HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 20, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

HMA LAUNCHES MEDICAID MANAGED CARE RULES IMPACT ANALYSIS, IMPLEMENTATION TOOL

This week, our *In Focus* section comes from HMA Principal Anne Winter and Consultant Nicole McMahon, who provide an overview of HMA's new impact analysis and implementation tool for the Medicaid manage care rules finalized earlier this year. 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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HMA Medicaid Roundup

California

Covered California Plans to Increase Premiums by an Average 13.2 Percent in 2017. *California Healthline* reported on July 19, 2016, that health plans participating on California's health insurance exchange, Covered California, will increase premiums by 13.2 percent on average in 2017. Covered California's two largest insurers, Blue Shield of California and Anthem, are increasing premiums 19.9 percent and 17.2 percent, respectively. Health Access executive director Anthony Wright and other consumer advocates oppose the increases, saying that higher premiums put more pressure on individuals. Covered California's Peter Lee and insurers argue that higher prices reflect a higher cost of care, especially for costly specialty drugs. While rates are subject to regulatory review as well as public comment, the state's insurance regulators do not have the authority to block the increases. Read More

Physicians Look to Ballot Initiatives to Increase Medi-Cal Rates. *California Healthline* reported on July 14, 2016, that the California Medical Association (CMA) is turning to the state's ballot initiative process in the hope of obtaining Medi-Cal rate increases, according to association president Steven Larson. The CMA represents about 41,000 doctors and has been working to increase Medi-Cal rates for providers. After an unsuccessful push to increase rates through legislation, the association is turning to Proposition 56, a proposed cigarette tax, and Proposition 55, an extension of the Proposition 30 income tax increases. The increased taxes are expected to provide money to Medi-Cal if passed this November. The CMA states that managed care reimbursements through Medi-Cal are much lower than commercial rates and are not sustainable for most providers. Read More

Connecticut

HUSKY A Transition Deadline Looms; 26 Percent of Parents and Caregivers Have Enrolled in New Coverage. *The CT Mirror* reported on July 15, 2016, that with two weeks left until the HUSKY A eligibility levels change, 26 percent (3,544 individuals) of the 13,811 parents and caregivers who will lose coverage at the end of July have enrolled in new plans. Of these, two-thirds enrolled in new HUSKY plans, while the remainder found coverage through the state exchange. Notices and postcards were mailed to all parents and caregivers affected. Read More

Iowa

Medicaid Services Agencies Not Being Paid by Private Medicaid Managers; Some At Risk of Closure. *The Des Moines Register* reported on July 17, 2016, that some Medicaid service providers continue to encounter billing and payment issues since the state shifted to a managed care model. As a result, many small service agencies are struggling financially. Human Services Director Charles Palmer stated that the billing issues are being worked out and has urged industry associations to let his administrators know if an agency is at risk of closing. Read More

Medicaid Home Care Payments Face Federal Investigation. *The Gazette* reported on July 14, 2016, that U.S. Health and Human Services Secretary Sylvia Burwell announced the federal government will investigate the timeliness of Medicaid payments to home care providers in Iowa. Home care providers say that they are receiving delayed payments, or no payments at all, after the program shifted to managed care on April 1 of this year. Read More

Maryland

State Requests 3 Year Extension on Medicaid 1115 Waiver. On June 30, 2016, Maryland submitted an application for a 3-year extension of the Medicaid 1115 waiver demonstration, Maryland HealthChoice, through December 31, 2020. The application includes the expansion of residential treatment for individuals with substance use disorder; of community health pilots, including limited housing support services and evidence-based home visiting services for high risk pregnant woman and children up to age 2; and of dental services for former foster youth. Public comments will be accepted from July 15, 2016 through August 14, 2016.

Missouri

Stakeholders Resist Managed Care Expansion. *The St. Louis Post-Dispatch* reported on July 19, 2016, that a coalition of groups requested that Governor Jay Nixon and the Missouri Department of Social Services halt the state's plan to expand Medicaid managed care statewide for non-disabled adults and children. In opposition to Missouri's plan, a coalition consisting of organizations such as Empower Missouri, Metropolitan Congregations United, and the Service Employees International Union submitted a letter in July arguing that managed care should not be expanded in Missouri and pointing out that managed care savings have been less than anticipated. The Department of Social Services is currently evaluating bids from companies and hoping to award contracts by October. The state originally planned to implement the Medicaid managed care plan by June 1, but is now targeting a May 2017 start date. Read More

Montana

Medicaid Expansion Enrollment Ahead of Projections. *Kaiser Health News* reported on July 18, 2016, that as of July, 47,399 Montanans have enrolled in Medicaid through the expansion program, nearly double the initial projection. Approximately 59,000 Montanans are estimated to be eligible for Medicaid expansion. The number of uninsured dropped from 15 percent to 7.4 percent. The state estimates it has also saved $5.3 million from shifting 8,458 people from traditional Medicaid to Medicaid expansion. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Requests Exception to CMS Safety Net Definition. New York State is requesting an exception from the Centers for Medicare and Medicaid Services (CMS) to the current Safety Net definition policy that would expand the definition of who qualifies as a safety net provider under the terms of New York's Delivery System Reform Incentive Payment program (DSRIP). The current definition requires that at least 35 percent of providers' patients be covered by Medicaid or have no insurance; the state proposes a threshold of at least 25 Medicaid beneficiaries. The expanded definition would allow an additional 7,000 primary care providers to qualify as safety net providers. According to *Modern Healthcare*, about one-third of the state's doctors meet the current safety net definition, and in some Performing Provider Systems, 90 percent of physicians do not qualify for safety net status. State officials feel that expanding the definition will encourage physicians to participate in DSRIP efforts, increasing the state's chances of meeting its performance goals and thus drawing down federal incentive payments. The proposal, which has been submitted to CMS, is open for public comment until August 10, 2016, and can be accessed by clicking here.

DSRIP FAQs Updated. New York State's DSRIP Frequently Asked Questions (FAQ) document has been updated to include information about the Public Approval and Oversight Panel, as well as the recently held public comment days. It includes a new section on the required Primary Care plans that each Performing Provider System must complete. It includes a discussion of the Mid-Point Assessment process, which is beginning now. Finally, it includes a discussion of two Equity Programs, the Equity Infrastructure Program (EIP) and the Equity Performance Program (EPP), and the Value Based Payment Quality Improvement Program. EIP payments will be paid to PPS for participating in select Delivery System Reform Incentive Payment (DSRIP) activities and implementing predetermined key DSRIP initiatives. EPP payments will be triggered by the PPS achieving a subset of DSRIP performance metrics. The Value Based Payment Quality Improvement Program (VBP QIP) program targets individual hospitals in severe financial distress, enabling them to maintain operations and vital services while they work towards long-term sustainability and improve quality, aligning closely with the NYS' Value Based Payment (VBP) initiatives. Through this program, facilities will need to develop a transformation plan that will promote the movement to VBP and improved financial stability. Read More

Upcoming Webinar on Fully Integrated Duals Advantage Program. The New York Department of Health Division of Long Term Care will provide an update on the Fully Integrated Duals Advantage (FIDA) program via webinar on Friday, July 22, 2016 from 2-3 p.m. EST. The state is particularly interested in receiving stakeholder input on the demonstration program. Click here to register for the webinar. The slides will be posted after the webinar on the MRT website, which can be accessed by clicking here.

Ohio

HMA Roundup – Jim Downie (Email Jim)

Governor Signs Two Bills Addressing Individuals with Developmental Disabilities. *Cincinnati.com* reported on July 14, 2016, that Governor John Kasich has signed two bills to improve care for children and adults with intellectual or developmental disabilities (I/DD). House Bill 483 will allow non-nursing medical staff to administer medication and services to individuals with I/DD, as well as expand an early intervention program for children under three years old. House Bill 158 will revise all Ohio code to refer to this population as individuals with an "intellectual disability" rather than "mental retardation." Advocates say these bills are a huge accomplishment for Ohio residents with I/DD, but that there is more work to be done to create a more respectful health care vocabulary around disabilities. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Passage of $1.3 Billion Revenue Package Completes State Budget. The Pennsylvania General Assembly approved a $1.3 billion election year revenue package that includes a $1-per-pack cigarette tax increase to balance the state's budget. The revenue package is a combination of tax increases and one-time infusions of cash, including a $200 million loan from a state medical malpractice insurance fund. A new sales tax on internet downloads will contribute money, as could a potential expansion of casino gambling. The tax bill passed the House, 116-75, and the Senate, 28-22. Governor Tom Wolf, without signing it, allowed a $31 billion spending bill to become law for the 2016-17 fiscal year, which started July 1. The tax package revolves around a $1-per-pack tax increase on cigarettes, to $2.60 per pack. It would extend the state's 6 percent sales tax to digital downloads of music, videos, games, books and apps and make Pennsylvania the last state to impose a tax on smokeless tobacco. There is also pending legislation for Pennsylvania to legalize casino-style gambling on the internet. One-time license fees could generate up to $100 million. That bill has stalled amid disagreements between the House and Senate but is expected to come up again in the fall. Read More

DHS Receives Nearly $3 Million Grant to Combat Opioid Addiction. Pennsylvania Department of Human Services (DHS) has received a federal grant to expand treatment for opioid addiction. The nearly $3 million grant will double the number of primary care physicians delivering care in the state. The grant, which will go into effect on September 30, 2016, and last three years, will be used to educate and train primary care providers to combat the opioid epidemic in rural Pennsylvania. DHS will open 20 Centers of Excellence (COE) statewide by October 1, 2016. The Department of Drug and Alcohol Programs

will license the COEs as drug and alcohol providers that provide one of the three FDA-approved medications. The 20 selected recipients are:

- Tadiso Incorporated, Allegheny County
- Gateway Rehabilitation Center, Allegheny
- New Directions Treatment Services, Berks County
- Pyramid Healthcare, Inc., Blair County
- Penn Foundation, Inc., Bucks County
- Alliance Medical Services-Johnstown, Cambria County
- Pennsylvania Counseling Services – Allison Hill, Dauphin County
- Crozer-Chester Medical Center – Community Hospital, Delaware County
- Esper Treatment Center, Erie County
- Habit OPCO Dunmore Comprehensive Treatment Center, Lackawanna County
- TW Ponessa & Associates Counseling Services, Inc., Lancaster County
- Treatment Trends, Inc., Lehigh County
- Pennsylvania Care LLC DBA Miners Medical, Luzerne County
- Crossroads Counseling, Inc., Lycoming/Tioga/Clinton/Centre Counties
- Resources for Human Development, Inc./Montgomery County Methadone Center, Montgomery County
- Thomas Jefferson Narcotic Addiction Treatment/Maternal Addiction Treatment, Philadelphia County
- Wedge Medical Center, Inc., Philadelphia County
- Temple University, Philadelphia County
- The CARE Center, Inc., Washington County
- Pennsylvania Counseling Services, York County

DHS is currently working with its actuaries to determine whether additional COEs can be funded by analyzing the impact they will have on the physical and behavioral health Medicaid managed care rates. For more information about the Centers of Excellence, visit www.dhs.pa.gov. Read More

Rhode Island

Rhode Island Issues Medicaid Managed Care Procurement. The Rhode Island Executive Office of Health & Human Services (EOHHS) on July 14, 2016, issued a procurement for Medicaid managed care services, requesting responses from interested health plans to serve the state's Medicaid managed care programs. The state intends to contract with at least two health plans for a contract term of five years, with five additional option years, beginning between February 1 and April 1, 2017. The procurement covers more than 231,000 members, including those in RIte Care, the Children with Special Health Care Needs program, children in substitute care (including foster care), the Medicaid expansion population, and children and adults with disabilities residing in the community under the Rhody Health Partners program. This procurement does not cover the Rhody Health Options program for members who are aged, blind, and disabled (ABD) or the state's dual eligible financial alignment demonstration. Fiscal year 2016 spending for the populations covered in this procurement was approximately $1.09 billion, although this only includes six months of spending for services that were carved in on January 1, 2016. As such, anticipated

spending under awarded contracts will be greater than the fiscal 2016 total. Responses to the procurement are due on September 12, 2016. Read More

Utah

CMS Requires Additional Feedback on Budget for Limited Medicaid Expansion Proposal. *The Salt Lake Tribune* reported on July 18, 2016, that the Centers for Medicare and Medicaid Services (CMS) requested that Utah gather additional feedback on its plan to extend Medicaid coverage. Earlier this month, Utah submitted its proposal to expand Medicaid coverage to 9,000 to 11,000 residents of Utah. The proposed plan focuses on two main groups: (1) Low-income childless adults who are involved in the criminal justice system, chronically homeless, or needing substance abuse or mental health treatment (2) and low-income parents with children that are not currently covered under Medicaid. The submitted proposal included 130 public remarks; however, none of them included comments on the budget, since the budget was not available during the public comment period. Subsequently, CMS requested that Utah get input on the budgetary portion of the proposal by August 15 before CMS holds its own public comment period. Read More

National

Exchange Co-op Plans Continue to Struggle; Only 7 to Remain in 2017. *Kaiser Health News* reported on July 13, 2016, that only seven of the 23 original Consumer Operated and Oriented Plans (co-ops) created under the Affordable Care Act will remain in 2017, following the closure of plans in Oregon, Ohio, Connecticut, and Illinois later this year. Even those remaining posted losses in 2015 and are being forced to expand beyond individual and small group or renegotiate contracts with providers. One Maryland co-op, Evergreen Health, is suing the federal government to avoid paying millions in risk corridor payments. A year ago, 20 co-ops insured 1 million Americans, but in 2017 that number is expected to drop to 350,000. In order to stay standing, most co-ops have proposed increasing premiums by at least 10 percent in 2017. Read More

Kaiser Publishes Analysis of Medicaid Drug Spending. *Fierce Pharma* reported on July 18, 2016, that a new report by the Kaiser Commission on Medicaid and the Uninsured shows that the top 19 costliest Medicaid drugs cost more per-prescription than three-fourths of other medications. The report covers Medicaid drug spending from January 2014 to June 2016 and shows that antipsychotic drug Abilify is more expensive than 90% of all medications used by Medicaid beneficiaries and is one of the most frequently prescribed. Hepatitis C treatment Sovaldi ranked second in total Medicaid spending with attention-deficit/hyperactivity disorder (ADHD) medication Vyvanse, hepatitis C drug Harvoni, HIV drug Truvada, and insulin drug Lantus following closely behind. On a per-prescription cost basis, hemophilia and multiple sclerosis drugs were costliest. Read More

Industry News

***Bloomberg* Reports DOJ to Block Health Insurance Mergers.** *Bloomberg* reported on July 19, 2016, that United States antitrust officials could potentially block Anthem's takeover of Cigna and Aetna's acquisition of Humana in court. Anthem and Cigna's $48 billion merger would create the largest health insurer by membership, covering 29 percent of the market. Aetna and Humana's $37 billion deal would create the biggest provider of Medicare Advantage plans, representing 25 percent of that market. Justice Department officials have expressed concern that the deals would negatively impact consumers by reducing competition in the health insurance market from five large insurers to only three. The final ruling on both mergers are expected this week, although both the Justice Department and insurers have not commented on the matter. 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 12, 2016	Rhode Island	Proposals Due	231,000
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
February, 2017	Rhode Island	Implementation	231,000
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

UnitedHealth, AmeriHealth Caritas, Neighborhood to Discuss Medicaid Plan, Health System Collaboration at HMA Conference on Vulnerable Populations in Chicago, October 10-12, 2016

Representatives from UnitedHealth, AmeriHealth Caritas and Neighborhood Health Plan of Rhode Island will discuss best practices for collaborating with health systems on integrated care delivery for vulnerable populations during a special keynote session 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.

Speakers during the session will include Catherine Anderson, vice president of state programs, UnitedHealthcare Community & State; Andrea Gelzer, MD, senior vice president and corporate chief medical officer, AmeriHealth Caritas; and Francisco (Paco) Trilla, MD, chief medical officer, Neighborhood Health Plan of Rhode Island. They will be joined by representatives of health systems that have successfully partnered with health plans on similar initiatives.

The session is titled, "Blueprint for Collaboration: How Medicaid Managed Care and Health Systems Can Work Together on Integrated Delivery for Vulnerable Populations."

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.