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 THE RAPIDLY CHANGING WORLD OF MEDICAID

This week, our *In Focus* section provides a recap of the third annual HMA Conference, *The Rapidly Changing World of Medicaid: Opportunities and Pitfalls for Payers, Providers and States*, held this Monday, October 1, and Tuesday, October 2, in Chicago, Illinois. More than 450 leading executives representing managed care organizations, providers, state and federal government, community-based organizations, and other stakeholders in the health care field gathered to address the opportunities and challenges facing health plans, states, and providers as they strive to provide the best possible care to Medicaid beneficiaries and other vulnerable populations at a time of significant uncertainty and change. Conference participants heard from keynote speakers,

engaged in panel discussions and connected during informal networking opportunities. Below is a summary of highlights from this year's conference.

Keynote Address

"Medicaid in an Era of Community Engagement and Shared Responsibility"

Michael Leavitt, General Partner of Leavitt Partners, former governor of Utah, and former Secretary of the U.S. Department of Health and Human Services spoke about how the nation is 25 years into a 40-year health care transformation, with the 2018 election representing another phase in the journey toward value-based care. While the 2018 election will see a reemergence of various ideas – including Medicare-for-all among Democrats and market-based solutions among Republicans – a middle ground suggests support for the key components of the Affordable Care Act, continued expansion of Medicaid, and stabilization of the ACA Exchanges. "The ACA lives on," Leavitt said adding, "This is how Democracy works." According to Leavitt, Democrats and Republicans agree that the need for cost control is driving efforts towards value-based health care; however, they remain divided on the structure of an integrated, value-based care model. He also noted that health care stakeholders need a shared definition of "value" and its metrics, information systems capable of supporting population health management, and a willingness to go beyond a "lukewarm defense" of the value-based concept.

State Medicaid Director Keynote Q&A Session

"How States Are Fostering Community Engagement and Innovation in Medicaid"

Next up, HMA convened five state Medicaid directors to discuss how they are using waivers to restructure Medicaid programs to meet the unique needs and priorities of their states, with an emphasis on member engagement, payer and provider accountability, and innovation. Speakers highlighted the impact of Medicaid work requirements and community engagement, including the challenges of alerting members to their responsibilities under these new requirements. Justin Senior, Secretary, Florida Agency for Health Care Administration, cited the unique challenges facing non-expansion states that might be considering the implementation of Medicaid work requirements, including the administrative level of effort related to managing such a program that will impact a very small number of current Medicaid beneficiaries. Other topics included efforts by Medicaid to change how providers practice, setting specific value-based payment targets for managed care plans, and efforts to address the opioid epidemic. Other speakers included Stephanie Muth, Associate Commissioner, Medicaid/CHIP Medical and Social Services Division, Texas Health and Human Services Commission; Allison Taylor, Director of Medicaid, Indiana Family and Social Services Administration; and Matt Wimmer, Administrator, Division of Medicaid, Idaho Department of Health and Welfare.

Medicaid Managed Care Keynote Q&A Session

"The Next Wave: How Medicaid Plans are Positioning Themselves for Success"

Executives from leading Medicaid health plans discussed what's next for Medicaid managed care, including a look at the types of investments,

partnerships, and initiatives that will best position the industry for success. A key theme surrounded the challenges of the request for proposal (RFP) process states use to award contracts to Medicaid managed care plans. One speaker noted, for example, that the RFP process does not invite effective partnership with states, but rather sets rules and limitations. Another noted RFPs are full of unfunded mandates, including requirements to provide a variety of social services. While a third pointed to considerable amounts of time, energy, and money spent on the RFP process that takes away from the focus on identifying areas where plans can have the most positive impact on Medicaid. Another key area of concern was the impact of social determinants of health. "Social determinates of health are real and we must acknowledge them," stated Jack Stephenson, President and Chief Executive of Empire BCBS HealthPlus. John Baackes, Chief Executive of L.A. Care Health Plan, added that income inequality must be addressed. Other speakers included Janet Grant, Head, Aetna Medicaid, Great Plains Region; and Catherine Anderson, Senior Vice President, Policy and Strategy, UnitedHealth Community and State.

Breakout Session

"Medicare-Medicaid Integration: Emerging Models and Opportunities"

Speakers during this session highlighted the complexity of the current Medicare and Medicaid systems for dual eligible beneficiaries and the status of current and future state and federal efforts to implement integrated managed care models. These efforts include comprehensive Medicare and Medicaid services delivered by Medicare-Medicaid plans (MMPs), Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs), Fully Integrated Dual Eligible Special Needs plans (FIDE SNPs), and the Program of All-Inclusive Care for the Elderly (PACE). Dually eligible beneficiaries need choice of a continuum of integrated care options that reflect their diverse needs, speakers noted. Consumer education is crucial, with a need for clear, understandable information on program options and benefits, particularly care coordination and care management. There have been successes in improved access to care and more appropriate use of services for individuals through these models. Continued efforts to extend, build on and further streamline models must be done with the beneficiary at the center of policy planning and program design. Speakers included Bernadette Di Re, Chief Executive, UnitedHealthcare Community Plan of Massachusetts; Peter Fitzgerald, Executive Vice President, Policy and Strategy, National PACE Association; Michael Monson, Senior Vice President, Medicaid and Complex Care, Centene Corp.; and Cheryl Phillips, MD, President, Chief Executive, SNP Alliance, Inc.

Breakout Session

"Behavioral Health: How Value-Based Contracting Is Driving Payer-Provider Partnerships"

Speakers discussed how value-based payments can be a market-based solution for behavioral health, helping to address the high cost of treating serious mental illness and substance use disorders. Ann Sullivan, Commissioner, New York State Office of Mental Health stated that under the value-based payment structure, Medicaid managed care organizations must aim to improve quality, reduce costs, focus on patient experience, and build care team well-being. Value must be go beyond staying out of the hospital and focusing on recovery, including employment, housing, and community stability. Other speakers included Lou Dierking, Senior Vice President, Behavioral Health Payer

Channel Lead, Optum; David Guth, Chief Executive, Centerstone America; Jim Spink, Former President, Mid-Atlantic Region, Beacon Health Options.

Breakout Session

"Addressing Social Determinants of Health: Emerging Payer-Provider Partnerships"

Using the Centers for Medicare & Medicaid Services Innovation's Accountable Health Communities framework to define social determinates of health, this panel discussion focused on efforts to improve outcomes by addressing health-related social needs such as housing and employment. Kathye Gorosh, Senior Vice President, Strategic Initiatives, AIDS Foundation of Chicago (AFC), discussed how social determinants of health play a key role in improving health equity for individuals with HIV or vulnerable to contracting the virus. She outlined a partnership between AFC's Center for Health and Housing and University of Illinois Hospital & Health Sciences System, which resulted in significant reductions in ER visits, inpatient days and hospital costs by bridging housing and supportive services to health care. Karin VanZant, Vice President, Executive Director, Life Services, CareSource, discussed how efforts to connect with non-traditional partners, such as major employers, to address members' most pressing needs. By hosting job fairs and linking members to high-quality employment opportunities, CareSource is creating a pathway to improve health outcomes and encourage self-sufficiency for their members, she said. James Kiamos, Chief Executive, CountyCare Health Plan, Cook County Health and Hospitals System, discussed CountyCare's role as a vehicle for engagement and stability in the public delivery system. As Cook County's largest Medicaid plan, CountyCare has partnered with Medical Home Network to address social determinants of health and improve health outcomes through care coordination. Cheryl Lulias, President, Medical Home Network and Chief Executive, MHN ACO, reviewed the practice-level care management her team provides to CountyCare members and the power of technology and data sharing in screening, risk stratifying and predicting rising risk in the member population.

Breakout Session

"How Health Plans and Providers Are Joining Forces to Improve Patient Care"

Speakers discussed some of the challenges and solutions to creating successful partnerships, while noting that the move toward value-based payment models has resulted in alliances that were once considered unlikely between payers and providers. Panelists emphasized the need for transparency, establishing a single mission and vision with aligned goals, emphasizing member communication, and focusing on improving care while reducing costs. Only after this initial foundation is built can these partnerships develop new models of care that improve patient outcomes and lower costs. Speakers included Edward Fishman, Managing Director, Cain Brothers; Brent Layton, Executive Vice President, Chief Business Development Officer, Centene Corp.; Pete November, Senior Vice President, Chief Administrative Officer, Ochsner Health System; James Schroeder, Vice President, Safety Net Transformation, Kaiser Permanente; and Ed Stellon, Executive Director, Heartland Alliance Health.

Breakout Session

"Beyond the Basics: The Future in Medicaid Pharmacy Management and Pharmaceutical Care"

Speakers discussed new pharmacy programs and initiatives aimed at improving patient care and controlling costs, with themes including how Medicaid drug rebates and waste act as barriers to controlling Medicaid pharmacy costs. Other highlights included the emerging role of ACOs, new clinical programs, State Innovation Model (SIM) grants, partnerships with community pharmacies to improve treatment adherence, new models that bring value to specialty drug spending, and a discussion of the need to engage pharmacists in patient care. Speakers included Paul Jeffery, Director of Pharmacy for MASSHealth; John Stancil, Director of Pharmacy, North Carolina Department of Health and Human Services; Scott Streator, Managing Principal, Government Program Services, MedImpact; Jim Gartner, VP Pharmacy and Retail Strategy, CareSource; Krista Ward, Senior Director, Medicaid, Express Scripts; and Andrew Fox, Director, Healthcare Segment Development, Walgreens.

Breakout Session

"Best Practices in Medicaid IT and Business Process Transformation"

Speakers outlined strategies for addressing the numerous challenges faced by states, managed care plans, and providers in the design and implementation of Medicaid information technology systems. A theme of the discussion was how Medicaid IT efforts are hindered by regulatory changes, insufficient focus, and resource constraints – despite billions of dollars of investment. Speakers cited realistic expectations, access to data, clearly defined projects and staff responsibilities, communication, use of pilots, investigating problems at an early stage, and recognizing built-in support structures as critical success factors for Medicaid IT initiatives. Luis Sylvester, Executive Account Manager, U.S. Virgin Islands, Molina Medicaid Solutions, discussed a partnership between West Virginia and the U.S. Virgin Islands that led to the first Medicaid Management Information System (MMIS) for a U.S. territory. By utilizing the existing MMIS platform West Virginia had created, the U.S. Virgin Islands implemented a certified MMIS within 10 months, allowing the territory to expand Medicaid and restore CHIP funding. This initiative resulted in successful completion of CMS annual audits, accurate and timely CMS reporting and payment of provider incentives. Other speakers included Jared Linder, CIO, Indiana Family and Social Services Administration and Jennifer Harp, Deputy Executive Director, Office of Administrative and Technology Services, Kentucky Cabinet for Health and Family Services.

Keynote Address

"What's Next for Integrated Care: A Status Report and Forecast"

John Jay Shannon, M.D., Chief Executive of Cook County Health & Hospitals System (CCHHS), highlighted the glaring health equities among Cook County residents, including differences in life expectancy of up to 15 years depending on a person's neighborhood. While charity care has decreased across the country since the introduction of the Affordable Care Act, Shannon said, CCHHS's payer mix still consists of 80 percent Medicaid or uninsured/self-pay patients who rely on the system as a safety net system. With a diminishing tax-payer allocation to its budget in recent years, CCHHS has emphasized the importance of adapting services and programs to meet the needs of its target population while continuing to operate at a high level of efficiency. In 2012, for example, CCHHS introduced CountyCare, its Medicaid Managed Care health plan, which now serves one in three Medicaid enrollees in Cook County. CCHHS also formed the Behavioral Health Consortium with 15 community-based organizations, creating a single behavioral health referral line that can immediately link individuals to appropriate care. CCHHS has established partnerships to divert individuals from jail through triage centers that provide transitional care and wrap-around services. Shannon also emphasized the importance of social determinants of health and partnering to address these needs at the community level.

Integrated Care for High-Cost Populations Keynote Session

"Managing Chronically Ill Medicaid Patients - Emerging Payer-Provider Models"

Speakers addressed emerging models for serving chronically ill Medicaid populations. "Complex patients are high cost because they are not getting the right care," said Susan Mende, Senior Program Manager with the Robert Wood Johnson Foundation. High cost populations often have underlying social needs, yet health care and social services are often fragmented and do not address social determinants of health, she said. Leanne Berge, Chief Executive, Community Health Plan of Washington, outlined the state's collaborative care model, which integrated mental health services in primary care settings to reduce inpatient medical admissions, inpatient psychiatric cost increases, and hospital days. Rebecca Kavoussi, President, West Landmark Health, which contracts with health plans in value-based arrangements to manage complex, chronically-ill members, sends physicians, nurses, case managers, and other providers to a patient's home – an effort that has reduced inpatient admissions, ER visits, and SNF days. Preston Cody, Division Director, Medicaid Program Operations & Integrity, Washington State Health Care Authority also contributed to the discussion as a panelist.

Keynote Session

"The Role of Value-Based Payments in Fostering Delivery System Reform"

Speakers discussed the role of value-based payment models in improving population health and outcomes of Medicaid beneficiaries, including how their organizations are positioning themselves to participate in emerging value-based models. Mandy Cohen, M.D., Secretary, North Carolina Department of Health and Human Services, revealed how North Carolina structured its 1115 waiver application to integrate value-based payments, with a goal of increasing value-based payment arrangements by 20 percent in its second year. By integrating best practices from other 1115 waivers and establishing regional pilots to test non-medical interventions, North Carolina will be able to align payment incentives and social determinants of health to improve health outcomes, she said. Lisa Trumble, Senior Vice President of Accountable Care Performance, Cambridge Health Alliance (CHA), said that 45 percent of the health system's business is now in value-based models. She outlined current strategies, including payer-provider relationships, health screenings and assessments, investment in community partnerships, and the utilization of evidence-based guidelines. James Sinkoff, Deputy Executive Officer, HRHCare Community Health, highlighted the internal infrastructure needed for a delivery system to properly implement value-based payments, including departments focused on analytics and informatics, clinical quality, care management, and credentialing. He also stressed the importance of building trust, especially in payer-provider relationships, and aligning with payers to save money, improve quality, enhance the patient experience, and simplify systems. Emily Stewart, Vice President of Policy, Planned Parenthood Federation of America, demonstrated how Planned Parenthood has looked to improve the health of women of a reproductive age through value-based mechanisms. Through innovative partnerships and programs, Planned Parenthood has challenged the traditional value-based models to respond to the needs of women, including offering behavioral health co-location in offices and shifting current policy and culture to address the health crisis women are facing in the United States.

HMA Medicaid Roundup

Alabama

Alabama Receives CMS Approval to Offer More Community Options to LTC Recipients. *WTVY* reported on October 1, 2018, that Alabama received federal approval for its Integrated Care Network (ICN) program, a statewide initiative aimed at offering more community options for long-term care (LTC) services. The goal of the ICN program, which the Centers for Medicare & Medicaid Services approved in September, is to increase the percentage of Medicaid recipients who receive in-home care. ICN is aimed at Medicaid patients living in nursing facilities or individuals who receive in-home services through Medicaid's Elderly and Disabled waiver or Alabama Community Transition waiver. The program will offer case management, outreach and education to an estimated 23,000 Alabama Medicaid recipients. Read More

Florida

Florida Faces Legal Challenge from Lighthouse Health Plan Over Medicaid Auto Assignment. *Health News Florida* reported on October 3, 2018, that Lighthouse Health Plan filed a legal petition in state administrative court challenging Florida's decision to automatically assign Medicaid patients in the northwestern part of the state to Humana. Both Lighthouse and Humana were awarded contracts by the Florida Agency for Health Care Administration to serve the state's Medicaid Managed Medical Assistance and Long-Term Care programs in regions one and two. The state will begin transitioning those regions to the new health plan contracts in February. Read More

Iowa

Iowa Long-Term Care Ombudsman Still Isn't Billing for Advocacy Work. *The Des Moines Register* reported on September 28, 2018, that the Iowa Ombudsman for Long-Term Care still isn't billing the federal government for reimbursable advocacy work on behalf of seniors. Nine months ago, Ombudsman Cynthia Pederson said her office had solved the billing problem, which was costing the state an estimated $224,000 annually. Read More

Iowa Medicaid Managed Care Is Unpopular Among Residents, Poll Finds. *The Des Moines Register* reported on September 26, 2018, that the popularity of Medicaid managed care among Iowans has dropped to 28 percent, according a poll sponsored by the *Register* and *Mediacom*. Forty-eight percent of those polled would like the state to return to fee-for-service Medicaid. Iowa Governor Kim Reynolds acknowledges that the transition to managed care has been difficult, but it is making the Medicaid program more efficient and sustainable. Read More

Kentucky

Kentucky Responds to Kentucky HEALTH Concerns Submitted During Federal Comment Period. *Insider Louisville* reported on October 1, 2018, that Kentucky has responded to concerns submitted by the public in regard to the state's planned Medicaid overhaul, known as Kentucky HEALTH. The state recorded over 11,500 online responses during the comment period announced by the Centers for Medicare & Medicaid Services following a federal judge blocking the approval of Kentucky's Medicaid Section 1115 waiver. In the responses, Kentucky estimates that the program could save almost $2 billion in federal and state tax dollars. Read More

New Jersey

New Jersey Awarded $30.6 Million in Federal Grants to Fight Opioid Crisis. On September 21, 2018, New Jersey's Murphy administration announced three federal grants the state has received to help fight the opioid epidemic with initiatives designed to prevent overdoses and expand treatment and recover services. The three grants include: Division of Mental Health and Addiction Services, Federally Qualified Health Centers and Department of Health. In addition, the Murphy administration has committed $100 million in state resources to address the opioid epidemic by expanding outpatient treatment, enhancing real-time data collection and focusing on risk factors and social support that will help New Jersey residents on a path to recovery. Read More

Receiving Agency	Federal Source	Grant Amount	Initiative
Division of Mental Health and Addiction Services	Substance Abuse and Mental Health Services Administration (SAMHS)	$21,566,035	Series of initiatives to expand access to Medication Assisted Treatment (MAT), Narcan, and alternatives to opioid pain medication; training for First Responders to assist and promote recovery services, re-entry services for detainees, expansion of telehealth services, and expansion of programs designed to reduce reliance on opioid pain medication
Federally Qualified Health Centers	Health Resources and Services Administration (HRSA)	$5,633,509	Expand access to integrated substance use disorder and mental health services in FQHCs
Department of Health	CDC	$3,412,500	Assist counties to expand treatment, prevent Neonatal Abstinence Syndrome and expand alternatives to opioid pain medication

Medicaid Managed Care Annual Open Enrollment Period Begins. On October 1, 2018, the New Jersey Division of Medical Assistance and Health Services (DMAHS) launched its annual open enrollment period, which runs through November 15, 2018. During this period existing Medicaid enrollees may choose a new health plan with an effective date of January 1, 2019. Five Medicaid managed care organizations are being offered to enrollees:

1. Aetna Better Health of New Jersey: Serving all counties
2. Amerigroup Community Care: Serving all counties
3. Horizon NJ Health: Serving all counties
4. UnitedHealthcare Community Plan: Serving all counties
5. WellCare Health Plans, Inc.: Serving all counties except Hunterdon

A copy of the Annual Open Enrollment notice can be found here.

New Jersey Publishes Changes to Home Care Services Rules. The New Jersey Register published the latest rule adoptions for Home Care Services, including a summary of over 100 public comments and agency responses for Home Care Services regulations pertaining to N.J.A.C. 10:60. Comments were received from The Arc of New Jersey, Community Health Law Project, Disability Rights New Jersey, Health Force, Home Care and Hospice Association of NJ, and New Jersey Association of Community Providers. Among the changes are:

- The addition of instrumental activities of daily living related tasks under the definition of Personal Care Assistant (PCA) services
- Clarification of IADL as non-hands-on personal care assistance services that are essential to the beneficiary's health and comfort
- Recognition that advance practice nurses can certify medical necessity for home care assistance in addition to physicians, by changing the term "physician" to "physician/practitioner" throughout
- Revision of the hourly reimbursement rate for PCA services from $18.00 to $19.00
- Revision of the term "foster care home" to "resource family home" in keeping with the term now used by the Department of Children and Families

The rule adoptions were published in the New Jersey Register and can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Medicaid Managed Care Advisory Review Panel Holds Quarterly Meeting. The New York Medicaid Managed Care Advisory Review Panel, the legislatively mandated oversight body for New York's Medicaid managed care program, held its quarterly meeting on September 28th. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the NY Department of Health, provided an update on Plan Mergers, Acquisitions, Expansions, and Closures. The meeting also included updates on behavioral health, managed long-term care, newly available harm reduction services and an overview of MAXIMUS's work in New York. Slides are available on the HMAIS website, or by request.

Program Update:

Three applications for new plans are under review. The applicants are all currently operating managed long-term care plans and are interested in expanding into the mainstream Medicaid managed care market so they can participate in the state's Specialized I/DD plan offering, likely to begin in 2019.

- Partners Health Plan, which operates the plan participating in the duals demonstration program for individuals with intellectual/developmental disabilities (FIDA-IDD) has applied to become a mainstream Medicaid managed care plan. Partners operates in NYC, Long Island, Westchester, and Rockland Counties. The FIDA-IDD plan, which began operations in April 2016, currently has 764 members.
- Hamaspik Choice – currently a managed long-term care plan operating in 6 counties, serving 2,200 members, has applied to become a mainstream Medicaid managed care plan. The Hamaspik Association is a statewide non-profit organization representing a network of member agencies that provide health and human services primarily serving families in the Orthodox Jewish community
- iCircle Care – currently a managed long-term care plan operating in 22 counties in Central NY, serving 2,600 members, has applied to become a mainstream Medicaid managed care plan. Their roots are in the I/DD provider community.

Additionally, four plan requests for geographic expansion are under review:

- YourCare – requesting a 5-county expansion for Medicaid, CHP, and HARP (Orleans, Genesee, Livingston, Wayne and Seneca) – The state is conducting financial review before approving expansion
- United Healthcare – requesting a 2-county expansion for CHP (Erie, Sussex) – The state has concerns about network adequacy and is conducting network validation.
- VNS Choice – requesting a 2-county expansion for MLTC (Nassau and Westchester) – The state is reviewing network adequacy.
- WellCare – requesting a 4-county expansion

HealthNow has also applied to add a Health and Recovery Plan to its current Medicaid managed care offerings.

Other program updates:

- Gender dysphoria – NY Medicaid now covers treatment for gender dysphoria. If plans want to establish UM criteria, they need to be submitted to DoH for approval.
- Doula Service – As part of Governor Cuomo's maternal mortality initiative, the state is undertaking a pilot program covering doula services. The pilot will occur in two counties – Erie and Kings. The benefit includes 3 prenatal visits and 4 post-natal visits, in addition to support during childbirth.
- Dental – Medicaid will now cover replacement dentures more frequently than every 8 years as long as there is supporting documentation from both the dentist and the primary care physicians. They will also cover implants, again with supporting documentation.

Behavioral Health Update

- The transition of children's behavioral health services into Medicaid managed care has been delayed due to CMS unwillingness to approve them under an 1115 waiver amendment. As a result, NY is moving forward with a 1915 waiver request to do the following:
  - The new waiver will add 6 new services to the Medicaid benefit that are designed to meet children's behavioral health needs earlier, thus avoiding emergency department visits.
  - These HCBS services are currently overseen by 4 different agencies. The proposed waiver will consolidate these services and put within children's health homes.
  - NY has submitted draft waiver language to CMS; they expect that the full array of children's behavioral health benefits will be available as of April 2019.
  - Managed care plans are now undergoing readiness review.
- HARPs are now serving 133,000 Medicaid beneficiaries with serious mental illness and/or substance use disorder.
  - Of those, only 18,500 have been assessed for eligibility for the enhanced home and community-based services that HARPs were designed to provide.
  - Only 3,219 individuals have been authorized to receive HCBS services, up from 2,584 in June.
  - Less than 2 percent of HARP enrollees have received a behavioral health HCBS service.
- NY conducted a root cause analysis to identify challenges to increasing access to HCBS services. They identified 4 challenges:
  - Difficulty in getting HARP members enrolled in health homes;
  - Locating enrollees and keeping them engaged through the assessment and Plan of Care development process;
  - Ensuring that care managers understand what HCBS includes;
  - Difficulty launching HCBS services due to the low number of referrals.
- The state has developed a series of interventions to address the challenges, ramping up outreach, improving training for care managers, enhancing rates in recognition of low volume, and streamlining the assessment process.

Managed Long-Term Care Update

- Licensed Home Care Service Agency (LHCSA) restrictions that were included in this year's budget go into effect on October 1, 2018, limiting the number of LHCSAs an MLTC can have in its network. The intent of the rule is twofold – to provide a better picture of who is providing what services, and to give plans more leverage over the LHCSAs so they could more effectively influence quality.
  - LHCSAs have been able to demand higher rates from plans by threatening to move their members to a different plan.
  - The state is also implementing a lock-in for MLTC members, which would give enrollees a 90-day window to switch plans, after which they would be locked into their MLTC for the next nine months. That proposal is in its formal federal public comment period.

- GuildNet, a NYC-based plan with 7,300 members, has filed a notice to close and is working with the state on a transition plan. Maximus will do telephone outreach to all GuildNet members to facilitate a smooth transition. Members who do not select a new plan will be auto-assigned at random.
- Medicaid beneficiary transition rights, including maintenance of their current plan of care and the ability to remain with their provider for up to 120 days, only apply to members who change plans as a result of written notice from the plans. In the GuildNet case the plan had sent a notice to employees advising them of their imminent closure, which led to members switching plans prior to having received formal notice. DoH is discussing how to protect those consumers extending consumer protections to all members affected by GuildNet's closing.

As part of this year's budget the Department of Health agreed to re-open conversations with CMS in regard to establishing a high-need rate cell for some high-utilizing MLTC members. CMS has rejected the proposed approach, and so DoH has abandoned the effort. They are still considering rate add-ons to address financial challenges of plans with a disproportionate number of high-cost members.

Harm Reduction Services

- New York is the first state to approve harm reduction services as a Medicaid benefit. This is an extension of grant-funded initiatives. This is being overseen by the AIDS Institute, which has expanded its focus to include drug abuse. Harm reduction services are meant to support people who use drugs and engage in behaviors that place them at risk for overdose or acquisition of bloodborne diseases.
- Five services are included in the new benefit:
  - Plan of care development
  - Individual supportive counseling
  - Group Supportive Counseling
  - Medication Management and Treatment Adherence Counseling
  - Psychoeducation Support Groups
- Benefits began in July 2018.

Maximus Contracts:

Maximus currently has two contracts in NY:

- Enrollment broker contract
  - Runs through September 2019; $130 million annual budget
  - Includes mailing, outreach, enrollment, helpline and assessments for MLTC, I/DD and children's HCBS services
- NY State of Health Customer Service Center Contract
  - $346 million in current year
  - Includes operation of consumer assistance call center to provide assistance with applications and renewals
  - Supports enrollment across qualified health plans, the Essential Plan, Child Health Plus and Medicaid
  - Runs the Medicaid helpline, the CHP Information line, and calls to the Small Business Marketplace

Ohio

Ohio Behavioral Health Providers Raise Concerns Over Drop in Medicaid Payments. *The Columbus Dispatch* reported on October 1, 2018, that Ohio behavioral health providers raised concerns over a drop in Medicaid reimbursements through the first six months of 2018. The Ohio Council of Behavioral Health & Family Services Providers reported that 150 behavioral health providers were paid $522 million through June 2018, compared to $587 million in the same period last year. In January, the Ohio issued updated behavioral health billing codes and in July transferred the responsibility of handling claims to managed care plans. Read More

Oregon

Oregon CCO Capitation Rates to Increase 4.2 Percent in 2019. *The Lund Report* reported on October 2, 2018, that Oregon will increase average 2019 capitation rates for coordinated care organizations (CCOs) by four percent to $449.69 per member per month. CCO costs rose faster than a targeted rate of 3.4 percent, driven by a sicker risk pool, pharmacy costs, and fluctuations in rural hospital costs. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Holds September MAAC Meeting. Pennsylvania's Medical Assistance Advisory Committee (MAAC) met on September 27, 2018 and Department of Human Services (DHS) staff provided an update on the Medical Assistance Transportation Program (MATP) Broker procurement mandated by the PA General Assembly earlier this year. A survey went out to stakeholders to gather information on challenges in the current program, key issues to consider in the transition, advantages of both the statewide single broker and regional broker arrangements and general concerns. Key themes in the feedback included:

- Coordination of transportation and impact on the shared ride program
- Rural access concerns
- Concerns about accessibility and scheduling requirements
- Concerns with application of the current MATP guidelines in the MATP model
- Concerns that there be sufficient technology to support the broker model
- Concerns about strained partnerships

DHS staff said that survey feedback would be incorporated into the broker model being developed. Legislation mandates that MATP follow either a statewide or regional model, and a procurement must be released by the end of this year.

Tennessee

Tennessee Releases Medicaid Work Proposal for Public Comment. *Modern Healthcare* reported on September 26, 2018, that Tennessee has posted a proposal for Medicaid work requirements and will accept public comments through October 28. The proposal would require beneficiaries to engage in at least 20 hours of work or community activities per week for four months out of every six-month period. The Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma has expressed concern over approving Medicaid work requirement in non-expansion states like Tennessee because enrollees could earn too much to qualify for Medicaid but not enough to get Exchange subsidies. Tennessee notes that eligibility levels in the state should help alleviate this concern. Read More

Texas

Texas Cancels Medicaid, CHIP Solicitations For Failing to Include HUBs; Bidding Reopens. *Dallas News* reported on October 2, 2018, that the Texas Health and Human Services Commission announced it was canceling solicitations for STAR and Children's Health Insurance Program (CHIP), STAR+PLUS and Children's Medicaid and CHIP dental services contracts which were slated to expire at the end of this year or the first half of next year. The state will re-open bidding on the three contracts. The cancellation comes after the commission uncovered 22 of 46 managed care bids for the three contracts failed to follow state requirements designed to include Historically Underutilized Businesses (HUB), or minority-owned businesses, as subcontractors in the state's procurement. Proposals in response to the STAR+PLUS request for proposals (RFP) are due November 15, while responses for the STAR and CHIP and Children's Medicaid and CHIP dental services RFPs are due November 30. Read More

National

Democratic Gubernatorial Candidates Focus on Medicaid Expansion in Conservative States. *The Hill* reported on September 29, 2018, that Democratic candidates for governor in conservative states across the country are promising to push for Medicaid expansion. Meanwhile, Republican candidates in states that did expand Medicaid are feeling pressured by their party's opposition to the Affordable Care Act. According to a Kaiser Family Foundation poll, an estimated 51 percent of individuals living in non-expansion states would support expansion. Read More

Supreme Court to Hear Medicare DSH Payment Case. *Modern Healthcare* reported on September 27, 2018, that the U.S. Supreme Court will decide whether federal regulators improperly changed the reimbursement formula for Medicare disproportionate-share hospital (DSH) payments. A lower court had sided with Minnesota-based Allina Health Services and other health systems, which argued in a lawsuit that the U.S. Department of Health & Human services acted improperly by making DSH reimbursement calculation changes without public notice and comment. HHS, which filed a petition in May asking the high court to review the case, could be required to make $3 billion to $4 billion in additional DSH payments for fiscal years 2005-13. Read More

CMS Administrator Defends Medicaid Work Requirements, Highlights New Initiatives. The Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma defended Medicaid work requirements during a presentation at the Medicaid Managed Care Summit in Washington, DC. "Community engagement requirements are not some subversive attempt to just kick people off of Medicaid," she said, adding, "Their aim is to put beneficiaries in control with the right incentives to live healthier independent lives." Verma also highlighted a series of new CMS initiatives aimed at transforming the Medicaid program, including substance abuse demonstrations in 10 states; the first CMS Medicaid & CHIP Scorecard, with data on quality, outcomes, and administrative performance; and plans for additional community engagement demonstrations. Read More

Congress Reaches Deal on Opioid Bill. *The New York Times* reported on September 26, 2018, that Congress has reached an agreement on an opioid bill, including a measure that permanently allows nurse practitioners and physician assistants to prescribe the anti-addiction drug buprenorphine. The bill also lifts the IMD exclusion, which prevents Medicaid to use federal funds to pay for treatment at inpatient addiction facilities with more than 16 beds for up to 30 days. An estimated 72,000 overdose deaths were reported in 2017, including almost 50,000 involving opioids. Read More

Medicaid Innovation Accelerator Program Launches New Technical Support Opportunity. The Medicaid Innovation Accelerator Program (IAP)'s Community-Integration through Long-Term Service and Supports (CI-LTSS) Program Area is launching a nine-month technical support opportunity for up to eight states seeking to implement housing and service changes that will increase community integration options for Medicaid beneficiaries requiring long-term services and supports. Consistent with Federal statute, CMS does not provide Federal Financial Participation for room and board in home and community-based services. CMS invites interested parties to join them for an information session to learn more about this opportunity on Thursday, October 18, 2018, from 3:00 – 4:00 PM ET. During the information session, participants will learn about the goals, structure, and technical support available for states interested in implementing housing and service changes. Selected states will have the opportunity to work with industry experts through individualized technical support and state-to-state learning activities. This technical support opportunity is open to all states, including those that: have previously participated in the Medicaid IAP State Medicaid-Housing Agency Partnerships Track; are ready to implement Medicaid and housing changes; and have a plan in place that includes identified goals, strategies, partners/resources, and timeline to guide their work. The Expression of Interest form will be posted on the CMS IAP website on October 18, 2018 after the information session; the deadline for receipt of Expression of Interest forms will be midnight (ET) on November 15, 2018.

Disclosure: *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.*

To participate in this webinar, register here.

Industry News

Amedisys Subsidiary Completes Acquisition of Bring Care Home. Amedisys, Inc. announced on October 2, 2018, that its subsidiary, Associated Home Care, has completed the acquisition of all assets of Bring Care Home, a personal care provider in northeastern Massachusetts. Bring Care Home, a privately-owned company provides personal care, companionship and skilled nursing to clients in the North Shore, Merrimack Valley and Greater Boston areas. Read More

Blue Sprig Acquires Autism Therapy Provider. Blue Sprig Pediatrics, Inc. announced on October 1, 2018, the acquisition of Houston-based autism therapy provider, The Shape of Behavior. The Shape provides Applied Behavior Analysis therapy services for children with Autism Spectrum Disorder with 22 clinics in four states, including 19 in Texas. The financial terms of the transaction were not disclosed. Read More

Varsity Healthcare Partners Completes Investment in Ideal Option. Varsity Healthcare Partners (VHP) announced on October 2, 2018, the completion of an investment in Ideal Option, a provider of Medication-Assisted Treatment (MAT) and behavioral counseling services for individuals with Opioid Use Disorder. VHP will partner with the founders of Ideal Option, Dr. Jeffrey Allgaier and Dr. Kenneth Egli, who will remain in senior executive roles and large shareholders of the company. Read More

Baylor Scott & White Signs Letter of Intent to Merge with Memorial Hermann. *Modern Healthcare* reported on October 1, 2018, that Dallas-based Baylor Scott & White Health has signed a letter of intent to merge with Houston-based Memorial Hermann Health System. The combined, not-for-profit entity would have 68 hospitals, two health plans, as well as 73,000 employees and 14,000 providers. Jim Hinton, chief executive of Baylor Scott & White, would become chief executive of the combined entity, while the board would be equally split between the two systems. Baylor Scott & White and Memorial Hermann expect to reach a definitive agreement by 2019. Read More

Aetna to Sell Medicare Part D Business to WellCare Health Plans. *Bloomberg* reported on September 27, 2018, that Aetna Inc. has agreed to sell its Medicare Part D drug plan business to WellCare Health Plans. Terms were not disclosed; however, Aetna said the purchase price was not material. Aetna said it believes the divestiture is a significant step toward completing the Justice Department's review of the company's planned merger with CVS Health. Read More

UnitedHealth Purchases Pharmacy Genoa Healthcare for $2.5 Billion. Bloomberg reported on September 27, 2018, that UnitedHealth Group Inc. acquired Genoa Healthcare from private equity firm Advent International for a reported $2.5 billion. Genoa, which operates pharmacies in behavioral health centers, will become part of UnitedHealth's OptumRx pharmacy benefit management unit. Genoa operates more than 425 pharmacies in 46 states and provides services for over 650,000 individuals. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
October 12, 2018	New Hampshire	Proposals Due	181,380
October 12, 2018	North Carolina	Proposals Due	1,500,000
November 1, 2018	Virginia Medallion 4.0 - Charlottesville/Western	Implementation	88,486
November 1, 2018	Puerto Rico	Implementation	~1,300,000
December 1, 2018	Virginia Medallion 4.0 - Roanoke/Alleghany	Implementation	72,827
December 1, 2018	Virginia Medallion 4.0 - Southwest	Implementation	46,558
December 1, 2018	Florida Statewide Medicaid Managed Care (SMMC) Regions 9, 10, 11	Implementation	3,100,000 (all regions)
2019	Hawaii	RFP Release	360,000
January 1, 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) Regions 5, 6, 7, 8	Implementation	3,100,000 (all regions)
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	181,380
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
February 1, 2019	Florida Statewide Medicaid Managed Care (SMMC) Regions 1, 2, 3, 4	Implementation	3,100,000 (all regions)
February 4, 2019	North Carolina	Contract Awards	1,500,000
July 1, 2019	New Hampshire	Implementation	181,380
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
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
January 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
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
January 1, 2020	Florida Healthy Kids	Implementation	212,500
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
June 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000

COMPANY ANNOUNCEMENTS

MCG Health Offers Certified Integration with Industry-Leading Care Management Application

HMA News

HMA Principal Barry J. Jacobs, Principal Heidi Arthur, and Principal Meggan Schilkie, recently wrote the article "System Transformation: What Does the Future Hold?" for the Fall 2018 issue of Behavioral Health News. Read more

New this week on HMA Information Services (HMAIS):

Medicaid Data and Updates:

- Illinois Dual Demo Enrollment is Up 3.3%, Aug-18 Data
- New Mexico Medicaid Managed Care Enrollment is Down 1.5%, Sep-18 Data
- New York Medicaid Managed Care Enrollment is Flat, Sep-18 Data
- Pennsylvania Medicaid Managed Care Enrollment is Flat, Aug-18 Data
- South Carolina Dual Demo Enrollment is Down 4.8%, Aug-18 Data

Public Documents:

Medicaid RFPs, RFIs, and Contracts:

- Texas Dental Services for Children's Medicaid and CHIP RFP Reissue, Oct-18
- Texas STAR and CHIP RFP Reissue, Oct-18
- Texas STAR+PLUS RFP Reissue and Related Documents, Oct-18
- Arizona, Hawaii IV&V Contractor for Electronic Visit Verification Project RFP, Sep-18
- Iowa Takeover of Core Medicaid Management Information System Services RFP, Sep-18
- Maine Healthcare Data Analysis, Professional Services and System Management RFP, Jul-18
- Michigan Pharmacy Benefits Manager Services (PBM) RFP, Proposals, Evaluation Sheets, and Award, 2018
- North Carolina Prepaid Health Plan Services RFP and Related Documents, Aug-18
- Oklahoma SoonerRide Non-Emergency Transportation (NET) RFP, Proposals, Evaluations, and Contract, 2018
- South Carolina Medicaid MCO Model Contract, 2018

Medicaid Program Reports, Data and Updates:

- CMS Actuarial Report on the Financial Outlook for Medicaid, 2017
- Arizona AHCCCS External Quality Review Annual Reports, 2017
- Arizona Inpatient DRG Calculator and Hospital Specific Rates, 2014-18 Data
- Arkansas Medicaid Annual Overviews, SFY 2013-17
- California Medi-Cal Managed Care Performance Dashboard, Jun-18
- Colorado Health Plan CAHPS Reports, 2017
- DC Medical Care Advisory Committee Meeting Materials, Apr-18
- DC Mental Health and Substance Abuse Expenditures and Service Utilization Reports, 2017-18
- Kentucky HEALTH Program Status Update, Sep-18
- Kentucky Section 1115 Demonstration Revised Waiver Application, Responses to Public Comments, Federal Ruling, and Related Documents, 2016-18

- Maryland Medicaid Advisory Committee Meeting Materials, Sep-18
- Oklahoma CAHPS Medicaid Survey Executive Summary, 2018
- Oregon Governor Brown's Health Care Agenda Report, Sep-18
- Oregon Medicaid Advisory Committee Meeting Materials, Sep-18
- South Carolina Medicaid Enrollment by County and Plan, Aug-18
- South Carolina Medicaid Managed Care Rate Certification, SFY 2019
- Tennessee TennCare II 1115 Waiver Amendment Draft, Sep-18
- Virginia Medallion 4.0 Launch Updates, Oct-18
- Washington State Health Care Innovation Plan Annual Status Report, Jan-18
- Washington State Medicaid Transformation Project (MTP) Demonstration Section 1115 Waiver Quarterly Reports, 2018
- Wisconsin Medicaid MCO Actuarial Rate Certifications and Capitation Rates, 2018

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:

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- Downloadable ready-to-use charts and graphs
- Excel data packages
- RFP calendar

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