HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 29, 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

KENTUCKY ANNOUNCES 1115 DEMONSTRATION WAIVER PROPOSAL, KENTUCKY HEALTH

This week, our *In Focus* section reviews the Section 1115 demonstration waiver proposal, Helping to Engage and Achieve Long Term Health, known as Kentucky HEALTH, unveiled on June 22, 2016, by Governor Matt Bevin's administration and the Cabinet for Health and Family Services (CHFS). The Kentucky HEALTH waiver offers two models of coverage for members – a new structure of coverage and benefit packages modeled on commercial insurance markets, provided through the state's existing Medicaid managed care organizations (MCOs); and an employer premium support program. Kentucky HEALTH also includes delivery system reforms targeting substance use disorder, chronic disease management, and improved quality and outcomes. The proposed five-year demonstration is estimated to save more than $2.2 billion in combined federal and state Medicaid spending, with $330 million in

state savings. The 30-day comment period for the proposal will run through July 22.

Kentucky HEALTH MCO Coverage

The state's existing MCOs will continue to cover existing Medicaid and Medicaid expansion beneficiaries; however, the waiver proposes a more consumer-driven model of coverage, adding high-deductible health plans with health care spending accounts (HSAs) for most adults in both traditional Medicaid and the expansion. Additionally, the Medicaid expansion population (also known as the new adult group) would transition to a more limited benefit package modeled after the Kentucky State Employees' Health Plan.

- **Eligibility.** Kentucky HEALTH coverage changes, as proposed, will apply to the Medicaid expansion (Adult Group), parents and other caretaker relatives, transitional medical assistance, pregnant women and newborn children, children under age 19, and the state's CHIP program. The waiver estimates more than 1.1 million Kentucky HEALTH members in each of the five demonstration years. Projected enrollment for the three broad groups of eligible members is provided for each demonstration year (DY) in the table below.

Eligibility Group	DY1	DY2	DY3	DY4	DY5
Expansion Group	532,250	549,917	568,187	587,000	606,500
Non-Expansion Adults	133,333	130,417	127,583	124,833	122,083
Children	489,000	477,583	466,333	455,417	444,750
Total	**1,154,583**	**1,157,917**	**1,162,103**	**1,167,250**	**1,173,333**

- **Monthly Premium Requirements.** Kentucky HEALTH will require a monthly premium, dependent on income, for most adult enrollees. As noted above, adults and children with disabilities are not eligible for Kentucky HEALTH; additionally, children and pregnant women will not be required to pay monthly premiums. Premiums will be as low as $1.00 per month for individuals with incomes below 25 percent of the federal poverty level (FPL), increase to $4.00 at 25 to 50 percent of FPL, and up to $8.00 at 51 to 100 percent FPL. For individuals with incomes of 101 to 138 percent FPL, premiums in DY1 and DY2 will be set at $15.00 per month, increasing in each successive year to $37.50 by DY5.

- **Deductible Account and *My Rewards Account.*** Kentucky HEALTH members will have two member-managed health spending accounts. The first, known as a deductible account, is fully funded by the state at the full annual deductible amount of $1,000. This account will cover all deductible payments until the member's deductible amount is met. The second account is the *My Rewards Account*, which members may use to pay for benefits not covered by Kentucky HEALTH. *My Rewards Account* funds may be earned through completion of community engagement activities (including job needs assessments, job skills training, and community services activities) and health incentive activities (including health risk assessments, chronic disease or weight management, and smoking cessation and drug counseling programs). Additionally, 50 percent of the members unused deductible account amount will roll over into the *My Rewards Account* at the end of each year. Finally, *My Rewards Account* funds may be deducted for inappropriate use of emergency department services, increasing with subsequent inappropriate utilizations. Children are exempt from both

accounts, while pregnant women will not be required to meet deductibles, and will only have a *My Rewards Account*.

- **Non-Payment Penalties.** After a 60-day grace period, non-payment of monthly premiums will result in disenrollment for members with incomes above 100 percent FPL, and copayment requirements and *My Rewards Account* suspension for members with incomes below 100 percent FPL. Additionally, members with incomes above 100 percent FPL will be locked out of coverage for six months. However, regardless of income, members may resume regular Kentucky HEALTH coverage at any time by paying outstanding premiums and current month premiums, as well as participating in a financial or health literacy course.
- **Alternative Benefit Plan.** The new adult group (Medicaid expansion) population will receive an alternative benefit plan (ABP), modeled after the Kentucky State Employees' Health Plan, with a more limited service package than what is covered for the rest of the Kentucky HEALTH population. Under the proposed benefit design, Adult Group members will not have private duty nursing, non-emergency medical transportation, or hearing exams and hearing aids covered. Additionally, many other services may have more limited service limits than under traditional Medicaid. Vision and dental benefits are carved out for the new adult group, and may be purchased if sufficient *My Rewards Account* funds are available.

Employer Premium Assistance Program

In an effort to shift members to the commercial market whenever possible, the waiver proposes an employer premium assistance program, which would subsidize the monthly premium for Medicaid beneficiaries with access to employer-based insurance. Members in the program would be required to meet the same sliding scale monthly premium contribution as under Kentucky HEALTH. Participation in the program will be optional for eligible members in DY1 of the waiver, and mandatory in subsequent demonstration years.

Delivery System and Payment Reforms

Substance Use Disorder Pilot Program. In response to increased rates of substance use disorder (SUD) in the Kentucky Medicaid population, the waiver proposes lifting the prohibition on federal financial participation for Medicaid services delivered in an IMD. Under the IMD exclusion waiver, Kentucky proposes a pilot program, to be developed with CMS, to expand access to SUD services in IMD settings.

Medicaid MCO Reforms. As part of the contract amendments with MCOs needed to implement Kentucky HEALTH, the state will continue to work to adjust Medicaid capitation payments, with the aim of limiting MCO profits, which are, according to the waiver submission, nearly five times the national average. Additionally, Kentucky will implement new MCO payment incentives for quality performance and outcomes, as well as require MCOs to implement a provider bonus program.

Link to Kentucky HEALTH 1115 Waiver Proposal Documents

http://chfs.ky.gov/dms/kh

HMA Medicaid Roundup

California

Legislative Committee on Health Passes Prescription Drug Transparency Bill. *Capital Public Radio* reported on June 29, 2016, that the California State Assembly Committee on Health passed a prescription drug transparency bill, which would require drug manufacturers to give advance notice to consumers when the price of a drug increases by more than 10 percent or when the annual cost of a treatment exceed $10,000. The bill now moves on to the Assembly Appropriations Committee. Opponents of the bill say it offers little in the way of policies that would benefit patients or reduce costs. Read More

District of Columbia

HMA Roundup – Jessica Foster (Email Jessica)

DC to Release Medicaid Managed Care RFP by September. Washington, DC, intends to release a Medicaid managed care request for proposal (RFP) by September 15, 2016. The announcement was made to stakeholders during a D.C. Medical Care Advisory Committee meeting on June 22, 2016. The procurement process will be managed through the District's Office of Contracting and Procurement (OCP). Medicaid and Alliance program enrollment in D.C.'s three full risk-based Medicaid MCOs (AmeriHealth Caritas, MedStar Family Choice, and Trusted Health Plan) totaled 182,206 as of December 2015, according to the Department of Health Care Finance's managed care end of year report.

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Republican Support for Medicaid Expansion Grows. *The Atlanta Journal-Constitution* reported on June 27, 2016, that a growing number of state Republican legislators support expanding Medicaid and will push for expansion during the 2017 legislative session. Senator Renee Unterman, chairwoman of the state Senate health committee, is working with a handful of other Republicans to lead the charge. However, Governor Nathan Deal and other legislative leaders continue to oppose expansion, citing costs the state would incur after federal funding for the expansion tapers off. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Land of Lincoln Health Files Lawsuit over Federal Risk Corridor Payments. *Crain's Chicago Business* reported on June 23, 2016, that Illinois co-op insurance plan Land of Lincoln Health is suing the federal government for $72.9 million in risk corridor payments. Land of Lincoln is one of nearly two dozen health insurance co-ops established through the Affordable Care Act to sell health insurance on the state and federal Exchanges. The risk corridor program was intended to incentivize plans to join the Exchanges by offering a degree of protection against early losses. Read More

Indiana

Indiana to Forgo Planned Medicaid Home Health Rate Cuts. *WFYI Indianapolis* reported on June 28, 2016, that the Indiana Family and Social Services Administration (FSSA) will not proceed with previously announced plans to cut Medicaid home health reimbursements. In May, FSSA announced it would lower Medicaid home health rates by up to 8 percent for registered nurses and up to 6 percent for home health aides. The state agreed to reexamine rate calculations after home health providers and advocates raised concerns around the proposed cuts. Read More

Kentucky

Medicaid Waiver Proposal Faces Criticism at First Public Hearing. The *Courier-Journal* reported on June 28, 2016, that Governor Matt Bevin's Medicaid waiver proposal, published last week and known as Kentucky HEALTH, faced heavy criticism at the first public hearing on the plan. There were reportedly few who spoke in favor of the waiver proposal, while critics expressed concerns that proposed changes would be too costly for consumers, are overly complicated, and would eliminate important benefits for many members, including dental and vision coverage. The most significant changes proposed would impact the state's 440,000 Medicaid expansion members. The Secretary of the Cabinet for Health and Family Services, Vickie Yates Brown Glisson, stated that she was not discouraged by the comments and feels that many critics may not understand or do not have enough information on the waiver. The public hearing was the first of three over the month-long public comment period. Read More

Louisiana

Medicaid Expansion Enrollment Rises to 220,000. *NOLA.com* reported on June 22, 2016, that to date the Louisiana Department of Health had enrolled more than 220,000 individuals in the state's Medicaid expansion program. The state is signing up about 2,500 people daily, with the vast majority automatically enrolled. About 9,000 were deemed eligible because they were receiving Supplemental Nutrition Assistance Program (SNAP) benefits. That's less than 10 percent of the 105,000 SNAP enrollees that the department has contacted. Although the department is continuing its push to find SNAP recipients eligible for Medicaid, those that move between temporary housing situations can be difficult to locate. The state is also making a push in rural areas. Read More

Medicaid Expansion to Provide Coverage to Inmates Leaving Prison. *USA Today* reported on June 27, 2016, that on July 1, that Medicaid expansion in Louisiana will allow prison inmates to receive healthcare coverage after they are released, including the type of mental health treatment that might help prevent recidivism. The article quotes Louisiana Secretary of Health Rebekah Gee as stating, "It's unconscionable to just drop them off at a Greyhound bus station. They're just going to come right back." Expansion in Louisiana is effective July 1, 2016. Until now, many people released from prison relied on emergency rooms or clinics, which often mean long waits and limited treatment options. Read More

Minnesota

BCBS to Scale Back Individual Business as Financial Issues Continue. *NPR* reported on June 24, 2016, that Blue Cross Blue Shield of Minnesota will significantly scale back its individual and family health insurance business beginning next year. The decision will affect about 103,000 members, including about 20,000 who purchased coverage through the state's MNsure insurance Exchange. The company blamed losses of $265 million in 2015 and a projected loss topping $500 million over three years. BCBS-MN's Blue Plus subsidiary, which has just 13,000 individual members, will continue to offer individual plans. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey's performance on the National Core Indicators Aging and Disability (NCI-AD) Adult Consumer Survey Mid-Year Report Released. The National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI) recently released the 2015-2016 mid-year results for their National Core Indicators Aging and Disability (NCI-AD) Consumer Survey. NASUAD and HSRI collaboratively created a tool that is being utilized by the state Medicaid, Aging, and Disability Agencies in thirteen states in an effort to track and hopefully improve the quality of long-term services and supports (LTSS) systems that serves seniors and adults living with disabilities. New Jersey is one of six states that voluntarily participated in a shortened data collection cycle and provided the project team in October of 2015 with their complete data. During the collection period, New Jersey was able to complete 727 surveys with participants stemming from the following programs: Managed Long Term Services and Supports (MLTSS)/Home and Community Based Services (HCBS), Older Americans Act, Program of All-Inclusive Care for the Elderly (PACE), and Nursing Home Residents–Fee for Service (FFS). NCI-AD compared the results of New Jersey against the other five states and the NCI-AD average.

The results of the NCI-AD Survey revealed information regarding the quality of LTSS in New Jersey.

1. The proportion of people living in New Jersey over the age of 90 is relatively higher than the NCI-AD average.

2. New Jersey has a lower average proportion of people who were participating in a self-directed supports option than the NCI-AD average (7 percent vs. 12 percent).
3. The proportion of surveyed New Jersey residents who have discussed their feelings of sadness and depression in the past 12 months is 54 percent, which is lower than the NCI-AD average of 62 percent.
4. About 37 percent of the people in New Jersey feel that paid staff changes occur too frequently, a rate which is higher than the NCI-AD average.
5. Optimistically, New Jersey has only an 11 percent proportion of people who have concerns about falling or being unstable, which is 10 percent below the NCI-AD average.
6. New Jersey has a significantly higher than average proportion of people who generally need a lot or some assistance for self-care at 1 percent higher than the NCI-AD average.

The following table details how New Jersey performed compared to the NCI-AD average on select quality metrics. Read more

New Jersey Performance on NCI-AD Survey, Select Measures

Measures	NJ Average	NCI-AD Average	Difference Between the NJ Average and the NCI-AD Average
Demographic Characteristics of Respondents			
Proportion of individuals 90 years of age and over	20%	12%	8.00%
Proportion of people with diagnosis of physical disability	62%	65%	-3.00%
Proportion of people with diagnosis of mental health	27%	28%	-1.00%
History of frequent falls	20%	27%	-7.00%
Relationships			
Proportion of people who sometimes or often feel lonely, sad or depressed	55%	53%	2.00%
Satisfaction			
Proportion of people whose paid support staff change too often	37%	32%	5.00%
Service Coordination			
Proportion of people who can reach their case manager/care coordinator when they need to (if know they have case manager/care coordinator)	82%	85%	-3.00%
Care Coordination			
Proportion of people who reported feeling comfortable and supported enough to go home after being discharged from a hospital or rehabilitation facility (if occurred in the past year)	84%	85%	-1.00%
Proportion of people who reported having one or more chronic conditions	83%	87%	-4.00%
Proportion of people who reported they know how to manage their chronic condition(s)	86%	90%	-4.00%
Access			
Proportion of people who have transportation to get to medical appointments when they need to	94%	91%	3.00%
Proportion of people who need an emergency response system to be installed	11%	21%	-10.00%
Safety			
Proportion of people who have concerns about falling or being unstable (or about whom there are concerns)	58%	60%	-2.00%
Health Care			
Proportion of people who have gone to the emergency room for falling or losing balance in the past year	11%	14%	-3.00%

Measures	NJ Average	NCI-AD Average	Difference Between the NJ Average and the NCI-AD Average
Proportion of people who have talked to someone about feeling sad and depressed during the past 12 months (if feeling sad and depressed)	54%	62%	-8.00%
Proportion of people who have had a flu shot in the past year	79%	77%	2.00%
Wellness			
Proportion of people who describe their overall health as poor	13%	16%	-3.00%
Rights and Respect			
Proportion of people who feel that their paid support staff treat them with respect	89%	93%	-4.00%
Self-Direction of Care			
Proportion of people who are participating in a self-directed supports option (as defined by their State—data for this indicator come directly from State administrative records)	7%	12%	-5.00%
Everyday Living			
Proportion of people who generally need a lot or some assistance with everyday activities (things like preparing meals, housework, shopping or taking their medications)	92%	88%	4.00%
Proportion of people who generally need a lot or some assistance for self-care (things like bathing, dressing, going to the bathroom, eating, or moving around their home)	84%	71%	13.00%
Control			
Proportion of people who feel in control of their life	73%	74%	-1.00%

Legislation to establish Office of Ombudsman for Individuals with ID/DD Passes Assembly. On June 27, 2016 the Assembly passed A3824 (S2392) which would provide individuals with intellectual or developmental disabilities (ID/DD) served by the Department of Human Services (DHS), Division of Developmental Disabilities, and the Department of Children and Families (DCF), Division of Children's System of Care with an Ombudsman, an independent resource for information and support within the Department of the Treasury. The ID/DD Ombudsman would coordinate efforts with the State Council on Developmental Disabilities. They would also identify patterns of complaints, and provide a written annual report that summarizes their services and recommendations to DHS and DCF. The Senate version is currently in the Senate Health, Human Services and Senior Citizens Committee. NJ Spotlight covered this in a story on June 23, 2016, which can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

Expansion of HIV Services. Governor Andrew Cuomo announced that all HIV-positive individuals in New York City will become eligible to receive housing, transportation, and nutritional support, a significant eligibility expansion for Emergency Shelter Assistance. The change comes as the result of a policy issued by the Department of Health's AIDS Institute that eliminates the technical distinction between those who are considered in need of care and those who are not, recognizing that all individuals who are diagnosed with HIV – whether they show symptoms or do not – benefit from receiving care. The Office of Temporary and Disability Assistance has determined that those diagnosed with

HIV will be eligible for Emergency Shelter Allowance, which includes a monthly transportation and nutrition allowance as well as a 30% income contribution cap toward rental costs for New York City Public Assistance recipients. The commitment will expand services to an estimated 7,000 people. The new rule will go into effect in 60 days. Read More

Value Based Payment Clinical Advisory Group Recommendations. As part of the shift to value based payment (VBP) that is required under New York's Delivery System Reform Incentive Payment (DSRIP) program, a number of Clinical Advisory Groups were established. The groups were charged with developing quality measures for each VBP arrangement. The Behavioral Health, HIV/AIDS and Maternity Clinical Advisory Groups (CAG) have completed CAG Recommendation Reports. The CAG reports have been posted for public comment on the DSRIP Website here. Comments are due by July 24th. The Behavioral Health CAG and I/DD CAG are currently meeting with the intent to complete their recommendation reports later this Summer.

DSRIP Timeline Updated. The DSRIP Year 2 Timeline has been updated to reflect recent changes to key DSRIP deliverables. The updates include the opening of Medicaid Analytics Performance Portal (MAPP) in August for PPS to add providers to their Performance Networks. Other additions to the timeline include PPS submission of their Primary Care Project Narrative by August 31, as well as several deliverables around Mid-Point Assessment recommendation public comment periods and Project Approval & Oversight Panel review. The DSRIP Year 2 Timeline is available here.

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 system reforms, including the Delivery System Reform Incentive Payment program. The waiver has been renewed several times since 1997, typically for a 5-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, any aspect of the Medicaid program. The upstate Public Comment Day will be held July 12, 2016, in Albany at the Empire State Plaza, Meeting Room #6 at 10:30am. The meeting will be webcast live and is open to the public. No pre-registration to the event is required. Any written public comment may be submitted through July 13 to dsrip@health.ny.gov.

NY Department of Health Annual Report 2015. The Department of Health has posted its Annual Report for 2015. The report includes updates on the many aspects of activity coordinated by DoH. Topics include:

- Improving the Health of New Yorkers
- Promoting Healthier Environments
- Promoting Health Equity
- Reforming the Health Care System
- Using Data for Good Health
- A Commitment to Research

Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Governor Kasich Signs Executive Order Allowing the Department of Medicaid to Make Chemical Dependency Counselors Eligible Providers. In order to meet a July 1, 2016, implementation date for a Medicaid State Plan Amendment recently approved by CMS, Governor Kasich signed Executive Order 2016-02K declaring an emergency that allows the Ohio Department of Medicaid (ODM) to bypass the normal rule-filing process. The rule allows the addition of Licensed Independent Chemical Dependency Counselors as eligible Medicaid providers. The Executive Order allows the rule to be effective July 1. ODM has 120 days to complete the normal rule-filing process. Read More

Oregon

CCO Report Shows Declining ER Use, Hospital Readmissions Among Medicaid Members. *Modern Healthcare* reported on June 23, 2016, that Oregon's Coordinated Care Organization program for Medicaid saw improvements in key quality measures in 2015, despite a large increase in membership driven by expansion, according to a report from the state. For example, the report noted that emergency department visits and hospital readmissions declined in 2015, while member satisfaction, diabetes screenings, and access to primary care physicians for children increased. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Updates from June 23 Medical Assistance Advisory Committee Meeting.

Office of Medical Assistance Update

- Provider Revalidation: As of June 11, 2016, 64 percent of providers have been revalidated. All service locations that have submitted their applications by July 30, 2016, will not be disenrolled. As of September 25, 2016, Fee for Service (FFS) claims will be denied if any ordering, prescribing or referring provider is not enrolled in the Medical Assistance Program.
- Health Choices Update: HealthChoices Physical Health is on track for a January 1, 2017, go live date. Full network submissions are due from the selected MCOs by July 29, 2016, with a Go/No Go decision made by the end of September.

Office of Long Term Living Update

- Community Health Choices Update: The SW Zone implementation date has been moved to July 1, 2017. Rollout timelines for the remainder of the Commonwealth's zones will remain the same. Each zone will have its own readiness review. The readiness review for the SW and SE zone will now have some overlap.

Support for Bill Suspending Medicaid for Individuals Entering Corrections System. Senate Bill 1279, sponsored by Pennsylvania State Senator Pat Vance, was publicly unveiled last week with support from the Wolf Administration represented by Department of Human Services Secretary Ted Dallas and Department of Corrections Secretary John Wetzel. SB1279 would suspend, as opposed to terminate, Medical Assistance benefits when an individual enters the corrections system. The bill proposes a temporary suspension, for no more than two years, of an individual's Medicaid benefits. SB1279 would provide access to mental health and addiction treatment services immediately upon release. The bill will be added as part of the upcoming budget. However, Senator Vance noted if the state faces another budgetary logjam, the bill could be passed on its own. Read More

DHS Releases Medicaid Access Monitoring Review Plan. Pennsylvania's Department of Human Services made available for public comment its Medicaid Access Monitoring Review Plan. The plan is built on the CMS model including documentation of access to care and service payment rates, Medicaid provider participation and public process to inform access to care. The Plan is available for a 30-day public review and comment period. This plan will only apply to the fee for service population. The first submission is due to CMS by October 1. Read More

South Dakota

Governor Daugaard Will Not Call Special Session on Medicaid Expansion. *The Sioux City Journal* reported on June 22, 2016, that South Dakota Governor Dennis Daugaard does not intend to call a special legislative session on Medicaid expansion. State lawmakers have pushed for more time to study the expansion proposal, ideally until after the fall elections. While Daugaard supports Medicaid expansion for up to 50,000 people, he faces opposition from the state's Republican-led house. Read More

Texas

Democratic Lawmakers Ask CMS to Ensure Children With Disabilities Have Access to Therapy Services. *The Texas Tribune* reported on June 23, 2016, that 50 Texas Democratic lawmakers wrote a letter asking the Centers for Medicare & Medicaid Services (CMS) to help ensure that funding cuts planned for Texas Medicaid speech, physical, and occupational therapy for children with disabilities do not restrict access to services. The Texas Health and Human Services Commission (HHSC) has put forward payment reductions on the basis that the state is overpaying for these services, while therapy providers maintain that the cuts could reduce revenues by 20 percent. The planned cuts have been on hold for 10 months after therapy providers and families sued the state. Texas won the lawsuit in April, and although the case was appealed to the Texas Supreme Court, HHSC says that it will implement the cuts on July 15, 2016. The Democrats' letter says that Texas is expected to submit a plan to CMS as soon as June 27, 2016, regarding implementation of the payment reductions. Read More

Industry News

Bayada Home Health Care to Transfer Ownership to Not-for-profit Foundation. *Home Health Care News* reported on June 28, 2016, that Bayada Home Health Care will transfer 80 percent of its ownership to a new not-for-profit foundation over the next three to five years. The remaining 20 percent will be held by the Baiada family. Bayada Home Health Care founder and President Mark Baiada, 70, who currently owns 100% of Bayada, will step down in 2017. His son David Baiada will be named president and oversee the transition of ownership to the new foundation. Bayada, based in Pennsylvania, is one of the 10 largest home health companies in the country, with roughly $1.1 billion in annual revenues and operations in 22 states. Read More

Change in Leadership at Affinity Health Plan. The Board of Directors of Affinity Health Plan announced today that Glenn A. MacFarlane has resigned as President and Chief Executive Officer, effective later this month. James A. Hooley, currently Chairman of Affinity's Board, will assume responsibilities as Interim President and CEO until a permanent successor is named. One of the oldest Medicaid managed care plans operating in New York, Affinity, which was founded in 1986, is an independent, not-for-profit organization. Affinity offers a variety of programs under Medicare, Medicaid, Child Health Plus, Essential Plan and Qualified Health Plans on the New York State of Health Marketplace for members in the Bronx, Brooklyn, Manhattan, Queens, Staten Island, as well as Nassau, Suffolk, Westchester, Rockland and Orange counties. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
June 30, 2016	Virginia MLTSS	Proposals Due	212,000
July 1, 2016	West Virginia	Implementation	450,000
July 1, 2016	Minnesota SNBC	Impementation (Northern Counties)	45,600
July 8, 2016	Massachusetts MassHealth ACO - Pilot	Responses Due	TBD
July, 2016	Nevada	RFP Release	420,000
July-August, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
August 1, 2016	Missouri (Statewide)	Proposals Due	700,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
September, 2016	Washington, DC	RFP Release	200,000
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November, 2016	Oklahoma ABD	RFP Release	177,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
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	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Implementation	177,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
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
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

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 (June 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	431,000	121,782	28.3%	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	47,556	32.1%	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	13,011	13.8%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	38,767	36.9%	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	5,480	4.4%	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	62,009	65.3%	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	5,419	10.1%	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	42,069	25.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	26,975	38.3%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,303,100**	**363,068**	**27.9%**	

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

HMA News

Eliot Fishman to Be Luncheon Keynote Speaker at HMA Conference on Integrated Care Delivery in Chicago, October 10-12, 2016

Eliot Fishman, PhD, director of the State Demonstrations Group as CMS' Center for Medicaid and CHIP Services will be luncheon keynote speaker at HMA's inaugural conference on "*The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*," October 10-12, 2016, in Chicago. This premier event, presented by HMA and HMA's Accountable Care Institute, will address key issues facing health systems, hospitals, clinics and provider practices seeking to integrate care in an environment of rising quality and cost expectations. More than 30 speakers have been confirmed to date. **Early Bird registration is now open.** Click here for complete conference details or contact Carl Mercurio at (212) 575-5929 or cmercurio@healthmanagement.com.

CHCF and HMA Publish Report, Case Studies on the Role of Health Plans in Opioid Epidemic

In June 2016, the California Health Care Foundation (CHCF) and Health Management Associates (HMA) published a report, "*Changing Course: The Role of Health Plans in Curbing the Opioid Epidemic,*" exploring the critical role of health plans in limiting opioid overuse. Authored by HMA's Donna Laverdiere; Margarita Pereyda, MD; Jason Silva, JD; and Margaret Tatar, the report addresses health plans' role as the primary payer for prescription drugs and how that position presents the opportunity to influence patient and provider behavior. The report identifies four key areas for investment to impact prescribing culture and overall population health:

1. Supporting judicious prescribing practices through formulary changes and provider education
2. Focusing on improved member outcomes, especially for those at highest risk (members on high doses of opioids, those taking high-risk medication combinations, and members with addiction)
3. Identifying and acting upon overuse, misuse, and fraud
4. Supporting safe communities through participation in opioid safety coalitions, and promoting naloxone

A companion case study, "*Three California Health Plans Take Action Against Opioid Overuse,*" highlights the efforts of three California plans that led to 25 to 50 percent reductions in opioid prescribing.

CHCF and HMA have also published an infographic, "*Health Plan Rx for the Opioid Epidemic.*"

The report, case studies, and infographic are available on the CHCF website: http://www.chcf.org/publications/2016/06/changing-health-plans-opioid

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.