HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 14, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

HMA CONFERENCE ON INTEGRATED DELIVERY IS JUST A MONTH AWAY, MORE THAN 200 ALREADY REGISTERED TO ATTEND

This week, our *In Focus* section provides an update on HMA's inaugural conference on *The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*, October 10-12, 2016, at The Palmer House in Chicago. More than 200 industry leaders have already registered to attend, including top executives from hospitals, health systems, clinics, provider practices, community-based organizations, and Medicaid managed care plans. Featuring 37 high-level industry speakers, conference panels and breakout sessions are designed to inspire discussion about real-world approaches to

helping provider organizations improve the health status of patient populations, lower costs, and ensure a more satisfactory patient experience. Visit the conference website at https://fpsh.healthmanagement.com/ for complete details.

Important Sessions on Integrated Care Delivery

HMA's inaugural conference, *The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*, October 10-12, 2016, in Chicago, will identify best practices, resources, tools and approaches to help providers deliver integrated care effectively within single systems and through collaboration among multiple providers and community-based services.

Among the Featured Sessions:

- Rush University Medical Center Chief Executive **Larry Goodman**, MD, will outline a new care model for academic medical centers, with an emphasis on provider collaboration, building communities, and fostering integrated care delivery for vulnerable patient populations.
- Representatives of leading public health systems will engage in a frank and high-level assessment of their ongoing efforts to re-evaluate every aspect of how they coordinate, integrate and deliver care. Speakers will include **Frederick Cerise**, MD, President and CEO, Parkland Health & Hospital System; **Barbara Garcia**, MPA, Director of Health, San Francisco Department of Public Health; **Ramanathan (Ram) Raju**, MD, President and CEO, NYC Health + Hospitals; and **John Jay Shannon**, MD, CEO, Cook County Health & Hospitals System.
- **Eliot Fishman**, PhD, Director of the State Demonstrations Group at CMS' Center for Medicaid and CHIP Services, will discuss the role of government in supporting innovation in Medicaid.
- Representatives from health systems, health plans, and community-based organizations will outline strategies for integrating behavioral health and addressing social determinants of health. Speakers will include **Frances Isbell**, CEO, Healthcare for the Homeless – Houston; **Marcia Guida James**, National Lead, Value-Based Solutions, Aetna; **Ross Owen**, Director, Hennepin Health; **Rachel Solotaroff**, MD, Chief Medical Director, Central City Concern; **Teri Trivisonno**, Interim National Director, Healthcare Operations, Planned Parenthood Federation of America; and **Martha Whitecotton**, SVP, Behavioral Health Services, Carolinas HealthCare System.
- Medicaid managed care executives and health systems executives will discuss best practices for collaborating on integrated care delivery for vulnerable populations. Speakers will include **Catherine Anderson**, Vice President of State Programs, UnitedHealthcare Community & State; **Andrea Gelzer,** MD, Senior Vice President and Corporate Chief Medical Officer, AmeriHealth Caritas; **Beth Marootian**, Director of Business Development, Neighborhood Health Plan of Rhode Island; and **Alvia Siddiqi,** MD, Medical Director, Advocate Physician Partners.
- **Arthur Gianelli**, President of Mount Sinai St. Luke's and Mount Sinai PPS, LLC; **Bruce Goldberg**, MD, Former Director, Oregon Health Authority; and **Cindy Mann**, Partner, Manatt Health, will show how

states are fostering integrated care delivery through provider-led organizations that coordinate care for Medicaid patients under global or capitated payment arrangements.

- **Bill Barcellona**, Senior Vice President, Government Affairs, CAPG; **Wendy Burkholder**, Chief Clinical Operating Officer, Arizona-based District Medical Group**;** and **Dan Castillo**, Chief Executive, LA County USC Medical Center, will outline the type of system-wide operational, organizational, and policy changes required by health systems when transforming into integrated delivery systems.
- Healthcare IT experts from hospitals, health plans and government will outline how the right type of IT framework can be used to target, profile, and stratify vulnerable populations. Speakers will include **David Horrocks**, President, Chesapeake Regional Information System for Our Patients (CRISP); **Jim Sinkoff**, EVP, CFO, Hudson River HealthCare; **Hope Glassberg**, VP, Strategic Initiatives & Policy, Hudson River HealthCare; and **Rick Hopfer**, Chief Information Officer, Molina Healthcare, Inc.
- How to design a successful, evidence-based care management program for vulnerable populations will be the topic of a panel of speakers including **Bonnie Pilon**, Alexander Heard Distinguished Service Professor, Vanderbilt School of Nursing at Scarritt Place; **Kate Erickson**, Integrated Care Program Manager, Community-University Health Care Center; **Molly Siegel**, Executive Director, Coordination of Healthcare for Complex Kids (CHECK), University of Illinois at Chicago; and **Kenita Perry-Bell**, Director of Care Coordination, CHECK.
- **Sharon Youmans**, PharmD, Professor, Vice Dean, UCSF School of Pharmacy; **Lee Francis**, MD, President & CEO, Erie Family Health Center; and **Anthony Perry**, MD, VP, Population Health and Ambulatory Services, Rush University Medical Center, will discuss the need to develop new skill sets among providers taking on increasingly managerial roles.
- A special session including case studies of successful integrated delivery models will include as speakers **Doug Elwell**, Deputy CEO for Finance and Strategy, Cook County Health and Hospitals System; **Cheryl Lulias**, Executive Director, Medical Home Network; **Sean Jessup**, Director of Medicaid Programs, Moda Health; and **Chuck Hofmann**, MD, Clinical Consultant, Eastern Oregon Coordinated Care Organization.

Unparalleled Lineup of Speakers; Plus Post-Conference Workshop

Keynote speakers and panelists from provider organizations, health plans, and government will identify proven strategies for implementing accountable care models, developing population health management infrastructures, and reengineering operational capabilities around care integration.

Breakout sessions and workshops will focus on the nuts and bolts of building integrated delivery systems, including important insights into care management, social determinants of health, behavioral health integration, leadership training, operational priorities, and information technology needs.

HMA will also join Rush University Medical Center to host a special Post-Conference Adaptive Leadership Workshop on October 12 to help your

organization identify and foster a unique, real-world approach to driving system transformation.

For additional information on the conference or the Workshop, contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates are available.

HMA Medicaid Roundup

Alabama

Alabama Received $100 Million in Federal Medicaid Overpayments, Audits Say. *DecaturDaily.com* reported on September 11, 2016, Alabama received more than $100 million in federal overpayments to the state's Medicaid program, according to recent federal audits. The overpayments included $75 million between 2010 and 2012 in wrongful claims for school-based Medicaid administrative costs, one audit says. The Alabama Medicaid Agency disagrees with the finding and hopes to work with CMS to resolve the issue. Read More

House Again Approves Use of Oil Spill Settlement Funds for Medicaid. *Montgomery Advertiser* reported on September 7, 2016, that the Alabama House again approved the use of funds from an oil spill settlement to help fund the state's Medicaid program. The compromise would free up $70 million in state funds to fill a Medicaid budget gap, as well as directly allocate $15 million to Medicaid fiscal 2017 and $105 million in fiscal 2018. The legislation still requires approval by the state Senate. The bill also requires the state to reverse cuts made to Medicaid physician reimbursements and fund outpatient dialysis care. The House passed a similar bill in August, but failed amid a disagreement over funding for roads. Read More

Arkansas

Arkansas Releases Draft RFP for Medicaid Managed Care Dental Services. On September 2, 2016, Arkansas released a draft request for proposals (RFP) for Medicaid dental managed care services, with the final RFP expected on October 31, 2016. Two vendors will be awarded contracts, with services starting January 1, 2018. The total life of the contracts, including any renewals, will not exceed seven years. Read More

Governor Releases Plan to Trim Medicaid Waiting Lists for Individuals with Developmental Disabilities. *KTHV* reported on September 13, 2016, that Arkansas Governor Asa Hutchinson wants to use tobacco settlement money to trim Medicaid waiting lists for individuals with developmental disabilities. The Governor released a proposal to spend an additional $30 million on Medicaid waivers to address the problem, including $8.5 million from the state's tobacco settlement and the rest from federal matching funds. The plan requires two-thirds majority approval from the state legislature. If approved, it would take effect in June 2017. Read More

Connecticut

Connecticut Extends Moratorium on Hospital Mergers, Certificate of Need Applications. *New Haven Register* reported on September 7, 2016, that Connecticut Governor Dannel P. Malloy extended a ban on hospital mergers for five months. A moratorium on certificate of need applications has also been extended to June 30, 2017. The moratoriums are tied to a broader effort to review the state's certification of need process. A task force studying the certificate of need process is expected to submit its final report by January 15, 2017. Read More

Illinois

Meridian Health Plan of Illinois to Expand into 10 Additional Counties. Meridian Health Plan of Illinois announced on September 13, 2016, that it will expand the availability of its Medicaid managed care plan to 10 additional counties in Central Illinois and offer its Medicaid Integrated Care Program (ICP) in the Quad City area. The move means that effective in 2017 a Meridian Medicaid product will be available in every region of the state. Meridian projects an increase in its Medicaid market share of about three to four percentage points from the expansion. It currently has an 18 percent Medicaid market share in Illinois. Read More

Illinois to Extend Hepatitis C Drug Medicaid Coverage to Patients with Stage 3 Liver Scarring. *Chicago Tribune* reported on September 10, 2016, that Illinois will extend Medicaid coverage of Hepatitis C medication to residents with stage 3 liver scarring. For the past two years, the state only covered drugs for Hepatitis C patients with stage 4 liver scarring. About 12,000 Illinois Medicaid recipients have been diagnosed with Hepatitis C. Among those enrolled in Medicaid managed care, 753 people received treatment last year. Read More

Kentucky

Medicaid Waiver Application Receives Federal Certificate of Completeness. *Lexington Herald Leader* reported on September 8, 2016, that the U.S. Department of Health and Human Services certified the completeness of Kentucky's Medicaid waiver application. The proposal now moves on to the 30-day federal comment period. The proposal would require most Medicaid recipients to pay a premium and also adds a requirement to work, volunteer, or take classes for at least 20 hours a week. Read More

Louisiana

School System in Franklin Parish Helps Employees Enroll in Medicaid Expansion. The Franklin Sun reported on September 7, 2016, that the Franklin Parish school system and Franklin Medical Center are working together to help school employees enroll in the state's Medicaid expansion program. The state expanded Medicaid effective July 1, 2016. Employees making less than $16,000 annually and those with a family of four making less than $33,000 annually are eligible. Franklin Parish School Superintendent Dr. Lanny Johnson estimates that 130 to 140 school employees qualify. Read More

Massachusetts

Massachusetts Starts Waiting List for Elderly Seeking Meal Preparation Services. *Boston Globe* reported on September 10, 2016, that Massachusetts has started a waiting list for elderly and disabled individuals applying for help with meal preparation through the state's home care program. The state's Executive Office of Health and Human Services (EOHHS) blamed budget constraints and growth in the meal preparation program. Effective September 1, up to 200 elderly individuals could be put on a waiting list each month. Elderly individuals with more extensive home care needs, such as help with bathing and grocery shopping, will continue receiving services. The state has resorted to waiting lists for Medicaid home care services three times since 2009, and legislators say they are working to find a long-term solution. Read More

Missouri

Missouri Clears Way for Medicaid to Support Telehealth Services in Schools. *State Scoop* reported on September 6, 2016, that a new Missouri law clears the way for the state's Medicaid program to pay for telehealth services in schools. Services might include physician video consultations, speech therapy, physical therapy, and mental health services. The provision is expected to increase access to care, especially in rural areas, and be particularly beneficial for special needs children. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

NJ Regulators Take Over Health Republic CO-OP Exchange Plan. *NorthJersey.com* reported on September 13, 2016, that New Jersey regulators have taken over health insurance Exchange plan Health Republic, citing the insurer's "hazardous financial condition." Health Republic will not be listed on the Exchange in New Jersey in 2017; however, regulators said the plan may rejoin the Exchange in 2018 if it improves its financial condition. Health Republic is one of just a handful of remaining Consumer Operated and Oriented (CO-OP) plans established under the Affordable Care Act, most of which have gone out of business. The New Jersey Department of Banking and Insurance initiated the takeover. Read More

NJ FamilyCare Covers Insect Repellents to Prevent Zika Infection. On September 9, 2016 the Department of Human Services, Division of Medical Assistance and Health Services released a newsletter to alert providers and contracting managed care organizations of its decision to cover certain over the counter (OTC) insect repellents that aid in preventing infection by the Zika virus, effective immediately. It acknowledged that OTC insect repellents are not covered by Medicare Part D and that for Medicaid beneficiaries who also have Medicare Part D coverage providers should bill this Medicaid claim as primary. The OTC insect repellents are not covered by the Pharmaceutical Assistance to the Aged (PAAD) or Senior Gold Prescription Discount Program (Senior Gold). Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Department of Financial Services Issues Emergency Regulation on Risk Adjustment. The NY Department of Financial Services has issued an emergency regulation intended to address the adverse effects of the federal risk adjustment program on New York's health insurers. The new regulation provides DFS authority to create a market stabilization pool for the small group health insurance market for the 2017 plan year. The new regulation follows a letter to Health and Human Services Secretary Sylvia Burwell in which DFS Superintendent Maria Vullo expressed concern that the CMS risk adjustment program has created inappropriately disparate impacts and unintended consequences among health insurers in New York.

The federal risk adjustment program is intended to result in financial transfers among insurers to account for the health of the insured populations. According to many observers, the federal formula is flawed. In New York, the program has resulted in transfers by insurers of upwards of 30% of premium to other insurers, rewarding larger insurers over smaller entities. Under the new regulation, after CMS makes its 2017 risk adjustment program calculations, DFS will determine if the CMS calculations will have an adverse impact on New York's small group health insurance marketplace. If there is an adverse impact, the Superintendent will implement a "market stabilization pool" taking into account certain factors relevant to the New York market. Utilizing these additional factors, insurers who received money from the risk adjustment program will pay an allocable percentage of that money into a fund administered by DFS. DFS will then transfer that money to those insurers who paid into the risk adjustment program and were adversely impacted. Read More

Medicaid Accountable Care Organization to Open in Buffalo. The Greater Buffalo United Accountable Care Organization has received state approval to form the first accountable care organization in New York State to serve Medicaid and commercial insurance patients. The Greater Buffalo United Accountable Care Organization includes 320 primary care physicians and specialists, handling about 65,000 patients. The local organization is a product of the Greater Buffalo United Accountable Healthcare Network, a medical services provider. Organizers expect the local organization to begin operations next month. Read More

NY Department of Health Long-Term Care Initiative. Department of Health Commissioner Howard Zucker, M.D., announced the appointment of Mark Kissinger to a newly created position of Special Advisor to the Commissioner for Long Term Care. Kissinger had been the Director of the Division of Long Term Care in the Office of Health Insurance Programs. In the new position, Kissinger will be responsible for policy development both within the Department of Health and across all relevant agencies to advance New York's aging and long term care system.

NY Department of Health Seeking Explanations. The New York State Department of Health released a Request for Applications to solicit applications from consortiums in three regions statewide to support Community Based Organizations in specific targeted areas that remain un-served/underserved as part of the DSRIP Program. Proposals were due last month, with awards expected before the end of the year. This week the state posted a message on its

Medicaid Redesign Team listserve seeking to understand the response to the RFA. The message read, in part: "If you did not submit a bid for this opportunity, or were not part of consortium submitting an application, the Department is requesting your assistance in knowing why your organization did not apply or become part of a consortium that did apply. Please send a response by email to OHIPContracts@health.ny.gov by Friday, September 16th."

NYS Office of Alcoholism and Substance Abuse Services Request for Applications. The NYS Office of Alcoholism and Substance Abuse Services (OASAS) announces the availability of funding to support or establish community coalitions and partnerships designed to help coordinate community resources to address substance use prevention, treatment and recovery efforts, respond to community-specific concerns, and increase cross-sector collaboration on the prevention, treatment and recovery of substance use disorders. Core objectives of the program are to develop a regional coalition that cuts across county lines representing a diverse group of stakeholders; demonstrate a partnership relationship with various stakeholders including linkages with an OASAS prevention provider; and develop a resource list of prevention providers, treatment providers and recovery resources.

Up to $100,000 is available annually to support a coalition in each of the 10 New York State Economic Development Zones for a total of $1M annually. Applications are due October 31, 2016. Read More

Ohio

1115 Waiver Proposal is Denied; CMS Cites Concerns Over Plan to Charge Premiums to Medicaid Recipients. *The Columbus Dispatch* reported on September 9, 2016, that CMS has denied Ohio's 1115 Waiver Demonstration application, stating that the proposal did not "support the objectives of the Medicaid program" and would lower access to healthcare for the neediest residents. The waiver, referred to as Healthy Ohio, proposed charging premiums to 600,000 Medicaid expansion members, as well as low-income parents, foster care youth and beneficiaries with breast and cervical cancer. Individuals would also be excluded from coverage until they paid any arrears, a requirement not authorized in any other state, according to CMS. In response to CMS' decision, the state is expected to discuss other options for addressing calls for personal responsibility in Medicaid. Read More

Oklahoma

Oklahoma Announces 3-Year Phase-In of SoonerHealth+. The Oklahoma Health Care Authority announced a three-year phase-in for SoonerHealth+, a fully capitated care coordination program for aged, blind, and disabled individuals. The first year would impact SoonerCare Choice Medicaid-only members and full benefit dual eligibles (including ADvantage and Medically Fragile waiver members). It would also include individuals with intellectual and developmental disabilities (I/DD) that only receive state plan services. The second year would include I/DD beneficiaries that receive waiver services, and the third year would include residents of long-term care facilities. The state plans to release an RFP for the program in November or December 2016, pending CMS approval, with contracts awarded in late Spring 2017. A total of 11

plans have expressed interest in bidding. Winning plans can operate in the state's eastern region, western region or both.

Oklahoma Health Care Authority Names Medicaid Director Becky Paternik-Ikard CEO. Oklahoma Health Care Authority (OHCA) announced on September 9, 2016, that it had named state Medicaid Director Becky Pasternik-Ikard to the position of OHCA chief executive effective October 4. Ikard, who has served with the agency for 22 years, will fill the post vacated by current OHCA chief executive Nico Gomez. As CEO, Pasternik-Ikard will provide overall direction for all SoonerCare Operations. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

CMS Awards Grant to Continue PA Navigator Program. On September 7, 2016, The U.S. Centers for Medicare & Medicaid Service (CMS) awarded a group of Pennsylvania mental health organizations a grant to continue the Health Insurance Marketplace Navigator Program. The Pennsylvania Mental Health Consumers' Association (PMHCA), Mental Health Association in PA (MHAPA), Mental Health America of Westmoreland County (MHAWC), and the Advocacy Alliance, has trained Navigators who help those who need health insurance, including individuals looking specifically at behavioral health coverage. The grant provides funding for another year of the program, which would be its fourth year of operation. Pennsylvanians may contact these Navigators for assistance, whether or not they are looking for insurance that specifically covers behavioral health needs. Open enrollment for the 2017 plan year runs November 1, 2016 through January 31, 2017. Read More

Department of Human Services Announces $648M in Recoveries and Cost Avoidance. On September 8, 2016, Pennsylvania's Department of Human Services (DHS) announced $648M in program integrity cost avoidance and recoveries – a $65M increase from FY 2014-15 and the highest level in more than five years. DHS cites an improved accuracy rate for issuing Supplemental Nutrition Assistance Program benefits and increased monitoring of out of state electronic benefit transfer usage as examples of improved program integrity. In a continued effort to modernize its program integrity methods, DHS is shifting to using predictive analytics. In September 2015, DHS issued an RFI for the use of innovative data analytics and technologies to modernize its handling of program integrity functions that block improper payments. Read More

Keystone HIE Develops Technology for Real-Time Delivery of Patient Information. On September 8, 2016, *Business Wire* reported the Keystone Health Information Exchange (KeyHIE®), launched intelligent "push" technology to deliver critical information, in real time, to its participating doctors and health care providers. KeyHIE is a network of more than 400 healthcare facilities in 53 counties of Pennsylvania. KeyHIE's Information Delivery Service (IDS), provides information to participating providers so they know when and where their patients receive care within the KeyHIE network. With IDS, providers can decide the quantity of information they wish to receive, including inpatient admission and discharge notifications, emergency admission and discharge notifications, and lab results/clinical documents delivery. KeyHIE is one of several Health Information Exchanges that participates in the Pennsylvania's Department of Human Services eHealth Partnership Program's health

information exchange network or Pennsylvania Patient and Provider Network (P3N). Read More

DDAP Holds First Hearing on Laws Governing Access to Addiction Treatment. On September 7, 2016, the Pennsylvania Department of Drug and Alcohol Programs (DDAP) held the first of six public hearings to examine existing laws governing access to drug and alcohol treatment and identify ways to help consumers access treatment. Acts 106, 152 and the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 provide for access to appropriate levels and lengths of care in most cases, but much of the testimony discussed how these laws are often not followed. Other barriers to treatment identified at the hearing included lack of funding across the treatment continuum and inadequate reimbursement rates. DDAP is charged with establishing and administering a task force to review compliance with all current relevant laws, regulations and agreements. In July, DDAP convened the task force, which includes representation from the Pennsylvania Departments of Health (DOH) and Human Services (DHS), the Pennsylvania Insurance Department (PID), addiction treatment programs, patient advocates and other stakeholders. A report detailing the task force's findings as well as recommendations to address identified barriers to treatment is due to the General Assembly in May 2017. Read More

Tennessee

Tennessee to Submit Medicaid Expansion Proposal to CMS. *The Tennessean* reported on September 12, 2016, that Tennessee is nearly ready to submit a Medicaid expansion plan to CMS for approval. The plan would initially expand coverage to veterans and individuals with mental health and substance abuse disorders who earn up to 138 percent of the federal poverty level in the first phase, then expand Medicaid to everyone up to 138 percent of poverty in the second phase. Read More

Texas

Legislators Show Little Interest in Medicaid Expansion. *The Texas Tribune* reported on September 13, 2016, that high-ranking Texas Republican state legislators continue to express little interest in expanding the state's Medicaid program. Texas Senate Health and Human Services Committee Chairman Charles Schwertner stated during a recent public hearing that expansion would do little to improve the finances of hospitals that treat the uninsured. Republican lawmakers pointed to a state-sponsored study suggesting uncompensated care costs were significantly higher than the amount of funding hospitals would receive through expansion. Read More

Medicaid Nursing Homes Struggle to Provide Quality Care, Study Says. The Dallas Morning News reported on September 7, 2016, that low pay and high staff turnover is leading to poor quality care at Texas nursing homes, according to a study commissioned by the Texas Health Care Association. The report found that health-standards violations and serious deficiencies in Texas nursing homes were on the rise, compared to four other large states (New York, California, Illinois, and Florida), where infractions and deficiencies were actually declining. Approximately 70 percent of Texas nursing home residents are enrolled in Medicaid. Read More

National

U.S. Uninsured Rate Falls to 9.1 Percent, Census Bureau Reports. *The Washington Post* reported on September 13, 2016, that the percentage of Americans without health insurance dropped to 9.1 percent in 2015, the lowest rate since the 2008 recession, according to the U.S. Census Bureau. About 4 million individuals gained health insurance coverage in 2015 from Medicaid, the Exchanges, or by purchasing an individual policy directly from a health plan. The number of people with health insurance through their employer remained relatively unchanged. Read More

Hepatitis C Drug Costs Strain Prison Budgets. *The Wall Street Journal* reported on September 12, 2016, that the high price of Hepatitis C drugs is putting a heavy strain on prison budgets across the nation. California's Department of Corrections and Rehabilitation, for example, spent $66 million on Hepatitis C drugs in the fiscal year ended June 30, up from $47 million in fiscal 2015. An estimated 17% of the nation's 1.3 million inmates are infected with Hepatitis, far higher than in the general population, largely because of higher rates of intravenous drug use. Read More

Children's Hospitals Post Heavy Financial Losses from Medicaid. *Reuters* reported on September 12, 2016, that children's hospitals are losing more money from Medicaid reimbursements than other health care facilities, according to a new study. Furthermore, children's hospitals may be under even greater financial pressure in 2018 when Disproportionate Share Hospital payments are reduced. About half of children's hospitals are losing more than $40 million a year, according to the study's lead author Dr. Jeffrey D. Colvin of Children's Mercy Hospitals and Clinics at the University of Missouri in Kansas City. Medicaid insures about a third of all U.S. children. Read More

CBO Projects Increase in Number of Money-Losing Hospitals by 2025. The Congressional Budget Office released a working paper on September 8, 2016, projecting that the percentage of hospitals with negative profit margins could rise to between 41 and 60 percent by 2025. The paper, which calculates hospital profit margins and financial losses under several scenarios, analyzes 3,000 acute care hospitals that are subject to Medicare payment cuts. Read More

Medicaid Expansion Benefits All Hospitals, Especially Rural Ones, Study Says. *Kaiser Health News* reported on September 7, 2016, that a new study shows that Medicaid expansion benefits all hospitals; however, the gains were more pronounced for rural hospitals. The study, conducted by researchers at the University of North Carolina Chapel Hill, says that overall hospitals in expansion states increased Medicaid revenues and reduced uncompensated care, with rural hospitals showing bigger improvements than city hospitals. The study also found that rural hospitals had a better chance of turning a profit following Medicaid expansion, while city hospitals showed no improvement in profitability. More than 70 rural hospitals have shut down since 2010, when states were given the option of whether or not to expand Medicaid. Read More

Industry News

Centerbridge Partners, Friedman Fleischer & Lowe Make Offer to Acquire Highmark's Vision Business. *Reuters* reported on September 9, 2016, that Centerbridge Partners and Friedman Fleischer & Lowe LLC have made an offer to acquire Highmark Health's Texas-based vision business HVHC Inc. for $2 billion. Highmark, which is the nation's fourth largest Blue Cross Blue Shield plan, declined to comment. HVHC includes Davis Vision, which provides managed vision benefits; Visionworks retail stores; and HVHC Manufacturing & Distribution, a manufacturer of eyewear. In April 2016, Centerbridge acquired Superior Vision Corp, which offers group vision plans. Read More

U.S. Files Lawsuit Against Vanguard Nursing Homes. The U.S. Department of Justice announced on September 7, 2016, that it is filing a false claims act complaint against Vanguard Healthcare, a Brentwood, Tennessee-based operator of 14 long-term care nursing homes across the country. The lawsuit alleges that the company submitted false claims to Medicare and Medicaid for skilled nursing home services. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
September 22, 2016	Nevada	Contract Awards	420,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Washington, DC	RFP Release	200,000
October, 2016	Massachusetts	RFP Release	860,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November 1, 2016	Texas STAR Kids	Implementation	200,000
November, 2016	Oklahoma ABD	RFP Release	177,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Massachusetts MassHealth ACO - Full	Selection	TBD
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Implementation	177,000
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
August, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
October, 2017	Massachusetts	Implementation	860,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
June, 2018	North Carolina	Proposals Due	1,500,000
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 (June 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	119,814	34.2%	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	48,218	35.5%	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	13,038	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	38,767	38.8%	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	5,480	4.4%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	217	1.1%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	62,009	54.4%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,419	10.1%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	42,069	25.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	26,975	40.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**362,006**	**28.9%**	

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

HMA News

HMA Telehealth Advisory Practice Group Supports Clients in Considering Telemedicine Solutions

Telemedicine is the use of technology to diagnose and manage patients outside of routine face-to-face visits. The implementation of telemedicine solutions to increase access, control cost and improve consumer experience is rapidly moving from innovation status to a basic operational necessity to meet market expectations. Use cases with strong access and quality impact are now clearly defined and the return on investment picture is beginning to crystalize.

Telemedicine, while well established in certain markets, is underutilized or nonexistent in others. Understanding and uptake are quite varied. Barriers such as restrictive payment models, licensure requirements and other regulations can slow the uptake of telemedicine adoption. As payment models shift toward value based purchasing and alternative payment models, telemedicine will become a more widely accepted solution for meeting the care and access needs of diverse populations and already has many use cases. HMA understands these drivers and barriers for telemedicine adoption and is prepared to lead organizations considering telemedicine solutions to meet their needs.

Telehealth encompasses a broad array of technology based solutions such as remote patient monitoring, store and forward models, mobile health applications, and platforms such as e-consults and Project Echo. These solutions are all distinctly different in how they use technology to share healthcare information and improve care. The HMA Telehealth Advisory Practice Group has a deep understanding of these nuances and can evaluate solutions based on the needs of the client.

Over the next few weeks, the Weekly Round Up will include a discussion of selected use cases and particular approaches to telehealth. These include e-consult solutions, models for telepsychiatry to improve access to mental health, auto-generated text message coaching, high-value use cases for remote patient monitoring, as well as payment and funding approaches, and a review of proposed legislation. For questions regarding telehealth please contact Dr. Jean Glossa at jglossa@healthmanagement.com.

What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs

The SCAN Foundation, with the support of the Alliance for Health Reform and Health Management Associates, convened a working group comprised of a diverse array of national experts working on behalf of adults with complex needs within the fields of health, long-term services and supports (LTSS), quality measurement, and consumer advocacy. Through a consensus process, this working group developed a goal statement and four Essential Attributes of a high-quality system of care from the vantage point of adults with complex care needs. The resulting Essential Attributes and accompanying full report are intended to help guide future efforts to develop quality measures that capture the goals, preferences, and desired life outcomes of adults with complex care needs.

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 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.

http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.