HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 10, 2016

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THIS WEEK

IN FOCUS

EARLY BIRD REGISTRATION ENDS AUGUST 15 FOR HMA'S CONFERENCE ON BUILDING INTEGRATED DELIVERY SYSTEMS

This week, our *In Focus* section highlights some of the important sessions to be featured at HMA's inaugural conference, *The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*, October 10-12, 2016, in Chicago. This premier three-day event, which is produced by HMA and HMA's Accountable Care Institute, will address key issues facing health systems, hospitals, clinics, provider practices and community-based services seeking to integrate care in an environment of rising quality and cost expectations. Thirty-five speakers have been confirmed to date. **Early Bird registration ends on August 15, 2016.**

Visit the conference website at https://fpsh.healthmanagement.com/ for complete details and to lock in the Early Bird discount.

Important Sessions on Integrated Care Delivery

HMA's inaugural conference, *The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*, October 10-12, 2016 in Chicago, will identify best practices, resources, tools and approaches to help providers deliver integrated care effectively within single systems and through collaboration among multiple providers and community-based services.

Among the Featured Sessions:

- Rush University Medical Center Chief Executive **Larry Goodman**, MD, will outline a new care model for academic medical centers, with an emphasis on provider collaboration, building communities, and fostering integrated care delivery for vulnerable patient populations.
- Representatives of leading public health systems will engage in a frank and high-level assessment of their ongoing efforts to re-evaluate every aspect of how they coordinate, integrate and deliver care. Speakers will include **Frederick Cerise**, MD, President and CEO, Parkland Health & Hospital System; **Barbara Garcia**, MPA, Director of Health, San Francisco Dept. of Public Health; **Ramanathan (Ram) Raju**, MD, President and CEO, NYC Health + Hospitals; and **John Jay Shannon**, MD, CEO, Cook County Health & Hospitals System.
- **Eliot Fishman**, PhD, Director of the State Demonstrations Group as CMS' Center for Medicaid and CHIP Services, will discuss the role of government in supporting innovation in Medicaid.
- Representatives from health systems and community-based organizations will outline strategies for integrating and advancing behavioral health within the framework of delivery system redesign. Speakers 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.
- Medicaid managed care executives will discuss best practices for collaborating with health systems on integrated care delivery for vulnerable populations. Speakers 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 **Beth Marootian**, Director of Business Development, Neighborhood Health Plan of Rhode Island.
- **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, will show how states are fostering an integrated care delivery through provider-led organizations that coordinate care for Medicaid patients under global or capitated payment arrangements.
- **Dan Castillo**, Chief Executive of LA County USC Medical Center, and **Wendy Burkholder**, Chief Clinical Operating Officer of Arizona-based

District Medical Group, will outline the type of system-wide operational, organizational, and policy changes required by health systems when transforming into integrated delivery systems.

Unparalleled Lineup of 35 Industry Speakers

Keynote speakers and panelists from provider organizations, health plans, and government will identify proven strategies for implementing accountable care models, developing population health management infrastructures, and reengineering operational capabilities around care integration.

Breakout sessions and workshops will focus on the nuts and bolts of building integrated delivery systems, including important insights into care management, social determinants of health, behavioral health integration, leadership training, operational priorities, and information technology needs.

A complete list of the 35 industry leaders confirmed as speakers appears below:

Confirmed Keynote Speakers

- *Frederick Cerise, MD, President and CEO, Parkland Health & Hospital System*
- *Eliot Fishman, Director, State Demonstrations Group, CMS Center for Medicaid and CHIP Services*
- *Barbara Garcia, Director of Health, San Francisco Department of Public Health*
- *Andrea Gelzer, MD, SVP, Corporate Chief Medical Officer, AmeriHealth Caritas*
- *Arthur Gianelli, President of Mount Sinai St. Luke's and Mount Sinai PPS, LLC*
- *Bruce Goldberg, MD, former Director, Oregon Health Authority*
- *Larry Goodman, MD, CEO, Rush University Medical Center*
- *Cindy Mann, Partner, Manatt Health*
- *Beth Marootian, Director, Business Development, Neighborhood Health Plan of Rhode Island*
- *Ramanathan (Ram) Raju, MD, President and CEO, NYC Health + Hospitals*
- *John Jay Shannon, MD, CEO, Cook County Health & Hospitals System*

Confirmed Breakout Session Speakers to Date

- *Wendy Burkholder, Chief Clinical Operating Officer, District Medical Group, Provider to Maricopa Health System*
- *Dan Castillo, CEO, LAC + USC Medical Center*
- *Pat Curran, Former CEO, CareOregon*
- *Karen Duncan, MD, Principal, HMA (Atlanta)*
- *Doug Elwell, Deputy CEO, Finance and Strategy, Cook County Health and Hospitals System*
- *Lee Francis, MD, President and CEO, Erie Family Health Center*
- *Hope Glassberg,* VP, *Strategic Initiatives & Policy, Hudson River HealthCare*
- *Andrea Gelzer, MD, SVP, Corporate Chief Medical Officer, AmeriHealth Caritas*
- *Deborah Gracey, Principal, HMA (Chicago)*
- *Clemens Hong, MD, Medical Director, Community Health Improvement, LA County Department of Health Services*
- *David Horrocks, President, Chesapeake Regional Information System for Our Patients (CRISP)*
- *Frances Isbell, CEO, Healthcare for the Homeless – Houston*
- *Art Jones, MD, Principal, HMA (Chicago)*

- *Cheryl Lulias, Executive Director, Medical Home Network (Chicago)*
- *Dennis Mauer, Community Mental Health Director, Community University Health Care Center*
- *Raegan McDonald-Mosley, MD, Chief Medical Officer, Planned Parenthood Federation of America*
- *Ross Owen, Director, Hennepin Health*
- *Anthony Perry, MD, VP, Population Health and Ambulatory Services, Rush University Medical Center*
- *Bonnie Pilon, Alexander Heard Distinguished Service Professor, Vanderbilt School of Nursing*
- *Jim Sinkoff, EVP, CFO, Hudson River HealthCare*
- *Rachel Solotaroff, MD, Chief Medical Director, Central City Concern (Portland)*
- *Pat Terrell, Vice President, Health Management Associates (Chicago)*
- *Sharon Youmans, Professor, Vice Dean, UCSF School of Pharmacy*
- *Martha Whitecotton, SVP, Behavioral Health Services, Carolinas HealthCare System*

Speakers will discuss their specific care integration initiatives. HMA has designed panels and breakout sessions to inspire discussion about real-world approaches to meeting new requirements and positively impacting the health of patients and populations.

The goals of these sessions are to help provider organizations improve the health status of entire patient populations, lower costs, and ensure a more satisfactory patient experience.

For the complete agenda for this event appears below, visit our website at https://fpsh.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates are available.

HMA Medicaid Roundup

California

Public Hospitals to Be Required to Contract With At Least One Medi-Cal Plan. *California Healthline* reported on August 4, 2016, that California public hospitals will be required to contract with at least one Medi-Cal managed care plan beginning in 2018 as part of the state's recently approved Medi-Cal 2020 waiver. Medi-Cal is the state's Medicaid program. However, advocacy groups such as the Western Center on Law and Poverty argue that public hospitals should be required to contract with all plans in a hospital's region. Furthermore, public hospitals that serve Medi-Cal members aren't necessarily required to offer a full range of services, which advocates believe should be required. Read More

Alameda County Awards Prison Health Contract to California Forensic Medical Group. *SF Gate* reported on August 5, 2016, that California's Alameda County awarded a three-year, $135 million prison health care contract to California Forensic Medical Group. The decision means the county will end its contract with Corizon Health, which faces a lawsuit alleging that the company provided inadequate health care resulting in several deaths. California Forensic Medical Group is also facing lawsuits in several counties; however, CEO Kip Hallman says lawsuits are common in prison health care. Corizon has been managing the county's prison healthcare since merging with Prison Health Services in 2011. Read More

Delaware

Delaware Medicaid to Cover Mosquito Repellent to Fight Zika. *The Associated Press* reported on August 9, 2016, that Delaware has announced its Medicaid program will cover over-the-counter mosquito repellent to help control the Zika virus. An authorized health professional must prescribe the repellent. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Hospitals to Challenge State on Proposed Medicaid Rates. *Politico* reported on August 5, 2016, that Florida hospitals have notified state officials of their intention to challenge proposed fiscal 2017 Medicaid outpatient hospital rates. Rates proposed by the Florida Agency for Health Care Administration (AHCA) are $142.5 million lower than authorized by the state Legislature. This rate proposal is up from AHCA's previously proposed rates, which came in even

lower until hospitals and other groups filed petitions in opposition. Meanwhile, the state is making an estimated $191 million in payments to compensate Medicaid managed care plans for an error resulting in three years of underpayments. Read More

Kansas

Legislative Primaries Offer Hope for Medicaid Expansion. *KCUR.org* reported on August 8, 2016, that a series of primary victories by moderate Republicans running for the Kansas state legislature bode well for advocates of Medicaid expansion. Moderate Republicans won eight state Senate primaries, and supporters of Medicaid expansion won 15 state House primaries. Additionally, several Democrats favoring expansion are expected to be competitive in the general election. Expansion in the state has been blocked by conservative Republicans and Governor Sam Brownback. Jan Kessinger, the GOP nominee in Johnson County's 20th House District, wrote that the refusal to expand Medicaid is "not only fiscally foolish but has taken health care options away from those who are most needy." He added, "The short-sighted refusal is an example of cutting off one's nose to spite the face." Read More

Oversight Committee Criticizes Brownback Administration over Medicaid Cuts. *The Associated Press* reported on August 5, 2016, that a bipartisan Kansas House-Senate oversight committee publicly criticized Governor Sam Brownback's administration over Medicaid reimbursement cuts impacting pharmacies, doctors, and hospitals. The committee also criticized officials at the state Department of Health and Environment over a backlog of Medicaid applications and the proposed KanCare program changes that are opposed by advocates and legislators, including the consolidation of seven programs providing in-home services to individuals who are elderly or disabled. Read More

Lawmakers to Address Medicaid Enrollment Backlog. *The Wichita Eagle* reported on August 4, 2016, that the Kansas Medicaid KanCare Oversight Committee is convening to discuss the state's backlog of Medicaid applications. State officials informed lawmakers that 3,587 applicants have been waiting for over 45 days, down from 10,961 in May. The backlog is partially due to the state changing the computer systems it uses to process Medicaid applications last year. The Kansas Legislative Division of Post Audit is looking into the problem and is expected to present findings at the end of September. Read More

Community Mental Health Centers Report Medicaid Payment Issues. *Kansas Health Institute* reported on August 4, 2016, that representatives for community mental health centers in Kansas outlined for a joint state legislative committee the difficulties they are having receiving reimbursements from Medicaid managed care organizations under KanCare. During a meeting of the Kansas Joint Committee on Home and Community Based Services and KanCare Oversight, community mental health center representatives reported that Medicaid plans are telling providers to cut down on psychosocial treatment and, in some cases, declining to pay for a full hour of psychotherapy. One mental health center did, however, report that MCOs are helping children get treatment out of state if the service is not available in Kansas. Read More

Dentists Say Low Medicaid Reimbursement Rates Are Impacting Access to Care. *Kansas Health Institute* reported on August 9, 2016, that low Medicaid reimbursement rates in Kansas are impacting access to care, according to dentists in the state. The Kansas Medicaid program KanCare pays significantly less than commercial insurance. Providers were hit with another 4 percent reimbursement cut earlier this year. Kansas Dental Association executive director Kevin Roberston says that oral surgeons in the state will usually see Medicaid children, but it is very difficult to get them to treat adults covered Medicaid given the low rates. Read More

Physical Disabilities Waiver Waiting List Is Cleared. *Kansas Health Institute* reported on August 5, 2016, that the Kansas Department for Aging and Disability Services had cleared the remaining 438 people on the physical disabilities waiver waiting list for Medicaid home and community-based services (HCBS), according to state officials. However, 3,837 individuals with developmental disabilities remained on the HCBS waiver waiting list as of July. Overall, KanCare covers seven HCBS waiver categories: physical disabilities, developmental disabilities, frail elderly, autism, traumatic brain injury, technology assisted, and serious emotional disturbance. In December 2015, the waiting list was 1,319 for individuals with physical disabilities and 3,455 for individuals with developmental disabilities. Read More

Louisiana

Louisiana Sees Surge of Low-Income Residents Signing Up for Medicaid Expansion. *Los Angeles Times* reported on August 4, 2016, that Louisiana is seeing a huge surge of low-income residents seeking health insurance after the state expanded Medicaid, with nearly 266,000 signing up since June. Louisiana has the fourth-lowest life expectancy in the country, and residents live nearly six years less on average than residents of the healthiest states. Other states that recently expanded Medicaid have had a similar flood of enrollment. Montana's enrollment doubled expectations, while Michigan surpassed 2020 projections last year alone. Nineteen states have still yet to enact a Medicaid expansion, affecting an estimated 3 million people. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

DMAHS Posts Medicaid MCO Contract Amendments. The Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has posted the January 2016 NJ FamilyCare managed care contract on its website. The same contract is separately signed by each of the five Medicaid MCOs operating in New Jersey: Aetna Better Health, Amerigroup NJ, Horizon NJ Health, UnitedHealthcare Community Plan and WellCare. Highlights of the changes to the contract that went into effect January 1, 2016 include:

Dental provisions. Various changes were made to dental contract language, including:

- the Second Opinions program provision to ensure that it applies to the treatment of dental procedures as well as medical procedures;

- that medical or dental procedures may be performed by a maxillofacial oral surgeon or prosthodontist;
- clarification that the NJSmiles program covers children up to and including age 6
- risk assessment must be provided in conjunction with an oral evaluation service by a primary care dentist;
- removal of certain MCO utilization management requirements in the referral of enrollees from a primary care dentist to a specialty dentist;
- allowing for increased frequency of dental services for enrollees with special needs.

EPSDT

- A preamble was added to the EPSDT Services contract section;
- General clarification was given that children in the MLTSS program cannot have limitations placed on their access to Medicaid EPSDT services;
- Clarification was made that the 16 hours per day limitation for Private Duty Nursing services does not apply to children under 21 years of age who are eligible for Medicaid/NJ FamilyCare EPSDT services.

ID/DD referrals to DDD. That MCOs will refer individuals aged 19 and older with an intellectual/developmental disability who are identified as needing MLTSS to the Division of Developmental Disabilities for screening prior to assessment for MLTSS eligibility;

HEDIS measures. Deletion of the HEDIS performance measure "Use of Appropriate Medications for People with Asthma" from the annual submission set.

Healthcare disparities. "Geographic location" was added to the MCO methods for identifying and evaluating healthcare disparities.

Incarceration and Medicaid coverage. Clarification was made to explain Medicaid eligibility and related actions for individuals who are incarcerated.

Provider Manual re: medical necessity dissemination. Language was added that medical necessity standards and practice protocols/guidelines must be disseminated to affected providers, and when requested, to current and potential enrollees.

Payment for increased access. A new provision was added to increase capitation payments to cover primary and preventive physician care, and postpartum physician services whereby the MCO must develop a rationale for the distribution of the additional funds through provider payments that link to key performance indicators.

MLTSS

A number of revisions were made to the MLTSS program section of the contract.

Involuntary transfer. A new provision defines the involuntary transfer of an enrollee who resides in a community alternative residential setting.

Coordination and continuity. A new provision requires the MCO to monitor the long term care needs of non-MLTSS members admitted to nursing facilities.

Consideration of institutional or community based MLTSS

- There is now a list of Interdisciplinary Team (IDT) documentation that the MCO must provide in advance of a Cost Effectiveness IDT meeting when considering options for members whose HCBS costs exceed the Annual Cost Threshold (ACT) Trigger.
- Specifications for calculating the numerator and the denominator of the Annual Cost Threshold were added.
- Clarifications were made to the process for MCO and Office of Community Choice Options (OCCO) review of exceptions when MLTSS services exceed the ACT.

Interdisciplinary Team Review

- There is expanded language for when the MCO must conduct an IDT review.
- There is clarification about the use of Private Duty Nursing, Personal Care Assistance and Self Direction and the services limitations, and how to address IDT exceptions within the 112-hour per week limit.

Care Management Training. There is a new requirement that the MCO submit to the Division of Aging Services its listing of Care Management trainings planned for the following month.

Assessments and Plan of Care

- Clarified Existing Plans of Care provisions for conducting an assessment when MCO members transfer from one MCO to another or are newly enrolled in managed care;
- Added conditions for training staff members as Master Trainers of the NJ Choice Assessment System;
- Decreased the number of days in which a face-to-face visit to conduct the NJ Choice Assessment must take place for members new to managed care or MLTSS from 45 to 30 calendar days.
- Decreased the number of days for when a member is mailed a copy of their initial Plan of Care from 45 to 30 calendar days of MLTSS enrollment notification.

MLTSS Dictionary. Updates and clarifications were made to the dictionary.

Transition to Improve Behavioral Health Reimbursement Rates with FFS Billing May Increase Financial Burdens for Patients without Medicaid. On August 4, 2016, *NJ Spotlight* reported problems that mental health and addiction agencies anticipate under New Jersey Medicaid billing reforms that began in July 2016. The Department of Human Services, Division of Mental Health and Addiction Services is phasing in a fee-for-service payment methodology from contract payments for mental health and substance use providers over 18 months. Most substance use providers have gone through the transition while mental health providers can choose to transition in January or July 2017. The

state's budget included $127.8 million in enhanced behavioral health services rates for providers; New Jersey will qualify for an enhanced federal match of $107.8 million. The shift to fee-for-service reimbursement will end the "sliding scale many providers used to help patients with private insurance that does not cover behavioral health, those who can't afford the copays…and those not covered by Medicaid or any other insurance." Read More

CMS Selects State to Participate in National 5-year Comprehensive Primary Care Plus (CPC+) Primary Care Medical Home Model. The Centers for Medicare & Medicaid Services (CMS) said on August 1, 2016, it had identified 14 regions nationwide that were selected to participate in CPC+ to improve care delivery in: (1) Access and Continuity; (2) Care Management; (3) Comprehensiveness and Coordination; (4) Patient and Caregiver Engagement; and (5) Planned Care and Population Health. This project begins in January 2017 and joins CMS, commercial health plans and the Division of Medical Assistance and Health Services (DMAHS) to align payments, data sharing and quality metrics. The following New Jersey payers will participate:

- Anthem
- Delaware Valley ACO
- Horizon Blue Cross Blue Shield of New Jersey
- UnitedHealthcare

Medical practices statewide may apply to participate in CPC+ from August 1 – September 15, 2016. Additional information is available on the CMS Innovation Center home page.

New Jersey Terminates Enrollment of FFS Providers Who Did Not Complete a Provider Re-enrollment Application; Impact Felt on Pharmacy Benefit Access. The Department of Human Services, Division of Medical Assistance & Health Services (DMAHS) issued a provider newsletter to alert: (1) providers of pharmaceutical services, and (2) prescribers who did not complete re-enrollment, of its decision to terminate Medicaid participation of pharmacies by August 15, 2016 and prescribers who have not re-enrolled in the NJ FamilyCare fee-for-service program by July 11, 2016. The provider terminations will result in the denial of payment for pharmacy services unless non-enrolled practitioners re-enroll or request participation in NJ FamilyCare as a non-billing provider. This action follows efforts by New Jersey Medicaid to comply with the Patient Protection and Affordable Care Act (ACA) of 2010. To minimize possible disruptions in pharmacy services DMAHS implemented a 15-day grace period for fee-for-service Medicaid enrollees to receive up to a 30-day supply of any prescribed in cases where the prescriber has not re-enrolled.

New York

HMA Roundup – Denise Soffel (Email Denise)

MVP Health Care Seeks Expansion into North County. *Albany Business Review* reported on August 4, 2016, that MVP Health Care is looking to expand its Medicaid managed care services into North County, New York. MVP has focused on Medicaid since its acquisition of Hudson Health Plan in 2013. In 2014, it expanded its managed care offerings into six additional counties in the state. Read More

State Proposes Regulations for All-Payer Database. New York has been working to develop an all-payer database that would provide information about how and where New York is spending its health care dollars. The intent is to make information on cost and quality more readily available to health plans, employers, providers and consumers. At this week's Public Health and Health Planning Council Meeting, Department of Health staff presented the proposed regulatory framework for the database. As reported by *Crain's HealthPulse*, the rules include definitions and guidelines for data submission and release. The state is also proposing the creation of an all-payer database advisory group whose duties would include monitoring data submission rules and addressing concerns over patient privacy and confidentiality. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Advocates Ask Federal Regulators to Reject Ohio's "Healthy Ohio" Medicaid Waiver. *Gongwer Ohio* is reporting that numerous advocacy and health care groups have submitted comments opposed to the state's "Healthy Ohio" waiver during the federal comment period, which started July 8 and ran through August 7. The waiver would require certain Ohioans on Medicaid to make regular payments into an account to cover co-pays. Failure to pay would result in a loss of coverage, even for some individuals below the poverty level. The Department of Medicaid held public meetings in April. Most who testified were opposed to the waiver concerned that it appears to be a premium forced on people who already could not afford to pay for insurance and other bills. Out of pocket cost, limiting access to care with declining health care outcomes, increased cost to other systems and increased administrative burden to hospitals, causing a decline in enrollment that could drive up charity care cost are also identified as potential problems with the waiver's design. Supporters of the waiver, including some legislators say it would save the state money and improve health outcomes by promoting healthy behaviors.

Disability Rights Ohio Launches New Website. Disability Rights Ohio, which replaced Ohio Legal Rights Service as Ohio's Protection and Advocacy (P&A) system, has launched a new website. The new site is intended to help visitors learn more about the Ohioans it serves. The website provides helpful quick links to related information and forms. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medical Assistance Coverage of Services Related to Gender Transition. The Department of Human Services (DHS) announced that it intends to amend the Medical Assistance (MA) regulations to remove language that prohibits payment for certain services related to sex reassignment and that medically necessary services related to gender transition that are within the scope of covered benefits will be compensable under the MA Program. Read More

DHS Adds Mount Nittany Exchange to the PA Patient & Provider Network. The Department of Human Services' (DHS) eHealth Partnership program announced that Mount Nittany Exchange (MNX) is now connected to the PA Patient & Provider Network (P3N). MNX is one of five active health information

organizations (HIO) in Pennsylvania. MNX joins St. Luke's University Health Network's eVantageHealth and the Keystone Health Information Exchange as a participant in the P3N. Pennsylvania's HIOs link health care providers within defined geographic areas and govern health information exchange among them for the purpose of improving health care in their communities. Health care providers who join a P3N-connected health information organization will also benefit from the Public Health Gateway, a single connection for reporting into Pennsylvania's various registries, including cancer, immunization, disease surveillance, electronic laboratory reporting, and clinical quality measurement. Read More

Tennessee

State Allows Insurers to Refile 2017 Exchange Rates, Seek Higher Premiums. *The Tennessean* reported on August 8, 2016, that Tennessee will allow health plans to refile their 2017 Exchange rate requests by August 12, after Cigna and Humana said their original rate requests were too low to cover projected health care costs. Tennessee is allowing the refiling in hopes of preventing the two plans from withdrawing from the state Exchange market. Cigna had originally sought a 23 percent increase, while Humana had asked for 29 percent. Another plan, Blue Cross Blue Shield of Tennessee, asked for a 62 percent average rate increase and does not plan to file again. Read More

National

CMS Encourages States to Use Medicaid Funds on Home Care for Individuals with Disabilities. *Modern Healthcare* reported on August 3, 2016, that the Centers for Medicare & Medicaid Services released guidance encouraging states to use Medicaid funds on home health care for individuals who are elderly or disabled in hopes of keeping people out of nursing homes. The guidance suggests states establish an open registry of home care workers, outline qualifications of workers, and develop adequate payment rates for home care services. Total federal and state Medicaid spending in the United States on long-term services and supports was $152 billion in 2014, up 4 percent from the previous year. The median annual cost in 2015 for nursing facility care was $91,250, compared to $46,000 for home health care. Read More

Medicaid Expansion Did Not Significantly Increase ER Use In 2014, Study Shows. *UPI.com* reported on August 10, 2016, that a study conducted by George Washington University showed that emergency room use rose less than 3 percent in 2014, the first year of Medicaid expansion. The study, published in the journal Health Affairs, is based on data from 478 hospitals in 36 states. However, the study did find that Medicaid expansion significantly altered the payer mix for ER visits, with Medicaid-paid visits rising 27 percent and uninsured visits falling 31 percent. Read More

Access to Care Improves Following Medicaid Expansion, JAMA Study Finds. *The Hill* reported on August 8, 2016, that a study published by the Journal of the American Medical Association (JAMA) found that access to care in Arkansas and Kentucky improved following Medicaid expansion. Both states also saw a drop in the number of residents who are uninsured. Compared to Texas, a large state that has not expanded Medicaid, patients in Arkansas and Kentucky were less likely to skip prescription medications, to have trouble paying medical bills,

and were more likely to have had a checkup in the past year, and to be receiving regular care for a chronic condition. Read More

National Psychiatric Bed Shortage Leaving Patients Stuck in Hospitals, Jails without Access to Care. *PBS* reported on August 2, 2016, that a shortage of state psychiatric beds is preventing patients from receiving mental health treatment. Patients are instead held in emergency rooms, hospitals, or jails, where they are, in some instances, strapped down or held in isolation. In the state of Washington, a federal judge ruled that this practice, known as psychiatric boarding, violates the constitutional rights of patients. The Washington Department of Social and Health Services was held in contempt and ordered to pay fines of $500 a day for each inmate waiting more than a week for a bed and $1,000 for each inmate waiting more than two weeks. In response, the state increased the number of beds and boosted spending on community mental health services. Other states have also been held in contempt for failing to admit inmates with a mental illness in a timely manner. The Treatment Advocacy Center recommends 40 to 60 psychiatric beds for every 100,000 residents; the national average is 11.7 per 100,000. Since 2010, the number of psychiatric beds has decreased by 13 percent. Read More

Industry News

Aetna, Humana Antitrust Trial to Begin in December. *Modern Healthcare* reported on August 10, 2016, that the U.S. Department of Justice's antitrust challenge to Aetna's proposed $53 billion acquisition of Humana will go to trial in federal court beginning December 5, 2016, with a decision expected in mid-January 2017. Aetna has until the end of the calendar year to close the acquisition or face a $1 billion break-up fee. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
August 25, 2016	Nevada	Proposals Due	420,000
August, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
September 6, 2016	Pennsylvania HealthChoices	Proposals Due	1,700,000
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	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
August, 2017	Georgia	Implementation	1,300,000
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.
New York - IDD	Capitated	4/1/2016	None	20,000	217	1.1%	Partners Health Plan
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**			**1,254,200**	**362,006**	**28.9%**	

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

HMA NEWS

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 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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