HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

December 7, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

OKLAHOMA RELEASES SOONERHEALTH+ RFP

This week, our *In Focus* section reviews the Oklahoma Health Care Authority's (OHCA's) request for proposals (RFP) for a new statewide Medicaid managed care program for individuals who are aged and individuals with disabilities (ABD). The program, called SoonerHealth+, will provide managed acute care, behavioral health, and managed long-term services and supports (MLTSS) to roughly 155,000 members, to be phased in over two years beginning in April 2018. Based on state fiscal year 2014 data, SoonerHealth+ spending per year could exceed $2.5 billion when fully implemented. Proposals are due on February 28, 2017.

Covered Populations, Services

SoonerHealth+ will enroll most individuals in the ABD category of eligibility in mandatory Medicaid managed care, including MLTSS. This includes:

- ABD members who are not eligible for Medicare;
- ABD members dually eligible for Medicaid and Medicare, with incomes below 100 percent of the federal poverty level (FPL);

- Children ages 18 or under receiving services under the Tax Equity and Financial Responsibility Act (TEFRA);
- Individuals meeting nursing facility level of care criteria, receiving home and community-based services (HCBS) through the ADvantage or the Medically Fragile waivers;
- Beginning April 2019 (year two of SoonerHealth+), individuals meeting ICF-ID level of care criteria in the Community or the In-Home Supports waivers; and
- Beginning April 2020 (year three of SoonerHealth+), individuals residing in institutional care settings, as well as children in the custody of the Oklahoma Department of Human Services or in Tribal custody.

As of June 2016, there were approximately 155,000 eligible members in the state – around 136,000 adults and just under 19,000 children. Included in the SoonerHealth+ covered populations are several HCBS waiver populations, with a little under 27,000 participants as of this year. There are roughly 5,000 additional members who are on waiver waiting lists who will be enrolled in SoonerHealth+.

Waiver Program	Covered Populations	Participants	Annual HCBS Spending
ADvantage Waiver	Aged, Adult Disabled	21,727	$181,004,859
Community Waiver	IID	3,102	$188,189,488
In-Home Supports Waivers	IID (Children, Adults)	1,905	$25,510,468
Medically Fragile Waiver	Adults	83	$4,266,953

Source: SoonerHealth+ RFP; OHCA Annual Report 2015

Native Americans, if eligible, will be able to voluntarily enroll in SoonerHealth+, but will not be mandated or auto-assigned.

Excluded from SoonerHealth+ are any non-ABD Medicaid beneficiaries, individuals enrolled in a behavioral health home, members of a Program of All-inclusive Care for the Elderly (PACE) plan, participants in the Homeward Bound waiver, and individuals enrolled in the Living Choice/Money Follows the Person program.

While nearly all benefits will be covered for SoonerHealth+ members when fully implemented, non-emergency medical transportation (NEMT) is carved-out of SoonerHealth+ and provided under a separate vendor contract.

Contract Awards, Term of Contract

SoonerHealth+ will be implemented statewide across two regions – East and West – established to be roughly equal in population size. Bidders on the SoonerHealth+ RFP may bid to serve one or both regions. OHCA anticipates awarding three contracts per region, though may award as few as two or as many as four.

The initial contract term will run through June 30, 2019, with four one-year optional extensions, plus one additional six-month extension, taking the potential full life of the contract through December 31, 2023.

RFP Timeline

OHCA will conduct two rounds of questions and answers from prospective bidders, both before and after the release of the data book and capitation rates in mid-January 2017. A non-binding letter of intent (LOI) is due on January 25,

2017. Proposals are due to OHCA on February 28, 2017. At this time, contract award announcement timing is yet to be determined. As noted above, implementation is scheduled for April 1, 2018, with implementation for individuals with intellectual disabilities to follow in April, 2019, and full implementation to all populations in April, 2020.

Milestone	Date
Deadline for Qs - Round 1	December 9, 2016
Q&A Responses - Round 1	December 22, 2016
Capitation Rates/Data Book Released	January 18, 2017
Non-binding LOI	January 25, 2017
Actuarial Bidders Conference	February 1, 2017
Deadline for Qs - Round 2	February 10, 2017
Q&A Responses - Round 2	February 17, 2017
Proposals Due	February 28, 2017
Contract Awards Announced	TBD
Implementation - Year One Populations	April 1, 2018
Implementation - IID	April 1, 2019
Implementation - Institutional, DHS/Tribal Children	April 1, 2020

Link to RFP Documents

http://okhca.org/about.aspx?id=3217

HMA Medicaid Roundup

Arkansas

Medicaid Waiver Agreement with CMS is Close, Governor Says. *Northwest Arkansas Democrat Gazette* reported on December 6, 2016, that Arkansas Governor Asa Hutchinson met again with U.S. Department of Health & Human Services (HHS) Secretary Sylvia Burwell in hopes of reaching an agreement on the state's proposed Medicaid waiver, with the Governor stating, "We're very close." The waiver would require some Medicaid recipients to make premium contributions, as long as payments are capped at 2 percent of income. Governor Hutchinson said the state will also be allowed to refer unemployed beneficiaries to work-training programs. One reported remaining point of contention involves incentives to businesses that provide health insurance to low-wage workers. Regardless of the outcome of these negotiations, Governor Hutchinson said the state will seek additional waivers after President-elect Donald Trump takes office in January. Read More

Connecticut

Plan to Privatize State-Run Group Homes Delayed. *The CT Mirror* reported on December 7, 2016, that Connecticut is delaying plans to privatize 40 state-run group homes and various services for individuals with intellectual disabilities. The move, opposed by unions like SEIU 1199 New England and CSEA-SEIU Local 2001, would result in an estimated 492 layoffs at the state Department on Developmental Services. A Hartford Superior Court hearing planned for this week is currently on hold while privatization plans are finalized. The state had already laid off 113 employees before the privatization plan was announced on August 16 of this year. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Legislature to Debate Renewal of Hospital Bed Tax. *The Atlanta Journal Constitution* reported on December 2, 2016, that Georgia legislators are readying for a potentially contentious debate over renewal of a hospital provider fee, known as the "bed tax," to leverage federal money for Medicaid. The state legislature previously approved the tax in 2013, at the time helping to fill a $700 million health budget shortfall. Read More

Indiana

Revamped HIP Link Premium Assistance Program Announced. Indiana announced on December 6, 2016, that the Healthy Indiana Plan (HIP) premium assistance program, HIP Link, will be renamed to HIP Employer Link. The program assists HIP-eligible members who have access to qualified employer-sponsored insurance with paying premiums and other cost-sharing obligations. The change will also aim for greater employer participation. Read More

Iowa

Governor Says Medicaid MCOs Unlikely to Need Further Payments to Offset Losses. *The Des Moines Register* reported on December 5, 2016, that Iowa Governor Terry Branstad does not expect Medicaid managed care plans to need additional funds to offset financial losses. The Governor's comments came as Medicaid plans continued to report significant losses in their first year of operation. In October, the state approved an additional $33 million, plus roughly $90 million in federal matching funds, to Medicaid plans to make up for unexpected losses. Iowa implemented statewide Medicaid managed care earlier this year. Read More

Medicaid Managed Care Plans Continue to Report Losses. *The Des Moines Register* reported on November 30, 2016, that Medicaid managed care plans in Iowa are continuing to see losses of tens of millions of dollars, according to a report from the Iowa Department of Human Services. Each of the plans reported negative underwriting margins in the third quarter of 2016: Amerigroup (-18 percent), AmeriHealth Caritas (-21 percent), and UnitedHealthcare (-25 percent). Reported medical loss ratios (MLRs) ranged from 110 percent to 114 percent. As previously reported, Iowa Governor Terry Branstad said the state will increase payments to managed care plans by $33 million to help offset the losses. Read More

Maryland

Individuals with Disabilities Improperly Charged for Residential Facility Stays. *The Baltimore Sun* reported on December 3, 2016, that Maryland improperly charged monthly fees to individuals with disabilities for residential facility stays, according to a state audit. Between February 2012 and April 2014, more than 2,500 individuals with disabilities may have been improperly charged as much as $4 million, the audit said. Most of the individuals were on Medicaid. The state Developmental Disabilities Administration has notified contractors who run the facilities that they must stop charging the fees. Refunds are unlikely, however, because of a lack of data on payments and because cash payments could impact an individual's Medicaid eligibility. Read More

Minnesota

Medica to Exit Medicaid Managed Care Market, Citing Inadequate Rates. *TwinCities.com* reported on December 1, 2016, that Medica will exit the Minnesota Medicaid managed care market in the coming year, claiming rates established through a competitive procurement last year were not actuarially sound. The move could impact 300,000 Medica members, including those in the MinnesotaCare expansion program. The company stated that it was unsuccessful in negotiating for higher rates with the Minnesota Department of Human Services. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Office of State Comptroller releases 2016 annual report. On November 30, 2016 the New Jersey Office of the State Comptroller (OSC), which includes audit, investigations, Medicaid fraud and procurement, released highlights of OSC accomplishments from the past fiscal year (FY) of July 1, 2015 to June 30, 2016. The report states that Medicaid Fraud Division recoveries improved by 30 percent from the previous year. Recoveries reached $112.6 million in improperly paid Medicaid funds in FY 2016. Anti-fraud efforts resulted in the exclusion of more ineligible providers from the Medicaid program than the prior year and cost avoidance of more than $814.5 million in potential Medicaid expenses, a 5.5 percent increase from the prior year. Read more

Medicaid agency files an amendment to the NJ 1115 Comprehensive Waiver with CMS – receives preliminary approval. On November 18, 2016 the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) submitted a request to amend the Special Terms and Conditions (STCs) of the 1115 NJ Comprehensive Waiver as it relates to the managed long term services and supports (MLTSS) program. The request seeks to revise and clarify the level of care requirements for adults and children who seek MTLSS enrollment. The revised level of care criteria for adults ages 21 and children ages birth through 20 are defined in the request. CMS posted a response and based on preliminary review determined the amendment request has met the requirements in accordance with the STCs. The amendment request will be posted on Medicaid.gov for a 30-day comment period. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

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:

- HealthNow has finalized a new management services agreement with Amerigroup; as a result, its enrollment freeze for both Medicaid managed care and Child Health Plus was lifted in October.

- Molina closed on its acquisition of Today's Options in August. The plan has filed for a name change, and the state is now reviewing all proposed member communications. The Department of Health does not expect the change in ownership to have any impact on current members.
- MVP continues to expand its operations, and is now enrolling members in Lewis, Oneida, and Washington counties.

New Benefits:

- Hemophilia blood products are being carved into the Medicaid managed care benefit effective April 2017. All FDA-approved products will be covered. The state is establishing a two-year transition, allowing all users to keep their current providers for up to two years at current reimbursement rates. The state plans to establish a high-cost pool (modeled on the current Hepatitis C high cost pool) to protect plans that have disproportionate enrollment.
- School Based Health Center services will transition into the Medicaid managed care benefit in July 2017. Medicaid managed care plans will be required to reimburse school-based centers at the current Medicaid rates for two years after the transition.

Fully Integrated Duals Advantage:

- New York has decided to extend its duals demonstration for an additional two years, through December 2019. Given the low enrollment levels, it was a difficult decision, but the state remains committed to the program, and hopes to achieve shared savings between the state and the federal government.

Health and Recovery Plans:

- Health and Recovery Plans, designed to meet the needs of individuals with serious mental illness and/or substance use disorders, began enrollment in New York City in October 2015, and in the rest of state in July 2016.
- Almost 80,000 individuals are enrolled in HARPs.
- The Office of Mental Health is tracking utilization patterns for HARP enrollees against historical fee-for-service claims. Utilization claims are down strikingly in some services (partial hospitalization, intensive psychiatric rehabilitation treatment, inpatient services), but OMH believes that is due to administrative glitches in billing and claims submission, and not due to service denials.
- Assessments for home and community based services continue to lag dramatically. HARP enrollees can only begin to access new HCBS benefits after an assessment conducted by a health home. Of the 44,000 individuals in New York City enrolled in a HARP, only 1,518 have gone through the assessment process; of those, 85 individuals have actually received any HCBS services. The state has said it is looking for creative ways to facilitate the assessment process and successfully link HARP enrollees to new benefits, but progress remains extremely slow.

GuildNet Withdrawal from Managed Long-Term Care not Final. Despite reports in the press that GuildNet was withdrawing from operating its managed long-term care plan in several counties, New York State officials say that has not occurred. GuildNet, one of New York State's largest Medicaid managed long-term care plans, sent a letter to the state saying that they would like to stop discontinue enrollment in Nassau, Suffolk and Westchester counties. Before they can proceed, however, they must file proper notice with the state and develop a transition plan.

Advanced Home Health Aides Bill Signed by Governor. Governor Andrew Cuomo signed into law a bill that will allow advanced home health aides to perform certain tasks—in particular, dispensing medication—that can now only be done by nurses. The bill reflects a recommendation of the Medicaid Redesign Tem, whose workforce flexibility work group proposed creating a certification for advanced home care aides who could carry out an expanded range of tasks. The legislation creates a program for home health aides to receive additional training that will allow them to administer premeasured medication under a nurse's supervision.

United Cerebral Palsy of NYC Joins Fully Integrated Duals Advantage for Individuals with Intellectual/Developmental Disabilities. United Cerebral Palsy (UCP) of NYC has joined Partners Health Plan (PHP), the only Fully Integrated Duals Advantage Plan (FIDA) to provide integrated health and long term care for dually eligible adults with Intellectual and Developmental Disabilities (IDD) in New York. FIDA/IDD is part of New York's Affordable Care Act duals demonstrations. The managed care model integrates a wide range of services provided in conjunction with UCP of NYC's full range of disabilities services, education, technology and living supports for thousands of New York individuals. According to Crain's HealthPulse, United Cerebral Palsy of NYC invested $7.5 million in the health plan, joining five downstate chapters of the statewide disability service organization NYSARC, which are also governing partners. People must actively sign up for the FIDA-IDD program, which has enrolled approximately 450 people since April. Read More

Ohio

Department of Medicaid to Shift Additional Populations to Managed Care in January 2017. The Ohio Department of Medicaid announced on December 7, 2016, that the state will be transiting additional Medicaid populations to managed care effective January 1, 2017. Populations included are Medicaid eligible individuals enrolled in the Bureau of Children with Medical Handicaps program, children in state custody and adopted children, and breast and cervical cancer project recipients. Enrollment will be optional for individuals in any of the Department of Developmental Disabilities home and community-based waivers. Currently, more than 84 percent of the Medicaid population in Ohio is served by managed care plans.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Announces Alternative Payment Methodologies for FQHCs and Rural Health Clinics. Pennsylvania's Department of Human Services announced the implementation of alternative payment methodologies for (1) delivery services provided in the Federally Qualified Health Center (FQHC) setting, (2) delivery services provided by FQHC personnel in the acute care general hospital inpatient setting, and (3) the payment by managed care organizations to FQHCs and Rural Health Clinics of rates that are not less than the Department of Human Services Fee-for-Service Prospective Payment System rate for beneficiary encounters. The full fee schedule is available in the *Pennsylvania Bulletin* and is projected to have minimal fiscal impact. Comments should be submitted within 30 days to Department of Human Services. Read More

Pennsylvania Department of Aging names Long-Term Care Council. The Pennsylvania Department of Aging announced appointments to the Pennsylvania Long-Term Care Council, a 35-member body charged with making recommendations on regulations, licensure, financing or any other responsibilities of the departments and agencies that relate to the Commonwealth's long-term services and supports system. The Council will be chaired by Secretary of Aging Teresa Osborne. Charles Quinnan will serve as executive director. The Council includes long-term care consumers, advocates, caregivers, providers, and policymakers. Read More

Texas

Guide to Mental Health Systems, Services Now in Third Edition. The Hogg Foundation for Mental Health published the third edition of *A Guide to Understanding Mental Health Systems and Services in Texas*. The report looks at behavioral health services in Texas, focusing primarily on state programs for treating behavioral health care needs under various state agencies and local entities. Read More

West Virginia

Governor Allocates $1.3 Million to Support Substance Use Disorder Treatment. *The Herald-Dispatch* reported on December 4, 2016, that West Virginia will allocate $1.3 million towards residential drug treatment facilities for women, increased detox beds, and support for law enforcement agencies. The funds will come from legal settlements with wholesale distributors that supply prescription drugs to pharmacies. West Virginia Governor Earl Ray Tomblin announced the plan in a meeting with the Governor's Advisory Council on Substance Abuse task force, which began work in 2011. Read More

Wyoming

Governor, Advocacy Groups Halt Push for Medicaid Expansion. The *Star Tribune* reported on December 4, 2016, that hopes for Medicaid expansion have died in Wyoming, with Governor Matt Mead ending plans to press lawmakers to consider expansion in the state's next legislative session. Mead, a Republican who has advocated expanding Medicaid for the past two years, blamed uncertainty following the election of Donald Trump. Elsewhere, lobbying group Healthy Wyoming, a coalition of businesses and other advocacy groups, met to reevaluate the political landscape and determined that expansion efforts should be put on hold. Read More

National

Senator McConnell Says ACA Repeal Will Be First on Agenda in January. *The New York Times* reported on December 6, 2016, that repealing the Affordable Care Act (ACA) will be the first item on the Senate's agenda in January 2017, according to Senate Majority Leader Mitch McConnell. Lawmakers are reportedly likely to use a budget reconciliation maneuver to pass repeal legislation. Read More

Republicans Could Delay Effective Date of ACA Repeal for Three Years. *Politico* reported on December 1, 2016, that Republican leaders in the U.S. House and Senate may vote to repeal the Affordable Care Act in 2017, but delay the effective date of the repeal for up to three years. Republicans hope to use that time to fully develop a replacement plan and pressure some Democrats to get behind it. However, some are warning that health insurers could pull out of the Exchanges immediately, leaving people with limited health insurance options during the three-year grace period. Meanwhile, U.S. Senators are reportedly considering introduction of replacement legislation in parts instead of under one large bill. Read More

Senate Majority Leader McConnell Outlines ACA Repeal and Delay Strategy. *ABC News/Associated Press* reported on December 3, 2016, that U.S. Senate Majority Leader Mitch McConnell has stated Congress will work to immediately repeal the Affordable Care Act (ACA), but will delay the effective date of the repeal until a replacement plan is solidified. Senator McConnell blamed the ACA for rising copays, deductibles, and premiums. Read More

Freedom Caucus Leader Calls for ACA Replacement Within Two Years. *Politico* reported on December 5, 2016, that the incoming head of the Republican-led House Freedom Caucus wants to see the Affordable Care Act repealed and replaced within the next two years, or before the end of the 2018 session. Representative Mark Meadows, a North Carolina Republican, opposes the three-year phase-out plan being promoted by some Republican leaders. Representative Meadows said the three-year plan will be met with heavy opposition from the 40 Caucus members. Read More

Republicans Remain Uncertain About ACA Replacement Following Meeting With Pence. *Politico* reported on December 7, 2016, that following a meeting with Vice President-elect Mike Pence to discuss plans to repeal the Affordable Care Act, Senate Republicans are still uncertain about the timing of a potential replacement plan. Lawmakers have discussed voting for repeal, but delaying the

effective date to as long as three years in order to allow insurance markets to prepare for the changes. Read More

Hospital Industry Says ACA Repeal Could Cost Them $165 Billion Over 10 Years. *The Washington Post* reported on December 6, 2016, that hospitals are estimating massive financial losses from uncompensated care – up to $165 billion over 10 years – if the Affordable Care Act (ACA) is repealed without a replacement. The American Hospital Association and Federation of American Hospitals wrote to President-elect Donald Trump and congressional leaders asking them to avoid "an unprecedented public health crisis." The move marks the first industry group to speak out publicly about the potential impact of an ACA repeal. Read More

AHIP Expresses ACA Repeal, Replacement Concerns. *CQ Roll Call* reported on December 6, 2016, that America's Health Insurance Plans (AHIP), the trade group representing health insurers, has outlined key issues for health officials and lawmakers over the next two years as the new administration works to repeal the Affordable Care Act. Topics include the individual mandate, Medicaid expansion transition, 2016 reinsurance payments, and tightening of special enrollment periods. The AHIP concerns come as other industry groups, such as the American Hospital Association and the Federation of American Hospitals, have called upon lawmakers to include them in discussions regarding plans to repeal or replace federal subsidies in the insurance marketplace.

Republicans in Discussions with Insurers to Soften Impact of Possible ACA Repeal. *The Hill* reported on December 1, 2016, that Republican congressional staffers are reportedly in discussions with insurance industry executives over ways to soften the immediate impact of a repeal of the Affordable Care Act. Republicans are talking about repealing the law, but delaying the effective date for up to three years or until they have a replacement. The concern is that insurers might just abandon the Exchanges in the interim. Options might include payments or regulatory changes to induce plans to remain in the Exchanges. Read More

Republican Lawmakers Working with Insurers to Keep Individual Markets Stable. *Modern Healthcare* reported on December 5, 2016, that Republican lawmakers are in discussions with health plans to avoid a collapse of the individual insurance market in light of efforts to repeal the Affordable Care Act. Health plans are particularly concerned about efforts to immediately end the individual mandate and premium tax credits. Regulatory actions reportedly under consideration include modified risk adjustment formulas, tightening special enrollment periods, and preserving federal payments to insurers to offset reductions in cost-sharing for certain members. Read More

More than $8 Billion in Exchange Plan Risk Corridor Payments Still Unresolved. *Modern Healthcare* reported on December 5, 2016, that industry observers are increasingly doubtful that health insurance Exchange plans will receive approximately $8.3 billion in risk corridor payments under the Affordable Care Act (ACA) for 2014 and 2015. The funds were meant to compensate for actual patient mix and help offset potential insurer losses in the first three years of the Exchanges. Republican lawmakers have called the risk corridor program a "bailout" of Exchange plans. Read More

Medicaid Spending Rose 9.7 Percent in 2015. *Modern Healthcare* reported on December 2, 2016, that Medicaid spending grew 9.7 percent in 2015, according to the latest data from the Centers for Medicare & Medicaid Services. Medicaid accounted for 17 percent of total national health expenditures of $3.2 trillion in 2015. Overall, health care spending rose 5.8 percent in 2015, following a 5.3 percent increase in 2014. Federal spending accounted for 29 percent of the total, households 28 percent, businesses 20 percent, and state/local governments 17 percent. The report predicts spending will continue to grow over the next decade, driven by an aging population and continued medical price inflation. Read More

States Failing to Enroll Former Inmates in Medicaid, Survey Says. *Kaiser Health News* reported on December 6, 2016, that many states are not successfully enrolling former inmates in Medicaid, according to a survey by the Marshall Project and Kaiser Health News. Of the 31 states that expanded Medicaid, seven states have not created large-scale inmate enrollment programs and many have small programs that leave large numbers without insurance. Nationwide, 16 state prison systems have no formal procedure to enroll prisoners in Medicaid and nine states have small, limited programs. Local jails have even lower rates. Statistically, individuals in the correctional system have higher rates of HIV, hepatitis, and tuberculosis. More than half have a mental illness and as many as three-quarters have a substance use disorder. As a result, many end up back in the correctional system or in hospital emergency rooms. Read More

Medicaid Expansion Did Not Necessarily Improve Coverage of SUD Treatment, Study Finds. *Kaiser Health News* reported on December 6, 2016, that the level of Medicaid coverage for substance use disorder (SUD) treatment did not necessarily improve following Medicaid expansion, according to a new study from Health Affairs. Researchers examined data from the National Drug Abuse Treatment System and state Medicaid Directors to analyze the availability of SUD services in expansion states as of 2014 in four service tiers: outpatient, intensive outpatient, short- and long-term residential services, and intensive inpatient detox. Among 31 expansion states and the District of Columbia, 13 covered each of the services in all four tiers, while 26 covered at least one service in each tier. According to the study, states were least likely to cover residential treatment. Read More

Industry News

CareFinders Total Care LLC Acquires Secura Home Health. *PE Hub* reported on December 1, 2016, that New Jersey-based CareFinders Total Care LLC has acquired Secura Home Health LLC, an adult home care services company, from MTS Health Investors and Oaktree Capital Management. Lincoln International advised Secura on the deal. Secura serves over 3,500 patients across 19 counties in New Jersey. Read More

Centene, Tenet Sign Three-Year Provider Network Deal. Members of Centene and its Health Net subsidiary will have in-network access to Tenet Healthcare hospitals, outpatient centers, and physicians in 18 states under a three-year, provider network agreement announced by the two organizations. The agreement takes effect January 1, 2017, and encompasses Medicaid, Exchange, Medicare Advantage, dual eligible demonstration, TRICARE, and the Department of Veterans Affairs Patient-Centered Community Care Program (PC3) products. Read More

Gateway Health and Wellbridge Health Announce Partnership. Wellbridge Health and Gateway Health announced a collaborative digital program that aims to reduce hospitalizations and emergency room visits. This new program targets Medicare and Medicaid plan members with specific high-risk needs. Wellbridge aims to provide clinical and behavioral interventions with a goal of reducing medical spending and promoting health and wellness. Read More

Health Insurers See Exchange Profits in Certain Markets. *USA Today* reported on December 4, 2016, that some insurers who have made public statements on losses in Exchange business have likely been profitable in certain markets. Aetna, which announced it is pulling out of 11 of 15 Exchange markets for 2017, posted individual Exchange plan profits in Texas and Pennsylvania in the second quarter of 2016, despite an overall second-quarter pretax loss of $200 million on individual market business. Blue Cross Blue Shield of North Carolina reported health care expenses of about $1.5 billion in its Exchange business through nine months of 2016 on premiums of $1.9 billion, indicating a $400 million margin before operating expenses. Meanwhile, Molina and Centene expect to post profits in their Exchange lines in 2017. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
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 (Sept. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	115,736	33.1%	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	46,330	34.1%	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	13,012	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,982	37.0%	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	4,990	4.0%	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	310	1.6%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	61,651	54.1%	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	8,156	15.2%	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	38,658	23.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,477	41.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**353,302**	**28.2%**	

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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