HEALTH MANAGEMENT ASSOCIATES

# HMA Weekly Roundup

Trends in State Health Policy

*May 4, 2016*




RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

**Edited by:**
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

## THIS WEEK



## IN FOCUS

### MISSOURI STATEWIDE MANAGED CARE EXPANSION, VIRGINIA MANAGED LTSS RFPS

This week, our *In Focus* section reviews two Medicaid managed care requests for proposals (RFPs) released on April 29, 2016. Missouri issued a RFP for the rebid of existing MO HealthNet contracts, as well as the expansion of MO HealthNet statewide. No changes in eligibility are included in the RFP, but enrollment could grow to more than 700,000 members when contracts go live in 2017.

Meanwhile, Virginia has released a RFP for the planned managed long term services and supports (MLTSS) program, which will serve an estimated 212,000 members with complex care needs. The Virginia MLTSS program is targeting a phased implementation process throughout the second half of 2017. HMA reviews the key RFP elements and market dynamics around the RFP target populations in each state.

# *Missouri Statewide Expansion RFP*

As of May 1, 2017, Missouri will expand the MO HealthNet managed care program statewide, expanding the Central region and adding a Southwestern region. The RFP covers all four statewide regions, and the state intends to conduct a statewide open enrollment period prior to implementation.

## Covered Populations and Market Size

The statewide expansion makes no changes to categories of eligibility for MO HealthNet managed care. Those eligible for the program include children, parents, pregnant women, and CHIP. Individuals eligible for SSI or in the foster care system may voluntarily disenroll from MO HealthNet. Individuals who are disabled, 65 or older, dual eligible, or receiving long-term care remain ineligible for managed care enrollment.

| | Estimated Membership in RFP (SFY 2015) | State Reported Membership (March, 2016) |
|---|---|---|
| Western | 139,272 | 158,766 |
| Eastern | 211,901 | 234,678 |
| Central *(Expanding)* | 175,952 | 95,273 |
| Southwestern *(New)* | 115,141 | |
| **Total Enrollment** | **642,266** | **488,717** |

Supporting documents with the RFP indicate there are more than 642,000 eligible MO HealthNet members under the statewide expansion as of state fiscal year (SFY) 2015. However, membership in the Western and Eastern regions has grown by more than 13 percent and more than 10 percent, respectively, since SFY 2015. Given this growth, it is likely that MO HealthNet enrollment under the statewide expansion could surpass 700,000. As a note, the Central region has also seen enrollment growth since SFY 2015; however, the Central region is expanding under the new contracts.

Based on capitation rate data provided in the RFP, 700,000 MO HealthNet members with an average PMPM of $210 would amount to more than $1.7 billion in annual spending. This figure could increase to $2 billion in annual spending if the state opts to expand Medicaid.

## Covered Services

The statewide expansion makes no changes to the existing benefit package, which covers all acute benefits, excluding pharmacy, which is handled under a carve-out arrangement. Additionally, the RFP makes note that four out of the five waivers for individuals with developmental disabilities (DD) are eligible for enrollment in MO HealthNet; however, all DD waiver services are carved out of managed care.

## Additional RFP Details

- **Health Home Coordination.** Missouri participates in the Section 2703 Health Homes program. The state will notify MCOs of members enrolled in a health home, and MCOs will be responsible for coordinating with the member's PCP.
- **Medicaid Reform and Transformation.** Contracted MCOs will be expected to further the Medicaid Reform and Transformation goals, including:
    - member incentives and personal responsibility programs;
    - provider incentives around quality, cost, and outcomes; and
    - the Local Community Care Coordination Program (LCCCP), which can include Accountable Care Organization arrangements, patient-centered medical homes, sub-capitation arrangements, and other provider models outside of the Health Homes program.
- **MLR Requirements and Performance Withhold.** MCOs will be required to meet an 85 percent minimum medical loss ratio (MLR). Additionally, capitation payments will be subject to a 5 percent performance withhold, to be earned back through meeting of quality, outcomes, and other measures.

## Contract Awards and Evaluation Criteria

Missouri intends to award a maximum of three contracts to serve all four statewide regions. The initial contract term will run from May 1, 2017, through June 30, 2018. An additional four one-year extensions will be exercisable at the state's discretion.

The full evaluation criteria are available in the table below, with the bulk of points awarded on quality, access and care management, and Medicaid reform and transformation goals. Additionally, bidders can receive five or ten points for having signed LOIs or contracts with Medicaid Accountable Care Organizations (ACOs). There is no cost component to the MO HealthNet bid.

| Evaluation Criteria | Points Available | % of Total |
|---|---|---|
| MBE/WBE | 10 | 4.8% |
| Organizational Experience/Method of Performance | 10 | 4.8% |
| Quality | 60 | 28.6% |
| Access to Care/Care Management | 80 | 38.1% |
| Medicaid Reform and Transformation | 40 | 19.0% |
| Accountable Care Organization | 10 | 4.8% |
| **Total Points Possible** | **210** | |

## RFP Timeline

Missouri will hold a pre-proposal conference on June 1, 2016, with proposals due one month later on July 1. A contract award announcement date has not been published but would be expected by the end of the year, with new contracts set to go live on May 1, 2017.

| RFP Milestone | Date |
|---|---|
| RFP Released | Friday, April 29, 2016 |
| Pre-Proposal Conference | Wednesday, June 01, 2016 |
| Proposals Due | Friday, July 01, 2016 |
| Contract Awards | TBD |
| Implementation | Monday, May 01, 2017 |

### Current Medicaid MCO Market

As of March, 2016, Aetna holds the largest MO HealthNet market share, with more than 55 percent of all members, followed by WellCare and Centene with 24 percent and 20 percent, respectively.

| | Eastern | Central | Western | Total | % Share |
|---|---|---|---|---|---|
| Aetna Better Health of Missouri | 136,473 | 45,389 | 88,103 | 269,965 | 55.2% |
| Missouri Care (WellCare) | 49,051 | 31,034 | 38,027 | 118,112 | 24.2% |
| Home State Health Plan (Centene) | 49,154 | 18,850 | 32,636 | 100,640 | 20.6% |
| **Total All Plans** | **234,678** | **95,273** | **158,766** | **488,717** | |

## *Virginia MLTSS RFP*

Beginning in the summer of 2017, Virginia's Department of Medical Assistance Services (DMAS) will begin to phase in a statewide managed long term services and supports (MLTSS) program, estimated to serve around 212,000 members, including non-LTSS dual eligibles and additional members who are aged, blind, and disabled (ABD). Virginia's MLTSS program will eventually replace the state's dual eligible financial alignment demonstration, pursuing coordination of care for dual eligible members through D-SNP contracting requirements.

### Covered Populations and Market Size

Virginia's MLTSS populations will include all fully dual eligible individuals for Medicaid services only, as well as individuals receiving LTSS either in an institutional setting or in one of the state's six home and community-based services (HCBS) waivers. This includes full-benefit dual eligibles not currently receiving any form of managed care, non-dual individuals receiving LTSS, dual eligibles enrolled in the Commonwealth Coordinated Care (CCC) capitated dual eligible financial alignment demonstration, and ABD beneficiaries currently enrolled in the Medallion 3.0 managed care program. The CCC program will sunset at the end of 2017, with any remaining members transitioning to MLTSS in January, 2018, along with ABD members in Medallion 3.0. All other members will transition to MLTSS in a phased regional enrollment process from July 1 through December 1, 2017. As a note, individuals in the Day Support (DS), ID, and DD waivers will be enrolled in a MLTSS MCO for their non-waiver services only while the state conducts a waiver redesign process. Waiver services may be included in MLTSS at a future date.

| LTSS Population | Timing for MLTSS Inclusion | Members, March 2016 |
|---|---|---|
| Duals - CCC-Ineligible | July-December, 2017 | 45,000 |
| Duals - CCC-Eligible, Not Enrolled | July-December, 2017 | 39,000 |
| Duals - CCC Enrolled | January, 2018 | 29,000 |
| Non-Duals - LTSS (FFS) | July-December, 2017 | 11,000 |
| Non-Duals - LTSS (HAP) | July-December, 2017 | 8,000 |
| ABD - FFS | July-December, 2017 | 4,000 |
| ABD - Medallion 3.0 | January, 2018 | 76,000 |
| | | **212,000** |

Based on MLTSS membership of 212,000 and historical per-member-per-month (PMPM) data provided by the state's actuary, the annual market size for a fully implemented MLTSS program can be conservatively estimated at around $3.4 billion.

## Covered Services

MLTSS MCOs will be responsible for nearly all Medicaid services for enrolled beneficiaries, including primary, acute, LTSS, behavioral health, and care coordination services. Carve-outs are limited to ID, DD, and DS waiver services, dental services, school health services, preadmission screenings, community ID case management, and DD support coordination.

## Additional RFP Details

- **Dual-Eligible Special Needs Plan (D-SNP) Requirement.** All awarded MCOs will be required to being operating a D-SNP plan within two years of contract award.
- **Value-Based Payment Targets.** Bidders are asked to detail a value-based payments (VBP) strategy, and DMAS will begin setting targets for VBP and alternative payments models in the annual MCO contracts beginning in the second year of the program. Targets will be separated by acute care, behavioral health, and LTSS providers, and different targets will be in place for dual and non-dual members.
- **Specialty Managed Care Plans.** DMAS is open to and will consider proposals for "Specialty Plans" that may target members with a specific diagnosis or condition.
- **Minimum MLR and Performance Withhold.** MCOs will be required to meet an 85 percent minimum medical loss ratio (MLR), with a provision in place to recoup the difference between actual and target MLR if the plan is deficient. Additionally, capitation payments will be subject to a 2 percent performance withhold, to be earned back through meeting of quality, MLTSS performance indicators, VBP targets, and other measures.

## Contract Awards and Evaluation Criteria

DMAS intends to award at least two MLTSS MCOs in each of the six regions across the state. DMAS intends to contract with plans for an initial five-year contract term, with five additional one-year extension options.

| Evaluation Criteria | Weight |
|---|---|
| **Technical Response** | |
| *Corporate Qualifications and Key Staff* | |
| *System of Care* | |
| *Relationship Management Approach* | **85%** |
| *Operations & Technology* | |
| *Readiness Plan* | |
| *Innovations and Experience with Value-Based Payment Strategies* | |
| **Past Experience** | **15%** |

## RFP Timeline

DMAS will hold a mandatory pre-proposal conference on May 10, 2016, with proposals due on June 30, 2016. Preliminary award selections will be made in August and will begin the contract negotiation process. Notices of intent to award will be made on December 9, 2016. Implementation will begin on July 1, 2017, with a phased regional approach, concluding with the CCC and Medallion 3.0 transition on January 1, 2018.

| RFP Milestone | Date |
|---|---|
| Mandatory Preproposal Conference | May 10, 2016 |
| Proposals Due | June 30, 2016 |
| Preliminary Selections, Negotiation Begins | August 19, 2016 |
| Notice of Intent to Award | December 9, 2016 |
| Implemenation - Tidewater (17,500 members) | July 1, 2017 |
| Implemenation - Central (24,000 members) | September 1, 2017 |
| Implementation - Charlottesville/Western (16,500 members) | October 1, 2017 |
| Implementation - Roanoke/Alleghany/Southwest (24,000 members) | November 1, 2017 |
| Implementation - Northern/Winchester (25,000 members) | December 1, 2017 |
| Implementation - CCC/Medallion 3.0 ABD (105,000 members) | January 1, 2018 |

## Current Medicaid MCO Market

At the start of 2016, Anthem HealthKeepers is the top MCO in terms of market share in the state, with nearly 35 percent of all members, followed by Virginia Premier and Optima Health Plan. Additionally, Anthem HealthKeepers, Virginia Premier, and Humana are the only three plans participating in the CCC demonstration program.

| | Medallion 3.0 Enrollment | Commonwealth Coordinated Care (CCC) Enrollment | Total Enrollment | % Share |
|---|---|---|---|---|
| Anthem HealthKeepers | 245,117 | 12,190 | 257,307 | 34.9% |
| Virginia Premier Health Plan | 187,466 | 6,128 | 193,594 | 26.2% |
| Optima Health Plan (Sentara) | 174,251 | | 174,251 | 23.6% |
| INTotal Health LLC (Inova) | 58,429 | | 58,429 | 7.9% |
| CoventryCares (Aetna) | 40,839 | | 40,839 | 5.5% |
| Humana | | 10,526 | 10,526 | 1.4% |
| Kaiser Foundation Health Plan | 2,559 | | 2,559 | 0.3% |
| **Total All Plans** | **708,661** | **28,844** | **737,505** | |

*Source: Medallion 3.0 Enrollment from HMAIS (adjusted for CCC enrollment), 2015. CCC Enrollment from DMAS, January 2016.*

## Link to RFP

http://dmasva.dmas.virginia.gov/Content_pgs/mltss-ihp.aspx

HMA Medicaid Roundup

## Alabama

**Oil Spill Settlement Spending Bill Approved by House Dies in Senate Committee.** *The Montgomery Advertiser* reported on May 3, 2016, that a bill to pay down certain state debt with a portion of a $1 billion BP oil spill settlement, thereby freeing up as much as $70 million in funding for Medicaid, has died in the state Senate Finance and Taxation General Fund Committee. The plan had already passed the state House earlier in the week. The settlement, which BP is scheduled to pay over 18 years, is related to the 2010 Deepwater Horizon spill. Earlier this month, the state Legislature approved a $700 million budget for Medicaid, $85 million short of what the agency said was needed to maintain service levels. Read More

**Medicaid Funding Hearings Focus on Hospitals.** The *Montgomery Advertiser* reported on April 27, 2016, that hearings regarding the state's Medicaid budget are focusing on hospitals. Hearings come after the state approved a $700 million Medicaid budget, which officials say is $85 million short of the necessary funding to maintain services. Medicaid Commissioner Stephanie Azar said earlier this month that the current budget could lead to cuts for adult prescription drugs or outpatient dialysis. Hospitals and providers argue that current funding levels would force them to cut spending, while legislators argue that they can't take any more funds from other state agencies to go towards Medicaid. Legislators created a Medicaid study group to assess the needs of the program and presented an overview last week which argued that hospitals could withstand cuts, but that reductions to other Medicaid providers could increase emergency rooms visits and strain hospitals' budgets. The next hearing to continue discussions will be next week. Read More

## Arkansas

**Lawsuit Claims Arkansas Arbitrarily Reduced, Terminated Home-Based Medicaid Services.** *Arkansas Online* reported on May 4, 2016, that Legal Aid of Arkansas filed a federal lawsuit against the Arkansas Department of Human Services this week alleging that the Department made arbitrary reductions and terminations to home-based Medicaid services for the elderly and individuals with disabilities. The plaintiffs argue that the state's eligibility assessment tool, ArPath, has caused several beneficiaries to see reductions in reimbursement for services that enable them to live in their homes instead of nursing homes. The assessment tool uses a series of 200 questions to give each beneficiary a score used to determine their eligibility for services, which is reassessed annually. The suit, filed in U.S. District Court for the Eastern District of Arkansas, argues that the Department does not provide any information regarding how the scores are

calculated, and therefore the service cuts are potentially arbitrary and violate Medicaid beneficiaries' rights under federal law. The service cuts are on hold pending administrative appeals. Read More

# California

### HMA Roundup – Don Novo (Email Don)

**Medi-Cal FFS Provider Enrollment System to Move Online.** *California Healthline* reported on May 3, 2016, that Medi-Cal's enrollment system for health care providers is moving to an online system. The change comes as the Affordable Care Act has increased provider monitoring requirements. However, the system will only be used for fee-for-service Medi-Cal, while the majority of Medi-Cal services are under managed care. The state previously used a paper system, which was difficult for both providers and the Provider Enrollment Division of the Department of Health Care Services. The new system is expected to speed up the enrollment process and will be available for physicians, surgeons, and nurse practitioners beginning July 29, while other providers will be added next year. Read More

# Colorado

**Universal Coverage Ballot Measure Slated for November.** *The New York Times* reported on April 28, 2016, that Colorado voters will decide in a ballot measure this November whether to replace the Affordable Care Act's coverage options with an estimated $38 billion taxpayer-funded universal healthcare system. The plan, called ColoradoCare, would eliminate deductibles and in-network vs. out-of-network distinctions. Critics say the proposal is too costly. If approved by voters, the program would begin in 2019. Read More

# Illinois

### HMA Roundup – Andrew Fairgrieve (Email Andrew)

**Home Health Overtime Freeze Threatens System, Advocates Say.** The *AP/SF Gate* reported on April 28, 2016, that advocates fear Illinois Governor Bruce Rauner's decision to ban overtime pay for Medicaid home health care workers will result in "chaos." The Governor's administration says the decision will curb fraud and abuse. Overtime pay can cost the state $14 million annually, anAP analysis suggests, with up to half covered by federal funds. Of 24,000 home workers, 27 percent worked over 40 hours in a week. SEIU Healthcare Illinois highlighted the cost-effectiveness of home care versus institutionalization, estimating that home care for individuals with disabilities costs around $16,000 a year, compared to $52,000 for nursing home care. The AP also reported that "SEIU released a statement…saying that the Rauner administration had offered flexibility on overtime-pay rules in exchange for a four-year wage freeze." Read More

# Maryland

**Maryland Seeks Streamlined Medicaid Enrollment for Inmates Leaving Prison.** *Kaiser Health News* reported on May 4, 2016, that as part of a draft 1115 waiver renewal application for its Medicaid managed care program, Maryland is asking for federal approval to streamline the Medicaid enrollment process for inmates leaving prison with chronic conditions, including individuals with mental illness and substance use disorder. The Maryland Department of Health and Mental Hygiene (DHMH) submitted the draft renewal application to HHS for the HealthChoices Medicaid managed care program, with public comments open from April 29, 2016, through May 30, 2016. With the expansion of Medicaid under the Affordable Care Act, Maryland made most former inmates eligible for Medicaid. However, the state Department of Public Safety and correctional Services has so far enrolled less than 10% of the more than 6,000 people leaving Maryland prisons annually. The proposal would allow former inmates to enroll in Medicaid for an initial two-month period after providing basic information such as residency and citizenship. After that, they would be required to complete the full enrollment process, including income eligibility verification and identification requirements. Read More

# New York

HMA Roundup – Denise Soffel (Email Denise)

**New York Requests Federal Approval to Provide Medicaid Coverage to Incarcerated Individuals 30 Days Prior to Release.** Governor Andrew Cuomo announced that New York State is seeking federal approval to provide Medicaid coverage to incarcerated individuals with serious behavioral and physical health conditions prior to release. The intent behind the program is to ensure a smooth transition back into the community for formerly incarcerated individuals, as well as reducing the rate of relapse and recidivism. The Medicaid coverage would apply to certain medical, pharmaceutical, and home health care coordination services. This would address the gap between medical care for individuals in jail or prison, and health coverage for individuals leaving incarceration. While in prison, medical care is provided through the correctional facility, and upon release, many inmates are left without any health coverage at all. New York seeks to be the first state in the nation to create a coordinated continuum of care to ensure individuals have access to the health coverage they need from release through re-entry. The Department of Health is in the process of finalizing a waiver request with the Centers for Medicare and Medicaid Services. If the request is granted, the state would use Medicaid funding to pay for essential coordination and services in the 30 days before release. According to the governor's press release, the state expects to see cost savings in future years, as the coverage will ensure greater continuity of care and less emergency admissions due to relapses in chronic conditions. The primary purpose of the waiver, however, remains to better connect these individuals to the outside healthcare system and prevent any unforeseen barriers that may otherwise impede their access to health coverage both in the short and long term. Read More

**Medicaid Coverage for Hepatitis C Drugs.** The New York State Drug Utilization Review Board approved changes to guidelines around Medicaid coverage for drugs to treat Hepatitis C. The state has removed guidelines that

denied Medicaid patients access to expensive medications such a Solvadi and Harvoni until they became very ill. Prior to yesterday's decision, Medicaid beneficiaries had to have stage 3 fibrosis or cirrhosis or a concurrent HIV-infection before they were given the new drugs, meaning that roughly 40 percent of the state's estimated 60,000 Medicaid patients with chronic hepatitis C could not receive treatment. The Drug Utilization Review Board decision directly affects individuals receiving benefits on a fee-for-service basis and also influences how Medicaid managed care plans structure their benefits. Read More

**Public Comment on New York's Section 1115 Medicaid Waiver.** New York State's Medicaid program has operated under a Section 1115 waiver from the federal government since 1997. The waiver, referred to as the Partnership Plan, provides the underpinnings of New York's mandatory Medicaid managed care program. It also the vehicle by which the state has implemented the initiatives of the Medicaid Redesign Team and all subsequent health systems reforms, including the Delivery System Reform Incentive Payment (DSRIP) program. The waiver has been renewed several times since 1997, typically for a five-year extension; the most recent extension was in October 2015. The Special Terms and Conditions of the waiver now require the state to solicit public comments on the waiver annually. The State is welcoming public comment on any and all aspects of the 1115 Waiver and, therefore, on any aspect of the Medicaid program. The state will be holding two public comment days, one downstate and one upstate. The downstate Public Comment Day will be this Wednesday, May 4th in New York City. No pre-registration is required. Individuals who wish to provide comment will be asked to register on site and will speak in their order of registration. The meeting will be webcast live and will be open to the public. The webcast link can be found here. The state is also accepting written public comment through May 13 at dsrip@health.ny.gov. Read More

**Lessons from New York State's Delivery System Reform Incentive Payment (DSRIP) Program.** The Commonwealth Fund is hosting a webinar about lessons from New York State's Delivery System Reform Incentive Payment (DSRIP) program. The webinar draws on the recent Commonwealth Fund report *Implementing New Yor''s DSRIP Program: Implications for Medicaid Payment and Delivery System Reform*, and offers insights from participants at the city, state, and federal level on early successes and challenges and on how New York's experiences can influence new state payment and delivery system reform initiatives nationally. The webinar will be held on Thursday, May 12, from 2 p.m. to 3 p.m., E.T. Participants include the report's coauthors Deborah Bachrach and William Bernstein; Kalin Scott from the New York State Department of Health; Christina Jenkins, M.D., President of the OneCity Health Services Performing Provider System; and Eliot Fishman from the State Demonstrations Group at CMS. Read More

**New York City To Launch Program Providing Health Care to Immigrants.** New York City is set to launch ActionHealthNYC, a new program intended to provide health care services to some of the city's immigrant population. The program, first announced as "Direct Access" by Mayor de Blasio, is part of a comprehensive plan to improve access to healthcare for the city's immigrant population. ActionHealthNYC will be accepting a limited number of participants in its first year. Eligible participants will have access to primary and specialized healthcare, and the program features a primary care home model, where patients will have the opportunity to build relationships with health

professionals who understand their individual medical history and needs and provide additional care and support mechanisms for individuals with high-risk or chronic conditions. Read More

**2017 Local Services Plan Guidelines for Mental Hygiene Services.** New York State Mental Hygiene Law requires the Office of Alcoholism and Substance Abuse Services (OASAS), the Office of Mental Health (OMH), and the Office for People With Developmental Disabilities (OPWDD) to guide and facilitate the process of local planning. The law also requires local governmental units (LGUs) (57 counties and New York City) to develop and annually submit a local services plan to each mental hygiene agency. That plan must establish long-range goals and objectives that are consistent with statewide goals and objectives. The state has released the 2017 Local Services Plan Guidelines for Mental Hygiene Services, which begins the annual planning process. The guidelines include revisions that better reflect the sweeping transformational changes toward integrated care in the physical and behavioral health care sectors. LGUs must submit their plans to the state by June 1. Read More

**New York's Medicaid Program Receives $7.7 Million in Kickback Settlement.** New York State Attorney General Eric Schneiderman announced a joint settlement with the federal government and a coalition of states to resolve allegations that Olympus Corporation of the Americas paid illegal kickbacks to healthcare providers, in violation of federal and state False Claims Acts, including New York's statute. The national settlement is $306 million, with the New York Medicaid program receiving over $7.7 million dollars in damages. Between January 1, 2006, and December 31, 2011, Olympus, a subsidiary of Olympus Corporation of Japan located in Center Valley, Pennsylvania, used improper financial incentives to induce doctors and hospital executives to buy a wide-ranging array of endoscopes and other surgical equipment manufactured by Olympus. It was alleged that these improper financial inducements took the form of grants, fellowships, consulting payments, free trips, and no-charge loans for equipment, along with other incentives. Read More

# *Ohio*

## HMA Roundup – Jim Downie (Email Jim)

**Democrats Urge Feds to Reject Proposed "Healthy Ohio" Medicaid Waiver.** *Gongwer Ohio* is reporting that Democrats held a Statehouse news conference to oppose the so-called "Healthy Ohio" plan. Senator Sherrod Brown and state legislators are actively urging the federal Center for Medicare and Medicaid Services to reject Ohio's 1115 waiver application. Since the waiver was opened for public comment April 15, opponents have criticized it as a way in which legislators have tried to undo the progress of Medicaid expansion. Medicaid participants who don't make the required contributions to the Buckeye Account – 2 percent of their income up to $99 per year – would lose coverage. Supporters of the program, including state Representative Jim Butler (R-Oakwood), have said it will improve personal responsibility among people on Medicaid and create incentives for more people to take advantage of primary and preventative care. Read More

**Infant Mortality Panel Discusses Ways to Improve Housing Access for Pregnant Women, New Mothers.** *Gongwer Ohio* is reporting out on the subcommittee of the Commission on Infant Mortality that is focused on social

determinants that contribute to problems for pregnant women and new mothers, including finding housing. The commission released its report last month and continues to look for ways to make the recommendations happen. A report is only as good as the people who are brave enough to do the things within the report to make a change," co-chair Senator Shannon Jones (R-Springboro) said. "I think there's plenty of hard work yet to come." Director of Job and Family Services Director Cynthia Dungey said her department has been working to make sure people are able to work before they are forced into the workplace. Last summer they requested a waiver from federal work participation restrictions that would allow them to focus on getting people on benefits into counseling, addiction treatment, education, and job training programs before sending them to the workplace. Read More

# *Oklahoma*

**Health Care Authority Approves Behavioral Health Cuts.** *The Oklahoman* reported on April 28, 2016, that the state's Medicaid agency approved cuts in rates to behavioral health providers and tighter limits on access to mental health and substance abuse therapy. The board of the Oklahoma Health Care Authority approved a 3 percent provider rate cut for freestanding psychiatric hospitals, a 10 percent cut for independent psychologists and behavioral health licensure candidates in outpatient clinics, a 15 percent cut for residential psychiatric services, and a 30 percent cut for independent licensed behavioral health practitioners. The cuts were proposed by the Oklahoma Department of Mental Health and Substance Abuse Services, which oversees Medicaid funds used for behavioral health. Read More

**Proposed Tax to Fund Medicaid Rebalancing Plan Faces Opposition.** The *AP/Washington Times* reported on April 30, 2016, that Oklahoma's proposed Medicaid Rebalancing Act, an alternative to Medicaid expansion, is gaining support from Republican lawmakers, although many are hesitant about funding the plan with a proposed $1.50 per-pack tobacco tax. The Rebalancing Act would expand coverage to 175,000 uninsured adults through Insure Oklahoma, a premium-assistance program for low-income residents whose employers offer health insurance. Additionally, the proposal would move 175,000 SoonerCare members, many pregnant women and children, into Insure Oklahoma. The tax increase requires a three-fourths vote from the legislature. Some Democrats have opposed the tax, arguing that Medicaid expansion would be a better and more affordable option than the rebalancing plan. Tobacco companies have opposed the tax as well. Additionally, the Medicaid Rebalancing Act still requires federal approval before it could be implemented. Read More

# *Pennsylvania*

## HMA Roundup – Julie George (Email Julie)

**Medical Assistance Advisory Committee Monthly Meeting Held April 28, 2016.** Pennsylvania's Medical Assistance Advisory Meeting was held April 28, 2016. Below are key items that were discussed during this meeting.

- Governor's Employment First Executive Order. Pennsylvania's Department of Human Services is seeking public comment on the development of an implementation plan as directed in Governor Tom

Wolf's Executive Order 2016-03, entitled "Establishing 'Employment First' Policy and Increasing Competitive Integrated Employment for Pennsylvanians with a Disability." This policy will affect the private and public sector and will not be limited to Medicaid customers. Written comments are due on May 30. A workgroup will present a plan to the governor's office by July 8. Read More

- Community HealthChoices Updates. Responses to the Community HealthChoices RFP were due on May 2. The CHC Waiver was posted for a 30 day comment period on April 23. The department's goal is to submit the waiver by mid-summer.

**Pennsylvania Launches Medicaid Third-Party Liability Portal.** On May 2, 2016, Pennsylvania's Department of Human Services (DHS) and the Governor's Office of Transformation, Innovation, Management and Efficiency (GO-TIME) announced the launch of an online portal designed to streamline Medicaid Third Party Liability processing and increase collections. DHS estimates it will collect $613 million by the end of this fiscal year, up from $582 million last fiscal year, for payments initially made by Medicaid that should have been covered by private insurance. The state expects the new portal to make it easier to process these cases and further increase the amount collected each year. Read More

**DHS Celebrates Medicaid Expansion Anniversary.** Pennsylvania marked the one-year anniversary of Medicaid expansion last week. To commemorate the occasion, Governor Wolf's Administration release an infographic highlighting the accomplishments throughout the year. Download the graphic here.

## *Rhode Island*

**Neighborhood Health Plan of Rhode Island Launches Dual Demo Plan.** The *Providence Journal* reported on April 29, 2016, that Neighborhood Health Plan of Rhode Island is launching a new dual eligible financial alignment demonstration plan and will begin accepting passive enrollments this summer. The plan, Integrity, is expected to cover 10,000 to 14,000 dual Medicaid and Medicare beneficiaries as the lone demonstration plan through a three-way contract with CMS and the state. The plan offers members a care coordinator to facilitate access to primary, behavioral, and long-term care. Neighborhood previously launched Rhody Health Options to coordinate Medicaid benefits for dual eligible beneficiaries. Rhode Island is the thirteenth state to finalize a three-way contract for a capitated dual eligible demonstration. Read More

**Medicaid Spending Below Budget Estimates.** The *Providence Journal* reported on April 25, 2016, that Rhode Island's Medicaid spending is currently $46.5 million below a budget estimate made in November, with the state share of costs $7 million below the estimate. State and federal spending is expected to total $2.23 billion in the fiscal year ending June 30, down from the November estimate of $2.27 billion. The state's portion is expected to total $892.5 million, down from an estimated $899.4 million. These projections put the state on track to meet Governor Gina Raimondo's $71 million savings target, which is part of her Reinventing Medicaid initiative. Read More

## South Dakota

**South Dakota Accused of Unnecessarily Putting Individuals with Disabilities into Nursing Homes.** *The New York Times* reported on May 2, 2016, that the U.S. Justice Department is investigating South Dakota for unnecessarily placing thousands of individuals with serious but manageable disabilities in nursing homes or long-term care facilities. The federal government has opened over 50 investigations and reached settlements with eight other states, allowing more than 53,000 patients to leave institutional care settings or avoid institutionalization altogether. The Justice Department said that it may take legal action against South Dakota for discrimination against individuals with disabilities. Read More

## Texas

**HHSC Receives Approval for 1115 Waiver Extension.** The Texas Health and Human Services Commission reported on May 2, 2016 they have received approval from CMS for a 15-month extension of the state's 1115 Waiver through December 2017. The original waiver was approved in 2011 and is set to expire in September 2016. The extension includes approval of three separate Medicaid initiatives authorized under the waiver: 1) continuation of Medicaid managed care; 2) continuation of current funding for the state's Uncompensated Care Pool (UC) for hospitals providing care to the uninsured, avoiding a potentially significant decrease in hospital reimbursements later this year; and 3) continuation of the Delivery System Reform Incentive Payment (DSRIP) program. Both UC and DSRIP received the full requested funding amount for the 15 month period, which is not to exceed $3.875 billion for each program for a total of $7.750 billion.

Nearly 300 providers currently oversee approximately 1,450 DSRIP projects that cover a broad range of health care improvement initiatives such as behavioral healthcare services, access to primary and specialty care, chronic care management, and health promotion and disease prevention. Unlike some states with DSRIP programs, the Texas program includes several types of providers including public and private hospitals, physician groups, community mental health centers, and local health departments. Through January 2015, more than $4.5 billion was earned by providers who met improvement goals associated with their specific projects.

As noted in the CMS letter authorizing the waiver renewal, HHSC will continue discussions with CMS over the next 15 months to secure a longer term extension that "supports adequate and appropriate levels of Medicaid payment under managed care." During this time, HHSC is required to submit an independent report analyzing the Uncompensated Care pool. HHSC has contracted with Health Management Associates and Deloitte to conduct the study, which is due to CMS by August 31, 2016.

CMS also states they will work with HHSC to develop an approach to the future of DSRIP that supports Texas' managed care program for Medicaid beneficiaries. The CMS letter notes that, while they are confident CMS and Texas will reach an agreement by the end of the 15 month extension period, failure to do so will likely mean that the "UC pool will not be renewed at the end of 2017 except at a reduced level consistent with CMS" principles for uncompensated

care." Absent an agreement, DSRIP will also phase down beginning at 25 percent in 2018, then by an additional 25 percentage points for each following year.

According to the *Texas Tribune*, response to the waiver announcement has been positive. John Hawkins, Vice President of Government Relations for the Texas Hospital Association, said the approval is a "positive development" that gives the state more time to study the impact of uncompensated care. Anne Dunkelberg, the Associate Director for the Center for Public Policy Priorities, also said the renewal is good news, but noted the federal government "is focused on getting people insured, rather than paying hospitals back for the uninsured." The full *Texas Tribune* story is available here.

The state has 30 days to submit written acceptance to CMS. For additional information on the wavier application, the CMS renewal approval letter and STCs, visit the HHSC waiver renewal website at: http://www.hhsc.state.tx.us/waiver-renewal.shtml

**Dental Clinics Accused of Overbilling, Endangering Children.** The *Houston Chronicle* reported on May 1, 2016, that Medicaid dental clinics in Texas are being accused of overbilling Medicaid and endangering children. The clinics are accused of using heavy sedative drugs and strait-jacket restraints called papoose boards on children to rush them through treatment. Medicaid dental claims in Texas rose by 400 percent to $1 billion from 2005 to 2015. Currently, there are 160 ongoing Medicaid dental fraud investigations in the state. According to a 2013 joint report by the committee staffs of U.S. Senator Chuck Grassley (R-IA) and then-Senator Max Baucus (D-MT), corporate-run dental practices "over-emphasize bottom-line financial considerations at the expense of providing appropriate high-quality, low-cost care." Read More

## *National*

**States Prepare to Implement CMS Medicaid Managed Care Rules.** *Modern Healthcare* reported on April 30, 2016, that states "will need money, manpower and some detailed direction" to implement sweeping new Medicaid managed care rules from CMS. Among the requirements are minimum medical loss ratios (MLRs) for insurers and tighter rules around provider network adequacy, quality rating systems, provider screenings, and rate certifications. The article relates comments from Camille Dobson, deputy executive director of the National Association of States United for Aging and Disabilities, who said states will implement the rules differently because their programs differ in their level of maturity and performance. While states with more mature Medicaid managed care programs already meet many of the new guidelines, others will have to make substantial changes. Read More

**New Medicaid Rule to Allow Federal Match for Short-Term Inpatient Mental Health Care.** *CQ Roll Call* reported on April 27, 2016, that a new CMS rule will allow matching federal reimbursements to institutions providing short-term inpatient mental health or substance abuse services to patients enrolled in Medicaid managed care plans. Currently, the law prohibits federal officials from providing Medicaid payments for patients in an institution. Advocates say the new rule may pressure Congress to pass stalled legislation expanding Medicaid coverage for inpatient treatment.

**HHS Urges States to Enroll Inmates in Medicaid Prior to Their Release.** *Kaiser Health News* reported on April 29, 2016, that the U.S. Department of Health and Human Services (HHS) is urging states to enroll inmates in Medicaid prior to their release from prison. HHS is also urging states to expand eligibility to those in halfway houses near the end of their sentences. The Affordable Care Act made almost all inmates eligible for Medicaid in expansion states upon their release. However, prisons have been slow to enroll inmates due to staffing issues and difficulty with enrollment processes. A Health Affairs study found that only 112,500 inmates were enrolled upon release across the country between 2013 and January 2015. Approximately 600,000 inmates are released from state and federal prison annually. Former inmates have high rates of HIV, Hepatitis C, diabetes, substance abuse, and other complex medical conditions. Read More

**Opioid Hospitalization Costs More Than Double to $15 Billion Over 10 Years.** *Kaiser Health News* reported on May 2, 2016, that according to a *Health Affairs* study, opioid-related hospitalizations rose 72 percent to 520,000 from 2002 through 2012, while infections, like endocarditis or septic arthritis, increased 92 percent to 6,535. Hospitals billed $15 billion in 2012 for opioid-related care, more than double compared to 2002. Over $700 million of the costs went to treating infections. Wilson Compton, deputy director of the federal National Institute on Drug Abuse, stated that there is overlap between people who are on Medicaid and those abusing opioids, and continued growth in opioid-related care costs will continue to drive Medicaid costs up. He said the findings add another reason to increase efforts to combat addiction. Read More


## Industry News

**Aetna Expects to Break Even on Exchange Business in 2016.** *CQ Roll Call* reported that Aetna will continue to participate in the ACA Marketplaces, but says large structural changes, such as increasing product and rating flexibility and adding separate risk pools, are needed or the dynamics of the market will get tougher going forward. Aetna expects its Exchange business to break even in 2016. The company offers Exchange plans in 15 states, covering nearly 1 million Exchange enrollees.

**Humana to Exit Some State Exchanges After Enrollment Declines, Anticipated Losses.** On May 4, 2016, *The Washington Examiner* reported that Humana announced in first quarter 2016 results that the company will exit individual and Exchange markets in the coming year after reporting a more-than 20 percent decline in individual market membership, much of it in the Exchanges. Humana is also anticipating losses associated with its Exchange business in 2016. The company did not state with markets it would exit at this time. Humana reported 875,000 individual members as of March 31, 2016, the majority of which are in Exchange plans. Read More

**Epic Health Services Acquires Care Resources.** *PE Hub* reported on April 29, 2016, that Dallas-based Epic Health Services is acquiring Care Resources, a Baltimore, Maryland-based provider of pediatric therapy and early intervention services for children with special needs. Epic operates in 17 states and provides pediatric skilled nursing, therapy, and enteral services. Read More

# RFP Calendar

| Date | State/Program | Event | Beneficiaries |
|---|---|---|---|
| May 2, 2016 | Pennsylvania MLTSS/Duals | Proposals Due | 420,000 |
| May 11, 2016 | Indiana | Cost Proposals Due | 900,000 |
| May, 2016 | Minnesota SNBC | Contract Awards | 45,600 |
| May, 2016 | Massachusetts MassHealth ACO - Pilot | Applications Open | TBD |
| May, 2016 | Oklahoma ABD | DRAFT RFP Release | 177,000 |
| June, 2016 | Indiana | Contract Awards | 900,000 |
| March 1, 2017 | Virginia MLTSS | Proposals Due | 212,000 |
| July 1, 2016 | Missouri (Statewide) | Proposals Due | 700,000 |
| July 1, 2016 | West Virginia | Implementation | 450,000 |
| July 1, 2016 | Minnesota SNBC | Impementation (Northern Counties) | 45,600 |
| July, 2016 | Georgia | Implementation | 1,300,000 |
| August, 2016 | Oklahoma ABD | RFP Release | 177,000 |
| July-August, 2016 | Massachusetts MassHealth ACO - Full | Applications Open | TBD |
| September 1, 2016 | Texas STAR Kids | Implementation | 200,000 |
| September, 2016 | Massachusetts MassHealth ACO - Pilot | Selection | TBD |
| October 1, 2016 | Missouri (Statewide) | Contract Awards | 700,000 |
| October, 2016 | Oklahoma ABD | Proposals Due | 177,000 |
| November 1, 2016 | Arizona ALTCS (E/PD) | RFP Release | 30,000 |
| December 9, 2016 | Virginia MLTSS | Contract Awards | 212,000 |
| December, 2016 | Massachusetts MassHealth ACO - Pilot | Implementation | TBD |
| December, 2016 | Massachusetts MassHealth ACO - Full | Selection | TBD |
| January 1, 2017 | Pennsylvania HealthChoices | Implementation | 1,700,000 |
| January 1, 2017 | Nebraska | Implementation | 239,000 |
| January 1, 2017 | Pennsylvania MLTSS/Duals | Implementation (SW Region) | 100,000 |
| January 1, 2017 | Minnesota SNBC | Implementation (Remaining Counties) | 45,600 |
| January 18, 2017 | Arizona ALTCS (E/PD) | Proposals Due | 30,000 |
| March 7, 2017 | Arizona ALTCS (E/PD) | Contract Awards | 30,000 |
| May 1, 2017 | Missouri (Statewide) | Implementation | 700,000 |
| July 1, 2017 | Virginia MLTSS | Implementation | 212,000 |
| October 1, 2017 | Arizona ALTCS (E/PD) | Implementation | 30,000 |
| October, 2017 | Massachusetts MassHealth ACO - Full | Implementation | TBD |
| TBD 2017/2018 | Oklahoma ABD | Implementation | 177,000 |
| January 1, 2018 | Pennsylvania MLTSS/Duals | Implementation (SE Region) | 145,000 |
| January 1, 2019 | Pennsylvania MLTSS/Duals | Implementation (Remaining Regions) | 175,000 |

# Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

| State | Model | Opt- in Enrollment Date | Passive Enrollment Date | Duals Eligible For Demo | Demo Enrollment (April 2016) | Percent of Eligible Enrolled | Health Plans |
|---|---|---|---|---|---|---|---|
| **California** | Capitated | 4/1/2014 | 5/1/2014<br>7/1/2014<br>1/1/2015 | 431,000 | 123,981 | 28.8% | CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore) |
| **Illinois** | Capitated | 4/1/2014 | 6/1/2014 | 148,000 | 48,272 | 32.6% | Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina |
| **Massachusetts** | Capitated | 10/1/2013 | 1/1/2014 | 94,000 | 12,307 | 13.1% | Commonwealth Care Alliance; Network Health |
| **Michigan** | Capitated | 3/1/2015 | 5/1/2015 | 105,000 | 31,766 | 30.3% | AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan |
| **New York** | Capitated | 1/1/2015 *(Phase 2 Delayed)* | 4/1/2015 *(Phase 2 Delayed)* | 124,000 | 5,617 | 4.5% | There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website. |
| **Ohio** | Capitated | 5/1/2014 | 1/1/2015 | 95,000 | 61,535 | 64.8% | Aetna; CareSource; Centene; Molina; UnitedHealth |
| **Rhode Island** | Capitated | 5/1/2016 | 7/1/2016 | 14,000 | | | Neighborhood INTEGRITY |
| **South Carolina** | Capitated | 2/1/2015 | 4/1/2016 | 53,600 | 5,954 | 11.1% | Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth) |
| **Texas** | Capitated | 3/1/2015 | 4/1/2015 | 168,000 | 45,219 | 26.9% | Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United |
| **Virginia** | Capitated | 3/1/2014 | 5/1/2014 | 70,500 | 27,116 | 38.5% | Humana; Anthem (HealthKeepers); VA Premier Health |
| **Total Capitated** | **10 States** | | | **1,303,100** | **361,767** | **27.8%** | |

*Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.*

# HMA News

## HMA Information Services Launches Daily Roundup

HMA Information Services is pleased to announce the launch of the *Daily Roundup*, which includes breaking industry news and state-by-state updates from HMA consultants in the field. The *Daily Roundup* will be available only to HMAIS subscribers and will include advance content from *the HMA Weekly Roundup*, which will otherwise remain unchanged and continue to be distributed to readers every Wednesday evening. For more information about the Daily Roundup please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

## HMA Upcoming Webinars

**"Understanding the Impact of the Mental Health Parity and Addiction Equity Act – Final Regulations"**

*May 11, 2016*

Learn More
Register Now

**"Using a Policy Framework to Foster Provider Practice Transformation: How the District of Columbia Launched Major Delivery System Change through its Medicaid Health Home Program for Individuals with Serious Mental Illness"**

*May 12, 2016*

Learn More
Register Now

**"Marrying Strategic, Operational and Information Technology Planning: Two Separate Frameworks in Support of Common Goals for Healthcare Organizational Efficiency and Effectiveness"**

*May 17, 2016*

Learn More
Register Now

**"Patient-Centered Medical Home Transformation: The Right Thing to Do for Patients and for Your Organization"**

*May 18, 2016*

Learn More
Register Now