The SNP Alliance

A National Health Policy Group Initiative Working to Change Policy and Practice for High-Risk Beneficiaries

Update on CMS/State Dual Demonstrations and States' MMI Related Activities

March 21, 2016

Information below is drawn from:
HMA Weekly Roundup
(http://www.healthmanagement.com/publications/hma-weekly-roundup/)
Bi-weekly Community Catalyst The Dual Agenda Newsletter
(http://www.communitycatalyst.org/initiatives-and-issues/initiatives/voices-for-better-health/dual-agenda-newsletter)
Publications from the period 12/2/2015 – 12/17/2015, and CMS MA and SNP Enrollment Reports:
http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/index.html

Financial Alignment Initiative Demonstrations:

- Capitated Model: CA, IL, MA, MI, NY, OH, RI, SC, TX, VA
- Managed FFS Model: CO, WA
- Alternative Model: MN

MMP Enrollment (September 2015 through February 2016).

	September 2015	October 2015	November 2015	December 2015	January 2016	February 2016
California	117,307	117,179	116,538	115,743	125,257	127,084
Illinois	49,586	48,779	53,136	54,770	47,340	49,294
Massachusetts	17,179	12,657	12,366	12,285	13,146	12,787
Michigan	42,728	37,072	36,335	34,858	34,297	34,833
New York	8,028	9,942	8,005	6,811	6,242	6,029
Ohio	59,697	61,428	62,287	59,887	60,622	61,246
South Carolina	1,530	1,355	1,359	1,331	1,357	1,364
Texas	45,949	56,737	52,232	48,085	55,671	50,296
Virginia	29,176	27,138	27,545	27,103	28,844	27,298
Rhode Island						
TOTAL	371,180	372,287	369,948	360,873	372,776	370,231

Source: HMA Duals Demonstration Enrollment Tracking February 17, 2016 (State Reporting, CMS). Please Note: The source for this data has changed. Since HMA already compiles this data, we will rely on their tracking sheets rather than duplicating that effort. Their methodology may result in slightly different numbers, therefore this chart may not exactly match previous enrollment numbers in earlier Updates.

SNP Enrollment (January, November, December, 2015 and January, February 2016)

	January 2015	November 2015	December 2015	January 2016	February 2016
C-SNPs	298,842 *(148 plans)*	339,010 *(148 plans)*	341,503 *(148 plans)*	323,778 *(139 plans)*	326,147 *(139 plans)*
I-SNPs	49,347 *(57 plans)*	53,073 *(57 plans)*	53,714 *(57 plans)*	54,643 *(79 plans)*	56,012 *(79 plans)*
D-SNPs (non FIDESNP)	1,538,011 *(299 plans)*	1,628,476 *(299 plans)*	1,641,076 *(299 plans)*	1,610,593 *(310 plans)*	1,637,577 (310 plans)
FIDESNPs	107,837 *(37 plans)*	113,202 *(37 plans)*	114,087 *(37 plans)*	121,530 *(40 plans)*	122,735 *(40 plans)*
Total	1,994,037 *(541 plans)*	2,133,761 *(541 plans)*	2,150,380 (541 plans)	2,110,544 *(568 plans)*	2,142,471 *(568 plans)*

Source: Special Needs Plan Comprehensive Reports for January, 2015 and November 2015 through February 2016, Centers for Medicare and Medicaid Services

NATIONAL ITEMS

MMCO Issues 2015 Report to Congress

The Medicare-Medicaid Coordination Office (MMCO) has issued its fiscal year 2015 report to Congress on its efforts to better coordinate care for dually eligible individuals. The report includes four legislative recommendations:

- Ensure Retroactive Part D Coverage of Newly-Eligible Low-Income Beneficiaries
- Establish an Integrated Appeals Process for Medicare-Medicaid Enrollees
- Allow for Federal/State Coordinated Review of Dual Eligible Special Needs Plan Marketing Materials
- Improve Alignment of Medicare Savings Program and Part D Low-Income Subsidy Income and Asset Definitions.

CMS Releases Initial Findings on Washington Duals Demonstration

The Centers for Medicare & Medicaid Services (CMS) released its report on initial findings across the Medicare Medicaid Financial Alignment Initiatives with a look at the initial findings on the Washington managed fee-for-service (MFFS) demonstration. CMS has published a January 4, 2016, report, "Measurement, Monitoring, and Evaluation of the Financial Alignment Initiative for Medicare-Medicaid Enrollees Preliminary Findings from the Washington MFFS Demonstration," also prepared by RTI International. The report presents preliminary findings from the Washington MFFS demonstration, which, a year-and-a-half after launching, has enrolled more than 10,000 dual eligible beneficiaries and generated Medicare savings in excess of $21 million.
https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/WAEvalResults.pdf

OMB Receives CMS Final Rule to Overhaul Managed Medicaid.

On February 19, 2016, Modern Healthcare reported that CMS sent its final rule to overhaul the managed Medicaid program to the Office of Management and Budget for review. The 653-page report includes the largest changes to Medicaid managed care regulations in a decade, including caps on insurer profits, network adequacy requirements, a minimum medical-loss ratio, and more. The review can take up to 90 days, meaning the final rule is expected to be published in mid-May, a year after it was proposed.
http://www.modernhealthcare.com/article/20160219/NEWS/160219886?utm_campaign=KHN:%20Daily%20Health%20Policy%20Report&utm_source=hs_email&utm_medium=email&utm_content=26487216&_hsenc=p2ANqtz-9-tmEHTIJelixkKpnFwDaQmPZh9NaoerT74BW4BMk_XIXhNm5w1Ko8-PfKhpOh05jhRynKY7xYq0hd3Vaki63xmMwsgakxde5mxNNcLCRoc4iuDdI&_hsmi=26487216

Stricter CMS Star-Rating Bonus System for Medicare Advantage Plans Seems to be Leading to Quality Improvements

The Kaiser Family Foundation reports that the quality-related bonus payments that now apply to Medicare Advantage (MA) plans seem to be having a positive impact on patient care. Many MA plans have taken steps to improve their star quality ratings in order to obtain significant bonus payments from Medicare. Such improvements include increased screening for osteoporosis, insuring that larger numbers of patients have their high blood pressure under control and handling complaints and appeals in a more consumer-friendly way. While results are still early and more research is needed, this is an encouraging early finding for using financial incentives to improve care for vulnerable patients.

Looking Beyond 2016 Elections to Possible Areas for Bipartisan Discussion on Social Determinants of Health

In an article in the *American Journal of Public Health,* John McDonough discusses the need to increase spending on services that address the social and economic determinants of health in order to improve health outcomes in the U.S., and posits there may be potential openings for bipartisan efforts in this area. In a response, Brookings Institution Senior Fellow Stuart Butler largely agrees with McDonough, and takes the discussion a step further by outlining several areas that offer the possibility of future bipartisan consensus. The authors concur that such no such progress is likely to emerge during the fractious 2016 Presidential race, but Butler encourages beginning quieter conversations now about policy options that could better balance medical and social service spending in the hope some progress can occur "after the election dust has settled."

New Dartmouth Atlas Offers Evidence, Path Forward to Improve Care of Older Adults

The Dartmouth Atlas Project has released Our Parents, Ourselves: Health Care for An Aging Population. This report, funded by The John A. Hartford Foundation, takes a person-centered view of health care and includes geographically specific data that demonstrates regional disparities in the health care experience of older adults. The report looks at geographic disparities for a variety of measures, including the number of days per year the average Medicare beneficiary is in contact with the health care system, hospital readmission rates, the provision of certain screening tests not recommended for adults over age 75, length of time before referral to hospice care and prescribing of high-risk medications.

CCEHI Submits Comments on Quality, Medicare Advantage, Population-Based Payment Models

The Center for Consumer Engagement in Health Innovation (CCEHI) at Community Catalyst submitted several sets of formal comments in the last few weeks:

- CMS' Draft Quality Measure Development Plan
- CMS' 2017 Medicare Advantage Advance Notice and Call Letter
- Health Care Payment Learning & Action Network's Accelerating and Aligning Population-Based Payment Models Draft White Papers on:
  - Patient Attribution
  - Financial Benchmarking

Supreme Court Ruling Stymies State Data Collection Efforts

In what can only be described as an adverse outcome for states seeking to better understand their health spending so as to improve care and lower costs, the U.S. Supreme Court issued a 6-2 decision that deals a serious blow to All-Payer Claims Databases (APCDs). APCDs, which are presently in use in at least 18 states, require payers to provide states with information on all health care claims. The decision means that self-insured plans – those governed by federal law under the Employee Retirement Income Security Act (ERISA) – cannot be compelled to share their data with states. This significantly compromises the accuracy of APCD data. In its decision, the court indicated that the U.S. Department of Labor may be able to compel collection of this data, which may provide states with an alternative avenue to obtaining the data.

ACA Co-ops Saw Deep Financial Losses in 2015, But Some Of Those Remaining Hope for Profit in 2016. On March 11, 2016, The New York Times reported that ACA co-ops suffered significant losses last year and that 2016 will be a critical year for the 11 that are still standing. While these nonprofit alternatives to traditional insurers were meant to boost competition, many struggled to build a customer base and to remain financially stable with high start-up costs, causing 12 to shut down in 2015. However, some note that enrollment is growing better than expected and the co-ops are learning more about their patient population, which seems to be getting younger and healthier. Maryland's Evergreen Health Cooperative did the best of the remaining co-ops in 2015, with losses of $10.8 million, compared to a $90.8 million for one Illinois co-op. Evergreen is expected to turn a profit in 2016.

STATE NEWS

Arkansas

Arkansas Legislative Task Force Supports Hybrid Expansion, Remains Hesitant About Managed Care for Special Needs Populations. On March 7, 2016, Lexington Herald-Leader reported that a legislative panel on Monday supported Governor Hutchinson's hybrid Medicaid expansion, but could not agree as to whether services for the individuals with mental illness and intellectual and developmental disabilities should be moved to managed care. While 11 members of the 16 person Health Reform Legislative Task Force voted yes for the hybrid proposal and suggested lawmakers consider the Governor's proposal to rework the "private option" that uses federal funds to purchase private insurance for low-income residents, lawmakers are concerned that ending the hybrid expansion could cost the state $757 million and would jeopardize support for the Medicaid expansion population. However, discussions regarding the managed care proposal for the individuals with severe mental illness and other disabilities are likely to cause more of a debate among lawmakers. http://www.kentucky.com/living/health-and-medicine/article64533557.html

California

Governor Brown Approves MCO Tax, Which Now Requires CMS Review. On March 1, 2016, The Sacramento Bee reported that Governor Brown approved Managed Care Organization (MCO) tax legislation Tuesday, one day after lawmakers approved the package to preserve $1 billion in federal matching dollars as well as provide several hundred million dollars to services for the developmentally disabled, debt relief, and other programs. The vote ended a yearlong process of negotiations among lawmakers. The proposal will now go to CMS, which has to review the new tax before the current one sunsets on July 1st. http://www.sacbee.com/news/politics-government/capitol-alert/article63206847.html

California to Close Three Institutions for Individuals with Severe Disabilities. On March 8, 2016, California Healthline reported that in less than six years, nearly all the residents of three large state-run institutions for individuals with severe disabilities will be transferred to smaller community-based homes. The state will close down facilities in Sonoma and Costa Mesa, and partially close a third site in Porterville, where half of the patients will be moved. California expects to save approximately $250 million a year. The Legislative Analyst's Office released a report raising concern about the potential loss of federal money during the roughly six years it will take to nearly empty the facilities. The state's final proposal will be presented to the legislature Apr. 1. Read More http://californiahealthline.org/news/state-finalizing-plans-to-close-centers-for-the-severely-disabled/

Providers Hesitant to Join Anthem Blue Cross and Blue Shield of California's Comprehensive Health Information Exchange. On March 2, 2016, Modern Healthcare reported that Anthem Blue Cross and Blue Shield of California teamed up in 2014 to build a comprehensive health information exchange, consisting of complete, longitudinal health records for every California resident, called the Cal Index. However, providers are reluctant to share the information. Thus far, only one health system, Dignity Health, agreed to participate in the data exchange, which will go live at the end of March. Cal Index has payer records on 9 million people, covering three years of data claims. The data does not include prices. Read More http://www.modernhealthcare.com/article/20160302/NEWS/160309963/california-insurers-want-to-build-a-huge-data-exchange-will

The Department of Health Care Services has released the Cal MediConnect Hospital Case Manager Toolkit. This resource is intended to be used in CCI counties participating in Cal MediConnect – California's dual eligible demonstration project – to support enrollees before, during and after hospitalization. The toolkit can support hospital case managers as they work with beneficiaries through the admissions and discharge processes and also includes details on how to access and build upon care coordination services provided by Cal MediConnect health plans.

Florida

Florida 2016 Legislative Session Concludes. Below is a summary of the major Medicaid LTC issues funded in the budget and passed by the legislature.

- Long Term Care (LTC) Waiver Waitlist ($8.1 million). Funding to serve approximately 502 elders on the Medicaid LTC Waiver waitlist who have been classified as a priority score of four or higher.
- Program of All Inclusive Care for the Elderly (PACE) ($10.7 million). Funding to support the Program of All-inclusive Care for the Elderly (PACE) program by funding 200 additional slots in Palm Beach County, 134 slots in Miami-Dade County, and 60 slots in Pinellas County.
- Intermediate Care Facilities for Developmentally Disabled Rate Increase ($10.3 million). Funding to increase reimbursement rates to ICF/DD providers by 4.1 percent.
- Medicaid APD Provider Rate Increases ($24.8 million). Funding for rate increases for adult day training, personal supports, and residential habilitation service providers.
- Medicaid APD iBudget Waiver Waitlist ($38.9 million). Funding to serve approximately 1,350 developmentally disabled individuals on the waitlist for services, including individuals diagnosed with Phelan McDermid Syndrome.
- Brain and Spinal Cord Injury Waiver Waitlist ($1.0 million). Funding to serve an additional 25 individuals from the waitlist that are at the greatest risk for institutionalization or developing secondary complications requiring hospitalizations.
- Long-term Managed Care Prioritization (HB 1335). Establishes a process to prioritize individuals for enrollment in the Medicaid LTC Program. (The bill was presented to the Governor on 03/11/16 and he has until 03/26/16 to act on this bill)

Iowa

CMS Approves Medicaid Privatization Plan; Sets Implementation Date. On February 23, 2016, Governor Terry Branstad announced that CMS approved the state's plan to shift Medicaid to managed care. CMS and Iowa agreed on an implementation date of April 1, 2016. The CMS letter to the state can be found here.https://governor.iowa.gov/2016/02/branstad-reynolds-announce-federal-approval-of-medicaid-modernization

Massachusetts

Governor Baker Plans to Introduce Medicaid ACOs and Increase LTSS Oversight. On February 23, 2016, Sentinel & Enterprise reported that Governor Charlie Baker's administration is working to move Medicaid toward population health and installing independent assessors for people in need of a range of services. The administration is looking to begin offering Medicaid coverage through accountable care organizations (ACOs). It is also seeking to increase oversight in long-term services and supports, where Medicaid funds home health visits, nursing-home care, and other long-term expenses. Long-term services makes up approximately $4.5 billion of all Medicaid spending.
http://www.sentinelandenterprise.com/news/ci_29550455/baker-team-planning-new-strategies-at-masshealth

Michigan

Challenges for Dual Demonstration. *Crain's Detroit Business* recently published a series of related articles about challenges facing MI HealthLink, the state's dual eligible demonstration project. One of the articles reports on the state's lack of progress in developing a key element of the project: the so-called "Care Bridge." This is an electronic database that was supposed to coordinate health care for MI HealthLink

members by seamlessly transferring their information among health plans, mental health organizations and physicians. However, the Care Bridge is not expected to be fully operational for two to three years. A related blog questions the state's ability to reach the demonstration's goals and a third article points to low enrollment as a source of provider frustration.

New Jersey

New Jersey Hospital Association releases report on economic impact of nursing homes. On February 17, 2016 NJHA reported that the state's nursing homes account for $5.4 billion in expenditures throughout the state, employ nearly 56,000 people, contribute at least $116 million in state income taxes and provide $2.1 billion in salaries, according to 2013 financial data from the Centers for Medicare and Medicaid Services (CMS). It found that 59 percent of nursing home reimbursements come from Medicaid and about 16 percent come from PAGE 8 February 24, 2016 Medicare. The report was conducted to underscore the economic impact the nursing home industry has on the state. It notes that while the state is working to reduce reliance on institutional long term care under Medicaid's managed long term services and supports program, demographic trends suggest that nursing home bed capacity should remain stable to care for the most senior and frail state residents. http://www.njha.com/media/333964/Final-Report-New-Jersey-Nursing-Home-Profile.pdf

New York

PACE Request for Information. In response to federal changes in the Program of All-inclusive Care for the Elderly (PACE), New York State (NYS) has released a Request for Information. The PACE Innovation Act allows providers who are not currently PACE providers to consider adapting the model to serve new populations in innovative ways, consistent with the Balancing Incentive Program, MRT initiatives, and the Olmstead Act, all of which encourage the provision of long term services and supports in the least restrictive setting possible. The RFI is intended to help the Department of Health (DoH) develop a comprehensive analysis of PACE and its current role in the provision of LTSS, as well as develop strategies to expand the current PACE model. The RFI seeks input from all interested parties, including current PACE providers, organizations interested in becoming PACE providers, individuals or family members of individuals currently enrolled in PACE, and DSRIP Performing Provider Systems. The RFI can be found on the MRT website: http://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2016-02-18_pace_model_expansion.htm

Home Care Agencies Facing Financial Risk. The Home Care Association of New York State released a report that profiles the financial condition of New York's home care community, including a review of emerging cost and reimbursement challenges. The report indicates that 70 percent of home care providers had negative operating margins, and one-half have had to borrow money to pay for operating expenses over the past two years. They argue that the Medicaid rates do not account for many critical costs needed in service structure and delivery. They note that among home care agencies with a managed care rate below their fee-for-service rate, the managed care rate was on average 20 percent below the fee-for-service rate for nursing and home health services. The report also includes a discussion of the financial impact of new overtime rules resulting from the Federal Labor Standards Act (FLSA), as well as the potential impacts of an increase in the state minimum wage to $15 an hour, as proposed by Governor Cuomo., HCA estimates that implementing the minimum wage would cost the home care industry $1.7 billion/year when fully implemented. The report can be found on the HCA website. http://hca-nys.org/wp-content/uploads/2016/01/RiskFactors2016HCAFinancialConditionReport.pdf

Partnership Plan Annual Report. The Department of Health has posted the Partnership Plan Annual Report on the Medicaid Redesign website. New York State´s Medicaid Section 1115 Waiver, called the Partnership Plan, has operated since 1997. The waiver has allowed the state to implement a managed care program that provides comprehensive and coordinated health care to most Medicaid recipients. The annual report includes enrollment and disenrollment information; outreach activities (largely conducted by MAXIMUS, the enrollment broker for NY Medicaid Choice; operational issues relating to health plan certificates of authority; benefit and other program changes; consumer issues including a review of complaints received; and quality monitoring for both mainstream and managed long-term care plans. A profile of the Managed Long Term Care Program includes a review of grievances and appeals by plan, including total grievances, total appeals, and grievances

and appeals per 1,000 enrollees. Rates of grievances ranged from four per thousand (United Healthcare) to 202 per 1,000 (ArchCare Community Life); appeals ranged from zero (Amerigroup, Elant, Fallon Health, I Circle, NSLIJ Health Plan, Prime Health Choice, Senior Whole Health) to 45 per 1,000 (VNS Choice).

CMS Posts FIDA-IDD Contract. The Centers for Medicare and Medicaid Services (CMS) has posted on its website the three-way contract for the New York Fully Integrated Duals Advantage Program for individuals with intellectual and developmental disabilities, often referred to as FIDA-IDD. Approximately 20,000 dually eligible individuals in the downstate region of New York will have an opportunity to enroll in the new program. The FIDA-IDD expands on the original FIDA dual eligible demonstration project launched in January 2015. HMA reported that plans participating in the original FIDA demonstration will receive Medicare rate increases retroactive to Jan. 1. The increases acknowledge a historical under-prediction of what it costs to manage care for dually eligible individuals. According to HMA, in Manhattan and the Bronx the Medicare rate will increase by about 5.7 percent while other areas will see an increase of up to 10.5 percent.

Enrollment in FIDA-IDD Beginning. Enrollment in the Fully Integrated Duals Advantage (FIDA-IDD) care coordination program will begin in March with services beginning as early as April 1, 2016. Voluntary enrollment is available to dual-eligibles over the age of 21 who receive long-term care and developmental disability services. The program is limited to individuals living in NYC, Long Island, Westchester, or Rockland Counties. The FIDA-IDD program offers greater opportunity to be involved in care planning and for greater self-direction through a care plan team designed to address all medical, behavioral, long-term supports and services, and social needs. Partners Health Plan (PHP) is the only plan selected by CMS to offer the FIDA-IDD program. PHP is a not-for-profit managed care organization dedicated solely to providing supports and services for those with intellectual and other developmental disabilities, with over six decades of experience supporting the needs of individuals with intellectual and other developmental disabilities. Enrollment is coordinated through New York Medicaid Choice, the New York State enrollment broker. Individuals can enroll or disenroll at any time. A presentation about FIDA-IDD can be found on the OPWDD web site. http://www.opwdd.ny.gov/opwdd_services_supports/people_first_waiver/care_management/FIDA_IDD

Governor Cuomo's Wage Hike Can Prove Difficult for Health Care Providers. On March 15, 2016, Politico reported that with Governor Cuomo's minimum wage hike to $15 per hour, health care providers are finding it increasingly difficult to find staff when retail stores and fast food restaurants are offering higher hourly wages. Raising wages is an arduous task for providers that rely primarily on state funding. Those who care for the aged, sick, and disabled must provide for medical, hygienic, and emotional needs of patients. Given the choice between this type of work and other, less demanding work that pays better, workers often choose the latter. As a result, vacancy rates are at an all-time high and rising.
http://www.capitalnewyork.com/article/albany/2016/03/8593394/state-wage-hike-intensifies-staffing-challenge-health-care-providers

North Carolina

Provider-Led Group Partners with Presbyterian Health Plan to Manage Medicaid. On March 3, 2016, Triad Business Journal reported that Provider-Led, Patient-Centered Care LLC (PLPCC), a group of 11 North Carolina health systems, is partnering with Presbyterian Health Plan of New Mexico to managed Medicaid under a new platform being crafted by state officials. The new Medicaid system must still gain federal approval before being implemented. Read More. http://www.bizjournals.com/triad/news/2016/03/03/new-mexico-group-partners-with-triad-health.html

Ohio

Consumer Coalition Obtains Increased Oversight for MyCare Service Plans. The Ohio Consumer Voice for Integrated Care (OCVIC) coalition recently influenced a procedural change aimed at improving the coordination of care in MyCare Ohio, the state's dual eligible demonstration project. With this change, the state has increased oversight of the requirement that MyCare Ohio enrollees review and sign their All Service Plans,

a document case managers develop that specifies all the services necessary for an enrollee to remain in his or her home. The signature requirement is important because it ensures the enrollee has reviewed, understood and agreed to the contents of the plan and had an opportunity to provide input on their care.

Consumers Request Hearing on Mergers. In response to the proposed Anthem-Cigna and Aetna-Humana mergers, UHCAN Ohio and other consumer groups submitted comments to the Director of the Ohio Department of Insurance, Lieutenant Governor Mary Taylor, requesting that she hold hearings on the mergers, which have the potential to reduce competition in Ohio's health care market and impact consumer choice and health care quality.

Oklahoma

Oklahoma House Passes Bill Cutting 110,000 Medicaid Enrollees. On March 2, 2016, The AP/Chicago Tribune reported that the Oklahoma House passed a bill cutting 110,000 residents from Medicaid to help fill the $1.3 billion budget hole. The bill would exclude adults younger than 65 who are not pregnant, deaf, blind or disabled from the program and is expected to save $130 million in state funds. The bill now goes to the Senate for debate. If passed, CMS would need to approve a waiver to exclude these individuals. Read More http://www.chicagotribune.com/lifestyles/health/sns-bc-ok-xgr--oklahoma-medicaid-20160302-story.html?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=26891266&_hsenc=p2ANqtz-881cb7Ju8Thf7-QI2mTy_rOCVNqxZN3PhZtzQO9x0QiFG-eNfyMWYlZIP546iHb_UNk8v_uTjFYgtAtG-MSnVbP9W_YB4Jao3Rc32F7rX8EnWHe7c&_hsmi=26891266

Pennsylvania

Pennsylvania Issues Community Healthchoices RFP for MLTSS, Duals.

The Community HealthChoices request for proposals (RFP), was issued on March 1, 2016 by the Pennsylvania Department of Human Services (DHS). Community HealthChoices is a new statewide managed care program that will provide managed long-term supports and services (MLTSS) to both dual eligible non-dual eligible Medicaid beneficiaries in the state, as well as managed acute care services for dual eligibles without LTSS needs. When fully phased in, Community HealthChoices is anticipated to cover an estimated 420,000 beneficiaries (more than 150,000 in MLTSS), with annual Medicaid expenditures of more than $7 billion. The goals of CHC are to: • Enhance opportunities for community-based services; • Strengthen health care and LTSS delivery systems; • Allow for new innovations; • Promote the health, safety, and well-being of enrolled participants; and • Ensure transparency, accountability, effectiveness, and efficiency of the program. The official release of the RFP is the first step in the procurement process for the selection of managed care organizations (MCOs). The commonwealth plans to coordinate health and LTSS through MCOs. Participants will have a choice of two to five MCOs in each region. Responses to the RFP by the managed care organizations are due on May 2, 2016.

Covered Populations and Historical Spending

Community HealthChoices managed care organizations (CHC-MCOs) will mandatorily enroll adults age 21 or older who meet a nursing facility level of care, regardless of whether they are in a private or county nursing facility, or reside in the community receiving HCBS. Additionally, any individual 21 or older who is dually eligible for both Medicaid and Medicare, and is not needing or receiving LTSS, will also be mandatorily enrolled. As mentioned above, there are an estimated 270,000 non-LTSS duals, 150,000 dual and non-dual users of LTSS, for total enrollment of around 420,000. With an estimated total annualized spend of more than $7.1 billion, equating to a statewide average per-member per-month (PMPM) cost of more than $1,400.

Excluded Populations

Dual eligibles and LTSS users will be excluded from CHC-MCO enrollment if they participate in the Act 150 program, receive services through the lottery funded Options program (unless dual eligible), or reside in a state-operated nursing facility. Additionally, individuals with intellectual or developmental disabilities (ID/DD) eligible for services through DHS' Office of Developmental Programs are ineligible for enrollment. Finally, individuals may opt to remain in the Living Independence for the Elderly (LIFE) program, Pennsylvania's Program of All-Inclusive Care for the Elderly (PACE) option, rather than participate in CHC.

RFP, Contract Provisions
Bidders on the CHC RFP may bid on any combination of five geographic zones, and must serve the entirety of each zone bid. The CHC zones are the same as the existing Health Choices managed care zones (Southeast, Southwest, Lehigh/Capital, Northeast, Northwest). All CHC-MCOs must have aligned dual-eligible special needs plan (D-SNP) and current MIPPA agreement with state by the time they being serving a CHC zone. The CHC RFP indicates that the state may, in future contract years, implement risk adjustment and risk-sharing/stop-loss provisions. Contract Awards and Term of Contract Pennsylvania DHS intends to award between two and five contracts per zone, depending on the zone. The initial contract term is dependent on zone, so that all five zones are aligned in their contract end date. As such, the Southwest Zone contract will begin January 1, 2017, with a five year term, and two options years. The Southeast Zone contract will begin January 1, 2018, with a four year term, and two option years. The Lehigh/Capital Zone, Northeast Zone, and Northwest Zone contract will begin January 1, 2019, with a three year term, and two option years. The option years for all five zones would be 2022 and 2023.

Proposal Evaluation
Proposals will be evaluated on a technical component and a small diverse business participation component. There is no cost component to the RFP evaluation process. The technical component accounts for 80 percent of points available. • Soundness of Approach: how the bidder specifically addresses the needs of the LTSS and duals populations, as well as the unique demographic, cultural, economic, geographic, other relevant characteristics of the regions, counties, municipalities covered in the bid. • Financial Conditions • Personnel Qualifications • Prior Experience. The Small Diverse Business Participation component accounts for 20 percent of points available. A "significant commitment" to SDB subcontracting is considered a minimum of five percent of the estimated average administrative PMPM. Under this section, all bids are scored relative to highest scoring SDB proposal.

RFP Timeline
DHS will conduct a Q&A process for potential bidders and hold a preproposal conference on March 16, 2016, with a proposal due date of May 2, 2016. A target date for contract awards has not been formalized at this time. Phase I of implementation is set for January 1, 2017, in the Southwest Zone. Phase II in the Southeast is to follow on January 1, 2018, with Phase III in the remaining three zones set for January 1, 2019.

Current Medicaid MCO Market
Pennsylvania's physical health managed care program (HealthChoices) is served by seven MCOs, which cover around 2.1 million beneficiaries as of September 2015, up more than 30 percent from March 2015 enrollment of 1.6 million. AmeriHealth Caritas is the largest of these MCO providers, with just over 30 percent market share. However, the state is currently in the process of rebidding HealthChoices contracts. As a note, this procurement includes a renaming of the New West and New East zones as Northwest and Northeast, respectively. More information is available at http://www.dhs.pa.gov/citizens/communityhealthchoices

Community HealthChoices Bidders Conference Held. The Request for Proposal for Community HealthChoices, Pennsylvania's new initiative that will use managed care organizations to coordinate physical health care and longterm services and supports (LTSS), was released on March 1, 2016. The PreProposal Conference for this procurement was held on March 16, 2016. The following potential bidders were represented: • United • Gateway Health • WellCare • Aetna • UPMC • Geisinger • Molina • Health Partners • AmeriHealth Caritas • Magellan • Atelier Health • Accenda Health

Availability of Renewal of the Office of Long-Term Living's Home and Community-Based Waiver for Persons with Other Related Conditions, OBRA Waiver. The Department of Human Services (DHS) has made available for public review and comments the Office of Long-Term Living's proposed OBRA waiver renewal and the Centers for Medicare and Medicaid Services (CMS) final rule transition plan. DHS proposed the following substantive changes to the OBRA waiver effective July 1, 2016: • A new entity to perform clinical eligibility determinations and redeterminations. • Four new employment-related service definitions are replacing two existing employment service definitions. • The transition of individuals from the OBRA waiver into

a managed care delivery system. • The implementation of a home modifications broker. • Revised language to reflect the current practice under the new child abuse clearance laws. The proposed OBRA waiver renewal and a summary of all revisions are available on DHS's website for review. The public comment period ends March 28, 2016. http://www.pabulletin.com/secure/data/vol46/46-9/335.html

Rhode Island

The Rhode Island Executive Office of Health and Human Services (EOHHS) has released a Request for Proposals (RFP) for parties interested in running the Ombudsman Program for the state's dual eligible demonstration project. Questions about the RFP should be submitted to EOHHS by Friday, Feb. 26, at 10:30 am, and proposals are due March 15, at 10:00 am.

South Carolina

CMS posted a document outlining the continuity of care provisions for South Carolina Healthy Connections Prime, the state's demonstration project for dual eligible beneficiaries 65 and older.

Virginia

Community Catalyst submitted comments to the Centers for Medicare and Medicaid Services (CMS) on Virginia's 1115 waiver request. If approved, the waiver would allow the state to transform its Medicaid program and shift the state's blind, elderly and disabled populations – including those with both Medicare and Medicaid – into capitated health plans. If approved, this move would result in the end of Commonwealth Coordinated Care , the state's dual eligible demonstration project, next year. The waiver also seeks approval to implement a Delivery System Reform Incentive Payment (DSRIP) program. This would allow the state to use federal Medicaid funding to create financial incentives for providers to pursue a variety of delivery system reforms.

Washington

Health Care Authority (HCA) to make changes to Medicaid enrollment policies. The Washington State HCA announced that, effective April 1, 2016, enrollees will be retroactively assigned to a managed care plan as of the first day of the month that the member enrolls, instead of the month following the member's enrollment. Providers have expressed concern with this proposed policy and how it would impact prior authorization and notification requirements and subsequent reimbursement.

Senate budget proposal would not move Medicaid program from Managed Care to Fee-For-Service. The new Senate Budget proposal would reform rate setting for the Categorically Needy Blind Disabled and Community Options Program Entry System (COPES) Medicaid program instead of moving it from managed care to fee-for-service. This change would reduce anticipated savings from $25.5 million to $12.8 million through 2017.