

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... December 14, 2016



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IN FOCUS

VIRGINIA JLARC ISSUES REPORT ON MEDICAID SPENDING MANAGEMENT

This week, our *In Focus* section comes to us from HMA Principal Barbara Markham Smith, JD, of our Washington, DC office. On December 12, 2016, Virginia's Joint Legislative Audit and Review Commission (JLARC), the audit arm of the General Assembly, issued findings from its two-year review of the Department of Medical Assistance Service's (DMAS's) management of the Medicaid program. In a review of DMAS's performance that largely foreshadows Medicaid reforms to be implemented in 2017-2018, JLARC notes that inflation-adjusted Medicaid spending in Virginia, per enrollee, remained essentially flat from FY2011 to FY2015. Program spending increases came from

growing enrollment due to expanded outreach activities and the addition of new waiver slots for people with intellectual and developmental disabilities. The growth in total spending (as opposed to per capita spending), amounted to average annual cost increases of 8.9 percent over the past 10 years. Services for individuals with disabilities accounted for the lion's share of cost increases, according to a budget report released earlier this year. Medicaid spending accounted for 22 percent of Virginia's general fund budget in FY2016.

Notwithstanding the overall performance, JLARC proposes areas for improvement in its 35 recommendations. It specifically notes throughout the report that implementing many of its recommendations will require additional legislative authorization and financial resources for DMAS. Most of its recommendations fall into three basic categories:

- MCO overpayment
- Better eligibility screening for long-term care services and supports (LTSS)
- Greater emphasis on minimizing institutional long-term care, i.e., improved rebalancing.

Some of the recommendations have significant implications for MCO payment and financial oversight, while many reflect issues that are explicitly addressed in four major initiatives Virginia will launch in 2017:

- Implementation of mandatory managed long-term care through Commonwealth Coordinated Care Plus (CCC+)
- New procurement of the "base" managed care program (Medallion 4) that integrates behavioral health
- Development of value-based payment (VBP) in both managed care programs
- Procurement of a new Medicaid Enterprise System (MES) that includes substantial data collection/analytic capabilities and a data warehouse.

MCO Overpayment

According to JLARC, overpayment to MCOs arises from three separate sources:

- A profit cap that is too high compared to other states
- Reluctance to aggressively impose sanctions for non- or under-performance
- Failure to prospectively reflect anticipated savings from care management improvements in the actuarial setting of capitation rates.

JLARC recommends implementing capitation rates that take prospective savings into account by FY2019. It specifically urges DMAS to recoup funds for inefficient services and notes that Virginia could save \$17 million to \$36 million dollars by recouping funds for avoidable ambulatory care-sensitive costs such as preventable inpatient admissions, preventable emergency room visits, and inappropriate pharmacy use.

The proposed contract for CCC+ and planning for Medallion 4 focuses on standards and payment intended to improve primary care coordination that avoids tertiary costs. DMAS disputes that past inefficiencies are carried forward

into subsequent-year capitation-setting. It notes that it is frequently difficult to quantify future savings and that the absence of a clear methodology poses other financial risks.

With respect to the profit cap, JLARC recommends that Virginia retain an “underwriting gain” cap rather than adopting medical loss ratio (MLR) standards in its new contracts, although not using MLR altogether would conflict with federal regulations. JLARC also proposes classifying as profit, medical spending that is higher than market value, although DMAS has noted the difficulty of defining market value. JLARC proposes a gain cap requiring that “at least a portion” of MCO revenue be returned to DMAS when profit exceeds three percent of premium income, with the percentage of returned revenue increasing to match the increases in the percentage of underwriting gain. In other words, it proposes a sliding scale of revenue rebates based on the profit percentage of the MCO. It also recommended changes in the treatment of administrative costs. Both JLARC and DMAS point out that legislation is required to implement some of these changes. Finally, JLARC believes that the Compliance Unit has been too lenient in waiving or mitigating sanctions that could have resulted in more recoupments to the program.

As part of this series of recommendations, JLARC notes that DMAS’s oversight efforts emphasize quality monitoring and improvement, which DMAS and JLARC agree can yield long-term savings. In addition, many of the issues regarding care coordination and avoidable utilization are addressed in the value-based payment being implemented across managed care programs in 2017-2018, and in the care coordination and integration standards developed in the new programs. However, JLARC recommends increased financial oversight and reporting on a quarterly basis, including increased utilization reporting and more detailed income statements. The potential effects of increased utilization scrutiny on access to care are not discussed. Again, both JLARC and DMAS note that additional resources will be needed to implement this level of financial and utilization oversight.

Eligibility Screening for LTSS

A large portion of the report focuses on the need for a validated Uniform Assessment Instrument (UAI) for children who comprise an increasing share of the population needing LTSS. Virginia uses the UAI for all LTSS screening; however, this tool has not been validated for children. JLARC notes that over 200 entities perform screenings in Virginia with significant variation in approval rates—ranging from 37 percent to 98 percent. The report reflects particular concern about the high rate of eligibility approvals from hospitals and the resulting admissions to institutional care. It flags the existence of conflicts of interest in screenings by institutions that provide long-term care.

JLARC proposes that the General Assembly authorize DMAS to develop an inter-rater reliability test for the pre-admission screening process and that DMAS develop a comprehensive training curriculum for people who screen for LTSS eligibility. It further proposes that new legislation require the training and certification of all screeners. JLARC also directs DMAS to focus its attention on oversight of hospital screening practices to ensure consistency.

DMAS basically embraces this series of recommendations. Again, additional administrative resources, as well as legislative authority, would be required to develop the curriculum and administer the certifications and oversight.

Rebalancing Toward Community-based Care

While recognizing the impending launch of CCC+ and Medallion 4, JLARC emphasizes the need to reduce institutional care and rely on community-based resources. It ties this recommendation to the UAI screening-process recommendations to ensure appropriate placements at the screening level. In addition, JLARC recommends tying financial incentives to greater success in keeping individuals with disabilities in the community, including implementing blended rates. DMAS will be using blended rates for the CCC+ program and VBP in its managed care programs, generally, as those programs come online. On December 12, DMAS posted for comment a *draft* of its proposed MCO contract for CCC+, encompassing blended rates and care planning and coordination requirements designed to reduce institutional care and improve outcomes. Comments are due on December 20. ([More Information Here](#))

Additional Recommendations

In addition to recommendations around these major themes, JLARC notes the importance of having the data collection and analytics capabilities to support increased utilization and financial monitoring. As discussed above, it is expected that the MES procurement, generally, will provide these capabilities. JLARC also flags the need to monitor the quality of care from behavioral health providers as those services are integrated into Medallion 4 and tie payment, generally, to the improved management of chronic diseases. These are practices that are explicitly included in the design of CCC+ and anticipated for Medallion 4. To ensure transparency and accountability, JLARC recommends that performance and quality report cards be distributed to program beneficiaries as part of their enrollment packages.

In terms of structural program changes to reduce spending, JLARC recommends that DMAS undertake an evaluation of the option to reduce eligibility thresholds in Virginia and require cost-sharing for LTSS from people in the 300 percent of SSI category of eligibility. It should be noted that Virginia already has highly restrictive eligibility standards. Only parents below 39 percent of the federal poverty level (FPL) are eligible for Medicaid, causing Virginia to rank 43rd nationally in eligibility standards; with no Medicaid expansion, poor childless adults are not eligible. The aged, blind, and disabled are eligible up to 80 percent of FPL. Children are generally eligible up to 148 percent of FPL.

Link to JLARC Report

The full JLARC report is available at <http://jlarc.virginia.gov/medicaid-2016.asp>. DMAS will post its response to the JLARC report in the coming days on its website www.dmas.virginia.gov.



HMA MEDICAID ROUNDUP

Arkansas

Changes to Medicaid Expansion Waiver Win Federal Approval. *Arkansas Online* reported on December 8, 2016, that Arkansas has received federal approval to make important changes to its Medicaid expansion waiver program. The changes include requiring certain Medicaid recipients to make premium contributions and the referral of unemployed beneficiaries to job-training programs. However, federal regulators limited the state's ability to help fund employer-sponsored coverage; only businesses that haven't previously offered coverage to employees will be supported under the waiver. Most enrollees will continue to receive coverage through the state's private option, which provides Medicaid funds for purchasing Exchange plans. Arkansas Governor Asa Hutchinson has made it clear that he plans to seek additional waivers from the incoming Trump Administration. [Read More](#)

California

HMA Roundup - Julia Elitzer ([Email Julia](#))

Bill Introduced Aims to Improve Denti-Cal. California Assemblyman Brian Maienschein (R-San Diego) proposed bipartisan legislation that would require the California Department of Health Care Services to boost pay for dentists participating in Denti-Cal. California's Denti-Cal reimbursements for participating dentists have not changed since 2001, and have long been among the lowest reimbursement rates in the nation. The bill would increase reimbursements for the 15 most common services for prevention and treatment, with the goal of attracting and keeping dentists in the Denti-Cal program. [Read More](#)

Florida

HMA Roundup - Elaine Peters ([Email Elaine](#))

Senate President Negron Pushes Review of Managed Care Waiver, Reconsideration of Mandatory Enrollment. *Politico* reported on December 12, 2016, that Florida Senate President Joe Negron may push the state legislature to reconsider mandatory enrollment for all Medicaid beneficiaries into Medicaid managed care. The Florida Health Care Association has been lobbying to eliminate mandatory enrollment for nursing home residents. The statewide Medicaid managed care program operates under an 1115 Medicaid waiver, with the state planning to submit a waiver extension request before the end of the year. Negron, who was a key figure in the development of the statewide

mandatory managed care program's development, has stated the legislature should fully review the program's design and outcomes before submitting a renewal request. [Read More](#)

Senate President Negron to Explore Medicaid Block Grant Options. *Politico* reported on December 12, 2016, that Florida Senate President Joe Negron announced that he would like to explore a block grant to fund the state's Medicaid program. The Senator added that he thinks the incoming Trump administration will give the state greater control its Medicaid spending. [Read More](#)

Medicaid Paid Health Plans \$26 Million for Deceased Beneficiaries, Audit Finds. *The Miami Herald* reported on December 13, 2016, that the Florida Medicaid program made payments of approximately \$26 million over five years to Medicaid managed care plans for individuals who were deceased, an audit from the U.S. Department of Health and Human Services (HHS) Office of Inspector General shows. The Florida Agency for Health Care Administration (AHCA), the state's Medicaid agency, has recovered approximately \$24 million of the payments. The federal share of overpayments is around \$15.3 million. HHS officials reviewed 124 capitated payments that AHCA made to Medicaid plans for deceased beneficiaries between July 2009 and November 2014. The overpayments were largely attributed to outdated state databases that did not account for deaths and a lack of communication among agencies. [Read More](#)

Georgia

HMA Roundup - Kathy Ryland ([Email Kathy](#))

Rankings Released of Rural Hospitals Eligible for Tax Credit Program. *Georgia Health News* reported on December 8, 2016, that Georgia officials released rankings of eligible rural hospitals most in need of financial assistance as part of a new state tax credit program. The program, created during the 2016 legislative session, allows individuals and corporations to make donations of up to \$4 million to each eligible rural hospital. Donors are eligible to receive tax credits, which are awarded on a first-come, first-served basis. The statewide cap for tax credits is \$50 million in 2017, \$60 million in 2018, and \$70 million in 2019. The rankings are meant to help people decide which rural hospitals to donate to under the three-year program. [Read More](#)

Georgia Allows Interstate Sale of Health Insurance; Insurers Have Shied Away. *Georgia Health News* reported on December 7, 2016, that not one health plan has taken advantage of Georgia's five-year-old law that allows the sale of health insurance across state lines. The bill was hailed at the time of its passage as a way to skirt the state's required benefit coverage package and lower insurance premiums, an approach supported by President-elect Donald Trump and U.S. Representative Tom Price, the Georgia congressman selected to lead the Department of Health & Human Services under the new administration. Basically, insurers are allowed to sell any policies in Georgia that they sell in other states. While some other states have passed similar laws, the reactions from insurers have been similar. [Read More](#)

Iowa

NEMT Services Eliminated for Iowa Health and Wellness Plan Members. *The Gazette* reported on December 9, 2016, that Iowa will eliminate coverage of non-emergency medical transportation (NEMT) for adults in the Iowa Health and Wellness Plan effective January 1, 2017. The change is the result of a recent waiver approval from the Centers for Medicare & Medicaid Services. Iowa Department of Human Services spokeswoman Amy McCoy said the decision was made in order to maintain sustainable Medicaid costs. The three managed care organizations providing NEMT to Medicaid beneficiaries spent \$7.6 million on the services between April and September 2016. [Read More](#)

Kansas

Rural Dental Networks, Already Strained, Seeing Impact of Medicaid Cuts. *KCUR* reported on December 12, 2016, that the decision by the state of Kansas to cut Medicaid payments by an additional four percent to balance the state budget has had a negative impact on already struggling rural dental networks. An increasing number of providers are considering limiting their acceptance of Medicaid patients. Access to dental care was already an issue in Medicaid, particularly in rural areas like western Kansas, where many patients need to drive hours to a dental appointment. There are an estimated 20 counties in western Kansas that do not have a single dentist that accepts Medicaid. Dental providers have not seen rates increase since 2001. Before the reduction, Medicaid paid only 40 cents on the dollar compared to private dental insurance. [Read More](#)

Maine

Ballot Initiative on Medicaid Expansion is Likely. *Centralmaine.com* reported on December 13, 2016, that a petition for a ballot initiative on Medicaid expansion in Maine is nearly complete, with an announcement expected soon from Maine Equal Justice Partners, the organization spearheading the effort. While the timing isn't clear, the ballot initiative will most likely be set for 2018. Maine Governor Paul LePage has repeatedly vetoed Medicaid expansion legislation and previous attempts to override his veto have failed. [Read More](#)

Maryland

Evergreen Health Cooperative to Exit Marketplace in 2017. *Modern Healthcare* reported on December 9, 2016, that Evergreen Health Cooperative will pull out of the Maryland Health Connection individual Exchange in 2017. The co-op is currently working to transition from a not-for-profit to a for-profit company. Evergreen has about 6,000 members in the Exchange market, of which approximately 4,000 will be switched to Kaiser Permanente and 2,000 to CareFirst. An additional 3,000 consumers who bought insurance directly from Evergreen or brokers will need to find a new plan. [Read More](#)

Exchange Officials Continue to Push Exchange Enrollment. *The Baltimore Sun* reported on December 12, 2016, that Maryland Exchange officials continue the push to enroll consumers ahead of the open enrollment deadline, despite the

potential repeal of the Affordable Care Act (ACA) in the coming weeks. Maryland sees it as “business as usual,” according to Traci Kodeck, chief executive of HealthCare Access Maryland. The state has signed up approximately 130,000 individuals so far for 2017. In 2016, the state had 163,000 Exchange enrollees. In total, 400,000 individuals received coverage under the ACA, including those enrolled under Medicaid expansion. [Read More](#)

Mississippi

Advocates Claim Proposed Medicaid Autism Therapy Payment Rates Too Low. *DJournal.com* reported on December 11, 2016, that proposed Mississippi Medicaid reimbursement rates for autism therapies are too low to maintain adequate services, according to advocates. The rates would reimburse behavioral technicians and behavioral analysts at \$30 an hour. The Mississippi Centers for Autism and Related Developmental Disabilities said the rates for technicians would only cover two-thirds of provider costs and rates for behavioral analysts are less than half of what other states provide. [Read More](#)

Missouri

Governor Blocks \$43 Million in Budgeted Medicaid Spending. *KSPR.com* reported on December 7, 2016, that Missouri Governor Jay Nixon is blocking \$43 million in budgeted Medicaid spending in an effort to balance the state budget before the end of his term. Governor Nixon said that savings achieved by his administration have made the spending unnecessary. His term ends January 9, 2017, when Republican Governor-elect Eric Greitens takes office. [Read More](#)

Montana

HMA Roundup – Rebecca Kellenberg ([Email Rebecca](#))

DPHHS Executive Director to Step Down; Governor Names Sheila Hogan as Replacement. Governor Steve Bullock announced that several of his first-term cabinet members would be leaving, including Richard Opper, executive director of the Department of Public Health and Human Services (DPHHS). Under Opper’s leadership, DPHHS implemented the HELP Act, which is the state’s Medicaid expansion program. As of November 2016, 61,233 individuals had enrolled in the program, significantly exceeding expectations. Opper plans to retire. Governor Bullock appointed Sheila Hogan to replace Opper. Hogan is the former director of the Department of Administration, and has served in that position since her appointment in 2013. Previously, she served as the executive director of the Career Training Institute in Helena for 20 years. She has a bachelor’s degree in business and public policy from Montana Tech-University.

State Republicans Defer to Trump Administration for Medicaid Changes. The Health and Economic Livelihood Partnership (HELP) Act marks its one-year anniversary next month. Since Montana’s Medicaid expansion program began in January 2015, more than 61,000 Montanans have secured health coverage, surpassing original estimates of 45,000 enrollees by 2020. HELP Plan participants with incomes above 50 percent of the federal poverty level receive health coverage through a third-party administrator (TPA) network, administered by Blue Cross Blue Shield of Montana. Medically frail individuals

and Native Americans are exempt from TPA enrollment. The state pays the TPA weekly for the services covered, as well as a monthly administrative fee which was set at \$26.39 PMPM in FY 2016, and contractually reduces to \$25.39 in FY 2017. HELP Program enrollees are required to pay copayments and monthly premiums based on income. The average premium amount in September 2016 was \$25.62. The Department Public Health and Human Services is projecting to record average monthly premium revenue of \$290,000 in FY 2016. The HELP Act also includes HELP-Link, a voluntary workforce development program, administered by the Montana Department of Labor and Industry. State Senator Ed Buttrey (R-Great Falls) introduced the act and promoted the HELP-Link workforce component of the act as a means of helping people move out of poverty and eventually off of Medicaid. Senator Buttrey recently stated that for the program to survive, participation in HELP-Link, currently 10 percent of HELP enrollees, needs to increase. Commissioner Pam Bucy, with the state's labor department stated, "Of the people who have gone through the program, 83 percent found employment and [they] showed a 42 percent increase in wages ... That's extremely successful." Two-thirds of people who qualify for the expansion already have jobs. "The challenge is connecting those people with Job Service to learn about ways to move from economic survival to stability," Bucy said. Recently, critics of the expansion program point to low participation in HELP-Link as a sign of the HELP program's failure. State Senator Bob Keenan (R-Bigfork) reserved a placeholder for a bill to repeal the expansion weeks before the program was implemented. But with less than a month before the state Legislature meets in Helena for its 2017 session, Senator Keenan said he's now "Counting on President-elect Donald Trump's administration to repeal and replace the Affordable Care Act."

New Jersey

HMA Roundup – Karen Brodsky ([Email Karen](#))

Department of Human Services Selects New Fiscal Intermediary for Participant Direction Programs. On December 13, 2016, the Division of Developmental Disabilities (DDD) released a general notice that New Jersey's Department of Human Services awarded a fiscal intermediary (FI) contract to Public Partnerships LLC (PPL), a subsidiary of Public Consulting Group, Inc. The contract runs for five years beginning November 14, 2016, through November 13, 2021, and may be extended for up to two years. PPL will operate as the FI for participant-directed services and supports for individuals served through the DDD, Aging Services, and Disability Services. The FI will work directly with individuals who chose to self-direct any of the following five services available in the "Supports Program" for which the use of a self-directed employee is an option: Community-based supports, interpreter services, respite, supports brokerage, and transportation. A copy of the award notice can be found [here](#).

Bill Would Create a Commission to Assess State's Network Adequacy Regulations. *NJBiz* reported on December 7, 2016, that Assemblyman Gary Schaer introduced a bill that would create a 13-member commission to assess New Jersey's network adequacy regulations. These regulations, which have remained largely unchanged since they were adopted in 1999, by the Department of Banking and Insurance, came under scrutiny following Horizon's tiered network plan. The bill would create a commission that would spend a

year analyzing and comparing New Jersey's network adequacy regulations to other states and national guidelines. Additionally, it would assess the adequacy of access to specific medical services, such as behavioral health. After multiple, failed attempts to pass legislation targeting the network adequacy of tiered networks, Assemblyman Schaer introduced this bill in hopes of creating a roadmap to drive changes that would make health care more reliable and accessible for New Jersey residents seeking in-network treatment. [Read More](#)

New York

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

Section 1115 Medicaid Waiver Extended. New York's Section 1115 Medicaid waiver has been extended for an additional five years, through March 2021. New York's waiver, known as the Partnership Plan, was originally approved in 1997, and provided the framework for the state's mandatory Medicaid managed care program. The waiver has been renamed the Medicaid Redesign Team (MRT) Demonstration in recognition of the ongoing MRT efforts to transform the health care delivery system. The waiver extension extends authorities for New York to continue to operate its demonstration with modest modifications. This includes extending authorities for the Delivery System Reform Incentive Payment (DSRIP) program and associated Designated State Health Programs (DSHP) through March 31, 2020. DSHP will be phased down from the current year through March 31, 2020. The extension also provides new expenditure authority to allow the state to make self-direction services available to Health and Recovery Plan and HIV Special Need Plan enrollees receiving behavioral health home and community-based services. The extension also includes provisions—special terms and conditions (STCs)—that describe consequences if New York does not come into compliance with required budget neutrality reporting. The STCs require the state to complete a reconciliation process by September 30, 2017. Failure to do so will result in forfeiture by the state of any budget neutrality savings from demonstration year (DY) 14 through DY 17.

Governor Warns of ACA Replacement Consequences for State.

Politico reported on December 8, 2016, that Medicaid block grants and a replacement of the Affordable Care Act (ACA) can have consequences for New York, according to Governor Andrew Cuomo. At \$62 billion, the state's Medicaid plan is one of the most expensive in the country. If the ACA is repealed, the state budget would be significantly impacted by the loss of funding for the Basic Health Plan, which offers low-cost health insurance for those who do not qualify for Medicaid assistance. ACA repeal would likely impact \$850 million in state funds and \$3.5 billion in federal funding. Governor Cuomo said the state will wait to see what proposals are passed and then respond accordingly. [Read More](#)

Advanced Primary Care Practice Transformation Request for Applications.

The New York State Department of Health (DOH) was awarded a \$100 million State Innovation Models (SIM) grant by the Centers for Medicare & Medicaid Innovation (CMMI) to implement the State Health Innovation Plan (SHIP). New York is pursuing a multidisciplinary approach to health system redesign that includes primary care delivery system and payment reform. A key component of the SHIP is the development and implementation of an integrated care delivery system with a foundation in Advanced Primary Care (APC). APC describes enhanced capabilities, processes, and performance of primary care

providers. As part of New York's Delivery System Reform Incentive Payment (DSRIP) program, all primary care practices participating in DSRIP must be recognized as either NCQA PCMH 2014 Level 3 or APC "Gate 2" by March 31, 2018. The state has recently released a Request for Applications for services related to practice transformation technical assistance. Contractors are meant to assist primary care practices and their providers to develop the systems and processes necessary to meet the goals of the "Triple Aim," which are to 1) improve patients' experience of care, including quality and satisfaction; 2) improve the health of populations; and 3) reduce the per capita cost of care. Applications are due January 18, 2017. [Read More](#)

DOH Awards Funds for Community-based Organizations Participating in DSRIP. The New York Department of Health has announced the awarding of funds to support strategic planning activities for community-based organizations (CBOs) to facilitate their engagement in DSRIP activities. CBOs are seen as essential for Performing Provider Systems (PPS) to be able to impact the social determinants of health. The state is concerned that smaller CBOs can be challenged in their ability to engage and contract with the lead organizations running the PPS in DSRIP. The grants are meant to assist CBO Consortiums 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. The winning application for the New York City region is the Arthur Ashe Institute for Urban Health and the winning application for the Rest of State region is S2AY Rural Health Network, Inc. No award was made for the third region, made up of Long Island and the mid-Hudson region.

Value-based Payment Recommendations for Long-Term Care. As part of its Delivery System Reform Incentive Payment program, 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 (VBP) methodologies. As part of the transition, the state has convened a series of clinical advisory groups (CAGs) to develop recommendations that are specific to a given clinical condition. A new recommendation report addressing long-term care has been released for review and public comment. The public comment period ends on January 9, 2017. The CAGs recommend allowing the VBP arrangements to cover only one component of long-term care: Home health providers contracting total (Medicaid) costs of care for those members assigned by the managed long-term care plan to home care, and nursing home providers contracting total (Medicaid) costs of care for those members assigned by the MLTC to a nursing home. The report provides definitions and associated quality measures for each VBP arrangement. [Read More](#)

Massena Memorial Hospital to Privatize. *Politico* reported on December 13, 2016, that the municipal hospital in Massena, a 50-bed hospital in the North Country, is converting to a nonprofit institution, a move the hospital believes will save \$2.5 million per year. The move was opposed by the Civil Service Employees Association and the New York State Nurses Association, concerned about job losses and reductions in benefits, particularly pension benefits. Apart from budgetary savings, becoming a private, nonprofit hospital will also allow the hospital to better cooperate with neighboring hospitals, which is key to survival under the Delivery System Reform Incentive Payment program. While the Massena hospital currently belongs to a system of hospitals, including Samaritan Medical Center, Watertown; Carthage Area Hospital; River Hospital

of Alexandria Bay; Clifton-Fine Hospital of Star Lake; and Claxton-Hepburn, it has been unable to fully participate with this group because of its municipally-owned status.

Ohio

Bill Mandates Coverage of Autism Spectrum Disorder. *Cleveland.com* reported on December 9, 2016, that the Ohio legislature passed a bill requiring health insurers to cover screening, diagnosis, and treatment of autism spectrum disorder. Coverage would include at least 20 speech or occupational therapy sessions a year. Supporters say that the measure will result in early treatment, thereby reducing the need for services later in life. The bill now goes to Governor John Kasich's desk for signature. [Read More](#)

Oklahoma

OHCA to Revamp Pharmacy Lock-In Program with Focus on Preventive Services. *The Times Record/The Oklahoman* reported on December 9, 2016, that the Oklahoma Health Care Authority (OHCA) will revamp its pharmacy lock-in program for SoonerCare members to focus on preventive services in 2017. Currently, members at risk for prescription drug misuse and overdose are placed in the state's lock-in program, which requires them to fill controlled substances at one specific pharmacy and receive prescriptions from a single physician. The OHCA will attempt to notify individuals before they are locked in next year by sending letters to SoonerCare members who are using more than four doctors and more than four pharmacies. [Read More](#)

Pennsylvania

HMA Roundup – Julie George ([Email Julie](#))

MAAC Meeting Provides HealthChoices and Community HealthChoices Update. At Pennsylvania's December 2016 Medical Assistance Advisory Committee (MAAC) meeting, deputy secretary of the Office of Medical Assistance Programs, Leesa Allen, provided an update on procurement for HealthChoices, the physical health Medicaid managed care program. Because awards have still not been publicly announced, the implementation date has been moved from April 1, 2017, to June 1, 2017. Allen made the caveat that the June 1 date is preliminary; due to all the activities that still need to occur, the date will likely be pushed back. The Office of Long Term Living (OLTL) provided procurement updated on Community HealthChoices (CHC), the managed long term services and supports program. Following an internal appeal process, four protests to the CHC awards were ruled in favor of the Department of Human Services. Protesters have until December 15, 2016, to file an appeal in Commonwealth Court; three of the four protesters already have. Those three protesters have also filed for an emergency stay, or injunction, to prevent OLTL from beginning contract negotiations with winning bidders. OLTL has voluntarily postponed beginning negotiations until December 15. They will then reassess to continue their voluntary stay pending the Court's ruling on requests for an injunction.

CHIP Enrollment Increases Following Administrative Changes. Since Governor Tom Wolf signed a bill last year, moving Pennsylvania's Children's

Health Insurance Program (CHIP) from the Department of Insurance to the Department of Human Services (DHS), enrollment has increased from 150,985 children in December 2015 to 168,238 in November 2016. The goal of moving the program was to save money and make enrollment and re-enrollment easier for the families of those covered. The application processing time has also decreased from 40 days at this time last year to one day. DHS expects enrollment to further grow with the advent of “express lane eligibility,” which reaches out to families who receive other forms of public assistance, whose children likely are eligible for CHIP but who aren’t enrolled. State officials also said they anticipate \$3.5 million in savings when IT systems are fully consolidated by 2018. [Read More](#)

Department of Human Services Launches a Mobile App for Benefits. Pennsylvania Governor Tom Wolf’s Office of Transformation, Innovation, Management and Efficiency (GO-TIME) and the Department of Human Services (DHS) have launched a mobile app for Pennsylvanians who have applied for or receive assistance benefits called myCOMPASS PA. By reducing mail processing time, manual information entry, and call center calls, this app is estimated to save an average of \$3.2 million per year. Users will be able to view benefit details and application status, update personal information and upload necessary documents. [Read More](#)

Texas

State to Release RFP for Upcoming Foster Care Mental Health Pilot Program. *The Texas Tribune* reported on December 7, 2016, that Texas will release a request for proposals (RFP) for a new \$8 million pilot program that provides specialized care and services for foster children with a high risk of mental health care needs, specifically children who are victims of crime, who have been admitted to inpatient psychiatric medical hospitals, and who have been admitted to at least two residential treatment centers in the past year. The state is seeking four organizations to lead the initiative, which is expected to begin in late spring or early summer of 2017. [Read More](#)

Lawsuit Filed Against State Over Medicaid Denial of ABA Treatment for Autism. *San Antonio Current* reported on December 7, 2016, that Texas Rio Grande Legal Aid (TRLA) and Disability Rights Texas (DRTx) filed a lawsuit against the state Medicaid program for refusing to fully fund applied behavioral analysis (ABA) treatment for children with autism. Currently, Texas covers 30 hours of treatment per month, for up to six months. However, specialists say patients need at least 20 hours a week for several years. The lawsuit claims Texas used to offer extensive ABA coverage, but has since phased it out. [Read More](#)

National

Half of States See Budget Shortfalls, Most Since Recession. *Governing* reported on December 13, 2016, that according to a survey from the National Association of State Budget Officers (NASBO), half of U.S. states saw budget shortfalls in fiscal 2016. The annual Fiscal Survey of the States added that 24 states found that weak revenue conditions carried over into fiscal 2017. This is the highest number of states reporting budget shortfalls since the recession in 2010. In reaction, 19 states made budget cuts in fiscal 2016, totaling \$2.8 billion, with Medicaid and education targeted for funding reductions. State revenues increased just 1.8

percent in fiscal 2016, compared to 5 percent in fiscal 2015. The report blamed slow income tax growth, slow sales tax growth, and a decline in corporate tax revenue. [Read More](#)

CMS Administrator Andy Slavitt Discusses Future of Medicaid, Medicare. *The Chicago Tribune* reported on December 8, 2016, that Andy Slavitt, acting administrator at the Centers for Medicare & Medicaid Services, said that Medicaid block grants will inevitably result in cuts to services and that Medicare reform should be focused on shifting individuals out of institutional settings and into the community. Slavitt stated that repeal of the Affordable Care Act while delaying implementation of a replacement would result in “chaos.” [Read More](#)

HHS, CEA Publish Report on the Implications of ACA Repeal. *The Hill* reported on December 13, 2016, that the U.S. Department of Health and Human Services (HHS) and the Council of Economic Advisers (CEA) jointly released a report outlining the implications of a repeal of the Affordable Care Act (ACA). The report asserts that the ACA has increased jobs, reduced insurance premiums, improved hospital care, and extended the solvency of Medicare. The report includes a state-by-state breakdown of enrollment and coverage figures. [Read More](#)

Senate Republicans Request Governor Input on Medicaid Expansion. *Washington Examiner* reported on December 13, 2016, that Senate Republicans are requesting input from state governors about the future of Medicaid expansion. Governors will participate in a Senate Finance Committee roundtable discussion in January 2017 to discuss potential modifications to the expansion program. While Republicans plan to repeal all or part the Affordable Care Act next year, they are looking at options that grant states flexibility on Medicaid expansion programs and want input from Republican Governors that have implemented expansion in their states. [Read More](#)

Senate Passes 21st Century Cures Act, Advancing Support for Mental Health. *Kaiser Health News* reported on December 7, 2016, that the U.S. Senate passed the 21st Century Cures Act and will send the bill to President Barack Obama for signature, marking the first piece of major mental health legislation in almost ten years. The Senate voted 94-5 to approve the act, which passed easily through the House last week. The act requires states to use at least 10 percent of their mental health block grants on early intervention for individuals with psychosis. It also aims to speed drug development, strengthen laws mandating parity for physical and mental health, grant funds for individuals with serious mental illness, and help fight opioid abuse. The Act also changes the way federal agencies provide mental health services. [Read More](#)

CMS Takes Aim at Improper Steering of Dialysis Patients into Commercial Insurance. *Modern Healthcare* reported on December 12, 2016, that the Centers for Medicare & Medicaid Services published an interim final rule aimed at preventing dialysis providers and other organizations from improperly steering Medicaid and Medicare-eligible patients into commercial insurance in order to receive higher reimbursement. Dialysis centers that help patients pay commercial premiums are now required to notify patients what commercial plans pay for and how that compares to Medicare and Medicaid. The rule affects 6,064 dialysis centers throughout the country and will go into effect on January 14, 2017. [Read More](#)

Industry Research

Anthem Institute Outlines Efforts to Integrate Physical, Mental Health. Anthem, Inc.'s Public Policy Institute has released four reports outlining efforts by Medicaid managed care organizations to integrate physical, mental, and substance abuse care. The reports highlight care coordination initiatives, partnerships with community-based organizations, effective information sharing, and increasing adoption of value-based payment models. [Read More](#)



INDUSTRY NEWS

CHS to Sell Two WA Hospitals to Sunnyside Community Hospital & Clinics. Community Health Systems, Inc. announced on December 13, 2016, the sale of two hospitals in the state of Washington to Sunnyside Community Hospital & Clinics for \$45 million, including working capital. The hospitals are - Yakima Regional Medical & Cardiac Center and Toppenish Community Hospital. The transaction is expected to close in the second quarter of 2017. [Read More](#)

Adventist Health System Promotes Terry Shaw to CEO. *Modern Healthcare* reported on December 8, 2016, that Adventist Health System has promoted Terry Shaw to chief executive, effective immediately. Shaw joined Adventist in 1982 and has served as executive vice president, chief financial officer, and chief operating officer. Under former chief executive Don Jernigan, who retired in August, Adventist added nine hospitals and increased revenue by nine percent. [Read More](#)

LogistiCare CEO to Step Down in January 2017. Providence Service Corporation and its subsidiary LogistiCare Solutions, LLC, announced on December 8, 2016, that LogistiCare chief executive Herman Schwarz will step down effective January 4, 2017. Chief Administrative Officer Albert Cortina will serve as interim CEO until a replacement is named. Schwarz served as CEO since May 2009. LogistiCare is the nation's largest manager of non-emergency medical transportation programs for state governments and managed care organizations. [Read More](#)

Neighborhood Health Plan Posts \$104 Million Operating Loss. *Boston Globe* reported on December 9, 2016, that Massachusetts Medicaid managed care organization Neighborhood Health Plan reported an operating loss of \$104 million for the year ending September 30, 2016. While Neighborhood's MassHealth Medicaid membership has increased 80 percent over the last three years, new membership had more significant health needs overall, with higher utilization than anticipated. Neighborhood previously froze MassHealth enrollment in October. Neighborhood is owned by Partners HealthCare, which reported a total operating loss of \$108 million for the year. [Read More](#)

CareSource Introduces New Plan Options on Ohio Exchange. *The Dayton Business Journal* reported on December 13, 2016, that CareSource has announced it will add two new plan options on the Ohio health insurance Exchange for 2017 - CareSource Simple Choice and CareSource Marketplace Silver Low Premium. Simple Choice is a Standard Benefit Design Plan aimed at simplifying consumer choice, while Marketplace Silver Low is a lower premium alternative silver plan. CareSource is also participating in the Kentucky, Indiana, and West Virginia Exchanges in 2017. Last year, CareSource had 124,000 sign-ups during open enrollment and is expecting an additional 50,000 to 75,000 new members this year. [Read More](#)

LifePoint CEO Says Company Will Not Bid for Community Health Systems Hospitals. *Modern Healthcare* reported on December 9, 2016, that LifePoint Health announced at the Citi 2016 Global Healthcare Conference that it will not bid to buy Community Health Systems' (CHS) hospitals. LifePoint chief executive Bill Carpenter stated that his company prefers to buy not-for-profit hospitals that benefit from new services and tighter quality controls. [Read More](#)

Inova Launches Investment Fund, Health Care Startup Incubator. Inova Health System announced on December 13, 2016, that it has launched Inova Strategic Investments (ISI) and Inova Personalized Health Accelerator (IPHA). ISI will invest in healthcare venture funds and companies involved in advanced analytics; innovations in safety, quality, and clinical practices; and advances in information technology. IPHA will provide education and capital to six to eight entrepreneurial companies each year aimed at driving development of personalized health innovations to predict, prevent, and treat disease. [Read More](#)

Envision Budgets \$700 Million for Acquisitions in 2017. *Modern Healthcare* reported on December 7, 2016, that Envision Healthcare Corp. announced that it is budgeting \$700 million for acquisitions in 2017, primarily targeted at physician practices. The announcement comes less than a week after Envision completed a \$10 billion merger with AmSurg Corp. The merger created the nation's largest physician-staffing company with total annual revenues of approximately \$8.5 billion. [Read More](#)

Universal Health Services Stock Price Drops in Wake of Investigation. *Modern Healthcare* reported on December 7, 2016, that Universal Health Services (UHS) stocks dropped 12 percent after *BuzzFeed News* published an [article](#) on a year-long investigation that alleged UHS involuntarily committed or kept psychiatric patients longer than necessary. The investigation looked into several lawsuits filed by patients as well as employee accounts of policies at the institutions that allegedly took advantage of patients and insurers. UHS denies all allegations and states that care delivered is based on clinical needs. The company claims the article "diminishes the complexity of behavioral health assessments and treatment." [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
December, 2016	Washington, DC	RFP Release	200,000
December, 2016	Massachusetts	RFP Release	860,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
December, 2016	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
January 23, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
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
April 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
May 1, 2017	Missouri (Statewide)	Implementation	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
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
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
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.

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