HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 4, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

MEDICAID MANAGED CARE PROCUREMENT UPDATES IN DC, MASSACHUSETTS, AND TEXAS

This week, our *In Focus* section reviews two active Medicaid managed care procurements – in the District of Columbia and Massachusetts – and a Medicaid managed care request for information issued by Texas. On December 22, 2016, the District of Columbia issued a request for proposals (RFP) to rebid Medicaid managed care organization (MCO) contracts for the DC Healthy Families and Alliance programs. One day prior, on December 21, 2016, Massachusetts issued

a request for responses (RFR) from MCOs interested in participating in the MassHealth managed care program, with a focus on preparing for Medicaid ACO implementation, as well as the planned carve-in of managed long-term services and supports (MLTSS). Finally, also on December 22, 2016, Texas issued a request for information (RFI) ahead of an upcoming statewide reprocurement of the STAR+PLUS Medicaid managed care program.

DC Healthy Families, Alliance Program RFP

On December 22, 2016, the District of Columbia's Department of Health Care Finance (DHCF) issued a request for proposals (RFP) to rebid the District's Medicaid managed care organization (MCO) contracts. The awarded contracts will provide Medicaid managed care to most Medicaid and CHIP-eligible beneficiaries under the DC Healthy Families Program, as well as residents with incomes below 200 percent of the federal poverty level (FPL) who are not eligible for Medicaid under the DC Alliance Program. Finally, contracted MCOs will also provide coverage to the Immigrant Children's Program for eligible individuals age 21 or younger, up to 300 percent of FPL, who are not eligible for Medicaid due to citizenship or immigration status. As of July 2016, more than 167,000 Medicaid beneficiaries and over 12,000 Alliance beneficiaries were enrolled with a MCO. HMA-collected figures put June 2016 enrollment at 174,200 in DC Healthy Families and 12,300 in the Alliance program.

Scope of RFP

Based on June 2016 enrollment data and the rate analysis provided by DHCF, annualized spending for the DC Healthy Families Program and Alliance Program under the RFP exceeds $860 million, based on more than 174,000 DCHFP members and more than 12,300 Alliance members. This equates to a blended per-member-per-month (PMPM) rate of more than $380.

	June 2016 Enrollment Data	RFP Rate (Oct.2017-Sept.2018)	Estimated Annual Spending
DC Healthy Families Program	174,250	$389.48	$814,400,000
Alliance Program	12,350	$308.63	$45,700,000
Total Under RFP	**186,600**	**$384.11**	**$860,100,000**

Source: HMAIS Data; Mercer Analysis for DHCF.

RFP Timing

The District issued the RFP on December 22, 2016, with proposals due to DHCF less than three weeks later, on January 11, 2017. Based on this accelerated timeline, the District may be favoring incumbent health plans. However, DHCF indicated at the December 29, 2016, bidders' conference that the due date could be extended if potential bidders requested an extension. While no implementation date is specified, contract start dates would likely be tied to the District's fiscal year, beginning October 1.

Term of Contract

DHCF will award contracts for an initial term of one year, with four optional one-year extensions. Total contract length will not exceed five years.

Evaluation Criteria

Responses will be primarily evaluated on technical criteria and past performance. Bidders are asked to provide a price bid based on actuarially sound rates set by DHCF. Additionally, entities that qualify as small, local,

disadvantaged, or veteran-owned business can quality for additional "Preference" points.

Evaluation Crtieria	Possible Points	Pct. of Total
Technical Approach and Methodology	40	35.7%
Technical Expertise	30	26.8%
Past Performance	20	17.9%
Price Proposal	10	8.9%
Preference Points	12	10.7%
Total Possible Points	**112**	

Current Medicaid Managed Care Market

There are three MCOs currently serving the DCHFP and Alliance managed care programs, with AmeriHealth Caritas the largest, at nearly 55 percent of the market. Maryland-based MedStar, which also operates Medicaid health plans in Maryland, is owned by the MedStar Health System. Trusted Health Plan, formerly known as Thrive Health Plan, scored highest out of five total bidders in the 2013 RFP as a newly formed MCO. Unsuccessful bidders in 2013 included incumbent United Healthcare and Maryland-based Riverside Health.

Medicaid MCO	DCHFP (June 2016)	Alliance (June 2016)	Total Enrollment	Market Share
AmeriHealth Caritas	96,478	5,973	102,451	54.9%
MedStar	47,903	3,590	51,493	27.6%
Trusted Health Plan	29,869	2,787	32,656	17.5%
Total - All MCOs	**174,250**	**12,350**	**186,600**	

Source: HMAIS Data

MassHealth Managed Care Organization RFR

On December 21, 2016, the Massachusetts Executive Office of Health and Human Services (EOHHS) issued a request for responses (RFR) for Medicaid managed care organizations (MCOs) to serve MassHealth, the state's Medicaid program, which operates under a Section 1115 Medicaid Demonstration waiver. Out of 1.8 million MassHealth members, around 1.3 million are served by one of four managed care programs: the MassHealth MCO Program; the Primary Care Clinician (PCC) Plan; the One Care program (the state's capitated dual eligible Financial Alignment Demonstration; and the Senior Care Options (SCO) program. This RFR applies to the roughly 850,000 MassHealth MCO Program members.

MassHealth Managed Care Overview

As of September 2016, MassHealth reports indicated nearly 1.34 million MassHealth members were in some form of managed care. Of these just over 900,000 were in one of the three risk-based managed care programs that include the MassHealth MCO Program, SCO, and OneCare. The PCC program is an enhanced fee-for-service (FFS) program that provides a care coordination fee to primary care providers.

	Sep-15	Sep-16	Y/Y Change
MassHealth MCO	835,692	844,295	1.0%
Senior Care Options (SCO)	39,525	43,898	11.1%
OneCare (Duals Demonstration)	17,147	12,961	-24.4%
Subtotal	**892,364**	**901,154**	**1.0%**
Program of All-inclusive Care for the Elderly (PACE)	3,603	4,108	14.0%
PCC (Enhanced FFS)	421,516	430,417	2.1%
Total - All Managed Care	**1,317,483**	**1,335,679**	**1.4%**

Source: MassHealth Enrollment Snapshot Report, September 2016

The MassHealth MCO Program covered under this RFR accounts for the majority of MassHealth managed care enrollment, covering children and adults through age 64, and includes individuals with disabilities. MassHealth members age 65 or older may voluntarily enroll in the SCO program or OneCare, dependent on eligibility. As noted above, this RFR does not include SCO or OneCare.

Scope of RFR

This RFR includes two notable changes under the MassHealth MCO program around the implementation of Medicaid Accountable Care Organization models and the carve-in of long-term services and supports (LTSS) benefits.

- Contracted MCOs will have new responsibilities and requirements around the support of the Medicaid ACO model implementation, detailed further below. The RFR specifically states the intention to support the uptake of Alternative Payment Models in the MassHealth MCO Program, including MCO-administered ACOs.
- Based on current timelines, MassHealth intends to add LTSS benefits for MassHealth MCO Program members around the start of 2020, around the third year of the contracts resulting from this RFR. There are roughly 63,000 members (7.5 percent) under age 65 in the MassHealth MCO Program who have a disability, as of September 2016. MassHealth has not provided spending or rate data for the RFR at this time, but based on some estimates of MassHealth LTSS spending from 2015, we estimate the potential impact of the LTSS carve-in at $900 million to $1.3 billion in annual managed care spending. FY 2015 spending for managed care capitation payments was approximately $4.3 billion.

Additionally, bidders have the option to submit a proposal to serve the Special Kids Special Care (SKSC) Program, which provides care to children (up to age 22 ½) who have complex health care needs. As of December 2016 there were 102 SKSC program members. While bidding on SKSC is not a prerequisite for bidding on the MassHealth MCO Program, plans may not submit a bid for the SKSC program only.

Medicaid ACO Model Overview

In preparation for the full launch of ACO models in 2017, MassHealth will conduct an ACO pilot with a small set of ACOs in 2016. In November 2016, MassHealth selected six provider networks to participate in a new accountable care organization (ACO) pilot program, initially covering around 160,000 members. Participants include some of the largest hospitals and health systems in the state, including Partners HealthCare, Steward Health Care System, UMass Memorial Health Care, Boston Medical Center, and Boston Children's Hospital.

Community Care Cooperative, a newly formed network of community health centers, will also participate in the ACO pilot.

The pilot will not change the payment model for any members that receive care and are currently enrolled in MCOs. Additionally, the pilot will utilize a retrospective shared savings and risk model for Primary Care Clinician (PCC) Plan members. The demonstration renewal plan offers flexibility for providers with three possible ACO models to choose from. The three models cater to a spectrum of provider capabilities.

Model A: Integrated ACO/MCO model	Model B: Direct to ACO model	Model C: MCO-administered ACO model
Fully integrated: an ACO joins with an MCO to provide full range of services Risk-adjusted, prospective capitation rate ACO/MCO entity takes on full insurance risk	ACO provider contracts directly with MassHealth for overall cost/ quality Based on MassHealth/ MBHP provider network ACO may have provider partnerships for referrals and care coordination Advanced model with two-sided performance (not insurance) risk	ACOs contract and work with MCOs MCOs play larger role to support population health management Various levels of risk; all include two-sided performance (not insurance) risk

In this new model, MCOs will be expected to take on additional roles. The expanded responsibility will include delivery and coordination of LTSS, facilitation of analytics and reports for population management, assisting ACOs in the integration of Behavioral Health Community Partners (BH CPs) and LTSS Community Partners.

RFP Timing

EOHHS issued the RFR on December 21, 2016, with proposals due on March 15, 2017. No target date has been set for contract award announcements. Implementation is tentatively set for December 18, 2017; however, timing may be dependent on contracting with Medicaid ACOs under a separate procurement.

RFR Milestone	Date
RFR Released	December 21, 2016
Bidder's Conference	January 10, 2017
Bidder Questions Due	January 13, 2017
Proposals Due	March 15, 2017
Contract Awards	TBD
Implementation	December 18, 2017

Contract Awards

EOHHS intends to contract with no more than three bidders per region, and bidders must propose to serve a minimum of two of the five managed care regions. Contract award preference may be given to plans who serve more regions, although it is not clear at this time whether all regions or a majority of regions would be needed to qualify for the preference.

Term of Contract

The initial contract term under this RFR is from approximately July 2017, or the date of execution, through December 31, 2022. Additionally, EOHHS may extend contracts for up to five additional years, through December 31, 2027.

Current Medicaid Managed Care Market

As of the end of 2015, Neighborhood Health Plan was the largest MCO in the state, with more than one-third of all members. Both Tufts Health Plan and Boston Medical Center Health Plan have market shares of 22 to 25 percent. MassHealth MCOs have reported financial issues in the past year, with both Neighborhood Health Plan (owned by Partners HealthCare) and Health New England's parent company (Baystate Health) reporting significant financial losses in the second half of 2016. Neighborhood Health Plan temporarily froze enrollment in October 2016.

MassHealth MCO	2015 Enrollment	Market Share
Neighborhood Health Plan	289,724	34.0%
Tufts Health Plan	209,803	24.6%
Boston Medical Center Health Plan	190,456	22.3%
Health New England (Baystate Health)	81,894	9.6%
CeltiCare (Centene)	49,051	5.8%
Fallon Community Health Plan	31,660	3.7%
Total - All MCOs	**852,588**	

Source: HMAIS Data

Link to RFR

https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-10209&external=true&parentUrl=bid

TEXAS STAR+PLUS MEDICAID MANAGED CARE RFI

On December 22, 2016, The Texas Health and Human Services Commission (HHSC) released a Request for Information (RFI) for organizations interested in serving the STAR+PLUS Medicaid managed care program. STAR+PLUS members include adults with disabilities who meet a nursing facility level of care and require home and community based services. STAR+PLUS covers more than 540,000 Medicaid beneficiaries, accounting for more than $8 billion in annual spending, based on FY 2016 rates. The RFI seeks responses from interested organizations, particularly around improved strategies that are innovative, cost-effective, and improve outcomes in the delivery of acute care and long-term services and supports (LTSS). Responses and questions are due January 30, 2017.

On November 15, 2016, HHSC announced that it would be reprocuring STAR+PLUS contracts statewide, after previously announcing the upcoming RFP would be for the Dallas and Tarrant service areas only. HHSC will maintain existing service areas under the statewide RFP. The target implementation date for new STAR+PLUS contracts is January 1, 2019.

STAR+PLUS Overview

The STAR+PLUS Medicaid managed care program integrates the delivery of acute care services, pharmacy services, and long-term services and supports (LTSS) to individuals age 65 and older and to individuals under age 65 who

have a disability, many of whom qualify for Supplemental Security Income (SSI) or SSI-related benefits. STAR+PLUS services and supports are delivered through five MCOs who contract with HHSC.

Enrollment in STAR+PLUS is mandatory for most adults receiving SSI, as well as adults who do not receive SSI (non-SSI), but who qualify for the STAR+PLUS HCBS program. Enrollment in STAR+PLUS was voluntary for children and young adults under the age of 21 who receive SSI and SSI-related Medicaid benefits until implementation of the STAR Kids managed care program on November 1, 2016. STAR+PLUS MCOs began covering most nursing facility services for members age 21 and older as of March 2015.

Current STAR+PLUS Medicaid Managed Care Market

As of September 2016, there were nearly 545,000 STAR+PLUS members across five MCOs. Centene's Superior Health Plan, Anthem's Amerigroup, and United Healthcare combine to cover nearly three quarters of all STAR+PLUS members. Both Superior and Amerigroup also have significant market presence in across all Medicaid managed care programs in the state. There are an additional 13 Medicaid MCOs who do not participate in the STAR+PLUS program.

STAR+PLUS MCO	STAR+PLUS Enrollment (September 2016)	Market Share	Total Enrollment (September 2016)	Market Share
Superior Health Plan (Centene)	145,812	26.8%	969,328	24.7%
Amerigroup (Anthem)	140,201	25.8%	783,019	19.9%
United Healthcare	116,604	21.4%	253,720	6.5%
Molina Healthcare	90,605	16.7%	233,783	6.0%
Cigna-HealthSpring	50,756	9.3%	52,402	1.3%
13 Non-STAR+PLUS MCOs	0	0.0%	1,635,100	41.6%
Total - All STAR+PLUS MCOs	**543,978**		**3,927,352**	

Source: HMAIS Data

Link to RFI

http://esbd.cpa.state.tx.us/bid_show.cfm?bidid=130086

HMA Medicaid Roundup

California

HMA Roundup – Julia Elitzer (Email Julia)

2017 Legislative Agenda Likely to Focus on Preserving ACA Gains. *California Healthfax* reported on January 3, 2017, that the 2017 legislative slate for California will likely feature multiple bills designed to counteract potential challenges to the Affordable Care Act (ACA) and preserve gains made in reducing the number of uninsured residents in California. In December 2016, California legislators introduced bills addressing prescription drug prices, Denti-Cal reimbursements, and undocumented residents' access to healthcare. Read More

Health Systems Continue to Expand Alternative Care Models. *California Healthfax* reported on January 3, 2017, that major California health systems are venturing into population health and alternative models of care due to the increased emphasis from hospitals and physicians transitioning from fee-for-service to value-based care. Dignity Health and St. Joseph Hoag Health are testing new delivery models with carefully located urgent care and wellness centers in an effort to expand beyond pre-existing health clinics and hospitals. Read More

Connecticut

New System for Tracking Home Care Provider Time Implemented January 1. *The CT Mirror* reported on December 30, 2016, on Connecticut's plans to implement a new electronic visit and verification (EVV) system for tracking hours and services performed by home care workers in certain Connecticut Medicaid programs effective January 1, 2017. The system is meant to improve billing accuracy and is estimated to save $8 million to $15 million in Medicaid payments per year. Providers must call into the system when they arrive at a member's home and again when they leave, recording the services provided. Home care providers and agencies worry that glitches may delay claims processing and payments. The rollout has been delayed several times in response to concerns raised by the agencies. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA to Pay Additional $75 Million to Medicaid MCOs to Make Up for Underpayments. *Naples Daily News* reported on December 23, 2016, that the Florida Agency for Healthcare Administration still needs to pay an additional $74.9 million to Medicaid managed care companies to make up for unintended

underpayments to plans for certain recipients who are elderly. The rate discrepancy affected less than 1 percent of Medicaid managed care members in the state. Florida had already paid back $73 million, and the additional $75 million is expected to cut into the state's budget. Read More

New Law Expands Prescribing Authority to Physician Assistants, Nurse Practitioners. *Health News Florida* reported on December 30, 2016, that effective January 1, 2017, a new law in Florida allows physician assistants and nurse practitioners to prescribe controlled substances without physician oversight. The law was signed last summer by Governor Rick Scott to help mitigate physician shortages in the state. Florida was one of the last states to expand prescribing powers to nurse practitioners. Read More

AHCA Awards All Payer Claims Database Contract. The Florida Agency for Health Care Administration announced on January 3, 2017, the award of the All Payer Claims Database contract to Heath Care Cost Institute, Inc. The 5-year contract is anticipated to begin February 1, 2017. The other respondent was Fair Health, Inc. The announcement can be accessed by clicking here.

Illinois

Individuals with Autism Report Limited Medicaid Coverage of Certain Services. *The Lincoln Courier* reported on January 2, 2017, that the only Medicaid managed care plan covering applied behavioral analysis (ABA) services for children with autism in central Illinois, Health Alliance Connect, has withdrawn from the state's Medicaid program effective January 1, 2017, increasing barriers to access to ABA. While not-for-profit programs, such as Springfield, Illinois-based The Autism Program, say they will try to continue ABA services for some Medicaid beneficiaries, the ongoing state budget crisis and funding uncertainties limit the number of beneficiaries they can serve. Illinois does not require Medicaid coverage of ABA therapy, although contracted Medicaid plans have the option to do so. Advocacy groups report it has been difficult to persuade MCOs to cover ABA. Read More

Indiana

FSSA Posts Public Notice of HIP 2.0 1115 Waiver Renewal Request. The Indiana Family and Social Services Administration (FSSA) on December 21, 2016, posted a public notice that it is requesting renewal of the state's Healthy Indiana Plan (HIP) 2.0 1115 Waiver. FSSA is holding a public hearing on the waiver extension application on January 4, 2017, as well as presenting to the Medicaid Advisory Committee (MAC) on January 5, 2017, before submitting the request to the Centers for Medicare & Medicaid Services. The renewal request would extend the current program through 2020, with minor revisions and some program enhancements. The 30-day public comment period will close January 20, 2017. Read More

Iowa

Medicaid MCOs Report to State on Inadequate Rates as Losses Continue. *The Des Moines Register* reported on December 21, 2016, that the three Medicaid health plans participating in Iowa's Medicaid managed care program informed the state that reimbursement rates are inadequate and that the situation has been a "catastrophic experience." The companies – Anthem's Amerigroup, AmeriHealth Caritas, and UnitedHealthcare – have posted heavy losses in the new statewide program, which was implemented earlier this year. There have been discussions around supplemental funding, but no agreement has been reached. Governor Terry Branstad remains confident that the state will still save more than $110 million through Medicaid managed care. Contracts with insurers run three years, with renewal options for up to another four years. Read More

Kentucky

Medicaid Expansion Results in Large Increase in SUD Treatment, Report Says. *WFPL* reported on December 28, 2016, that the Kentucky Medicaid expansion has resulted in a 740 percent increase in substance use disorder (SUD) services among the expansion population from 2014 through mid-2016, according to a report by the Foundation for a Healthy Kentucky. Traditional Medicaid enrollees saw SUD treatment rates rise four times between 2014 and 2016. Kentucky has seen particularly high rates of SUD, compared to other states, under the nationwide opioid epidemic. Read More

Nebraska

State Officials Hope to Save HIPP Program. *Live Well Nebraska* reported on December 28, 2016, that Nebraska officials are hoping to save the Health Insurance Premium Payment (HIPP) program, which allows the state's Medicaid program to pay private health insurance premiums, deductibles, and co-payments for certain people who qualify for Medicaid but have private insurance. There are currently 247 people in the program. The state's transition to a new Medicaid managed care program, Heritage Health, would have forced HIPP enrollees to switch over to Medicaid in 2017. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

DHS Updates Medicaid Fee-for-service Rates for State Plan Services. On December 30, 2016, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) posted a public notice of its intent to seek approval from the Centers for Medicare and Medicaid Services (CMS) for amendments to the State Plan to reflect updates to the New Jersey Medicaid fee-for-service rates, effective January 1, 2017. The fee schedule is published on the DHS fiscal agent's website, under "rate and code information." Comments or inquiries may be submitted in writing by January 29, 2017. Read More

New Jersey Received $95 Million in Federal Overpayments for Medicaid Mental Health Services, Audit Finds. *NJ.com* reported on December 30, 2016, that the New Jersey Department of Human Services received $95 million in federal overpayments for outpatient Medicaid mental health services, according to an audit by the U.S. Department of Health & Human Services inspector general. The audit looked at 100 claims under the partial care services program, which provides therapy and medication management to adults with serious mental health care needs, and found that only eight of those reviewed met federal and state guidelines. The audit suggests the state should increase oversight of providers and provide guidance for Medicaid reimbursements to prevent further issues. Read More

Assembly, Senate Pass Bills Urging Congress and President Not to Repeal the ACA. On December 15, 2016, the New Jersey Assembly introduced ACR222, which urges Congress and the President not to repeal the Patient Protection and Affordable Care Act (ACA). The bill was passed on December 19, 2016, received in the Senate (SCR137), and passed on the same date. It has been filed with the Secretary of State. The bill estimates that an ACA repeal would result in 528,000 adults (or 10 percent of the state's adult population) losing health care coverage, and in a loss of $3 billion in federal funds per year as well as $4.1 billion in lost economic activity and jobs per year.

New Mexico

$30 Million in Planned Medicaid Behavioral Health Rate Cuts Cancelled. *KRQE* reported on January 1, 2017, that New Mexico will no longer implement rate reductions for Medicaid behavioral health providers. The planned $30 million in cuts were scheduled to begin January 1, 2017, to offset lower oil and gas revenues. It is not clear at this time if the funds will be cut from other areas of the state budget. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Governor Cuomo Vetoes Enhanced Medicaid Funding for Safety Net Hospitals; Approves Step Therapy Restrictions. Governor Cuomo vetoed a bill that would have provided enhanced Medicaid funding for safety net hospitals, a bill that unanimously passed both houses of the NY legislature last spring. The bill would have created a supplemental Medicaid rate adjustment for "enhanced safety net hospitals," including public hospitals and federally designated critical access and sole community hospitals that serve a high number of Medicaid and uninsured patients. As the bill was not included in the budget that was passed in April, the bill comes with no new funding. According to Crain's Health Pulse, the governor noted that the bill would result in increased and unbudgeted costs to the Medicaid program, and suggested the bill should be addressed as part of this year's budget negotiations. In other action, the governor signed a bill that changes the rules surrounding step therapy, a process by which insurers can require that certain drugs be tried first before approving a physician's prescription. After years of consumer advocacy, Governor Andrew Cuomo has signed a bill that provides a standardized process to appeal the practice. The law does not ban step therapy, but will require insurers to respond to step therapy appeal requests within 72 hours (24 hours in emergency situations). The bill

provides standards that must be documented to grant an exception. The law applies to all contracts with commercial plans delivered, renewed or amended after January 1, 2017 when it went into effect. The bill was opposed by the New York Health Plan Association, a trade group representing insurers, which worried about vague language in the law that could let physicians declare their preference is in the "best interest of the patient" - a subjective term - and override an insurer's decision. Read More

Value-Based Payment Recommendations for Individuals with Intellectual/Developmental Disabilities. As part of its Delivery System Reform Incentive Payment program (DSRIP), New York is committed to shifting payments made by Medicaid managed care plans to providers away from fee-for-service arrangements and toward value-based payment methodologies. As part of the transition the state has convened a series of clinical advisory groups to develop recommendations that are specific to a given clinical condition. A new interim progress report addressing care for individuals with intellectual/developmental disabilities (IDD) has been released for review and public comment. The public comment period ends on January 20, 2017. The IDD Interim Progress Report is not a final report from the IDD Advisory Group. The report is intended to provide a review of efforts underway that are related to this important topic. Public comments will be collected and used to inform further deliberations on VBP arrangements.

New York State's Value Based Roadmap describes how the State will transition 80 to 90 percent of all payments from Managed Care Organizations to providers from Fee for Service (FFS) to VBP. New York's Office for Persons with Developmental Disability (OPWDD) provides services to more than 128,000 New Yorkers with developmental disabilities. It provides services directly and through a network of approximately 750 nonprofit service providing agencies, with about 80 percent of services provided by the private nonprofits and 20 percent provided by state-run agencies. One VBP option is a total cost of care arrangement for designated member populations, designed to incentivize maximum gains from care coordination across the multiple care "silos" with whom these members interact. The IDD VBP arrangement is envisioned as a total cost of care arrangement.

In order to help develop the kinds of provider networks needed to support managed care and total cost of care VBP arrangements, OPWDD is working with the provider community to develop Care Coordination Organizations (CCOs). A primary goal of the CCOs will be to coordinate services across multiple service systems including medical, behavioral health, and long-term support services. In addition to a focus on holistic care, the CCOs will have added information technology capabilities to support pay for performance through value-based payments. CCOs are expected to become a logical nexus for member attribution; their exact role in VBP arrangements will be finalized as they evolve. Total cost of care for IDD would include primary and acute care, as well as OPWDD specialty services such as supported employment, day services, residential supports, Home and Community Based Services (HCBS), and care coordination. Other services relevant to members with IDD and families may be included as the arrangement evolves. Read More

New York Medicaid 1115 Waiver Evaluation. As part of New York's Medicaid 1115 waiver the state is required to conduct an evaluation of its waiver implementation. The state has posted a draft of the evaluation design for public comment, prior to submitting the plan to CMS for approval. The draft design

includes a discussion of the goals, objectives, and hypotheses, with consideration of the beneficiaries, providers, plans, market areas, and/or expenditures specific to each of the programs. The primary goals of the waiver demonstration are to increase access, improve quality, and expand coverage to low income New Yorkers. To accomplish these goals, the demonstration includes several key activities including enrollment of new populations, quality improvement and coverage expansions. This evaluation plan will assess the degree to which the key goals of the demonstration have been achieved and/or the key activities of the demonstration have been implemented. The demonstration evaluation covers the overall demonstration, and includes following domains:

- Managed Long-Term Care
- Mandatory Medicaid Managed Care
- Individuals Moved from Institutional Settings to Community Settings for Long Term Services and Supports
- Temporary Assistance to Needy Families
- Twelve-Month Continuous Eligibility Period
- Express Lane Eligibility

The evaluation of DSRIP, Health and Recovery Plans and the Self-Direction Pilot are to be conducted separately. A competitive bidding process will be used to contract with an independent entity to conduct the evaluation, in which a Request for Proposals (RFP) will be developed and issued by NYSDOH. The draft evaluation plan is posted for public comment. Public comments will be accepted until January 10, 2017. Read More

New York Selected for Certified Community Behavioral Health Clinic (CCBHC) Demonstration. The U.S. Department of Health and Human Services announced that New York is one of eight states selected for participation in a two-year Certified Community Behavioral Health Clinic (CCBHC) demonstration program designed to improve behavioral health services in their communities. This demonstration is part of a comprehensive effort to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high quality care for people with mental and substance use disorders. Read More

Community Based Organization Planning Grant Request for Applications for the Long Island/Mid-Hudson Region. The Department of Health has reissued the Community Based Organization (CBO) Planning Grant Request for Applications (RFA) for the Long Island/Mid-Hudson Region only. The RFA makes funding available to support strategic planning activities for CBOs to facilitate their engagement in DSRIP activities. CBOs are seen as essential for Performing Provider Systems be able to impact the social determinants of health. The grant is meant to assist CBO Consortia in planning activities to identify business requirements and formulate strategies for short-term needs as well as longer term plans that the CBO consortium may envision for sustainability in system transformation. Awards for two consortia were announced in December: the Arthur Ashe Institute for Urban Health in New York City, and S2AY Rural Health Network, Inc. for the rest of the state. No award was announced at that time for the third region, made up of Long Island and the mid-Hudson region. It is anticipated that the contract will run from May

2017 – April 2018. The maximum funding for this opportunity is $2,500,000. Applications are due February 10. To locate the opportunity on Grants Gateway, search by the opportunity name: Community Based Organization (CBO) Planning Grant - Reissue for the Long Island and Mid-Hudson Region. Link to Grants Gateway

North Carolina

Physician Group Illustrates Challenges of ACO Payment Model. *The New York Times* reported on December 23, 2016, that the experience of North Carolina-based Cornerstone Health Care, one of the earliest physician groups to form an accountable care organization (ACO), illustrates the financial challenges associated with alternate payments models. Cornerstone launched its ACO effort several years ago, but soon encountered obstacles as many physicians left the group, and the organization faced a shortage of capital for necessary IT investments. In May 2016, Cornerstone was bought by Wake Forest Baptist Medical Center in hopes that the larger system could bolster the group, which posted a combined $17 million in operating losses in the second and third quarters of 2016. Most ACOs are backed by a hospital system, while some are run by physician practices like Cornerstone and health insurers. Read More

Ohio

Medicaid Expansion Improved Health Status, Financial Stability of Enrollees, Assessment Shows. The Ohio Office of Health Transformation announced on January 4, 2017, that Medicaid expansion in the state improved access to care, decreased emergency department use, helped detect members at risk for chronic health conditions, and improved the health and financial status of expansion beneficiaries, according to a new report published by the Ohio Medicaid Department. The findings were based on a combination of medical records, Medicaid data, and surveys. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Awarded Innovative Behavioral Health Grant. Pennsylvania was awarded a Certified Community Behavioral Health Clinic (CCBHC) demonstration grant by Substance Abuse and Mental Health Services Administration (SAMHSA), according to an announcement by Pennsylvania Department of Human Services (DHS) Secretary Ted Dallas. DHS was previously awarded a planning grant used to certify CCHBCs, solicit input from stakeholders, and establish prospective payment systems for demonstration reimbursable services. This work has been going on for the past year. All the states that received the planning grant were in the running for a demonstration grant. Pennsylvania is one of eight states selected out of 24 applicants to receive the grant. While the ultimate amount of additional funds received is dependent on the usage of the CCBHC program, DHS estimates it could be an additional $10 million in federal funding. DHS selected 10 CCBHC locations, set to implement in July 2017, that will:

- Enhance access to behavioral health services for Medicaid and CHIP beneficiaries,

- Help individuals with mental health and substance use disorders obtain the health care they need to maintain their health and well-being,
- Allow individuals to have access to a wide array of services at one location, and
- Remove the barriers that too often exist across physical and behavioral health systems.

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Puerto Rico

Task Force Urges Congress to Consider Overhaul of Benefit System for Individuals with Disabilities. *The New York Times/Reuters* reported on December 21, 2016, that Congress should consider overhauling Puerto Rico's benefits system for individuals with disabilities, according to recommendations from a legislative panel. The Congressional Task Force on Economic Growth in Puerto Rico made the recommendations following a *Reuters* special report, which showed that individuals with severe mental illness and individuals with physical disabilities in Puerto Rico receive limited assistance compared to similar individuals across all 50 states. The panel recommended that Congress provide Supplemental Security Income (SSI) to Puerto Rican residents or increase benefits through the Administration of Children and Families. The *Reuters* Special Report looks deeper into the territory's economic crisis. Read More

Texas

HHSC Releases IDD Managed Care Pilot RFP. The Texas Health and Human Services Commission (HHSC) released a request for proposal (RFP) on January 3, 2017, for the state's Intellectual and Developmental Disability (IDD) Pilot Program. The state anticipates contracting with one or more vendors to deliver Medicaid long-term services and supports integrated with acute care services to pilot participants. The program will test up to four managed care Service Delivery Models and cover one to four regions determined by the HHSC based on regions proposed by respondents. Proposals are due February 16, 2017, and contracts are anticipated to be effective May 1, 2017.

CVS Sues HHSC Over Medicaid Fraud Allegations. *The Austin American-Statesman* reported on December 28, 2016, that CVS Health has filed a lawsuit against the Texas Health and Human Services Commission (HHSC) in an ongoing dispute over Medicaid drug prices. The state has argued that CVS pharmacies improperly inflated the number of prescriptions purchased through the company's Health Savings discount program, resulting in $30 million in fraudulent billings. CVS maintains that HHSC approved its billing practices. Read More

West Virginia

Health and Human Services Secretary to Step Down. *The Charleston Gazette-Mail* reported on December 30, 2016, that West Virginia Department of Health and Human Services (DHHS) Secretary Karen Bowling announced her resignation, ending a three and a half year term. She is leaving to return to the private sector, where she previously worked as CEO of Raleigh General Hospital and as a nurse practitioner. While at DHHS Secretary Bowling focused her efforts on fighting substance use disorders and implementing the state's Medicaid expansion. Her term will end this month, with the end of Governor Earl Ray Tomblin's term. Read More

National

Medicaid Innovation Accelerator Program National Webinar scheduled for January 9, 2017. As part of the Medicaid Innovation Accelerator Program's (IAP) *Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs* [(BCN) also referred to as "Superutilizers"] program, the Center for Medicaid and CHIP Services (CMCS) has been working with five states (District of Columbia, New Jersey, Oregon, Texas, and Virginia) since October 2015. As work continues with these states, IAP BCN has launched a four-part national dissemination webinar series highlighting lessons learned and sharing resources. The next webinar in this series will be held on January 9, 2017 from 2:00 pm to 3:30 pm ET and focuses on ***Effective Care Management Strategies for Medicaid Beneficiaries with Complex Care Needs and High Costs***. This webinar will provide participants with an overview of the role of care management in BCN initiatives - identifying core components and common concepts; highlighting best practices and tools. Presenters will share experiences and lessons learned from both the practice level and the state level. This webinar is open to all states and interested stakeholders. HMA is one of several organizations working as a subcontractor under a 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 Beneficiaries with Complex Needs and High Costs (BCN) track through webinars, coaching assistance to participating states, resource papers and bi-weekly program updates. Registration Link

State Medicaid Directors Seek Greater Involvement in Reform Discussions. *Bloomberg* reported on January 3, 2017, that the National Association of Medicaid Directors (NAMD) is working to ensure that state Medicaid directors are included in policy discussions concerning potential reforms to the Medicaid program, including earlier review of proposed federal rules and guidelines. NAMD executive director Matt Salo said that Medicaid directors understand the detailed implications of policy changes such as work requirements and block grants and should be more involved in discussions around reform efforts. Read More

HHS Awards Grants to Eight States for New Behavioral Health Services Demo. The U.S. Department of Health & Human Services (HHS) announced on December 21, 2016, that eight states were selected to participate in a two-year Certified Community Behavioral Health Clinic demonstration to improve behavioral health services. Minnesota, Missouri, New York, New Jersey, Nevada, Oklahoma, Oregon, and Pennsylvania have until July 1, 2017, to

implement their demonstration programs. The program aims to integrate behavioral health with physical health care, increase consistent use of evidence-based practices, and improve access to high quality care for individuals with mental illness and substance use disorders. Read More

New Nursing Home Regulations Grant More Control to Residents. *Kaiser Health News* reported on January 4, 2017, that the first in a series of three new federal nursing home regulations aimed at giving residents more control of care took effect in November 2016. The new rules require timely care plans, flexibility in meals and snacks, enhanced review of individual drug schedules, improved security, better grievance processes, and more oversight of involuntary discharges. The nursing home industry successfully pushed back against a provision that would have prohibited homes from requiring residents to agree to a private dispute process. Read More

Industry News

WellCare to Acquire Medicaid Assets from Tenet's Phoenix Health Plan. WellCare announced on December 22, 2016, that it has signed a definitive agreement to acquire Medicaid members and other assets, such as provider contracts, from Tenet Healthcare's Arizona subsidiary, Phoenix Health Plan. As of December 1, 2016, Phoenix had approximately 50,000 Medicaid members in Maricopa County. The transaction is expected to close in the second quarter of 2017. Financial terms were not disclosed. Read More

LifePoint Health, LHC Group Form Joint Venture for Home Health, Hospice. LifePoint Health announced on January 3, 2017, that it has formed a home health and hospice services joint venture with LHC Group, a provider of non-acute healthcare services. The venture will operate LifePoint's 20 home health agencies and 10 hospice locations, as well as certain LHC Group agencies close to LifePoint hospitals. The two entities first announced a definitive agreement to co-own and operate the venture on November 2, 2016.

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
January 11, 2017	Washington, DC	Proposals Due	190,000
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
January 23, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
February 16, 2017	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
February 28, 2017	Oklahoma ABD	Proposals Due	155,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
March 15, 2017	Massachusetts	Proposals Due	850,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
June 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
July 1, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

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

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Nov. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	112,468	32.1%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	46,216	34.0%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	13,857	14.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,656	36.7%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	4,860	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	384	1.9%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	70,315	61.7%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	4,086	16.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	9,611	17.9%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	36,736	21.9%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	29,186	44.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**364,375**	**29.1%**	

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

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; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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