Improvement Organization and Utilization Management contracts.

Governor Scott Proposes $1.2 Billion Funding for APD, Eliminating Critical Needs Waiting List for Third Year. On November 23, 2015, the Agency for Persons with Disabilities reported that Governor Rick Scott is recommending $1.2 billion in total funding for APD, an increase of $23.6 million. The proposed "Florida First" budget includes:

- $15 million to enroll over 700 individuals with developmental disabilities on the critical needs waiting list to the APD Home and Community-Based Services Medicaid waiver
- $10 million to reinstate Department of Education funding for the Adults with Disabilities program
- $1 million for the Employment Enhancement Project
- $2.6 million for staff to perform customer needs assessments using the Questionnaire for Situational Information
- $400,000 for a Medicaid waiver Provider Rate Study.

The full list of budget recommendations can be found here.

Express Enrollment – Florida Medicaid received approval of an amendment to the 1115 Managed Medical Assistance waiver to allow Express Enrollment that will be implemented beginning in early January 2016. Through Express Enrollment, health plan enrollment will be effective the same day the individual's Medicaid application is approved, allowing new enrollees to immediately take advantage of provider networks and access standards and expanded benefits offered by the plan. Read More

Corizon Health Cancels Prison Health Care Contract; State Considers Hiring Temp Agencies to Fill the Gap. On December 1, 2015, *Health News Florida* reported that Corizon Health will end its contract providing health care services to Florida prison inmates as of May 31. Corizon Health was awarded the five-year contract in 2013. The company claims the contract is "too constraining." The Department of Corrections announced an intention to re-bid the prison health contracts through an invitation to negotiate. Read More Corizon will be able to participate in the forthcoming invitation to negotiate. In the meantime, the state is considering hiring temp agencies to fill in the gap. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

WellStar to Buy Tenet's Hospitals for $575 Million. On December 1, 2015, *Georgia Health News* reported that WellStar entered a deal to purchase Tenet Healthcare's five metro Atlanta hospitals for $575 million. In addition to the acquisition price, WellStar will assume $86 million in debt related to North Fulton Hospital. If approved by regulators, WellStar would become the largest health system in the state. Read More

Illinois

Cook County Awards Valence Health CountyCare Medicaid Contract. On November 18, 2015, *Chicago Tribune* reported that Valence Health was awarded the CountyCare Medicaid managed care contract in Cook County, replacing IlliniCare Health. The contract is worth $72.1 million over three years and includes two one-year renewal options. If approved by the health system's board, it will go into effect April 1. The previous contract with IlliniCare was cancelled abruptly after one year due to a conflict of interest. CountyCare serves approximately 163,000 members. Read More

Iowa

Judge Proposes Removing WellCare from Medicaid Program; Other Three Companies Can Proceed. On November 26, 2015, *The Gazette* reported that an administrative judge proposed a ruling to remove WellCare of Iowa from the privately managed Medicaid program, citing improper communication and misconduct. WellCare did not initially disclose its past legal troubles, including millions of dollars in fines in other states and three former executives going to prison for fraud. However, the judge stated that the remaining three companies, Amerigroup, AmeriHealth Caritas, and UnitedHealthcare, can proceed. Read More

Governor Branstad Says Judge's Ruling Will Not Delay Medicaid Managed Care Plan. On November 30, 2015, *Radio Iowa* reported that Governor Terry Branstad said there is no need to delay the Medicaid managed care plan due to an administrative judge's recommendation to remove WellCare. Branstad does not know when the Department of Administrative Services director may complete the review of the case and decide whether WellCare is in or out of the mix. Read More

Hospitals Not Signing Up to Participate in New Privatized Medicaid System. On November 19, 2015, *The Des Moines Register* reported that most Iowa hospitals and physicians have not signed contracts to participate in the state's new privatized Medicaid system. None of the four participating managed care companies have reported signing more than 17 of the 118 hospitals now participating in Medicaid; WellCare has signed none and AmeriHealth has only signed two. Pharmacies, doctors, and other health care providers have signed a total of 12,000 contracts thus far. Read More

Kentucky

Gov.-elect Matt Bevin Plans to Close Kynect, Shift Consumers to Federal Exchange. On December 2, 2015, *Kaiser Health News* reported that Gov.-elect Matt Bevin plans to dismantle the state exchange, Kynect, and shift consumers to the federal exchange. Health experts say the transition will have little impact on consumers but ACA advocates and Governor Steve Beshear strongly oppose the plan. The plan will revive questions regarding whether the state or the federal government are better positioned to run the marketplaces. Read More

Louisiana

DHH's Plan to Close Budget Deficit to Delay $126 Million Medicaid Payments to FY 2016. On November 20, 2015, *The Times-Picayune* reported that a plan to close the $500 million state budget gap will delay $126 million in Medicaid payments into the next fiscal year, beginning July 1. The Department of Health and Hospitals is calling the plan a "Medicaid fraud identification" initiative that would give department officials two extra weeks to issue checks to providers. This will move $126 million off of the current budget and into the spending plan of the next governor. Governor Bobby Jindal will leave office in January. A budget analyst with the Louisiana Budget Project stated that the change will not address the department's larger fiscal problems. Both

gubernatorial candidates have also expressed that the fiscal problem is just being pushed into the next administration. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Horizon's OMNIA Tier 2 Hospitals Appeal the State's Approval of the Plan. On November 20, 2015, NJ Spotlight reported that 17 hospitals are appealing the Department of Banking and Insurance (DOBI) approval of OMNIA plan, a Horizon Blue Cross and Blue Shield of New Jersey product which establishes hospital tiers using several measurements: clinical quality; experience providing a broad range of services, including both inpatient and outpatient care; consumer-preference data; capacity and commitment to provide value-based services; and a hospital system's size and scale. Under the plan Tier 2 hospitals would cost patients more than Tier 1 hospitals. Steven M. Goldman, former Commissioner of DOBI leads the appeal on behalf of the 17 hospitals. The appeal raises concerns about DOBI's review process to evaluate network adequacy and access to care, and for "not making transparent the weights and scores used to determine which hospitals it included in Tier 1." Meanwhile, *NJBIZ* reported on November 24, 2015 on the details behind how hospitals earned OMNIA Tier 1 status. Read More

New Jersey Medicaid Extends Long Term Care and Additional Behavioral Health Benefits to Medicaid Expansion Enrollees. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) released a December 2015 notice to providers and managed care organizations of a change in policy that now provides long term services and supports to individuals who are eligible for NJFamilyCare's Alternative Benefit Plan (ABP). NJFamilyCare ABP began on January 1, 2014 with the implementation of Medicaid expansion, providing Medicaid state plan benefits to parents, single adults and childless couples ages 19 to 64 with incomes up to 133% of the Federal Poverty Level, who are not eligible for Medicare. A copy of the notice can be found here.

Updated MLTSS Provider Frequently Asked Questions (FAQ) Document Issued by New Jersey Medicaid. On November 24, 2015 DMAHS released a newsletter for providers who deliver long term services and supports with the latest answers to frequently asked questions about managed long term services and supports (MLTSS). The document covers a number of topics including, for example: 1) clinical and financial eligibility determination; 2) benefit coordination with other providers; 3) authorization and claims contract parameters; 4) MCO provider network; 5) patient pay liability/cost share; and 6) Qualified Income Trust. The FAQs are directed toward MLTSS providers including nursing and assisted living facilities, special care nursing facilities, community residential services and for home and community based providers such as home improvement contractors, emergency response system providers, meal delivery providers and more.

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Care Plan Update. The Medicaid Managed Care Advisory Review Panel, NYS's legislatively mandated oversight body, convened on December 2. The following plan changes were reported.

- Crystal Run, a new plan entering the Medicaid managed care market, has completed the NYS certification process and is awaiting CMS approval to begin operations. Crystal Run is a large multispecialty group practice in Sullivan and Orange Counties. Crystal Run also operates an ACO and participates in the Medicare Shared Savings Program.
- UnitedHealthcare has been approved to expand operations to Dutchess, Erie, Greene, Livingston and Wyoming Counties
- WellCare has been approved to expand operations to Nassau, Niagara, Schenectady, Schuyler and Steuben Counties.
- Independent Health is withdrawing from participation in Niagara County as of January 1. Independent Health has 15,000 members in Niagara County, representing over 40 percent of the Medicaid managed care market. With WellCare's entry into the county, three Medicaid managed care plans will be present – Fidelis Care, United Healthcare, and WellCare.
- The Monroe Plan, a Rochester-based IPA, acquired Univera and renamed it YourCare. YourCare has applied for an expansion into nine additional counties. The Department of Health is reviewing the request in three counties – Monroe, Ontario and Wyoming, and is deferring consideration of the others until YourCare has gained some operating experience.
- HealthNow has been evaluating its participation in Medicaid managed care for over a year, including possible partnerships with other plans. Their enrollment has been frozen pending resolution, and has declined from 40,000 to 27,000 over the last 12 months, a decline of 33 percent.

In addition, Vallencia Lloyd, long-time Director of the Division of Managed Care, announced she is retiring this month. Jonathan Bick, currently Deputy Director, has been named Acting Director.

EmblemHealth Narrowing Network. Karen Ignani, newly named CEO of EmblemHealth, has notified 750 physicians that their contracts will not be renewed as of January 1. In a letter to the Department of Financial Services she explained her decision as a result of moving away from volume-based payment and toward value-based payment. She described EmblemHealth's commitment to "minimize fee-for-service for volume based payment," and to further progress toward value based payment methodologies. Her letter can be found here. In response, the Medical Society of the State of New York has expressed deep concern about the impact of this pared-down network on patients' access to care.

Another Plan Exiting FIDA. Empire BlueCross Blue Shield HealthPlus Fully Integrated Duals Advantage plan is exiting the program, making it the fifth insurer to drop out of FIDA within the first year. The other plans that have left the program are ArchCare, EmblemHealth, Montefiore HMO and Integra; seventeen plans remain. Empire sent a letter to members in October indicating

that their coverage would end Dec. 31. While beneficiaries are able to return to fee-for-service Medicare, the mandatory managed long-term care program in NYS requires that they switch back to the managed long-term care plan they had been enrolled in prior to FIDA. Alternatively, they can select another FIDA plan. Empire BCBS HealthPlus had fewer than 300 members enrolled in FIDA 10 months into the program.

There were 7,540 people enrolled in FIDA as of Nov. 2, according to a presentation given by DOH officials last week. The number of opt-outs was not disclosed. As of Sept. 1, 57,000 people had elected not to join a FIDA plan. Read More

NYC Health + Hospitals Reports Operating Loss. NYC Health + Hospitals, New York City's public hospital system, reported an operating loss of $263.6 million during the first quarter of its current fiscal year. Modern Healthcare reports that the loss was driven by a combination of declines in patient revenue and increases in operating expenses. While patient revenue declined by seven percent, expenses increased by four percent. This presents a sizeable challenge for newly appointed CFO Plachikkat Anantharam, who replaced long-time HHC CFO Marlene Zurack. HHC is also losing Senior Vice President LaRay Brown, who has been with HHC for 30 years, as well as four network senior vice presidents who are retiring, and whose positions have been eliminated as part of a corporate reorganization. In September HHC president Dr. Ramanathan Raju announced that he was ending the regional network model that had been in place for decades, replacing it with three lines of service: in-patient care, long-term and post-acute care, and ambulatory care.

DSRIP Data Opt-Out. The Delivery System Reform Incentive Program is predicated in part on the ability of network providers within a Performing Provider System to share patient-level information about the Medicaid beneficiaries that have been attributed to their PPS. CMS has determined that all Medicaid beneficiaries must be educated about DSRIP and Performing Provider Systems, and given the option of not allowing their personal health information to be shared. The Department of Health will be sending a letter explaining the DSRIP program´s state-wide efforts on healthcare system change, and information about the data sharing option, to every Medicaid enrollee in the state (over 6 million individuals). The state held a webinar on the opt-out process, and has subsequently developed an FAQ document. Links to the webinar and the FAQs, along with the letters that will be distributed, are on the DSRIP website.

United Hospital Fund Issues Two Reports. The United Hospital Fund released two reports last week. The first, "Setting the Stage for Payment Reform: Updating New York's Regulations on Risk Transfers between Health Plans and Providers," explores issues related to the regulatory environment shaping risk transfer agreements. Agreements between insurance plans and health care providers have become increasingly common in New York as the state continues to move toward value-based payment. The report, which is available on the UHF website, provides an overview of the current rules on risk transfers (as well as historical context for them), and includes a checklist of issues for policymakers, state regulators, health plans, providers, and other stakeholders to consider in updating the current regulatory system. The report notes that "Effective regulation must protect the health care system as a whole from financial risk that could undermine the viability of health plans and risk-bearing entities; it must protect health care consumers who might otherwise

unknowingly be receiving care from provider organizations with financial incentives to limit services; and it must protect health plans and risk-bearing entities from burdensome reporting and financial requirements that could raise the cost of doing business (thereby increasing premiums) and hinder their ability to focus on the broader goals of improving care and reducing costs."

The second report examines NYS's Roadmap for Medicaid payment reform, which was approved by CMS in July 2015. The Roadmap lays out the State's strategy to move most Medicaid managed care payments from volume- to value-based systems. This plan parallels and supports the Delivery System Reform Incentive Payment (DSRIP) program. The UHF guide is intended to help stakeholders become familiar with the Roadmap and the coming changes it maps out by explaining the complex vision presented in the Roadmap in simple terms. It also highlights the many unanswered questions that still need to be addressed. The report, "Navigating the New York State Value-Based Payment Roadmap," is available here.

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Ohio Awards $2.5 million in Grants for Recovery Housing. Access to safe housing can be key to successful recovery. According to the Ohio Department of Mental Health and Addiction Services, recovery housing is defined as a safe and healthy living environment that promotes abstinence from alcohol and other drugs and enhances participation and retention in traditional clinical treatment. "When it comes to maintaining sobriety, a destructive living environment can derail recovery for even the most highly-motivated individual," said Ohio MHAS Director Tracy Plouck. "Recovery housing provides a safe, supportive environment where a person in recovery can adjust to sobriety, rebuild shattered relationships, obtain employment and seek permanent housing." The award of these grants brings the total state investment in recovery housing the past three years to $12.5 million. An additional $2.5 million has been set aside for State Fiscal Year 2017.

Ohio to Review Its Title V Program. At the December meeting of Ohio's Joint Medicaid Oversight Committee (JMOC), Ohio's Children with Medical Handicaps (CMH) Program will be reviewed. The program is operated by the Ohio Department of Health and, according to the Department's Director, the program provides diagnoses, treatment plans and service coordination without requiring financial eligibility. Actual treatment does required income to be at or below 185% FPL, but income credits can be used to lower countable income.

JMOC's chair is interested in both financial and medical eligibility requirements of the program. Although other payer programs that have experienced decreases in enrollment since the ACA and Medicaid expansion were enacted in Ohio, CMH reports a spike in enrollment. In Fiscal Year 2015, it served 41,000 individuals at a cost of about $43 million. Chairwoman Barbara Sears says that there is no conversation about eliminating the program. Rather, she is concerned about mission creep, who is covered in treatment, and eligibility issues. "We all know that resources are limited in every state and we should be making sure we prioritize those that truly need this service so we're making sure we're taking care of fragile children. It's incumbent upon us to make sure we do a continual study of where we're at with that." Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Announces Record Levels of Interest in Changes to Pennsylvania Medicaid. Department of Human Services (DHS) Secretary Ted Dallas announced that the state received the highest number of bids on record for its recent request for proposal issued for physical health services provided through HealthChoices, Pennsylvania's mandatory Medicaid managed care program since 1997. Governor Tom Wolf launched Pennsylvania's Medicaid expansion plan in April 2015. Since the launch, more than 485,000 new Pennsylvanians have enrolled in HealthChoices, which now provides health care coverage to more Pennsylvanians than ever before. "The interest that we are seeing from our existing managed care organizations (MCOs) and from national MCOs who have never chosen to do business with the commonwealth before is a sign we are on the right track," said Secretary Dallas. The department received 11 proposals, several of which bid on the entire state:

- Accenda Health (Capital Blue Cross)
- Aetna Better Health of Pennsylvania
- Gateway Health
- Geisinger Health
- Health Partners Plans
- Meridian Health Plan of Pennsylvania (Meridian Health Plan of Michigan)
- Pennsylvania Health and Wellness (Centene)
- Trusted Health Plan
- United Healthcare of Pennsylvania, Inc.
- UPMC for You
- Vista Health Plan as Keystone Family Health Plan and AmeriHealth Caritas Health Plans

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DHS Posts Addendum to Financial Management Services RFI. The Pennsylvania Department of Human Services (DHS) is evaluating the structure of the current financial management services (FMS) agreement in the Aging, Attendant Care, COMMCARE, Independence Waivers and Act 150 Program administered by the Office of Long-Term Living, as well as the Consolidated and the Person-Family Directed Support) Waivers administered by the Office of Developmental Programs. DHS is soliciting input on how to improve FMS and broaden DHS' perspectives regarding potential strategies and solutions to enhance participant choice, to enhance the quality and efficiency of this program, and to integrate FMS into the future managed long-term services and supports delivery system, known as Community HealthChoices. Read More

Pennsylvania Medicaid to Expand Health Home Pilot Program for Pregnant Women with Substance Abuse Disorders. During the first half of calendar year 2016, the Pennsylvania Medicaid program is planning to launch a new program designed to better coordinate care for pregnant women with substance abuse disorders. Under the pilot model, the health homes were reimbursed through existing Medicaid services. Moving forward in 2016, the physical health HealthChoices Medicaid managed care organizations (MCOs) will be required to develop their health home reimbursement structures for labor and delivery provider organizations. The physical health HealthChoices MCOs will be

allowed to set value-based purchasing reimbursement structures for the health homes. No details about these potential value-based arrangements are currently available. The HealthChoices physical health MCOs will collaborate with the behavioral health MCOs that manage Pennsylvania's carved out Medicaid behavioral health services. Though they are being called health homes, this program is not part of the national Medicaid health home program established by the Centers for Medicare and Medicaid Services (CMS) under provisions of the Patient Protection and Affordable Care Act. Read More

Highmark Wins Medicare Dispute with UPMC at Pa. Supreme Court. Pittsburgh-based UPMC must continue to provide in-network services to members of Highmark's Medicare Advantage plans, the Pennsylvania Supreme Court ruled. The ruling affirms a state judge's decision in May which said the system must remain an in-network provider for Highmark's Medicare Advantage plans through the term of a consent decree reached between the two battling organizations and state officials last year. Pennsylvania Governor Tom Wolf said in a statement Monday he was pleased with the decision, calling it a "victory for seniors across Western Pennsylvania." The decision comes about a week before the end of Medicare Advantage open enrollment. Read More

Children's Health Safety Net Expiring Unless Legislators Act by Year's End. Without reauthorization, Pennsylvania's Children's Health Insurance Program, or CHIP, expires on Dec. 31. About 150,000 children statewide are enrolled in CHIP, according to statistics from the state Insurance Department. Advocates say they want to make sure the reauthorization doesn't get lost in the end-of year scramble to finish a months-overdue state budget that could result in possible large overhauls of the state's pension and liquor systems. Two bills under consideration in the House and Senate would reauthorize CHIP for another two years, but the program will sunset at the end of the year unless legislation is signed into law. One of the bills also would streamline enrollment, and, advocates say, help enroll more children who currently are uninsured. Steve Miskin, a spokesman for House Republicans, said he expects the House will take up House Bill 1633 on Tuesday. If it passes, it would still need to pass the Senate. A spokesman for Governor Tom Wolf said the Democratic governor is hopeful that both bills will be passed by the end of the year. Read More

County Threatens to Withhold $6.5 Million in State Funds Amid Budget Standoff. Members of Delaware County Council said they may have to resort to withholding $6.5 million in funds normally sent to Harrisburg and redirect it toward local human services if the state budget impasses continues. "We are calling on Governor Wolf to pass a budget, as the state constitution requires him to do," Delaware County Councilman David White said on Wednesday. White said county officials are considering withholding the $6.5 million they collects in taxes and fees from Court Financial Services, the Sheriff's office, the Recorder of Deeds and the Office of Judicial Support, and redirect the funds toward county services, which have not received their share of state funding since July. Wolf Administration spokesman Jeff Sheridan said Wolf spoke with Republican lawmakers and has said a deal may be in place by Dec. 4. According to White, they've received approval from Pennsylvania Human Services to take $7.5 million from the HealthChoices managed care fund that usually covers mental health, drug and alcohol and medical assistance programs to use to pay for human services. The councilman said the county is also restricting travel, monitoring hiring and purchases and prioritizing payments. Read More

Washington

HCA Awards Molina and Community Health Plan Apple Health Medicaid Contracts. On November 18, 2015, the Washington State Health Care Authority announced that following a competitive bid process, Molina Healthcare of Washington and Community Health Plan of Washington will serve Apple Health Medicaid recipients. Apple Health will provide clients with physical health, mental health, and substance use disorder services through a single integrated health plan beginning in April 2016. HCA will finalize contracts by Dec. 31 that will be effective April 1, 2016. Read More

West Virginia

DHHR Agrees to Competitive Bids for Medicaid Managed Care Contracts. On November 20, 2015, the Department of Health and Human Resources agreed to the settlement of a lawsuit filed by five citizens who say the state is losing $100 million a year by not bidding its Medicaid managed care contracts. Following the settlement, the state will conduct a competitive bid process for all Medicaid managed care contracts as of the next state fiscal year, which begins July 2016. The settlement requires that contracts do not exceed 48 months and must have a medical loss ratio of 85 percent. The current Medicaid managed care contracts are with the Health Plan of the Upper Ohio Valley, Unicare (Anthem), CoventryCares (Aetna), and The Family Health Plan (Highmark). Read More

Wyoming

Governor Mead Continues to Push for Medicaid Expansion. On September 26, 2015, *Casper Star Tribune* reported that Governor Matt Mead is pushing to expand Medicaid again. He is asking the Joint Appropriations Committee and the Legislature to evaluate expansion. Mead said the state could receive a total of $60 million or $70 million. The Wyoming Department of Health is currently obtaining an estimate from the federal government. Mead will submit two Health Department budgets - one with expansion and one without – by Dec. 1. Read More

National

Congress Reviews Bill to Expand Medicaid Payments in Psychiatric Hospitals. On November 25, 2015, *CQ News* reported that Congress is reviewing a broad bill (HR 2646) that will overhaul the mental health system. The proposal is reviving a debate over whether treatment should be administered in the community or in institutions and reopening the question of whether states should be allowed to shift some of the financial cost of operating psychiatric hospitals to the federal government. The bill includes allowing psychiatric hospitals to bill Medicaid for up to 20 days of care each month for adult patients. The Congressional Budget Office estimated that it would cost between $40 billion and $60 billion in federal spending per decade. Read More

CMS Allowing States to Use Medicaid Money to Help House Homeless People and Those with Long-Term Disabilities. On November 23, 2015, *The Huffington Post* reported that states are turning to "housing first" strategies after

CMS released a policy statement in June allowing states to use Medicaid money to find and maintain permanent housing for the chronically homeless and those with long-term disabilities. States will be able to use funding on more services for the homeless, including constructing housing or paying rent. California and Washington already have signaled an interest in using Medicaid funds for supportive housing. Housing-first programs include services that help in identifying appropriate housing, assist with the application process and understanding the terms of a lease, and aid in moving into and furnishing a home. New York spent $34 million of state-only Medicaid dollars on capital housing projects for the homeless and other targeted groups this year. Read More

CMS Proposes Minimum Provider-Network Standards for ACA Plans in 2017. On November 20, 2015, *Modern Healthcare* reported that CMS proposed a rule mandating minimum provider-network standards for health plans to be sold on the marketplace in 2017 in response to the shift toward narrow provider networks. The rule asks states to establish a quantitative measure to ensure ACA policyholders have sufficient access to healthcare providers. If the state does not choose a standard, CMS proposed a default setting that measures adequacy by maximum travel times or distances to providers. Comments on the proposed rule are due by Dec. 21. Read More

Study Finds Hepatitis C Drugs Significantly More Likely to be Denied Under Medicaid. On November 20, 2015, *Kaiser Health News* reported that a University of Pennsylvania Perelman School of Medicine study found that hepatitis C prescriptions are more likely to get denied under Medicaid than under Medicare or private commercial policies. Medicaid denied payment for 46 percent of prescriptions, while only 5 percent were denied under Medicare and 10 percent under private insurance. Overall, insurers denied 16 percent of Hepatitis C prescriptions. The results were presented at the 2015 meeting of the American Association for the Study of Liver Diseases. Read More

CMS Developing Strategy to Increase Dual-Eligible Rates in 2016. On November 18, 2015, *Modern Healthcare* reported that CMS is developing a strategy to increase rates for dual-eligible plans sooner. When CMS revealed that it was underpaying health plans serving dual-eligibles, the agency noted that any raise wouldn't come until 2017. Now, the office hopes to increase payments in 2016. It is currently working out the logistics of providing the raise in the Financial Alignment Initiative and plans to retroactively enhance payments back to the beginning of 2016. Read More

INDUSTRY NEWS

Acadia Healthcare Acquires MMO Behavioral Health Systems. On December 2, 2015, Acadia Healthcare Company announced that it has acquired MMO Behavioral Health System, which operates two acute inpatient behavioral health facilities in Baton Rouge, Louisiana. MMO had revenues of approximately $16 million for the 12 months ending September 30, 2015. Read More

Molina Acquires Better Health Network in Cook County. On November 30, 2015, Molina Healthcare announced that it has entered a definitive agreement to acquire Better Health's Medicaid business in the state of Illinois. Molina will transition Better Health's Medicaid members in Cook County and assume certain assets related to the operation of the Medicaid business.

Molina Acquires a portion of HAP Midwest's Medicaid Business. On November 24, 2015, Molina Healthcare announced that it has entered a definitive agreement to acquire the Medicaid and MIChild assets of HAP Midwest Health Plan of Michigan in Region 9 and 10 of the state. HAP Midwest currently serves 85,000 Medicaid and MIChild members in these two regions. The transaction is expected to close on January 1, 2016. Read More

Blue Cross Complete to Acquire Medicaid Assets of Sparrow PHP. On December 1, 2015, *Crain's Detroit Business* reported that Sparrow PHP's 21,000 Medicaid members will be acquired by Blue Cross Complete effective January 1, 2016. Sparrow PHP was unsuccessful in winning a new contract with the state in the most recent procurement. Financial terms were not disclosed. Read More

Wellspring Capital Acquires AdvoServ from GI Partners. On November 24, 2015, GI Partners announced that it has completed the sale of AdvoServ, a behavioral healthcare provider, to WellSpring Capital. No financial terms were disclosed. AdvoServ specializes in clinical, educational and residential services for children and adults with severe intellectual and developmental disabilities and dual diagnoses. Read More

BCBS of Michigan Acquires ikaSystems. On November 25, 2015, Blue Cross Blue Shield of Michigan announced that it acquired ikaSystems Corp., a health insurance software vendor. Financial terms were not disclosed. ikaSystems serves Blue Cross' Medicare Advantage managed care plan and other health insurers nationally. It will become an independent subsidiary of Blue Cross and keep its existing management stuff. Read More

United CEO Says Entering Exchanges Was a Bad Decision. On December 1, 2015, *The Washington Post* reported that UntedHealth CEO Stephen Hemsley said that increasing the company's participation in the ACA's public insurance exchanges was a "bad decision." In 2015, United entered two-dozen state-based exchanges. Hemsley stated that the company should have waited to learn more about the new businesses before expanding. UnitedHealth lowered its 2015 outlook after experience steep losses from the exchanges. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
November, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
December 11, 2015	Pennsylvania MLTSS/Duals	DRAFT RFP Comments Due	450,000
December 22, 2015	Nebraska	Proposals Due	239,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 7, 2016	Indiana	Technical Proposals Due	900,000
January, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
March 1, 2016	Nebraska	Contract Awards	239,000
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
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)	450,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	450,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	450,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	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)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care (*exiting demo*); Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	30,000	X	5/12/2014	9/1/2014	7/30/2015	12/1/2015	2/1/2016	Neighborhood INTEGRITY
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	4/1/2016	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***12***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

Dual Eligible Financial Alignment Demonstration Enrollment Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active capitated model demonstration enrollment.

State	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
California	122,520	122,798	122,846	120,452	117,449	117,307	117,179
Illinois	58,338	55,672	52,763	52,170	50,631	49,586	49,038
Massachusetts	17,621	17,637	17,705	17,671	17,518	17,179	12,657
Michigan		9,216	14,867	28,171	35,102	42,728	37,072
New York	6,660	7,215	5,031	7,122	9,062	8,028	9,942
Ohio	63,625	63,446	62,958	61,871	62,418	59,697	61,428
South Carolina	1,398	1,366	1,317	1,388	1,380	1,530	1,355
Texas	15,335	27,589	37,805	44,931	56,423	45,949	56,737
Virginia	27,349	30,877	29,970	29,507	29,200	29,176	27,138
Total Duals Demo Enrollment	**312,846**	**335,816**	**345,262**	**363,283**	**379,183**	**371,180**	**372,546**

HMA NEWS

New this week on the HMA Information Services website:

- **West Virginia** Medicaid Managed Care Enrollment is Up 88 percent, Nov-15 Data
- **Indiana** Medicaid MCO Market Share, Oct-15 Data
- Public documents such as Medicaid FFS Provider Fee Schedules and the **New York** Performing Provider System Primary Care Plan Draft, Oct-15
- Plus upcoming webinars on "*Provider Network Adequacy Monitoring: Findings and Recommendations from the 2015 the RWJF-Funded Survey of States and Health Plans"* and "*Total Cost of Care Benchmarks and Physician Practices: An Early Stage Evaluation of 5 Regional Healthcare Improvement Collaboratives Funded by RWJF"*

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.