

HEALTH MANAGEMENT ASSOCIATES

# HMA Weekly Roundup

Trends in State Health Policy

..... July 17, 2019 .....



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## IN FOCUS

### HMA SUMMARY OF CMS INNOVATION MODELS PERTAINING TO RADIATION ONCOLOGY, KIDNEY CARE, AND END-STAGE RENAL DISEASE

This week, our In Focus section reviews the four new payment models addressing radiation oncology, kidney care, and end-stage renal disease released by the Centers for Medicare & Medicaid Services (CMS), through the Center for Medicare and Medicaid Innovation (CMMI) on July 10, 2019. Two of the models would be mandatory in randomly selected geographies and were

published as proposed rules: the End-Stage Renal Disease Treatment Choices (ETC) and Radiation Oncology (RO) models. For these two proposed models, stakeholders have until what will likely be mid-September 2019 (60 days following publication of the forthcoming publication of the proposed rules in the federal register) to submit comments to CMS. The other two models are voluntary demonstrations: the Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) models. This is the first time this administration has proposed a mandatory model since the hip fracture and cardiac bundled payment models, which were cancelled in 2017. For these two models stakeholders will not have the opportunity to submit comments.

The newly-announced models offer an array of opportunities for radiation therapy providers and suppliers as well as nephrologists and dialysis facilities to take on risk for the services they provide to Medicare beneficiaries. These four models differ with regard to the services and beneficiaries covered, payment methodologies, benefit enhancements, and timelines. The table below outlines the key parameters of these new payment models:

**Table 1: Key Parameters of New Payment Models**

	<b>Radiation oncology (RO)</b>	<b>ESRD Treatment Choices (ETC)</b>	<b>Kidney Care First (KCF)</b>	<b>Comprehensive Kidney Care Contracting (CKCC)</b>
<b>Participation</b>	Mandatory	Mandatory	Voluntary	Voluntary
<b>Timeline</b>	2020 to 2025	2020 to 2026	2020 to 2025	2020 to 2025
<b>Eligible participants</b>	Radiation oncology providers and suppliers	Nephrologists and ESRD facilities	Nephrologists or nephrology practices	Nephrologists or nephrology practices, dialysis facilities, and other providers
<b>Eligible Medicare beneficiaries</b>	Beneficiaries with any of 17 cancer types	Adult ESRD patients	Beneficiaries with stage 4 or 5 CKD, receiving dialysis, or post kidney transplant	
<b>Payment method</b>	Site-neutral 90-day episode-based payment	Positive or negative payment adjustments for home dialysis and kidney transplant rates	Capitated payments, adjusted based on health outcomes, and bonus payments are possible	Three options <ul style="list-style-type: none"> <li>• Upside-only risk model</li> <li>• 50% risk model (savings and losses)</li> <li>• 100% risk model (savings and losses)</li> </ul>
<b>Benefit expansions/waivers</b>	No	Yes: kidney disease education benefit	Yes: kidney disease education, telehealth, SNF 3-day stay rule, home visits, home health	

### Proposed Mandatory Radiation Oncology Model

CMS's proposed Radiation Oncology (RO) model will test prospective site-neutral episode-based payments for radiotherapy services (RT) services. The RO model aims to better align incentives to provide RT services, reduce provider burden by moving toward a simplified and predictable payment system, and improve the quality of care for cancer patients receiving RT treatment.

In forming this model, CMS is seeking to address three specific concerns about the existing RT payment system. CMS intends to:

1. Eliminate incentives to steer patients to higher-paying settings.
2. Resolve difficulties in coding RT services and in setting payment rates appropriately for RT services.
3. Improve the patient experience by rewarding high-quality patient-centered care and incent high-value RT that results in better patient outcomes.

Participation in this model will be mandatory for all physician group practices, hospital outpatient departments, and freestanding radiation therapy centers that provide RT within randomly selected Core-Based Statistical Areas (CBSAs). CMS will release the list of CBSAs upon release of the Final Rule. However, CMS intends to include 40 percent of all RT episodes in the demonstration, and will exclude providers in Maryland, Vermont, and parts of Pennsylvania due to other ongoing initiatives in those areas. The model is also limited to a distinct set of RT services that are provided for 17 different cancer types.

Providers will receive prospective episode-based payment amounts covering a 90-day episode of care that will vary based on the type of cancer. The episode payments will be split into a professional component (PC) and a technical component (TC), and payment amounts will be determined based on national base rates, trend factors, case-mix, and geographic location. Noting that the technical/facility payments for RT are lower for freestanding RT locations than for hospital outpatient departments (HOPD), CMS is intending to use the average payment rates received by HOPDs in constructing the initial cancer-specific base rates.

CMS also proposed two adjustments that seek to address perceived payment disparities for RT. First, providers that historically have had higher-than-average episode costs will receive a downward adjustment that will become larger over the five years of the demonstration, while providers that historically have had lower-than-average episode costs will receive an upward adjustment that will remain constant during the demonstration. Second, CMS proposed that the episode payment will be reduced by a discount factor, which will reserve savings for the Medicare program and reduce beneficiary cost-sharing. The discount factor is proposed to be 4 percent of the PC and 5 percent of the TC.

Finally, CMS proposed a 2 percent quality withhold for the PC portion and a 1 percent beneficiary experience withhold for the TC portion, which may be earned back by participating providers. The RO Model will qualify as an Advanced APM and a Merit-based Incentive Payment System APM for purposes of the Physician Quality Payment Program.

The proposed timeline of the RO Model is January 1, 2020, to December 31, 2024. CMS estimates the RO model will reduce total Medicare spending by \$260 million between 2020 and 2024.

### Proposed Mandatory End-Stage Renal Disease Treatment Choices Model

The End-Stage Renal Disease Treatment Choices (ETC) Model aims to encourage greater use of home dialysis and kidney transplants for Medicare beneficiaries with ESRD. In general, home dialysis and kidney transplant are viewed as preferable alternatives to in-center dialysis, which is more widely

used in the U.S. than in other countries. CMS proposed to achieve these goals by adjusting the existing payment rates made to ESRD facilities and to the monthly capitation payments made to nephrologists who care for ESRD beneficiaries. CMS's goal is that these adjustments should create strong incentives for clinicians and facilities to work with beneficiaries and other caregivers to consider the use of home dialysis and kidney transplant.

CMS proposed mandatory participation in the ETC Model in order to generate broad participation by ESRD providers. CMS proposed to select all relevant providers in a select set of hospital referral regions (HRR) but exclude low-volume ESRD service providers. CMS will identify these HRRs upon release of the Final Rule. However, CMS seeks to include providers serving approximately 50 percent of all ESRD beneficiaries. CMS intends to permit providers to participate in any of the voluntary ESRD payment models, including the currently-active ESRD Seamless Care Organization (ESCO) and the newly-proposed Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC). Payment adjustments under the ETC would count as part of the payments measured in these other demonstrations.

CMS will attribute ESRD beneficiaries to participating providers on a month-to-month basis based on where the beneficiary receives the most dialysis treatments. CMS proposed to exclude from the ETC Model beneficiaries who are under 18 years of age, enrolled in hospice care, diagnosed with dementia, or receiving dialysis due to acute kidney injury.

During the initial three years of the ETC Model, CMS proposed to increase payments, including the per treatment facility payment rate and the monthly physician capitation payment, by 1 to 3 percent for each patient receiving home dialysis services. In subsequent years, CMS proposed to adjust payments based on an ETC participant's home dialysis rate and transplant rate compared to its own historical performance as well as compared to other participants in the same HRR. These adjustments could be positive or negative, reaching +10 percent or -13 percent in the final periods. Home dialysis utilization rates will be adjusted to control for differences in patient case-mix across providers, using the same risk model that CMS uses to adjust payments to Medicare Advantage plans for ESRD enrollees.

In addition, CMS proposed to expand coverage eligibility for the Kidney Disease Education (KDE) benefit to beneficiaries with stage 5 chronic kidney disease (CKD) as well as beneficiaries diagnosed with ESRD. Currently, CMS covers up to six KDE sessions for beneficiaries with stage 4 CKD. In addition, CMS proposes to expand the range of practitioners currently permitted to perform KDE services, including dietitians and social workers performing the services under the direction of a participating clinician.

CMS proposed that the ESRD Treatment Choices Mandatory Model will operate from January 1, 2020 to June 30, 2026. The Agency estimates the ETC model will reduce total Medicare program spending by \$169 million over 6.5 years, including \$4 million in lower payments to clinicians and \$181 million in lower payments to ESRD facilities, offset by \$5 million in higher KDE payments and \$10 million in additional home dialysis training costs.

### Voluntary Kidney Care First Model and Comprehensive Kidney Care Contracting Models

The Kidney Care First (KCF) and Comprehensive Kidney Care Contracting (CKCC) Models are accountable care organization (ACO) models that build upon the existing structure of the Comprehensive ESRD Care (CEC) Model, in which dialysis facilities, nephrologists, and other ESRD providers may form targeted ACOs to manage care for ESRD beneficiaries. The design of the two newly announced models draw from the recently announced Primary Care First and Direct Contracting models.

The KCF and CKCC Models are designed to incentivize better management of kidney disease by holding a single set of providers responsible for a patient's kidney care from late-stage CKD through dialysis and post-transplant care. Both models rely on financial incentives to encourage providers to furnish care that best meets beneficiaries' needs and is efficient in terms of spending. Participants will be given the incentive to delay the progression of CKD to ESRD through improved care management, manage the transition into dialysis, support beneficiaries through the transplant process, and manage their health post-transplant. CMS will encourage participants to educate beneficiaries about kidney disease and will discourage providers from withholding care by implementing risk adjustment and quality measurement systems.

Both models build upon the CEC Model by:

- Including beneficiaries with stage 4 and stage 5 CKD before they progress to ESRD;
- Incorporating financial incentives to promote greater utilization of transplants;
- Including post-transplant beneficiaries;
- Empowering nephrologists to take the lead in coordinating care for all eligible beneficiaries;
- Altering payment policy for nephrologists; and
- Incorporating benefit enhancements like increased access to skilled nursing care, telehealth services, and Kidney Disease Education (KDE).

The two models address the same range of beneficiary participants, including:

- Beneficiaries with CKD stages 4 and 5;
- Beneficiaries with ESRD receiving maintenance dialysis; or
- Beneficiaries aligned with one of the two models' participants that have received a kidney transplant.

Attribution of beneficiaries to a model participant will be determined by where the beneficiary receives the majority of their kidney care. Beneficiaries will remain aligned to that participant for three years following a successful kidney transplant. Beneficiaries can be realigned to a different participant if a kidney transplant fails.

These two models differ with regards to which types of providers are permitted to participate. Participation in the KCF Model is limited to nephrologists or nephrology practices. Participants in the CKCC are required to include nephrologists or nephrology practices and transplant providers, but also permits optional participation by dialysis facilities and other providers.

Payment incentives in the two models also differ. In the KCF Model, participants will receive adjusted capitated payments based on historical claims. The adjustments will be made on the basis of beneficiaries' health outcomes and utilization compared to the participants' own past performance, national standards, and quality measures. KCF participants will receive a bonus payment for every aligned beneficiary who receives a kidney transplant.

In the CKCC model, participants have three distinct accountability or payment frameworks, which are identical to the frameworks contained within the Primary Care First and Direct Contracting models:

1. Graduated Model: A one-sided risk-model which allows certain participants to begin under a lower-reward one-sided model and incrementally phases into greater risk and greater potential reward.
2. Professional Model: Participants may earn 50 percent of shared savings or be liable for 50 percent of shared losses based on the total cost of Medicare Part A and Part B services of aligned beneficiaries.
3. Global Model: Participants have 100 percent risk of the total cost of care for all Part A and Part B services of aligned beneficiaries.

CMS is considering several benefit enhancements and waivers for both models. Those being considered include:

- Permitting additional types of providers to provide kidney disease education services;
- Permitting the provision of telehealth services in non-rural areas;
- Waiving the skilled nursing facility 3-day rule;
- Permitting auxiliary personnel to furnish in-home services following beneficiary hospital discharge;
- Permitting home visits for the purposes of care management; and
- Waiving the "confined to home" requirement for home health services.

Participation in the KCF and CKCC Models is voluntary and they will operate from January 1, 2020, through December 31, 2023. Participants of both models will not be subject to payment penalties until the second year of the Models, 2021. Both models are expected to qualify as Advanced APMs beginning in 2021.

HMA continues to analyze these payment and care delivery models including modeling the payment impact of these changes for our clients. We will monitor any additional announcements from CMS related to these payment models. For more information or questions about HMA's Medicare Practice, please contact Mary Hsieh or Jon Blum.

## MORE THAN 300 HAVE ALREADY REGISTERED TO ATTEND HMA'S ANNUAL MEDICAID CONFERENCE

More than 300 executives from health plans, providers, state and federal government, investment firms, and community-based organizations have already registered to attend HMA's annual conference, titled *The Next Wave of Medicaid Growth and Opportunity: How Payers, Providers, and States Are Positioning Themselves for Success*, September 9-10, at the Chicago Marriott Downtown Magnificent Mile.

This is the fourth annual Medicaid conference presented by HMA. Visit our website and register now: <https://conference.healthmanagement.com/> or contact Carl Mercurio at 212-575-5929 or [cmercurio@healthmanagement.com](mailto:cmercurio@healthmanagement.com). Group rates and sponsorships are available.

The conference will feature a high-level list of 45 industry speakers who will address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations. There will also be a Pre-Conference Workshop on Sunday, September 8.

Speakers this year include:

### State Medicaid Speakers (In alphabetical order)

- Natalie Angel, Healthy Indiana Plan Director, Indiana Office of Medicaid Policy and Planning
- Mari Cantwell, Chief Deputy Director, Health Care Programs, California Department of Health Care Services
- Mandy Cohen, MD, Secretary, North Carolina Department of Health and Human Services
- Doug Elwell, Medicaid Director, Illinois Department of Healthcare and Family Services
- Carole Johnson, Commissioner, New Jersey Department of Human Services
- Rebecca Jones-Gaston, Executive Director, Social Services Administration, Maryland Dept. of Human Services
- Karen Kimsey, Chief Deputy, Virginia Department of Medical Assistance Services
- Tricia Roddy, Director, Planning Administration, Health Care Financing, Maryland Medicaid
- Dennis Smith, Senior Advisor, Medicaid and Health Care Reform, Arkansas Department of Human Services
- Jami Snyder, Director, Arizona Health Care Cost Containment System
- Betsey Tilson, MD, Chief Medical Officer, North Carolina Department of Health and Human Services
- Carol Steckel, Commissioner, Kentucky Division of Medicaid Services

### Medicaid Managed Care Speakers (In alphabetical order)

- Jean Caster, HIP Program Director, Anthem Indiana Medicaid
- Heidi Garwood, President Medicaid, Health Care Service Corp.
- Janet Grant, Regional Vice President, Great Plains Region, Aetna Medicaid
- Brad Lucas, MD, Senior Medical Director, Buckeye Health Plan

- Joanne McFall, Market President, Keystone First Health Plan
- Sarita Mohanty, MD, VP, Care Coordination, Kaiser Permanente
- Kevin Moore, VP, Policy, Health & Human Services, UnitedHealthcare Community & State
- Dennis Mouras, CEO, UnitedHealthcare Community Plan of Michigan
- Elise Pomerance, MD, Senior Medical Director, Practice Transformation, Inland Empire Health Plan
- Allison Rizer, VP, Strategy & Health Policy, Medicare/Medicaid Integration, UnitedHealthcare Community & State
- Lois Simon, EVP, Policy and Programs, Seniorlink
- Patrick Sturdivant, President, Virginia Medicaid Health Plan, Anthem, Inc.
- Paul Tufano, Chairman, CEO, AmeriHealth Caritas

#### Provider Speakers (In alphabetical order)

- Fred Cerise, MD, President, CEO, Parkland Health & Hospital System
- Alan Cohn, CEO, President, AbsoluteCARE Inc.
- Deepu George, Division Chief - Behavioral Medicine, Department of Family & Preventive Medicine, UTHealth
- Mitchell Katz, MD, President and CEO, NYC Health + Hospitals
- Rebecca Kavoussi, President, West, Landmark Health
- Sharon Raggio, President, CEO, Mind Springs Health
- Walter Rosenberg, Director, Social Work and Community Health, Rush University Medical Center
- René Santiago, Deputy County Executive, County of Santa Clara, CA
- Deborah Weidner, MD, VP, Safety and Quality, Behavioral Health Network, Hartford HealthCare

#### Additional Leading Industry Speakers (In alphabetical order)

- Jonathan Blum, Managing Principal, HMA; former CMS Deputy Administrator for Medicare
- John Coster, Director, Division of Pharmacy Center for Medicaid and CHIP Services, CMS
- Terry Cothran, Director, Pharmacy Management Consultants, University of Oklahoma College of Pharmacy
- Jack Dailey, Director of Policy and Training, Coordinator of Consumer Center for Health Education and Advocacy, Legal Aid Society of San Diego, Inc.
- Josh Fredell, Senior Director, Specialty Product Development, CVSHealth
- Ray Hanley, President and CEO, AFMC
- Jimmy Lewis, CEO HomeTown Health, LLC
- Darren Moore, Senior Director, Value and Market Access, Melinta Therapeutics
- Corey Waller, Principal, HMA
- Tracy Wareing Evans, Executive Director, American Public Human Services Association
- Alan Weil, Editor-in-Chief, Health Affairs





## HMA MEDICAID ROUNDUP

### *Arizona*

**Arizona Releases RFP for Managed Foster Care ASO Serving Children Enrolled in CMDP.** On July 15, 2019, the Arizona Department of Child Safety released a request for proposals for an administrative service organization (ASO) to provide managed foster care services to children enrolled in the state's Comprehensive Medical and Dental Program. The selected ASO will implement, manage, and provide integrated services, including network development, claims/encounter processing, and provider claim disputes.

**Arizona Faces Concerns Over Choice of New Correctional Health Care Company.** *The Arizona Republic* reported on July 10, 2019, that Centurion, a Centene subsidiary and new managed health care provider for the Arizona Department of Corrections, has faced lawsuits alleging inadequate care. The state recently named Centurion to replace Corizon as the correction health care provider, following similar complaints. [Read More](#)

### *Florida*

**Rural Counties Express Concerns About Medicaid Expansion Proposal.** *The Daily Commercial/The News Service of Florida* reported on July 16, 2019, that 29 counties in rural Florida are concerned about the prospect of Medicaid expansion because they might have to raise property taxes to support the program. These small, poor counties in northern and south-central Florida expressed their reservations to state economists, who are analyzing the potential impact of a proposed Medicaid expansion ballot initiative. [Read More](#)

### *Indiana*

**Indiana Implements Medicaid Work Requirements.** *The Associated Press* reported on July 14, 2019, that Indiana is the latest state to implement Medicaid work requirements, impacting about 72,000 beneficiaries, effective July 1. Medicaid members must report 20 hours of work per month (increasing to 80 hours per month by July 2020) to maintain coverage. [Read More](#)

## Iowa

**Iowa Medicaid Managed Care Plans to Receive An 8.6 Percent Rate Increase.** *The Des Moines Register* reported on July 10, 2019, that Iowa officials have agreed to an 8.6 percent rate increase in fiscal year 2020 for the two Medicaid managed care plans in the state. Amerigroup and Iowa Total Care (Centene) will receive a \$386 million total increase in capitation rates. [Read More](#)

## Maryland

**Maryland Files Lawsuit Against Group Home Provider Over Treatment of Children with Disabilities.** *ProPublica* reported on July 12, 2019, that the Maryland Attorney General has filed a lawsuit against Bellwether Behavioral Health (formally AdvoServ), claiming the group home abused children with intellectual and developmental disabilities. Bellwether has faced similar allegations in other states. Maryland paid the company more than \$230,000 a year to care for each child. [Read More](#)

## Minnesota

**Commissioner of Health Services Resigns.** *The Star Tribune* reported on July 12, 2019, that Tony Lourey, commissioner of the Minnesota Department of Human Services, has resigned after just six months on the job. Pam Wheelock, who was most recently with Twin Cities Habitat, will serve as acting commissioner. Lourey's departure immediately follows the resignations of long-serving deputy commissioners Claire Wilson and Charles Johnson. [Read More](#)

## Missouri

**Missouri Advocates Gather Signatures for Medicaid Expansion Ballot Initiative.** *KBIA* posted on July 12, 2019, that Missouri advocates are gathering signatures for a Medicaid expansion ballot initiative in 2020. Missouri Jobs with Justice, Faith Voices of Southwest Missouri, and state Representative Crystal Quade (D-Springfield) support the effort. [Read More](#)

## New Mexico

**New Mexico Plans Overhaul of Developmental Disabilities Program to End Waiting Lists.** *Las Cruces Sun News* reported on July 10, 2019, that New Mexico Governor Lujan Grisham plans to overhaul the state's program for individuals with developmental disabilities, in hopes of improving care and ending a decades-long waiting list within six years. About 5,000 people are currently on the waiting list. [Read More](#)

## New York

### HMA Roundup – Denise Soffel ([Email Denise](#))

**New York to Host Webinar on EPIC Program Assistance with Medicare Part D.** On July 30, 2019, the New York Department of Health will host a webinar on Elderly Pharmaceutical Insurance Coverage (EPIC) program policies for providing assistance with the Medicare Part D Late Enrollment Penalty from 10:00 am to 11:00 am. To register, please click [here](#).

**UHF Report Reviews New York Delivery System Reform Incentive Payment Program Promising Practices.** The United Hospital Fund has released a report that examines New York’s Delivery System Reform Incentive Payment program (DSRIP). Under DSRIP, health and social care providers across the state formed collaborative networks called Performing Provider Systems (PPSs) to implement innovative demonstration projects focused on system transformation, clinical improvement, and population health improvement. The report distills a review of PPS projects to assess common themes across the projects, and identify key lessons. The report identifies four arenas of DSRIP activity: Core Infrastructure and Capacity Building; Social Needs, Community Partnerships and Cross-Sector Collaborations; Care Coordination, Care Management and Care Transitions; and Transforming and Integrating Behavioral Health Care. Five take-aways are identified:

- Substantial infrastructure is required to support projects with sufficient scope to drive outcome improvement across large populations of Medicaid members attributed to individual PPSs.
- Projects targeting complex patients, who drive much of Medicaid utilization and spending, can substantially improve outcomes for small groups of patients (and likely generate cost savings).
- DSRIP has greatly accelerated the focus on social determinants of health by facilitating partnerships between health care providers, community-based social service organizations, and other community partners.
- For the most complex populations, substantial care management/coordination and support for care transitions appear necessary to change patients’ trajectories.
- Given the prevalence of individuals in Medicaid with behavioral health needs, the heterogeneity of those needs, and this population’s relatively high utilization and costs, some of the most promising practices focused on expanding access and developing new approaches to meeting patients where they are as ways to better engage them in treatment.

The report concludes that with additional time and support to bridge the gap to Value Based Payment DSRIP’s substantial investments could yield a lasting impact. The DSRIP waiver ends on March 31, 2020; the state is in the process of developing a waiver extension request to CMS. [Read More](#)

**OIG Releases New York Health Home Program Audit.** The Office of the Inspector General has released an audit of New York’s Health Home program that found that the state claimed federal reimbursement for some payments to health home providers that did not meet Medicaid requirements. OIG looked at all health home claims from 2012-16 and selected a sample of 100 claims to review. They found problems with 22 of the 100, and from that extrapolated that 22 percent of all health home claims over the four-year period were problematic. OIG noted deficiencies in five areas:

- Care plan not documented or provided, or no beneficiary participation in care plan development - 13
- Services not documented - 5
- Services billed incorrectly - 4
- Services not provided - 1
- Duplicate services billed - 1

The OIG recommends that New York refund \$65 million to the federal government. They also recommend that New York improve monitoring of the Health Home program to ensure that health home providers comply with Federal and State requirements. In its response the state identifies a series of steps it has taken to improve monitoring of the program. These include:

- On-site re-designation surveys, and technical assistance and quality monitoring to review policies and procedures, quality management activities, and performance improvement projects. (August 2015)
- Implementation of a state-wide health home tracking system (April 2016)
- Development of a health home quality monitoring and oversight policy (June 2017)
- Implementation of a Health Home Dashboard
- Release of a Health Home Care Management Assessment Reporting Tool

**New York Used Budget Maneuver to Keep Medicaid Spending Within Global Cap.** The Empire Center reported on July 9, 2019, that New York's Medicaid program would have far exceeded the global Medicaid spending cap last year had Medicaid payments for the last week of the fiscal year been made before the end of the fiscal year on March 31. Instead, payments were delayed a week, shifting payments of \$1.7 billion into the new fiscal year. That allowed spending for SFY 2019 to remain within the cap. It raises concerns, however, about the state's ability to control spending in the current fiscal year. The Medicaid program has been operating under a global spending cap enacted as part of the state budget as a part of New York's delivery system redesign efforts since 2012, calculated as the 10-year average of the medical care consumer price index. New York's Medicaid spending exceeded the Global Cap for the first time in late 2017 and continued through early 2018. Spending came in \$6 million under the \$19.5 billion target for FY 2018; spending exceeded last year's cap of \$20.8 billion by \$900 million. Should spending exceed the cap, the Commissioner of Health in conjunction with the Department of Budget is empowered to enact spending cuts to meet the cap. That authority has never been tested, but remains a potential threat should costs growth exceed the spending cap. [Read More](#)

## *North Carolina*

**North Carolina Begins Transition to Medicaid Managed Care Despite Budget Dispute.** *The Winston-Salem Journal* reported on July 15, 2019, that North Carolina began its transition to Medicaid managed care with enrollment in the Triad and Triangle areas for coverage effective November 1. Coverage is set to take effect in the rest of the state in February. However, the transition could be delayed by a budget dispute, which is holding up start-up funding needed for the transition. [Read More](#)

## Oregon

**Oregon CCO Struggles to Build Portland Provider Network.** *The Portland Business Journal* reported on July 15, 2019, that Centene's Trillium Community Health Plan, a coordinated care organization serving Lane County, OR, is struggling to build a provider network in the Portland area where it is hoping to expand. Trillium hasn't been able to sign any of the the large hospital systems in Portland, all of which are part of the area's only CCO - Health Share of Oregon. [Read More](#)

**Exchange Rates to Rise 1.5 Percent for 2020 After Final Adjustment.** The Oregon Division of Financial Regulation announced on July 16, 2019, that individual health insurance premium rates for 2020 Exchange plans will increase an average of 1.5 percent for 2020. That's 100 basis points lower than the division's preliminary rate decision and two percent below what insurers requested. Rate changes range from a 3.2 percent decline to an 8.9 percent increase. Insurers have 21 days to respond before the final rates are set for 2020. [Read More](#)

## Puerto Rico

**Medicaid Funding Bill Advances Amid Corruption Scandal.** *The New York Times* reported on July 11, 2019, that the U.S. House Health Subcommittee advanced legislation that would give the Puerto Rico Medicaid program an additional \$12 billion over four years. The bill does not address the recent allegations of Medicaid fraud by former Health Insurance Administration executive director Angela Avila-Marrero or other top government officials indicted Wednesday. The bill is intended to prevent a massive shortfall of federal funds for the Medicaid program, and lawmakers hope to add rigorous oversight components to the bill in response to the scandal. [Read More](#)

## Tennessee

**Children Lost Medicaid Coverage Over Paperwork.** *The Tennessean* reported on July 14, 2019, that late, incomplete, or unreturned paperwork was the most likely reason why a child in Tennessee might lose Medicaid coverage from 2016 through 2018. TennCare, the state Medicaid program, had relied on paper forms and postal mail until earlier this year, when a new system was implemented. Over the last three years, at least 220,000 children lost coverage or were at risk of losing coverage in the state. [Read More](#)

## West Virginia

**West Virginia Delays CHIP Transition to Managed Care to 2020.** West Virginia announced on July 10, 2019, that it has delayed the transition to managed care of the state's Children's Health Insurance Program until July 2020. The transition had originally been set for July 1, 2019. The West Virginia Department of Health & Human Resources is expected to release more details next year. [Read More](#)

## National

**CMS Releases Medicaid Section 1332 Waiver Application Resource Tools.** The Centers for Medicare & Medicaid Services (CMS) released on July 15, 2019, resource tools to help states better understand and apply for Medicaid Section 1332 waivers. The tools include a checklist of required waiver elements and model templates designed to help states better understand and navigate the waiver application process. [Read More](#)

**Biden Unveils \$750 Billion Proposal to Build on Affordable Care Act.** *NN* reported on July 15, 2019, that Democratic presidential candidate Joe Biden unveiled a health care proposal to provide federal Exchange subsidies to anyone regardless of income and launch a public option allowing people to buy into a program similar to Medicare. The option would also cover individuals in non-expansion states who would have been covered under Medicaid expansion. The proposal would cost \$750 billion over 10 years. Biden's proposal builds on former President Barack Obama's Affordable Care Act. [Read More](#)

**CMS Proposes Elimination of Access Monitoring Review Plans.** The Centers for Medicare & Medicaid Services (CMS) announced on July 11, 2019, a proposed rule that would eliminate the state requirement to submit access monitoring review plans (AMRP) every three years. AMRPs were established in 2015 to help ensure sufficient access to Medicaid fee-for-service programs. CMS called the requirements outdated and an administrative burden. [Read More](#)

**CMS Hopes to Recoup \$1 Billion in Medicare Advantage Overpayments in 2020.** *Kaiser Health News* reported on July 16, 2019, that the Centers for Medicare & Medicaid Services (CMS) hopes to recoup \$1 billion in overpayments to Medicare Advantage plans by 2020. The proposed initiative includes use of an enhanced audit tool. Government estimates suggest that overpayments have reached nearly \$30 billion in the past three years. [Read More](#)

**Trump Administration Backs Off Plan to Limit Medicare Drug Rebates.** *The Wall Street Journal* reported on July 11, 2019, that the Trump administration is withdrawing a proposal to curtail Medicare drug rebates paid by pharmaceutical companies to pharmacy benefit managers. The proposal had been a key component of the president's blueprint to lower prescription drug prices. [Read More](#)

**Value-Based Care Advocate Adam Boehler to Leave HHS.** *Bloomberg News* reported on July 10, 2019, that Adam Boehler, who led the federal push for value-based payments, will be leaving his position as director of the Center for Medicare & Medicaid Innovation. Boehler, who has been nominated to lead the International Development Finance Corp., helped create value-based payment models, worked to pay competitive drug prices, and advocated for in-home dialysis treatment. [Read More](#)

**Medicaid Innovation Accelerator Program to Host National Learning Webinar: Widening the Lens: Treatment for Alcohol and Stimulant Use Disorders.** On August 8, 2019, from 3:00 PM – 4:30 PM EDT, the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program's (IAP) Reducing Substance Use Disorder (SUD) program area is holding a webinar on the topic of broadening the national focus from opioid use disorder (OUD) to address alcohol and stimulant use disorders. In this webinar, participating states will learn about strategies for the treatment of alcohol use disorder (AUD), including medication-assisted treatment and AUD treatment coordinated with primary care. The webinar speakers will also provide an overview of treatment issues regarding stimulant use disorder such as patient retention and evidence-based models. Lastly, the webinar will walk participants through California Medicaid program's efforts to build a robust treatment delivery system to broadly address substance use disorders. *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](#).

**Medicaid Innovation Accelerator Program to Host National Learning Webinar: Demonstrating the Impact of Supportive Housing.** On August 7, 2019, from 2:00 PM – 3:30 PM EDT, the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program (IAP) is hosting a national learning webinar. During this webinar, a framework and measures to demonstrate the impact of supportive housing will be presented. The webinar includes a discussion on the benefits of undertaking this type of work, as well as specific measures used across the country to assess the impact that providing supportive housing can have on health care utilization costs, homelessness, criminal justice, and other systems. Participants will also learn about tips to get started measuring supportive housing impact and considerations for working with outcomes data. Two state Medicaid directors will serve as webinar respondents and will share information about their states' work in measuring the impact of supportive housing and the importance of state Medicaid-housing partnerships in developing supportive housing options for Medicaid beneficiaries. *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

**Optum to Manage Key Administrative Functions for John Muir Health.** Optum, a UnitedHealth Group company, will manage key non-clinical functions for San Francisco-based John Muir Health, the two organizations announced on July 17, 2019. Functions will include information technology, revenue cycle management, analytics, purchasing and claims processing. Optum will also support ambulatory care coordination and utilization management. As part of the arrangement, approximately 540 John Muir Health employees will become Optum employees. [Read More](#)

**Aflac to Acquire Argus Holdings.** *Health News Florida* reported on July 16, 2019, that supplemental insurer Aflac is acquiring Florida-based Argus Holdings, a dental and vision insurance company, for \$75 million. Aflac already sells group dental and vision insurance. The acquisition will allow Aflac to expand into the individual market, including Medicaid, Medicare Advantage, and the Children's Health Insurance Program. [Read More](#)

**Blue Sprig Pediatrics Acquires Thrive Autism Solutions.** On July 11, 2019, Blue Sprig Pediatrics announced the acquisition of Thrive Autism Solutions, a provider of autism Applied Behavioral Analysis therapy services in Missouri and Arkansas. Terms of the transaction were not disclosed. [Read More](#)

**Rideshare Companies Are Eager to Build NEMT Footprint.** *The Wall Street Journal* reported on July 10, 2019, that rideshare companies have been working to build a footprint in non-emergency medical transportation (NEMT), but it's unclear how popular the services will be with Medicaid patients. Uber says it is working with more than 1,000 health care organizations, and Lyft is also expanding into new markets, including Arizona. [Read More](#)

**Little Spurs Pediatric Urgent Care Acquires All Children's Urgent Care.** Great Point Partners portfolio company Little Spurs Pediatric Urgent Care announced on July 10, 2019, the acquisition of All Children's Pediatric Urgent Care, a Garland, TX-based clinic that provides comprehensive health care for children. The acquisition expands Little Spurs into the Dallas-Fort Worth metro area. [Read More](#)

**Norwest Venture Partners Invests in Gateway Learning Group.** Norwest Venture Partners announced on July 10, 2019, that it has invested in Gateway Learning Group, an Applied Behavior Analysis provider for children with autism spectrum disorder. Gateway provides services in 17 counties in California. [Read More](#)



**MVP Health Care to End Relationship With Beacon Health Options.** MVP Health Care, a New York-based insurer, announced on July 9, 2019, that it will be ending its relationship with managed behavioral health company Beacon Health Options in early 2020. MVP will manage its own behavioral health benefits in hopes of better integrating physical and behavioral health care. Beacon has been administering behavioral benefits for MVP since 2009. [Read More](#)

## RFP CALENDAR

Date	State/Program	Event	Beneficiaries
2019	Hawaii	RFP Release	360,000
July 2019	Louisiana	Awards	1,500,000
July 19, 2019	Minnesota MA Families and Children; MinnesotaCare	Awards	679,000
July 19, 2019	Minnesota Senior Health Options; Senior Care Plus	Awards	55,000
August 2019	Ohio	RFI #2 Release	2,360,000
August 30, 2019	Texas STAR+PLUS	Awards	530,000
August 30, 2019	Texas STAR and CHIP	Contract Start Date	3,400,000
September 1, 2019	New Hampshire	Implementation	181,380
Early Fall 2019	Massachusetts One Care (Duals Demo)	Awards	150,000
October 1, 2019	Arizona I/DD Integrated Health Care Choice	Implementation	~30,000
November 1, 2019	North Carolina - Phase 1	Implementation	1,500,000
2020	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	RFP Release	315,000
2020	California Two Plan Commercial - Los Angeles	RFP Release	960,000
2020	California Two Plan Commercial - Riverside, San Bernardino	RFP Release	148,000
2020	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	RFP Release	265,500
2020	California GMC - Sacramento	RFP Release	430,000
2020	California GMC - San Diego	RFP Release	700,000
2020	California Imperial	RFP Release	76,000
2020	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	RFP Release	295,000
2020	California San Benito	RFP Release	8,000
January - March 2020	Ohio	RFP Release	2,360,000
January 1, 2020	Louisiana	Implementation	1,500,000
January 1, 2020	Wisconsin MLTC Family Care and Family Care Partnership Select Service Areas in GSR 9, 10, and 13	Implementation	
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2020	Hawaii	Implementation	360,000
January 1, 2020	Minnesota MA Families and Children; MinnesotaCare	Implementation	679,000
January 1, 2020	Minnesota Senior Health Options; Senior Care Plus	Implementation	55,000
January 1, 2020	Washington Integrated Managed Care - Great Rivers (Cowlitz, Grays Harbor, Lewis, Pacific, and Wahkiakum Counties); Salish (Clallam, Jefferson, and Kitsap Counties); Thurston-Mason (Mason and Thurston Counties)	Implementation for RSAs Opting for 2020 Start	~1,600,000 program total
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	150,000
January 1, 2020	Florida Healthy Kids	Implementation	212,500
January 1, 2020	Oregon CCO 2.0	Implementation	840,000
February 1, 2020	North Carolina - Phase 2	Implementation	1,500,000
July 1, 2020	Kentucky	Implementation	1,200,000
September 1, 2020	Texas STAR+PLUS	Operational Start Date	530,000
September 1, 2020	Texas STAR and CHIP	Operational Start Date	3,400,000
September 1, 2021	Texas STAR Health (Foster Care)	Operational Start Date	34,000
January 2023	California Two Plan Commercial - Alameda, Contra Costa, Fresno, Kings, Madera, San Francisco, Santa Clara	Implementation	315,000
January 2023	California Two Plan Commercial - Los Angeles	Implementation	960,000
January 2023	California Two Plan Commercial - Riverside, San Bernardino	Implementation	148,000
January 2023	California Two Plan Commercial - Kern, San Joaquin, Stanislaus, Tulare	Implementation	265,500
January 2023	California GMC - Sacramento	Implementation	430,000
January 2023	California GMC - San Diego	Implementation	700,000
January 2023	California Imperial	Implementation	76,000
January 2024	California Regional - Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba	Implementation	295,000
January 2024	California San Benito	Implementation	8,000

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## HMA NEWS

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Upcoming Webinar on July 24, 1-2 ET. [Initiating a Successful Medicare Advantage Plan: Strategic, Operational and Planning Considerations](#)

### New this week on HMA Information Services (HMAIS):

#### Medicaid Data

- Delaware Medicaid Managed Care Enrollment Is Flat, Jan-19 Data
- Kentucky Medicaid Managed Care Enrollment is Flat, May-19 Data
- Massachusetts SNP Membership at 54,033, Mar-19 Data
- Minnesota Medicaid Managed Care Enrollment is Down 1.7%, Jul-19 Data
- Missouri Medicaid Managed Care Enrollment is Down 7.7%, Jun-19 Data
- Oregon Medicaid Managed Care Enrollment is Down 2.9%, Jun-19 Data
- Utah Medicaid Managed Care Enrollment is Down 2.1%, Jul-19 Data
- Wisconsin Medicaid Managed Care Enrollment is Up 1.6%, May-19 Data

#### Public Documents:

##### *Medicaid RFPs, RFIs, and Contracts:*

- Alaska Medicaid Vision Program Services RFP, 2019
- Arizona AHCCCS Works Portal RFP, Award, Scoring Summary and Proposals, Jun-19
- Arizona Medicaid Foster Care Administrative Service Organization - Integrated Healthcare RFP, Jul-19
- Hawaii Dental Services for Youth Incarcerated at the Hawaii Youth Correctional Facility RFP, Jul-19
- Iowa Health Link: New Contract Summary, Jul-19
- Kentucky Medicaid Managed Care Contract Summary of Modifications, SFY 2020
- Virginia Medicaid Behavioral Health Services Administrator RFP, Response, and Contract, 2012-18

##### *Medicaid Program Reports, Data and Updates:*

- Iowa Health Link Managed Care Contracts and Amendments, 2019
- Iowa Medicaid Managed Care Rate Certification, FY 2019
- Iowa Medicaid MCO Quarterly Performance Reports, 2016-3Q19
- Kentucky HEALTH Substance Use Disorder (SUD) 1115 Demonstration Update Presentation, Jun-19
- Kentucky Medicaid Oversight and Advisory Committee Meeting Materials, Jul-19
- Kentucky Section 1115 Demonstration Revised Waiver Application, Statement on Work Requirements Ruling, and Related Documents, 2016-19
- Missouri Rate Increase for Behavioral Health Services, Jul-19
- New York DOH Medicaid Updates, Jun-19
- South Carolina Medicaid Managed Care Rate Certifications, SFY 2019-20
- Virginia Medallion 4.0 Rate Reports, 2019-20
- Virginia Medicaid Member Advisory Committee Meeting Materials, Jun-19
- West Virginia Children's Health Insurance Program (CHIP) Annual Report, 2018

- West Virginia Medicaid Pharmacy Savings Report, Apr-19
- West Virginia Medicaid Provider Newsletters, 2016-18

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