HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

MASSACHUSETTS' DUALS DEMO 2.0 TO GROW THE SCO AND ONE CARE PROGRAMS

This week, our *In Focus* section comes from Ellen Breslin in our Boston office who provides an overview of MassHealth's Duals Demonstration 2.0 ("Duals Demo 2.0") proposal to the Centers for Medicare and Medicaid Services (CMS)

which is designed to "grow and sustain One Care and Senior Care Options (SCO) while encouraging innovation and care delivery improvement." MassHealth currently provides coverage to about 310,000 dually-eligible individuals. Combined, MassHealth and Medicare spend more than $9 billion annually with costs nearly evenly split across the two payers.

The One Care and SCO programs are unique to Massachusetts. The programs provide dually-eligible individuals access to Medicaid and Medicare benefits in an integrated, coordinated and person-centered manner. The fact sheet below describes the key characteristics of each programs.

Fact Sheet of MassHealth's Current One Care and SCO Programs Prepared to Provide Context for Understanding the Duals Demo 2.0		
Program Information	**One Care**	**SCO**
Launch date	2013-Present. Based on the last amendment approved by CMS, the program was slated to end on December 31, 2018. In June 2018, however, CMS approved the program to run until December 31, 2019 to "bridge One Care's authority while the Commonwealth works with CMS to develop the new Demonstration terms."	2004-Present.
Program authority	1115A Duals Demonstration: both a Financial Alignment Initiative (FAI) and a State Demonstration to Integrate Care for Dual Eligible Individuals.	SCOs must be Dual Eligible Special Needs Plans (SNPs).
Eligible population	Adults ages 21-64 years and living with a disability, who are dually eligible for Medicaid and Medicare coverage.	Seniors, 65 and older, who are dually eligible for Medicaid and Medicare coverage, or Medicaid only coverage.
Enrollment policy	Voluntary enrollment, using a passive enrollment approach; no fixed enrollment period today.	Voluntary enrollment; there is no passive enrollment for dually-eligible individuals today. MassHealth currently uses a passive enrollment policy for eligible seniors who are covered by Medicaid only. No fixed enrollment period today.
Enrollment (2018)	Approximately 20,000 members.	Approximately 54,000 members.
Participating plans	Two (2) plans (Commonwealth Care Alliance and Tufts Health Plan under the name of Unify).	Six (6) plans including both plans participating in One Care.
Payment model (key provisions)	Capitated payments from Medicaid and Medicare for care management and for all covered benefits including Medicare Parts A, B, and D, MassHealth, and additional services.	Capitated payments from Medicaid and Medicare for care management and for all covered benefits including Medicare Parts A, B, and D, MassHealth, and additional services

Fact Sheet of MassHealth's Current One Care and SCO Programs Prepared to Provide Context for Understanding the Duals Demo 2.0		
Program Information	**One Care**	**SCO**
	Other financing features include risk corridors. One Care plans do not currently bid as Medicare Advantage D-SNPs. Refer to a One Care contract for more details on current methodologies.	(or Medicaid only for those members with only Medicaid coverage). SCO plans currently operate at full risk. SCO plans currently bid as Medicare Advantage D-SNPs using the established bidding process for Medicare Parts A, B, and D.

On June 14, 2018, MassHealth released a concept paper on the Duals Demo 2.0, which describes the five key objectives around which this demonstration has been designed. MassHealth is currently seeking approval from CMS to move One Care and the SCO program to a newly aligned 1115A Demonstration and is requesting federal flexibilities to achieve these five key objectives.

HMA Summary of MassHealth's Five Key Objectives for Dual Demo 2.0		
#	**Key Objectives**	**Proposal Summary**
1	Grow enrollment of SCO and One Care among dually-eligible individuals	MassHealth proposes to grow enrollment in the program by: (1) expanding the passive enrollment policy to the SCO program in tandem with fixed enrollment periods for both SCO and One Care; and, (2) establishing robust member protections. (MassHealth does not currently use a passive enrollment policy for the SCO program for those who are dually eligible and there is no fixed enrollment period for either the One Care or the SCO program today.)
2	Achieve a more seamless member experience by increasing administrative alignment and integration	MassHealth proposes to: (1) unify communications and member materials about the Medicare and Medicaid benefits and services provided; and, (2) streamline the appeals and grievances process.
3	Strengthen the fiscal stability of the One Care program for both the Commonwealth and CMS	MassHealth proposes to: (1) establish a Medicaid rate-setting methodology that appropriately accounts for the enrolled population and their complex service needs. MassHealth is currently developing a risk adjustment methodology that will account for functional needs and social factors; and, (2) update the One Care financial methodology to more closely reflect the financial methodology used in the Medicare Advantage (MA) program. This proposal would move One Care to the MA bidding process, which is applicable to Dual Special Needs Plans (D-SNP) for Parts A, B, and D. MassHealth also proposes to implement a modified quality performance rating system specific to under 65 dually-eligible individuals. According to MassHealth, One Care plans will be required to be D-SNPs but not FIDE SNPs.

HMA Summary of MassHealth's Five Key Objectives for Dual Demo 2.0		
#	**Key Objectives**	**Proposal Summary**
4	Use innovative approaches to ensure fiscal accountability and sustainability for: CMS, plans and providers, and MassHealth	MassHealth proposes to establish new approaches to protect plans, as well as MassHealth and CMS from financial instability. These new approaches include: (1) the use of value-based purchasing; (2) increased transparency and data sharing; and, (3) an integrated calculation of the percent of the combined Medicare and Medicaid funds that One Care and SCO plans spend on direct care for members. More specifically, MassHealth proposes to implement a plan-specific post-risk corridor Medicare-Medicaid blended Medical Loss Ratio (MLR) to reflect a more accurate representation of a plan's performance and a more integrated approach to plan financing.
5	Enter into a shared savings agreement with CMS and measure value and quality of care achieved system-wide	MassHealth proposes to: (1) create a shared savings arrangement between MassHealth and CMS to reflect system wide value generated; and, (2) evaluate Duals Demo 2.0 for quality of care and value.

Bringing One Care and SCO to Scale: How Many Dually-Eligible Individuals Live in Massachusetts?

The Duals Demo 2.0 proposal includes two changes in the enrollment policy for the One Care and SCO programs by extending the passive enrollment policy to the SCO program, and a fixed enrollment period for both programs. These changes in the enrollment policies could lead to a big increase in the membership for integrated care plans. In terms of the potential increase, a few facts are helpful to consider. As of January 2018, there were 311,000 dually-eligible individuals in Massachusetts, of whom 23 percent were enrolled in an integrated program including consideration of the three programs: One Care, SCO, and the Program-of-All-Inclusive Care for the Elderly (PACE) model. The following chart provides the numbers, indicating that 77 percent of all dually-eligible individuals or close to 240,000 individuals are not enrolled in a MassHealth integrated program. These members receive care on a fee-for-service (FFS) basis from MassHealth. This includes about 131,000 individuals who are under the age of 65 and about 109,000 individuals who are 65 years and older. The Duals Demo 2.0. would presumably affect these members. Note that PACE is not the focus of the Duals Demo 2.0.

Dually-Eligible Individuals Covered Under MassHealth in Massachusetts (January 2018)						
Program	**Under 65**	**65 and older**	**Total**	**Under 65**	**65 and older**	**Total**
One Care	18,733	538	19,271	13%	0%	6%
SCO	-	48,684	48,684	0%	30%	16%
PACE	396	3,847	4,243	0%	2%	1%
FFS	130,572	108,787	239,359	87%	67%	77%
Total	**149,701**	**161,856**	**311,557**	**100%**	**100%**	**100%**
Integrated Care	*19,129*	*53,069*	*72,198*	*13%*	*33%*	*23%*

Beyond the Concept Paper: Looking Ahead

On June 15, 2018, the day after the release of the concept paper, the One Care Implementation Council (IC), which oversees implementation of the One Care program, convened a special meeting to talk about the Dual Demo 2.0. Attendees included IC Council members; special guests Tim Engelhardt, Director for the Medicare-Medicaid Coordination Office at the Centers for Medicare and Medicaid Services and his staff; Daniel Tsai, the Assistant Secretary for MassHealth and the Medicaid Director for the Commonwealth of Massachusetts, and his staff; and many key stakeholders including current One Care and SCO plans, dually-eligible individuals, consumer advocacy groups, and members of the public.

At the One Care IC meeting, Director Tim Engelhardt announced that CMS will be able to extend authorization for the One Care program through December 31, 2019. This extension will provide the time for MassHealth and CMS to discuss and negotiate the Duals Demo 2.0. This will also provide the time for One Care enrollees to make a smooth transition to a new program. Assistant Secretary Dan Tsai made the point that "nothing is simple …" but there must be a "better way to structure care for duals."

Over the next several months, MassHealth and CMS will hold extensive discussions and negotiations, and continue to engage stakeholders. MassHealth hopes that, by 2019, MassHealth and CMS will be ready to execute a Memorandum of Understanding (MOU) granting authorities for "Duals Demo 2.0." MassHealth does not expect Duals Demo 2.0 to be in effect before 2020. MassHealth plans to re-procure the One Care program.

In the coming months, MassHealth plans to engage stakeholders, who will want to know more about how the financing methodology will work in tandem with the proposed risk mitigation provisions including risk adjustment, risk corridors, and stop-loss, as these will drive payment accuracy and plan incentives to meet person-centered needs, and drive the integrated model. On other fronts, stakeholders, including consumer advocates expressed concerns at this One Care IC meeting about the proposed enrollment policy which includes the adoption of a fixed enrollment period for potential One Care and SCO enrollees. Consumer advocates asked that the Duals Demo 2.0 keep innovation at the center of these integrated programs, adding that MassHealth not "place greater emphasis and value on scale over innovation."

MassHealth's concept paper is available at: https://www.mass.gov/service-details/duals-demonstration-20.

MassHealth also recently released a Request for Information (RFI) to health plans and other stakeholders about the development and use of high utilizer risk corridors for One Care:

https://www.commbuys.com/bso/external/bidDetail.sdo?bidId=BD-18-1039-EHS01-EHS01-27810&parentUrl=activeBids

HMA Medicaid Roundup

Delaware

Lawmaker Seeks Study of Potential Medicaid Buy-In Option. *The Delaware News Journal* reported on June 15, 2018, that Delaware Senator Margaret Rose Henry (D-Wilmington-East) wants to study the impact of a potential Medicaid buy-in option in the state. Henry introduced a resolution calling for the formation of a study group to evaluate a buy-in option, which would be available to individuals with incomes too high to qualify for Medicaid and as an alternative to marketplace coverage. Read More

Florida

Florida Awards Molina Healthcare Medicaid Managed Care Contracts in Regions 8, 11 Following Protest. Molina Healthcare, Inc. announced on June 18, 2018, that it had won the Florida Medicaid Managed Care contracts in Regions 8 and 11, effective January 1, 2019. Molina was not originally among the winning bidders, but the company filed a protest with the state. Molina serves an estimated 105,000 Medicaid enrollees in the two regions. Read More

Illinois

Illinois Adds Preventive Dental Care Coverage for Adult Medicaid Beneficiaries. *The State Journal-Register* reported on June 17, 2018, that Illinois will add preventive dental care coverage for adult Medicaid beneficiaries, with funding included in the state's fiscal 2019 budget. The change will largely impact 450,000 Medicaid beneficiaries in the state's fee-for-service Medicaid program. Most beneficiaries enrolled in Medicaid managed care plans in Illinois already receive dental coverage; however, health plans will now be reimbursed for the cost. Read More

Iowa

Iowa Medicaid Director Says Managed Care Is Saving Money. *The Des Moines Register* reported on June 13, 2018, that Iowa is saving money from the state's transition to Medicaid managed care, according to Medicaid director Mike Randol. He added, however, that it's difficult to say exactly how much. Democratic lawmakers in the state have questioned savings projections from the Iowa Department of Human Services, which have shifted over time. Read More

Kentucky

Medicaid Work Requirements Case Begins With Oral Arguments. *The Hill* reported on June 15, 2018, that oral arguments began in the federal court case over Medicaid work requirements in Kentucky. The lawsuit brought by advocates of Medicaid beneficiaries against the Kentucky Department of Health and Human Services seeks to overturn a waiver allowing the state to implement work requirements, premiums, and other changes to the state Medicaid program. Kentucky argued that if the waiver is invalidated, other states will be less likely to expand Medicaid. Plaintiffs, represented by the National Health Law Program, Kentucky Equal Justice Center, and Southern Poverty Law Center, said that the waiver allows the state to unlawfully deny coverage. Under the waiver, Kentucky would also become the first state to charge premiums up to 4 percent and lock people out of coverage for up to six months. Read More

Kentucky Governor Says He Will End Medicaid Expansion If Work Requirements Are Not Approved. *Talking Points Memo* reported on June 14, 2018, that Kentucky Governor Matt Bevin has threatened to end the Medicaid expansion program if a federal court prevents the state from adopting work requirements and other eligibility restrictions. Sixteen Kentucky Medicaid beneficiaries challenged the state's plan to implement Medicaid work requirements, scheduled to take effect July 1. Read More

Maine

Maine Judge Orders Governor LePage to Submit Medicaid Expansion Plan. *The Seattle Times* reported on June 18, 2018, that a Maine judge has ordered the state to submit a formal plan to implement Medicaid expansion, despite an ongoing legal battle over the voter-approved measure led by Governor Paul LePage. As previously reported, Maine Supreme Court Justice Michaela Murphy denied a motion to delay the process. LePage has stated that he will not implement expansion without additional funding from the state legislature. Read More

Mississippi

Mississippi Medicaid to Maintain Limits on Physician Visits, Prescriptions. *The Clarion Ledger* reported on June 19, 2018, that the Mississippi Division of Medicaid (DOM) announced it will maintain existing Medicaid benefit limits of 12 physician visits annually and five prescriptions monthly effective July 1, 2018. Lawmakers had passed legislation aimed at eliminating the limits. However, DOM issued a statement saying the law provided "additional flexibilities" and that it wouldn't make any changes until it "researches these possibilities." Read More

Montana

Montana Job Services Program Helps Medicaid Expansion Members Find Jobs. *The Missoulian* reported on June 18, 2018, that a voluntary state job services program called Help-Link has helped about 200 Montana Medicaid expansion members find a job, according to the state Department of Labor and Industry. Others used Help-Link to find a higher paying job, according to a report commissioned by the Montana Healthcare Foundation. Help-Link has served a total 22,000 Medicaid members, with 2,500 receiving one-on-one counseling. Nearly 80 percent of those who received one-on-one counseling found a job or a better paying job. The report also found that of the state's 96,000 expansion members, about 67 percent already were working, while most of the rest were sick, disabled, in school, or providing care to someone. Read More

Judge Blocks Medicaid Provider Cuts Pending Hearing. *The Sacramento Bee* reported on June 13, 2018, that Montana District Judge James Reynolds ordered the state to reinstate last year's Medicaid reimbursement rates for nursing homes and assisted-living facilities pending a July 11 hearing. The order temporarily reverses a 2.99 percent cut that went into effect in January. The cuts were challenged by the Montana Health Care Association and six companies that own nursing facilities. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Health Care Quality Institute Releases End-of-Life Care Strategic Plan. On June 12, 2018 New Jersey Health Care Quality Institute published a strategic plan to improve end-of-life care for New Jersey residents. The strategic plan was funded by the Nicholson Foundation and responds to New Jersey's poor ranking in delivering more high-intensity care for seniors at the end-of-life than most other states. The state also ranks poorly on rates of completion of Living Wills, Advance Directives, Proxy Directives, and Practitioner Orders for Life Sustaining Treatment (POLST) forms. The strategic plan focuses on four key areas:

1. Technology. Building a sustainable statewide electronic POLST registry for use by providers.
2. Payment. Increasing and expanding reimbursements for end-of-life consultations and rewarding providers for doing so.
3. Education. Implementing training and coaching programs for practicing physicians and nurses and medical students about having discussions with patients on end-of-life care matters.
4. Culture. Conducting an awareness campaign for New Jersey residents about care options at the end of life.

A copy of the strategic plan can be found here.

New Jersey Provides Update on Fiscal Intermediary Transition. The New Jersey Department of Human Services (DHS), Division of Developmental Disabilities has been transitioning to a new fiscal intermediary vendor which began July 1, 2017, to work with individuals who self-direct their services. DHS sent an email notification on June 19, 2018, to let beneficiaries with the Division of Developmental Disabilities in self-direction know that enrollment with new fiscal intermediary, Public Partnerships, LLC, will be voluntary, and that individuals enrolled with the current fiscal intermediary, Easterseals New Jersey, may remain enrolled with them with no changes to their services or budget until further notice.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Director of the Division of Long Term Care Resigns. Andrew Segal, Director of the Division of Long Term Care in the Office of Health Insurance Programs, New York Department of Health, announced that he is resigning from his position effective August 1, 2018. Segal joined the Department of Health in 2016, replacing Mark Kissinger, who moved into a newly created role as Special Advisor to the Commissioner for Long Term Care. No replacement has been announced.

New York Hosts Webinar on Best Practices in Value-Based Payment. The New York Department of Health will be hosting a webinar highlighting the experiences of two participants in the Value Based Payment (VBP) Pilot Program, St. Joseph's Hospital and SOMOS Community Care. Areas covered in the webinar will include:

- Target budget calculations;
- Shared savings/loses determinations;
- Best practices/lessons learned.

The webinar will be held on Wednesday, June 27th from 2:00-3:00pm. To register for the webinar click here.

Assembly Passes Single Payer Bill. The New York Assembly passed the New York Health Act, which would establish a universal single payer health plan that would provide comprehensive health coverage for all New Yorkers. The bill, sponsored by Assembly Health Committee Chair Richard Gottfried, would combine state and federal funding currently received for Medicare, Medicaid and Child Health Plus to create the New York Health Trust Fund. The state would also seek federal waivers that will allow New York to completely fold those programs into New York Health. Under the bill, every New York resident would be eligible to enroll; the program would impose no network restrictions, deductibles or co-pays. Benefits would include comprehensive outpatient and inpatient medical care, primary and preventative care, prescription drugs, laboratory tests, rehabilitative, dental, vision, hearing and all benefits required by current state insurance law, by publicly funded medical programs or provided by the state public employee package. It is the fourth year in a row that the Assembly has passed a single-payer bill. Although the bill has a Senate sponsor, it has not been brought to the Health Committee for a vote. Read More

Center for New York City Affairs Releases Report on Health Homes Serving Children. The Center for New York City Affairs has released a report on the current status of health homes serving children in New York. The report describes the Health Homes Serving Children program as a kind of broad-spectrum care management, designed for children with a combination of complex health conditions and chaotic life circumstances. Care managers work with children and families, helping them navigate the maze of needed services, not only of doctor's appointments but therapists, special-education evaluations, public benefit applications, and so on. The report notes that 18 months after the program's 2016 launch, many providers are struggling just to keep their care management services running. Enrollment is a small fraction of what was anticipated; the program is hobbled by a lack of investment in technology that would help community-based providers operate in the big-budget world of health care; and many of the nonprofits offering frontline services are unable to cover their overhead costs. The report reviews a number of specific challenges facing health homes serving children, and offers concrete recommendations to strengthen the program, in six specific areas: enrollment, assessments, complex trauma, technology, transparency, and administrative requirements. They observe that while it is too early to measure concrete outcomes, the program struggles with several operational obstacles to achieving its goals. The significant majority of enrolled children are being served in Health Homes run by community-based organizations, which need far greater support until the Health Homes program becomes more stable. The report concludes that fully realized, the Health Homes Serving Children program has the potential to pay for itself several times over, helping vulnerable children to access better, more appropriate care and, in the long run, to live healthier, more successful lives. Read More

New York Paid $1.28 Billion in Improper Medicaid Managed Care Premiums Over 6 Years, Audit Finds. *The Times Union* reported on June 13, 2018, that New York paid Medicaid managed care plans $1.28 billion in premiums over six years for individuals who already had comprehensive, private health insurance coverage, according to an audit by the state Comptroller's Office. An estimated $1.17 billion is believed to be unrecoverable. The audit found that almost $591 million in payments were made despite knowledge of overlapping health coverage. The improper payments were made from January 2012 through September 2017. Read More

North Carolina

House Passes Bill to Study Cost of Medicaid Expansion. *The News & Observer* reported on June 12, 2018, that the North Carolina House passed a rural health care bill, which included an amendment ordering the state Department of Health and Human Services to study the costs and benefits of Medicaid expansion. The bill now moves on to the state Senate. Rep. Darren Jackson (D-Wake County) proposed the amendment after House Speaker Tim Moore shot down another Democratic attempt to expand Medicaid in the state. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Auditor General to Review Prescription Drug Pricing. Pennsylvania Auditor General Eugene DePasquale is conducting a review of practices by pharmacy benefit managers (PBMs) in negotiating prescription prices with insurers and drug companies. According to DePasquale, the Department of Human Services (DHS) has no oversight over the four major PBMs in Pennsylvania: CVS/Caremark, Perform Rx, Optum Rx, and ESI. DePasquale said the state has no oversight authority because of the subcontracting arrangement with the benefit managers, nor does it have access to data on the drug prices being charged. PBMs receive state and federal funding through subcontracts originated in the Department of Human Services (DHS) and paid for through Medicaid. DHS contracts managed care organizations (MCOs) and the MCOs contract with PBMs. DHS reports the state paid $3.4 billion to PBMs in 2017, a nearly 90 percent increase from 2013. The review aims to increase transparency in drug pricing and ensure small community pharmacies receive equal treatment. In addition to the Auditor General's review, there are two bills in the PA House pertaining to pharmacy benefit managers. House Bill 2211 bans PBMs from forcing gag orders on local pharmacies, and House Bill 2212 addresses inconsistent reimbursement rates for independent pharmacies. Read More

Texas

House Schedules Hearings on Medicaid Managed Care; Lawmakers Call for Greater Oversight. *The Texas Tribune* reported on June 19, 2018, that three separate Texas House committees have scheduled hearings this month to address reported problems in the state's Medicaid managed care program, with several lawmakers urging greater oversight. The Texas House Human Services Committee will hold its hearing June 20, while the House General Investigating and Ethics Committee and a subcommittee of House Appropriations will hold hearings June 27. The call for hearings follow a *Dallas Morning News* investigation that uncovered evidence that some of the state's most vulnerable Medicaid recipients, including foster children, chronically ill children, the disabled and the elderly, didn't have adequate access to care. Read More

Most Texas Residents Support State Medicaid Expansion, Survey Finds. *Kaiser Health News* reported on June 14, 2018, that approximately two-thirds of Texas residents think the state should expand Medicaid to cover more low-income individuals, according to a survey conducted by the Kaiser Family Foundation and the Episcopal Health Foundation. The survey found that 61 percent of Texans said lowering the amount individuals pay for healthcare should be a top health care priority for the state Legislature. Texas is one of 17 states that have not expanded Medicaid under the Affordable Care Act. Read More

Utah

Voters Would Overwhelmingly Support Medicaid Expansion Ballot Measure, Survey Finds. *Deseret News* reported on June 18, 2018, that nearly 63 percent of Utah voters would support a ballot measure expanding Medicaid to individuals with incomes up to 138 percent of the federal poverty level, according to a Utah Policy survey conducted by Dan Jones & Associates. About 150,000 individuals would benefit from the measure. Read More

National

MACPAC Calls for End to Blending of Brand, Authorized Generic Pricing in Medicaid Drug Rebate Program. *Modern Healthcare* reported on June 19, 2018, that the Medicaid and CHIP Payment and Access Commission (MACPAC) called for an end to the law requiring drug manufacturers to calculate the average manufacturer price of a brand-name drug in the Medicaid drug rebate program by blending both brand and authorized generic prices. A blended price based on both brand-name drugs and authorized generics produced by the same company creates a loophole allowing drug makers to lower rebate payments, the report says. The report also urged Congress to grant the U.S. Department of Health & Human Services authority to impose sanctions on drug manufacturers that provide inaccurate drug classification data. Read More

Most Rural Hospital Closures Are in Non-Expansion States, Report Finds. *KBIA* reported on June 20, 2018, that 90 percent of rural hospital closures occurred in states that didn't expand Medicaid, according to a report from Protect Our Care, which analyzed 84 rural hospital closures since 2010. Medicaid expansion can provide a lifeline to vulnerable hospitals, said Tim McBride, co-director of the Center for Health Economics and Policy at Washington University. Read More

Conservatives to Release New Proposal for ACA Repeal, Replace. *The Wall Street Journal* reported on June 19, 2018, that the Health Policy Consensus Group (HPCG) is expected to release a new proposal aimed at repealing the Affordable Care Act and replacing it with block grants and expanded health savings accounts. HPCG includes analysts from Heritage Foundation, American Enterprise Institute, Galen Institute and Manhattan Institute. Read More

Rush University Medical Center Says CMS Hospital Star Ratings Are Inaccurate. *Modern Healthcare* reported on June 15, 2018, that the federal star quality rating system for hospitals is based on an improper weighting of measures, according to an analysis by Rush University Medical Center. Rush found, for example, that a hospital's score relies heavily on just one of eight measurements, most recently complications from hip and knee replacement. The Centers for Medicare & Medicaid Services announced that it would postpone the July release of the hospital star ratings. Read More

SAMHSA to Award $930 Million in State Opioid Treatment Grants. *Modern Healthcare* reported on June 15, 2018, that U.S. states and territories may now apply for a share of the $930 million in federal grants available for opioid prevention and treatment from the Substance Abuse and Mental Health Services Administration (SAMHSA). Fifteen percent of the funding will go to 10 states with the most overdose deaths or the highest proportion of residents with untreated substance use disorder. States can receive a minimum of $4 million in grants for projects lasting up to two years and focusing on identifying and addressing gaps in treatment access. SAMHSA will award up to 59 grants. Read More

To Address Rising Medicaid Costs, Some States Consider ACO Model. *Kaiser Health News* reported on June 15, 2018, that some states, such as Minnesota, are responding to rising Medicaid costs by implementing new Medicaid payment models. The models reward accountable care organizations (ACO) that help keep costs down and reach quality targets. Health care providers do this by ensuring enrollees' underlying medical and social needs, like housing, transportation and nutrition, are met. Read More

Industry News

Attorney General Approves Centene Acquisition of Fidelis Care. New York Attorney General Barbara Underwood has approved Centene's purchase of Fidelis Care, the final regulatory step required to complete the transaction. The acquisition had already been approved by the Department of Health and the Department of Financial Services. The Attorney General's review falls under the state's not-for-profit conversion law, which regulates the transfer of assets from a not-for-profit to a for-profit entity, to ensure the public good is being protected. The transaction was supported by Governor Andrew Cuomo, who saw the deal as a way for New York to recoup some of the value that Fidelis has amassed over 20 years participating in the state's Medicaid managed care program. Ultimately the state will collect $2 billion of the $3.75 billion sale: $1.5 billion from Fidelis, and $500 million from Centene Corp., payable upon completion of the transaction.

The Office of the Attorney General of New York posted a petition submitted by Fidelis Care outlining details of the sale, and plans for the foundation, for public comment. According to Politico, over the course of the 14-day public comment period, 5,887 of the nearly 6,000 submissions were supportive of the transaction. Fidelis plans to use the proceeds from the transaction to establish a charitable foundation, the Mother Cabrini Health Foundation. The foundation anticipates making up to $150 million/year in grants annually targeted at improving the health and well-being of vulnerable New Yorkers and bridging gaps in services that address the health and wellness needs of low-income communities. Read More

Community Health Center Visits Increase 33 Percent, Analysis Finds. *Modern Healthcare* reported on June 14, 2018 that, according to an analysis by George Washington University's Milken Institute School of Public Health, community health center visits increased 33 percent between 2010 and 2016. Many experts believed that community health center visits would decline as previously uninsured patients gained coverage under the Affordable Care Act. Community health centers primarily serve medically undeserved areas. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
Spring/Summer 2018	North Carolina	RFP Release	1,500,000
June 2018	New Hampshire	RFP Release	160,000
June 2018	Puerto Rico	Contract Awards	~1,300,000
June 2018	Kansas KanCare	Contract Awards	380,000
June 4, 2018	Wisconsin LTC (Milwaukee and Dane Counties)	Contract Award	~1,600
June 7, 2018	Alabama ICN (MLTSS)	Proposals Due	25,000
June 8, 2018	Mississippi CHIP	RFP Release	47,000
June 26, 2018	Florida Children's Medical Services	Contract Award	50,000
June 29, 2018	Minnesota Special Needs BasicCare	Contract Award	53,000 in Program; RFP Covers Subset
July 1, 2018	Pennsylvania HealthChoices (Delay or Rebid Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
July 2, 2018	Texas STAR and CHIP	Proposals Due	3,342,530
July 11, 2018	Alabama ICN (MLTSS)	Contract Award	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
October 2018	Puerto Rico	Implementation	~1,300,000
October 1, 2018	Alabama ICN (MLTSS)	Implementation	25,000
October 1, 2018	Arizona Complete Care	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 2019	Kansas KanCare	Implementation	380,000
January 1, 2019	Wisconsin LTC (Milwaukee and Dane Counties)	Implementation	~1,600
January 1, 2019	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2019 Start	~1,600,000
January 1, 2019	Florida Children's Medical Services	Contract Start	50,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay or Rebid Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January 1, 2019	Minnesota Special Needs BasicCare	Contract Implementation	53,000 in Program; RFP Covers Subset
January 24, 2019	Texas STAR and CHIP	Contract Start	3,400,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
July 1, 2019	Mississippi CHIP	Implementation	47,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Impementation	~30,000
January 1, 2020	Texas STAR+PLUS, STAR, and CHIP	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Washington Integrated Managed Care (Remaining Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA News

Medicaid Managed Care CEOs to Discuss Industry Opportunities, Prospects During HMA Conference on the Rapidly Changing World of Medicaid

Top executives from the nation's largest Medicaid managed care plans will participate in a keynote Q&A discussion on the future of Medicaid managed care, including a look at the types of investments, partnerships, and initiatives that will best position the industry for success.

The session will take place during HMA's 2018 conference on *The Rapidly Changing World of Medicaid: Opportunities and Pitfalls for Payers, Providers, and States*, October 1-2 at The Palmer House in Chicago.

More than a dozen Medicaid plan C-suite executives, including CEOs and division presidents, will speak, including representatives from Aetna, Anthem, CareSource, Centene, Community Health Plan of Washington, CountyCare Health Plan, Gateway Health Plan, L.A. Care Health Plan, and UnitedHealth Group.

Early Bird registration is now open. Last year's conference attracted more than 400 attendees. Visit the conference website for complete details: https://conference.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- CO RCCO Enrollment is Down 3.4%, May-18 Data
- IL Medicaid Managed Care Enrollment is Up 19.1%, May-18 Data
- SC Medicaid Managed Care Enrollment is Up 1.2%, May-18 Data
- MI Medicaid MCOs Generate $7.6 Billion in Premiums, 2017 Data
- MS Medicaid MCOs Generate $2.3 Billion in Premiums, 2017 Data
- MLRs at KY Medicaid MCOs Average 87.6%, 2017 Data
- PMPMs at KY Medicaid MCOs Average $476, 2017 Data
- MLRs Average 103% Among IA Medicaid MCOs, 2017 Data
- PMPM Premiums Average $595 Among IA Medicaid MCOs, 2017 Data
- MLRs Average 88.3% Among HI Medicaid MCOs, 2017 Data
- PMPM Premiums Average $448 Among HI Medicaid MCOs, 2017 Data
- MLRs Average 80.2% Among DC Medicaid MCOs, 2017 Data
- PMPM Premiums Average $400 Among DC Medicaid MCOs, 2017 Data
- ID Medicaid Enrollment by MCO, County and Eligibility Group, 2014-17
- GA Medicaid Enrollment by MCO and Eligibility, 2014-17

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- WA 2019/2020 Integrated Managed Care (IMC) Scoring Sheets, 2018
- FL Statewide Medicaid Managed Care Re-procurement ITN Additional Awards, 2018
- DC Third Party Liability (TPL) Verification RFP, 2018
- NH Correctional Medical-Dental Professional Services RFP and Contract, 2018
- NE Medicaid Managed Care Actuarial and Consulting Services RFP and Evaluation Criteria, Jun-18
- WA Medicaid Enterprise Independent Verification and Validation (IV&V) Services RFQQ, Jun-18
- AK Medicaid Coordinated Care Demonstration Project Evaluations, 2018
- MS Third Party Data Matching and Recovery Services IFB, Jun-18

Medicaid Program Reports and Updates:

- AL Medicaid "Pivot Entity" Meeting Materials, Jun-18
- CA Managed Care External Quality Review Reports, 2017
- CA Medi-Cal Managed Care Quality Strategy Reports, 2017
- NY Medicaid Managed Care Premiums Audit, Jun-18
- NY Medicaid Managed Care Health Plans CAHPS Survey Reports, Mar-18
- NY Medicaid Managed Care Health Care Disparities Report, 2017
- NY Managed Care Statewide Executive Summary Report, 2017
- NY Managed Care Quality Incentives Report, 2017
- NY Health Plan Service Use Report, 2017
- NY Health Plan Quality Comparison Report, 2017
- PA HealthChoices Performance Trending Report, 2017

A subscription to HMA Information Services puts a world of Medicaid information at your fingertips, dramatically simplifying market research for strategic planning in healthcare services. An HMAIS subscription includes:

- State-by-state overviews and analysis of latest data for enrollment, market share, financial performance, utilization metrics and RFPs
- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

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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 Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Costa Mesa, California; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Raleigh, North Carolina; Sacramento and San Francisco, California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.
http://healthmanagement.com/about-us/

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