HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 27, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

RHODE ISLAND EOHHS ISSUES MEDICAID MANAGED CARE PROCUREMENT

This week, *our In Focus* section reviews the Medicaid managed care procurement issued by the Rhode Island Executive Office of Health & Human Services (EOHHS) on July 14, 2016. EOHHS is 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 to serve more than 231,000 members in the RIte Care and Children with Special Health Care Needs programs, as well as children in 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 dual eligible members who are aged, blind, and disabled (ABD). Responses to the procurement are due on September 12, 2016.

Scope of Procurement

There are more than 231,000 members across the five broad managed care programs or populations covered under this procurement.

- **RIte Care** covers low-income children and families.
- **Medicaid expansion** adults were mandated into managed care as of January 2014.
- **Rhody Health Partners** covers non-dual, or "Medicaid-only," individuals who are aged, blind, and disabled (ABD) and reside in the community. The program has been mandatory since 2009.
- Children with Special Health Care Needs (**CSHCN**) have been mandatory in managed care since 2008, including children in **substitute care** (foster care).

Based on rate-setting data for the upcoming contracts, estimated spending for these 231,000 members exceeds $1.1 billion on an annual basis, with an average per-member-per-month (PMPM) rate of just over $400.

Estimated Eligibles, PMPM, and Annualized Spending by Program/Population

Program/Population	Est. Eligibles	Est. Avg. PMPM	Est. Annual $
RIte Care	142,500	$230	$393,300,000
Medicaid Expansion	65,000	$500	$390,000,000
Rhody Health Partners	14,800	$1,350	$239,760,000
CSHCN	6,700	$1,030	$82,812,000
Substitute Care	2,300	$750	$20,700,000
Total Under Procurement	**231,300**	**$406**	**$1,126,572,000**

Source: EOHHS Data, HMA Estimates

As mentioned above, the Rhody Health Options contract, currently held by Neighborhood Health Plan of Rhode Island, is not part of this procurement. Rhody Health Options covers dual eligibles (including the duals demonstration), and Medicaid-only members residing in institutional long term care settings. There were about 22,000 Rhody Health Options members as of June 2016.

Reinventing Medicaid Act of 2015

One of the key goals of this procurement is to implement portions of the state's Reinventing Medicaid Act of 2015 under new MCO contracts. This includes a number of initiatives, several of which are summarized below. A full list of contract initiatives is detailed in the procurement file.

- **Alternative Payment Models:** EOHHS is implementing requirements for percentages of provider payments that must be in alternative payment arrangements. This percentage will increase from 20 percent by the end of FY 2016 to 80 percent by the end of FY 2020, with a requirement that 65 percent be made under a total cost of care model.
- **Patient-Centered Medical Homes (PCMHs):** By the end of FY 2019, MCOs will be expected to meet a target 80 percent of all members assigned to a primary care practice recognized as a PCMH by the Rhode Island Office of the Health Insurance Commissioner.

Timeline, Contract Awards, and Evaluation Criteria

Proposals are due on September 12, 2016, at 10:00 AM Eastern Time. There are no plans for a pre-bid or pre-proposal conference at this time. Interested parties may submit questions on the procurement through August 4, 2016.

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.

Bidders must meet all pass/fail requirements and score a minimum of 77 points on the technical proposal criteria, as detailed in the table below, to be eligible for a contract award.

Evaluation Criteria	Possible Points	Pct. of Total
Letter of Transmittal	Pass/Fail	N/A
Assurances/Attestations	Pass/Fail	N/A
Health Plan Financial Viability	Pass/Fail	N/A
Health Plan Experience	5	4.5%
Health Plan Licensure/Organization	5	4.5%
Plan for Meeting Contract Goals, Special Initiatives	20	18.2%
Plan for Meeting Member Enrollment/Disenrollment	4	3.6%
Plan for Meeting Provider Network, Service Accessibility	12	10.9%
Description of Plan for Providing Covered Services	12	10.9%
Plan for Care Coordination and Care Management	10	9.1%
Plan for Providing Member, Provider Services	4	3.6%
Plan for Conducting Medical Management, QA Efforts	5	4.5%
Plan for Meeting Grievance and Appeals	5	4.5%
Plan for Meeting Operational Data System and Reporting	5	4.5%
Plan for Meeting Program Integrity and Compliance	8	7.3%
Security and Confidentiality	5	4.5%
Plan for Service Children in Substitute Care Arrangements	10	9.1%
Total Technical Points Available	**110**	

Current Managed Care Market

As of May 2016, Neighborhood Health Plan of Rhode Island enrolls 63 percent of the members covered under this procurement, with United Healthcare covering the remaining 37 percent. Neighborhood also covers around 22,000 Rhody Health Options members as of June 2016.

Program/Population	Neighborhood Health Plan of RI	United Healthcare	Total Enrollment
RIte Care	95,554	46,892	142,446
Medicaid Expansion	35,535	29,312	64,847
Rhody Health Partners	7,051	7,709	14,760
CSHCN	5,284	1,711	6,995
Substitute Care	2,250	0	2,250
Total - All Programs	**145,674**	**85,624**	**231,298**
% of Total	*63.0%*	*37.0%*	

Source: EOHHS Data

Procurement Library

Link to Procurement Documents; Link to Procurement Library

HMA Medicaid Roundup

Alabama

Medicaid Agency to Cut Primary Care Physician Payments. *The Anniston Star* reported on July 22, 2016, that Alabama Medicaid is cutting payment rates to primary care physicians beginning August 1, 2016, as part of an effort to make up for a $85 million Medicaid budget shortfall. Alabama Medicaid is also considering eliminating adult prescription drug coverage and coverage for outpatient dialysis and prosthetic benefits to cut costs. Alabama Governor Robert Bentley said that a special legislative session to address the shortfall is also an option. Read More

Arizona

CHIP Enrollment Re-Opens Following CMS Approval. The Centers for Medicare & Medicaid Services (CMS) announced on July 25, 2016, that it has approved Arizona's plan to re-open its Children's Health Insurance Program (CHIP) program after freezing enrollment for several years. The program, called KidsCare, will allow new applications beginning July 26, 2016, with coverage effective September 1, 2016. KidsCare covers children up to 18 years old in families between 133 percent and 200 percent of the federal poverty level (FPL). The state estimates that 30,000 to 40,000 children will be eligible. Read More

California

United, Aetna Prepare to Enter Medi-Cal Market in 2017. *California Healthline* reported on July 26, 2016, that United and Aetna are preparing to join the Medi-Cal managed care program in San Diego and Sacramento counties in 2017, pending state approval. The two companies were awarded Medi-Cal contracts in January of this year under a request for applications. Aetna Better Health reportedly expects to start small and grow to approximately 150,000 Medi-Cal members, likely expanding to other counties. United has stated it will work with local health and community organizations as it begins rolling out services in the two counties. United recently announced plans to exit the state's Covered California health insurance Exchange, as well as most other state Exchanges. The state Department of Health Care Services said the Medi-Cal start date for both companies would be July 2017 or later. Read More

Idaho

Lawmakers Exploring Alternative Options for Medicaid Expansion. The *Idaho Statesman* reported on July 20, 2016, that Idaho lawmakers are exploring options to close the Medicaid coverage gap in the state for the approximately 78,000 residents who earn too much to be eligible for Medicaid, but do not qualify for coverage on the Exchange. Although the state chose not to expand Medicaid under the Affordable Care Act, which would have included this population under Medicaid coverage, health officials and Governor Butch Otter's administration are considering alternative options. Although efforts for legislative action were unsuccessful this session, lawmakers plan to reconvene August 11 to further discuss options for closing the coverage gap. Read More

Indiana

HIP 2.0 First Year Evaluation Report Released. *Modern Healthcare* reported on July 25, 2016, that a new report on the first year of the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion waiver contains both positives and negatives. HIP 2.0 provides basic coverage to people up to 138 percent of the federal poverty level (FPL), but requires contributions to health savings accounts for enhanced benefits like dental and vision. The analysis, conducted by the Lewin Group, found that over 90 percent of HIP 2.0 beneficiaries have been able to make HSA contributions. HIP 2.0 members at 100 percent FPL who fail to contribute to a HSA are moved to the basic plan, while members above 100 percent FPL are disenrolled. Of the 345,656 HIP 2.0 enrollees in January 2016, nearly 21,500 were transitioned to the basic plan for failing to contribute to a HSA and another 2,677 were disenrolled. Most members cited confusion over needing to make the contributions. Read More

Iowa

Legislators Urge Medicaid MCOs to Pay Providers. *The Des Moines Register* reported on July 26, 2016, that Iowa legislators urged Medicaid managed care plans at a state Senate hearing to improve payments to providers. Provider have been experiencing problems with billing and payments since the state's transition to Medicaid managed care this spring. Several providers testified that they have had to borrow money to make payroll. Iowa Medicaid director Mikki Stier said her staff is working with providers to help understand how to submit bills correctly to receive prompt payments. Read More

Kentucky

Proposed 1115 Waiver, Exchange Changes Receive Pushback from HHS, Advocacy Groups. *The Courier-Journal* reported on July 26, 2016, that U.S Secretary of Health and Human Services (HHS) Sylvia Burwell, as well as health advocacy groups, are challenging Kentucky Governor Matt Bevin's proposed Medicaid 1115 waiver, which would roll back part of the state's Medicaid expansion and introduce premiums and other requirements. Additionally, Governor Bevin's administration is proposing a transition from the state's Kynect Exchange to the federal Exchange. State Cabinet for Health and Family Services officials are currently reviewing public comments and plan to submit the plan to

federal officials for approval by August 1. HHS Secretary Burwell expressed concerns over reversing the coverage improvements achieved by Medicaid expansion and questioned the Governor's plans to dismantle Kynect. Advocacy group Kentucky Voices for Health contends that Medicaid expansion has improved coverage for working Kentuckians. Read More

Louisiana

Louisiana, CNSI Settle Wrongful Termination Lawsuit. *The News & Observer* reported on July 25, 2016, that Client Network Services Inc. (CNSI) and the state of Louisiana have settled a lawsuit in which the company claimed the state had wrongfully terminated a $200 million Medicaid contract. The settlement will provide additional reimbursement to CNSI for work performed as well as some termination charges. Payments from the state are capped at $5 million; however, the company can get additional federal money. CNSI won the 10-year contract in 2011, but Louisiana terminated the contract in 2013, after former Health and Hospitals Secretary Bruce Greenstein, a former CNSI vice president, was accused of inappropriate contact with the company throughout the bid process. The company maintains it did nothing inappropriate to win the contract. Read More

Massachusetts

Steward Health Care System Reports Profit in 2015. The *Boston Globe* reported on July 24, 2016, that Boston-based Steward Health Care System saw its first-ever profit of $131 million in 2015, after it posted a $75 million operating loss in 2014. The company attributes the profit to changes in its employee pension plan and reduced expenses. However, Steward is still in a dispute with state officials for not disclosing financial statements for 2014 and for submitting 2013 and 2015 statements late. Steward is a private, for-profit system backed by private equity firm Cerberus Capital Management. It is one of the largest hospital systems in the state with nine total facilities, including St. Elizabeth's Medical Center and Carney Hospital. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

DMAHS Posts ACO Gainsharing Plans. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has released the gainsharing plans of each of the three approved demonstration ACOs: 1) Camden Coalition of Healthcare Providers; 2) Healthy Greater Newark Medicaid ACO; and 3) Trenton Health Team. Camden Coalition has contracted with United Healthcare Community Plan and Horizon NJ Health and will be entitled to up to 50 percent of net shared savings in each MCO contract. The gainsharing methodology varies with each MCO depending on the size of shared savings and performance on quality metrics. The other ACOs did not identify MCO partners in their gainsharing plans. All three ACOs will follow the *risk model* described in the *"Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project,"* published by DeLia and Cantor from the Center for State Health Policy and based on the Chronic Disability and Illness Payment System economic risk framework from AHRQ. All of the ACOs are following state

mandated quality metrics to assess performance, as well as addition voluntary quality metrics. Read More

Behavioral Health Agency Releases Supportive Housing and Community Support Services RFP. On July 11, 2016, the Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) issued an RFP to develop or expand medically enhanced supportive housing to serve individuals who are in a state psychiatric hospital. It seeks to facilitate the discharge of individuals on Conditional Extension Pending Placement (CEPP) status. CEPP is for individuals who no longer meet the standard for involuntary commitment, but for whom there is no present appropriate placement in the community. A mandatory bidders conference was held on July 22, 2016. Proposals are due by August 19, 2016.

Home Health Care Agency Owner Sentenced for Role in Defrauding Medicaid over $7 Million. On July 18, 2016, the U.S. Attorney's Office, District of New Jersey issued a press release concerning the owner of People Choice Home Care Inc., who was sentenced to over four years in prison for his role in falsifying certification and visit records that led to fraudulent bills to Medicaid for services not rendered. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Director Provides Update at United Hospital Fund Conference. Jason Helgerson, New York Medicaid Director, provided an update on New York's Medicaid program at the United Hospital Fund annual Medicaid conference. The presentation largely focused on the state's Delivery System Reform Incentive Payment program and the state's move toward value based payment. Helgerson described the need for "fact-based optimism" and showcased the successes of several Performing Provider Systems. He described the types of value based payment (VBP) pilot projects the state intends to launch this year. The pilots are meant to create momentum in VBP under various VBP arrangements and to create success and best practices, learning what works in practice to allow for more effective scaling. The State plans to launch 15 pilots by the end of CY 2016. Finally, Helgerson spoke of a larger vision of social transformation, of a future system where we think more broadly, on a community basis, where all of the systems that have an impact on an individual's well-being are coordinated. He talked about developing an ecosystem designed to achieve the most important outcomes to a community. He noted that they health care sector is uniquely positioned to address certain social challenges that are not explicitly health care related. He gave as an example a partnership of managed care plans, pediatricians and key stakeholders to ensure all children enter school ready to learn, whose goals are to increase awareness among providers, plans, and parents, ensure follow-up actions are met, and ensure all children have an equal opportunity for academic success, beginning in kindergarten. Helgerson noted that throughout the activities of the Medicaid Redesign Team, DSRIP and the move to VBP, addressing the Social Determinants of Health has been an important focus. He recommended that we be creative in developing these. Cross-System Collaborations as a way to improve Medicaid member quality of life and move the needle on health outcome metrics. Helgerson's presentation can be found on the United Hospital Fund website.

Department of Health Provides Update on Duals Demonstration. The New York State Department of Health hosted a webinar on the future of its duals demonstration program, Fully Integrated Duals Advantage (FIDA). The webinar reviewed recently posted enrollment data for the FIDA program. The program continues to be plagued with low enrollment. As of May, 5,370 beneficiaries have enrolled, while 61,701 have opted out of the program. The state noted that opt-outs are higher among duals whose primary language is not English (Russian, Chinese and Spanish). While the state reports that individuals enrolled in the program have expressed satisfaction, they acknowledge that not a lot of people have chosen to participate. During the webinar the state revisited the program changes it had implemented at the end of 2015 in an effort to make FIDA more flexible for enrollees, as well as for providers and plans, although they acknowledged it was premature to know whether the changes had the desired result of increasing enrollment. The state also described an advertising campaign it is about to launch targeting providers, especially those who are providing care to a FIDA-eligible population. They are encouraging both providers and eligible beneficiaries to "take another look at FIDA." The state has requested feedback from stakeholders on several questions regarding the future of FIDA. The first is whether the state should extend the demonstration for an additional two years after its current end of December 2017. The second is whether they should move ahead with FIDA in region 2, which includes Suffolk and Westchester Counties, starting in January 2017 or January 2018. Finally, the state is seeking feedback on whether existing FIDA plans should be allowed to serve additional current FIDA counties. Slides from the webinar are posted on the Medicaid Redesign Team website.

New York to Carve Health Home Payments into Medicaid Managed Care Rates for Both Children and Adults. New York will be carving health home payments into the Medicaid managed care rate. The intent is to mitigate the significant delay in the time it takes for Health Home payment claims to be submitted by the managed care plans to Medicaid, back down to the Health Home, and then to the care management agency. Effective December 1, 2016, the Department of Health will include the Health Home payments for both children and adults in the MCO capitation rates. This will simplify the billing process and better align managed care plans with health homes, improving accountability. The state hopes to improve cash flow stability to health homes and downstream providers by expediting payments. The start date for health homes to begin enrolling children has shifted from October to December 1, so children's health homes will not be subject to a change in billing procedures shortly after beginning operations.

Department of Health to Submit Amended HCBS Transition Plan. The New York State Department of Health is submitting an amended Home and Community-based Services (HCBS) Statewide Transition Plan (STP) to the Centers for Medicare & Medicaid Services (CMS). This document tracks the initial STP and provides more specificity about both systemic and site compliance with the requirements of the rule, details the assessment process and remediation plans, and identifies categories of sites that will require heightened scrutiny in order to remain HCBS sites funded through Medicaid. The state is seeking public comment on the plan. The deadline for comments is August 19, 2016, by close of business. Read More

Study Shows Increase in Hearings Regarding Medicaid Home Care Reductions. *The New York Times* reported on July 20, 2016, that a new study shows that Medicaid managed long term care (MLTC) plans in New York have been reducing hours for home care providers for Medicaid beneficiaries, as well as denying requests for additional hours. The study, conducted between June 2015 and December 2015 by advocacy group Medicaid Matters, found a six fold increase in number of hearings challenging home care reductions. Many hearings resulted in a reversal of the hours reductions, or in the MLTC plan rescinding proposed reductions. Senior Health Partners, one of over twenty New York MLTC plans, was involved in 56 percent of hearings covered in the study. The Department of Health defended the health plans, citing a satisfaction report in which 87 percent members rated their MLTC plan as "good" or "excellent." Read More

New York Health Plan Association Argues Reductions in Long-Term Care Services Reflect Medical Necessity. The New York Health Plan Association responded to a recent report alleging that managed long-term care plans have been inappropriately reducing hours of home care services for Medicaid beneficiaries enrolled in those plans. The report, which was prepared by the consumer advocacy group Medicaid Matters New York, documented dramatic increases in requests for fair hearings regarding cuts in home care hours in the months following the implementation of New York's mandatory Medicaid managed long-term care program. The program, which mandates enrollment in an MLTC plan for dual eligibles requiring more than 180 days of community-based long-term care services, began in New York City at the end of 2012, and was fully implemented across the state in 2015. The Health Plan Association argues that the report inappropriately makes an assumption that all personal care hours provided to Medicaid members prior to their enrollment in a MLTC plan were medically necessary. They go on to note that, "It is inappropriate for a plan to provide services that are not medically necessary. Where a plan determines that services currently being provided are not medically necessary, a reduction in such services is appropriate… New medical necessity determinations by the plans in line and in compliance with regulatory requirements will undoubtedly result in more internal appeals and fair hearings." Part of the reason that New York made the decision to implement a mandatory MLTC program was in response to wide variations in hours of personal care services approved to Medicaid beneficiaries that could not be fully explained by individual beneficiary characteristics. *Crain's HealthPulse* includes a link to the Health Plan Association statement. Read More

State Posts Slides from Webinar on Integrated Delivery. New York State has posted slides from a recent webinar on integrated services. The webinar focuses on the various licensure requirements of health care clinics and behavioral health settings, which currently severely limit the ability of facilities to integrate physical and behavioral health services in a single setting. The slides can be found at the DSRIP website in the "Integrated Services" section of the Webinar and Presentations webpage. The state has indicated that the webinar recording and transcription will be posted in the near future.

North Carolina

Democratic Lawmakers Ask Federal Officials to Deny Medicaid Reform Plan. *WFAE News* reported on July 20, 2016, that North Carolina's Democratic members of Congress are asking federal officials to reject the state's proposed Medicaid overhaul, which would shift responsibility for managing Medicaid patients to provider-led organizations and Medicaid managed care plans. After years of discussion, the state settled on the reform plan last year in the form of an 1115 Demonstration Waiver. Democratic lawmakers argue that the state's current primary care case management (PCCM) program, Community Care of North Carolina, is working well and saves the state money while improving outcomes. Democrats are also pushing for an expansion of Medicaid before making any other changes. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Department of Medicaid Posts Information on Managed Care Enrollment for New Populations. Ohio Medicaid has updated key points about its Managed Care Program. The recently posted Power Point slides indicate when newly enrolling populations are expected to transition into the managed care delivery system, including Individuals enrolled in the Bureau of Children with Medical Handicaps program, children in custody and children receiving adoption assistance, breast and cervical cancer project recipients and adult extension members in need of home and community based waiver services. People enrolled in a waiver for individuals with developmental disabilities may voluntarily enroll in managed care in January of 2017. Read More

Center for Community Solutions Reviews Status and Action to Date on 1115 Healthy Ohio Waiver Request. On July 8, 2016, Center for Community Solutions (CCS) Public Policy Fellow, Loren Anthes posted an update on Ohio's 1115 waiver request process as well as an analysis of who the Healthy Ohio waiver may affect by county. Included is a map of Ohio's counties that shows the percent of the population that would be affected by the proposal. Read More

Governor Kasich Signs Bills Impacting Developmental Disabilities System. Governor John Kasich recently signed into law two bills that will have an impact on the state's developmental disabilities system. Under House Bill 483, nonmedical staff are permitted to help with basic tasks like applying sunscreen; the ratio of patients to nurses for certain visits to home and community programs is changed; county boards of developmental disabilities are permitted to combine levies under a single ballot question; and October is designated as Disability History and Awareness Month. The bill also includes various changes related to reimbursement for intermediate care facilities for individuals with intellectual disabilities; and it transfers responsibilities from the Department of Health to the Department of Developmental Disabilities for the State's Early Intervention Services Program among other things. The Governor also signed House Bill 158 removing the phrase "mentally retarded Person" in the Ohio Revised Code and replaces it with "person with an intellectual disability."

Over Half of Medicaid Expansion Population Received Mental Health, Substance Use Disorder Services. *The Columbus Dispatch* is reporting that just over 50 percent of the 954,887 people brought onto Medicaid (not all at once) under the Affordable Care Act expansion were treated for mental health and drug addiction problems and more than 1 in 10 were diagnosed with severe mental illness. State officials are also cited as saying that nearly all of the 481,903 newly enrolled Medicaid eligible individuals with behavioral health or addiction issues had been uninsured before gaining coverage through Medicaid. Read More

HRSA Awards $4.8 Million to Boost Access to Primary Care. Various sources, including the *Associated Press*, are reporting that eighteen universities, medical schools and hospitals in Ohio have been awarded almost $4.8 million in federal Health Resources and Services Administration (HRSA) workforce grants to help improve access to primary care. The University of Cincinnati and the Ohio State University are among the grant recipients. The grants are intended to improve nursing opportunities for minorities, training for postdoctoral health care professionals in primary care research and to permit nursing schools to offer partial loan forgiveness. Read More

Oklahoma

OHCA Proposes Reversal of 3 Percent Cut to Certain Providers. The Oklahoma Health Care Authority (OHCA) said in a public notice dated July 21, 2016, that it was proposing a reversal of a three percent rate reduction implemented on January 1, 2016, for certain providers. The reversal would benefit providers of emergency transportation, private duty nursing, Medically Fragile Waiver, Living Choice Program, and Program of All-Inclusive Care for the Elderly (PACE). OHCA added, however, that it is unable to do the same for all providers and programs. OHCA also proposed changes to the methodology for certain outpatient behavioral health assessments from a percentage of the Medicare Physician Fee Schedule to a single reimbursement rate per assessment session. The reimbursement methodology changes will be discussed in two public hearings on August 1 and August 11.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Reissues HealthChoices RFP. The Pennsylvania Department of Human Services (DHS) reissued the HealthChoices request for proposal (RFP) to deliver physical health services on July 21, 2016. The procurement will be open to all bidders, even if a plan did not bid on the original 2015 RFP, Leesa Allen, Deputy Secretary of the Office of Medical Assistance Programs, announced today at a Medical Assistance Advisory Committee meeting. Responses are due August 22, 2016. DHS anticipates that the rebid will have no impact on the award and implementation timeline of the Community HealthChoices RFP to provide managed long-term services and supports. In April 2016, eight plans were awarded contracts to provide services under the HealthChoices program: Aetna, Centene, Gateway, Geisinger, Health Partners, United, UPMC, and Vista (Keystone First Health Plan/AmeriHealth Caritas).

Updates from the July 21 Medical Assistance Advisory Committee Meeting.

- Office of Medical Assistance Programs: Leesa Allen, Deputy Secretary of the Office of Medical Assistance Programs announced a reissue of the HealthChoices RFP. As a result of a petition to Court of Common Pleas, where the court granted the petitioner relief on July 19, 2016, DHS reissued a new HealthChoices RFP. In addition, she indicated that the RFP was open to all bidders. Responses are due August 22, 2016. DHS states the rebid of Physical HealthChoices will have no impact on the award and implementation timeline of Community HealthChoices, a separate state initiative to coordinate health and long term services and supports under managed care for older state residents and adults with physical disabilities.
- Office of Long Term Living Update: Jen Burnett, Deputy Secretary for the Office of Long Term Living, shared that OLTL is working with CMS to get authority for Community HealthChoices approved. Deputy Secretary Burnett anticipates CHC awards will be announced mid-August.
- Office of Mental Health and Substance Abuse Services (OMHSAS) Update: Pennsylvania is one of three states to receive a federal grant for medical assistant treatment for opioid abuse specifically in rural communities and will receive $3 million over three years. The state is also one of eight states being considered by the federal government as an implementation state for Certified Community Behavioral Health Clinics (*CCBHC*). Deputy Secretary Dennis Marion explained that OMHSAS is currently visiting prospective sites around the Commonwealth that will focus on the "localized needs assessments." Fifteen out of 16 clinics have been selected to continue in the certification process.

DHS announced awards for Pennsylvania's Telephonic Psychiatric Consultation Service Program (TiPS). TiPS is a new HealthChoices program designed to increase the availability of provider-to-provider, or peer-to-peer, child psychiatry consultation teams to primary care providers (PCPs), medical specialists, and other prescribers of psychotropic medications for children insured by Pennsylvania's Medical Assistance programs. The physical health MCOs selected one vendor to serve each of the five HealthChoices zones:

- Children's Community Pediatrics – Southwest, Northwest Zones
- Penn State Children's Hospital – Northeast, Lehigh/Capital Zones
- The Children's Hospital of Philadelphia – Southeast Zone

The TiPS teams are available to assist any PCP who sees children or adolescents covered by HealthChoices and the Fee-for-Service program. TiPS teams will help to connect people to the appropriate care, as TiPS psychiatrists do not prescribe medications. This model is now being used in more than 30 states throughout the country. Read More

Texas

Nursing Home Supplemental Medicaid Payments to End in August 2016. *Dallas News* reported on July 24, 2016, that the Centers for Medicare & Medicaid services (CMS) will end supplemental Medicaid payments to nursing homes operated by public hospitals in August 2016. The payments, amounting to $601 million so far this year, have been available since October 2012 through the Minimum Payment Amount program. Public hospitals were able to grab a share of the enhanced payments by acquiring nursing home licenses and then paying the prior owners to continue to operate the facility under a management contract. The payments helped public and safety-net hospitals offset the cost of treating Medicaid patients by having them stay in the newly acquired nursing homes. Although the Texas Health and Human Services Commission asked for an extension of the payments, CMS did not grant the request. Read More

West Virginia

Department of Health and Human Services to Continue KEPRO Contract. KEPRO announced on July 20, 2016, that the West Virginia Department of Health and Human Resources (DHHR) has signed a new contract with the Pennsylvania-based company for administrative, clinical, and consulting services for DHHR's Bureau for Medical Services, Bureau for Children & Families, and the Bureau for Behavioral Health & Health Facilities. KEPRO's new contract will include assistance with the state's health homes program, as well as the implementation of a new Medicaid transportation program and the restructuring of the Child Residential Programs. KEPRO has contracted with the state since 2000. Read More

National

States Encouraging Dental Therapists to Provide Dental Care to Increase Access. *Roll Call* reported on July 21, 2016, that some states are encouraging dental therapists to perform tasks usually carried out by dentists. Vermont is the latest state to acknowledge dental therapists, who are licensed as dental hygienists and have completed dental therapy graduate school. Maine and Minnesota have also allowed dental therapists to practice under dentist supervision. Therapists can fill cavities, insert crowns, and extract teeth. While dentists have expressed concerns that the lack of training therapists receive could lead to lower quality care, states argue that allowing therapists to provide more services will increase access to dental care. States continue to look for ways to improve access to dental care, as the U.S. Department of Health and Human Services has projected a shortage of 15,600 dentists by 2025. Read More

Industry News

Humana, Centene Win Five-Year TRICARE Military Health Contracts. *Military Times* reported on July 22, 2016, that Humana Military and Centene's subsidiary, Health Net Federal Services, have won five-year TRICARE contracts to manage Department of Defense health care programs. Humana will now manage the TRICARE South and East regions, which includes 29 states and the District of Columbia, and is valued at $40.5 billion over the five years. Centene's Health Net Federal Services will manage the TRICARE North and West regions, which includes 18 states, valued at $17.7 billion over the course of the contract. United Healthcare has managed the TRICARE West Region since 2012. Read More

Rocky Mountain Health Plans to Be Acquired by UnitedHealth. *The Denver Post* reported on July 26, 2016, that UnitedHealthcare has agreed to acquire not-for-profit Rocky Mountain Health Plans for an undisclosed amount. Rocky Mountain provides Medicaid coverage to nearly 300,000 individuals, primarily in rural Colorado. Rocky Mountain also sells qualified health plan products on the Connect for Health Colorado Exchange. However, beginning in 2017, it will offer Exchange products only in Mesa County, after announcing plans to trim its Exchange offerings. Read More

Houston-Based Memorial Hermann Health Plan to Acquire 14,000 Molina Members. *Houston Business Journal* reported on July 26, 2016, that Memorial Hermann Health Plan will acquire 14,000 Medicaid STAR and Children's Health Insurance Plan (CHIP) members in the Houston area from Molina Healthcare. The deal is expected to close in the second half of 2017. Memorial is a provider-owned HMO with 73,000 Houston-area members. As part of the transaction, Memorial Hermann Health System will also become a contracted provider in Molina's networks for dual eligible, D-SNP and STAR+PLUS members. Read More

Aetna and Humana Continue Push for Merger Despite DOJ Lawsuit. *The New York Times* reported on July 22, 2016, that Aetna and Humana plan to fight a lawsuit filed by the Department of Justice (DOJ) to block the merger of the two insurers, which has been in discussions for the past year. Federal officials argue that the consolidation would negatively impact consumers; however, Aetna maintains that private Medicare Advantage plans and fee-for-service Medicare options preserve consumer choice. Aetna CEO Mark Bertolini has indicated the company is prepared to sell assets in the 364 counties where the DOJ has identified a lack of competition under the merger, with *The New York Times* reporting WellCare and Molina as potential buyers. The Justice Department also filed a lawsuit to block the Anthem-Cigna merger, with some analysts believing that if that deal falls through, Aetna and Humana may be more successful in winning their appeal. Read More

Centene Second Quarter Revenues Nearly Double After Health Net Acquisition. The *St. Louis Post-Dispatch* reported that Centene Corporation's revenues nearly doubled to $10.9 billion in the second quarter of 2016. The company's recent acquisition of Health Net drove an eight-fold increase in commercial membership and an 11-fold increase in Medicare and dual eligible membership. Centene's medical loss ratio improved to 86.6 percent from 89.1 percent a year earlier. Centene completed the Health Net deal at the end of March. Read More

Humana to Limit Exchange Market Presence Next Year. *Politico* reported on July 21, 2016, that Humana is planning to exit several of its 15 state Exchange markets for the 2017 plan year, as well as some non-Exchange individual markets. The insurer will only offer individual plans in 11 states in 2017, down from a total of 19 Exchange and non-Exchange individual markets this year. Humana did not provide details on which markets would remain, but indicated that the company would be pulling out of states where Humana has a limited presence. Read More

Gilead's Hepatitis C Drug Revenues Drop 19 Percent in Second Quarter. *The Wall Street Journal* reported on July 25, 2016, that Gilead Sciences saw revenues from its hepatitis C drugs fall 19 percent in the second quarter of 2016. The company reported Harvoni sales decreased 29 percent to $2.56 billion, while Sovaldi sales rose 5.2 percent to $1.36 billion. Increased competition, pricing pressures, and a growing number of government-funded payers contributed to the decline in sales. 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 22, 2016	Pennsylvania HealthChoices	Proposals Due	1,700,000
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	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	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

Behavioral Health Integration to Be a Key Topic at HMA Conference on Vulnerable Populations in Chicago, October 10-12, 2016

Representatives from health systems and community-based organizations will outline strategies for integrating and advancing behavioral health within the framework of delivery system redesign during a special session at HMA's inaugural conference on "*The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*," October 10-12 in Chicago.

Speakers during the session will include Martha Whitecotton, SVP, Behavioral Health Services, Carolinas HealthCare System; Frances Isbell, CEO, Healthcare for the Homeless – Houston; Rachel Solotaroff, MD, Chief Medical Director, Central City Concern; and Raegan McDonald-Mosley, MD, Chief Medical Officer, Planned Parenthood Federation of America.

The session is titled, "**Integrating Behavioral Health: A Strategic and Operational Framework for Integrated Delivery Systems**."

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.

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:

Anne Winter
480.229.0418
awinter@healthmanagement.com

Nicole McMahon
317.818.1005
nmcmahon@healthmanagement.com

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

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

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