HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 6, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

NEVADA ISSUES MEDICAID MANAGED CARE REQUEST FOR PROPOSALS (RFP)

This week, our *In Focus* section reviews the request for proposals (RFP) issued by Nevada's Division of Health Care Financing and Policy (DHCFP) on July 1, 2016, to rebid contracts for the state's Medicaid managed care program. The RFP solicits bids for managed care organizations to serve the existing two-county service area, in Clark and Washoe counties, although the RFP states that any geographic expansion of the program would be covered under this procurement. The current contracts are held by United Healthcare's Health Plan of Nevada and Anthem's Amerigroup Nevada. Medicaid managed care enrollment has grown significantly during the last contract term due to the state's expansion of Medicaid. There were more than 400,000 members in managed care in Nevada at the start of 2016; fiscal year 2015 spending on Medicaid managed care in Nevada totaled roughly $1.3 billion.

RFP Overview

Covered Populations. Contracts awarded from this RFP will cover the existing managed care populations, which include the Family Medical Coverage (FMC) populations, including Nevada Check Up (CHIP) and the AO group, made up of children who have aged out of foster care. At this time, there are no plans to expand the program to individuals who are aged, blind, or disabled (ABD), or receiving long term services and supports (LTSS), although a state task force has been charged with developing a plan for possible inclusion in managed care.

Qualified Health Plan (QHP) Provision. Bidders who currently have or will have, at minimum, a Silver QHP on the state's Health Insurance Exchange will receive a higher score in the proposal evaluation process. This QHP must meet the qualifications of a MCO Transition QHP, which aims to provide a more seamless transition process from the Exchange to Medicaid or vice-versa.

Geographic, Eligibility, Service Expansions. The RFP does not, at this time, expand the managed care program in terms of geography, categories of eligibility, or covered services. However, the RFP states that if any of these expansions were to occur, such as the inclusion of new counties, or the addition of beneficiaries who meet ABD eligibility to managed care, the contracts awarded under this RFP would be amended to cover an expansion, rather than a separate procurement.

Medicaid Managed Care Redesign

This RFP to rebid the state's existing managed care contracts falls in the midst of a broader effort by the state to evaluate potential changes to the Medicaid managed care program. In a presentation from early 2016, DHCFP outlined four potential options under consideration by the state:

1. Expanding Managed Care statewide;
2. Including services that are not currently covered by managed care;
3. Expand managed care to include ABD individuals; and
4. Increasing the number of Managed Care Plans to offer greater choice and flexibility of services.

The state has conducted stakeholder outreach and issued a RFP for a contractor to assist the state in evaluating the various options with a tentative goal of making recommendations to the legislature and the Governor's office in late 2016. As noted above, at least the first three options could be implemented, at the state's discretion, into contracts awarded under this RFP. A link to the redesign presentation slides is available here.

RFP Timeline

Proposals are due on August 25, 2016, with a tentative contract award date of September 22, 2016. Contracts are set to go live on July 1, 2017, with a four year term through June 30, 2021, and two optional extension years.

RFP Event	Date
Q&A Round 1 Due	July 12, 2016
Q&A Round 1 Responses Posted	July 19, 2016
Q&A Round 2 Due	July 28, 2016
Q&A Round 1 Responses Posted	August 4, 2016
Proposals Due	August 25, 2016
Vendor Selections	September 22, 2016
Implementation	July 1, 2017

Current Managed Care Market Overview

Nevada's managed care program is currently served by United's Health Plan of Nevada and Anthem's Amerigroup Nevada plans. United covers more than 240,000 members (57.8 percent market share) with Anthem covering the remaining 175,000 (42.2 percent). Both plans have seen significant enrollment growth in the past two years, with Anthem adding more than 81,000 and United adding more than 69,000 net new members since 2013.

Medicaid MCO	Enrollment (2015)	% Market Share
Health Plan of Nevada (United)	240,215	57.8%
Amerigroup Nevada (Anthem)	175,069	42.2%
Total – 2 Plans	**415,284**	

Source: HMAIS (SNL Financial, NAIC, HMA)

Link to RFP

http://purchasing.nv.gov/Solicitations/Documents/RFP3260/

HMA Medicaid Roundup

Alabama

Facing $85 Million Medicaid Budget Shortfall, Medicaid Considers Provider Cuts. *The Montgomery Advertiser* reported on July 1, 2016, that the Alabama Medicaid agency is considering cuts to several Medicaid programs and groups of providers, including pharmacies, hospitals, and physicians, to address a projected $85 million budget shortfall. Reductions to physician reimbursements, which are currently set at Medicare levels, could be the most problematic. A recent survey by the Alabama Academy of Pediatrics showed that 42 percent of pediatricians would not be able to serve Medicaid patients at lower rates and could be forced to reduce staff or close their practices. The shortfall could also impact the state's plan to transition Medicaid to a Regional Care Organization model. Read More

California

Bill to Transition Children with Complex Care Needs to Managed Care Moves Ahead. *California Healthline* reported on a June 29, 2016, that the California Assembly Committee on Health has passed a bill to transition children in the "medically fragile" eligibility category into a Medi-Cal managed care program. The bill now moves to the Assembly Appropriations Committee. Medically fragile children are currently served by the 89-year-old California Children's Services (CCS) program, which provides care to children who typically live with chronic conditions like hemophilia or cerebral palsy. The bill that passed was revised from an earlier version to address certain concerns raised by parents about the transition. For example, the revised version would transition children over a longer period of time, with the first 25,000 children moving into the new program by July 2017 and all 190,000 by January 2021. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

Several HCPF Rules Under Review in 2016. In 2016, the Colorado Department of Health Care Policy and Financing (HCPF) is reviewing Program Integrity rules:

- Section 8.076 - Program Integrity;
- Section 8.012 - Providers Prohibited from Collecting Payment from Recipients; and
- Section 8.040 - Recoveries from Providers.

HCPF is also reviewing many additional rules from the Health Programs Office (Benefits Management, Operations, Provider Relations and Dental Program, Behavioral Health and Managed Care); the Client and Clinical Care Office (Pharmacy Program); and the Community Living Office (Intellectual and Developmental Disabilities Division, and the Long-term Services and Supports Division); among others. Colorado state agencies are required to review, on a continuing basis, all existing rules to ensure they use the best, most innovative, and least burdensome strategies for achieving their goals. As part of this process, State agencies are also required to give the public a meaningful opportunity to comment on the existing rules under review in the context of established criteria. A full list of rules the Department is reviewing for 2016 is on their website. Read More

Connecticut

Low-Income Parents About to Lose HUSKY A Coverage Fail to Sign Up for Alternatives. *The CT Mirror* reported on July 1, 2016, that of the nearly 14,000 parents expected to lose HUSKY A coverage on August 1, 2016, just over 2,000 have found coverage in a different Medicaid plan or through Access Health CT, the state's insurance Exchange. Beginning in August, the income threshold for HUSKY A parent coverage will be lowered from 201 percent of the federal poverty level (FPL) to 155 percent FPL. Officials have sent letters and postcards to those affected and will begin making calls on July 11. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

State Falls Short on Providing Housing for Individuals with Serious Mental Illness, Report Finds. *Georgia Health News* reported on June 29, 2016, that the state of Georgia is failing to meet its court-supervised obligations to provide access to supported housing for certain individuals with serious mental illness, according to a newly released report. The report, produced annually by independent reviewer Elizabeth Jones, found that state-run psychiatric hospitals continue to discharge patients to homeless shelters. Many of these individuals lack adequate follow-up treatment plans, and many end up being re-hospitalized. A 2010 settlement with the U.S. Department of Justice requires the state of Georgia to provide access to supported housing. Read More

Idaho

State Signs Medicaid Transportation Contract with Veyo. *The Times-News* reported on July 4, 2016, that San Diego-based medical transportation company Veyo has signed a three-year contract, worth $23 million annually, to provide non-emergency transportation to Idaho's 290,000 Medicaid members. Veyo has over 60 providers and 900 vehicles statewide and expects to provide 3,500 to 4,000 trips daily. Veyo replaced American Medical Response (AMR), which has contracted with the state since 2010. A group of providers unhappy with the new contract have launched a website to express concerns over transportation rates and problems with unfamiliar drivers, among other issues. Veyo has operations in Arizona, Colorado, Texas, and California. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Illinois DOI Takes Steps to Protect ACA Co-op, Land of Lincoln Health. *Crain's Chicago Business/Modern Healthcare* reported on July 5, 2016, that the Illinois Department of Insurance is taking steps to protect co-op insurance plan Land of Lincoln Health, insisting the plan stop renewing policies for small and large businesses, stop selling new plans without permission, and forego making $31.8 million in federal risk adjustment payments. The state believes that a liquidation of the plan would cause market disruption on the state Exchange, as well as potential harm to at least 49,000 enrollees. Land of Lincoln Health reportedly lost $90.8 million in 2015 and has already seen losses of $17 million through May 31, 2016. Read More

Kansas

Kansas Hospital Association Letter Asks CMS to Intervene on KanCare Cuts. *Kansas Health Institute* reported on June 30, 2016, that the Kansas Hospital Association submitted a letter to the Centers for Medicare & Medicaid Services (CMS), asking for intervention on Governor Sam Brownback's administration's proposed cuts to KanCare, the state's Medicaid program. The Association letter warns that the $56.4 million in cuts would limit beneficiary access to care and trigger a loss of $72.3 million in federal matching funds. The proposed cuts are set to take effect as of July 1, 2016. Read More

Maryland

DHMH Seeks Federal Funding for Residential Drug Treatment. *The Baltimore Sun* reported on June 30, 2016, that the Maryland Department of Health and Mental Hygiene (DHMH) is asking the federal government for funding to cover residential drug treatment at small community facilities and private institutions, providing greater treatment options for Medicaid beneficiaries, in an attempt to tackle growing rates of opioid addiction. Currently, only inpatient treatment at hospitals is covered. DHMH is also asking to limit Medicaid payments for observational stays in hospitals to 48 hours, to provide presumptive Medicaid eligibility to people getting out of jail or prison, and to expand dental coverage for former foster children. Read More

Massachusetts

EOHHS Issues RFR for Long Term Services and Supports TPA. On July 1, 2016, the Commonwealth of Massachusetts Executive Office of Health and Human Services (EOHHS) issued a request for responses (RFR) for a third-party administrator (TPA) to assist the state in managing the administration and delivery of Medicaid fee-for-service (FFS) long term services and supports (LTSS) under MassHealth. According to the RFR, around 14 percent of all MassHealth members (roughly 250,000 members) use LTSS services under a variety of delivery models, including FFS, managed care organizations (MCOs), as well as the Senior Care Options (SCO), Program of All-Inclusive Care for the Elderly (PACE), and One Care (dual eligible demonstration) programs. The vast majority, roughly 200,000 of the 250,000, received LTSS on a FFS basis in 2015.

The primary focus of the LTSS TPA is to provide augmented administrative capacity to EOHHS to administer LTSS Provider facing activities. The TPA's responsibilities will be implemented in two phases. Phase 1 core functions will include: Provider Enrollment and Relations; Prior Authorization and Utilization Management; Program Integrity; Quality Improvement; and Reporting and Informatics. Phase 2 TPA functions will include planning for and implementing Claims Adjudication and Electronic Visit Verification. EOHHS intends to award a single statewide contract as a result of this RFR to a TPA with at least three years of experience as a TPA, benefit manager/administrator or insurer with responsibility for administering LTSS clinical programs, program integrity, and provider management, among other requirements. An initial three-year contract term will run from January 1, 2017, through December 31, 2019, with the option of two additional extension years. Responses to EOHHS are due on August 15, 2016. Read More

Massachusetts Removes Restrictions to Hepatitis C Drugs for Medicaid Beneficiaries. The Centers for Medicare & Medicaid Services (CMS) announced on June 30, 2016, that Massachusetts will remove restrictions to Hepatitis C drug coverage for Medicaid beneficiaries. Massachusetts will join other states, like Florida and Delaware, to increase access to newer Hepatitis C treatments that often have high costs. In November 2015, CMS sent letters to pharmaceutical manufacturers, AbbVie, Gilead Sciences, Johnson & Johnson, and Merck & Company, providing guidance on keeping Hepatitis C drugs affordable. Read More

Missouri

Governor Nixon Vetoes Legislation to Impose Late Fees on Medicaid Patients. *The St. Louis Post-Dispatch* reported on July 5, 2016, that Missouri Governor Jay Nixon has vetoed a bill that would have allowed providers to charge Medicaid beneficiaries late fees for missing appointments, as well as deny new appointments until the fee is paid. Members would have been required to give 24 hours notice to avoid the penalty. The bill would also require Medicaid beneficiaries to pay co-pays for using hospital emergency rooms for non-emergency care. Supporters argued that the legislation would have saved the state money by shifting patients to cheaper treatment options. Read More

Nevada

Saint Mary's Health Network Drops Medicaid MCOs from Network. *The Reno Gazette-Journal* reported on June 29, 2016, that Nevada's Saint Mary's Health Network is no longer accepting patients from the state's two Medicaid managed care organizations (MCOs), UnitedHealth's Health Plan of Nevada or Anthem's Amerigroup plan. About 37,000 Health Plan of Nevada members will be affected beginning July 18. The health system's move is raising concerns around provider access for a Medicaid population which has nearly doubled to more than 600,000 as a result of the Medicaid expansion. Marta Jensen, acting administrator of the Nevada Department of Health and Human Services' health care financing and policy division, stated that while Medicaid enrollment has doubled, the number of Medicaid providers has not, equating Nevada's access issues to those faced by other expansion states. Read More

New Hampshire

Substance Use Disorder Benefits Extended to All Medicaid Beneficiaries. *The New Hampshire Union Leader* reported on July 4, 2016, that under revisions to New Hampshire Medicaid policies, 140,000 additional beneficiaries are now eligible for a full range of substance use disorder (SUD) treatment benefits effective July 1. The service expansion includes traditional (non-Medicaid expansion) Medicaid recipients, whether they are in fee-for-service Medicaid, or one of the state's two Medicaid managed care organizations (MCOs), New Hampshire Healthy Families or Well Sense Health Plan. About 49,000 beneficiaries have already been eligible for SUD benefits under the Medicaid expansion. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Seeks to Expand Substance Use Disorder Benefits; Updates Medicaid FFS Rates. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services, released a public notice stating that it hopes to expand eligibility for substance use disorder benefits to all Medicaid members. Currently, SUD benefits are available only to Medicaid expansion members. In addition, the state wants to require prior authorization for SUD treatments. The state also announced that Medicaid fee-for-service rates were updated, effective July 1, 2016. The fee schedule can be found here. The changes are expected to cost $127.8 million, including $107.8 million in federal fund and $20 million in state funds.

New Mexico

Medicaid Provider Reimbursement to be Cut Less than Originally Proposed. *AP/The Tribune* reported on July 1, 2016, that New Mexico is lowering proposed cuts to Medicaid reimbursements after hearing from providers and Native Americans. Rates will now be cut by up to 5 percent for hospitals and by 2 percent for dentists, down from a proposed 3 percent. Cuts to the University of New Mexico Hospital have also been eased, after being singled out for higher cuts than other hospitals. Medicaid reimbursements are being reduced ahead of a projected funding shortfall for fiscal year 2017. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Cuomo Administration Seeks Changes to Federal Risk Adjustment Program. The Centers for Medicare & Medicaid Services (CMS) released the results of its risk adjustment transfer payments, a component of the Affordable Care Act meant to reduce the risk of adverse selection and minimize cherry-picking by insurers. CMS scores all health plans participating in the insurance Exchanges based on enrollee demographics and medical diagnoses, and lower-scoring health plans transfer payments to higher-scoring plans. Several of the smaller plans participating in New York's marketplace, New York State of Health, owe significant amounts of money in the small group market risk adjustment

program. Concerned about the impact of these payments on plan solvency, Department of Financial Services Superintendent Maria Vullo wrote to CMS requesting changes to the program. As quoted in Politico, the letter articulates concerns that "the Risk Adjustment program has created inappropriately disparate impacts among health insurance issuers in New York and unintended consequences." She alleges that the program rewards health plans that are better at coding and data management, rather than accurately reflecting the relative health of each plan's enrollees. The article notes that Oxford Health Insurance, part of UnitedHealthCare, which controls roughly 70 percent of the small group market, is owed $315 million from the Risk Adjustment program, meaning that the state's smallest insurers, including start-ups Oxford and CareConnect, are subsidizing their largest competitor. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Submits Healthy Ohio 1115 Waiver to CMS. The *Ohio Department of Medicaid* announced submission of the Healthy Ohio Waiver application. The Healthy Ohio Program mandates enrollment in a Health Savings Account (HSA) for every non-disabled adult enrolled in Medicaid regardless of income. Each *Healthy Ohio* enrollee would be required to deposit two percent of family income up to a $99 annual limit into an HSA administered by their health plan, and the Ohio Medicaid program would be required to deposit an additional $1,000 annually into each person's account. *Healthy Ohio* enrollees also would be subject to copayments, but only if there is a balance in their HSA. Read More

State Faces $1.1 Billion Budget Gap Due to Medicaid MCO Tax Restructuring. *The Columbus Dispatch* reported on July 5, 2016, that Ohio state officials are discussing how to deal with a $1.1 billion budget gap expected for the state's next two-year budget beginning in January 2017. The gap is a result of the Centers for Medicare and Medicaid (CMS) decision in July 2014 that Ohio could no longer apply a tax only to Medicaid managed care organizations (MCOs), and gave the state until June 30, 2017 to fix it. The 5.75 percent tax, technically a sales tax, has been in place since 2009 and taxes Medicaid MCOs in order to allow the state to use that money to draw down millions in additional federal matching dollars each year. The state expects to lose $558 million in fiscal year 2018, and $1.1 billion over the two-year budget period. In addition, the state expects to lose $400 million in county and transit authority sales taxes. Since the recession, counties have grown increasingly reliant on sales tax revenue, most of which comes from Medicaid services. State budget director Tim Keen has said that changes in the state's sales tax will eliminate half of the state's projected tax revenue growth and that the state is working through potential solutions. Read More

The Ohio Departments of Medicaid and Mental Health and Addiction Services Release Provider Toolkit to Help Prepare for New Specialized Recovery Services Program. The *Ohio Department of Medicaid and the Ohio Department of Mental Health and Addiction Services* have released a toolkit to assist providers. The toolkit includes an agency checklist, information about services offered through SRS, eligibility requirements, billing codes and rates, guidance on enrolling individuals and more. The SRS program was designed to help individuals with serious and persistent mental illness, who currently spend down their income to be Medicaid-eligible, keep their coverage. In addition to

full Medicaid coverage, individuals will have access to three new services: recovery management, Individualized Placement and Support – Supported Employment (IPS-SE) and peer recovery support. Read More

Governor Kasich signs legislation to coordinate local health assessments and improvement plans. The Ohio Office of Health Transformation announced the signing of Ohio Revised Code 3701.981. The new law requires tax-exempt hospitals and local health districts to submit their existing community health improvement plans to the state to post online beginning in July 2017. It also requires them to complete future assessments and aligned plans every three years beginning in 2020. Read More

The Ohio Department of Medicaid Announces Infant Mortality Grants. The *Ohio Department of Medicaid* has awarded grants to eight counties aimed at reducing high infant mortality rates. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Insurance Commissioner Announces Public Hearing On Proposed Rate Increases. Pennsylvania Insurance Commissioner Teresa Miller announced a public informational hearing on the proposed rates requested by insurers for 2017 individual health plans. The hearing is scheduled for Wednesday, July 27. The department will use the hearing to receive critical feedback from consumers on the impact of proposed rate increases stemming in part from federal mandates under the Affordable Care Act. Last year, Commissioner Miller reduced the proposed rate increases from insurers by nearly $81 million. Information on the proposed rates for 2017 are posted on the Insurance Department website homepage. Read More

Regulators to Focus on Mental Health and Substance Use Disorder Coverage Parity. The Pennsylvania Insurance Department is prioritizing the enforcement of the Mental Health Parity and Addiction Equity Act. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurance plans to contain the same level of coverage for mental health and substance use disorders as for medical or surgical care. The Pennsylvania Insurance Department currently reviews all individual and small group plans to ensure that they contain all state and federal policy requirements, including mental health parity. This review will be extended to large group plans for the 2018 policy year. The department is not required to review large group plans but is choosing to do so in order to take a comprehensive approach to parity enforcement across Pennsylvania. The Insurance Department is also in the process of conducting market conduct examinations to ensure that insurance companies are in compliance with state and federal law. These examinations, which will continue over the next 18 months, emphasize mental health and substance use disorder parity as a key point. Read More

South Carolina

After WellCare Acquisition, Advicare to Exit SC Dual Demonstration Program. The South Carolina Department of Health and Human Services (SCDHHS) announced on July 6, 2016, that Advicare is exiting the state's duals demonstration program, impacting about 3,650 members. The announcement follows WellCare's acquisition of the Medicaid managed care operations of Advicare on June 1, 2016. Members currently covered by the Advicare Advocate dual plan have until August 30, 2016 to choose another plan or return to fee-for-service Medicaid. After that they will be passively enrolled in another plan. Read More

Tennessee

TennCare Director Darin Gordon Steps Down. Darin Gordon, Director of TennCare, stepped down on June 30, 2016, after 10 years, the longest stint of a Medicaid director in the state's history. Replacing Gordon is Dr. Wendy Long, who is now serving as both Director of TennCare and of the Tennessee Health Care Finance and Administration. Dr. Long was previously TennCare's Deputy Director and Chief Medical Officer.

CMS Grants Two-Month Extension on Medicaid 1115 Waiver. *Modern Healthcare* reported on June 30, 2016, that the Centers for Medicare & Medicaid Services (CMS) has granted a two-month extension to Tennessee's Medicaid 1115 waiver, which was to expire at the end of the month. The short-term extension will provide the state extra time to negotiate terms of a permanent extension. Tennessee has historically relied on waiver funding for the state's Unreimbursed Hospital Cost pool. However, hospital funding pools have been under greater CMS scrutiny in states that have yet to adopt the Medicaid expansion in the last few years. Attempts at passing expansion legislation in Tennessee have so far been unsuccessful. Read More

House Task Force Proposes Alternative Medicaid Expansion Plan Focused on Behavioral Health. *The Tennessean* reported on June 30, 2016, that a Tennessee House health care task force proposed a Medicaid expansion plan that prioritizes enrollment for veterans and individuals with mental health diagnoses and substance use disorder. The proposal includes measures to encourage greater physician-patient relationships, as well as greater integration of behavioral health and physical health. Additionally, the plan includes an employment and education push, with the goal of eventually moving members to commercial insurance. In the first phase of the plan, recipients will need a qualifying diagnosis of a mental illness or proof of honorable discharge from the U.S. military, as well income under 138 percent of the federal poverty level to be eligible. The task force estimates up to 115,000 people could enroll in the first phase. The second phase would open up enrollment to anyone under 138 percent of the poverty level. Read More

National

Medicaid Programs Begin to Lift Limits on Hepatitis C Drugs. *Kaiser Health News* reported on July 5, 2016, that state Medicaid programs and commercial insurers are lifting previously imposed restrictions on expensive hepatitis C medications following lobbying efforts and legal battles. Sovaldi (Gilead), Harvoni (Gilead), Viekira Pak (AbbVie), and Zepatier (Merck) are used to treat hepatitis C and can cost between $54,600 and $94,500 for a 12 week course of treatment. Medicaid and Medicare are required to cover medically necessary treatments, meaning states and managed care plans can't exclude classes of effective medications on the basis of cost alone. However, many states have limited use of C drugs, for example, only paying for prescription for patients with certain levels of liver damage. Massachusetts is the latest state to reduce restrictions and cover all hepatitis C drugs under the state's Medicaid program. In recent months, Florida, New York, and Delaware have also reduced limits on hepatitis C medications in their Medicaid programs. Read More

Providers, Health Plans at Odds Over Care Coordination for Children with Complex Care Needs. *CQ Roll Call* reported on July 5, 2016, that the House Energy and Commerce Health Subcommittee has scaled back proposed legislation concerning a new care management program for children with complex care needs. A hearing is scheduled for July 7. The scaled-back draft would allow states to opt in to the program, which builds on home health demonstrations already in place in some states. A prior version of the legislation would have established regional or national rules for children with complex care needs. The changes were partly in response to concerns expressed by Medicaid managed care plans, contending they are better positioned to coordinate care management for this population. Hospitals, meanwhile, argued that care coordination efforts should be provider-led and cautioned that the revised legislation will create state-by-state variation that could impact access to care.

U.S. to Increase Cap on Number of Patients Doctors Can Treat for Opioid Addiction. *The Washington Post* reported on July 6, 2016, that President Barack Obama's administration is increasing the number of patients a doctor can treat for opioid addiction with the drug buprenorphine. Physicians must apply for the increase, which will now cap patients-per-doctor at 275. The current patient-per-doctor cap is set at 100. The move comes as the President's administration urges Congress to approve $920 million in additional funding for opioid abuse treatment programs. Both parties have pledged to address the opioid issue, and Democratic legislators are increasing pressure on Republicans to agree the additional funding. Read More

Industry Research

ACL Policy Brief Argues States Could Reduce Nursing Home Utilization by Providing More HCBS for Older Adults with Disabilities. The Administration for Community Living (ACL) published a policy brief last month, *"Promoting Community Living for Older Adults Who Need Long-term Services and Supports,"* authored by Jane Tilly, DrPH, of ACL's Center for Policy and Evaluation.

Summary of report points: Many states could be providing more home and community-based services (HCBS) to older adults with disabilities and:

1. Documents problems with nursing home residents' access to assistance in leaving their facilities to live in their communities.
2. Documents differences in beneficiaries' receipt of LTSS by age and state.
3. Offers recommendations to states for promoting community living for older adults with disabilities.
4. Documents the impact of providing increased HCBS to older adults with disabilities.
5. Describes the special circumstances of older adults with dementia, who are at high risk of nursing home use.

Expanding HCBS saves money: Expanding HCBS for older adults is particularly advantageous to states because their per capita HCBS costs are lower than those of other Medicaid beneficiaries. Older Medicaid beneficiaries' HCBS cost 37.4% less on average than other adults. In FY 2012, Medicaid benefit spending per "full-year equivalent enrollee" was $2590 for "aged" beneficiaries who received HCBS, compared to $4135 for "disabled" beneficiaries under age 65 (MACPAC, 2015). The disparity that older Medicaid beneficiaries experience related to receiving HCBS persists, despite the fact that older adults are among the least costly Medicaid HCBS beneficiaries.

Risk factors for nursing home utilization: Many studies reveal statistically significant risk factors related to older adults' use of nursing homes. These factors include: prior hospitalization, symptom burden, limitations in 3 or more ADLs, cognitive impairment, age, and living alone. States can target these groups and provide them with Medicaid HCBS before they enter a nursing home and potentially lose their housing in the community.

Addressing caregiver burnout and stress can reduce nursing home use: In addition to older adults' health and function, their family caregivers' stress predicts nursing home use. A study concluded high caregiver stress led to a 13 percentage point increase in the likelihood of nursing home use over 1 year and 20 percentage points over 2 years. The highest sources of stress for family caregivers were physical and financial. Physical stressors may include lifting heavy people or having to stay awake when a person needs help 24 hours a day. Financial stress may result from having to quit a job to care for a loved one.

Conclusion: The research supports the conclusion that states could make progress in helping older adults remain in the community longer, if they target HCBS to older adults at risk of nursing home use and provide supports to family caregivers. States could identify the family caregiver(s) of Medicaid beneficiaries, and assess and address their unmet needs for information, education, and supportive services, especially when following the person-centered service plan involves reliance on a family caregiver. Link to ACL Policy Brief

Industry News

Seven Northeast Health Systems to Form Regional Group Purchasing Organization. *Modern Healthcare* reported on June 29, 2016, that the Allspire Health Partners alliance of seven health systems from Maryland, New Jersey, New York, and Pennsylvania are forming a group purchasing organization (GPO) to better aggregate purchasing volumes, streamline negotiations, and find opportunities for efficiency between networks. The GPO will be called AllSpire Health GPO. Current members are: Atlantic Health System (NJ), Hackensack University Health Network (NJ), Lehigh Valley Health Network (PA), Meridian Health (NJ), WellSpan Health Health System (PA), and Lancaster General Health (PA). AllSpire also signed an exclusive deal with HealthTrust, a national GPO that requires customers to use the GPO's contracts for 80 percent of their spending on most types of products. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
July 8, 2016	Massachusetts MassHealth ACO - Pilot	Responses Due	TBD
July-August, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
August 1, 2016	Missouri (Statewide)	Proposals Due	700,000
August 25, 2016	Nevada	Proposals Due	420,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
September 22, 2016	Nevada	Contract Awards	420,000
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
July 1, 2017	Nevada	Implementation	420,000
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

Larry Goodman, MD, to Address Changing Role of Academic Medical Centers in Delivering Integrated Care to Vulnerable Populations at HMA Conference in Chicago, October 10-12, 2016

During his keynote address at the inaugural HMA conference on *The Future of Publicly Sponsored Healthcare,* October 10-12 in Chicago, Rush University Medical Center chief executive Larry Goodman, MD, will outline a new care model for academic medical centers, with an emphasis on provider collaboration and initiatives that help build communities and foster integrated care delivery for vulnerable patient populations. This premier event, presented by HMA and HMA's Accountable Care Institute, is focused on 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.