HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 13, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION ENROLLMENT UPDATE

This week, our *In Focus* section reviews publicly available data on enrollment in capitated financial and administrative alignment demonstrations ("Duals Demonstrations") for beneficiaries dually eligible for Medicare and Medicaid (duals) in 10 states: California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia. Each of these states has begun either voluntary or passive enrollment of duals into fully integrated plans providing both Medicaid and Medicare benefits ("Medicare-Medicaid Plans," or "MMPs") under three-way contracts between the state, the Centers for Medicare & Medicaid Services (CMS), and the MMP. Rhode Island is the latest state to launch its demonstration, with the first wave of opt-in, voluntary enrollment

effective July 1, 2016. As of June 2016, more than 360,000 duals are enrolled in an MMP, according to state and CMS enrollment reports.

Note on Enrollment Data

Five of the nine states (California, Illinois, Massachusetts, Michigan, and South Carolina) report monthly on enrollment in their Dual Demonstration plans, although there is often a lag in the published data. Other states, including New York and Virginia, publish intermittent enrollment reports.

Duals Demonstration plan enrollment is also provided in the CMS Medicare Advantage monthly enrollment reports, which are published around the middle of each month. In the table below, we provide the most current state-reported data, with CMS data supplementing where needed. Historically, we have seen minor inconsistencies between state-reported data and the CMS enrollment report, potentially due to reporting timing discrepancies.

Dual Demonstration Enrollment Overview

As of June 2016, just under 362,000 dual eligibles were enrolled in a demonstration plan across the nine states with active demonstrations as of June 2016. Since January 2016, enrollment in Dual Demonstrations across nine states below (Rhode Island has yet to report enrollment) is down 11,112 members or 3.0 percent.

State	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
California	125,257	124,292	123,560	122,087	120,971	119,814
Illinois	47,340	49,238	47,888	48,651	47,335	48,218
Massachusetts	12,949	12,766	12,596	12,223	13,195	13,038
Michigan	34,297	32,735	32,040	31,766	30,813	38,767
New York	6,242	6,029	5,801	5,617	5,370	5,480
Ohio	60,622	60,980	62,192	61,535	61,946	62,009
South Carolina	1,689	1,778	1,824	5,954	5,696	5,419
Texas	55,671	50,926	48,010	45,219	43,676	42,069
Virginia	28,844	27,298	27,259	27,116	29,374	26,975
Total Duals Demo Enrollment	**372,911**	**366,042**	**361,170**	**360,168**	**358,376**	**361,789**

Sources: State Enrollment Data, CMS Enrollment Data

So far, enrollment in these nine states represents just under 30 percent of the potential enrollment of more than 1.2 million across all ten capitated demonstration states. Participation rates range from a low of 4.3 percent in New York to 54.4 percent in Ohio.

	Opt-In Enrollment Date	First Passive Enrollment Date	Current Enrollment	Potential Enrollment	% Enrolled (Full Potential)
California	4/1/2014	5/1/2014	119,814	350,000	34.2%
Illinois	4/1/2014	6/1/2014	48,218	136,000	35.5%
Massachusetts	10/1/2013	1/1/2014	13,038	97,000	13.4%
Michigan	3/1/2015	5/1/2015	38,767	100,000	38.8%
New York	1/1/2015	4/1/2015	5,480	126,000	4.3%
Ohio	5/1/2014	1/1/2015	62,009	114,000	54.4%
Rhode Island	7/1/2016	10/1/2016		25,400	0.0%
South Carolina	2/1/2015	4/1/2016	5,419	53,600	10.1%
Texas	3/1/2015	4/1/2015	42,069	168,000	25.0%
Virginia	3/1/2014	5/1/2014	26,975	66,200	40.7%
Total (All States)			**361,789**	**1,236,200**	**29.3%**

Sources: State Enrollment Data, CMS Enrollment Data, HMA Estimates.

As noted above, Rhode Island's first opt-in enrollments were effective on July 1, 2016, but no enrollment data is available at this time. Passive enrollment will be phased in over the October 2016 through March 2017 period.

Dual Demonstration Enrollment by Health Plan

As of June 2016, more than half (55.2 percent) of all duals in the demonstrations are enrolled in a publicly-traded MMP. Molina and Centene are the largest in terms of enrollment with more than 50,800 and 48,200 demonstration enrollees, respectively. Centene's enrollment was bolstered by its acquisition of Health Net at the end of March 2016.

Health Plan	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Molina	52,592	51,085	50,506	50,248	49,365	50,855
Centene	27,761	28,165	27,194	46,668	45,210	45,287
Anthem	38,731	36,362	35,304	34,063	34,224	32,713
Aetna	25,880	25,685	25,616	25,287	25,135	26,990
United	19,203	18,467	18,118	17,582	17,354	17,089
Humana	17,343	16,747	16,655	16,486	17,286	16,320
CIGNA/HealthSpring	9,850	9,621	9,248	9,061	8,737	8,419
WellCare	207	199	177	168	155	2,062
Health Net	20,838	20,325	19,797	-	-	-
Total Publicly Traded Health Plans	**212,405**	**206,656**	**202,615**	**199,563**	**197,466**	**199,735**

Among non-publicly traded health plans, Inland Empire in California is the largest, with more than 21,000 members, making it the fifth largest MMP overall. CalOptima (CA), CareSource (OH), BCBS of Illinois (IL), LA Care (CA), Meridian (IL, MI), and Commonwealth Care Alliance (MA), all have more than 10,000 enrolled members as of June 2016. Enrollment by non-publicly traded health plans for the past six months is detailed below.

Health Plan	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Inland Empire (CA)	21,642	21,620	21,655	21,438	21,375	21,362
CalOptima (CA)	16,336	16,973	17,567	17,942	18,387	18,439
CareSource (OH)	15,436	15,695	15,911	15,886	16,035	16,084
BCBS of Illinois (HCSC) (IL)	13,617	13,845	13,845	13,787	13,690	13,671
LA Care (CA)	13,154	12,996	12,903	12,805	12,643	12,546
Meridian Health Plan (IL, MI)	10,882	10,576	10,282	10,211	9,980	11,158
Commonwealth Care Alliance (MA)	10,124	10,127	10,022	9,768	9,994	10,050
Health Plan of San Mateo (CA)	9,605	9,573	9,503	9,445	9,382	9,396
Santa Clara Family Health Plan (CA)	8,734	8,584	8,426	8,215	8,061	7,925
Care 1st (CA)	7,903	7,728	7,561	7,366	7,189	7,036
AmeriHealth Caritas (MI, SC)	3,603	3,486	3,364	4,970	4,746	5,894
HAP Midwest Health Plan (MI)	5,174	4,853	4,708	4,658	4,504	5,783
Virginia Premier (VA)	6,128	5,720	5,570	5,659	6,203	5,621
Community Health Group Partner (CA)	5,076	4,999	4,950	4,855	4,793	4,769
Upper Peninsula Health Plan (MI)	3,773	3,677	3,597	3,569	3,507	4,043
Network Health (MA)	2,825	2,639	2,574	2,455	3,201	2,988
Advicare Advocate (SC)	525	516	542	2,164	2,057	-
VNS Choice (NY)	2,264	2,281	2,181	2,100	1,939	1,978
Managed Health Inc. (NY)	1,237	1,208	1,159	1,128	1,058	1,072
GuildNet (NY)	923	909	898	874	822	829
The New York State Catholic Health Plan (NY)	379	368	352	338	318	317
Elderplan (NY)	304	302	303	298	299	285
MetroPlus Health Plan (NY)	183	183	187	189	173	184
Partners Health Plan (NY)	-	-	-	-	87	175
Centerlight Healthcare (NY)	215	195	180	170	169	159
Independence Care System (NY)	189	187	172	165	161	156
Senior Whole Health (NY)	63	61	61	70	67	71
AlphaCare of New York (NY)	44	22	21	22	36	19
North Shore-LIJ (NY)	29	18	17	16	28	17
AgeWell New York (NY)	53	31	30	28	41	15
Centers Plan for Healthy Living (NY)	37	14	14	14	25	12
Village Senior Services Corp. (NY)	34	-	-	-	24	-
Elderserve Health (NY)	15	-	-	-	7	-
Total Local/Other Plans	**160,506**	**159,386**	**158,555**	**160,605**	**161,001**	**162,054**

Sources: State Enrollment Data, CMS Enrollment Data

Looking Ahead

All ten of the financial alignment demonstration states detailed above have submitted letters of intent to extend their duals demonstrations beyond the initial three-plus year demonstration period. CMS offered the option to extend to allow more time for states and CMS to evaluate the demonstrations. It appears likely that all states will continue to operate their duals demonstrations through at least 2019 or 2020, with the exception of Virginia, who has announced their intentions to end their Commonwealth Coordinated Care demonstration at the end of 2018, transitioning members into a new managed long term services and supports (MLTSS) and dual eligible managed care program.

HMA Medicaid Roundup

Arkansas

Arkansas Works to Cost $25 Million More Than Expected, Driven by Drug Costs. *Arkansas News* reported on July 11, 2016, that the Arkansas Medicaid expansion program will cost the state $25 million more than expected over the next five years, with the increase driven largely by drug costs. The revised estimate was presented by external consultants to the Arkansas Health Reform Legislative Task Force and reflects the cost of Arkansas Works, a revised version of the state's private option expansion plan being proposed by Arkansas Governor Asa Hutchinson and state legislators. The state's share of the costs of the program is now projected to be $735 million over five years, while the total cost is projected to be $9.35 billion. The state will be picking up a portion of the cost of expansion for the first time beginning in 2017 when it pay 5 percent of the total tab, rising to 10 percent by 2021. Since the program began in 2013, the federal government has paid the entire cost. The Arkansas Works waiver application is currently awaiting approval. Read More

Colorado

HMA Roundup – Lee Repasch (Email Lee)

CDPHE Launches Toolkit for Providers on Building Immunization Programs. The Colorado Department of Public Health and Environment (CDPHE) launched a new web-based resource for providers who want to build a successful immunization program. This new resource hub is designed to give health care providers tools to help improve vaccination rates for their patient population and manage vaccination administration activities.

The resource hub offers a variety of tools to assist providers with challenges they may encounter in their immunization programs, including:

- Resources to support providers with vaccine administration
- An overview of private sector services and vendors that support inventory management
- Job aids and video training to support providers in the proper storage and handling of vaccines
- Resources for providers seeking reimbursement for services offered to insured patients
- Tools and resources to improve vaccination rates
- Information regarding the Vaccines for Children (VFC) program which uses federal funding to provide low- or no-cost vaccines to children who might not otherwise be vaccinated because of inability to pay
- An online form to submit questions to CDPHE immunization staff

CDPHE has also begun a peer-to-peer provider mentoring project. The project goal is to promote vaccine administration during the well-child visit for all children seen in a primary care medical home. Read More

Connecticut

Connecticut Health Care Cabinet Hears Proposal to Form CCOs; Reorganize State Agencies. The *CT Mirror* reported on July 13, 2016, that the Connecticut Health Care Cabinet was presented with recommendations from a contracted consulting firm on how the state can control health care costs. Recommendations include the creation of Consumer Care Organizations, Medicaid provider-led organizations taking on full-risk, and building upon the Patient-Centered Medical Home model to include other key health care providers. The recommendations also include the formation of the Connecticut Health Authority, a new agency that would take over the responsibilities of multiple existing state agencies; the formation of a quasi-independent oversight agency called the Office of Health Reform to track and limit health care cost increases; and implementing value-based payments and promoting the utilization of low-cost, high-quality providers. The Cabinet will deliberate on the recommendations and meet again in August to begin drafting their final report, expected in November. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Computer Error Leaves 106,000 Children Without Insurance. *Politico* reported on July 8, 2016, that a computer glitch prevented the names of 186,000 children no longer eligible for Medicaid from being sent to the Florida Healthy Kids Corporation for help in finding other coverage options. Florida Healthy Kids is the state's Children's Health Insurance Program (CHIP). Families of about 80,000 of the kids were able to find coverage on their own, while 106,000 were left uninsured. Florida Healthy Kids has reached out to the families of the affected children, but only 4,100 have re-enrolled. The computer error did not cause any children to be disqualified from the program. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Health Alliance to Exit Medicaid Managed Care Market. *The News-Gazette* reported on July 7, 2016, that Illinois-based Health Alliance Medical Plans is exiting the Medicaid managed care business at the end of 2016, expected to impact 129,500 members. The Carle Foundation-owned insurer cited unsustainable losses in its decision to end Medicaid operations. Health Alliance will end contracts with the Illinois Department of Healthcare and Family Services for clients in the Integrated Care Program for seniors and persons with disabilities (7,800 members) and the Family Health Plan for children, families, and childless adults (121,700 members). However, the insurer will continue to cover individuals in the Dual-Eligible Special Needs Plan. Read More

Land of Lincoln Health Co-op Plan to Cease Operations. *Crain's Chicago Business* reported on July 12, 2016, that Land of Lincoln Health, a co-op health plan on the Illinois health insurance Exchange, will cease operations. The news came after federal officials rejected a plan that would have allowed Land of Lincoln Health to forego making $31.8 million in risk adjustment payments. The Illinois Department of Insurance has asked the state Attorney General to petition the Circuit Court of Cook County to begin liquidating the co-op. Land of Lincoln Health has nearly 50,000 members and reported losses of $90.8 million in 2015 and more than $17 million through May 31, 2016. Land of Lincoln Health filed a lawsuit in June, claiming it was owed nearly $73 million under the risk adjustment program. The state will work with federal officials to open a 60-day enrollment period for members to select a new plan. Read More

Iowa

Medicaid Home Care Providers Experience Payment Problems. The *Des Moines Register* reported on July 8, 2016, that approximately 6,700 Medicaid home care providers in Iowa's Consumer Directed Attendant Care (CDAC) program have been working without pay since the state shifted to Medicaid managed care in April 2016. The American Federation of State, County, and Municipal Employees (AFSCME) notes that these providers only make $9 to $12 per hour, adding that some providers may have to stop providing services. Iowa Department of Human Services spokeswoman Amy Lorentzen McCoy has said that the Medicaid managed care plans are working to help providers adjust to the new billing system to avoid payment issues and is hoping the glitches will be fixed soon. The CDAC program provides in-home bathing, medication, and feeding assistance to individuals with disabilities. Read More

Kansas

Community Mental Health Centers Raise Concerns Over Funding Cuts. *Kansas Health Institute* reported on July 7, 2016, that the Association of Community Mental Health Centers (ACMHC) of Kansas, which represents the state's 26 centers, issued a statement expressing their concerns about the impact of $30 million in funding cuts over the last year. A 4 percent Medicaid reimbursement rate reduction along with the elimination of the state's health home pilot is taking a toll on mental health centers and could ultimately result in more hospital admissions, ACMHC said. Tim DeWeese, Executive Director of Johnson County Mental Health Center, said that inadequate funding and the state's rejection of Medicaid expansion have put considerable strain the state's mental health system. Read More

Kentucky

1115 Waiver Proposal Met with Strong Opposition at Final Public Hearing. *The Courier-Journal* reported on July 7, 2016, that Kentucky Governor Matt Bevin's Medicaid waiver proposal continued to face strong opposition during a third and final public hearing on July 6. Opponents are voicing opposition against efforts to scale back coverage under the state's Medicaid expansion, which added 440,000 members to Kentucky's Medicaid rolls. AARP of Kentucky, for example, expressed concerns for residents between 50 and 64 who

lost their jobs and insurance coverage during the recession, but do not yet qualify for Medicare. The finalized waiver is expected to be submitted by August 1. Under the waiver, adults would be required to work or volunteer at least 20 hours a week, pay premiums, and may have some benefits reduced. Read More

Massachusetts

MassHealth Accepting LOIs for Interested Duals Demo Plans to Start in 2018. On July 7, 2016, MassHealth, the Massachusetts Medicaid authority, issued a call for non-binding letters of intent (LOIs) from plans interested in participating in the state's dual eligible financial alignment demonstration, known as One Care. LOIs are non-binding and are not required to bid on the upcoming One Care procurement, tentative planned for September 2016. Under the anticipated procurement timeline, bids would be due in November, with plan selections announced in the first half of 2017, and enrollment effective January 1, 2018. The state is accepting questions from interested parties through July 18, 2016, and is accepting LOI submissions until August 1, 2016. One Care currently has two Medicare-Medicaid Plans participating – Commonwealth Care Alliance and Tufts Health Plan – serving just over 13,000 duals. Read More

Nebraska

Home Health Providers Struggling With Timely Medicaid Payments. The *Lincoln Journal Star* reported on July 11, 2016, that Nebraska home health providers are struggling with Medicaid payment delays, threatening access to care for members. The delays stem in part from new Department of Labor rules requiring overtime pay for in-home care providers. Also contributing to the delays is the approval and re-approval process to work as an in-home care provider in the state. An expanded payroll process and more complex time sheets have also created difficulties for many providers. Calder Lynch, Nebraska's Medicaid director, said that the changes in the provider approval process were required by the Affordable Care Act and are aimed at protecting Medicaid recipients and taxpayers. The state has acknowledged the problems, and says it is working to improve the system. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

SIM Report Identifies Barriers of Sharing Patient Health Information in the Integration of Physical and Behavioral Health. In June 2016, the Center for Health & Pharmaceutical Law & Policy at New Jersey's Seton Hall University School of Law published a report titled, *"Integrating Behavioral and Physical Health Care in New Jersey: Legal Requirements for the Sharing of Patient Health Information among Treatment Providers."* This report was conducted as part of New Jersey's State Innovation Model (SIM) Grant to analyze the hurdles related to sharing patient health information (PHI) as it pertains to the integration of physical and behavioral health care. The first section of the report provides an overview of both federal and New Jersey laws on sharing PHI amongst providers. The report goes on to identify challenges in sharing PHI as New Jersey integrates physical and behavioral health care. The Center for Health &

Pharmaceutical Law & Policy discovered that barriers were actually created by providers' misconceptions and fears of violating privacy laws. Based on the legal assessment of the laws surrounding and PHI and the interviews conducted, the Center determined that the complexity of the law and its lack of clarity makes it operationally overwhelming in the delivery of health care. In an effort to reduce the barriers of sharing PHI in the integration of physical and behavioral health care, the report provided recommendations, including harmonization of legal requirements, legal guidance and standards, support for technical improvements, and public education. Read More

New Mexico

Presbyterian Health Plan to Leave Exchange at End of Year. The *Albuquerque Journal* reported on July 11, 2016, that Presbyterian Health Plan will stop offering individual and family plans on New Mexico's health insurance Exchange after 2016, affecting about 10,000 members. Presbyterian will continue to offer small group options on the Exchange. Presbyterian indicated that its individual Exchange members had 30 percent higher utilization than non-Exchange members. Separately, Presbyterian is requesting an average rate increase of 21 percent in premium rates for its non-Exchange, individual plans for 2017. Other insurers in the state are also be seeking rate increases. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

State Welcomes Public Comments on Section 1115 Medicaid Waiver. New York State's Medicaid program has operated under a federal Section 1115 waiver since 1997. The waiver, referred to as the Partnership Plan, provides the underpinnings of NY's mandatory Medicaid managed care program. It also is the vehicle by which the state has implemented the initiatives of the Medicaid Redesign Team and all subsequent health systems reforms, including the Delivery System Reform Incentive Payment (DSRIP) program. The waiver has been renewed several times since 1997, typically for a 5-year extension. The most recent extension was in October 2015. The Special Terms and Conditions of the waiver now require the state to annually solicit public comments on the waiver. The State is welcoming public comment on any and all aspects of the 1115 Waiver and the Medicaid program. These meetings will be webcast live and are open to the public. The webcast link can be found here, and will go live the morning of the event. Any written public comments may be submitted through July 13 to dsrip@health.ny.gov

Fully Integrated Dual Advantage Enrollment Update for May 2016. The New York Department of Health has posted updated enrollment information for the Fully Integrated Dual Advantage (FIDA) program, NY's duals integration demonstration. Enrollment has declined since the state last posted enrollment data; enrollment dropped from 6,252 in January 2016 to 5,370 in May 2016. Every plan saw a decline in enrollment. Of the 126,000 potentially eligible individuals, over 61,000 people have opted out of the program. Enrollment by plan ranges from a high of 1,939 enrollees enrolled in VNS Choice, to a low of only 7 enrollees in RiverSpring, which is part of a long-term care provider system that used to be called ElderServe. Of the 23 plans that originally

participated in the program, 17 plans remain. Expansion of the program to Phase 2 counties, Suffolk and Westchester, remains on hold. Read More

Fidelis Care Reports Dip in 2015 Earnings. Fidelis Care New York, a Medicaid managed care plan sponsored by the Diocesan Bishops of the State of New York, earned $215 million in net income last year, a drop of 19 percent from the year before as increases in premium revenue were exceeded by medical costs. As reported in the Buffalo News, Fidelis Care saw premium revenue rise 22 percent, to $6.7 billion, between 2014 and 2015, as membership rose 16 percent, to 1.3 million across the state. However, the cost of providing services to the company's members rose even more, by 23 percent, to $6.1 billion. Fidelis operates exclusively in publicly sponsored programs and the health exchange; it does not operate in the commercial market. Fidelis Care is the only Medicaid managed care plan to operate in every county across the state. It is the largest Medicaid MCO, serving 1,164,416, or 26 percent of all Medicaid managed care enrollees in the state. Read More

New York Attorney General Files Lawsuit Against Armor Correctional Health Medical Services. The *Washington Post* reported on July 12, 2016, that New York state Attorney General Eric Schneiderman filed a lawsuit against Armor Correctional Health Medical Services for failing to provide proper health services to inmates at a Long Island jail. Armor, which is based in Miami, FL, provides health care services to jails in 29 counties in eight states. The lawsuit alleges that five of the twelve deaths at the Long Island jail in the last five years were due to inadequate medical care. Attorney General Schneiderman wants to prevent Armor from being able to bid on any future health care service contracts in New York, as well as to pay fines and damages. Armor called the allegations false. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Medicaid Spending Is Below Budget Projections In Fiscal 2016. Ohio Medicaid spending was 4.8 percent, or $1.3 billion, lower than expected in the fiscal year ending June 30, 2016, according to a report from the Governor's Office of Health Transformation. The state's share of spending was 6.7 percent, or $550 million, below budget projections. The federal share of Medicaid spending was 3.9 percent, or $715 million, below budget projections. The report notes that total Medicaid enrollment in Ohio has remained steady at around 3 million, 32,301 members below enrollment projections. Medicaid expansion enrollment came in 26,076 members above projections, while traditional (non-expansion) Medicaid enrollment was 58,377 members below projections. Read More

MHAS, Medicaid Delay Implementation of Behavioral Health Redesign. The Ohio Department of Mental Health and Addiction Services (MHAS) and the Department of Medicaid have announced that the transition to the new evaluation and management (E & M) and nursing activity code set will take place July 1, 2017, instead of January 1, 2017. Additionally, there will be no voluntary transition period. January 1, 2017, remains the implementation date for rendering practitioners to be reported on Medicaid community behavioral health service claims. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Governor Wolf Will Allow Appropriations Bill to Become Law. Governor Tom Wolf announced that he would allow General Appropriations Bill (SB 1073) to become law without his signature. Governor Wolf emphasized that this appropriations bill is a compromise that includes, among other things, funding necessary to combat the state's heroin epidemic. Progress has been made on a compromise revenue package that will sustain the investments made in the budget, but a revenue bill has not yet passed. The House and Senate have indicated they will send a $1.3 billion revenue bill to Governor Wolf's desk that pays for the budget. Read More

Risk-Sharing Program to Help Medicaid Plans with Hepatitis C Drug Costs. *The Philadelphia Inquirer* reported on July 8, 2016, that Pennsylvania regulators have launched a risk-sharing plan to help Medicaid managed care plans pay for Hepatitis C drug costs. Under the program, the state will pay a larger share of the cost of the drugs. The state will also offer quality incentives to plans based on the success of the treatments. Jeff Myers, chief executive of the trade group Medicaid Health Plans of America, says the program will help offset health plan losses on Hepatitis C treatments. Read More

South Dakota

State Seeks Timely Provider Cost Reports to Guide Reimbursements. *The Rapid City Journal* reported on July 6, 2016, that the South Dakota Bureau of Finance and Management is seeking timely Medicaid provider cost reports to help it determine adequate reimbursement rates. Bureau Commissioner Jason Dilges told a panel of state legislators he'd like to help make provider cost reports easier to file. Commissioner Dilges also seeks to complete a three-year plan to raise reimbursement rates closer to actual costs, as proposed in 2015 by the administration of South Dakota Governor Dennis Daugaard. Cost reports filed by Medicaid providers are often late or not filed at all, in part because they are expensive to submit and have differing federal and state requirements. The Legislature assigned an interim committee to study Medicaid provider reimbursements. Final recommendations are expected on October 15 for consideration in the 2017 session that opens in January. Read More

Texas

State Supreme Court Further Delays Medicaid Therapy Provider Cuts. *The Texas Tribune* reported on July 8, 2016, that the Texas State Supreme Court has issued a temporary injunction delaying $350 million in Medicaid budget cuts aimed at physical, speech, and occupational therapy providers serving children with disabilities. The cuts, which have been held up for a year, were scheduled to take effect July 15, 2016. Seventy-five lawmakers wrote to state and federal officials last month asking to delay the cuts, and families of eligible children have continued to voice strong opposition. The Supreme Court injunction does not rule on the validity of the reductions. Read More

Industry News

Evolent Health to Acquire Valence Health for $145 Million in Cash, Stock. Evolent Health and Valence Health announced on July 13, 2016, that the two firms have reached a definitive agreement for Evolent to acquire Valence in a deal valued at $145 million in cash and stock. Evolent said it expects Valence to generate revenues of approximately $80 million to $85 million on a standalone basis in 2016. Evolent, founded in 2011, helps providers manage population health and performance-based payment arrangements. Valence, founded in 1996, provides value-based administrative, population health and advisory services. Together, the two organizations serve 23 health plans, accountable care organizations, and risk-bearing entities and a total of more than 1.8 million members. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
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 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 1, 2016	Texas STAR Kids	Implementation	200,000
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	350,000	119,814	34.2%	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	136,000	48,218	35.5%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	13,038	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	38,767	38.8%	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	114,000	62,009	54.4%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400			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	66,200	26,975	40.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,234,200**	**361,789**	**29.3%**	

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

HMA News

Cindy Mann, Arthur Gianelli, Bruce Goldberg to Discuss Emergence of Provider-Led Managed Care for Vulnerable Populations at HMA Conference in Chicago, October 10-12, 2016

States are fostering an integrated approach to health care delivery by moving toward innovative models that rely on provider-led organizations to coordinate care for Medicaid patients under global or capitated payment arrangements. This exciting development is the subject of an important panel discussion at HMA's inaugural conference on *The Future of Publicly Sponsored Healthcare,* Oct. 10-12 in Chicago. The panel is titled *The Emergence of Provider-Led Managed Care: How Innovative State Models Are Transforming the Relationship Between Payers and Providers* and will feature Arthur Gianelli, President of Mount Sinai St. Luke's and Mount Sinai PPS, LLC; Bruce Goldberg, MD, Former Director, Oregon Health Authority; and Cindy Mann, Partner, Manatt Health. Gianelli, Goldberg, and Mann have directed or participated in initiatives at the local or national level, such as Oregon's shift to provider-led Coordinated Care Organizations (CCOs) and New York's implementation of a Delivery System Reform Incentive Payment (DSRIP) program. Speakers will provide important insights into the challenges and results of implementing and participating in these programs, outline best practices for incentivizing delivery system change, and discuss whether these same innovations could potentially be replicated in other states.

HMA's conference on *The Future of Publicly Sponsored Healthcare,* October 10-12 in Chicago is a premier event, presented by HMA and HMA's Accountable Care Institute and 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.

Final Medicaid Managed Care Rules Implementation Assistance for Medicaid Managed Care Organizations

On April 25, 2016, the Centers for Medicare & Medicaid Services (CMS) issued the final Medicaid managed care rules to modernize federal Medicaid managed care regulations. Many of the new rules go into effect July 2017. The hard work of implementing the new Medicaid managed care regulations will fall squarely on the shoulders of states and Medicaid managed care health plans. For managed care plans, they must step up their operational, administrative, and reporting capabilities to accommodate new state oversight requirements across all aspects of the contract performance.

The final rule unifies requirements across all forms of managed care, including managed care organizations (MCOs) operating under comprehensive risk contracts, prepaid inpatient and ambulatory plans (PIHPS and PAHPS), and primary care case management (PCCM), recognizing variation in size and scope. The broad implications of the new rules for health plans are:

- More standardized approaches across and within states, particularly in financial management

  - Medical Loss Ratio and other rate setting issues
  - Appeals and grievances policies and timelines
  - Provider enrollment shifted to the state level
  - Encounter data and annual reports
- Specific policy standards and requirements related to MLTSS
- Substantial new reporting and oversight requirements
- Some areas of considerable state flexibility—particularly in delivery system reform
- Quality strategy still to be developed

On May 17, 2016 HMA provided the free webinar "Preparing for the New Medicaid Managed Care Regulations." During this webinar, HMA experts provided a framework for assessing the final rule, analyzing your organizational needs, and implementing the operational and functional changes needed. HMA experts provided an overview of the final rule and outlined the HMA Impact Analysis and Implementation Tool, a rigorous process for identifying opportunities and challenges the new rules pose to managed care organizations. **Click here to view this webinar.**

In preparation for this significant overhaul to Medicaid managed care regulations, HMA geared the managed care regulation Impact Analysis and Implementation Tool toward MCOs. The purpose of the tool is to help MCOs understand and assess the impact of the new regulations. It can be used to complete a gap analysis and serve as a tracking document and work plan/project plan to bring the organization into compliance. The tool can also help MCOs proactively engage in discussions with states about implementing the new rules.

Organizations can purchase the tool as a stand-alone, or work with HMA to help complete the analysis, manage implementation, and/or incorporate new requirements into operations. HMA also can amend the tool to address compliance for non-MCO organizations.
For more information about the tool or assistance from HMA in implementation, operations, education and training, or understanding the impact of the new rules to your organization, please contact *your current HMA project manager/contact* or:

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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.

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