HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

HIGHLIGHTS FROM THIS WEEK'S HMA CONFERENCE ON FUTURE OF MEDICAID

This week, our *In Focus* section provides a recap of the second annual HMA Conference, *The Future of Medicaid is Here: Implications for Payers, Providers, and States*, held this Monday, September 11, and Tuesday, September 12, in Chicago, Illinois. More than 300 leading executives from health plans, providers, state and federal government, community-based organizations, and others in the health care field gathered to address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations given the priorities of the new Administration and Congress.

Keynote Address

"The Future of Medicaid is Here: Implications for Payers, Providers and States"

Diane Rowland, Executive Vice President of the Kaiser Family Foundation, set the stage with an overview of Medicaid's role in the Affordable Care Act (ACA) debate and what the next steps are for Medicaid going forward. Medicaid's importance to the American public, as well as its role in supporting Medicare, the long term care system, and the health care safety net were discussed before looking at the key upcoming issues that those in the Medicaid world will address: (1) the future of the Medicaid expansion; (2) Medicaid waivers and other administrative actions at the federal level; (3) Medicaid's role in public health and the opioid crisis; (4) the growth of the aging population and demand for long term care; and (5) potential restructuring of Medicaid's programmatic design and financing. While Congress may have little appetite to address much beyond CHIP reauthorization and market stabilization, the desire to reduce federal spending over time, cap entitlement programs, and generate savings could present real concerns to the Medicaid program. A key question that will shape the future of Medicaid is whether Congress will enact nationwide changes, or whether the future of Medicaid will be shaped by state-level actions.

Keynote Q&A Session

"The Future of State Innovation in Medicaid"

Next up, HMA convened three current or former state Medicaid directors, as well as Matt Salo, the Executive Director of the National Association of Medicaid Directors (NAMD), to discuss the environment around state innovation in Medicaid. California's Mari Cantwell, State Medicaid Director & Chief Deputy Director, Health Care Programs, California Department of Health Care Services; Kansas' Michael Randol, Director, Division of Health Care Finance, Kansas Department of Health and Environment; and Texas' Gary Jessee, Former Deputy Executive Commissioner, Medical and Social Services, Texas Health and Human Services, each provided an overview on their respective state's innovation activities and their views on innovation going forward, while Matt Salo brought insights from NAMD members, before fielding questions from HMA Managing Principal Kathleen Nolan and from the audience.

Innovation around social determinants of health and a real focus on the member were major topics, presenting both significant opportunities and significant challenges, particularly around financing and aligning across state and federal programs. Cost-containment will be another issue in innovation, and Medicaid programs will need to communicate effectively around what it really means to contain costs going forward when innovation can appear to be increasing spending. The role of state partners – particularly MCOs – will be key to successful innovation in Medicaid, while organizations and vendors will need to be thoughtful in their approach to working with states. Finally, flexibility was a key word used across the discussion on innovation in Medicaid. In light of what looks to be a new era of federal flexibility, states are going to be the leaders and Medicaid is the mechanism for states to act on health care. States will have to be creative and thoughtful in weighing options and setting a course for innovation.

Health Plan Keynote Q&A Session

"Managed Care and the Brave New World of Medicaid Innovation"

"Cutting $800 million from the Medicaid budget is not our idea of reform," said Pam Morris, chief executive of CareSource (Dayton, Ohio) in commenting on failed Congressional efforts to repeal and replace the Affordable Care Act. She did note that a shift to block grants could force remaining fee-for-service states to move to Medicaid managed care. Morris also praised the concept of a Medicaid buy-in option.

Janet Grant, Regional Vice President, Great Plains Region, Aetna Medicaid, said that a Medicaid funding model using per capita caps could work; although, she noted, there would be winners and losers among the states. Grant said she was looking to state Governors in the Medicaid reform debate, hoping they will help drive federal policy.

Mario Molina, Director and former Chief Executive, Molina Healthcare, described managed care as the only large-scale solution that has successfully reduced costs. Molina also said that the biggest challenge concerned new provider risk-sharing arrangements is the providers themselves, noting that many are unable or unwilling to take on risk. He said the best approach to provider risk sharing is capitation.

Judith Candice Davis, Divisional Vice President, Clinical Operations for Government Programs at Blue Cross Blue Shield of Illinois, said that Federally Qualified Health Centers are some of the most trusted Medicaid providers in the Illinois market and can be slowly migrated into risk-sharing arrangements. She also said the health plans can address social determinants of health by focusing on health workers best equipped to help members in certain settings. For example, social workers in many cases have higher engagement with members than primary care physicians, while EMT workers can have even higher levels of engagement in certain situations.

Luncheon Keynote

Matt Salo, Executive Director of NAMD, said that the battle over repeal and replace of the Affordable Care Act "is not over by a long shot." While the window of opportunity for Republicans is narrowing, there is still nearly three weeks to pass some form of repeal and replacement legislation with 51 votes under reconciliation in the Senate, according to parliamentary rules. "We have three weeks to see if this zombie comes back from the grave….After that it goes away," Salo said. He described the House and Senate versions of repeal and replace as "bad public policy." Despite attempts by NAMD to educate lawmakers on the complexities of Medicaid, Salo said it was clear from the proposed legislation that "they didn't listen." While there are a lot of things that can be improved, Salo said, the type of changes envisioned in the repeal and replace proposals "are not the kind of changes we need in Medicaid." Salo said reforms should focus on the "four P's:" payers, plans, providers, and patients. Payers need to think differently in serving markets like Medicaid, Medicare and commercial insurance; plans need to recognize that what worked before might not work today, and that serving children is different from serving the frail elderly; and providers need to realize they're going to be held accountable.

Breakout Session

"Medicaid Waivers – A Future of Innovation, A Danger of Disruption"

Judy Mohr Peterson, Medicaid Director, Hawaii State Department of Human Services, kicked off the discussion on Medicaid waivers with the concept of "kuleana," a shared responsibility, and how it relates to the health and wellbeing of Medicaid members. This responsibility influences Hawaii's approach to its Section 1115 waiver, built on community conversation. The next generation of waivers will focus on the delivery system and financial alignment, integrated at the community level. Waiver innovations will be rethinking the roles of primary care and prevention, focusing on social needs as true drivers of innovation, and will involve more than Medicaid.

Chris Priest, Medicaid Director, Michigan Dept. of Health and Human Services, took the stage next to discuss the era of flexibility under the new federal administration. While waivers have always been the way to implement change in Medicaid, a new conversation is needed on how much can be changed and how fast. States will need to move both deliberately and cautiously, as well as be wary of "innovation fatigue" after years of ACA implementation. Furthermore, in the new era of flexibility, waivers should not be expected to bring in significant new funding, but rather provide an opportunity to optimize and innovate, particularly around social determinants of health.

Finally, Karen Brach, President, Meridian Health Plan of Illinois, provided the MCO perspective, stressing that managed care can and will continue to be a partner to states in innovation. MCOs can bring invaluable experience with successes and failures in other states and markets. MCOs can be a partner in the waiver conversation to minimize member disruption, increase provider awareness and preparedness, support provider engagement, and encourage stakeholder involvement. On the running theme of flexibility, Brach noted that this applies to contracting and program requirements as well: inflexibility can be a barrier to successful innovation.

Breakout Session

"Value-Based Payments and the Future of Payer-Provider Collaboration"

Susan Fleischman, Vice President of Medicaid, CHIP, and Charitable Care at Kaiser Permanente; Rachel Quinn, Director of the Office of Value Based Purchasing at the Washington State Health Care Authority; and Paco Trilla, Medical Director of the Neighborhood Health Plan of Rhode Island shared strategies on how their organizations are working towards successful value-based payment (VBP) goals across payers, providers, and plans, and the importance of data. The Washington State Health Care Authority has set a goal to reach 90 percent VBP by 2021 through payment reform initiatives that focus on elements, including withholding premiums for managed care organizations, risk sharing, and rewarding improvement. Fleischman stressed the importance of electronic health records to connect everyone and improve outcomes. Kaiser uses an integrated model that aligns the health plans, hospitals, and physician groups to drive coordination of care across all settings. In Rhode Island, Medicaid Accountable Entities are used to improve quality. In 2016, the entities saved $11.6 million and improved quality for patients. Trilla stated, "data improves lives."

Breakout Session

"Opportunities and Challenges for Community-based Organizations"

Barbara Ferrer, Director of Public Health at Los Angeles County Health Agency, and June Simmons, President and CEO at the Partners in Care Foundation, shared their experiences on how community-based organizations can leverage resources and build partnerships to address social determinants of health through non-clinical interventions. Social and economic factors heavily influence health outcomes, especially within the Medicaid population. The speakers emphasized the importance of best practices, evidence-based models, innovative payment structures, and technology to address health outcomes linked to social determinants of health. The speakers provided case studies on addressing both children's asthma and high hospital readmission rates for home and community-based services utilizers through interventions provided by community-based organizations. Identifying champions and new partners, including managed care organizations and housing authorities, can create new funding streams and support pilots that demonstrate results. Non-clinical interventions are powerful and many times inexpensive, especially when supporting wellness in the home and community.

Breakout Session

"Medicaid Managed Care and the Future of Long-Term Services and Supports"

Melanie Bella, national consultant; Patti Killingsworth, Assistant Commissioner for TennCare; and Michael Monson, Corporate Vice President of Long-Term Care and Dual Eligibles at Centene Corp., addressed the use of managed care for Long-Term Services and Supports (MLTSS) populations, including individuals who are dually eligible for Medicare and Medicaid. Bella noted that implementation of the federal duals Financial Alignment Initiative had some initial bumps, but today it covers 400,000 members and is delivering positive outcomes. She said one of the biggest challenges is getting eligible individuals enrolled. Monson pointed out that there are no effective metrics today to measure the quality of MLTSS plans. He pointed to an initiative by the National MLTSS Health Plan Association to identify measures in five domains: quality of life, transition to most integrated setting, integration risk factors, person-centered planning and coordination, and satisfaction. Killingsworth said that MLTSS has the potential to improve outcomes, reduce costs, and increase access to home and community-based services. She stressed services and supports that enable people to stay connected and integrated in their local communities, not just at home and out of a nursing home. She added that investment is needed because the healthcare system is largely unequipped to serve the LTSS population.

Breakout Session

"Behavioral Health Integration: A Care Management Imperative"

Patrick Gordon, Associate Vice President of Rocky Mountain Health Plan, a UnitedHealthcare plan; Tamara Hamlish, Executive Director of ECHO-Chicago and Project Manager of HepCCATT; Virna Little, Senior Vice President of Psychosocial Services and Community Affairs at the Institute for Family Health; and Joe Parks, Medical Director of the National Council for Behavioral Health talked about the importance of integrating behavioral health in this breakout session. The cost of taking care of patients with mental health conditions is significantly higher. To lower costs and improve lives by

successfully integrating behavioral health, there needs to be shared accountability, shared plans of care, and competent providers. Speakers stressed sharing the risk by increasing dependency and vulnerability. Education and cross-training are extremely important to developing workforce competency. Additionally, plans must increase behavioral provider rates to cover the actual cost of care in order for integration to work. The speakers spoke of specific models and processes to integrate care, as well as the benefits of doing so.

Breakout Session

"Investor Views on the Future of Publicly Sponsored Healthcare"

David Caluori, Principal at General Atlantic; Josh Raskin, a Wall Street Analyst; Todd Rudsenske, Managing Director at Cain Brothers & Company LLC; David Schuppan, Private Equity Investor; and Tim Sheehan, Managing Director at Beecken Petty O'Keefe, discussed investment opportunities in the Medicaid market and trends they are tracking since the election. Investors are looking for opportunities that create value, demonstrate results, and offer savings. Medicaid managed care is an area that is data driven and has demonstrated savings, including a competitive advantage over government-provided services. Additionally, given the amount of spending that exists outside of managed care, there remains significant room for growth in the industry. Another area of opportunity is behavioral health care, with undiagnosed and untreated behavioral health causing a tremendous strain on the economy over the past decade. New models that bring coordinated care into the community can reduce the overall costs on society, making this an opportunity for investors. For the dual eligible population, there are several areas of opportunity for investors, including home health, adult day, home-delivered meals, and home and community-based services that replicate services offered in an institutional setting, offer choice for Medicaid beneficiaries, and replace one-on-one care. Alternatively, highly fragmented areas and services with high variability between states can make investors cautious. There was additional discussion on the overall inflation in valuation of health care deals, particularly as investors in other sectors begin to look to the health sector for new value opportunities. Overall, the speakers emphasized the importance of opportunities of growth within a five to ten-year cycle and high-quality services that benefit the individual and the community.

Keynote Address and Q&A Session

"The Pros and Cons of Shared Responsibility in Medicaid"

In one of the conference's most spirited conference sessions, former Indiana Medicaid Director Joe Moser discussed the state's hybrid HIP 2.0 Medicaid expansion, which includes premium contributions equal to 2 percent of income and health savings accounts. The program also includes penalties for not making premiums payments. Anyone at or below poverty loses enhanced benefits like vision and dental; those above poverty up to 138 percent experience a six-month lock-out period. Moser noted that the program was a way of bringing coverage to thousands of expansion members in Indiana, a state that politically was not prepared to launch a more standard expansion under the Affordable Care Act. Moser noted that after two years, 65 percent of people are making their contributions and receiving enhanced benefits. He attributes the success of the program in part to reimbursing providers at

Medicare rates, which helps ensure a robust network. He also noted that the dental benefit has been extremely popular. Indiana is now in the process of seeking additional changes, including a work requirement.

Kristen Metzger, President of Indiana Medicaid for Anthem Blue Cross and Blue Shield, said that members in HIP 2.0 are much more engaged than traditional Medicaid members, calling for information about benefits at least five times more than in other states. "They ask a lot of questions, but we're okay with that," she said. Member satisfaction is also higher, along with HEDIS quality measurement scores, Metzger noted. About 70 percent of HIP 2.0 expansion members enrolled with Anthem make their premium payments.

Toby Douglas, Senior Vice president, Medicaid Solutions, Centene Corporation, said that Indiana Medicaid members appreciate the enhanced benefits, especially dental coverage. He agreed that member engagement is much higher than other Medicaid populations and ER use is lower. Douglas said that HIP 2.0 allows for a partnership between the state and health plan, allowing plans to innovate, for example, by offering certain incentives and rewards for work, housing, and childcare.

Christopher Perrone, Director, Improving Access, California Health Care Foundation, expressed skepticism over many of the features of HIP 2.0, citing studies showing that premium contributions act as a barrier to obtaining and maintaining coverage, and that cost-sharing reduces utilization of needed services. As for work requirement, Perrone said, voluntary programs have proven to be just as effective as mandates that penalize members by holding back coverage.

Provider Keynote Q&A Session

"Trends in Provider Innovation and Delivery System Reform"

Allen Dobson, MD, Chief Executive of Community Care of North Carolina; Allison McGuire, Executive Director, Montefiore Hudson Valley Collaborative; and Paco Trilla, MD, Medical Director, Neighborhood Health Plan of Rhode Island discussed the development of clinically and financially integrated delivery systems like Accountable Care Organizations to further improve quality, cost and member experience of care. Trilla pointed to success in Rhode Island's Accountable Care Entity program, noting that per member per month costs for 89,000 members enrolled in five ACEs in 2016-17 declined 3 percent, compared to a 4 percent increase among 47,000 non-ACE members. McGuire pointed to the challenges of delivery system redesign, noting that system redesign takes time and that state regulations must align with program goals and allow organizations to innovate. Dobson pointed to four initiatives to take advantage of opportunities to improve outcomes and care management: (1) integration of community pharmacists; (2) behavioral health integration; (3) stressing "impactability" of data, i.e., making sure data can be used to drive decisions; and (4) organizing the delivery system.

HMA MEDICAID ROUNDUP

Arizona

AHCCCS Proceeds with Plans to Implement Work Requirements and Five-Year Lifetime Limit. *The Arizona Daily Star* reported on September 9, 2017, that Arizona will proceed with plans to tighten Medicaid eligibility by implementing work requirements and a five-year lifetime limit on able-bodied adults, as the Arizona Health Care Cost Containment System (AHCCCS) awaits final waiver approval from the Centers for Medicare & Medicaid Services (CMS). Arizona's waiver amendment request also requires that beneficiaries verify work adherence to requirements and changes in family income monthly, and allows AHCCCS to terminate enrollment if beneficiaries fail to do so. CMS is expected to issue its decision on the state's Medicaid waiver in 2018. Read More

State Supreme Court to Vote on Medicaid Expansion Tax Legality. The *Arizona Capitol Times* reported on September 12, 2017, that the Arizona Supreme Court will decide whether a hospital tax that funds the state's Medicaid expansion program was legally enacted. The $265 million annual tax did not receive the required two-thirds vote from both the state House and Senate. Instead, then-governor Jan Brewer proposed giving AHCCCS Director Tom Betlach authority to impose a charge on hospitals, which lawmakers approved. GOP lawmakers then sued saying the tax did not follow the 1992 voter-approved amendment to the Arizona Constitution requiring a two-thirds vote. Hospitals did not oppose the tax because it led to reductions in unpaid medical bills from the uninsured. Read More

California

CalOptima to End Mental Health Administration Contract with Magellan. *Voice of OC* reported on September 11, 2017, that CalOptima's Board of Directors voted to move the administration of mental health services in-house by the end of the year, phasing out the health plan's contract with Magellan Health. The decision was a result of a contract dispute between the two entities around changes to Magellan's reimbursement rates for applied behavioral analysis (ABA) services. Magellan currently administers benefits for around 6,700 CalOptima members each month. The transition is expected to cost CalOptima an additional $4.1 million annually on top of one-time costs of $2.5 million. Read More

Connecticut

Hospitals Cast Doubts on Governor's Hospital Tax Proposal. *The CT Mirror* reported on September 12, 2017, that hospitals have expressed concerns over Governor Dannel Malloy's proposed hospital provider tax, which would increase taxes on hospitals by 55 percent. However, the revenues generated from this tax are expected to be funneled back into the industry through federal Medicaid matching funds. The tax is predicted to generate $820 million in the first year and $850 million in the second year. Governor Malloy made a similar proposal six years ago. Read More

Iowa

Medicaid Billing Issue Forces Oak Place Crisis Stabilization Center to Close. *The Des Moines Register* reported on September 8, 2017, that Oak Place center in Centerville, Iowa, is on the verge of closing, citing a lack of state action to allow the center to bill Medicaid. Oak Place, which is one of 11 "crisis-stabilization" centers established in the past few years in the state, offers an innovative program that provides mental health services to those in rural areas. Since opening, the center has reduced the number of individuals admitted to psychiatric hospitals in Appanoose County by approximately 80 percent. Oak Place is expected to close in late-October. Read More

Maine

Mainers Will Vote on Medicaid Expansion Through November Ballot Initiative. *Modern Healthcare* reported on September 8, 2017, that Maine's residents will vote to expand Medicaid through a ballot initiative this fall; however, the initiative faces significant opposition. Governor Paul LePage previously vetoed five bills that would have allowed the state to expand Medicaid and draw down federal funding. If voters pass the referenda and legislators do not try to amend the results, Governor LePage will not have authority to veto the measure. Additionally, the Secretary of State recently announced final language for the ballot question, which describes the Medicaid expansion as "healthcare coverage." Opponents of expansion had pushed to change the question's language to "government benefits." Read More

Massachusetts

Amended MassHealth Section 1115 Waiver Submitted to CMS. The Massachusetts Executive Office of Health and Human Services (EOHHS) announced on September 11, 2017, that the office submitted an amendment to its MassHealth Section 1115 Waiver to the Centers for Medicare & Medicaid Services (CMS). The amended waiver seeks to align coverage for non-disabled adults with commercial plans; adopt commercial tools to obtain lower drug prices and enhanced rebates; and improve care, reduce costs, and achieve administrative efficiencies within MassHealth. Read More

Montana

Legislative Committee Votes to Block Medicaid Funding Cut. *KTVH* reported on September 11, 2017, that the Montana Children, Families, Health and Human Services Interim Committee voted to block Governor Steve Bullock's administration from enacting more than $20 million in proposed budget cuts to Medicaid. The committee's vote sustains Medicaid funding through at least November. To balance the budget next month, Governor Bullock's administration requested state agencies to submit proposed ten percent reductions to their overall budget. Unless more permanent actions are taken, however, the Bullock administration intends to implements cuts on January 1. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Division of Aging Services Requests Applications to Expand PACE Program. On September 5, 2017, the Department of Human Services Division of Aging Services (DoAS) released a Request for Applications for new Program of All-Inclusive Care for the Elderly (PACE) Programs. The solicitation is seeking applicants for new PACE centers in Ocean and Essex counties. In addition. DoAS anticipates soliciting applications for PACE in Bergen, Passaic, and Middlesex counties in the next year. The application process involves seven steps:

1. Letter of Intent
2. Request for Additional Information
3. CMS PACE Application
4. New Jersey Architectural Reviews
5. New Jersey Ambulatory Care Facility License
6. State Readiness Review
7. PACE Agreements

Letters of Intent are due by December 18, 2017. A complete copy of the application along with Frequently Asked Questions can be found here.

Trenton Health Team Selected to Participate in BUILD Health Challenge. The Trenton Health Team (THT) announced on September 12, 2017, that they have been selected as one of 19 communities to participate in the Bold, Upstream, Integrated, Local, and Data-Drive (BUILD) Health Challenge, a national program that puts multi-sector community partnerships at the foundation of improving health. As part of this program, THT will develop a "Safe & Healthy Corridor" from the Trenton Battle Monument Park to Capital Health Regional Medical Center. The $250,000 two-year grant and matching funds from Capital Health and Trinity Health/St. Francis Medical Center will be used to physically transform vacant lots, establish community garden and other green spaces, create soccer fields, update current park facilities, and improve streetscapes to align with the Complete Streets vision. Read more

Office of the State Comptroller Launches Medicaid Fraud Amnesty Program. *NJ.com* reported on a September 12, 2017, that the Office of the State Comptroller initiated the Ocean County Recipient Voluntary Disclosure Program, a 90-day pilot that allows Ocean County residents who either purposely or unintentionally received unwarranted Medicaid benefits to

withdraw from the program and avoid criminal prosecution charges. The pilot program was initiated after 26 fraud charges in Lakewood found that $2 million was wrongfully collected through public assistance benefits. Participants in the program will be required to pay full restitution to Medicaid, additional penalties, and voluntarily withdraw from Medicaid for one year. Read more

New Mexico

HSD to Seek Federal Approval to Charge Medicaid Co-Pays, Eliminate Free Dental, Vision Benefits. *KUNM* reported on September 6, 2017, that the New Mexico Human Services Department intends to move ahead with a plan to seek federal approval for a revised Medicaid waiver, allowing the state to charge co-pays, penalize beneficiaries for missed appointments, and eliminate free vision and dental benefits for adults. The proposed amendment, which has faced strong opposition, will be open for public comment before being submitted to the Centers for Medicare & Medicaid Services for review. Read More

State Files Suit Against Drug Companies, Distributors Over Opioid Crisis. *Reuters* reported on September 7, 2017, that New Mexico has filed a lawsuit against five drug manufacturers and three wholesale distributors seeking to hold them accountable for the opioid crisis. The lawsuit claims that Purdue Pharma LP, Johnson & Johnson, Allergan Plc, Endo International PLC, and Teva Pharmaceuticals Industries Ltd understated the risks of opioids through deceptive marketing. It also claims distributors McKesson Corp, Cardinal Health Inc., and AmerisourceBergen Corp breached their legal duties to monitor, detect, and report suspicious prescription opioid activity. Similar cases have been filed in Oklahoma, Mississippi, Ohio, Missouri, New Hampshire, and South Carolina. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

HHS OIG Reports on $1.4 Billion in Improper Managed Long-Term Care Payments. The Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services (HHS) conducted an investigation into New York's claims for Medicaid reimbursement for payments made to managed long-term care (MLTC) plans. The OIG reviewed 100 claims and found that 36 of them were problematic. The report calculates that New York may have paid out $1.4 billion in one year to plans who were not in compliance with contract requirements, out of a total of $4.8 billion in payment to MLTC plans. The OIG report states that New York did not ensure that MLTC plans documented eligibility assessments of program applicants and reassessments of those already in the program, and conducted these assessments in a timely manner. New York also did not ensure that the plans provided services to beneficiaries according to a written care plan. Further, New York did not ensure that the plans enrolled and retained only those beneficiaries who required community-based services, and disenrolled beneficiaries who requested disenrollment in a timely manner. In addition, CMS physicians found that for 71 beneficiaries associated with the payments reviewed, the beneficiaries' MLTC plans did not comply with New York's contract requirements for service planning and care

management. In its written response, the New York Department of Health indicated that it had already created a Surveillance Unit within the Bureau of Managed Long Term Care that is tasked with monitoring MLTC plans to assure compliance with federal and state regulation and the terms of the Medicaid contracts. Read More

DACA and Medicaid in New York State. Ending Deferred Action for Childhood Arrivals (DACA), as has been proposed by President Trump's administration, would have an impact on those DACA individuals who are currently covered by New York's Medicaid program. New York is one of a small number of states that provides Medicaid coverage to non-citizens who are residing under the color of law (PRUCOL). As a result of litigation in 2001 that argued that denying Medicaid to any legal resident violated the equal protection clause of the New York constitution, immigrants in New York who are not citizens, but are living in the state lawfully, are entitled to Medicaid. As reported in Politico, because the federal government does not recognize the state court's decision, New York pays the full cost for Medicaid coverage for these immigrants. If they lose their DACA status and revert to being undocumented immigrants in the eyes of the law, they lose their right to Medicaid. Of the 42,000 DACA recipients in New York, an estimated 5,000 – 10,000 are covered by Medicaid. Read More

Department of Health Sponsors Value Based Payment Learning Series. The New York Department of Health has announced a second round of trainings referred to as Value Based Payment (VBP) Boot Camps. VBP boot camps are a regional learning series designed to equip VBP contractors and interested parties such as managed care organizations, providers, associations, and community based organizations, with the knowledge necessary to implement payment reform. This boot camp session will be a one-day session held in five regions across the state. The boot camps will address the following subjects:

- VBP Financing
- VBP Contracting
- VBP and the Social Determinants of Health/Community Based Organizations
- VBP Quality Measures
- VBP for Managed Long Term Care

The schedule and locations for VBP boot camps are as follows:

- October 10, 2017 Capital Region
- October 18, 2017 New York City
- October 23, 2017 North Country
- November 3, 2017 Central New York
- November 15, 2017 Long Island

All of the sessions for the boot camp will be recorded. Read More

New York Limits Addiction Treatment Providers. In response to concerns about unscrupulous addiction service providers, New York has decided to limit the provision of addiction services to providers that are certified and credentialed by the Office of Alcoholism and Substance Abuse Services. According to a letter issued by OASAS, the current opioid crisis has "given rise to many who seek to exploit the pain and fear at the root of addiction by falsely representing their credentials, expertise, background, and connections with treatment programs, some also fraudulent, to further their own financial gain."

In response, the state has issued a directive that includes the following prohibitions:

- No substance use disorder services may be provided as part of an arrangement between a practitioner and a program for the exchange of remuneration solely to entice an individual or a provider program to direct a potential patient to one of the parties.
- Authorized practitioners and programs must provide services consistent with both state and federal laws including, but not limited to, patient confidentiality, fraud and deceptive business and marketing practices, labor and employment.
- Authorized practitioners may not engage in "dual relationships" or "multiple relationships."
- Authorized practitioners may only provide substance use disorder services, including pre-admission consultations, as an employee of an authorized program.

Read More

FAIR Health Launches Health Care Cost Website. A new, interactive health care cost transparency website launched in New York. Developed by FAIR Health with funding from the New York State Health Foundation, the web site offers unbiased, transparent, user-friendly information on health care costs. The website allows you to compare out-of-network and in-network costs on a range of procedures for any zip code in New York State. The free website also features educational content, videos, and resources to help consumers better understand health care quality and engage them in decision-making. Read More

New York Office of Mental Health Appoints Executive Deputy Commissioner. New York State Office of Mental Health Commissioner Ann Marie Sullivan announced the appointment of Christopher Tavella, Ph.D. as the new Executive Deputy Commissioner of the agency. He succeeds Martha Schaefer, who retired at the end of July. Tavella, who holds a Ph.D. in Clinical Psychology, had most recently served as OMH's Deputy Commissioner for the Division of Quality Management. He had previously worked at both the Manhattan Psychiatric Center and the Rockland Psychiatric Center.

New York-Presbyterian Hospital to Complete Merger with Lawrence Hospital. Consolidation across New York's hospital sector continues with New York-Presbyterian Hospital looking to complete its merger with Lawrence Hospital, a 288-bed facility in Bronxville. According to *Crain's HealthPulse*, New York-Presbyterian is seeking approval from the Department of Health to complete a full-asset merger with New York-Presbyterian/Lawrence. New York-Presbyterian has served as the active parent of NYP/Lawrence since July 2014. Crain's reports that Lawrence will become the sixth division of New York-Presbyterian Hospital. The hospital system operates a total of 3,200 beds, including 270 behavioral health beds at its Westchester division. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Department of Medicaid Releases 2017 Managed Care Plans Report Card. *The Ohio Department of Medicaid* released the 2017 Managed Care Plans Report Card on September 8, 2017. Two of the five plans, CareSource and Molina Healthcare, scored average or above average on all five scored criteria. CareSource was above average on "Doctor's Communication and Service" and "Keeping Kids Healthy." Molina Healthcare was above average on "Living with Illness." Centene's Buckeye Health Plan was below average in "Living with Illness," but above average in "Women's Health." UnitedHealthcare Community Plan scored below average in both "Living with Illness" and "Women's Health," but was above average in "Getting Care." Paramount Advantage was below average in "Getting Care" and "Doctor's Communication and Service," and average in the other three categories. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Provides Update on HealthChoices Awards Court Challenge. In a September 7, 2017, announcement, the Pennsylvania Department of Human Services clarified the status of the recent physical health HealthChoices procurement. Earlier this year, DHS announced the selection of six managed care organizations (MCOs) for negotiations to administer health care to Medical Assistance beneficiaries. Several of the MCOs that were not selected filed bid protests. After those protests were denied, the MCOs appealed those decisions to Commonwealth Court. As a result, the department is in what is called a stay, meaning that until the Commonwealth Court issues a decision on the pending appeals, DHS is unable to move forward with the selected MCOs. In the meantime, Current HealthChoices MCOs will continue providing services. The stay of the physical health HealthChoices procurement does not impact the Community HealthChoices (MLTSS) implementation. Community HealthChoices will go live in the South West zone in January 2018. Similarly, the behavioral health HealthChoices program is not impacted.

DHS Official Named to NAMD Board. Leesa Allen, Deputy Secretary of the Pennsylvania Department of Human Services' Office of Medical Assistance Programs, has been named to the board of the National Association of Medicaid Directors (NAMD). Allen will represent East Region which includes Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, Virginia, and West Virginia. NAMD members voted Allen in to fulfill a remaining 16-month term when a seat representing the East region recently became vacant. Read More

Pennsylvania House Returns with Fight over $2.2B Unresolved. On Monday, September 11, 2017, the Pennsylvania House returned for their fall session and to finalize a state budget now over two months late. A spending plan was passed in early July with no corresponding revenue plan to pay for it. The Senate passed a revenue package with Governor Wolf's support, though the House has yet to act on it. Upon returning to session, House members debated

a new budget-balancing plan. This new proposal avoids the borrowing, casino gambling expansion and utility service tax increases that underpins the $2.2 billion revenue package the Senate approved in July and leans heavily on transferring money from off-budget accounts that support public transportation systems and environmental cleanups and improvements. Read More

Virginia

Optima Pulls Back Exchange Participation, Leaving 48 Counties at Risk. *The Wall Street Journal* reported on September 6, 2017, that Virginia could have no Exchange options in 48 counties following a decision by Optima Health to scale back its Exchange presence in the state. The state's Corporation Commission is seeking other insurers to fill the gap. Optima is owned by Sentara Healthcare. Read More

Wisconsin

Anthem, Inclusa Launch Medicaid Pilot to Connect Individuals with Disabilities to Social Services. *Journal Sentinel* reported on September 6, 2017, that Anthem BlueCross and BlueShield and Inclusa are initiating a Medicaid pilot project in Wisconsin to help connect individuals with disabilities to social services and community resources. The program will focus on rural geographies. Anthem and Inclusa manage Medicaid long-term services and supports for 15,500 individuals in Wisconsin. The pilot program will run through the end of this year. Read More

National

Medicaid Industry Leaders Meet at Health Management Associates Conference. *Axios* reported on September 12, 2017, that public officials, health insurance executives, providers, consultants, and health industry professionals met on Monday and Tuesday at a conference hosted by Health Management Associates in Chicago. Participants expressed relief that Republicans were unable to cut Medicaid spending and acknowledge that states need to better articulate how their programs function. Read More

MACPAC Meeting Scheduled for September 14-15. The Medicaid and CHIP Payment and Access Commission (MACPAC) has scheduled a meeting for September 14 at 8:45 a.m. to 4:30 p.m. and September 15 at 9:00 a.m. to 12:00 p.m., in Washington, DC. The first day will include a panel to discuss ways to sustain long-term Medicaid reform and lessons learned from value-based payment. The second day's meeting will focus on issues surrounding state flexibility and accountability, managed care oversight, Medicaid eligibility requirements, and performance measure and evaluation methods for Section 1115 demonstration waivers. A full agenda can be found here.

Senate Finance Agrees on Five-year CHIP Reauthorization. *Politico* reported on September 12, 2017, that the Senate Finance Committee has agreed to extend funding for the Children's Health Insurance Program (CHIP) for an additional five years, according to Senators Orrin Hatch (R-UT), Chairman of the Senate Finance Committee, and Ron Wyden (D-OR). The proposed

legislation would provide states with more flexibility to administer the program and continue to provide a 23 percent increase in federal matching funds for 2018 and 2019, with the caveat that the federal match will begin to decline in 2020. A draft bill is expected to be released in the next few days. Read More

Uninsured Rate Declines in 2016, But Signs of Increase in 2017 Emerge. *Politico* reported on September 12, 2017, that there are early indications that the percentage of uninsured Americans is beginning to gradually increase after three consecutive years in which the U.S. has seen a decline in the uninsured rate. The most recent Gallup survey found that there has been a 0.8 percent increase in the uninsured rate since 2016, with the greatest upticks among adults between the ages of 35 and 49 and individuals at or above 400 percent of the federal poverty level. According to a report released by the U.S. Census Bureau, the number of Americans without coverage fell to 8.8 percent in 2016, a 0.3 percent decrease from the year previous. Read More

Governors Ask Senate for Federal Reinsurance Program, Commitment to Cost-Sharing Subsidies. *Kaiser Health News* reported on September 7, 2017, that five state Governors called for a federal reinsurance program and a commitment to cost-sharing subsidies to help stabilize the Affordable Care Act Exchanges. Governors explained to the Senate Health, Education, Labor and Pensions (HELP) Committee that states would not be able to establish their own reinsurance programs in time for the 2018 enrollment period, an approach favored by HELP Committee Chairman Lamar Alexander (R-TN). Governors Bill Haslam (R-TN), John Hickenlooper (D-CO), Charlie Baker (R-MA), Gary Herbert (R-UT), and Steve Bullock (D-MT) also pressed for a two-year commitment to cost-sharing reduction (CSR) payments. Read More

State Insurance Commissioners Offer Ideas During Senate Hearing on How to Stabilize Insurance Exchanges. *Kaiser Health News* reported on September 6, 2017, that state insurance commissioners offered ideas during a Senate Health, Education, Labor, and Pensions (HELP) Committee hearing on how to stabilize the Affordable Care Act Exchanges. Commissioners suggested funding of cost-sharing reduction payments for more than a year, a federal reinsurance program, and a streamlined federal waiver process. Commissioners also raised concerns about reductions in advertising to promote the enrollment period. Read More

Disagreement over ACA Coverage Flexibility Emerges in Senate Health Committee. *Modern Healthcare* reported on September 12, 2017, that bipartisan disagreements have emerged in the Senate HELP Committee regarding how much flexibility to give to states on redesigning the Affordable Care Act's (ACA's) coverage requirements under state 1332 innovation waivers. The Senate hopes to pass a stabilization package by September 27. However, differences between Democratic and Republican Senators on state flexibility for coverage requirements could disrupt this timeline. Without a market stabilization bill, health plans and others warn that uncertainty will further destabilize the market, potentially leading to rate increases of 20 percent or more and additional insurer exits from Exchanges. Read More

Senate Republicans Seeking to Allow Insurers to Opt Out of Consumer Protection Requirements. *The Hill* reported on September 8, 2017, that some Senate Republicans are seeking to leverage funding for cost-sharing reduction (CSR) payments and other market stabilization measure to allow insurers to

opt out of certain Affordable Care Act (ACA) requirements that protect consumers. Senate Republicans are willing to commit to one year of funding for CSR payments to insurers, while Democrats are seeking multiple years of funding. The Senate hopes to reach an agreement by the end of next week and pass a bill by the end of the month. Read More

Community Health Centers Face Closures Unless Congress Reauthorizes Funding. *Modern Healthcare* reported on September 7, 2017, that a projected 2,800 community health centers across the country could be at risk of closure unless Congress reauthorizes nearly $4 billion in annual funding. The closures could impact more than 9 million patients. Read More

Senate Budget Subcommittee Recommends Increase in HHS Funding. *Modern Healthcare* reported on September 6, 2017, that a Senate budget subcommittee has recommended an increase in discretionary funding for the U.S. Department of Health and Human Services (HHS), rejecting a proposal by President Trump to cut the agency's discretionary funding. The Appropriations Committee's Subcommittee on Labor, Health and Human Services, Education, and Related Agencies suggested a $1.7 billion increase in discretionary funding to $79.4 billion. Trump had called for a $15 billion reduction. An appropriations bill is expected to be released by the end of the week. Read More

Medicaid Innovation Accelerator Program Releases Data Use Agreement Factsheet. The Medicaid Innovation Accelerator Program's (IAP), Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program area has released a *Data Privacy, Data Use, and Data Use Agreements (DUAs)* Factsheet. Data sharing is a critical component of many Medicaid payment and delivery system reform efforts, particularly for those targeting BCNs. Leveraging data from many different sources and across agencies can be complex and extremely challenging, often requiring the creation of inter-agency Data Use Agreements (DUAs). The brief highlights some of the challenges faced by states participating in the BCN program area, as well as several resources these states found useful in developing DUAs, including two state example DUAs. States embarking on inter-agency data use can leverage these tools as they pursue data sharing as part of their Medicaid delivery system reform efforts. *HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (CMCS) contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs (BCN) program areas through webinars, technical support assistance to participating states, resource papers, and bi-weekly program updates.* Link to Factsheet

Industry Research

Medicaid Can Drive Delivery System Reform Around Social Determinants of Health. *HealthAffairs* reported on September 7, 2017, that growing evidence suggests Medicaid may be the ideal program upon which an integrated system can be built to address both health care needs and the social determinants of health. Medicaid, *HealthAffairs* maintains, can serve as a vehicle to address the social determinants of health given its large infrastructure in each state, its ability to adapt to meet each state's population and needs, and its experience in

serving diverse populations across states and the U.S. a a whole. State Medicaid programs in states such as Pennsylvania, Colorado, and Louisiana provide models where Medicaid is beginning to serve as a driver social determinants of health integration. Read More

Industry News

Centene to Acquire Fidelis Care. Centene Corporation announced on September 12, 2017, that it will acquire New York's Fidelis Care for $3.75 billion, with Fidelis to become Centene's health plan in the state. Fidelis Care, a not-for-profit plan, serves over 1.6 million members in New York across Medicaid, MLTC, dual eligible, Medicare Advantage, and Exchange markets. Reverend Patrick J. Frawley will continue to act as Fidelis Care CEO. The terms of the agreement are subject to certain adjustments. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
TBD	Delaware	Contract Awards (Optional)	200,000
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
September 22, 2017	Massachusetts	Contract Awards	850,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
Timeline to be Revised	Alabama ICN (MLTSS)	Proposals Due	25,000
November 1, 2017	Florida Statewide Medicaid Managed Care (SMMC)	Proposals Due	3,100,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
November 3, 2017	New Mexico	Proposals Due	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Delaware	Implementation (Optional)	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
Timeline to be Revised	Alabama ICN (MLTSS)	Implementation	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	New Mexico	Implementation	700,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of state dual eligible financial alignment demonstration status.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	117,302	33.5%	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	50,064	36.8%	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	16,809	17.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	39,046	39.0%	AmeriHealth Michigan; Coventry (Aetna); Michigan Complete Health (Centene); Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015	4/1/2015	124,000	4,566	3.7%	There are 14 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	561	2.8%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	74,347	65.2%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	13,717	54.0%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	7,915	14.8%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	39,919	23.8%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,194	41.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**391,440**	**31.2%**	

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

HMA WELCOMES…

Hope Plavin, Senior Consultant – Albany, New York

Hope Plavin joins HMA most recently from UnitedHealthcare Community & State where she served as Director of Medicaid Policy. In this role, Hope provided policy guidance and support to states throughout the Northeast, as well as generated targeted briefings on emerging issues ranging from population health to value-based contracting to emerging health delivery models.

Prior to UnitedHealthcare, Hope served as Director of Health Innovation Center at the New York State Department of Health (NYSDOH). In this role, Hope was responsible for the implementation of the New York State Health Innovation Plan (SHIP), which envisions an all-encompassing integrated care delivery infrastructure that is inclusive of population and behavioral health. The delivery system is premised on a strong foundation of primary care, evolved health information technologies, payment models that incent and promote value, and a strong workforce that is consistent with newly developed team-based care models. Additionally, Hope managed a $100 million State Innovation Model (SIM) testing grant.

Hope previously served as Director of Division of Quality and Patient Safety at NYSDOH, where she was involved in policy formulation, program development, leadership, and direction of state policy initiatives to promote quality and ensure patient safety in healthcare settings throughout New York State. Hope developed place-based strategies to promote health and well-being at the neighborhood level, and developed innovative strategies to finance public health initiatives such as social impact bonds.

Hope also held multiple director and assistant director positions at the AIDS Institute during her tenure at NYSDOH.

Hope earned her Master of Public Administration degree in Public Policy Analysis from Rockefeller College and her Master of Health Care Delivery Science degree from Dartmouth College. She received a Bachelor of Art's degree in Economics from Stony Brook University. In 2014, Hope received a certificate of completion for the Shaping Healthcare Delivery Policy program at Harvard University.