HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 6, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

MEDICAID MANAGED CARE SPENDING IN 2015

This week, our *In Focus* section reviews Medicaid spending data collected in the annual CMS-64 report. Specifically, we provide some analysis around the sharp acceleration in Medicaid managed care spending in federal fiscal year (FFY) 2015. This increase reflects the expansion of Medicaid under the ACA which began in January 2014 and a number of managed care implementations/expansions that occurred during the twelve-month period ending September 30, 2015.

Total Medicaid Managed Care Spending

Total Medicaid managed care spending (including the federal and state share) in FFY 2015 across all 50 states and 6 territories was $238 billion, up from $181 billion in FFY 2014. This figure includes spending on comprehensive risk-based managed care programs as well as prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs). PIHPs and PAHPs refer to non-comprehensive prepaid health plans that provides only certain inpatient (PIHPs)

or outpatient (PAHPs) services, such as dental services or behavioral health care. Fee-based programs such as primary care case management (PCCM) models are also counted in this total. Below we highlight some key observations:

- Total Medicaid managed care spending grew 31.2 percent in FFY 2015, the largest single year increase in the last ten years and an acceleration from 27.8 percent in FFY 2014.
- Medicaid managed care spending has increased at a double digit annual growth rate every year since FFY 2006/2007.
- In dollar terms, the increase from FFY 2014 to FFY 2015 was $56.7 billion, more than was spent in total on Medicaid managed care in FFY 2006.
- Medicaid managed care spending has increased at an 18.0 percent compounded annual growth rate (CAGR) since FFY 2006, compared to 6.5 percent growth in total Medicaid spending.
- Medicaid managed care spending represented 45.3 percent of total Medicaid spending in FFY 2015. Since FFY 2009, the year prior to the passage of the Affordable Care Act (ACA), Medicaid managed care spending as a percentage of total Medicaid spending has more than doubled.
- The growth in Medicaid managed care spending in FFY 2014 and 2015 was attributable to four key factors:

    1. **Existing Managed Care Program Expansions:** The most impactful driver of spending growth in FFY 2015 was the impact of managed care program expansions in states that added benefits and/or eligibility categories to existing program designs on a mandatory basis. Most significant was the expansion of managed long term care (MLTC) programs in FFY 2015 either in coordination with CMS through a dual eligible demonstration pilot or independently.
    2. **Medicaid Expansion:** Since the federal fiscal year ends September 30, FFY 2015 Medicaid managed care spending figures include one incremental quarter of spending attributable to Medicaid expansion under the ACA in the states that adopted Medicaid expansion in January 2014 as compared to the FFY 2014 figures. The FFY 2015 figures also reflect spending increases in one state that implemented the Medicaid expansion in 2015 (we note that Pennsylvania and Indiana which expanded eligibility in 2014 did not do so through Medicaid).
    3. **New Programs/Elimination of Competing Programs:** In FFY 2015 only one state, New Hampshire, experienced rapid growth due to the implementation of a newly designed Medicaid managed care program (launched in December 2013) from a fee-for-service (FFS) delivery model. However a number of states including Illinois, Louisiana, Florida and Puerto Rico replaced fee-based care management models with risk-based managed care in FY 2015.
    4. **Health Insurance Provider Fee:** We estimate the health insurance provider fee contributed approximately 2 percent to Medicaid MCO spending in FFY 2014 and a smaller percentage increase in FFY 2015.

Medicaid MCO Expenditures as a Percentage of Total Medicaid Expenditures FFY 2006-2015 ($M)

$M	FFY 06	FFY 07	FFY 08	FFY 09	FFY 10	FFY 11	FFY 12	FFY 13	FFY 14	FFY 15	CAGR
Medicaid MCO expenditures*	$53,522	$60,663	$71,318	$78,644	$90,394	$102,478	$120,325	$141,998	$181,421	$238,089	18.0%
% y/y		*13.3%*	*17.6%*	*10.3%*	*14.9%*	*13.4%*	*17.4%*	*18.0%*	*27.8%*	*31.2%*	
Total Medicaid expenditures	$299,009	$311,014	$337,055	$356,285	$381,615	$406,459	$408,850	$432,944	$467,426	$525,772	6.5%
% y/y		*4.0%*	*8.4%*	*5.7%*	*7.1%*	*6.5%*	*0.6%*	*5.9%*	*8.0%*	*12.5%*	
% of Total	**17.9%**	**19.5%**	**21.2%**	**22.1%**	**23.7%**	**25.2%**	**29.4%**	**32.8%**	**38.8%**	**45.3%**	

**Includes Prepaid Ambulatory Health Plans and Prepaid Inpatient Health Plans*

Source: CMS-64

The data breaks down the state and federal share of Medicaid expenditures which illustrates the impact that the Medicaid expansion, which has been 100 percent federally funded in the states in which it has been adopted, has had on the sources of funding.

As the table below indicates, 62.9 percent of FFY 2015 spending was contributed by federal sources which is 5.5 percentage points higher than the pre-Medicaid expansion share in FFY 2013.

Federal vs. States Share of Medicaid Expenditures, FFY 2012-2015

$M	FFY 12	FFY 13	FFY 14	FFY 15
Federal Share	$235,070	$248,641	$281,269	$330,708
% of Total	*57.5%*	*57.4%*	*60.2%*	*62.9%*
State Share	$173,780	$184,303	$186,157	$195,063
% of Total	*42.5%*	*42.6%*	*39.8%*	*37.1%*
Total	**$408,850**	**$432,944**	**$467,426**	**$525,772**

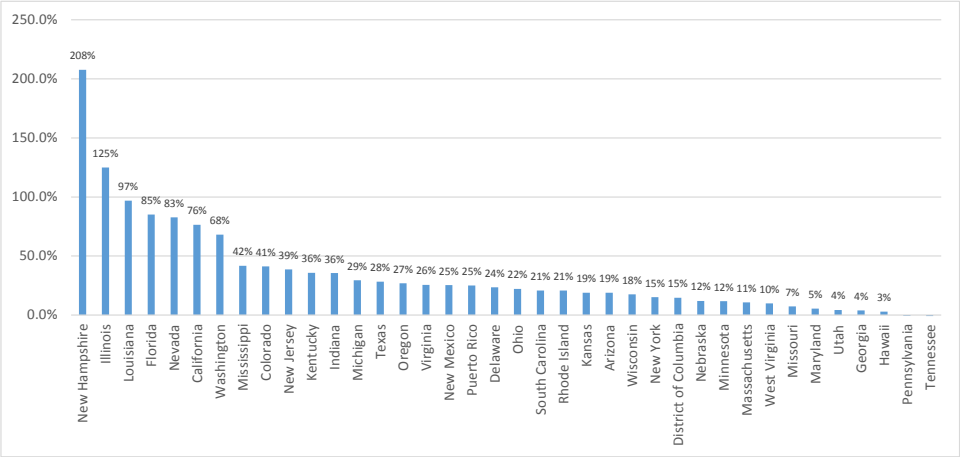
Source: CMS-64

State-specific Growth Trends

Fourty-three states report MCO spending on the CMS-64 report of which five states (Iowa, Idaho, North Carolina, Oklahoma and North Dakota) utilize a PCCM and/or PIHP/PAHP models exclusively. Of the remaining 38 states that contract with risk-based MCOs, average spending growth in FFY 2015 increased 35.1 percent. On a percentage basis, New Hampshire experienced the highest year over year growth in Medicaid managed care spending at 208 percent attributable to its Medicaid expansion and the roll-out of its managed care program which began in December 2013. Illinois' progress toward achieving 50 percent Medicaid managed care penetration as stipulated by legislation passed in 2011 drove a 125 percent increase there, while Louisiana replaced its shared shavings model with risk-based managed care in 2014. The roll-out of Florida's statewide managed care program for acute and long-term care services began in 2013 but the staggered roll-out resulted in 85 percent growth from FFY 2014 to FFY 2015. Carving long term services and supports into the managed care benefit package contributed to above average growth in California and New Jersey.

The chart below provides additional detail on Medicaid managed care spending growth in states with risk-based managed care programs in FFY 2015. Interestingly, all states experienced year over year growth in spending except Pennsylvania and Tennessee which experienced very slight (<1 percent) reductions.

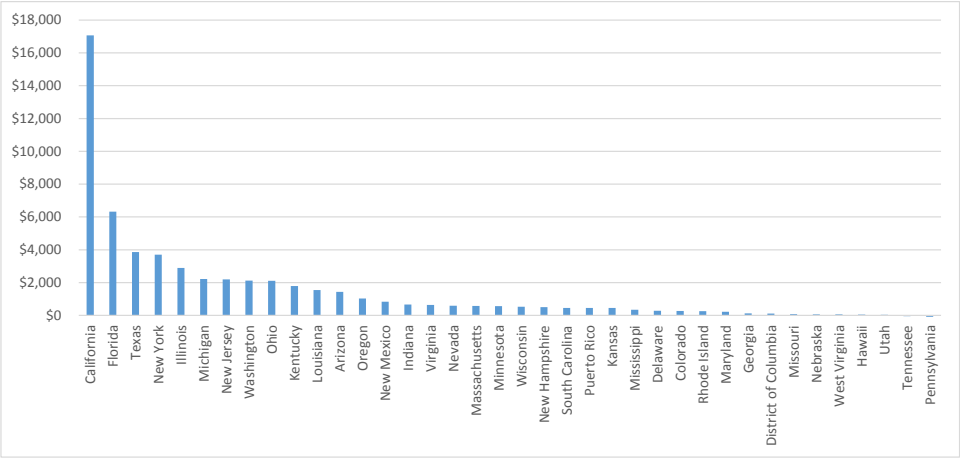
Medicaid Managed Care Spending Growth on a Percentage Basis by State FFY 2014-15



Source: CMS-64

Looking at year over year spending growth in dollar terms, California's Medicaid expansion and the carve-in of long term services and supports (LTSS) to managed care in the counties in which the dual eligible demonstration pilot (CalDuals) is being implemented drove a $17 billion increase in managed care spending. This represents 30 percent of the total year over year increase in Medicaid MCO spending nationally. Other states with significant year over year spending increases in dollar terms included Florida ($6.3B), Texas ($3.9B), New York ($3.7B), Illinois ($2.9B), Michigan ($2.2B), New Jersey ($2.2B), Washington ($2.1B) and Ohio ($2.1B). Nearly all of these states expanded existing managed long term care programs or implemented new ones over the measurement period either independently (Florida, New Jersey) or in conjunction with their participation in a dual eligible demonstration pilot (Texas, New York, Illinois, Michigan, Ohio).

Medicaid Managed Care Spending Growth on a Dollar Basis by State FFY 2014-15 ($M)



Source: CMS-64

The percentage of Medicaid expenditures directed through risk-based Medicaid MCOs increased by more than ten percentage points in seven states from FFY 2014 to FFY 2015. Florida led the pack with a 27.8 percent increase to 64.8

percent of Medicaid spending followed by a 25 percent increase in New Hampshire and a 17.3 percent increase in Louisiana. An additional twelve states experienced a five to ten percentage point increase in FFY 2015.

Medicaid MCO Expenditures as a Percentage of Total Medicaid Expenditures in States with a 10 percent or Greater Increase From FFY 2014 to FFY 2015 ($M)

	FFY 2014			FFY 2015			
Medicaid Expenditures	MCO	Total	% of Total	MCO	Total	% of Total	Change in % of total
Florida	$7,427	$20,071	37.0%	$13,752	$21,211	64.8%	27.8%
New Hampshire	$243	$1,323	18.4%	$747	$1,716	43.5%	25.2%
Louisiana	$1,594	$7,056	22.6%	$3,139	$7,863	39.9%	17.3%
Illinois	$2,313	$16,616	13.9%	$5,201	$16,938	30.7%	16.8%
California	$22,321	$63,384	35.2%	$39,394	$84,983	46.4%	11.1%
Nevada	$713	$2,281	31.3%	$1,303	$3,106	42.0%	10.7%
New Jersey	$5,667	$12,470	45.4%	$7,862	$14,049	56.0%	10.5%
Delaware	$1,219	$1,692	72.0%	$1,506	$1,860	81.0%	8.9%

Source: CMS-64

The table below ranks the 38 states with risk-based comprehensive Medicaid managed care programs by the percentage of total Medicaid spending that is through Medicaid MCOs. Puerto Rico reported the highest such percentage at 99.3 percent, followed by Kansas at 94.3 percent and Hawaii at 88.4 percent. We note that in many states, there are certain payment mechanisms which may never be directed through managed care such as supplemental funding sources for institutional providers and spending on retroactively eligible beneficiaries. As such, the maximum acheivable penetration rate in each state will vary and may be below that achieved in these states. Nevertheless, we note that there are a number of large states that are committed to moving as much program administration and spending through managed care as they can where the penetration rates are currently below two-thirds of the total including Florida, Michigan, New Jersey, Ohio, Texas, New York and California. Accordingly, we expect that in FFY 2016 we will see continued growth in Medicaid MCO penetration, though likely at a more moderate pace.

Medicaid MCO Expenditures as a Percent of Total Medicaid Expenditures, FFY 2014-2015

Rank	State	2014	2015	Rank	State	2014	2015
1	Puerto Rico	98.4%	99.3%	20	New York	46.2%	48.7%
2	Kansas	87.5%	94.3%	21	California	35.2%	46.4%
3	Hawaii	86.3%	88.4%	22	South Carolina	41.4%	46.1%
4	Arizona	82.7%	85.1%	23	Wisconsin	41.0%	45.2%
5	New Mexico	79.1%	84.1%	24	Maryland	43.7%	45.1%
6	Delaware	72.0%	81.0%	25	New Hampshire	18.4%	43.5%
7	Kentucky	64.1%	71.9%	26	Nevada	31.3%	42.0%
8	Tennessee	66.8%	67.1%	27	Louisiana	22.6%	39.9%
9	Florida	37.0%	64.8%	28	Virginia	33.4%	39.4%
10	Michigan	55.9%	61.6%	29	District of Columbia	33.6%	38.5%
11	Oregon	56.8%	60.9%	30	Massachusetts	37.3%	38.3%
12	Rhode Island	50.1%	57.1%	31	Georgia	35.2%	35.6%
13	New Jersey	45.4%	56.0%	32	Nebraska	31.7%	34.1%
14	Pennsylvania	54.6%	54.8%	33	Illinois	13.9%	30.7%
15	Ohio	48.8%	54.1%	34	Indiana	20.5%	27.3%
16	Texas	43.4%	50.4%	35	Mississippi	16.9%	22.8%
17	Minnesota	48.8%	50.1%	36	West Virginia	17.8%	17.9%
18	Washington	44.0%	49.8%	37	Colorado	11.2%	12.8%
19	Utah	49.2%	49.3%	38	Missouri	12.0%	12.0%

Source: CMS-64

Non-MCO Expenditures

As illustrated above, despite the rapid growth in Medicaid managed care over the last ten years, program spending still represented less than half of total Medicaid expenditures in FFY 2015. So where is the remaining FFS spending (approximatley $287 billion) going? First, as noted above, there are many states/territorires with Medicaid managed care programs where certain beneficiaries or services are carved-out of the program and these are typically associated with high cost populations. The total amount of non-MCO spending in these 38 states in FFY 2015 was $241 billion. If we were to assume for the sake of argument that "full penetration" was 85 percent of total Medicaid spending, then we estimate that an additional $170 billion could migrate to a managed care model just in the states that already employ managed care for a subset of services and/or beneficiaries.

Next, there are 18 states/territories that did not utilize a comprehensive risk-based managed care model in FFY 2015. One of these states, Iowa, is implementing a statewide program later this year and two others, Oklahoma and North Carolina, are in early stage planning. In general, the 18 states/territories that do not utilize managed care today are smaller states, North Carolina being the largest at $13 billion of Medicaid spending in FFY 2015. Total Medicaid spending across all 18 non-managed care states was $50 billion. The 18 states/terrirtories that did not employ a risk-based comprehensive Medicaid managed care model in FFY 2015 were Alabama, Alaska, Amer. Samoa, Arkansas, Connecticut, Guam, Iowa, Idaho, Maine, Montana, N. Mariana Islands, North Dakota, North Carolina, Oklahoma, South Dakota, Vermont, Virgin Islands and Wyoming.

Finally, in terms of spending by service line, the largest remaining FFS category is inpatient services at $73 billion or 25.5 percent of FFS spending. This amount is split fairly evenly between regular FFS payments and supplemental/DSH funding sources. Measured as whole, however, we estimate long term care services and supports (including nursing facility, waiver and other home and community based services) represent the largest FFS funding category at $115 billion or 40 percent of the total.

FFS Medicaid Expenditures by Service Line, FFY 2015

Service	FFY 2015 FFS Spending	% of FFS Spending
Inpatient Services*	$73,419	25.5%
Home and Community Based Services	$48,953	17.0%
Nursing Facility*	$45,395	15.8%
Outpatient Services*	$16,239	5.6%
Physician and Surgical Services*	$11,158	3.9%
Medicare - Part B	$10,586	3.7%
Intermediate Care	$8,990	3.1%
Clinic Services	$5,700	2.0%
Personal Care Services	$5,181	1.8%
Federally-Qualified Health Center	$4,313	1.5%
Dental Services	$4,199	1.5%
Other	$53,551	18.6%
Total	**$287,683**	

** Includes regular payments, supplemental payments and DSH if applicable*

Source: CMS-64

Finally, we note that while the CMS-64 report provides valuable detail by service line for all FFS expenditures, it does not capture how spending directed to Medicaid MCOs is allocated to providers. As such, it is not possible to calculate total spending by service line, a challenge that will only intensify as more spending runs through MCOs. Given this challenge, we anticipate that over time CMS will refine its managed care data reporting requirements to better capture MCO expenditures by service category.

HMA Medicaid Roundup

Alabama

Alabama Health Care Improvement Task Force Recommends Finding a Way to Provide Coverage to Uninsured. On December 17, 2015, *Becker's Hospital Review* reported that the Alabama Health Care Improvement Task Force, assembled by Gov. Robert Bentley, approved a recommendation to find a way to provide coverage to uninsured residents. The recommendation does not explicitly propose Medicaid expansion but includes a two-page paper outlining additional benefits Medicaid would yield. Read More

Arkansas

Arkansas Task Force Votes Against Pursuing Medicaid Managed Care. On December 16, 2015, the Arkansas Health Reform Legislative Task Force voted to direct the state's consultant (The Stephen Group) to identify $835 million in Medicaid savings over the next five years without capitated, full-risk managed care. The state had previously conducted a request for information (RFI) process around capitated managed care for the ABD, LTSS, and other high-cost Medicaid populations. The Task Force also voted in support of the Governor's effort to negotiate with CMS on waivers to support the Arkansas Works framework. Read More

California

HMA Roundup – Don Novo (Email Don)

CMS Approves Five-Year, $6.2 Billion 1115 Waiver. On December 4, 2015, *California Healthline* reported that CMS approved a five-year, $6.2 billion 1115 waiver for California, effective Jan 1. The waiver, called Medi-Cal 2020, includes:

- $3.27 billion in performance incentives for public hospitals
- $1.5 billion over five years for the Whole Person Care pilot program
- $1.4 billion for the Global Payment Program Pilot
- Funding for dental system reforms in the Dental Transformation Incentive Program

The waiver can be found here. Read More

Gov. Brown's Budget Proposal to Address Medi-Cal Funding. On January 6, 2015, *California Healthline* reported that Gov. Jerry Brown's fiscal year 2016-17 budget proposal will likely address several health priorities, including Medi-Cal funding. The Legislature adjourned for 2015 without passing a bill to restructure

the managed care organization tax, leaving a $1.1 billion hole in the budget. The tax is set to expire in June. Without a replacement, officials stated that it could force offsetting cuts in the upcoming budget proposal. Additionally, advocates predict the budget proposal will address managed care to seniors and people with disabilities, and Medi-Cal estate recovery. Read More 2

Adventist Health Partners with Community Medical Centers To Launch Medi-Cal HMO. On December 18, 2015, *Sacramento Business Journal* reported that Adventist Health reached an agreement on a joint venture with Community Medical Centers to launch a Medi-Cal HMO in the San Joaquin Valley in 2016. The HMO may deliver care for up to 200,000 patients within two years of launch. The agreement is subject to state approval. Read More

Colorado

ColoradoCareYES Single-Payer Health System to be on 2016 Ballot. On December 21, 2015, *Kaiser Health News* reported that the ColoradoCareYes group gathered enough signatures to put a single-payer health system on the ballot for 2016. The single-payer health system would require employers to pay a 7 percent payroll tax and employees to pay 3 percent. The self-employed would need to cover the entire 10 percent. The tax hike would raise approximately $25 billion to provide health care to everyone with no deductibles, and fewer and smaller copays. A group called Advancing Colorado is opposing the single-payer ballot measure. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Chief Insurance Regulator, Kevin McCarty, Resigns. On January 5, 2015, *Miami Herald* reported that Florida's chief insurance regulator, Kevin McCarty, will resign effective May 2. McCarty said he will be able to review all insurance legislation out of the 2016 session and make recommendations to Gov. Rick Scott. Scott attempted to remove McCarty last year, as well as state agency head of the Department of Revenue, Marshall Stranburg and chief banking regulator Drew Breakspear. McCarty's resignation follows the departure of Stranburg. Read More

Lawmakers to Discuss Keeping Medicaid Costs Under Control, Increasing Access in Legislative Session. On January 2, 2015, *Naples Daily News* reported that lawmakers will spend this year's Legislative session discussing ways to keep Medicaid costs under control and will not be fighting over expanding the program. Currently, Medicaid is the largest single program expense in the state, making up over 31 percent of all spending. House Health Care Appropriations Subcommittee Chairman Matt Hudson said lawmakers this year would try to reduce Medicaid costs by making medical help easier to access. Florida's proposed Medicaid budget for 2017 is $24.7 billion; $9.8 billion of which are state funds. Read More

Audit Finds Medicaid Managed Care Plans Overpaying Hospitals. On December 22, 2015, *Politico Florida* reported that an audit found that Medicaid managed care plans had paid hospitals more than what is allowed under a 2011 law. A total of 2,835 agreements and payment arrangements were reviewed between hospitals and HMA. About 38 percent violated a law limiting hospital

payments to 120 percent of Medicaid. To go beyond the cap, the HMOs needed approval from the Agency for Health Care Administration, but none received it. Further audits for specific providers have been opened. The Florida Association of Health Plans president and CEO, Audrey Brown, stated the HMOs are currently in compliance with the requirements. Read More

Georgia

Judge Orders State Officials to Speed Efforts on Reaching Georgia-DOJ Settlement Deal Agreement. On December 17, 2105, *Georgia Health News* reported that federal judge Charles Pannell told state officials to increase efforts to improve Georgia's system for people with mental illness and developmental disabilities. Georgia, under a five-year settlement agreement with the U.S. Department of Justice, agreed to end all admissions of people with developmental disabilities to state psychiatric hospitals and move those already in the hospitals out. However, a September 2015 report described the state's lack of progress. Read More

Idaho

Lawsuit Filed Against Idaho Department of Health and Welfare Over Medicaid Reimbursement Cuts. On December 30, 2015, *KBOI* reported that eight providers and two patients have filed a lawsuit against the Idaho Department of Health and Welfare seeking to halt the Medicaid reimbursement cuts on in-home care for the developmentally disabled. In December the state announced that it will delay the cuts until February, previously set to start in January. Providers would see cuts ranging from about 37 to 46 percent, based on the level of support. The state said it costs taxpayers $1 million a month to delay the change. Read More

Iowa

Judge Denies Iowa Hospital Association's Request to Delay Medicaid Program Transition. On December 31, 2015, *Quad-City Times* reported that a district judge denied Iowa Hospital Association's request for a temporary injunction to delay the Medicaid transition to managed care. The Iowa Hospital Association raised questions over the legality of a transfer of fees to the managed care program in the original filing. However, the judge stated that, "there is no longer any present need for some extraordinary remedy to maintain the status quo of the parties prior to final judgment or to protect the subject of this litigation." He said that CMS' decision to delay implementation from Jan. 1 to March 1 will allow Iowa to bring its statues and regulations in compliance with the new model. Read More

Kansas

KanCare Forum Explores Conservative Approaches to Medicaid Expansion, Including Premiums and Co-pays. On January 5, 2016, *KCUR* reported that a forum on expanding the Kansas Medicaid program looked at conservative approaches to waivers, using Indiana's program as an example. One idea was to have recipients pay premiums and co-pays. Enrollees who failed to pay their

share of monthly premiums face added co-pays and other fees. Another idea was to pay providers Medicare rates. It is unclear if the Kansas Legislature will hold committee hearings on Medicaid expansion in the session. If it comes up for debate, it is not expected to pass. Read More

Lawmakers Propose Dropping Medicaid for Some Hepatitis C Patients. On January 1, 2016, *The Kansas City Star* reported that the KanCare Oversight Committee is recommending to remove hepatitis C patients who drink alcohol or stop using medication from Medicaid. The panel also recommended that the state use step therapy to begin patients on cheaper medication and move to more expensive treatment only after the cheaper medication has proven to have failed. This is currently not legal in the state. Read More

Kentucky

Gov. Bevin Announces Plans to Develop Transformative Medicaid Program Waiver for 2017. On December 30, 2015, *WTVQ* reported that Governor Matt Bevin enlisted Mark D. Birdwhistell, former Secretary of the Cabinet for Health and Family Services, to assemble a group of experts to draft and evaluate a Medicaid waiver. Bevin stated the Medicaid overhaul plan for 2017 will be a "transformative" program. There are currently 400,000 residents who receive coverage under expansion. Bevin's platform promised to dismantle the Medicaid program. Read More

Louisiana

Lawmakers Approve $46 Million Medicaid Billing Contract Extension for Molina. On December 17, 2015, *KATC.com* reported that lawmakers approved a $46 million, one-year contract extension for Molina Information Systems through Dec. 31, 2016. Without the extension, payments to doctors, hospitals, and other providers of Medicaid services would have stopped Jan 1. Health and Hospitals Secretary Kathy Kliebert said her agency was still working on a public bid process to select new contractors. Read More

Michigan

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

Michigan Approves Waiver to Continue Medicaid Expansion. On December 17, 2015, *Crain's Detroit Business* reported that Michigan secured a waiver to continue Medicaid expansion. Approximately 600,000 residents receive coverage through expansion. Beginning in April 2018, Medicaid enrollees between 100 and 133 percent of the poverty line will have to engage in one of a number of healthy behaviors or buy private insurance through the federal health exchange. A grace period will be given to new enrollees. Additionally, healthy behavior or annual health risk behavior assessments will be rewarded with lower copays and contributions. Read More

Nebraska

Nebraska Medicaid RFP Bidders Publicized. On January 5, 2016, Nebraska published a list of six bidders on the state's RFP for statewide Medicaid managed care integrating physical, behavioral, and pharmacy services. The bidders are:

- AmeriHealth Caritas
- Aetna
- Meridian Health Plan
- Nebraska Total Care (Centene)
- UnitedHealthcare
- WellCare

Contract awards are anticipated in March, with contracts taking effect on January 1, 2017. We previously reviewed the Nebraska RFP in our November 4, 2015, Weekly Roundup, available here.

New Hampshire

New Hampshire to Receive Up to $150 Million to Treat Addiction and Mental Illness Over Five Years. On January 5, 2016, *NHPR* reported that New Hampshire will receive up to $30 million a year for five years for mental health and addiction from the federal government. Gov. Maggie Hassan and DHHS officials hope to create new regional collaboration networks that build addiction treatment capacity throughout the state. Public meetings regarding the funds will begin later this month. Read More

Lawmakers Increase Medicaid Copayments. On Jan. 1, Medicaid copayments will increase for people who make more than 100 percent of the federal poverty limit. The change will affect roughly one-third of the more than 40,000 residents enrolled in the state's Medicaid expansion program and 5,500 residents enrolled in traditional Medicaid. Co-payments for mental health and substance abuse inpatient services will be hit hardest. Rep. Mary Jane Wallner stated that the more than doubled co-pays for substance abuse services will be a barrier to treatment. State officials predict drug overdose deaths will top 400 in New Hampshire this year. Read More 2

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Issues Two Medicaid RFPs. On December 17th and 18th, 2015 the state's Procurement Bureau issued RFP #17-X-23318 and #16-X-24130 on behalf of the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) to solicit proposals for a Health Benefits Coordinator and a non-emergency medical transportation broker.

- **Health Benefits Coordinator RFP for its Medicaid managed care program.** On December 18, 2015 the state's Procurement Bureau issued RFP #16-X-24130 to solicit proposals for a Health Benefits Coordinator (HBC) for the Medicaid managed care program. Among its responsibilities, the HBC is responsible for screening and processing applications, determining eligibility for NJ FamilyCare, providing

customer call center operations, developing and collecting premium, and providing marketing, outreach and education. This is a re-procurement of the current HBC contract with Xerox, which is set to expire on December 31, 2015. The state projects that there will be close to 1.7 million Medicaid enrollees in New Jersey in January 2016. Proposals are due by February 3, 2016 at 2:00 pm. Information about this RFP can be found here.

- **Non-emergent Medical Transportation Broker RFP for Medicaid beneficiaries.** On December 17, 2015 the state's Procurement Bureau issued RFP #17-X-23318 to solicit proposals for a statewide non-emergent medical transportation broker to arrange for non-emergency medical transportation for all Medicaid managed care and fee-for-service enrollees. These include livery, mobility assistance vehicle transportation services, air transportation services, basic life support, ground ambulance services, and routine specialty care services. Among its responsibilities the broker will be expected to maintain and pay a provider network; determine the appropriate mode of transport; dispatch vehicles for transport; and develop a quality assurance program. This is a re-procurement of the current contract with Logisticare, which is set to expire on June 30, 2016. The current volume of non-emergency medical transports is 366,136 per month by 172 transportation providers per month, on average. Proposals are due by February 10, 2016 at 2:00 pm. Information about this RFP can be found here.

Division of Developmental Disabilities (DDD) Issues Mandatory Staff Training Quick reference Guide. On December 21, 2015 and 18th, 2015 the Department of Human Services, DDD disseminated a guide that details the updated training requirements for new and current employees. The guide includes the mandatory training topics, services to which they apply, completion timeframe, and entities to which the training applies. Training topics include, for example: 1) prevention of abuse, neglect and exploitation; 2) provider orientation on cultural competence, individual rights and working with families; 3) support coordination modules; and 4) positive behavioral support and functional assessment. A copy of the training guide can be found here.

Horizon's New OMNIA Plan Can Proceed on Schedule. On December 24, 2015 NJBIZ reported that a New Jersey court denied an injunction in the rollout of a new Horizon Blue Cross Blue Shield plan that will introduce a tiered provider network. OMNIA Health Plans is scheduled to begin operating on January 1, 2016. A hearing will be scheduled in early 2016 to provide St. Peters University Hospital with an opportunity to argue its claim of a breach in contract by Horizon.

New York

HMA Roundup – Denise Soffel (Email Denise)

Delay in Behavioral Health Home and Community Based Services. As part of NY's behavioral health carve-in and the development of a Medicaid managed care product designed for individuals with serious mental illness and/or substance use disorders, a new set of home and community based services will be offered. Implementation of Behavioral Health Home and Community Based Services (BH HCBS) for the HARP population in NYC began January 1, 2016, allowing a 3 month time period between the implementation of non-HCBS behavioral health services in both mainstream plans and HARPs and the implementation of BH HCBS. The timeline for the implementation of Behavioral Health Home and Community Based Services for the HARP population for the non-NYC, rest of state counties has been delayed from July 1, 2016 to October 1, 2016 to follow the implementation timeline for NYC. The date of the implementation of non-HCBS behavioral health services in managed care in Rest of State has not changed and is on schedule for July 1, 2016. For more information about the timeline for the behavioral health transition to managed care, please visit the following webpage: http://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health/index.htm

NYS Releases RFP for DSRIP Evaluation. The NYS Department of Health has released an RFP for an independent evaluator to provide evaluation of the Delivery System Reform Incentive Payment Program. The evaluation is meant to address the following questions:

1. To what extent did PPSs achieve health care system transformation?
2. Did health care quality improve as a result of clinical improvements in the treatment of selected diseases and conditions?
3. Did population health improve as a result of implementation of the DSRIP initiative?
4. Did utilization of behavioral health care services increase as a result of DSRIP?
5. Was avoidable hospital use reduced as a result of DSRIP?
6. Did DSRIP reduce health care costs?
7. What were the successes and challenges with respect to PPS planning, implementation, operation and plans for program sustainability from the perspectives of DSRIP planners, administrators and providers, and why were they successful and challenging?

Proposals are due by March 1. While the evaluators are to provide annual summaries of major DSRIP evaluation results, the final report is not due until March 2012, a full year after the demonstration has ended. The RFP can be found on the DoH website.

VillageCare Selling Licensed Home Care Service Agency. VillageCare, a community-based, not-for-profit organization serving people with chronic care needs, as well as seniors and individuals in need of continuing care and rehabilitation services, is selling its home care subsidiary, Village Care Plus, to All Metro Health Care. Village Care Plus, a licensed home care service agency,

provides home health aides and personal care services. VillageCare is retaining its certified home health agency, which provides skilled nursing care. All Metro Health Care is a for-profit home health care provider that operates in New York, New Jersey and Florida. The deal is expected to close in early March.

Albany Medical Center and Columbia Memorial Health Finalize Affiliation Agreement. Albany Medical Center and Columbia Memorial Health (CMH) announced the finalization of an affiliation between the two organizations. The agreement, which has been in development for more than a year, was approved by the state Public Health and Health Planning Council in October. The affiliation is structured to enhance the complementary strengths of both organizations and enable coordinated planning. In addition to providing better access to primary and specialty care services for the broader region, the agreement will yield a better experience for patients who use both Albany Med and CMH services, allowing for a more seamless transfer of information and enhanced coordination between the two organizations.

Albany Med, a 734-bed facility, provides advanced medical treatments as the region's tertiary care center, in addition to routine care, and serves as the trauma center for a 25-county region. CMH is a single site community hospital that has transformed itself into a multi-specialty health system, including a network of more than 40 outpatient services at 13 locations. The agreement provides for Albany Med and CMH to each retain their own distinct boards of directors/trustees, executive leadership teams, medical staffs and employees.

North Carolina

11 Hospital Systems Collaborate on Potential Medicaid-only Prepaid Health Plan. On December 28, 2015, *Winston-Salem Journal* reported that 11 hospital systems are collaborating in a potential provider-led and owned prepaid health plan to cover Medicaid in the state's urban areas. The plan is a response to the Medicaid reform legislation approved by the North Carolina General Assembly. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Many Psychiatric Beds Off Limits to Medicaid Patients. On December 29, 2015, *The Columbus Dispatch* reported that a large disparity exists between private and Medicaid patients. An old federal law dating back half a century states that private hospitals with at least 16 psychiatric beds cannot care for Medicaid enrollees who are 21 to 64 years old. The policy has become a significant barrier for Medicaid patients, putting most beds off limits. Meanwhile, local nonprofit hospitals have been reluctant to add inpatient psychiatric beds, which are not as profitable as other inpatient health care services. CMS has proposed a rule that would allow managed-care organizations to pay free-standing psychiatric hospitals for stays of up to 15 days. The proposed rule change might be finalized by spring, and industry officials hope that Ohio Medicaid might begin reimbursement in 2017. Read More

Petition Submitted to Limit State Costs on Prescription Drugs. On December 28, 2015, *The Columbus Dispatch* reported that a petition was submitted by the AIDS Healthcare Foundation to bring the Ohio Drug Price Relief Act to the Ohio

General Assembly. The statute would require the state and state-funded agencies to pay no more for prescription drugs than the lowest price paid by the U.S. Department of Veterans Affairs. Michael Weinstein, the president of the AIDS Healthcare Foundation, the world's largest provider of drugs and health care for HIV/AIDS, is pushing issues in California and Ohio to rein in drug prices. He stated that the exorbitant drug prices are hurting everyone but the drug makers' bottom lines. He believes the group will need to raise more signatures to put the issue to voters in Nov. 2016 ballot, if the state lawmakers do not enact the proposal. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medicaid Expansion Approaches One-Year Anniversary in Pa. Expanding Medicaid was one of Governor Tom Wolf's significant moves in his first year. More than a half million people have since signed up. In this radio interview, WITF's Ben Allen sits down with Department of Human Services Secretary, Ted Dallas, for his perspective as the expansion approaches its one-year anniversary. Secretary Dallas also discusses CHIP, the Children's Health Insurance Program, which covers about $150,000 kids in low-income families. The human services agency will soon be in charge of oversight, after legislators and Governor Tom Wolf approved moving CHIP from the Department of Insurance. Secretary Dallas also released a statement further elaborating on the shift from paying for services to paying for outcomes. He emphasized investments in accountable care organizations, bundled payments, patient centered medical homes and other performance-based payments. Read More

Pa. to Help Ease Transition for Inmates Addicted to Drugs. When a person goes to state prison, they lose Medicaid benefits -- and it can take up to 30 days to get them re-enrolled in the program when they are released. Department of Human Services Secretary Ted Dallas says if his agency can reduce or eliminate that waiting period, it'll be easier for people addicted to drugs to get help. That can include inpatient or outpatient care, counseling, or vital medication. Dallas says the change should happen by the middle of this year and would essentially be suspending the Medicaid benefit rather than cancelling it. Dallas says it will take complicated IT changes to make the switch work, but didn't know what it might cost. The state plans to expand the program to county jails as well, but he admits it will be more complicated because of the rapid turnover in county facilities. The Department of Corrections estimates about 12 percent of inmates in state prison are addicted to drugs. Read More

Stopgap Budget Releases Nearly $3.3 Billion in Back Payments. Following Gov. Tom Wolf's signing of a $23.4 billion emergency funding plan on Tuesday, the Pennsylvania Treasury began the work of processing approximately 16,400 payment requests from the governor's budget office. The Pennsylvania Treasury is moving fast to disburse nearly $3.3 billion in back payments to school districts, counties and human service organizations. Treasury officials expect the first payments to be received by the middle of next week. They include payments to school districts, Head Start programs and public libraries; public welfare payments for child care, homeless assistance and some health services; veterans' payments; and critical lease and utility payments. Read More

South Carolina

State to Consider Cutting Medicaid Services or Reimbursement Rates Unless Funds Increase. On January 4, 2016, *The Post and Courier* reported that the South Carolina Department of Health and Human Services will consider cutting Medicaid services or reimbursement rates unless the General Assembly provides a $1.1 billion budget for 2016-17 fiscal year, $130 million more than appropriated this year. Approximately 1 million South Carolinians are insured through Medicaid. Read More

Vermont

Gov. Shumlin Not to Raise Taxes for Medicaid Expansion; To Use Funds from Other Agencies. On December 29, 2015, *VPR* reported that Gov. Peter Shumlin said he will not be raising taxes to fund Medicaid expansion. Instead, he will look to other state agencies for the money. Last session, lawmakers rejected a tax hike. The state budget currently has a shortfall of $30 million and is projected to be $50 million next year. Shumlin stated this is not sustainable and that he is frustrated lawmakers have rejected efforts to dedicate a revenue source to pay for Medicaid. Medicaid sign-ups have exceeded projections in the state. Read More

Washington

Washington State Dental Association Blocking Potential Fix to Medicaid Dental Crisis. On January 4, 2016, *The Seattle Times* reported that Washington has one of the lowest Medicaid reimbursement rates for dental care, at 28.7 percent, with only 30 percent of dentists accepting Medicaid. Additionally, dental problems are the number one reason for emergency care for the uninsured. State public health officials believe the solution can be dental therapists, mid-level licensed health-care professionals who can perform simple procedures. However, the Washington State Dental Association has thwarted five years of efforts to bring dental therapists to the state. Washington's dental lobby is following the lead of the well-funded American Dental Association (ADA), which has opposed therapists nationwide, denigrating them as unneeded and unsafe. Advocates are frustrated that dentists are blocking an evidence-based way to improve oral health. Studies show therapists can provide quality care and even boost revenue for dentists. Read More

National

Studies Show Medicaid Expansion Helping Increase Access to Medical Care and Decreasing Rate of Uninsured at Hospitals. On January 5, 2015, *Los Angeles Times* reported that two studies published in Health Affairs have found that low-income residents are facing fewer problems paying medical bills after expansion while hospitals are benefitting with fewer uninsured patients. Kentucky and Arkansas saw major declines in reports of trouble paying medical bills, skipping prescriptions, or delaying care after Medicaid expansion began in 2014. Additionally, the number of residents who had a check-up during the year increased as well. Read More

Health Industry Submits Comments Opposing CMS's Proposed Rule to Regulate Provider Networks and Standardize Plan Options. On December 22, 2015, *Modern Healthcare* reported that CMS received over 500 comments regarding its proposed 2017 ACA health insurance market rule to regulate provider networks and standardize plan options. Insurance companies and business groups criticized the proposal, saying it would not stabilize the individual market and prevent the ability to keep healthcare premiums low. CMS released the proposed rule in Nov. 2015, mandating minimum network standards for health plans sold on the federal insurance market to make sure consumers have enough access to healthcare providers as more insurers move to narrow-network products. Hospitals and doctor groups support the proposal. Read More

Industry News

Comvest Partners Acquires D&S Community Services. On January 5, 2015, Comvest Partners announced that it has acquired D&S Community Services, a provider of residential and community-based services to individuals with intellectual and developmental disabilities. No financial terms were disclosed. D&S is based in Austin, Texas. Read More

Duke LifePoint Healthcare Acquires Central Carolina Hospital and Frye Regional Medical Center. On January 4, 2016, Duke LifePoint Healthcare announced that it has acquired Central Carolina Hospital and Frye Regional Medical Center. Both were previously owned by Tenet Healthcare Corporation. The acquisition also included 19 regional physician practices. Read More

LifePoint Health Acquires St. Francis Hospital. On January 4, 2016, LifePoint Health announced that it has acquired St. Francis Hospital. St. Francis is a 376-bed facility offering inpatient, outpatient, and emergency room services. Read More

Community Health Systems to Acquire Indiana Hospitals. On December 29, Community Health Systems announced a definitive agreement to acquire a majority ownership of 227-bed IU Health La Porte Hospital in La Porte and 50-bed IU Health Starke Hospital in northwestern Indiana. The subsidiaries will assume 80 percent ownership of the hospitals and Indiana University Health will have 20 percent.

RFP Calendar

Date	State/Program	Event	Beneficiaries
January 7, 2016	Indiana	Technical Proposals Due	900,000
January, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
February 5, 2016	Nebraska	Letter of Intent to Contract	239,000
March 1, 2016	Iowa	Implementation	550,000
March 15, 2016	Nebraska	Contract Awards	239,000
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
March, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
TBD Winter/Spring 2016	Virginia MLTSS	RFP Released	130,000
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
June, 2016	Oklahoma ABD	RFP Released	177,000
July, 2016	Georgia	Implementation	1,300,000
August, 2016	Oklahoma ABD	Proposals Due	177,000
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
March 1, 2017	Virginia MLTSS	Implementation	130,000
TBD 2017	Oklahoma ABD	Implementation	177,000
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 demonstration enrollment.

State	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
California	122,520	122,798	122,846	120,452	117,449	117,307	117,179	116,538
Illinois	58,338	55,672	52,763	52,170	50,631	49,586	48,779	53,136
Massachusetts	17,621	17,637	17,705	17,671	17,518	17,179	12,657	12,366
Michigan		9,216	14,867	28,171	35,102	42,728	37,072	36,335
New York	6,660	7,215	5,031	7,122	9,062	8,028	9,942	8,005
Ohio	63,625	63,446	62,958	61,871	62,418	59,697	61,428	61,333
South Carolina	1,398	1,366	1,317	1,388	1,380	1,530	1,355	1,359
Texas	15,335	27,589	37,805	44,931	56,423	45,949	56,737	52,232
Virginia	27,349	30,877	29,970	29,507	29,200	29,176	27,138	28,644
Total Duals Demo Enrollment	**312,846**	**335,816**	**345,262**	**363,283**	**379,183**	**371,180**	**372,287**	**369,948**

HMA NEWS

New this week on the HMA Information Services website:

- **Georgia** Medicaid Managed Care Enrollment Share by Plan, Jan-15 Data
- **Illinois** Medicaid Managed Care Enrollment is Up 79 percent, Nov-15 Data
- Public documents such as the **Washington** Apple Health Southwest Region Responses and Scoring, 2015, the **Texas** MLTSS Pilot for IDD RFI and Responses, 2015, and **Massachusetts** MassHealth Contracts, 2014 and 2010

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.