HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

October 5, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

VERMONT PUBLICIZES DRAFT ALL-PAYER MODEL WAIVER

This week, our *In Focus* section reviews the draft waiver agreement between the Centers for Medicare & Medicaid Services (CMS) and the Governor of Vermont, the Green Mountain Care Board (GMCB), and the Vermont Agency of Human Services (AHS) to form an all-payer accountable care organization (ACO) model in Vermont. The agreement, if approved by all parties, would implement ACO assignment targets, outcomes and quality milestones, and would require Vermont to keep all-payer and Medicare-specific total cost of care growth per beneficiary below annual growth rate thresholds. The all-payer model (APM)

encourages alignment across Medicare, Medicaid, and commercial payers, moving toward next generation ACO models with all-inclusive population-based payments. Vermont and CMS have reached preliminary agreement on the draft waiver, with state and federal officials conducting further review at this time.

All-Payer Model Overview

Under the APM, the GMCB will oversee the flow of funds from Medicare, Medicaid, and participating commercial payers to the participating ACOs. ACOs will be paid an all-inclusive population based payment (AIPBP) based on their attributed members, similar to a capitation payment. The annual growth rate of per member AIPBPs will be capped based on total cost of care targets. The APM builds on existing Medicare ACO models, and is aligning itself with the Next Generation ACO model, which offers broader financial arrangements, greater risk- and gain-sharing, and movement to AIPBPs. Additionally, the Next Generation ACO model expands access to services, including post-discharge home visits, telehealth services, and skilled nursing facility services for Medicare beneficiaries. Medicaid and commercial ACO models would be aligned with the Medicare Next Generation ACO model under the APM. The state must also develop a plan to align the financing and delivery of Medicaid behavioral health and home and community based services (HCBS) with the APM by the end of the third year of the program.

Total Cost of Care Growth

A key driver of Governor Peter Shumlin's administration's efforts around the APM are rising health care costs for Vermont residents. Health care spending in Vermont is projected to grow by 6 percent annually over the ten year period from 2013 to 2023. In the next ten years, individual health care costs are projected to grow from 38 percent of average income to 56 percent of income. By capping total cost of care growth at 3.5 percent, instead of the 6 percent projected, the state estimates it can save nearly $9.75 billion over 10 years.

Under the APM, total cost of care growth per beneficiary in the APM would be capped at 3.5 percent annually for the five years of the APM. Meanwhile, Medicare total cost of care growth per beneficiary would be capped at 0.2 percent annually for the first two years of the agreement.

ACO Scale Targets

The APM would implement scale targets for Medicare and all-payer beneficiaries aligned to an ACO in each year of the demonstration. By the end of year 5 (2022, if implemented next year), the APM targets 90 percent of Medicare beneficiaries aligned to an ACO and 70 percent of all-payer scale target beneficiaries aligned to an ACO.

	Year 1	Year 2	Year 3	Year 4	Year 5
Medicare	60%	75%	79%	83%	90%
All-Payer	36%	50%	58%	62%	70%

Population Health and Delivery System Targets

The APM includes population-level health outcomes targets including reduction of substance use disorder (SUD)-related deaths; deaths due to suicide; limiting the increase in rates of COPD, diabetes, and hypertension; and maintaining and expanding access to primary care. The APM also includes delivery system targets around mental health and SUD, including follow-up appointment targets

and decrease in emergency department visits. Targets on chronic conditions and timely access to care are included as well.

Timeline

If agreed to by Vermont and CMS, the APM would begin in January 2017 and run through December 2022. The APM proposes 2017 to be "year zero" of the program, to allow the state, CMS, and participating ACOs to prepare for implementation in 2018.

Link to All-Payer Model Information

http://gmcboard.vermont.gov/payment-reform/APM

HMA Medicaid Roundup

Arizona

Arizona Approved For Some, Not All, Requested Changes to Medicaid Expansion Plan. *The Arizona Republic/AZcentral.com* reported on September 30, 2016, that Arizona has received federal approval for certain changes to the state's Medicaid expansion plan, including contributions of up to 2 percent of household income and the creation of savings accounts to help pay for dental, vision, and weight loss services. However, the Centers for Medicare & Medicaid Services did not approve other changes sought by Arizona Governor Doug Ducey, including a job search requirement and a five-year limit on benefits. CMS ruled on the changes in conjunction with granting the state a five-year extension of the Arizona Health Care Cost Containment System (AHCCCS), the state's longstanding Medicaid managed care waiver. Read More

Arkansas

State Seeks 90-Minute Weekly Limit on Medicaid Therapy Services for Children. *KATV.com* reported on October 4, 2016, that the Arkansas Department of Human Services has proposed a 90-minute weekly limit on coverage of speech, occupational, and physical therapy services for children on Medicaid. Children needing more than 90 minutes per week would require prior authorization. A public hearing will be held on October 5 to discuss proposal. Historically, Arkansas has allowed up to 180 minutes per week of Medicaid therapy services for children. Read More

Connecticut

Hospital Margins Declined in Fiscal Year 2015. *The CT Mirror* reported on September 29, 2016, that short-term acute care hospitals in Connecticut saw profit margins fall to 3.9 percent in fiscal year 2015, ending September 30, 2015, compared to 6.2 percent in fiscal year 2014. Of the state's 28 hospitals, 17 turned a profit in 2015, compared to 24 in 2014. Hospital officials blamed inadequate Medicaid funding, adding that the profit squeeze has led many facilities to tighten budgets, cut jobs, or decrease services. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA Releases All Payer Claims Database Invitation to Negotiate. The Florida Agency for Health Care Administration (AHCA) released an Invitation to Negotiate (ITN) on September 26, 2016, for a vendor to develop and operate the state's All Payer Claims Database. Responses are due November 7, 2016, with the 5-year contract anticipated to begin February 1, 2017. The ITN can be accessed by clicking here.

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Tax Credit Donation Program Aims to Support Rural Hospitals. *Georgia Health News* reported on September 27, 2016, that Georgia is about to kick off a new program that will grant tax credits to individuals and companies that donate money to one of 48 eligible rural hospitals. The program, which was created during the state's 2016 legislative session, is aimed at shoring up financially strapped rural facilities. Those who donate up to $4 million will receive tax credits on a first-come, first-served basis, with no more than $50 million in tax credits awarded in 2017, $60 million in 2018, and $70 million in 2019. Five rural hospitals have closed since 2013, and others like Phoebe Worth and Southwest Georgia Regional continue to struggle financially. The program is set to expire after three years. Read More

Kansas

KDHE Faces Lawsuit Over Medicaid Application Backlogs. *Kansas Health Institute* reported on October 3, 2016, that South Dakota-based not-for-profit The Evangelical Lutheran Good Samaritan Society, which runs 32 long-term care facilities in Kansas, has filed a lawsuit against the Kansas Department of Health and Environment (KDHE) over Medicaid application backlogs. The lawsuit, filed on behalf of 21 nursing home residents waiting to be enrolled in the state's Medicaid managed care program, alleges that KDHE violated federal law by not using an electronic asset verification program for Medicaid eligibility determinations and failed to process applications within 45 days. Nursing homes in the state say the backlog is creating financial stress as they wait to be reimbursed for Medicaid care for patients whose applications have yet to be processed. State officials have begun expediting applications for assisted living facilities that contacted the state and are deploying more staff in hopes of eliminating the backlog by November 1. Read More

Kentucky

Kentucky Approved to End Kynect, Move to Federal Health Exchange. The *Courier-Journal* reported on October 4, 2016, that federal officials approved Kentucky's request to transition to the federal Healthcare.gov insurance Exchange platform, effective November 1, 2016, a move that will impact about 500,000 individuals. The state will dismantle its state-run Kynect Exchange.

Individuals who could have obtained Medicaid coverage through Kynect will now be directed to the state's Benefind online enrollment system. Read More

Maryland

Evergreen Health Seeks For-Profit Status to Prevent Closure. *The Washington Post* reported on October 3, 2016, that Evergreen Health, a co-op health plan on the Maryland Exchange, is seeking federal approval to transition to for-profit status in order to avoid closure. Evergreen's board recently approved a deal in which a group of private equity investors would take over the company. Evergreen currently serves 38,000 individual members in the state. About 8,000 signed up through the Exchange, while the remainder chose Evergreen on the off-Exchange individual market or received coverage through their employer. Evergreen began struggling financially after it was required to make risk-adjustment payments under the Affordable Care Act. Read More

Michigan

From HMA's *The Michigan Update*: State Innovation Model – Patient-Centered Medical Homes. In the June 2016 edition of *The Michigan Update*, we reported on the Michigan Department of Health and Human Services' (MDHHS) plan to implement the first phase of its *Blueprint for Health Innovation* Initiative focused on Patient-Centered Medical Homes. Funded by a federal State Innovation Model (SIM) grant, this first phase is targeted for implementation in early 2017. Notices of "Intent to Participate" were due to the state in June from interested physician practices. *Crain's Detroit Business* reports that MDHHS and the federal Centers for Medicare & Medicaid Services are in the final stages of signing contracts with regional managing organizations and selecting an information services company to be the central repository of clinical and patient use data that will be used to manage costs and monitor quality. According to Crain's, the selected information services company has not yet been announced, however the regional managing organizations have been chosen and will be responsible for linking medical practices, hospitals, payers and social services organizations to more comprehensively coordinate care for the individuals being served. The five designated regional managing organizations are:

- Flint Health Coalition for the Genesee County region
- Jackson Health Network for the Jackson County region
- Muskegon Health System for the Muskegon County region
- Center for Healthcare Research and Transformation for the Livingston and Washtenaw county region
- A coalition of health departments for the Northern Michigan region (Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Manistee, Missaukee, and Wexford Counties)

Additional information about the department's SIM activities is available on the MDHHS website.

From HMA's *The Michigan Update*: Improved Coordination of Physical Health and Behavioral Health Services. In previous editions of *The Michigan Update*, most recently in June, we have reported on discussions occurring around improving the coordination of physical health and behavioral health services in Michigan. To gather additional input from stakeholders that will help inform the development of recommendations, the Michigan Department of Health and Human Services announced on September 28th that it will hold Affinity Group meetings with stakeholders. The first of these meetings, focused on eligible populations and their families, have been scheduled for October 4 and 5, 2016. Future meetings will be held with providers and payers. Information about the times and location of these first meetings appears in the department's announcement.

Priority Health, BCBS-MI to Lead Comprehensive Primary Care Plus Pilot in Michigan. Priority Health and Blue Cross Blue Shield of Michigan will lead the federal Comprehensive Primary Care Plus pilot program in Michigan. The Centers for Medicare & Medicaid Services recently announced the five-year national pilot, which is set to begin in 2017 and is aimed at strengthening primary care and improving quality through regionally based multi-payer payment reform and care delivery transformation. A total of 57 health plans in 14 regions nationwide are participating in the pilot, which hopes to enroll about 5,000 primary care physicians. The initiative extends to all patients of participating primary care physicians, whether they are enrolled in Medicare, Medicaid, or commercial health plans.

Nebraska

CMS Approval Allows Medicaid Managed Care Rollout to Proceed. *The Omaha World*-Herald reported on October 4, 2016, that Nebraska has received federal approval to carve behavioral health and pharmacy benefits into Medicaid managed care and expand the program statewide. Nebraska awarded statewide contracts to three health plans earlier this year: United Healthcare Community Plan, Nebraska Total Care (Centene), and WellCare of Nebraska. Eligible members will have until December 1 to make a plan selection or be auto-assigned. Under the revamped program, called Heritage Health, all three plans will operate statewide effective January 1, 2017. Read More

Nevada

St. Mary's May Exit Health Plan of Nevada Network. The *Reno Gazette-Journal* reported on September 29, 2016, that Saint Mary's Health Network of Reno, Nevada, intends to stop serving Health Plan of Nevada members in October. The move would impact 37,000 Health Plan of Nevada Medicaid members and 20,000 Medicare and commercial members. Health Plan of Nevada is a subsidiary of UnitedHealth. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Care Quality Incentive. New York has for the first time released its annual report on the Quality Incentive Program for Medicaid managed care plans. New York has had public reporting of performance measures for over 20 years; its performance reward system began in 2001. Under the program, Medicaid managed care plans are eligible for bonuses added to their premiums, based on composite scores from quality and satisfaction measures. This year's incentive program used 26 quality measures taken from HEDIS and NY-specific measures; three patient satisfaction measures taken from the CAHPS survey; and two measures of avoidable hospital use. For 2015, only one plan, Healthfirst, received the full incentive premium award (three percent of premium). Two plans, HIP and Total Care/Today's Options, did not receive any quality incentive payments. The remaining plans received partial payments. Scores ranged from Healthfirst's high of 79 percent to Total Care, which scored 20 percent. The report, which includes a more detailed description of the methodology, is posted on the Department of Health website. Read More

Medicaid Managed Care Advisory Review Panel. The Medicaid Managed Care Advisory Review Panel, the statutorily established oversight panel for New York's Medicaid managed care program, had its quarterly meeting last week. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight, provided a program update.

Plan News:

- MVP has been approved to expand operations into Columbia, Greene, Lewis, Oneida, Putnam and Washington Counties. MVP completed the migration of members from Hudson Health Plan, which it acquired in 2013, earlier this year.
- HealthNow had its enrollment freeze lifted as of September. HealthNow, a Medicaid managed care plan operated by BlueCross BlueShield of Western New York, had announced in August 2014 that they would exit the Medicaid program in six Western New York counties following $40 million in losses over three years. Since then the plan has been evaluating its participation in Medicaid managed care, including possible partnerships with other plans. Their enrollment had been frozen pending resolution. In August BlueCross BlueShield of Western New York announced a partnership with Amerigroup Partnership Plan to help administer and manage the company's Medicaid managed care programs.

New Benefits/New Populations:

- Nursing Home Transition and Diversion and Traumatic Brain Injury waiver participants will be moved into mandatory Medicaid managed care in January 2018. A draft transition plan has been shared with stakeholders.
- School-based Health Centers will be carved into the Medicaid managed care benefit effective July 2017. A guidance document outlining the transition policy has been drafted and is under review.

Hospital Merger Receives Board Approval. NYU Langone Medical Center and Winthrop-University Hospital announced in July that they were exploring a plan to create an integrated health network on Long Island in July. Crain's reports that their respective boards have approved the affiliation agreement. Winthrop is one of the few remaining unaffiliated hospitals in NY, which has seen an acceleration in hospital consolidation over the last five years. If the agreement is approved by the state regulatory process, NYU Langone Medical Center will make a capital investment in Winthrop-University Hospital, with plans for a full asset merger after five years. Winthrop-University Hospital would end its other affiliations on Long Island, including membership in the ten-hospital Long Island Health Network, if its agreement to develop an integrated health network with NYU Langone Medical Center is approved. NYU Langone sees the affiliation agreement as part of a much broader strategic plan that will allow it to grow and stave off competition. The partnership is intended to lead to an integrated health system on Long Island. NYU Langone is one of five health systems that dominate the hospital market in New York State, the others being Northwell Health, New York- Presbyterian, Montefiore Health System and Mount Sinai Health System. Read More

North Carolina

Medicaid Guidelines Lead to Rise in Personal Care Services Denials. *Carolina Public Press* reported on September 28, 2016, that thousands of North Carolina Medicaid recipients are being denied personal care services, such as help with bathing, dressing, and eating, after the state issued new guidelines changing the way it determines when a patient requires personal care. The North Carolina Department of Health and Human Services Division of Medical Assistance issued the new guidelines in 2015, and denials rose steadily to 19 percent in November 2015, compared to just 5 percent under the old rules. The state uses Liberty HealthCare Corporation to make the determinations. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Audit Finds Doctors Are Not Checking Prescription Histories. *The Dayton Daily News* reports that a state Pharmacy Board audit found 12,000 physicians are not checking the state website prior to prescribing painkillers. The policy is designed to stem the opioid epidemic in Ohio. The Pharmacy Board turned the list over to the Ohio Medical Board which licenses physicians. The board said its priority will be the 45 physicians who prescribed painkillers to more than 200 patients without running the required check. One physician prescribed painkillers to 705 patients in one month without running a single check. The Medical Board said serious violators can face license suspension or revocation, probation, or fines. Read More

Oklahoma

Exchange Plan Premiums to Rise an Average 76 Percent in 2017. *The Washington Examiner* reported on October 4, 2016, that premiums for individual plans on Oklahoma's health insurance Exchange are expected to rise an average of 76 percent in 2017. The only insurer available on the Oklahoma Exchange next

year will be Blue Cross Blue Shield of Oklahoma, a division of Health Care Service Corp. UnitedHealth was the only other plan; however, it will exit the state's Exchange market this year. Oklahoma is one of five states that will have only one Exchange plan. The others are Alabama, Alaska, South Carolina, and Wyoming. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania MLTSS Medical Assistance Advisory Subcommittee Meeting. On October 3, 2016 at Pennsylvania's Managed Long Term Services and Supports MAAC Subcommittee meeting, Kevin Hancock, Office of Long Term Living (OLTL) Chief of Staff, provided an update on the MLTSS Community HealthChoices (CHC) procurement. On August 30th, OLTL announced the winning bidders. Since then, nine of the 11 unselected bidders have requested debriefs and the department has received six protests. The protests are being reviewed and OLTL is responding to the questions and issues raised therein. While responding to protests, OLTL will not go into negotiations with the CHC winning bidders. Protests were made by: United; WellCare; Gateway; Molina; Geisinger; and Aetna (withdrawn).

Utah

Medicaid Expansion Likely to Miss Targeted Start Date. *The Salt Lake Tribune* reported on September 30, 2016, Utah's limited Medicaid expansion proposal will likely miss its targeted start date of January 1, 2017, as federal review of the plan continues. Utah approved a limited expansion, which is expected to cover 9,000 to 11,000 individuals, including childless adults struggling with homelessness, the justice system, and mental health or substance abuse issues; as well as low-income parents with dependent children not covered by Medicaid. Separately, a full Medicaid expansion would likely cost the state millions of dollars more than previously projected, according to data presented at a recent meeting of the state's Health Reform Task Force. Read More

Virginia

Clarification Regarding Virginia MLTSS RFP Plan Selections. In last week's *HMA Weekly Roundup*, it was announced that Virginia had made preliminary contract awards for the state's upcoming Managed Long Term Services and Supports (MLTSS) program. As a point of clarification, the announcement was not a preliminary award, but rather an announcement of the seven plans that were selected by the Virginia Department of Medical Assistance Services (DMAS) to enter into the negotiation phase of the RFP. Additionally, it was stated that United Healthcare was the only non-incumbent plan entering the negotiation phase. Magellan Complete Care is also a non-incumbent bidder. Magellan holds the managed behavioral health contract in the state.

West Virginia

CareSource Expands Exchange Plan to 32 Counties. *Dayton Daily News* reported on September 29, 2016, that Ohio-based CareSource is expanding its Just4Me insurance Exchange plan offerings in West Virginia to 32 counties in 2017, up from 10 in 2016. CareSource also participates on the Ohio, Indiana and Kentucky Exchanges, covering 100,000 total Exchange members. Read More

Wisconsin

Clarification Regarding Wisconsin Family Care and Family Care Partnership RFP. In last week's *HMA Weekly Roundup*, the *In Focus* section highlighted the Family Care and Family Care Partnership RFP for managed long term services and supports (MLTSS) issued by the Wisconsin Department of Human Services. As a point of clarification, the RFP is not opening the Family Care programs to private managed care organizations (MCOs) for the first time. Under Wisconsin statute, private MCOs have always been able to bid on Family Care contracts. Further, under recent legislation, all county and long-term care district plans in Family Care are required to, and are in the process of, converting to nonprofit entities.

National

CMS Issues Rule Barring Arbitration Clauses in Nursing Home Contracts. *The New York Times* reported on September 28, 2016, that the Centers for Medicare & Medicaid Services (CMS) has issued a rule that would bar any nursing homes receiving federal funding from requiring residents to settle disputes in arbitration, rather than in court. Currently, nursing homes can force residents or families to settle claims of elder abuse, sexual harassment, and wrongful death in arbitration hearings, preventing cases from ever being heard in a court of law. The new rule, which impacts an estimated 1.5 million nursing home residents, comes after officials in 16 states and the District of Columbia joined to urge CMS to cut off funding for nursing homes that use arbitration clauses. The American Health Care Association released a statement claiming the new rule exceeds statutory authority and goes beyond what is necessary to protect patients. Read More

U.S. Hopes to Settle Lawsuit Over Exchange Plan Risk Payments. *The Washington Post* reported on September 29, 2016, that the U.S. Department of Health and Human Services (HHS) is working to settle a lawsuit filed by Exchange plans over promised risk corridor payments by tapping into the Treasury Judgment Fund. As part of the Affordable Care Act, HHS was expected to make risk payments of $2.9 billion to health plans participating in the Exchanges to help offset early losses. Instead, plans received less than $400 million because opponents of the Affordable Care Act in Congress blocked HHS from making additional payments. The lack of expected risk payments caused several plans to collapse or exit the market. By tapping into the Treasury Judgment Fund, the Obama Administration would be circumventing the HHS ban. The settlement could result in payments made to 174 Exchange plans. Read More

States Wants to Opt Out of Medicaid FFS Access Rule. *Modern Healthcare* reported on September 29, 2016, that several states want to opt out of a federal rule designed to ensure access to care in the Medicaid fee-for-service (FFS) program. The rule requires states to develop a plan that assesses whether FFS Medicaid members have easy access to services like primary care, pre- and post-natal obstetrics, and behavioral health. However, state officials say that the rule is overly burdensome and a waste of administrative resources, especially for states with small Medicaid FFS enrollment. In Florida, for example, officials said the state is doing as much work to ensure access for 15,000 to 30,000 Medicaid members as is done to ensure access for 3 million Medicaid managed care members. Read More

Industry Research

Prisoners Have Little Access to Hepatitis C Drugs. *Health Affairs* reported in its October 2016 issue that less than one percent of prisoners with Hepatitis C in the United States are receiving treatment. A twelve-course treatment can costs anywhere between $43,000 and $95,000, and correctional departments often receive smaller discounts than other government agencies. *Health Affairs* suggests states should increase funding for inmates with Hepatitis C to reduce the spread of the disease. Read More

Industry News

WellCare to Acquire Care 1st Arizona. WellCare Health Plans announced on October 5, 2016, that it had agreed to acquire Care 1st Arizona, a subsidiary of Care 1st Health Plan, for $157.5 million in cash. The plan serves 114,000 Medicaid and Medicare members in Maricopa and Pima counties. Care 1st Health Plan is an affiliate of Blue Shield California. The transaction is expected to close by the end of the first quarter of 2017. Read More

Community Health Systems Announces Short-Term Stockholder Protection Rights Agreement. *Modern Healthcare* reported on October 3, 2016, that Community Health Systems (CHS) announced a Short-Term Stockholder Protection Rights Agreement, sometimes referred to as a "poison pill," which will make it harder for shareholders to accumulate a controlling interest in the company while it pursues a sale. If a shareholder's stake reaches 15 percent, common shares would cost the buyer nearly five times as much to purchase. The agreement comes after Chinese billionaire investor Tianqiao Chen raised his stake in CHS to 13.8 percent. The agreement will expire April 1, 2017, giving CHS a six-month time period to explore the sale of company assets. Read More

Community Health Systems to Sell Four Hospitals in Florida, Mississippi. Community Health Systems announced on September 29, 2016, that it has signed a definitive agreement to sell four hospitals to Curae Health, Inc. Three of the hospitals are in Mississippi (Health Gilmore Memorial, Merit Health Batesville, and Merit Health Northwest Mississippi); and one is in Florida (Highlands Regional Medical Center). The transaction is expected to close in the fourth quarter of 2016. Read More

Bain Capital, Blackstone in Talks to Acquire Team Health Holdings. *The Wall Street Journal* reported on October 4, 2016, that Bain Capital and Blackstone Group LP are in discussions to take Tennessee-based Team Health Holdings private. Shares in the provider of outsourced emergency care, hospital medicine, and anesthesiology rose 16 percent on the news. Team Health has a market value of about $2.4 billion. Read More

Evolent Health Acquires Valence Health for $219.4 Million. Evolent Health announced on October 3, 2016, that it had completed the previously announced acquisition of Valence Health for $219.4 million, including 7.05 million shares of Evolent and $50.3 million in cash. The transaction also includes potential earn-out potential of up to $12.4 million in Evolent stock. Evolent expects Valence to generate about $80 million to $85 million in revenues in 2016. Read More

Tenet to Pay $513 Million in Medicaid Settlement. *The New York Times* reported on October 3, 2016, that Texas-based hospital operator Tenet Healthcare and two of its Georgia-based subsidiaries will pay a total of $513 million to settle claims it improperly paid prenatal clinics to refer pregnant Medicaid patients to its hospitals. The two subsidiaries, which previously operated Atlanta Medical Center and North Fulton Medical Center (now owned

by WellStar Health System), will forfeit $145 million in Medicaid and Medicare funds. Tenet will also pay $368 million to the federal government, Georgia, and South Carolina. "The conduct in this matter was unacceptable," said Trevor Fetter, chairman and chief executive of Tenet. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
October, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Nevada	Contract Awards	420,000
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
November 9, 2016	Wisconsin Family Care/Partnership (MLTSS)	Proposals Due	14,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
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
December, 2016	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
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	Contract Awards	177,000
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
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
April, 2018	Oklahoma ABD	Contract Awards	177,000
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.

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