HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 22, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

WASHINGTON RELEASES APPLE HEALTH FULLY INTEGRATED MANAGED CARE RFP FOR NORTH CENTRAL RSA

This week, our *In Focus* section reviews the Washington Health Care Authority's (HCA's) request for proposals (RFP) for the North Central Regional Service Area (RSA) transition to Fully Integrated Managed Care (FIMC) under the Apple Health Medicaid program. Under the RFP, HCA will

contract with fully integrated Medicaid managed care organizations (MCOs) – integrating physical and behavioral health – for the North Central RSA, which consists of Chelan, Douglas, and Grant counties. HCA previously issued a FIMC RFP for Clark and Skamania counties in the second half of 2015. The state eventually intends to transition all counties to the Apple Health FIMC model. Awarded MCOs will begin serving the North Central RSA on January 1, 2018. There are more than 66,200 Apple Health members in the North Central RSA as of February 2017.

Target Population

The RFP indicates that nearly all Medicaid beneficiaries in the North Central RSA will be covered under the FIMC program. Apple Health currently covers most populations, including individuals who are aged, blind, and disabled (ABD) and HCBS waiver beneficiaries.

Additionally covered under the FIMC program will be select individuals receiving behavioral-health- services-only through their choice of MCO while continuing to receive medical services through HCA's fee-for-service system. These behavioral-health-services-only (BHSO) eligibility categories include:

- Dual eligibles
- Apple Health foster care children
- Individuals residing in an IMD (Institution for Mental Disease)
- Medically needy spenddown enrollees, pregnant women who are not citizens of the U.S., and individuals with other health coverage, but eligible for BHSO.

American Indian/Alaska Native populations are exempted from mandatory Apple Health enrollment, but may voluntarily enroll in the FIMC program.

Behavioral Health Integration

Successful bidders will be awarded two contracts: one for Apple Health – FIMC, and one for the Behavioral Health Services Wraparound contract. The Behavioral Health Services Wraparound contract integrates non-Medicaid funded mental health and substance use disorder (SUD) services funded by block grants and state-only funds, which are currently provided by the behavioral health Regional Service Network, the county, or SUD residential treatment providers. A full list of mental health/SUD services is provided in the sample Wraparound contract.

RFP Requirements

At this time, HCA is accepting bids only from health plans with current Apple Health contracts, although plans are not required to currently serve enrollees in the North Central RSA.

RFP Timeline

A mandatory non-binding letter of intent must be submitted to HCA by March 1, 2017, with proposals due on April 5, 2017. The state intends to announce successful bidders on May 11, 2017, with contract negotiations to follow. FIMC operations will begin on January 1, 2018.

RFP Timeline	Date
Letter of Intent (LOI) Due	March 1, 2017
Questions Due to HCA	March 13, 2017
HCA Responses to Questions	March 23, 2017
Proposals Due	April 5, 2017
Preliminary Award Announcement	May 11, 2017
Contract Negotiations Begin	July 1, 2017
Implementation	January 1, 2018

RFP Evaluation Process

The RFP evaluation process places the highest weight on responses around care coordination, behavioral health access, management, and network. More than 22 percent of all available points are based on medical, mental health, and SUD provider network adequacy.

Evaluation Criteria	Points	% Total
RFP Compliance	***Pass/Fail***	
Mandatory Management Review	***Pass/Fail***	
Technical & Management Proposal		
Management	*100*	*11.2%*
Behavioral Health Access	*130*	*14.5%*
Network Description	*100*	*11.2%*
Community Linkages	*65*	*7.3%*
Quality Assessment and Performance Improvement	*40*	*4.5%*
Information Systems/Claims	*50*	*5.6%*
Utilization Management/Authorization of Services	*50*	*5.6%*
Care Coordination	*160*	*17.9%*
Total Management/Technical Proposal	**695**	**77.7%**
Provider Network		
Medical Health Provider Network	100	11.2%
Mental Health Provider Network	50	5.6%
SUD Provider Network	50	5.6%
Total Network Adequacy Submission	**200**	**22.3%**
Total Points Available	**895**	**100.0%**

Contract Awards/Term of Contract

HCA intends to award contracts to two MCOs, but allows for the potential of a third award. Contracts will be in effect for two years, from January 1, 2018, through December 31, 2019. However, HCA may extend the contracts beyond this date at their discretion.

Existing Apple Health Market

Molina Healthcare is the largest Apple Health MCO in the North Central RSA at this time, with just over 50 percent of the market. Community Health Plan of Washington and Centene's Coordinated Care Corporation combine to cover another 40 percent of the market. Enrollment in the table below is as of February 1, 2017. All of the major Apple Health MCOs in Washington have a presence in the North Central RSA.

Health Plan	Chelan Co.	Douglas Co.	Grant Co.	Total North Central RSA	%	Total Statewide	%
Molina Healthcare of Washington	12,482	7,071	14,165	33,718	51%	696,928	44%
Community Health Plan of Washington	1,839	1,181	11,262	14,282	22%	290,526	18%
Coordinated Care Corp. (Centene)	5,563	2,293	5,524	13,380	20%	204,904	13%
United Health Care/OptumHealth	1,242	617	1,071	2,930	4%	235,428	15%
Amerigroup Washington (Anthem)	577	251	221	1,049	2%	148,690	9%
Community Choice	372	133	413	918	1%	3,484	0%
Total North Central RSA MCOs	**22,075**	**11,546**	**32,656**	**66,277**		**1,579,960**	**99%**
Other Regional Plans/Tribal Authorities						*14,067*	*1%*
Total All MCOs						**1,594,027**	

Link to RFP, Additional Documents

http://www.hca.wa.gov/about-hca/bids-and-contracts

HMA Medicaid Roundup

Alabama

Medicaid Program Could Lose Federal Funding Reduced For Rejecting Certain Enrollees. *Modern Healthcare* reported on February 16, 2017, that the Centers for Medicare & Medicaid Services (CMS) may reduce Alabama's Medicaid funding after learning that the state has rejected enrollment of eligible individuals who were accused but not convicted of fraud and abuse. CMS could reduce the state's administrative Medicaid budget by 1 percent starting next fiscal quarter if the state does not address the issue, with the amount increasing by 1 percent every quarter the state is not compliant. Alabama's Medicaid administrative budget was $231 million in 2015. State officials say they are trying to prevent individuals from providing false information on their applications about criminal activity, but CMS notes that the state should report potentially falsified applications to law enforcement to investigate fraud instead. Alabama Medicaid officials have 30 days to request a hearing with CMS. Read More

Alaska

Medicaid Coordinated Care Demonstration RFP Data Book to be Released End of February. The Alaska Department of Health and Social Services is planning to release a Medicaid data book by the end of February pertaining to the Medicaid Coordinated Care Demonstration Project (CCDP) request for proposals (RFP) issued in December 2016. The CCDP RFP allows interested bidders to submit proposals for Medicaid care coordination ranging from enhanced fee-for-service models, such as a primary care case management (PCCM) model, to partial capitation, such as a prepaid inpatient health plan (PIHP) or prepaid ambulatory health plan (PAHP) model, to full risk-based capitation through traditional managed care organizations (MCOs) or provider-led entities. Proposals must address at least 3 of the 9 elements identified in the legislation that authorized the RFP, such as primary care, coordination, accountability and sustainability. Bidders specify the population and geography they propose to cover under the project if selected. The release of the Alaska Medicaid Data Book on February 28, 2017, and the responses to questions on the RFP, which are due March 27, 2017, may provide further clarity on the scope of the potential CCDP and the types of models that may be proposed. Proposals are due to the state on April 17, 2017, with an anticipated contract effective date of January 1, 2018. The RFP and related documents can be found here.

Colorado

Medicaid Program to Receive Mid-year Budget Increases. *The Denver Post* reported on February 14, 2017, that despite a $191 million budget deficit, the Colorado legislature is considering a series of mid-year budget adjustments that would result in an additional $105 million in spending this year. The increase in discretionary spending from the state's General Fund is only $14 million, with most of the money coming from federal funds for state-run programs. The additional funding would mostly be used to cover the newly insured population under the Affordable Care Act. The Senate approved the measures last week with little hesitation. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA Posts SMMC Non-binding Letters of Intent to Bid. The Florida Agency for Health Care Administration (AHCA) posted, on February 22, 2017, a compilation of responses received by February 13, 2017, related to the voluntary request for non-binding Letters of Intent to Bid on the upcoming Statewide Medicaid Managed Care (SMMC) Invitations to Negotiate to be issued during the summer of 2017. A total of 40 responses were received. Read More

House Republicans Propose Health Care Overhaul Plan. *Naples Daily News* reported on February 17, 2017, that Florida House Republicans proposed a plan nicknamed "CorcoranCare" to overhaul the state's health care system. Originally introduced four years ago, CorcoranCare would create a private prepaid plan for all patients to see primary care doctors and redirect Medicaid money to help subsidize private health insurance for individuals with lower incomes. The proposal originally died during the 2015 session, which was shut down early and blocked the state's Medicaid expansion plan. Florida lawmakers say they want to move forward with their own reforms ahead of the federal government. House legislators are expected to draft a memo next week to the White House detailing the plan. Read More

Senate Committee Approves Direct Primary Care Bill, Medicaid Amendment. *Health News Florida* reported on February 22, 2017, that the Florida Senate Health Policy Committee approved a direct primary care bill, which would reduce the role of insurers, letting patients make regular payments to providers for primary care services. The committee also approved an amendment calling for the Agency for Health Care Administration, which administers the state's Medicaid program, to seek approval to allow direct primary care to be used in Medicaid managed care. Read More

Florida releases ITN to provide Electronic Visit Verification (EVV) for Home Health Services. The Agency for Health Care Administration (AHCA) released an Invitation to Negotiate (ITN), on February 21, 2017, for a vendor to provide Electronic Visit Verification (EVV) for home health services. AHCA is seeking to enter into a contract with a qualified vendor to implement an EVV program in regions of the state with moderate to high utilization volume of home health visits, private duty nursing, and personal care services. This may include (but is not limited to) regions in or around Orlando, Tampa, Miami-Date, Fort-Lauderdale, Palm Beach, and Jacksonville. The EVV program must verify the

utilization and delivery of home health services using technology that is effective for identifying delivery of the service and deterring fraudulent or abusive billing for the service. The EVV program must provide an electronic billing interface and require the electronic submission of claims for home health services. Proposals are due to AHCA on April 14, 2017; anticipated dates for negotiations are May 15, 2017 to May 24, 2017; and anticipated posting of intent to award is May 30, 2017. Read More

Indiana

HMA Roundup – Sarah Jagger (Email Sarah)

MDwise Withdraws from Hoosier Care Connect. Effective April 1, 2017, Indiana-based non-profit health plan MDwise, Inc., will exit Hoosier Care Connect, the state's Medicaid managed care program for individuals in who are in the aged, blind, and disabled (ABD) category of eligibility. MDwise says it lost between $75 million to $100 million providing coverage during the first year of Hoosier Care Connect. The company and the state have reached an impasse over the program's capitation rates. Hoosier Care Connect members currently enrolled with MDwise will transition to one of the other two managed care entities currently administering the program, Anthem or Centene's Managed Health Services (MHS). Read More

Maine

Medicaid Expansion to Appear on November Ballot. *The Bangor Daily News* reported on February 21, 2017, that as a result of the Mainers for Health Care campaign, Medicaid expansion will appear on Maine's November ballot. However, potential changes to Medicaid funding at the federal level are creating uncertainty around the possibility of implementing the expansion in Maine. Read More

Minnesota

Audit Finds Lacks of Adequate Oversight of HCBS Providers. *The Star Tribune* reported on February 21, 2017, that Minnesota spent $2.4 billion on home and community-based (HCBS) services in 2015, but failed to provide adequate financial oversight of HCBS providers, according to a new legislative auditor report. The Minnesota Department of Human Services (DHS) does not regularly conduct financial investigations of HCBS providers or require routine reporting, but rather investigates issues that arise from claims or complaints. The report details state spending and oversight of programs that are supposed to be lower-cost alternatives to institutions, including home health care and occupational therapy services. While Minnesota spends a much higher share of Medicaid dollars on HCBS services, the investment has not resulted in greater independence for individuals with disabilities, according to the audit. The legislative auditor suggested that HCBS workers be required to enroll with DHS and be limited in the number of hours that they can bill the states as well as require documentation of services. The report also recommended that DHS develop a core set of HCBS services, rather than providing the services through five distinct waiver programs with different eligibility requirements. Assistant

DHS Commissioner Claire Wilson said the agency supports the report's recommendations. Read More

Montana

HMA Roundup – Rebecca Kellenberg (Email Rebecca)

Legislative Committee Approves DPHHS Budget Cuts. The Montana legislative committee charged with setting the Department of Public Health and Human Services (DPHHS) 2017-2018 budget slashed funding for services to seniors and long term care on Friday. Sheila Hogan, Executive Director of DPHHS, said the subcommittee cut $10 million in general fund spending on Medicaid, which effectively is a $30 million reduction in funds available for the elderly, disabled, and low-income people. The general fund budget for DPHHS for the next two years approved Friday was $10.6 million less, or 1 percent less, than the $1.049 billion that Governor Steve Bullock had requested in his budget proposal, the Fiscal Division figures showed. The panel's proposed budget will next go to the full House Appropriations Committee, then before the full House, before moving to the Senate Finance and Claims Committee and then the full Senate. Read More

New Hampshire

DHHS $1.4 Billion FY 2018-19 Budget Proposal Calls for Increased Pay to Nurses, Other Providers. *New Hampshire Union Leader* reported on February 21, 2017, that the New Hampshire Department of Health and Human Services (DHHS) presented a $1.4 billion budget for fiscal years 2018-19 to state lawmakers. The proposed budget calls for a 15 percent reimbursement increase for nurses, estimated to cost $1 million over two years. The pay increase is aimed at improving retention issues. Additionally, the budget seeks $5 million in state funds to hire and retain other health care providers. As the private sector increases incentives, pay, and benefits, New Hampshire has struggled to retain state workers in the health care field. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Delivery System Reform Incentive Payment Program Mid-Point Assessment. As part of the Delivery System Reform Incentive Payment Program Mid-Point Assessment, the Project Approval and Oversight Panel (PAOP) met to review the DSRIP mid-point assessment reports and recommendations. PAOP is a stakeholder panel established to serve as advisors and reviewers of Performing Provider Systems status and project performance during the five-year DSRIP program. During the mid-point assessment meetings, which took place over four days, each of the 25 PPSs presented their progress to date on meeting the goals of the DSRIP Program. A majority of the PPSs were faulted for not having developed sufficient plans for engaging community-based partners. The recommendation states, in part, "The PPS must develop a detailed plan for engaging partners across all projects with specific focus on Primary Care, Mental Health, Substance Used Disorder providers as well as Community Based Organizations (CBOs). The Plan must outline a detailed timeline for meaningful engagement. The Plan must also include a description of how the

PPS will flow funds to partners so as to ensure success in DSRIP." Details from each of the PPS presentations, a summary of the meeting proceedings, and PPS recommendations as voted on by the PAOP, can be found on the Medicaid Redesign Team website. A summary of comments received during the public comment session, as well as written comments submitted, are also posted. Read More

Budget Hearings Update. The New York State Senate and State Assembly held a joint legislative hearing on the Governor's 2017-2018 executive budget. The Governor presented his budget in January; the budget must be approved by the start of the new fiscal year on April 1, 2017. Read More

Home Care in New York. The Home Care Association of New York (HCA) released a report documenting the financial and program conditions of New York's home care providers. The report notes that the state's Managed Long-Term Care (MLTC) plans are operating at negative operating margins. This affects the home care provider community, which operates largely within the MLTC networks. According to the HCA survey, 61 percent of MLTC plans have negative premium income, and 72 percent of Certified Home Health Agencies have negative operating margins. The report argues that these system-wide operating losses are due to inadequate Medicaid reimbursement methodologies that result in rates that are below the baseline cost of care. The report goes on to note that despite the Delivery System Reform Incentive Payment program (DSRIP), whose overarching goal is to reduce unnecessary hospital utilization, Performing Provider Systems are not including home care providers in their efforts in a meaningful way, nor are they directing financial resources to home care. Home care workforce shortages, recruitment, and retention are another area of urgent concern, jeopardizing the capacity of the home care system to meet patient care needs. Read More

New York Abandons $550 Million MMIS Overhaul with Conduent. *Politico Pulse* reported on February 22, 2017, that New York is walking away from a $550 million contract with Conduent Inc., a spin-off of Xerox, to build an entirely new Medicaid Management Information System (MMIS) for the state and is instead looking to build individual modules. Conduent was awarded the contract in 2014. Under the Affordable Care Act, the Obama administration had agreed to pay 90 percent of the costs to build the new system and 75 percent for maintenance costs. However, State Medicaid director Jason Helgerson said that the system would not have been finished until 2018 and that funding uncertainties were part of the reason for stalling the project. Instead, Conduent is in talks with the state to design certain individual modules rather than a full system. Conduent's Director of Health Care Communications, Erin Isselmann, said that the complexity of the project caused delays and that the modular system is better for both Conduent and New York State.

Ohio

HMA Roundup – Jim Downie (Email Jim)

Governor Criticizes Plan to Phase Out Medicaid Expansion Funding. *The Columbus Dispatch* reported on February 19, 2017, that Ohio Governor John Kasich criticized a U.S. House Republican plan to phase out Medicaid expansion funding, citing 700,000 Ohio residents who gained coverage, as well

increased access to mental health and substance use disorder treatment. Governor Kasich added that it is possible to repeal and replace the Affordable Care Act and include Medicaid reform to make the program more affordable. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Proposed Appendices to the Consolidated and Person/Family Directed Support Waivers Available for Public Comment. The Pennsylvania Department of Human Services' Office of Developmental Programs announced Appendices I and J of proposed renewals of the Consolidated and Person/Family Directed Support Waivers. The current Waivers expire on June 30, 2017, and proposed renewals must be submitted to CMS by March 30, 2017. It is anticipated that there will be an additional $399.413 million ($192.477 million in State funds) cost to the Commonwealth in Fiscal Year 2017-2018 from the waivers. Nine new services are being proposed, including Benefits Counseling and Housing Transition and Tenancy Sustaining Services. Appendices I and J are currently available for public review and comment. Read More

Tennessee

Bill Would Allow State to Implement Block Grant, Expand Medicaid. *The Tennessean* reported on January 17, 2017, that a bill in the Tennessee state legislature would allow the state to pursue a Medicaid block grant and expand Medicaid eligibility if President Donald Trump's administration adopts the funding structure. The bill, filed by State Senator Richard Briggs, would allow the state to expand TennCare, its Medicaid managed care program, to individuals up to 138 percent of the federal poverty level. Under a block grant Tennessee would get a fixed level of funding to provide care for Medicaid beneficiaries. Currently, the Governor is required to obtain legislative approval for expansion. However, the bill would make it easier for the Medicaid agency to apply for a block grant waiver without legislative sign-off. Stakeholders say the state wants to be ready if given the opportunity for block grants. Read More

Texas

CHIP Rural and Hidalgo Service Areas RFP Released. The Texas Health and Human Services Commission (HHSC) released a request for proposal (RFP) on February 21, 2017, for Children's Health Insurance Program (CHIP) managed care services for the Rural and Hidalgo Services Areas. This RFP will align the CHIP Service Areas with the Medicaid managed care service areas, which was required by 2013 legislation. In order to accomplish the alignment, the single CHIP Rural Service Area (RSA) will be broken into four service areas (Central Texas, Northeast Texas, West Texas, and Hidalgo), which the RFP covers. HHSC will award contracts to at least two MCOs per region. As of February 2016, there were more than 85,000 enrollees in the CHIP RSA. Proposals are due April 10, 2017, the award announcement is expected September 1, 2017, and the operational start date is September 1, 2018. Contracts will be through

February 29, 2020. The state may extend the contract, but the total length of the contract may not exceed eight years. Read More

National

House Leaders Lay Out Elements of ACA Repeal and Replace. *The Washington Post* reported on February 16, 2017, that U.S. House Republican leadership met to discuss the Affordable Care Act (ACA) repeal and replace plan. Lawmakers laid out potential elements including health savings accounts, tax credits based on age, state high-risk pools for individuals with chronic conditions, and an overhaul of the Medicaid program, including a discussion of whether to institute Medicaid per capita limits or block grants. A policy brief released by the lawmakers outlines plans to eliminate the tax penalties associated with the individual and employer mandates, as well as adjusting the subsidies available to Exchange enrollees "to provide additional assistance for younger Americans and reduce the over-subsidization older Americans are receiving." House Speaker Paul Ryan (R-Wisconsin) expects legislation to be introduced later this month. Meanwhile, President Donald Trump stated that his replacement plan was in the "final stages" and would be announced in March. Read More

Health Insurers Concerned Over New House Republican Plan for ACA Repeal. *The Wall Street Journal* reported on February 17, 2017, that health insurers expressed concern over the new House Republican Affordable Care Act (ACA) repeal plan. The plan called to immediately end enforcement of the ACA's coverage mandate, but did not offer a replacement to motivate healthy individuals to buy plans. Some insurers have expressed uncertainty around their participation in the Exchanges in 2018. Humana recently announced it will exit all Exchange markets next year. Anthem, Cigna, and Aetna stated they will be reconsidering participation and pricing for 2018. An America's Health Insurance Plans (AHIP) spokesperson, said the Republican plan does not address many industry concerns, including subsidies that help lower-income marketplace consumers pay premiums and out-of-pocket costs. Read More

U.S. Health Spending Growth Slows in 2016, Expected to Rise 5.4 Percent in 2017. *The Wall Street Journal* reported on February 15, 2017, that the rate of increase in U.S. health care spending slowed to 4.8 percent in 2016, down from 5.8 percent in 2015. However, spending is projected by the Centers for Medicare & Medicaid Services to rise 5.4 percent in 2017. Prescription drug spending grew 5 percent in 2016, compared to 9 percent in 2015. Health spending accounted for 17.8 percent of the GDP in 2015. It is expected to rise to 19.9 percent by 2025. Read More

U.S. House Proposes Increased Payments to States Rejecting Medicaid Expansion. *The Hill* reported on February 15, 2017, that U.S. Representative Brett Guthrie (R-Kentucky), who is vice chairman of the House Energy and Commerce subcommittee on health, has proposed a bill to freeze Medicaid expansion enrollment in expansion states, while increasing Disproportionate Share Hospital (DSH) payments in non-expansion states. Guthrie's proposal aims to satisfy lawmakers in expansion states who do not want to lose federal funding, while not disadvantaging states that did not expand. The bill would allow states to keep expansion coverage for individuals currently enrolled. Read More

CMS Nominee Would Reassess Medicaid MCO Network Adequacy Oversight Rules. *Modern Healthcare* reported on February 16, 2017, that Seema Verma would reassess rules on Medicaid managed care organization (MCO) network adequacy oversight and quality ratings if confirmed as President Donald Trump's pick for the Centers for Medicare & Medicaid Services (CMS) Administrator. Verma indicated during a Senate confirmation hearing that she would assess whether it's a burden to require states to vigorously supervise the adequacy of Medicaid MCO networks and establish quality rating systems. Verma also indicated an openness to changes in the structure of Medicaid, including block grants and other funding models. "The Medicaid program as a status quo is not acceptable," Seema said. "I'm endorsing the Medicaid system being changed to make it better for the people relying on it…and whether that's a block grant or per capita cap, there are many ways we can get there." Read More

HHS/SAMHSA Confidentiality of Substance Use Disorder Patient Records. In January 2017, SAMHSA published in the Federal Register a long-awaited and much-discussed update to regulations concerning the Confidentiality of Alcohol and Drug Abuse Patient Records (§42 CFR part 2). SAMHSA's updates were meant to modernize the regulations and make them more applicable to today's largely electronic healthcare data system and to encourage better integration of care. As currently construed, these regulations pose a major operational challenges to the emerging healthcare system owing to the confluence of three factors: 1) the widespread adoption of health information technology including EHRs and HIEs; 2) the functional merging of the publically funded health silos serving individuals with mental illnesses and those with substance abuse disorders; and 3) the growing recognition that individuals with mental health conditions—including both mental illnesses and substance abuse disorders—have co-occurring health conditions that create strong clinical and financial incentives to integrate care. In addition to updating the regulations to permit electronic signatures (as opposed to live, or "wet" signatures), a key feature of these changes will enable patients to use a "general designation" when consenting to share their substance treatment information. In other words, patients will be able to consent to a range of unnamed providers who participate, for example, in a Health Information Exchange, or HIE. A key caveat is that intermediaries like HIEs that permit the general designation in their consent must also be capable of tracking and reporting on to whom data is disclosed over a two-year period. The technology deployed via HIE today does not currently support this level of data tracking. Although these changes will *eventually* support wider consent-supported exchange--in a manner largely consistent with how healthcare data is shared under HIPAA—in all likelihood, little will change in the *short term*. Originally, SAMHSA established a single effective date of 30 days after the publication of the final rule, or February 17, 2017, when the revised 42 CFR part 2 will replace the 1987 version of part 2 in the CFR. However, President Trump's administration issued a memorandum delaying implementation of all new and pending federal regulations, which includes the 42 CFR Part 2 Final Rule. As a result of the regulatory "freeze," the confidentiality Final Rule is delayed for 60 days from the date of the memorandum and will not become effective before March 20, 2017 at the earliest. For more information, please contact David Bergman (dbergman@healthmanagement.com) or Kristan McIntosh (kmcintosh@healthmanagement.com).

Medicaid Innovation Accelerator Program National Webinar scheduled for February 27. As part of the Medicaid Innovation Accelerator Program's (IAP) *Improving Care for Medicaid Beneficiaries with Complex Care Needs and High Costs* [(BCN) also referred to as "Superutilizers"] program, IAP has been working with four states (New Jersey, Oregon, Texas and Virginia) and the District of Columbia since October 2015 on issues such as: identifying/ stratifying target population, designing effective care management strategies, creating partnerships to address non-medical needs and alternative payment methodologies. IAP is holding a four-part webinar series to share insights, lessons learned and tools that states can use as they design and implement activities related to Medicaid beneficiaries with complex care needs and high costs. During the February 27th webinar, ***Creating Partnerships to Address Non-Medical Needs of Medicaid Beneficiaries with Complex Care Needs and High Costs***, two states – Connecticut and Michigan – will share strategies used in their state Medicaid programs to address the non-medical needs of Medicaid beneficiaries through linkages across state agencies and through connections with community-based organizations. The featured speakers for this webinar are Kate McEvoy, Director, Division of Health Services, Department of Social Services, State of Connecticut and Tom Curtis, Director, Michigan SIM Project, Michigan Department of Community Health. This webinar is open to all states and interested stakeholders. HMA is one of several organizations working as a subcontractor under a CMCS contract with Truven Health Analytics, an IBM Company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Beneficiaries with Complex Needs and High Costs (BCN) track through webinars, coaching assistance to participating states, resource papers and bi-weekly program updates. Read More

Industry News

Community Health Systems Posts $1.7 Billion in Losses for 2016, Announces Sale of 8 More Hospitals. *Modern Healthcare* reported on February 20, 2017, that Community Health Systems (CHS) announced that in addition to letters of intent to sell 17 hospitals, the company plans to sell eight additional hospitals to Steward Health Care. The announcement came as the company posted $1.7 billion in losses for 2016, including $220 million in the fourth quarter of the year. Revenue dropped from $19.4 to $18.4 billion in 2016, largely due to a spin-off of 38 hospitals into a separate company, Quorum Health, last summer. CHS expects net proceeds of approximately $1.5 billion from the sale of 25 hospitals, most of which will be used to address the company's operating losses and debt. Read More

Aetna CEO Says Exchanges in "Death Spiral," Policy Experts Disagree. *The Washington Post* reported on February 15, 2017, that Aetna CEO Mark Bertolini believes the Affordable Care Act Exchanges are in a "death spiral." Aetna currently covers 240,000 members through the Exchanges in Delaware, Iowa, Nebraska, and Virginia. Aetna has not decided whether to continue participating on the Exchanges in 2018, having exited 11 markets in 2017. Bertolini argued that with too many higher-cost individuals buying insurance and too few healthy individuals, premiums will continue to keep going up and that soon several Exchange markets may have no insurers remaining. However, health policy experts argue that there are no signs of a death spiral yet, noting that young people are continuing to buy coverage and 85 percent of those on the Exchanges are protected from premium increases because of subsidies. Read More

Company Announcements

- **"MCG Health and Casenet Expand Partnership"** Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
February 24, 2017	MississippiCAN	Mandatory LOI Due	500,000
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
March 15, 2017	Massachusetts	Proposals Due	850,000
March, 2017	Washington, DC	Contract Awards	190,000
April 7, 2017	MississippiCAN	Proposals Due	500,000
April 10, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
April 27, 2017	Alaksa Coordinated Care Demonstration	Proposals Due	TBD
May 1, 2017	Missouri (Statewide)	Implementation	700,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
June 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
July 1, 2017	Georgia	Implementation	1,300,000
Summer 2017	Florida	RFP Release	3,100,000
September 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
January 1, 2018	Alaksa Coordinated Care Demonstration	Implementation	TBD
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

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 (Jan. 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	114,804	32.8%	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	45,469	33.4%	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	16,039	16.5%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,752	36.8%	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	4,827	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	448	2.2%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	69,634	61.1%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	9,934	39.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	8,981	16.8%	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	50,924	30.3%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	28,835	43.6%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**386,647**	**30.8%**	

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

HMA News

HMA's Ellen Breslin to Present at World Congress Workshop

February 27, 2017
Arlington, Virginia

The World Congress 10th Annual Medicaid Managed Care Summit coming up on February 27-28, 2017. Visit www.worldcongress.com/MMC for more information.

HMA Webinar: *"How CBOs Contract, Receive Reimbursement for HCBS in Medicaid Arrangements – A Blueprint for Success"*

March 1, 2017
1:00 to 2:00 PM Eastern

Registration Link

Community-based organizations (CBOs) have a long history of supporting people with disabilities and older adults to live and thrive in the community, through a variety of funding structures. States are increasingly realizing the value of these organizations as providers and partners in their Medicaid-funded programs. At the same time, many states are partnering with Medicaid managed care organizations to provide long-term services and supports (LTSS) and considering value-based payment structures for LTSS. This creates both opportunities and challenges for CBOs who have had experience serving individuals who need assistance to be able to live independently in their own homes.

During this webinar, a panel of experts will provide real-world strategies that CBOs can use to effectively expand access to their services, work with state Medicaid programs, contract with managed care, and ensure sufficient reimbursements.