HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 1, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

ILLINOIS ISSUES RFP TO REBID MEDICAID MANAGED CARE PROGRAMS, EXPAND STATEWIDE

This week, our *In Focus* section reviews the request for proposals (RFP) issued on February 27, 2017, by the Illinois Department of Healthcare and Family Services (HFS) to rebid the majority of the state's existing Medicaid managed care program contracts, consolidate multiple programs into a single streamlined program, and expand managed care statewide. The RFP will consolidate the current Family Health Plans/ACA Adults (FHP/ACA) program, the Integrated Care Program (ICP), and the Managed Long Term Services and Supports (MLTSS) program into a single contracting approach, while reducing the number of contracted managed care organizations (MCOs) from 11 to between four and seven. The RFP does not impact the Medicare-Medicaid Alignment Initiative (MMAI) duals demonstration at this time. When fully implemented by the end of 2018, the new managed care program will

cover roughly 2.7 million Medicaid beneficiaries, integrating physical, behavioral, and LTSS, in all 102 counties in Illinois.

RFP Covered Populations

The RFP covers all non-MMAI (duals demonstration) beneficiaries currently covered under the FHP/ACA, ICP, and MLTSS programs, a little over 2 million members. In addition, the RFP geographically expands managed care to more than 680,000 new members, of which about 500,000 are families, children, and ACA adults. The expansion also includes around 93,000 dual eligibles who are not covered under the MMAI demonstration, as well as 25,000 non-dual seniors and adults with disabilities. The RFP also significantly expands managed care for children with special health care needs, defined as enrollees under the age of 21 who are eligible for Medicaid through Supplemental Security Income (SSI), Division of Specialized Care for Children (DSCC), or a disability category of eligibility.

Finally, a separate contract will be awarded to one successful statewide bidder for the Department of Children and Family Services (DCFS) Youth population, for children who are or have previously been under the care of DCFS. DCFS Youth will be mandatorily enrolled in managed care, except for those children who have been adopted or entered a guardianship, who will have the opportunity to opt-out of managed care.

Population	Current Managed Care	New Managed Care	Total Under RFP
Families and children eligible through Title XIX or XXI	1,434,000	368,000	1,802,000
ACA Expansion Adults	449,000	127,000	576,000
Adults with disabilities, non-dual older adults	121,000	25,000	146,000
Dual-eligible adults (non-MMAI)	21,000	93,000	114,000
Children with special needs	1,800	29,300	31,100
DCFS Youth	<50	39,400	39,400
Total	**2,026,800**	**681,700**	**2,708,500**

The RFP does not carve-in home and community-based services (HCBS) waiver or intermediate care facility services for individuals with intellectual or developmental disabilities (I/DD), but bidders must be capable of assuming responsibility for these services with 180 days' notice if the state decides to include them in the managed care service package at a future date.

Behavioral Health 1115 Waiver, Integrated Health Homes

On October 5, 2016, HFS submitted a Section 1115 demonstration waiver proposal (link) to the Centers for Medicare & Medicaid Services (CMS) with the goals of strengthening the state's behavioral health care system and promoting greater integration of physical and behavioral health. The waiver specifically proposes the inclusion of a package of new benefits (link) for individuals with severe mental illness (SMI) and substance use disorders (SUD), as well individuals nearing release from the Illinois Department of Corrections (IDOC) and Cook County Jail systems. Additionally, the waiver proposes four initiatives aimed at increasing behavioral health integration and the use of value-based payment structures in Medicaid. This includes providing MCOs and providers with resources to pursue development of integrated health homes (IHHs) (link). Illinois intends to design and implement IHHs, and is requesting support around workforce integration,

provider readiness assessment, encouraging partnerships and integration between physical and behavioral providers, the launching of disease-specific pilot projects, and data collection and reporting.

Evaluation Process, Financial Proposals

Bidders will be evaluated on meeting pass/fail proposal requirements, a technical proposal section (worth 500 out of 900 total points), a financial proposal (300 out of 900), and an oral presentation (100 out of 900). The technical proposal includes topics around integration of physical and behavioral health, IT solutions, specific sections on children with special needs and LTSS, and alternative and value-based payments. Under the financial proposal, bidders will submit bid rates that must fall within the rate cell ranges to be provided by HFS in the forthcoming data book.

Contract Awards

Under the RFP, interested bidders may submit a Proposal Option A, under which a MCO bids to serve all populations in all 102 counties statewide (new regions are designated in the RFP for the purposes of rate-setting alone). Alternatively, government-owned or minority-owned MCOs may submit a Proposal Option B, under which they bid only to serve Cook County. HFS intends to award between three and five MCO contracts under the statewide option (including Cook County), and between one and two additional MCO contracts under Option B for Cook County only. Contracts will be for an initial term of four years, with two optional two-year extensions, taking the potential full life of the contracts to eight years.

RFP Calendar, Implementation Timing

A mandatory bidders/offerors conference will be held on March 10, 2017. There will be two rounds of questions and answers, a data book release, and a second, encouraged but optional, conference before proposals are due to HFS on May 15, 2017. Award announcements are tentatively planned for the end of June, with contracts in effect on January 1, 2018. The RFP indicates that HFS will plan to transition all current MCO enrollees covered under the RFP to new contracts within the first 90 days of implementation, or during the first quarter (Q1) of 2018. This will be followed by the transition of all new MCO enrollees under the RFP in the following 90 days, or during Q2 2018.

RFP Activity	Date
Mandatory Offeror Conference	March 10, 2017
Round 1 Questions Due	March 15, 2017
Data Book Release	March 29, 2017
Round 1 Questions Answered	March 29, 2017
Second Offeror Conference	April 4, 2017
Round 2 Questions Due	April 10, 2017
Round 2 Questions Answered	April 24, 2017
Proposals Due	May 15, 2017
Award Announcements	June 30, 2017
Implementation	January 1, 2018
Transition Current MCO Enrollees to new Contracts	Q1 2018
Transition New MCO Enrollees to new Contracts	Q2 2018

Current Medicaid Managed Care Market

As of December 2016, there were 12 MCOs in contract with HFS across the three managed care programs under this RFP, as well as the MMAI duals demonstration. As of January 1, 2017, however, Health Alliance has ended its contracts in both the FHP/ACA and ICP programs. While Meridian Health Plan and Blue Cross Blue Shield of Illinois are the largest plans in terms of current market share, no plan has greater than 20 percent of the market.

Plan Name	FHP/ACA	ICP	MLTSS	Total Membership (Under RFP	Market Share
Meridian Health Plan	350,050	12,094	5,726	367,870	18.3%
Blue Cross Blue Shield of Illinois	295,482	12,735	9,099	317,316	15.8%
Family Health Network/CCAI	237,783	8,540		246,323	12.3%
Aetna Better Health	178,114	28,590	7,298	214,002	10.7%
IlliniCare Health Plan (Centene)	173,925	26,412	5,563	205,900	10.3%
Molina Healthcare of Illinois	184,685	6,183		190,868	9.5%
Harmony Health Plan (WellCare)	165,847			165,847	8.3%
CountyCare	139,033	4,999		144,032	7.2%
Health Alliance	80,713	6,570		87,283	4.4%
Next Level	52,152	4,454		56,606	2.8%
Cigna HealthSpring of Illinois		5,148		5,148	0.3%
Humana Health Plans		5,101		5,101	0.3%
Total	**1,857,784**	**120,826**	**27,686**	**2,006,296**	

Additionally, MCO participation across the five current mandatory managed care regions, and sometimes across the counties within a region, varies from program to program. A map of MCO participation by region is available here, current as of July 1, 2016.

Link to RFP, Appendices, Related Documents

https://www.illinois.gov/hfs/info/MedicaidManagedCareRFP/Pages/default.aspx

HMA Medicaid Roundup

Alabama

Centene Drops Out of Alabama RCO Program. The Alabama Medicaid Agency announced on February 28, 2017, that Centene Corp. is exiting the state's Regional Care Organization (RCO) program. Centene's Alabama Healthcare Advantage (AHA) was set to operate RCOs in all five regions of the state. However, a press release from the Medicaid agency notes, that Centene's Envolve subsidiary is "ending its agreement as a capital contributor" to all five AHA RCOs. There are now only two remaining probationary RCOs in Alabama, down from 11 in 2015. Both have expressed interest to providing services in the regions that AHA would have served. State officials say they still plan to move forward implementation of the RCO program in October 2017. Read More

California

Lawmakers, Advocates Once Again Push Single-Payer Health Care. *The Los Angeles Times* reported on February 26, 2017, that California politicians and health care advocates are once again promoting a state-run, single-payer healthcare plan in light of the Trump administration's efforts to repeal and replace the Affordable Care Act. Under a single-payer plan, California residents would pay into a state agency, which would then reimburse providers when individuals sought treatment. As an alternative to single-payer, California is also considering a public option that would be sold on the Covered California exchange. The public option could then one day morph into a single-payer plan. Read More

Connecticut

Budget Proposal Would Negatively Impact Hospitals by $116 Million, Hospital Association Estimates. *The CT Mirror* reported on February 27, 2017, that tax increases included in Connecticut Governor Dannel Malloy's state budget proposal would result in a $116 million net negative impact to hospitals starting next year, according to the Connecticut Hospital Association (CHA). CHA estimates that taxes would rise from $556 million in fiscal 2017 to $623 million in fiscal 2018 and $625 in fiscal 2019. Not-for-profit hospitals would no longer be exempt from real estate taxes, representing $212.1 million in additional taxes for hospitals. Malloy also plans to eliminate an $11.8 million grant pool for small hospitals and reduce payment rates by another $27 million. These costs are offset by roughly $250 million in supplemental

payments that hospitals receive through the state's provider tax, which was implemented in 2011. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

House Delays Changes to Nursing Home Reimbursement Methodology. *Florida Politics* reported on February 22, 2017, that the Florida House of Representatives decided not to pursue a proposal to change the reimbursement methodology for Medicaid nursing home stays this year. Under the proposed plan, the state would reimburse nursing homes using a per diem rate based on four elements, with patient care accounting for 80 percent. Health Care Appropriations Subcommittee Chairman Jason Brodeur says the prospective payment system is appealing, but rate calculations could be improved. For example, the plan uses cost of living indices only for Broward and Miami-Dade counties, with a single index for the rest of the state. Additionally, the committee is interested in a five to six-year transition to limit disruption for nursing homes, more than twice as long as the proposal's two-year transition plan. Read More

AHCA Seeks Renewal of the Adult Cystic Fibrosis and Traumatic Brain and Spinal Cord Injury Waivers. The Agency for Health Care Administration (AHCA) announced on February 27, 2017 that it is seeking federal authority to renew the following Florida Medicaid Waivers for the period July 1, 2017 through June 30, 2022: 1915(c) Adult Cystic Fibrosis (ACF) Waiver; and 1915(c) Traumatic Brain and Spinal Cord Injury (TBI/SCI) Waiver. The 30-day public notice and public comment period will run from February 27, 2017 through March 28, 2017. The Agency will consider all public comments received during the public notice period regarding the proposed waiver extension. The full waiver renewal requests may be viewed on the Agency's website.

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Medicaid Expansion Repeal Could Cost Cook County $300 Million Annually. *Crain's Chicago Business* reported on February 23, 2017, that Cook County could see a fiscal impact of at least $300 million annually if the Medicaid expansion and associated federal funding were repealed. A spokesperson for the Cook County Health & Hospital System estimated roughly $200 million in reimbursements are at risk under repeal, as well as an estimated $100 million in new charity care costs. One county commissioner stated that these estimates appeared low, and the annual impact to the County could reach $450 million annually. Cook County Board President Toni Preckwinkle reiterated the County's commitment to providing care, regardless of Congressional action on the Medicaid expansion. An estimated 483,000 Cook County residents could lose coverage under a full repeal of the Affordable Care Act. Read More

Iowa

Medicaid MCOs Anticipating $450 Million in Combined Losses this Year. *Quad-City Times* reported on February 22, 2017, that Iowa's three Medicaid managed care organizations (MCOs) told legislators that they expect $450 million in losses this year. AmeriHealth Caritas Iowa anticipates losses of over $200 million, Amerigroup Iowa $150 million, and United Healthcare of the River Valley $100 million. While UnitedHealthcare CEO Kim Foltz said that the number was higher than expected, all three plans say they are committed to continue participating in the program. Talk of financial issues began to arise in October 2016, when the state increased payments to insurers by $33 million to help cover the costs of prescription drugs and the Medicaid expansion population. However, insurers have allegedly been lobbying for rate increases since the start of the program. The state and insurers will begin renegotiating capitation rates in April for an effective date of July 1, 2017. The plans are required to file detailed financial reports with the Iowa Insurance Division on March 1, 2017. Read More

Kansas

House Advances Bill to Expand Medicaid. *The Wichita Eagle* reported on February 22, 2017, that the Kansas House of Representatives voted to advance a bill that includes the expansion of KanCare, the state's Medicaid program. The vote came after numerous amendments failed and the House committee tabled a separate bill on expansion until April 3, 2017. While supporters say the bill will expand access to Medicaid for 150,000 Kansans, critics question whether the state should expand as Congress prepares to repeal or replace the Affordable Care Act, as well as whether the state can afford expansion. The vote is a victory for supporters of expansion, which regained attention after moderate Republicans gained seats in the legislature in November. However, the bill must be fully passed by the House before heading to the Senate and Governor Sam Brownback, who has consistently opposed expanding Medicaid. Read More

Mississippi

University Medical Center Faces $35 Million in Additional Medicaid Cuts. *The Clarion-Ledger* reported on February 24, 2017, that the University of Mississippi Medical Center (UMMC), the state's largest Medicaid provider, is facing an additional $35 million in Medicaid cuts, after the state already reduced funding by $8.2 million. The cuts are a result of a decrease in "allowable" uninsured costs and a change in a state Medicaid formula used to determine the disproportionate share hospital (DSH) payments to compensate hospitals that serve large numbers of Medicaid and uninsured patients. UMMC said the cuts could result in layoffs and program eliminations. However, the center promises to "protect the patient experience." UMMC received $120 million in funding in fiscal year 2015 and $104 million in fiscal year 2016. It will receive $68 million in fiscal 2017. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Department of Health Posts DSRIP Update. The New Jersey Department of Health (DOH) posted a February 2017 update on the state's Demonstration Reform Incentive Payment Program (DSRIP) which is scheduled to expire under the 1115 Comprehensive Waiver on June 30, 2017. Forty-nine New Jersey hospitals are participating in DSRIP. The Division of Medical Assistance and Health Services (DMAHS) and DOH had been in discussions with the Centers for Medicare and Medicaid Services (CMS) to continue DSRIP for two years with an optional one-year extension, however CMS has not been supportive of the current DSRIP program. DMAHS now plans to request a one-year extension with revised plans that address CMS concerns. The extension would: 1) place greater emphasis on population health outcomes; 2) shift from a hospital-centric model to one that is based on a regional planning collaborative (ACO-like models with additional community partners); 3) revise current use of Hospital Relief Subsidy Fund (HRSF) for hospital DSRIP funding to a community-based DSRIP funding model; 4) use more national performance measures including community partner measures; 5) be sustainable to continue population health improvements. Slides from the DOH DSRIP hospital industry meeting can be found here.

Rutgers Center for State Health Policy Releases Findings on NJ's Medicaid ACO Demonstration. The Rutgers University, Center for State Health Policy posted a Year 1 report of the state's Medicaid ACO demonstration, with an assessment of ACO operations and care management strategies from July 1, 2015, to June 30, 2016. The report covered the experience of the three certified ACOs: the Camden Coalition of Healthcare Providers, Healthy Greater Newark, and the Trenton Health Team. Interviews were also held with leadership from two ACOs that were not certified but had plans to pursue ACO activities in Paterson and New Brunswick. Five themes emerged:

1. The ACO demonstration is considered part of a larger community health improvement strategy;
2. ACOs aim to engage and bring value to Medicaid MCOs, who remain unconvinced of the value of the demonstration;
3. ACOs continue to consider which patient subgroups should be their focus;
4. ACOs are developing provider engagement strategies and related quality measures;
5. ACO funding sources are many, lack stability and have uncertain funding limits.

The Camden ACO is the most developed with well-defined care coordination strategies and shared savings contracts with two Medicaid MCOs. The Trenton ACO negotiated a contract with one Medicaid MCO and has made progress with data analytics and provider engagement. The Newark ACO is the least developed and is focused on building infrastructure, data analytics and provider and social service engagement. The Paterson community remains committed to accountable care while the New Brunswick community has not pursued a Medicaid ACO area of focus. Read More

***New Jersey Policy Perspective* Projects Impact on State Residents if the ACA is Repealed.** On February 21, 2017, the *New Jersey Policy Perspective* published a report that projects extensive, statewide losses in federal funding, health insurance coverage including pharmacy benefits for seniors, jobs and lives. More than 1 million residents would lose health care coverage from Medicaid expansion and Marketplace insurance plans. Of those, over 300,000 residents would lose access to their Marketplace plan and 550,000 adults could lose Medicaid eligibility. In addition, more than 200,000 older residents on Medicare would lose prescription drug coverage that the ACA provided to cover a gap in Medicare's coverage terms known as the "donut hole." The report projects that over 86,000 jobs would be lost and close to 800 state residents would die due to loss of access to health care coverage. A county by county impact analysis is available in the report. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Medicaid Managed Care Advisory Review Panel Updates. The New York Medicaid Managed Care Advisory Review Panel, the legislatively mandated oversight body for the state's Medicaid managed care program, held its quarterly meeting on February 23, 2017. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the New York Department of Health, provided a program update. In addition, the panel received reports on auto-assignment for the SSI population, and on the status of managed long-term care.

Program Update - Plan News:

- Molina Healthcare completed its purchase of Total Care, a Today's Options of New York health plan, and has received approval to change the name of the plan. The plan will be known as Molina Healthcare of NY. Molina is providing Medicaid managed care, HARP (Health and Recovery Plan) and CHP (Child Health Plus) products in Onondaga, Tompkins and Cortland counties (CHP is also available in Oswego County).
- MetroPlus, a managed care plan operated under the auspice of NYC Health + Hospitals, the New York City public hospital system, has received approval to expand operations into Staten Island.

Program Update - New Benefits and Populations:

- Hemophilia and blood clotting products will be carved into the Medicaid managed care benefit effective April 2017. Read More
- School-based health services are on track to be carved into the Medicaid managed care benefit effective July 2017. Plans will be responsible for reimbursing School Based Health Center (SBHC) sponsor agencies for SBHC services provided to managed care enrollees. The goal of the transition is to maintain access to critical SBHC services while integrating the services into the larger health care delivery system. A guidance document outlining the transition and FAQ can be found on the Medicaid Redesign Team website.

- New York has begun implementation of a Step Therapy Reform bill which took effect January 1, 2017. The bill will regulate insurance plans and health maintenance organizations, including Medicaid managed care plans, who impose step therapy protocols on patients, and will provide an expedited appeals process for patients and their health care professionals to override such protocols. The Department of Health is in the process of developing and reviewing protocols; it is not clear when health plans will be required to adopt them.

Auto-Assignment of SSI Enrollees in Medicaid Managed Care:

The Office of Quality and Patient safety presented findings from a study on auto-assignment of SSI beneficiaries into Medicaid managed care, which aimed to examine differences in utilization and in quality of care between enrollees who selected a plan at the time when SSI beneficiaries were moved from fee-for-service into managed care, and those who were auto-assigned. The study found that those who were auto-assigned used fewer Medicaid services, and were less engaged in care. Both groups demonstrated an increase in emergency department use as well as pharmacy claims. Few significant differences were seen in quality metrics.

Managed Long-Term Care:

- Minimum Wage: As part of the 2016 budget, New York increased its minimum wage. The Medicaid program will be increasing reimbursement to managed long-term care plans in order for home care agencies to cover the wage increases. A stakeholder group on Minimum Wage Oversight and Education is being convened, and guidance is being developed on how plans should pass funds on to home care agencies and workers.
- Community First Choice Option: The Community First Choice Option implementation has been moved back from July 2017 to January 2018. As a result, the Nursing Home Transition and Diversion waiver and Traumatic Brain Injury waiver transition into Medicaid managed care has been delayed from January to April 2018.
- PACE: As part of the PACE Innovation Act, NY's PACE Model Expansion will include individuals with intellectual/developmental disabilities (I/DD).
- FIDA: New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed due to programmatic challenges, as well as concerns about network adequacy. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment will occur. The state is planning to launch a new stakeholder process to review the FIDA program, with a focus on easing regulatory burdens.
- MLTC Eligibility: The Governor's budget proposes changing eligibility for managed long term care, limiting enrollment to individuals who meet the nursing home level of care. This proposal was a budgetary cut rather than a program initiative, as enrollment in MLTC plans has

grown more rapidly than the state had projected. The Department thinks this will affect only a small number of enrollees, somewhere between 1 and 3 percent of individuals currently participating in the state's MLTC program.

Affordable Care Act and Medicaid Expansion in New York. City & State hosted an event where a panel examined how New York would respond to a repeal of the Affordable Care Act. A recent report by the Center on Budget and Policy Priorities notes that if federal match for the Medicaid expansion population is reduced to the overall state FMAP, in 2019 New York would lose over $6.6 billion in federal matching funds for the expansion population alone. While only a small percentage of New York's expansion population is newly eligible, based on New York's previous eligibility expansions under its Family Health Plus program, almost 2.3 million New York Medicaid beneficiaries fall within the federal expansion enrollment population. In addition, funding for the Essential Plan, New York's Basic Health Program, would have to be made up with state-only funds. Over 665,000 individuals are covered under the Essential Plan. Lawmakers noted that even in a relatively fiscally health state such as New York, finding several billion dollars in new funds to cover health care programs will be a challenge. Read More (1); Read More (2)

North Carolina

Mark Benton Named Deputy Secretary for Health. *News Observer* reported on February 22, 2017, that former state Medicaid director Mark Benton has rejoined the North Carolina Department of Health and Human Services (DHHS) as the Deputy Secretary for Health. Benton most recently started a public policy consulting firm, called the Paratum Group, in 2015. Before that, he worked for Community Care of North Carolina and the Milbank Fund, a foundation focused on health policy research. Read More

Cape Fear Valley Health System Joins Medicaid MCO. *FayObserver* reported on February 22, 2017, that Cape Fear Valley Health System trustees approved $11.2 million in funding to start a Medicaid managed care organization (MCO) with 10 other North Carolina providers, aiming to begin operations by July 2019. New Mexico-based Presbyterian Health will operate the MCO for the 11 systems and retain a 25 percent ownership stake in the venture. The MCO, which aims to operate in six regions, is targeting a 90 percent medical loss ratio (MLR). Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

February 23rd Pennsylvania Medical Assistance Advisory Committee Meeting. On February 23, 2017, the Pennsylvania MAAC held their monthly meeting. Leesa Allen, Deputy Secretary of the Office of Medical Assistance Programs, provided a budget update. The total proposed appropriation for medical assistance is $19.4 billion and includes: $15 billion for capitation; $3 billion for Fee for Service; $800 million for Medicare Part D; $400 million for specialty hospitals and $200 million for the Medical Assistance Transportation Program (MATP). Deputy Secretary Allen also discussed the upcoming MMIS re-procurement that will be redesigned per federal requirements.

Governor Wolf's 2017-2018 Budget for Individuals with Disabilities. Pennsylvania Governor Tom Wolf's 2017-2018 Executive Budget provides $26.2 million for services for individuals with intellectual disabilities (ID) and autism. Services for this population will be provided by the newly created Department of Health and Human Services. Funding will reduce the waiting list by 1,000 individuals through a new community support waiver; expand the Adult Autism Waiver by 50 additional people; provide employment and community services to an additional 820 special education graduates; fund community services for 120 individuals transitioning from state centers; add more than 2,000 individuals to the Targeted Services Management State Plan and establish two bio-behavioral units to support people with complex neurodevelopmental needs. Read More

Health Choices' Unsuccessful Bidders Protest Contracts. *The Philadelphia Inquirer* reported on February 23, 2017, that Pennsylvania's Health Choices Medicaid managed care procurement awards are once again under protest from multiple unsuccessful bidders for "irregularities" in the selection process. United and Aetna were not awarded contracts, while AmeriHealth Caritas was not awarded a contract in its largest market. Pennsylvania State Representative Robert Matzie (D-Beaver/Allegheny) criticized the procurement process, citing proposal scoring errors, improper negotiations with a bidder, and a change in the weighting of evaluation factors without notice. An earlier attempt at procuring the Health Choices contract also resulted in protests and ultimately a decision to rebid. Read More

Tennessee

TennCare Outlines Benefit Cuts to Offset End of Hospital Assessment Program. Tennessee announced its intent to seek certain cuts to certain TennCare Medicaid benefits currently funded through the state's hospital assessment program, which is scheduled to expire in June 2017. Should the hospital assessment be renewed, however, the cuts would not take effect. The Tennessee Department of Finance and Administration said it will file an amendment with the Centers for Medicare & Medicaid Services, asking permission to make the following benefit cuts to the TennCare II Demonstration: elimination of coverage of Medicaid occupational, speech, and physical therapy services; and an annual per person limit of eight days for inpatient hospitals services, eight non-emergency outpatient hospital encounters, eight practitioner office visits, and eight lab and x-ray services. Read More

Vermont

All-Payer ACO Model Set to Begin with Medicaid Pilot. *Kaiser Health News* reported on February 27, 2017, that Vermont will kick off efforts to implement an all-payer accountable care organization (ACO) in the state with a pilot aimed at serving 30,000 of the state's 190,000 Medicaid beneficiaries in 2017. OneCare, which is a network of providers and hospitals, will receive $93 million in monthly capitated payments in the pilot phase. OneCare will be at risk for costs above that amount, but would share in any excess funds. If successful, the program would be expanded to encompass the rest of the state's Medicaid population as well as commercial and Medicare lives. Vermont

received authority to initiate the ACO through a broad-based waiver granted by the Centers for Medicare & Medicaid Services. Read More

Wisconsin

DHS Releases Family Care and Family Care Partnership RFP for Service Areas 2, 3, 11, 12. The Wisconsin Department of Health Services released on February 22, 2017, the Family Care and Family Care Partnership RFP for Geographic Service Areas (GSR) two, three, 11, and 12. Family Care and Family Care Partnership are health and long-term care programs for low-income frail elderly and adults with developmental, intellectual, or physical disabilities. The state is seeking managed care organizations to provide coverage for Family Care in GSRs two, three, 11, and 12 and Family Care Partnership in GSRs three, 11, and 12. Proposals are due on April 13, 2017. Family Care implementation is slated to begin January 2018 and Family Care Partnerships January 2018 or January 2019. Read More

National

ACA Repeal Would Create Funding Gaps for States, Report Finds. *The Associated Press* reported on February 27, 2017, that an Affordable Care Act (ACA) repeal would significantly reduce federal dollars for Medicaid and subsidized insurance, creating funding gaps for states, according to a new report. By phasing out Medicaid expansion money and putting caps on funding, states will see meaningful cuts, which could then lead to cuts in eligibility, benefits, or payments to hospitals, the report finds. That's especially true of states that expanded Medicaid. Read More

House Republicans Raise Concerns Over ACA Repeal, Replacement Plans. *The Wall Street Journal* reported on February 27, 2017, that some Republicans in the U.S. House of Representatives are expressing growing concern over Republican proposals to repeal and replace the Affordable Care Act, especially plans to rely on age-adjusted tax credits to help individuals purchase private insurance. Representative Mark Walker (R-North Carolina), who chairs the 170-member Republican Study Committee, called the proposal "a new health insurance entitlement with a Republican stamp on it," adding that he would not support it in its current form. The House Freedom Caucus has also raised concerns over the use of tax credits in the Republican plan. Walker had earlier voiced concerns over the cost of the proposed tax credits, which would amount to $2,000 annually for individuals under 30 and $4,000 for those over 60. Read More

Republican Governors Support Medicaid Work Requirements, Program Flexibility. *CQ Roll Call* reported on February 28, 2017, that a draft healthcare proposal from the Republican Governors Association (RGA) calls for Medicaid work requirements and recommends giving states the option of choosing between Medicaid block grants and per capita caps. The proposal is aimed at giving states more flexibility in shaping their Medicaid programs. The RGA is expected to attempt to work with the Office of Management and Budget and the Congressional Budget Office to hammer out details of the plan.

Republican State Leaders Push for Medicaid Eligibility Limits, Cost Sharing, Work Requirements. *The Wall Street Journal* reported on February 23, 2017, that more than a half-dozen Republican-led states are seeking federal waivers to revamp their Medicaid programs, including new restrictions on Medicaid eligibility, work requirements and cost sharing. For example, Maine wants to limit Medicaid beneficiaries to five years of benefits, Kentucky is looking to impose work requirements, and Wisconsin wants to beneficiaries to undergo drug testing. While some of the requests were previously filed under the Obama administration, others are unprecedented. Republicans say these new requirements would help states try new approaches to reducing costs and improving outcomes. Read More

ACA Revalidation Provision Removed 65,000 Providers from Medicaid. *Modern Healthcare* reported on February 22, 2017, that an Affordable Care Act (ACA) provision mandating providers to revalidate or recertify their Medicaid reimbursement eligibility has resulted in an estimated 65,000 providers dropped from the program, according to an analysis on data from 15 Medicaid agencies. Texas, for example, cut more than 28,000 of its 298,000 Medicaid providers, while Indiana removed more than 3,200. The ACA provision, which aims to reduce fraud, waste, and abuse, required providers that enrolled in Medicaid before March 25, 2011, to send in revalidation notices to the Centers for Medicare & Medicaid Services by September 25, 2016. The American Medical Association and American Academy of Family Physicians both stated they have received no reports of access issues in response to the revalidation effort. Read More

Community Clinics Share Concern Around Affordable Care Act Repeal. *Kaiser Health News* reported on February 24, 2017, that the potential repeal of the Affordable Care Act has left the nation's 1,300 community clinics in limbo, according to interviews with clinic directors. Most of the centers are not-for-profit and meet the criteria for federally qualified health centers, which means they receive higher rates from Medicare and Medicaid. The additional revenues and federal funding has allowed clinics to expand and add services such as mental health care or urgent care. Now the clinics are in a holding pattern, waiting to see what will happen to the health care law. Read More

Industry News

Tenet Healthcare Insurance Business Posts 2016 Loss. *Modern Healthcare* reported on February 28, 2017, that Tenet Healthcare suffered $29 million in losses from its insurance business lines in the fourth quarter of 2016, according to the company's earnings report. Tenet had expected the losses to amount to $15 million. The company announced earlier this year that it had definitive agreements in place to sell two of its health plans. Read More

Envision Healthcare Weighs Options for Ambulance, Population Health Businesses. *Modern Healthcare* reported on March 1, 2017, that Envision Healthcare is considering potential joint ventures, alternative structures, or possible divestiture of its ambulance and population health lines of business. Envision will focus $750 million of its $900 million capital budget on acquiring physician practices in 2017. The remaining funds will go to medical transportation and ambulatory surgery centers. The company merged with AmSurg in December, posting a net loss of $137.8 million on merger-related cost. Envision projects 2017 revenues of $10.4 billion to $10.7 billion. Read More

Company Announcements

- **"MCG Health Releases 21st Edition Industry Leading Care Guidelines"** Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
March 1, 2017	Oklahoma ABD	Proposals Due	155,000
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
May 15, 2017	Illinois	Proposals Due	2,700,000
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
June 30, 2017	Illinois	Contract Awards	2,700,000
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	Illinois	Implementation	2,700,000
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%**	

** New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment.*

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 Barbara Markham Smith Authors AcademyHealth Blog Post on High-Deductible Health Plans in the Marketplaces

A number of solutions have been proposed to help lower costs and improve access to care by attracting healthier people to risk pools. In a February 28, 2017, blog post for AcademyHealth, HMA Principal Barbara Markham Smith, JD, shares her thoughts on the role of high-deductibles in the instability of the Marketplaces. Read More

HMA Welcomes…

Laquisha Grant, Senior Consultant – New York, New York

Laquisha joins HMA most recently from the New York City Mayor's Office of Criminal Justice where she served as Program Administrator for the Mayor's Taskforce on Behavioral Health in the Criminal Justice System. In this role, Laquisha oversaw the $140 million multi-agency mayoral initiative designed to keep individuals with mental illness and substance use issues from cycling in and out of the criminal justice system. She convened working groups of over 50 city, state and federal agencies, service providers, individuals with lived experience, and other stakeholders to advance the goals of the task force. She also convened and facilitated regular meetings with judges, commissioners, and various city and state government leadership to discuss and implement policy and systemic change. Laquisha created public facing reports and presentations to demonstrate the purpose and progress of mayoral initiatives and developed a mechanism for collecting and reporting data from various city agencies to meet funding requirements.

Prior to the Mayor's Office, Laquisha served as Special Assistant to the Assistant Commissioner for Mental Health at NYC Department of Health and Mental Hygiene. In this role, Laquisha researched best practices in the field of mental healthcare to develop and implement special projects requested by the Assistant Commissioner. She managed communications including speeches, correspondence, publications and presentations on issues and topics related to mental health. Additionally, Laquisha coordinated the Division of Mental Hygiene's role in healthcare and Medicaid Reform implementation in the NYC behavioral health sector. She managed quarterly program reviews and assisted with developing metrics and improving outcomes orientation. Laquisha also served as a Grant Manager with where she oversaw a $1 million budget of emergency response programs and provided high-level analytic support to the Deputy Director.

Previously, Laquisha served as a Grants Analyst with NYC Health + Hospitals where she provided financial management of grant-funded programs and affiliate contracts and acted as a liaison between funding agencies, Central Office and program administrators.

Laquisha earned her Master of Public Administration degree (with a concentration in Health Care Administration) from Long Island University and received her Bachelor of Science degree in Political Science from Trinity College.

Health Management Associates (HMA) is an independent health care research and consulting firm, specializing in the fields of health system restructuring, health care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, payers, and providers, with a special concentration on those who address the needs of the medically indigent and underserved. Founded in 1985, Health Management Associates has offices in Albany, New York; Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Phoenix, Arizona; Portland, Oregon; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

http://healthmanagement.com/about-us/

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.