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Putting Medicaid in the Larger Budget Context: An In-Depth Look at Four States in FY 2016 and FY 2017

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Introduction

Medicaid has long-played an important role in the U.S. healthcare system, accounting for one in every six dollars of all U.S. health care spending while providing health and long-term services and supports coverage to millions of low-income Americans.[1] Medicaid also plays an important role in states budgets as both an expenditure item and the largest source of federal revenue for states.

Since 2014, an improving economy and the implementation of the Affordable Care Act (ACA) have been the primary drivers of Medicaid enrollment and spending trends. Medicaid enrollment and spending peaked in FY 2015, the full state fiscal year for states implementing the ACA, but growth slowed significantly in FY 2016 and FY 2017. Across the country, states remain focused on the ACA, but also on other priorities such as payment and delivery system initiatives designed to control costs and achieve better health outcomes. These policy priorities are playing out in the context of broader state budgets and an economy that varies across states, with some states experiencing steady economic growth and others facing declines in state revenues.

This report provides an in-depth examination of Medicaid program changes in the larger context of state budgets in four states:

- Maryland
- Montana
- New York
- Oklahoma

These case studies build on findings from the 16th annual budget survey of Medicaid officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA). Additional research on budget activity, economic conditions, and other relevant health policy activity was collected to supplement survey responses.

Maryland

Economic and Budget Outlook

Economy and State Revenues

Maryland's economy has shown signs of continued recovery from the Great Recession. The state's Gross Domestic Product (GDP) in 2014 was $350.3 billion, ranking 15th in the United States. Finance, insurance, real estate, rental, and leasing was the largest industry in Maryland, followed by government; professional and business services; and educational services, healthcare, and social assistance.[2] The state had an unemployment rate of 4.3 percent in July 2016, down from 5.1 percent in July 2015 and below the U.S. average of 4.9 percent.[3] The state experienced revenue growth of 3.9 percent in FY 2016 and projects 2.7 percent growth in FY 2017. This includes a projected 5.2 percent increase in revenues from the individual income tax in FY 2017 as well as a 2.1 percent projected increase in corporate income tax and sales tax revenue.[4]

State Budget

Governor Larry Hogan's budget proposal of $42.3 billion for FY 2017 focused strongly on assuring that the state's economic recovery stayed on track. Maryland faced $5.1 billion in accumulated structural deficit when the Governor took office in 2015, and addressing this deficit has been a primary focus for the Hogan Administration.[5]

The FY 2017 budget proposal included a tax and fee relief plan that would reduce general fund revenues in FY 2017 by $23.2 million. The budget proposal also included a 7 percent increase in state support for Medicaid. Even with these changes, the Governor's proposed budget projected a surplus of $449 million for FY 2017 and an ending Rainy Day Fund balance of $1.1 billion. The Governor's priorities included education, addressing transportation infrastructure, and spurring continued economic development. The budget as enacted included state general funds to offset the reduction in federal matching rate (from 100 percent to 95 percent FMAP) for the Medicaid adult expansion population, and reflected a 5.9 percent projected growth in total Medicaid expenditures.[6]

Update on the Affordable Care Act

Maryland Medicaid covers almost 1.3 million residents, including 258,000 adults who gained coverage as a result of Maryland expanding Medicaid eligibility under the Affordable Care Act. Like other states, Maryland saw higher growth than expected in the newly eligible adult population and some corresponding reduction in the rate of enrollment for other population groups, suggesting that some individuals were able to enroll through the income-only based category rather than depend on more complex eligibility under the aged, blind or disabled or other categories. The state is still evaluating the cost and utilization profile for the expansion adult population, which initially had a lower cost experience than the state expected.

Maryland experienced a slowing of enrollment during FY 2015 and FY 2016 due to resumption of eligibility redeterminations which had been temporarily delayed. Growth in the expansion population rebounded later in the fiscal year, and the state projects an enrollment increase of 17 percent in FY 2017 for this eligibility group.

Maryland implemented several new service options or grant programs under the ACA that target home or community based services for individuals with chronic or disabling conditions. In FY 2014, the state introduced health homes to support integration of physical and behavioral health care services for an estimated 15,000 individuals with behavioral health needs who are at high risk of additional chronic conditions. Health home providers can be psychiatric rehabilitation programs, mobile treatment service providers, or opioid treatment programs.[7]

The state also adopted the Section 1915(k) Community First Choice (CFC) benefit in FY 2014 to provide personal assistance services, accessibility adaptations, transition services and other supports for Medicaid beneficiaries requiring an institutional level of care. CFC services are provided in an individual's home, including in assisted living settings. In FY 2015, the state implemented a new Section 1915(i) HCBS state plan option for children with Serious Emotional Disturbances (SED). This state plan option was implemented to sustain and refine the services that Maryland had offered under the Residential Treatment Center Waiver (RTCW).[8,9]

In addition, Maryland received a Balancing Incentive Program (BIP) grant, which provided an enhanced 2 percent rate of federal matching funds for all HCBS expenditures through September 30, 2015 to support state efforts to achieve a target that at least 50 percent of LTSS funds be spent on HCBS. By the second quarter of Federal FY 2016, Maryland reported that 60.5 percent of the state's LTSS were for HCBS, a significant increase over the pre-BIP rate of 36.8 percent reported in Federal FY 2009.[10] Other elements of BIP required development of a functional assessment for use in the state's Medicaid LTSS programs, adoption of conflict-free case management in LTSS, and a No Wrong Door approach to providing information and entry for state residents seeking LTSS.

Health System Reform in Maryland

For many years, Maryland has pursued health system reform for Medicaid and other health care payers through a combination of two large federal waiver strategies. Both waiver programs are undergoing further reforms to support achievement of improved health outcomes and reduced rates of cost growth.

Section 1115 HealthChoice Waiver

Maryland Medicaid has operated HealthChoice, a statewide mandatory managed care program for Medicaid enrollees, since 1997 under a Section 1115 demonstration waiver.[11] The HealthChoice program aims to provide patient-focused, coordinated care through medical homes. Over 80 percent of Maryland's Medicaid beneficiaries are served through MCOs, including almost 97 percent of children and 94 percent of the expansion adult population. Enrollment in HealthChoice for physical health care services is mandatory for all children and non-Medicare eligible adults, including persons with intellectual and developmental disabilities, most adults with physical disabilities, most children with special health care needs and persons with a serious mental illness. (Note: Specialty mental health and substance use services are carved out of HealthChoice MCOs and managed by a single Administrative Services Organization. Long-term services and supports are provided in a fee-for-service arrangement outside the HealthChoice arrangement.)

In June 2016, Maryland filed a HealthChoice waiver renewal application with CMS (to cover January 2017-December 2019). Under a renewed waiver, Maryland is proposing a variety of system reforms designed to improve outcomes for covered individuals. These include but are not limited to[12]:

- Residential treatment for adults with substance use disorders. As one part of a comprehensive approach to solving Maryland's substance abuse epidemic, Maryland proposes to include coverage of residential treatment in facilities that would otherwise not qualify for Medicaid reimbursement under the federal financing exclusion for individuals in Institutions for Mental Disease.[13]
- Presumptive eligibility for individuals with criminal justice involvement to better connect individuals to health coverage at release and bolster efforts to prevent recidivism.
- Dental coverage for former foster youth up to age 26. Under current rules, EPSDT dental benefits end at age 21.

The renewal proposal also includes pilots to allow local entities to receive federal matching funds for care coordination and other services that address key social determinants of health. These include:

- Limited housing support services for up to 300 Medicaid beneficiaries statewide who are at risk of becoming or are currently homeless.
- Evidence-based home visiting for high-risk pregnant women and children.

CMMI Approved Maryland All-Payer Model

Maryland has operated an all-payer hospital payment system under its Health Services Cost Review Commission (HSCRC) since 1977, and is now the only all-payer hospital payment system in the country. This all-payer system has operated under a Medicare waiver, codified in Section 1814(b) of the Social Security Act, that exempted Maryland from the Medicare Inpatient Prospective Payment System and Outpatient Prospective Payment System and allowed Maryland to continue its state-developed approach to hospital reimbursement.[14] In 2014, Maryland received a new waiver from the Center for Medicare and Medicaid Innovation (CMMI) that authorized the HSCRC to pursue more significant reforms to support state goals for health system improvement.[15]

Under the five-year waiver, Maryland is authorized to require every hospital payer, whether Medicare, Medicaid, a commercial payer, or an individual consumer, to pay the same charge for the same service. In addition, Maryland will shift all of its hospital revenue over the five-year performance period into global payment models. The state will limit all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58 percent and the annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate per year for 2015-2018. Hospitals have committed to achieving significant quality improvements across all populations, including reductions in the 30-day hospital readmissions rate and hospital acquired conditions rate. Hospitals will submit annual reports of various population health measures.[16] Maryland is responsible for submitting a plan for the progression of the All-Payer Model to the Centers of Medicare and Medicaid Services (CMS) by January 2017.

The state implemented an All Payer Claims databased (APCD) that includes enrollment, provider and claims data for Maryland residents enrolled in private insurance, Medicare or Medicaid MCOs. The APCD is a decision support tool for various state health reform partners, including the HSCRC and the Maryland Insurance

Administration.[17] In addition, the State's designated Health Information Exchange (HIE), CRISP (Chesapeake Regional Information System for our Patients) allows clinical information to move electronically among disparate health information systems. The goal of HIE is to deliver the right health information to the right place at the right time – providing safer, more timely, efficient, effective, equitable, patient-centered care.

State Innovation Model

Maryland received a CMMI Round Two State Innovation Model (SIM) grant that is supporting state development of a strategy to integrate care delivery for individuals who are dually-eligible for Medicare and Medicaid. The state is engaging stakeholders to design an approach that is aligned with the All-Payer Model, will reduce service fragmentation, and will improve outcomes for individuals with complex health conditions.[18] In an effort to mitigate the financial misalignment between Medicare and Medicaid, the all-payer model progression plan due at the end of 2016 to CMMI will include an implementation plan and timeline for including the duals in the future total cost of care calculations.

Addressing the Opioid Abuse Crisis

Maryland has placed a high priority on addressing the public health emergency resulting from abuse of opioid prescription drugs and heroin. In response to a dramatic increase in the number of deaths from overdose, Governor Hogan created the Opioid and Heroin Emergency Task Force (Task Force) in 2015 to engage experts and the broader public in identifying strategies to fight the problem. Under the auspices of an Inter-Agency Coordinating Council, Maryland state agencies work together to promote prevention, treatment and recovery efforts to reduce opioid overdose deaths. Strategies include identifying patterns of overdose activity through timely review and analysis of data from the Office of the Chief Medical examiner, improving access to substance use disorder treatment and recovery services, providing clinical education and training for healthcare providers, and implementing a Prescription Drug Monitoring Program. Effective October 1, 2015, physicians, advanced practice nurses, dentists and other providers with prescribing authority can prescribe Naloxone to any patient considered at risk of experiencing an opioid overdose or who is in a position to assist an individual at risk of overdose. This provision includes protections from civil lawsuits for prescribers and pharmacists who prescribe or dispense in good faith and according to statutory requirements. In addition, the law enhanced the Maryland Overdose Response Program, which trains and certifies community members in opioid overdose response with Naloxone.[19]

Maryland has continued to experience significant increases in heroin and opioid-related abuse; between 2014 and 2015, heroin-related fatal overdoses rose 29 percent and deaths from Fentanyl rose 83 percent[20], while deaths from misuse of prescription drugs increased 6 percent. The Governor's FY 2017 budget proposed $4.8 million in new funding to implement recommendations of the Task Force, including initiatives to enhance quality of care and expand access to treatment and support services. The Governor signed the National Governors Association (NGA) Compact to Fight Opioid Addiction in July 2016, and Maryland received a grant award in August 2016 from the U.S. Department of Health and Human Services under the Strategic Prevention Framework Partnerships for Prescription Drugs program.

The Maryland Medicaid program has established a workgroup on opioid harm reduction that includes both state staff and medical and pharmacy staff leadership from the Medicaid MCOs. This workgroup is engaged in developing a consistent set of prior authorization and step therapy strategies and is working to adopt the

prescribing guidelines issued by the Centers for Disease Control, and in some cases go beyond the CDC recommendations. The state intends to expand use of prior authorization requirements for use of Fentanyl and Methadone in FFS arrangements in FY 2017 and all Fentanyl products in MCOs in FY 2017 and to add PA requirements in FY 2018 for Methadone and all long-acting opioid-based treatments, in both fee-for-service and MCO arrangements. In addition, MCO Medicaid prescribers will be required to check the Prescription Drug Monitoring Program before prescribing opioids in FY 2018. The state is implementing enhanced education efforts in both FFS and MCO arrangements in FY 2017, sending letters to patients and providers when patients are receiving high dose or other high risk combinations of drugs.

Maryland Medicaid Policy Changes FY 2016 and FY 2017
Eligibility, Application and Renewal Policies
• Participating in Connecting Criminal Justice with Health Care learning collaborative to identify best practices for Maryland. Does not suspend of terminate coverage, but restricts payments to inpatient hospital stays longer than 24 hours. • Requesting presumptive eligibility under Section 1115 waiver renewal (FY 2018).
Delivery System and Payment Reforms
• Medicaid participation in All-Payer Claims database in FY 2016. • HealthChoice Section 1115 waiver renewal filed in June 2016 proposing new initiatives, including residential treatment for substance use disorder in facilities regardless of size; local pilots to provide limited housing related services for certain individuals who are homeless or at risk of homelessness; and local pilots to provide home visiting for high risk pregnant women. (While the waiver renewal has a proposed effective date of January 1,2017; many changes are proposed to be effective July 1, 2017.)
Provider Rates and Provider Fees/Taxes
• Across the board rate increases, except for nursing facilities. (2016) • Rate increases for nursing facilities and hospitals; rate changes for MCOs: 5.9% in CY 2016 and 1% for CY 2017. • Provider tax rate for hospitals decreased in FY 2017.
Benefits and Pharmacy
• Adding Applied Behavioral Analysis services for qualified children with Autism Spectrum Disorder. (FY 2016) • Proposing in Section 1115 waiver renewal to extend dental benefits to young adults aging out of the foster care system. (FY 2017) • Added Physician Assistants as a new provider type. (FY 2016) • The state intends to expand use of prior authorization requirements for use of Fentanyl and Methadone in FFS arrangements in FY 2017 and all Fentanyl products in MCOs in FY 2017. The state is implementing enhanced education efforts in both FFS and MCO arrangements in FY 2017, sending letters to patients and providers when patients are receiving high dose or other high risk combinations of drugs.

Montana

Economic and Budget Outlook

Economy and State Revenues

At the beginning of 2016, economists at the University of Montana Bureau of Business and Economic Research reported on the strong performance of Montana's economy in 2015 noting that the state reached full employment with wage growth more than twice as strong as 2014 and experienced broad growth across most industries boosting state tax revenues and wages.[21] While overall results were strongly positive, the economists also noted weaknesses in the energy, mining and agricultural sectors driven by falling prices for grains, oil and natural gas, weakened demand for coal and an associated slow-down in oil and gas-related energy activity. According to the Montana Department of Commerce, the state's Gross Domestic Product (GDP) grew by 3.4 percent in 2014 and 2.8 percent in 2015[22] while the unemployment rate in July 2016 stood at 4.2 percent, below the national average rate of 4.9 percent.[23]

Montana's total state General Fund (GF) revenue is heavily reliant on individual income taxes which comprise over half of total GF collections. Although oil, gas and coal revenues make up less than 3 percent of total GF revenues,[24] oil production from the Bakken shale formation has brought a new oil boom to the state, making the price of oil an increasingly important variable impacting state revenue collections.[25] The state experienced robust GF revenue growth of 5.9 percent in FY 2015, but revenue collections weakened in FY 2016, finishing the year $79 million (3.6%) below FY 2015 levels and $142 million (6.3%) below the budgeted amount largely driven by declining oil prices which affected revenues and corporate income taxes.[26] GF balances were estimated to fall to $109 million by the end of FY 2017,[27] down from $455.1 million at the end of FY 2015.[28]

State Budget

The Montana legislature meets only in odd-numbered years, when it addresses the full range of legislative issues and also must adopt a balanced biennial budget. Heading into the 2015 legislative session, Governor Bullock proposed a FY 2016-2017 budget that included a state general fund spending increase of 5.5 percent for FY 2016 and almost 3 percent for FY 2017, $300 million in public works projects statewide, and a projected FY 2017 general fund minimum ending balance of $300 million.[29] The most contentious issue in the Governor's proposal was the adoption of the Medicaid expansion under the Affordable Care Act (described further below).[30] The biennium budget ultimately passed by the legislature included total general fund spending of $2.0 billion in FY 2016 and $2.05 billion in FY 2017, lower than the Governor's proposal, but higher than FY 2015 spending levels.[31]

Montana's ACA Medicaid Expansion

In January 2015, Democratic Governor Steve Bullock unveiled proposed legislation to create the "Healthy Montana Plan."[32] The Governor's proposal to expand Medicaid to approximately 70,000 adults and serve them through competitive state contracts with managed care companies was modeled on the Healthy Montana Kids program, which provides coverage for children in low-income families. Republican lawmakers had narrowly defeated a similar bill at the end of the 2013 session on the grounds that the state would eventually have to cover the costs. Despite having the support of the Montana hospitals[33] and a provision to terminate coverage if federal funding dropped below 90 percent; Republican lawmakers remained opposed and introduced a variety

of alternatives to the Governor's proposal, some that included the Medicaid expansion and others that did not (Big Sky Health[34]). One proposal, the Montana Healthy Family Plan, would have covered an estimated 15,000 Montanans providing Medicaid coverage on a smaller scale with the commitment of serving the "neediest among us" before considering expansion of non-disabled adults without children.[35]

A party-line vote (10-7) in the House Human Services Committee in favor of a "do not pass" motion, came after a marathon, six-hour hearing on the proposal, attended by scores of supporters who traveled from across the state to advocate for the measure.[36] A "do not pass" vote was described as a rarely used motion that made resurrecting a bill very unlikely as a three-fifths vote of the House rather than a simple majority is needed to overturn the motion and allow the full House to consider the bill.[37] Republicans held a 59-41 majority in the House. Three Republican alternatives to the Healthy Montana Plan were also voted down on the floor of the House that day. One Medicaid expansion bill survived, Senate Bill 405, the Health and Economic Livelihood Partnership (HELP) Act sponsored by Republican Senator Ed Buttrey. The HELP Act mirrored the Governor's proposal calling for coverage of nearly 70,000 Montanans; however in an effort to obtain bi-partisan support the bill included measures intended to achieve a compromise and appeal to conservatives, most notably a jobs plan and premiums.[38]

Despite its bi-partisan approach, the HELP Act was subjected to numerous procedural motions to prevent a floor debate. In the House, it took nine mostly procedural floor votes before Senate Bill 405 reached its final vote for approval.[39] Throughout the session, a group of Republicans joined with all Democrats to provide the majority needed to advance the bill through the process. On April 29, 2015, Governor Bullock signed the HELP Act into law.

Seven months later (on November 2, 2015) CMS approved Montana's HELP program and 13 related state plan amendments, with coverage effective on January 1, 2016. The waiver expands coverage to approximately 70,000 parents and childless adults, aged 19 to 64 earning up to 138 percent of the federal poverty level (FPL).[40] With the exception of certain exempt groups of people[41], newly eligible adults receive services through a managed fee-for-service Third Party Administrator (TPA) arrangement (described below). The HELP Program requires monthly premiums up to 2 percent of household income for newly eligible adults from 51 to 138 percent FPL receiving services through the TPA. Beneficiaries from 101 to 138 percent FPL may be disenrolled for failing to pay premiums after notice and a 90-day grace period. Re-enrollment is required (without a new application) upon payment of arrears or when the state Department of Revenue assesses the debt against income taxes. Beneficiaries subject to premiums receive a credit toward accrued copayments up to 2 percent of income. All cost-sharing is limited to 5 percent of quarterly household income. Finally, the waiver provides all HELP Program beneficiaries (including those exempt from the TPA) with twelve months of continuous eligibility to reduce the effects of churning between Medicaid and Marketplace coverage as income fluctuates. This continuous eligibility authority granted by an 1115 waiver is unique among states seeking Medicaid expansion waivers.

The Montana HELP Act also authorized the Montana Department of Labor & Industry (DLI) to administer a workforce program, HELP-Link[42], in conjunction with expanded health coverage. HELP-Link offers enrollees the opportunity to develop a customized employment plan, connect with local employers, and open access to training resources. As of June 30, 2016, 1,004 Montana HELP Plan participants have or are currently receiving

workforce services from DLI through the HELP-Link program, the Workforce Innovation and Opportunity Act (WIOA) program, and the RESEA program (an Unemployment Insurance partnership program providing intensive employment services to Montanans who have recently lost a job).[43]

Enrollment as of July 2016 (47,399) was nearly double Montana's initial projection that 25,000 would enroll in the first six months. The state also reports that $5.3 million was saved by shifting 8,458 people from traditional Medicaid into the expansion.[44] Further, the HELP Act has also had a significant impact on the state's insured rate. In 2013, approximately 195,000 Montanans, or 20 percent of the population, lacked health insurance. In 2015, before the Medicaid expansion took effect, an estimated 151,000 Montanans lacked health insurance (15% of the population). Under the HELP Act, the percentage of Montanans who are uninsured dropped to 7.4 percent, a 50 percent decline from 2015 to 2016.[45]

Delivery System Reform

HELP Program Third-Party Administrator

Montana was the first state in the country to expand Medicaid using a private TPA arrangement where the TPA vendor receives an administrative fee but is not at risk for medical claims. Also, claims continue to be paid by the TPA on a fee-for-service basis. The state's Healthy Montana Kids program, its Children's Health Insurance Program uses a TPA model as well. Montana opted to contract with a TPA to deliver services to HELP Program enrollees using the provider network and administrative infrastructure of an insurer already providing services in the state. In order to implement the TPA and require enrollees to receive services from the TPA's provider network, the state received approval to waive freedom of choice requirements (except family planning providers) using Section 1915(b) selective contracting authority.[46] To promote continuity of care between Medicaid and the Marketplace, the state chose an insurer that offered a qualified health plan on the Marketplace.

Other Medicaid Initiatives

Benefit Expansions

With the expansion of Medicaid in Montana, the Bullock Administration sought to ensure that newly eligible adults would have access to a comprehensive benefit package. One example is dental coverage, which Montana's children, aged, blind, and disabled population had long benefited from. Newly eligible adults now have access to dental coverage of $1,125 per benefit year exclusive of diagnostic, preventive, denture and anesthesia services. In order to provide access to dental coverage for the expansion population and to maintain the unlimited benefit for the aged, blind and disabled, Montana is amending an existing Section 1115 waiver to leverage savings that have accrued under the waiver. As of May 12, 2016, less than six months into the HELP Program, 11,727 preventive dental exams had been provided.[47]

In addition to dental services, Montana implemented changes to its behavioral health benefit to improve access to mental health and substance use disorder services. Limits on mental health therapies were removed and age limits for substance use disorder treatment were eliminated. Prior to the Medicaid expansion, substance use disorder services for the adult population were funded by the state mental health agency. Many individuals receiving these services were uninsured and therefore did not have access to a full benefit package. As a result

of the Medicaid expansion and associated federal funding, these individuals now have access to a comprehensive benefit package and the state has realized savings in its state-funded mental health program.

Additional Medicaid policy actions taken in FY 2016 or planned for FY 2017 are described below.

Montana Medicaid Policy Changes FY 2016 and FY 2017
Eligibility, Application and Renewal Policies
• Implemented the ACA Medicaid expansion on January 1, 2016. • Implemented twelve months of continuous eligibility for newly eligible adults on January 1, 2016. • Established new Medicaid outreach/assistance strategies to facilitate enrollment of corrections-involved individuals prior to their release in FY 2016 and plan to expand at least one of these strategies in FY 2017. • Expanded Medicaid eligibility suspensions for enrollees who become incarcerated in FY 2016 and plan to further expand this policy in FY 2017.
Provider Rates and Provider Taxes/Assessments
• Increased rates for inpatient and outpatient hospitals, primary care physicians, specialist physicians, dentists and nursing facilities in FY 2016. • Plan to increase rates for primary care physicians, specialist physicians, dentists, and nursing facilities in FY 2017. Plan to hold other rates flat.
Monthly Contributions/ Premiums and Cost-Sharing
• Implemented premiums and cost-sharing for non-exempt ACA Medicaid expansion adults on January 1, 2016.
Benefits and Pharmacy
• Implemented a dental benefit with a monetary cap for expansion adults on January 1, 2016. The cap excludes diagnostic, preventive, denture, and anesthesia services. • Removed limits on mental health therapy and occupational, speech, and physical therapy for all Medicaid beneficiaries on January 1, 2016. • Removed age limits for substance use disorder treatment on January 1, 2016. • Implemented Actual Acquisition Cost (AAC) reimbursement with a Professional Dispensing fee for general and specialty drugs on July 1, 2016. • Plans to expand step-therapy edits to morphine and quantity limits to methadone.
Long-Term Services and Supports Rebalancing
• Plans to expand the geographical service area and number of persons with Severe Disabling Mental Illness (SDMI) served under the state's home and community-based waiver in FY 2016 and FY 2017. • Plans to add additional services available under the 1915(c) SDMI waiver in FY 2016 and FY 2017. • Transition residents of the Montana Developmental Center into community settings by the end of CY 2016 and close the facility by the end of FY 2017.
Delivery System Reform
• Expanded enrollment in primary care case management with enrollment of non-exempt newly eligible adults into a TPA on January 1, 2016.

New York

Economic and Budget Outlook

Economy and State Revenues

The State of New York has the third largest economy in the United States (behind California and Texas) with a Gross Domestic Product (GDP) of $1.4 trillion in 2015.[48] Among the various industry sectors comprising the state's economy, the education and health care sector is now the largest (in terms of employment), has steadily grown reaching 15.2 percent of total nonfarm payroll employment in 2015. By contrast, the manufacturing sector has decreased over the last 15 years to 4.9 percent in 2015. The financial sector is also very important to the overall health of the state's economy but was especially hard-hit by the Great Recession (2007-2010). This sector has rebounded slowly as technology, stricter regulations, and high operating costs have inhibited hiring, accounting for 7.6 percent of total nonfarm payroll employment in 2015.[49]

In line with the national economy, the New York economy has experienced slow and steady growth since the last recession with GDP growth of 1.2 percent in 2014[50] and 1.4 percent in 2015.[51] Employment has also steadily grown since 2010 and the unemployment rate fell to 4.7% in July 2016.[52] In February 2016, the New York State Assembly Ways and Means Committee Economic and Revenue Report forecasted that state employment and personal income in New York would continue to grow in 2016 and 2017, but at somewhat more moderate pace.

State tax growth has been positive in recent years growing by 1.9 percent in FY 2015 and 5.1 percent in FY 2016.[53] While growth in FY 2017 was originally forecasted at 3.3 percent, that estimate was reduced to 2.4 percent in the first quarter update issued by the Division of the Budget in August 2016.[54] According to that report, through the first quarter of FY 2017, personal income tax collections fell $595 million below planned levels reflecting continued weak performance in the financial sector. Other taxes, however, remain on target with earlier estimates.

State Budget

Unlike most other states whose fiscal years begin on July 1, the State of New York operates on an April 1 – March 31 state fiscal year. New York's enacted budget for FY 2017 of $96.2 billion[55] holds state spending to a 2 percent growth rate for the sixth consecutive year,[56] but grows school aid by $1.5 billion (6.5%)[57] and includes the largest state transportation plan ($55 billion) ever approved.[58] The enacted budget for FY 2017 also authorizes regional, phased-in increases to the state's minimum wage to $15 an hour and the nation's only 12-week paid family leave program.[59]

The FY 2017 Medicaid budget growth of 3.4 percent reflects the continuation of the Medicaid spending cap (called the "Global Cap") adopted in FY 2012 which limits year-to-year growth in the state share of Medicaid spending to the ten-year rolling average of the medical component of the Consumer Price Index (CPI).[60] The Division of the Budget currently estimates that projected CPI reductions will reduce the Medicaid Global Cap to 3.2 percent in FY 2018, 3.0 percent in FY 2019 and 2.8 percent in FY 2020.[61] The FY 2017 Medicaid budget also includes additional funding to cover increased costs associated with the phased-in increases to the hourly minimum wage rate, which is expected to increase annual Medicaid spending, above previously forecasted Global Cap limits.[62]

The FY 2017 budget also authorizes new middle class tax cuts that take effect in FY 2018, including a reduction in the marginal tax rates on middle incomes from 5.9 percent and 6.65 percent to 5.5 percent and 6 percent. These cuts are expected to reduce tax collections by $236 million in FY 2018, growing to $1.5 billion in FY 2020, on a cash basis. When fully effective in CY 2025, the tax reduction is estimated to reach $4.2 billion on a liability basis.[63]

ACA Implementation

New York is one of 31 states and the District of Columbia that have implemented the ACA Medicaid expansion and is one of 13 states that operate a state-based Marketplace.[64] In FY 2015, New York also implemented a new program under an ACA coverage option called the "Basic Health Plan" (BHP). Under this ACA option, states may offer health coverage to individuals with family incomes between 133 and 200 percent of the federal poverty level (FPL) and for individuals from 0-200 percent FPL who are lawfully present in the United States but do not qualify for Medicaid due to their immigration status. This coverage takes the place of subsidized coverage in the Marketplace. States electing this option receive federal funding equal to 95 percent of the premium tax credit and the cost-sharing reductions that would have been provided for Marketplace coverage.[65] New York is using the BHP authority and federal funding to offer the "Essential Plan" which has allowed the state to realize savings by transitioning certain Medicaid waiver populations and certain immigrants (previously covered with state-only dollars) to BHP coverage.[66]

Medicaid Redesign Team

After years of rapid growth, New York's Medicaid program had per enrollee costs in FY 2011 that were far in excess of those in other states, but these higher expenditures had not produced correspondingly high quality results or rankings.[67] To address these concerns, Governor Cuomo appointed the Medicaid Redesign Team (MRT) to design strategies to lower Medicaid expenditure growth and improve quality in the program. The 27 member MRT is led by the Medicaid Director and includes representatives from various health care providers and stakeholders.[68] Since its inception, more than 200 initiatives have been created as a result of the MRT addressing programmatic changes in the way health care is provided, reimbursed and managed to ensure that quality care is provided in the most efficient manner.[69] During that time, Medicaid spending growth has not exceeded the Medicaid Global Cap (described above).

In 2012, the MRT issued a multi-year action plan that incorporated three broad Medicaid redesign strategies: increased reliance on managed care, development of new service delivery mechanisms and use of value-based payments.[70]

Medicaid Managed Care

New York began contracting with capitated managed care organizations (MCOs) in the late 1980's, and by 2010, approximately two-thirds of all Medicaid enrollees were enrolled in "mainstream" MCOs offering acute care services but excluding coverage for most long term services and supports (LTSS), prescription drugs, some dental care and behavioral health services. There were also several MCOs at that time specializing in LTSS (some offering both acute care and LTSS) serving about 40,000 Medicaid enrollees who voluntarily enrolled. [71] In 2011, the MRT added prescription drugs, personal care, and some home health care to the mainstream MCO benefit package. Dental services (2012), hospice care (2013) and nursing home care (2015) were added later.

Beginning in 2015, coverage of certain mental health services, including substance abuse treatment, began to be phased-in (through 2017). [72]

Since 2011, managed care enrollment has also become mandatory for a number of previously exempt groups including HIV positive individuals (2011), homeless individuals, low birth-weight infants, persons with end-stage renal disease (2012), and some foster care children (2013). Mandatory enrollment for adults receiving home and community-based services (HCBS) for an extended period of time was phased-in during 2012 and 2013, was applied to adults entering a nursing home in 2015, and will be applied to children entering a nursing home in 2017. [73] Also, in 2015, the state implemented a voluntary Financial Alignment Demonstration with the Centers for Medicare and Medicaid Services (CMS) for persons dually eligible for Medicare and Medicaid that provides a comprehensive benefit including Medicare and Medicaid acute care and LTSS on a capitated basis by Fully Integrated Duals Advantage (FIDA) plans.

More recently, the state has begun to phase-in mandatory managed care for persons with severe mental illness (in FY 2016 and FY 2017) by contracting with specialized MCOs called "Health and Recovery Plans" (HARPs). An estimated 140,000 persons will be served in these plans.[74] Also, as part of the Financial Alignment Demonstration referred to above, the state currently contracts with one "FIDA-IDD" plan to provide coordinated care, on a voluntary basis, for people with intellectual and developmental disabilities who are eligible for both Medicare and Medicaid services. The FIDA-IDD plan provides Medicare and Medicaid benefits through an integrated benefit design that includes a dedicated interdisciplinary team to address each individual´s medical, behavioral, long-term supports and services, and social needs.[75]

Delivery System Reform Incentive Payment Program (DSRIP)

In April 2014, CMS approved an amendment to New York's existing Section 1115 waiver allowing the state to reinvest over a five-year period (2015-2019) $8 billion of the $17.1 billion in federal savings generated by MRT reforms.[76] From this total, $6.42 billion is to be used to implement delivery system reform incentive payment projects (the "DSRIP program"), $1.08 billion is for Health Home development and investments in long term care, workforce and enhanced behavioral health services, and $500 million in one-time funding will be used to assist safety net providers.[77] [78] New York's DSRIP program is designed around 25 "Performing Provider Systems" (PPSs) – newly created provider partnerships who have agreed to cooperate and coordinate services for the Medicaid population in the counties they serve. The PPSs can receive DSRIP payments for implementing at least five reform projects from a list of 44 and meeting performance metrics.[79] PPSs are coalitions of providers with a lead organization that is often a major medical center. Among the most frequently selected projects are primary care/behavioral health integration, integrated delivery systems, chronic disease transitions, and adult cardiovascular high risk management.[80] As of October 2016, the PPSs have received 99.4% of all available funds to date.

Value Based Payments

As a condition for approval of the DSRIP Section 1115 waiver amendment described above, and to ensure the long-term sustainability of the improvements made possible by the DSRIP investments, CMS required the State of New York to submit a multiyear Roadmap for comprehensive Medicaid payment reform including how the state would amend its MCO contracts. In June 2015, the New York State Department of Health released "A

Path Toward Value Based Payment: New York State Roadmap for Medicaid Payment Reform," (the "VBP Roadmap").[81] The VBP Roadmap outlines the state's strategy for assuring that 80-90 percent of MCO payments are shifted from fee-for-service (FFS) to VBP by 2020 and describes the new payment approaches and the types of provider organizations that will be involved.[82] In June 2016, the state released the results of MCO survey designed to get a baseline for measuring statewide progress toward the overall 80-90 percent VBP goal and towards a second goal that at least 35 percent of MCO payments to providers be risk-based VBP arrangements (at "Level 2 or 3" as defined in the VBP Roadmap).[83] Overall, the survey results indicated that 63.2 percent of MCO payments were FFS while 25.5 percent reflected VBP Levels 1-3. The remaining 11.3 percent reflected VBP "Level 0" (FFS payments with bonus and/or withhold based on quality scores)

Additional Medicaid policy actions taken in FY 2016 or planned for FY 2017 are described below.

New York Medicaid Policy Changes FY 2016 and FY 2017
Eligibility Changes
• In FY 2017, individuals incarcerated in a New York State Department of Corrections and Community Supervision (NYS DOCCS) facility with suspended coverage (limited to inpatient hospital only) will have their Medicaid benefits reinstated 30 days prior to release based on electronic pre-release files from NYS DOCCS to facilitate access to care upon release. Medicaid will continue to only pay for inpatient hospitalization during the 30-day period. A benefit card will be made available to the individual at release.
Provider Rates and Provider Taxes/Assessments
• In FY 2016, provider rates were increased for MCOs, inpatient and outpatient hospital, primary care physicians, and nursing facilities. • In FY 2017, provider rates are expected to increase for nursing facilities and MCOs. • In FY 2017, NYS Medicaid FFS began reducing payment for early elective deliveries by 50% (up from 10% at implementation in 2013 and 25% in FY 2016). The 50% payment reduction for early elective deliveries without an acceptable medical indication was effective for MCOs on July 1, 2016.
Cost-Sharing
• In FY 2016, exemption from Medicaid co-pays was eliminated for members with incomes below 100% FPL, hospice patients, and American Indians/Alaska Natives who have never received a service from IHS, tribal health programs, or under contract health services referral.
Pharmacy and Benefits
• In FY 2016, made the following benefit changes: ○ Discontinued coverage for viscosupplementation of the knee for an enrollee with a diagnosis of osteoarthritis of the knee and limited coverage of DEXA Scans for Screening to one time every 2 years for Women Over Age 65 and Men Over Age 70. ○ Expanded smoking cessation counseling providers to include dental practitioners, telehealth services, dental hygienist services and services for adults with serious mental illness services under 1915(i) authority as part of the state's Health and Recovery Plans (HARP) managed care program. • In FY 2016 and FY 2017, implementing standard clinical criteria for the coverage of AIDS/HIV anti-retroviral drugs under inclusive FFS and MCO supplemental rebate contracts. • Key pharmacy policy changes include:

- Obtained supplemental rebates for FFS and MCO utilization for certain anti-retrovirals used in the treatment of HIV/AIDS. (FY 2016)
- Increase rebate requirements for utilization of generic drugs having major price increases (until such time the federal CPI penalty for generic drugs is implemented). (FY 2017)
- Require MCOs to require prior authorization of opioids in excess of 4 prescriptions in 30 days. (FY 2017)

LTSS, Delivery System and Payment Reforms

- Increasing the number of persons receiving long term services and support in home and community-based settings in both FY 2016 and FY 2017, including increases in the number of persons served in a PACE site.
- In FY 2016, increased the number persons transitioned from a residential setting to an HCBS setting.
- In both FY 2016 and FY 2017, rebalancing incentives built into MCO contracts covering LTSS.
- Implemented the Community First Choice Option in FY 2016.

Managed Care and Delivery System and Payment Reforms

- In FY 2016, enrolled the following populations into managed care:
  - For all counties outside of New York City, mandatory enrollment of Medicaid eligible adults in need of long term nursing home services on or after the transition date (scheduled phase-in)
  - Voluntary enrollment of adults in nursing home/long term placement prior to the applicable phase in date for the specific county.
- In FY 2016, eliminated the behavioral health carve-out for SSI enrollees in New York City and in FY 2017, will eliminate the carve-out in the rest of the state.
- In FY 2017, adding Assisted Living to MLTSS plans.
- Current MCO contracts require MCO to increase the percentage of payments made using an alternative payment model from the previous year's percentage.
- Integration of social determinants of health is being encouraged throughout DSRIP demonstration and is being considered as one of the integral parts of successful transformation of health care system in the state and a key component of service delivery within the VBP reform initiative.
- Continuing to expand Patient Centered Medical Home and Health Home initiatives in both FY 2016 and FY 2017.

Oklahoma

Economic and Budget Outlook

Economy and State Revenues

In recent years, Oklahoma has typically accounted for more than 3 percent of total U.S. oil production and almost one-tenth of the nation's natural gas production.[84] It is one of seven states, along with Alaska, Louisiana, New Mexico, North Dakota, Texas and Wyoming, in which the oil and gas sector's share of the state's Gross Domestic Product (GDP), personal income and payroll employment is more than 3.5 times larger than in the nation as a whole.[85] Because of their heavy reliance on the oil and gas sectors, the economies of these states have been adversely affected to varying degrees by the price of oil which began falling in mid-2014.[86] By December 2015, Oklahoma had lost 11,600 energy jobs and 59 percent of the state's active oil and gas rigs.[87] While crude oil prices had partially rebounded by the end of August 2016, they remained below the

price in effect a year earlier and less than half of the July 2014 price. [88] [89] Oklahoma's unemployment rate rose for the sixth consecutive month in July 2016 to 5.0 percent (compared to 4.3 percent in July 2015), exceeding the national rate (4.9 percent) for the first time in 26 years. [90] [91]

Falling oil prices have also negatively impacted state General Revenue Fund (GRF) collections. At the end of FY 2016, state GRF collections were $541.3 million (9.4%) below official estimates and $521.9 million (9.1%) below prior year collections.[92] Oklahoma's constitution prohibits revenue increases without approval of three quarters of both the House and Senate or a vote of the people, limiting the state's ability to raise taxes in response to budget issues.[93]

State Budget

On June 1, 2015, Governor Mary Fallin signed into law the FY 2016 budget, praising legislators for closing a $611 million shortfall without cutting funding for K-12 education. The FY 2016 budget was 1.03 percent less than the FY 2015 appropriated budget.[94] By December 2015, low GRF collections, triggered a "revenue failure" declaration which forced across the board spending cuts as well as a one-time appropriation of $500 million from the Day Fund and from other cash reserves to balance the budget.[95]

As lawmakers worked to balance the FY 2016 budget, they were also faced with a $1.3 billion shortfall for the FY 2017 budget, the largest in the state's history.[96] Public schools feared aid reductions of up to 20 percent while the Oklahoma Health Care Authority (OHCA), which administers the state's Medicaid program, prepared to implement provider rate cuts of up to 25 percent that would have jeopardized the ability of some hospitals and nursing homes to remain open.[97] The final FY 2017 budget, signed into law by Governor Fallin on June 10, 2016, averted these outcomes maintaining current funding levels for the State Department of Education and adding $83.8 million in appropriations for the OHCA (one of four agencies to receive an increase), while also keeping the state's eight-year transportation infrastructure plan intact.[98] [99] The FY 2017 budget also eliminated or reduced various tax breaks, relies on a number of dedicated fund transfers including $66 million from the Rainy Day Fund, and $200 million in transportation bonds.[100] Overall, the FY 2017 budget of $6.8 billion is $360.7 million (5%) less than the FY 2016 budget prior to the mid-year revenue failure and $67.8 million (1%) less than the FY 2016 appropriations as adjusted by the mid-year revenue failure.[101]

When the state completed its final reconciliation of FY 2016 state revenues in July 2016, it determined that the mid-year reductions imposed in December 2015 and February 2016 were deeper than necessary and funds were returned to state agencies instead.[102]

ACA Medicaid Expansion

As a result of the 2012 Supreme Court decision, Oklahoma has not adopted the ACA Medicaid expansion. In April 2016, faced with dwindling reserves, enrollment growth, and budget deficits, Governor Fallin and the CEO of OHCA, Nico Gomez, proposed the Medicaid Rebalancing Act of 2020 legislation, an alternative Medicaid expansion proposal. The plan would have provided coverage through a Private Option for Oklahomans age 19 to 64 with incomes at or below 138 percent of the federal poverty level (FPL) (similar to Arkansas using Medicaid funds to purchase coverage for enrollees from the Marketplace). In addition, the plan called for 175,000 pregnant women and children with Medicaid coverage to transition to coverage in the

Marketplaces. The proposed plan also called for creating member health savings accounts, called "HealthStead accounts," that would help pay for medical expenses with financial incentives for healthy lifestyle choices, and partially finance it with an increase in the cigarette tax of $1.50 per pack.[103] The plan was expected to reduce the number of uninsured by 30 percent, stimulate the economy and generate state savings of $55 million.[104] The Plan failed to receive legislative approval, after some lawmakers labeled it a Medicaid expansion under the ACA. Legislators also could not agree on revenue enhancing measures such as a cigarette tax to help fund the proposal.[105]

Medicaid Managed Care and Other Payment and Delivery System Reforms

In 1996, Oklahoma implemented managed care, branded as SoonerCare, which initially consisted of two programs: (1) SoonerCare Plus, which contracted with health plans in urban areas of the state using a fully capitated delivery system and (2) SoonerCare Choice – a primary care case management (PCCM) program – which provided services in rural areas of the state. In 2004, SoonerCare Choice expanded statewide and became the sole model of care in the state, supplanting the fully capitated risk based managed care system. This program provided most Medicaid beneficiaries with acute, primary, specialty, and behavioral health services on a fee-for-service (FFS) basis; care coordination services and limited primary care services were covered through a fixed per member per month fee paid to contracted primary care providers.

Since 2004, Oklahoma has implemented other initiatives to promote cost-effective care and improved health outcomes. In 2006, the state began the Health Management Program (HMP) to conduct intensive nurse case management with the highest need patients and facilitate practice transformation. Under the HMP, Oklahoma contracts directly with primary care physicians to provide primary care and care coordination services, and pays them a monthly case management fee that is risk-adjusted to reflect variations in the expected service intensity for patients served in each medical home. Three local non-profit organizations serve as Health Access Networks, which receive a nominal per member per month payment to provide care management to persons with complex needs, in addition to the monthly case management fee paid to individual primary care providers. In 2009, Oklahoma also adopted a patient-centered medical home model for SoonerCare Choice in which primary care providers are paid a bundled care coordination payment and are eligible for additional performance payments; all medical services continue to be paid on a FFS basis. Children and families, pregnant women, children and adults with disabilities, and older adults are mandatorily enrolled in the program; American Indians/Alaska Natives have the choice of selecting either an Indian Health Service (IHS) or non-IHS provider to under SoonerCare.

As of July 2016, 74.8 percent of total SoonerCare enrollees were enrolled in the state's PCCM program. The state also operates Insure Oklahoma, an Employer-Sponsored Insurance (ESI) program where premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent).[106]

Recent Delivery System Reform Initiatives and Quality Improvements

Despite ongoing budget challenges, the OHCA continues to move forward with the delivery system reform and quality improvement initiatives described below.

SoonerHealth+: Care Coordination for the ABD Population

In 2015, the United Health Foundation's Senior Health Rankings ranked Oklahoma 46th in the nation.[107] Several factors considered in this ranking include nursing home quality, hospital readmission rates, chronic health conditions, and community involvement. According to the report, there is a high prevalence of physical inactivity among Oklahoma's senior population, and a low percentage of seniors in the state receive health screenings and recommended hospital care. This low health ranking suggests that Oklahoma will face additional challenges caring for the baby boomer generation in the years to come.

With the intent of providing better access to care, improving quality and health outcomes, and controlling costs for the Medicaid aged, blind, and disabled (ABD) populations, the state legislature passed legislation in 2015 requiring the OHCA to create an ABD care coordination program. The "SoonerHealth+" program will be a fully capitated program implemented statewide with services beginning in April 2018.[108] According to the 2015 legislation, members receiving institutional care will be phased-in two years after the initial program enrollment period. The state expects to release a Request for Proposals (RFP) that includes model contract standards for managed care organizations (MCOs) in November 2016. OHCA plans to use a third party options counselor to assist members with plan choice. PACE will continue to be an option for eligibles in lieu of an MCO. Behavioral Health Homes will also continue to serve qualified members in lieu of MCO enrollment, and MCOs will be required to have Patient Centered Medical Homes for their Medicaid members.[109]

CMMI CPC and CPC+

Oklahoma is one of 14 states and regions recently awarded a Center for Medicare and Medicaid Innovation (CMMI) grant for the Comprehensive Primary Care Plus program (CPC+) program. The five-year multi-payer advanced primary care medical home model grant begins in January 2017 and builds on the earlier Comprehensive Primary Care (CPC) initiative that began in October 2012 and runs through December 31, 2016. The greater Tulsa region is one of seven markets participating in the CPC initiative.[110] The CPC+ program will include advances in payment to support primary care practices to provide more comprehensive care that meets the needs of all of their patients, particularly those with complex needs.[111]

CPC+ has two tracks for physician practices. Track 1 features a relatively simple financial model and less ambitious clinical goals than Track 2. Practices in both tracks are expected to make changes to address key CPC functions: (1) access and continuity; (2) care management; (3) comprehensiveness and coordination; (4) patient and caregiver engagement, and (5) planned care and population health. Highlights of the Track 1 model include physician practices receiving a per beneficiary per month (PBPM) care management fee ranging from $6 to $30. In addition, a performance-based payment incentive as high as $2.50 PBPM will be paid to primary care practices at the beginning of a CPC+ performance year. The Track 2 model includes a PBPM care management fee based on a five-tier risk-stratification scale. The lowest four tiers mirror the risk-stratification scale for Track 1, with fees ranging from $9 to $33. In the fifth tier, physician practices can earn a $100 PBPM fee for treating high-risk patients. In addition, a performance-based payment incentive as high as $4 PBPM will be paid to primary care practices at the beginning of a CPC+ performance year.[112]

Supportive Housing

Recognizing that stable housing is a critical element of healthy living, OHCA staff assist SoonerCare members with affordable housing support services. In 2016-2017, OHCA will target persons with physical disabilities

and persons with intellectual and developmental disabilities for this support, and has created a Social Supports and Outreach unit dedicated to assisting members with housing or other community supports.[113]

Additional Medicaid policy actions taken in FY 2016 or planned for FY 2017 are described below.

Oklahoma Medicaid Policy Changes FY 2016 and FY 2017
Eligibility Changes
• No changes
Provider Rates and Provider Taxes/Assessments
• Provider rates were cut by 3% across the board in 2016 and are equivalent to 86.57% of Medicare rates. • Beginning in 2016, the OHCA implemented use of 3M's Potentially Preventable Readmissions (PPR) methodology for the evaluation and comparison of readmissions rates by hospital. OHCA will reduce payment rates to hospitals determined to have higher rates of readmissions, after applying the PPR method's risk adjustment. Percentages are being determined.
Benefits and Pharmacy
• In FY 2016, coverage of sleep studies was eliminated and virtual visits were added as a benefit, with annual limits. • In FY 2017, polycarbonate lenses for children are being mandated and covered high risk OB visits are being reduced based on utilization data. • Telemedicine policy rules around origination sites were removed. Patients no longer have to be at a specified "origination site" (e.g. they can now be in their homes). OHCA developed an after-hours app for PCs and mobile devices to allow members to find access to care after normal working hours. The app allows the member to enter age and zip code of current location, and provides locations of urgent care that have agreed to maintain after-hours services.
LTSS, Delivery System and Payment Reforms
• OHCA expanded the number of persons served in home and community-based services (HCBS) waivers in FY 2016 and plans to do so again in FY 2017. • SoonerHealth+, a capitated care coordination program for the ABD population, is under development with an expected RFP release in November 2016. Services are expected to begin in 2018. • State selected as a CMMI Comprehensive Primary Care Program Plus (CPC+) grantee with the grant beginning January 2017.

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