HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 11, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

RHODE ISLAND LAUNCHES DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION

This week, our *In Focus* section reviews the second phase of Rhode Island's Integrated Care Initiative (ICI), which integrates Medicaid and Medicare benefits under a capitated dual eligible financial alignment demonstration. After finalizing a three-way contract between the Rhode Island Executive Office of Health and Human Services (EOHHS), the Centers for Medicare & Medicaid Services (CMS), and Neighborhood Health Plans of Rhode Island's Neighborhood INTEGRITY plan, EOHHS is able to begin allowing voluntary opt-in enrollment to Neighborhood INTEGRITY as of May 1, 2016, and will begin passive enrollment on July 1, 2016. EOHHS estimates around 30,000 dual eligible members will be eligible for enrollment in ICI Phase 2.

ICI Phase 1 Overview

Phase 1 of the ICI included two model options for coordinating care for dual eligibles and users of long term services and supports (LTSS). The first was an enhanced primary care case management (PCCM) model, known as the Connect Care Choice Community Partners (CCCCP). The second option was a Medicaid health plan model, including integrated LTSS benefits, known as Rhody Health Options (RHO), served by Neighborhood Health Plan of Rhode Island's Neighborhood UNITY plan. As of February 29, 2016, there were more than 21,400 members, nearly all of them dual eligibles, enrolled in RHO/Neighborhood UNITY, as detailed in the table below.

Integrated Care Initiative (ICI) - Phase I Enrollment by Program and Setting
As of February 29, 2016

Setting	Rhody Health Options/ Neighborhood UNITY	Not Enrolled	Total ICI Eligible
Nursing Home >90 Days	2,820	2,035	**4,855**
ID/DD	2,073	403	**2,476**
Community w/ LTSS	1,763	1,316	**3,079**
SPMI	1,784	550	**2,334**
Community w/o LTSS	12,421	4,085	**16,506**
Medicaid Only (Includes DD/SPMI)	556	207	**763**
Total	**21,417**	**8,596**	**30,291***

**Total ICI Eligible includes an additional 278 Program of All-Inclusive Care for the Elderly (PACE) members, as of February 29, 2016*

Source: Rhode Island Long Term Care Coordinating Council Meeting, March 9, 2016.

ICI Phase 2 Enrollment

Given that Neighborhood INTEGRITY is the only participating Medicare-Medicaid Plan (MMP) in the ICI demonstration, passive enrollment, slated to begin the first of six monthly enrollment waves on July 1, 2016, will be limited to current Neighborhood UNITY members. The six waves of passive enrollment will take place on the first of each month, July through December, 2016. As in other dual eligible demonstrations, members may opt-out of the MMP at any time, and may receive their Medicaid services through Rhody Health Options/ Neighborhood UNITY, and their Medicare services through a Medicare Advantage plan, PACE plan, or fee-for-service.

MMP Payment Provisions

Aggregate Savings, Quality Withhold. As with other capitated dual eligible demonstrations, rate setting will occur between CMS and the State of Rhode Island. Medicare and Medicaid will each contribute to the capitation rate, consistent with projected baseline spending projections. Aggregate savings percentages will be applied equally to the Medicaid and Medicare Part A and B components of the capitation rate. Additional quality withhold percentages will be deducted from the capitation rate to be earned back based on a set of quality measures.

The demonstration years (DY), aggregate savings, and quality withhold percentages for Neighborhood INTEGRITY are detailed in the table below.

	Demonstration Year/Timing	Aggregate Savings	Quality Withhold
DY1	May 1, 2016 - December 31, 2017	1.0%	1.0%
DY2	January 1, 2018 - December 31, 2018	1.25%	2.0%
DY3	January 1, 2019 - December 31, 2019	3.0%	3.0%
DY4	January 1, 2020 - December 31, 2020	3.0%	3.0%

The three-way contract specifies that the DY3 aggregate savings percentage may be reduced to 1.5 percent if losses exceed 3 percent of total adjusted capitation rate revenue in DY2.

Medicaid Rate Cells, Risk Share. The Medicaid component of the MMP capitation will be set for the following Medicaid rate cells:

- Community non-LTSS
- Community LTSS
- Facility LTSS
- Individuals with intellectual or developmental disabilities (I/DD)
- Individuals with severe and persistent mental illness (SPMI)

Additionally, risk corridors will be in place throughout the life of the demonstration, with increasing gain/loss sharing responsibility for Neighborhood INTEGRITY in later years.

Alternative Payment Arrangement Targets. CMS and RI EOHHS have included target levels of alternative payment arrangements with providers in the three-way contract. For calendar year 2017, Neighborhood INTEGRITY is expected to develop alternative payment arrangements covering at least 20 percent of provider payments for Medicaid and Medicare A/B services. This increases to 50 percent in 2018, and must meet RI EOHHS standards in 2019 and 2020. Additionally, beginning in 2018, 80 percent of provider payments for Medicaid and Medicare A/B services must be linked in some way to quality and/or value.

More Information

Link to ICI Home Page:
http://www.eohhs.ri.gov/Initiatives/IntegratedCareInitiative.aspx

Link to Three-Way Contract:
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/RhodeIslandContract.pdf

HMA Medicaid Roundup

Alabama

Governor Considers Special Session on Medicaid RCOs, Other Issues. The *Montgomery Advertiser* reported on May 6, 2016, that Alabama Governor Robert Bentley could consider a special legislative session to address several unresolved issues, including additional Medicaid funding from the state's oil spill settlement with BP, which was scrapped in a Senate committee this week, as well as a renewed push to implement Medicaid Regional Care Organizations (RCOs), which were delayed in the same session. Governor Bentley may also seek approval of an $800 million prison construction proposal in the session. Read More

Alabama Delays Medicaid Reform Plan Due to Lack of Funding. *The Anniston Star* reported on May 4, 2016, that Alabama legislators voted to delay the state's Medicaid reform plan because of lack of funding. The overwhelmingly approved reform plan, which was scheduled to begin October 1, would place around two-thirds of the state's 900,000 Medicaid members in provider-based Regional Care Organizations. RCOs would take risk through capitated contracts with the state, manage benefits, and coordinate care. The state has struggled to find money to fund Medicaid given surging enrollment and a stagnant General Fund. The Medicaid agency stated that it needs $785 million to run the program, but lawmakers were only able to appropriate $700 million. Read More

Arizona

HMA Roundup – Jeff Smith (Email Jeff)

Arizona Governor Signs Bill Restoring KidsCare CHIP Program. Despite the objections of Republican leadership, the Arizona legislature voted on May 6 to restore KidsCare, a program it had dropped six years ago during an economic slowdown. Governor Douglas Ducey wasted no time in signing the bill. The legislation will allow Arizona to accept federal dollars to restart KidsCare, which is the state's Children's Health Insurance Program. The program is expected to provide health care coverage to approximately 30,000 children in families with incomes up to 200% of FPL or approximately $41,000. Senate Majority Leader Steve Yarbrough, a Republican who opposes the measure, has said he anticipates a lawsuit claiming SB 1457 is illegal because the provision to restore KidsCare was attached to language dealing with eligibility of students with disabilities to continue to get vouchers to attend private and parochial school at taxpayer expense. Senator Yarbrough said that violates a provision of the Arizona Constitution that says legislation can deal with only one subject. But Representative Kate Brophy McGee (R-Phoenix), one of the legislation's

architects, said there is a connection between the two subjects and that the legislation will survive any legal challenge.

California

California Reverses Course on Passive Enrollment for Duals. *California Healthline* reported on May 5, 2016, that California's Department of Health Care Services (DHCS) announced this week that it will not go ahead with plans for annual passive enrollment in the state's dual eligible financial alignment demonstration, Cal MediConnect, under the state's Coordinated Care Initiative (CCI). The decision is aimed at reducing opt-outs and disenrollments from members who do not understand their options and changes to their coverage. DHCS hopes that the decision, along with other changes, including streamlined enrollment processes and extending the duration a member can stay with their existing Medicare providers under a new plan from six months to one year, will boost enrollment and strengthen the program. However, DHCS has not ruled out revisiting passive enrollment if voluntary enrollment does not pick up. The changes are expected to be implemented this summer. Read More

Minimum Wage Increase to Benefit Home Care Workers. *California Healthline* reported on May 10, 2016, that the California's minimum wage increase will positively impact the state's In-Home Supportive Services (IHSS) home care workers. The state's current minimum wage of $10 per hour, which was effective January 1, 2016, will gradually increase to $15 an hour by 2022 for businesses with more than 25 workers (2023 for smaller workplaces). The increases will be phased in annually, rising to $10.50 an hour next year for those businesses with over 25 employees. Approximately 400,000 IHSS workers in the state will benefit from the increase. With a mean annual pay of $26,700, home care workers in California make less than half the average worker in the state. Opponents are concerned that increased wages will make it harder for families to hire home care workers. Read More

Colorado

Bill Requiring Audits of Community-Centered Boards Awaits Governor's Signature. *The Denver Post* reported on May 10, 2016, that the state legislature passed a bill requiring periodic audits of not-for-profit community-centered boards, which serve as case managers for individuals with disabilities. The measure is now headed to Governor John Hickenlooper for signature. Community-centered boards, which receive about 90 percent of their funding from taxpayers, are under scrutiny concerning the amount of money spent on administrative costs versus patient care. Read More

Iowa

Legislature Moves to Increase Oversight of Medicaid Managed Care. *The Des Moines Register* reported on May 9, 2016, that the Iowa legislature has passed a bill that would increase oversight of Medicaid managed care plans. However, Iowa Governor Terry Branstad hasn't indicated yet whether he would sign the measure. Iowa launched its new Medicaid managed care plan, IA Health Link, on April 1, after conducting an RFP last year to cover nearly all of the state's

570,000 Medicaid beneficiaries. Contracted plans for the new IA Health Link program are Anthem, AmeriHealth Caritas, and UnitedHealth. Read More

Kansas

Supporters Launch New Push for Medicaid Expansion. *The Topeka Capital-Journal* reported on May 9, 2016, that proponents of Medicaid expansion in Kansas have launched a new campaign to push for expansion, which could cover up to 150,000 uninsured adults in the state. Religious leaders, health advocates, and businesses have joined together to lobby for expansion in the face of strong opposition from Governor Sam Brownback, House Speaker Ray Merrick, and other Republican lawmakers. Proponents argue that the state has turned down an extra $1.15 billion in federal Medicaid funding by refusing to expand. "We will not support an expansion plan that does not have a work requirement, is not sustainable and which puts the needs of able-bodied adults above the disabled and our most vulnerable citizens," said Eileen Hawley, the governor's spokeswoman. Read More

Louisiana

DHH Seeks Federal Approval to Use SNAP Data for Medicaid Eligibility. *The Times-Picayune* reported on May 6, 2016, that the Louisiana Department of Health and Hospitals (DHH) has requested federal approval for a Medicaid state plan amendment that would allow the use of food stamp applications to qualify individuals for Medicaid expansion. Since eligibility requirements for Medicaid and the Supplemental Nutrition Assistance Program are similar, the amendment would allow the state to automatically qualify thousands. Six other states currently use a similar approach through Medicaid waivers. Overall, enrollment in the Healthy Louisiana expansion program could reach 375,000. Louisiana is already in the process of enrolling in Healthy Louisiana members of two existing programs providing coverage to low-income individuals: Greater New Orleans Community Health Connection and the Take Charge. Read More

Michigan

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

From HMA's *The Michigan Update*: MDHHS Aims to Boost Duals Demo Enrollment through New Passive Enrollments. The Michigan Department of Health and Human Services (MDHHS) has recently announced that, within allowable parameters, it will begin passively enrolling certain duals into the ICOs on a monthly basis, including duals newly eligible for MI Health Link enrollment since the last passive assignment process in 2015, duals who recently moved into one of the demonstration areas, certain duals eligible for passive enrollment but who temporarily lost their Medicaid eligibility in 2015, and qualified individuals newly eligible for Medicare for whom the Centers for Medicare & Medicaid Services has not already assigned a plan. The first passive enrollment group is expected to include about 15,000 individuals: at least 900 in the Upper Peninsula region, more than 2,750 in each of the Southwest and Macomb County regions, and more than 9,000 in the Wayne County region. These passive enrollments are scheduled to be effective June 1, 2016. Read More

From HMA's *The Michigan Update*: Integration of Behavioral Health and Physical Health Services. As we reported in last month's edition of The Michigan Update, Governor Rick Snyder's Executive Budget Recommendation included language (Section 298) that would transfer funds currently appropriated to the state's ten Prepaid Inpatient Health Plans (PIHPs) for the provision of behavioral health services to the Medicaid-contracted Medicaid Health Plans (HMOs) that provide physical health services. As a result of the immediate reaction to the language, Lieutenant Governor Brian Calley recommended the language be deleted and convened a group of more than 120 stakeholders that will meet over the coming months to develop a framework to better coordinate physical and behavioral health care while improving access to and funding for direct services. A fact-finding subcommittee of approximately 15 members of the larger group has been meeting to develop a set of consensus facts on the performance of the PIHPs and HMOs and to develop an "end statement" (objectives) and "core values" (principles) for further discussion by the full group. The Legislature has also become involved in the issue, and neither chamber has included the Governor's language in their proposed budget bill. The House of Representatives included language requiring a written report and recommendations from the workgroup by December 2016. The Senate's bill included similar language but provides two additional months for the submission of a report and recommendations. The Legislative Conference Committee will have to reconcile the language differences in the final budget bill. Read More

From HMA's *The Michigan Update*: Michigan Medicaid Budget for FY 2016-2017. The Senate Appropriations Committee and the full House of Representatives have completed action on the Fiscal Year (FY) 2016-2017 budget for the Michigan Department of Health and Human Services (MDHHS). Both bills include changes to the Governor's Executive Budget Recommendation, and there are significant differences between the two bills. As a result, once the full Senate has acted on the MDHHS budget, there will be a number of issues to address in the Conference Committee. As noted in the Integration of Behavioral Health and Physical Health Services discussion above, both chambers have modified the language related to integration of behavioral health and physical health services, but not in an identical manner. Among the policy-related funding changes made by either or both the House and Senate are the following:

- Adult Dental Services: The Senate increases rates for adult dental services effective 7/1/2017 to rates that would allow for a contract for adult dental services. Cost is $23.0 million.
- Private Duty Nursing: The Senate increases rates by 20 percent at a cost of $6.6 million. The House provides $3.3 million for a 10 percent rate increase.
- Primary Care Rates: The Senate increases rates for primary care services by 6 percent at a cost of $21.3 million.
- State Innovation Model: The Senate reduces funding from $25 million to $100 to create an opportunity to discuss the Blueprint for Health Innovation in the Conference Committee.
- Specialty Drugs - Hepatitis C and Cystic Fibrosis: The House concurs with the Executive's Cystic Fibrosis treatment costs, but reduces growth in funding for Hepatitis C treatment by $84 million, based on an estimate of 5,250 persons receiving treatment.

- Medicaid Pharmacy Reserve: The Executive Budget includes $86.1 million. The House reduces the reserve fund to just over $43 million and the Senate reduces it to $28.7 million.
- University of Detroit Dental Clinic: The Senate reduces the funding from $1 million to a $100 placeholder while the House increases funding to $4.3 million, of which 50 percent is one-time funding and 50 percent is ongoing funding.

Since this is an election year, it is likely that the Conference Committee and final legislative action will occur in early May. Read More

House Approves Legislation to Move Certain Prisoners to Nursing Homes. The *AP/Chicago Tribune* reported on May 5, 2016, that the Michigan House of Representatives approved a plan to release approximately 120 prisoners per year who are considered "medically frail" and have long-term care needs to live in nursing homes. The plan is expected to save the state $5.4 million annually as these prisoners cost three to five times more than healthy prisoners, according to analysis conducted by the House Fiscal Agency. About 9,000 Michigan prisoners are at least 50 years old. The legislation will now go to the state Senate. Read More

Missouri

Medicaid Dental Coverage Expansion Approved by CMS. *KY3* reported on May 10, 2016, that the Centers for Medicare & Medicaid Services (CMS) has approved Missouri's plan to cover an expanded set of dental services for 282,000 adults on Medicaid, with payments to dental providers retroactive to January 1, 2016. Previously, Medicaid had covered only trauma of the mouth, jaw, or teeth from an injury or medical condition. The new measure adds coverage for preventive services, restorative services, periodontal treatment, oral surgery, extractions, and more. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Bill Would Establish 120 Day Deadline To Issue New Jersey Home Health Aide Applicants With Licenses. *NJ Spotlight* reported that on May 2, 2016, the Senate Health Committee voted unanimously in favor of S-2036, which would require that the New Jersey Board of Nursing issue conditional certificates for homemaker-home health aides within seven days and review the applications and issue the final certifications within 120 days. This bill was introduced earlier this year by Senator Robert M. Gordon to lessen the period of time that a home health aide candidate would have to wait for a license after submitting an application. Paul Loriquet, who oversees the Consumer Affairs Division that operates the Board of Nursing, expressed that this legislation is unnecessary and the State has recently been able to provide faster turnaround times on applications. Regardless, supporters hope that reducing the amount of time to become certified will deter individuals from opting for alternative employment options and ultimately reduce the risk of a home health aide workforce shortage. Read more

Advocates for Individuals with SMI, SUD Express Rate Concerns. *NJ Spotlight* reported on May 4, 2016, that many of New Jersey's community mental health and substance abuse agencies remain concerned about Medicaid reimbursement rates as the state implements new payment models over the rest of 2016 and into the first half of 2017. State Medicaid officials assured state lawmakers that they are working closely with agencies during the transition, and the agencies themselves are welcoming the $127 million increase in funds. However, agencies and advocates continue to express concern around the reimbursement formula, and caution that the new rates, particularly those for outpatient mental health services, could generate systemic funding shortages and impact access to care. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

DSRIP Year Two Theme – Fact-Based Optimism. The Department of Health has posted a new video in its White Board series explaining New York's Delivery System Reform Incentive Payment (DSRIP) Program. In recognition of the beginning of DSRIP Year 2, NYS Medicaid Director Jason Helgerson discusses the need for fact-based optimism. An idea developed by Bruce Mau of massivechangenetwork.com, fact-based optimism emphasizes developing a culture of possibility. The video describes DSRIP as an exciting and challenging opportunity for improving outcomes in healthcare in NYS and why optimism is essential going forward as Performing Provider Systems face challenges in implementing their project plans. The video can be viewed here.

Psychiatrist Loan Repayment Program. The New York State Office of Mental Health (OMH) has received approval to administer its own segment of the Doctors Across New York (DANY) loan repayment program for newly recruited psychiatrists. Beginning April 1, 2016 OMH will be able to make awards of $150,000 distributed over five years for newly recruited psychiatrists that meet the eligibility requirements and commit to working at OMH facilities for five years. Read More

Office for People With Developmental Disabilities Reorganization. The Office for People With Developmental Disabilities (OPWDD) has announced a reorganization. Acting Commissioner Kerry Delany led the agency's Transformation Panel, which released a sweeping series of recommendations designed to guide the service delivery system of the future. In the coming year she plans to focus on developing implementation plans for the Transformation Panel's recommendations. To support these efforts, leadership and structural changes were made. The new Table of Organization is available on the OPWDD website. Read More

New York State Health Foundation Announces New Awards. To mark its 10th anniversary in 2016, the New York State Health Foundation (NYSHealth) has created two special awards programs to recognize influential organizations and/or leaders working to improve health in New York State. The NYSHealth Luminary Awards will recognize leaders who have made extraordinary contributions to improve the health of New Yorkers over the past ten years. Luminary Award winners must be employees of nonprofit, New York State-based organizations that are past and/or current grantees of NYSHealth. These leaders will be recognized with awards of $5,000 made to the nonprofit

organizations that employ them. The NYSHealth Emerging Innovator Awards will recognize New York-based nonprofit organizations poised to make radical improvements to the state of New York's health over the next ten years. The goal of the program is to identify and recognize new and innovative approaches to tackling New York's thorniest, most persistent health challenges. Organizations selected as NYSHealth Emerging Innovators will receive $25,000 each in recognition of their potential to improve health and/or health care in New York State. Read More

United Hospital Fund Report on Capitation and the Evolving Roles of Providers and Payers in New York. The United Hospital Fund has released a report describing the emerging capitation models that are being developed across the country. It lays out the basics of capitation, detailing the range of new skills and capacities required by providers to be successful. It presents the changing roles for accountable care organizations and payers, and notes the different ways accountable care organizations may acquire needed infrastructure. It also lays out the benefits and implementation challenges for various groups affected by the shift: providers, health plans, consumers, and policymakers. Read More

New York City to Conduct Outreach Campaign to Undocumented New Yorkers. The Mayor's Office of Immigrant Affairs has received a grant of $344,000 from the New York State Health Foundation to conduct a media and education campaign targeted at the city's uninsured immigrants. Noncitizen New Yorkers have uninsured rates of more than 25%, the highest rate of any subpopulation. The Deferred Action for Childhood Arrivals (DACA) is a policy that offers deferred action for undocumented immigrants who were brought to the United States before the age of 16 years and who have been in the country for at least five years. In New York State, DACA also provides an opportunity for Medicaid eligibility, but remains underused in large part because the eligible population is unaware of this option. Under the grant, the Mayor's Office will conduct a major public education campaign to reach more than 100,000 immigrants expected to be Medicaid eligible now or in the future through federal DACA expansions. Read More

Value Based Payment Boot Camps. The Department of Health announced that it is hosting a series of three boot camps focused on value based payment. The boot camps will be held across the state, beginning in June. The goal of the sessions is to equip future VBP contractors with the knowledge necessary to implement payment reform. The first session, Introduction to VBP, will provide a foundational understanding of VBP, the implementation work that has been done to date, and where implementation is heading in the coming years. The second installment of the VBP Bootcamp series, Contracting and Risk Management, will familiarize participants with VBP contracting as well as risk management techniques. It will provide examples of strategizing and contracting value-based arrangements and a panel discussion on contracting and implementation challenges, and lessons learned. The final Bootcamp session, Performance Management, will be devoted to performance measurement and how performance results will impact the adjustment (upward or downward) in target budgets and shared savings/losses. The audience will be educated on the roles of the State, MCOs and providers in this process. Information on the boot camp schedule, as well as registration details, can be found on the DSRIP website. Each of the sessions will also be webcast live. The VBP Bootcamps page and a VBP library are available here.

Physician Shortages in New York State. The Health Care Association of New York State released findings from its annual survey on issues related to physician shortages in New York State. HANYS' members report that they continue to struggle with the recruitment and retention of many specialists, particularly those in upstate regions. The report notes that primary care physicians (PCPs) are the most sought-after specialty and often the most difficult to recruit and retain. In New York State, only 29 percent of physicians currently provide primary care. Only 21 percent of all PCPs work in health centers, clinics, or hospital settings. While New York State remains the third highest state for the number of physicians per 100,000 population, there are still under-served areas in the state. Additionally, 30 percent of New York's physicians are over the age of 60. The report includes a series of recommendations, including:

- Expand the pipeline of PCPs who are likely to work in underserved areas.
- Adequately fund the Doctors Across New York Program each year to provide opportunities to recruit PCPs into underserved communities.
- Continue to fund the Primary Care Service Corps program to incentivize non-physician clinicians to practice in rural and underserved areas of the state.
- Utilize telehealth options in under-served areas to expand outreach of current primary care services.

Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Fourteen Insurers Submit Bids for Community HealthChoices MLTSS, Duals RFP. Fourteen health insurers submitted proposals this week to Pennsylvania officials to coordinate managed care in a new program covering medical and long-term care services for older and disabled adults. Decisions on which insurers will be chosen could come by the end of June, with several insurers to be selected to compete with one another in each of five regions of the state. The following companies submitted responses:

- Accenda
- Aetna
- AmeriHealth Caritas
- Cedar Woods Care Management
- Cigna-Health
- Gateway Health Plan
- Geisinger Health Plan
- Health Partners Plus
- Molina Healthcare
- PA Health & Wellness (Centene)
- Trusted Health Plan
- United Healthcare
- UPMC for You
- WellCare

Read More

Judge Denies Injunction on Hershey-Pinnacle Merger, FTC to Continue Challenge. The Federal Trade Commission (FTC) has lost its bid for a preliminary injunction that would halt the merger of PinnacleHealth System and Penn State Milton S. Hershey Medical Center. The FTC filed for a Preliminary Injunction on the argument that a merger would reduce competition for health care in the Harrisburg region. In a 26-page ruling issued Monday, Harrisburg-

based federal Judge John E. Jones III found that "the FTC failed to meet its burden to show a likelihood of ultimate success on the merits of their antitrust claim against the Hospitals." An FTC hearing is set to begin May 17 to hear the full arguments for and against the merger. Read More On May 11, 2016, Modern Healthcare reported that the FTC will continue its challenge of the proposed merger, arguing that Judge Jones III used an incorrect methodology to define the hospitals' geographic markets. Read More

UPMC, Lycoming County Health System Join Forces. University of Pittsburgh Medical Center (UPMC) announced a plan to bring Williamsport-based Susquehanna Health into the Pittsburgh health system's fold. The proposed deal to add the four-hospital Susquehanna Health system in Lycoming County must first be approved by regulators. UPMC currently has 17 hospitals in Pennsylvania. Read More

Utah

Utah Opens Draft Medicaid Expansion Plan for Public Comment. *The Salt Lake Tribune* reported on May 9, 2016, that the Utah Department of Public Health has issued its draft plan to expand Medicaid and is accepting public comments. The expansion would cover about 16,000 uninsured adults, targeting individuals with mental illness, who are homeless, and recently released inmates. The Department plans to submit a waiver to CMS for approval by July 1; enrollment isn't expected to begin until January 2017. Read More

National

CMS Tightens Exchange Special Enrollment Periods, Simplifies Rules for CO-OPs. CMS announced on May 6, 2016, that it is taking steps to tighten rules for Special Enrollment Periods (SEPs) in the health insurance exchanges and simplifying rules for Consumer Operated and Oriented Plans (CO-OPs). Going forward, SEPs will only be available in six defined and limited types of circumstances: (1) losing other qualifying coverage; (2) changes in household size like marriage or birth; (3) changes in residence, with significant limitations; (4) changes in eligibility for financial help, with significant limitations; (5) defined types of errors made by Marketplaces or plans; (6) other specific cases like cycling between Medicaid and the Marketplace or leaving Americorps coverage. To prevent individuals from changing residences solely to seek an SEP, the new rule only allows individuals to request a "permanent move" SEP if they have minimum essential coverage for one or more days in the 60 days preceding the permanent move. The CO-OP changes are designed to enhance the ability of CO-OPs to enter into affiliations or capital arrangements among other changes. Read More

INDUSTRY NEWS

Clearview's Pyramid Healthcare Acquires Two Outpatient Substance Abuse Providers. Clearview Capital announced on May 6, 2016, that its portfolio company Pyramid Healthcare acquired two outpatient substance abuse treatment service providers in Pennsylvania. The additional providers, Mazzitti & Sullivan Counseling Services and Quest Services, bring the company's number of outpatient locations to 40 in Pennsylvania. Clearview Principal Matt Blevins states, "Pyramid continues to play a lead role in consolidating the highly fragmented behavioral healthcare market in Pennsylvania, New Jersey and North Carolina….We believe the company is viewed as a preferred acquirer by many local providers. In addition to continuously evaluating acquisitions within Pyramid's existing footprint, we will selectively pursue opportunities to expand the Company into additional geographies." Read More

Optum Partners with Medecision, TriZetto to Launch MMIS Solution. Optum announced on May 4, 2016, that it is partnering with Medecision and TriZetto to launch a new MMIS solution for state Medicaid agencies. Optum Medicaid Management Services is a Software-as-a-Service (SaaS) and Business Process-as-a-Service (BPaaS) model, designed to "enable Medicaid agencies to purchase only the IT, administrative and clinical services they need to effectively manage their programs," the companies announced. Under new CMS rules, the federal government provides enhanced funding for certain Medicaid eligibility, enrollment, and MMIS claims systems. 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
June 30, 2016	Virginia MLTSS	Proposals Due	212,000
July 1, 2016	Missouri (Statewide)	Proposals Due	700,000
July 1, 2016	West Virginia	Implementation	450,000
July 1, 2016	Minnesota SNBC	Impementation (Northern Counties)	45,600
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	Georgia	Implementation	1,300,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	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 7/1/2014 1/1/2015	431,000	123,981	28.8%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	148,000	48,272	32.6%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	94,000	12,307	13.1%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	31,766	30.3%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	5,617	4.5%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
Ohio	Capitated	5/1/2014	1/1/2015	95,000	61,535	64.8%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	5/1/2016	7/1/2016	30,000			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,954	11.1%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	45,219	26.9%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	27,116	38.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,319,100**	**361,767**	**27.4%**	

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

HMA News

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

"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

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

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"Preparing Your Organization for the New Medicaid Managed Care Regulations"

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

May 18, 2016

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