HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

NEBRASKA RELEASES LTSS REDESIGN DRAFT

This week, our *In Focus* section reviews the Medicaid long-term services and supports (LTSS) redesign draft paper published on March 7, 2017, by the Nebraska Department of Health and Human Services (DHHS). The paper is the follow-up to a January 2016 DHHS concept paper, which identified increasing pressure on the state's Medicaid LTSS system. The LTSS redesign paper addresses identified high-priority systemic issues in the current LTSS system, recommends longer-term system changes, and outlines a transition to

managed LTSS (MLTSS). Nebraska has long been in discussion around a transition to MLTSS, and this draft redesign paper potentially puts the state on a timeline to begin providing mandatory MLTSS statewide to older adults and individuals with disabilities (Phase 1) as of January 1, 2019, with MLTSS to follow for individuals with intellectual or developmental disabilities (Phase 2) on July 1, 2019. We estimate the potential MLTSS population at more than 50,000 beneficiaries with annual LTSS spending between $800 million and $850 million.

MLTSS Approach

Rather than recommending a standalone MLTSS program or a separate contracting approach, as many states have, the Nebraska recommendations would expand the scope of the existing statewide Heritage Health program MCOs to cover the target MLTSS population. Heritage Health is Nebraska's new statewide Medicaid managed care program, which launched on January 1, 2017, with three MCOs under contract. These three plans – Centene's Nebraska Total Care, UnitedHealthcare, and WellCare – are already administering physical, behavioral, and pharmacy benefits for individuals enrolled in Nebraska's home and community-based services (HCBS) waivers, while their waiver services and other LTSS benefits are reimbursed fee-for-service. These waivers include:

- Aged and Disabled Waiver;
- TBI Waiver;
- Children's Developmental Disabilities Waiver (consolidated with the DD adult waiver effective April 1, 2017);
- Adult Day HCBS Waiver; and
- Developmental Disabilities Adult Comprehensive Waiver (consolidated with the DD child waiver effective April 1, 2017).

The report also recommends that individuals in nursing facilities and assisted living homes be included from the outset, rather than delayed as some states have, to encourage meeting the state's long-term care rebalancing goals and reduce incentives to avoid community-based settings.

Finally, the report recommends preserving Nebraska's Program of All-Inclusive Care for the Elderly (PACE), which is available only in the Omaha area, as an option for individuals over 55.

Based on information provided by the state's MLTSS Advisory Council in 2014, as well as historical data on I/DD waiver populations, we estimate the fully-implemented MLTSS population at more than 50,000 beneficiaries statewide. Federal fiscal year 2016 spending for LTSS services was more than $840 million, with a fairly even split between HCBS and institutional services.

Additional Models Considered

The LTSS redesign report considered two alternative models to the MLTSS approach: expanding Medicare ACO models or provider-led networks. The report concludes that expanded ACOs would not provide statewide coverage, nor do the existing ACOs in Nebraska have experience in providing LTSS to Medicaid beneficiaries. In fact, the report concluded that there is no active model anywhere in the country in which a standalone ACO is successfully providing Medicaid LTSS.

On the provider-led network approach, the report again notes that there is no existing program in which provider-led organizations are providing integrated MLTSS, although the report acknowledges that Alabama, Arkansas, and North Carolina are pursuing this model. Ultimately, the report concludes that DHHS could pursue this model if there were adequate interest and capacity among providers, but that provider-led networks would require significant assistance to get to a point where they could accept full-risk for the MLTSS population.

Timing, Next Steps

Nebraska DHHS will be holding a series nine listening sessions across the state over the next two weeks, between March 20 and March 20, with two public webinars scheduled for March 28 and 29. Public comments will be accepted through April 14, with a finalized LTSS redesign plan expected to be made public in May 2017. Based on this timeline, and assuming the state moves forward with the recommended MLTSS approach, the state's three Heritage Health MCOs would begin providing mandatory MLTSS statewide to older adults and individuals with disabilities (Phase 1) as of January 1, 2019, with MLTSS to follow for individuals with I/DD (Phase 2) on July 1, 2019.

Current Heritage Health MCOs

Across the three Heritage Health MCOs, there are more than 226,000 Medicaid beneficiaries enrolled, with enrollment distributed fairly evenly across UnitedHealthcare, Centene's Nebraska Total Care, and WellCare. Each plan has between 71,000 and 79,000 members, or between 31 percent and 35 percent of the total market.

Heritage Health MCO Enrollment and Market Share (January - March 2017)

	Jan-17	Feb-17	Mar-17	% Share
UnitedHealthcare	76,886	78,905	78,549	34.7%
Nebraska Total Care (Centene)	77,623	77,028	76,422	33.8%
WellCare	71,237	70,353	71,343	31.5%
Total - All MCOs	225,746	226,286	226,314	

Source: Nebraska DHHS

Link to LTSS Redesign Report, More Information

The "*Nebraska Long Term Care Redesign Plan – Draft,*" prepared for DHHS by Mercer Consulting and the National Association of States United for Aging and Disabilities (NASUAD), is available here.

Listening session presentation slides are available here, with dates, times, and locations, and webinar and other information are available at: http://dhhs.ne.gov/medicaid/Pages/medicaid_LTC.aspx

HMA Medicaid Roundup

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Recovered $165 Million in Medicaid Fraud in Fiscal 2016, HHS Report Says. *SaintPetersBlog.com* reported on March 9, 2017, that according to a U.S. Department of Health and Human Services (HHS) report, Florida's Medicaid Fraud Control Unit recovered $165 million in Medicaid fraudulent funds in fiscal 2016. The state ranked second in total funds recovered in the nation behind New York, which recovered $229 million. Since 2011, Florida has recovered more than half a billion dollars in settlements and judgments. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Rural Hospitals Continue to Struggle Financially. *WABE.org* reported on March 10, 2017, that six rural hospitals in Georgia have closed since 2010, while others continue to struggle financially, according to the NC Rural Health Research Program. Nationally, 80 hospitals have closed, and half of all rural hospitals are losing money. The issues in Georgia are attributed in part to the state's decision not to expand Medicaid, as well as the high proportion of older patients and patients with higher utilization served by rural hospitals. Read More

Iowa

Medicaid MCO Seeks to Renegotiate Deal with Mercy Health Network. *The Des Moines Register* reported on March 9, 2017, that AmeriHealth Caritas is working to renegotiate contract terms with Mercy Health Network. If a deal is not reached by July 1, approximately 220,000 members could lose access to Mercy's network, which includes Mercy Medical Center, 12 other hospitals, and 200 clinics. AmeriHealth Caritas said it is seeking to establish a sustainable Medicaid program, while Mercy says the plan is attempting to reduce reimbursement rates already agreed to. The three plans participating in Iowa's Medicaid managed care program have reported heavy financial losses in their first year. Read More

Minnesota

Medica Files Lawsuit over Medicaid Contract Negotiations. The *Twin Cities Pioneer Press* reported on March 14, 2017, that health plan Medica has filed a lawsuit claiming the Minnesota Department of Human Services acted improperly by contracting with competing plans for the company's Medicaid and MinnesotaCare business in the state. Medica wants the state to re-bid the business in 2018, instead of extending current contracts through 2019 or beyond. The suit suggests that the state improperly offered more favorable rates to competing organizations to take over the Medica business, after denying a request by Medica to negotiate higher rates. Medica announced it would exit the Medicaid market after the state declined the renegotiation request. Read More

HealthEast to Merge with Fairview Health Services. *TwinCities.com* reported on March 8, 2017, that Minnesota hospital network, HealthEast, has agreed to merge with Fairview Health Services. The deal would likely create the largest health system in the Twin Cities area. HealthEast operates Bethesda Hospital, St. John's Hospital, St. Joseph's Hospital, Woodwinds Health Campus, and 14 primary care clinics, representing 8.3 percent of the hospital revenues in the Twin Cities market. HealthEast has been losing patients in recent years and is one of the smaller systems in the region. Meanwhile, Fairview represents 22.6 percent of Twin Cities hospital revenues. The combined network will be run by Fairview chief executive James Hereford. The deal must still be approved by regulators. Read More

Mayo Clinic to Prioritize Private Pay Patients Amid Medicaid Pressure, Says CEO. *Star Tribune* reported on March 14, 2017, that Mayo Clinic chief executive John Noseworthy, MD, announced that his organization will give preference to patients with private insurance over those on Medicaid or Medicare. The strategy illustrates growing financial pressure on organization's like Mayo, which are serving a growing number of patients in lower-paying, government-sponsored programs like Medicaid. Mayo has seen unreimbursed costs for Medicaid patients rise from $321 million in 2012 to $548 in 2016. While Mayo will continue to take patients regardless of the payer, Noseworthy said, it will prioritize private pay patients in cases where two patients are referred with similar conditions. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

DMAHS Updates Information on Contracted Dual Special Needs Plans. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) posted online an updated set of Frequently Asked Questions (FAQs) about the state's Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) program. As of January 2017, Horizon NJ TotalCare has joined the other three FIDE SNP Programs (Amerivantage Dual Coordination, United Healthcare Dual Complete ONE, and WellCare Liberty) and is operating in 15 counties across the state. Additionally, UnitedHealthcare Dual Complete ONE expanded its service area within the state. These changes expand FIDE SNPs to 20 of the state's 21 counties (Cape May does not have a FIDE SNP plan). FIDE SNP enrollment continues to be voluntary. Read More

Adequate Funding for Charity Care is Unclear if ACA Repealed. *NJ Spotlight* reported on March 13, 2017, about a growing concern among New Jersey hospitals that a repeal of the Affordable Care Act would result in a spike in uncompensated care. New Jersey hospitals saw a state budget reduction in the charity care pool, coinciding with an increase in state residents who obtained health care coverage under Medicaid Expansion and the Marketplace. If fewer residents are insured at the same time that the state sees a reduction in federal support for the Medicaid program, without increasing charity care funds, hospitals will see a drop in payment for uncompensated care. Read More

NJPP Issues Blueprint for Economic Justice & Shared Prosperity. On March 10, 2017, New Jersey Policy Perspective (NJPP) issued a report, "*Blueprint for Economic Justice & Shared Prosperity,*" which provides a framework of policies for New Jersey. These policies address supporting working families, making the tax code fairer and the state budget more responsible, providing affordable healthcare, strengthening the state's safety net, and investing in the foundations of the state's economy. In terms of providing affordable healthcare in New Jersey, the blueprint provides the following recommendations:

- *Oppose the repeal of the Affordable Care Act (ACA).* This recommendation addresses the impact for individuals covered under Medicaid expansion, the Marketplace, and the Medicare "donut hole."
- *Oppose structural changes to Medicaid, such as block-granting.* This could result in cuts in Medicaid eligibility, covered benefits and/or provider payments.
- *Avoid making children's health care under CHIP a bargaining chip.* About 230,000 children are covered by CHIP in New Jersey and the continuation of this program should not become a condition for repealing the ACA, which may end Medicaid Expansion, limit Marketplace coverage, or result in other policies that would discontinue or limit access to health care.
- *Providing universal health coverage for children.* In addition to CHIP, NJPP identifies opportunities to realize universal health coverage for children in New Jersey. These include expanding eligibility, making undocumented immigrant children eligible, improving outreach, removing administrative barriers to enrollment, maximizing federal funds, and reducing the cost of health coverage for children who are not eligible for publicly subsidized coverage by negotiating with insurers.
- *Eliminating surprise medical billing and excessive out-of-network medical charges.* The report notes that legislation has been introduced in New Jersey to address this issue and should be enacted as soon as possible. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Department of Health, Empire Center Release Statements on American Health Care Act Impact. In response to the proposed American Health Care Act, the New York Department of Health released a statement on its likely impacts in New York State. The analysis concludes that over 1 million New Yorkers would face a loss of coverage, and over $4.5 billion in costs would be shifted from the federal government to the state, counties, and safety net hospitals over the next four years. The state calculates an annual burden of at least $2.4 billion after 2020. Meanwhile, a report from the Empire Center notes two other potential issues for New York. The American Health Care Act includes age-based premium tax credits. But New York's insurance regulations ban insurance companies from charging different premiums based on age. The state's community rating rules require insurers to charge the same premium to all customers buying a particular plan, regardless of age or health status, effectively having younger insurance customers subsidizing older customers. The tax credits in AHCA, if they become law, would compound the inequity – giving less support to the younger consumers and a larger break to older consumers. The House GOP plan also conflicts with New York's policies on abortion: AHCA would bar using premium tax credits to buy insurance that covers abortion, while New York says state-regulated health plans must cover abortion.

Brooklyn Health Care Initiative. Governor Andrew Cuomo announced a plan targeting problems of poverty and poor health in Brooklyn, New York's largest county, with a population of 2.6 million. Over 23 percent of county residents live below the poverty level. The plan, called Vital Brooklyn, allots $700 million to health care in the form of capital grants. It would also create 3,000 affordable housing units and 7,600 new jobs, and it also includes anti-violence programs and job-training efforts. According to the *New York Times,* the health care investment would help create a network of 36 ambulatory care centers, which would include partnerships with existing community-based providers. Read More

Health Care Capital Funds for Kings County. The Department of Health recently released a Request for Applications for the Kings County (Brooklyn) Health Care Facility Transformation Program. Capital grant funds are available to strengthen and protect continued access to health care services in communities within Kings County whose residents are experiencing significant levels of health care disparities and health care needs compared to other communities within Kings County. A total of up to $700 million is available to health care providers in support of projects that replace inefficient and outdated facilities as part of a merger, consolidation, acquisition or other corporate restructuring activity intended to create a financially sustainable system of care. In order to get approved, projects must be aligned with a recent report prepared by Northwell Health that recommended a plan for restructuring health care in the borough. The document proposed restructuring four local hospitals -- Brookdale University Hospital and Medical Center, Kingsbrook Jewish Medical Center, Interfaith Medical Center, and Wyckoff Heights Medical Center -- into a new regional health system, developing an extensive primary and ambulatory care network and creating a

Health Enterprise Zone to focus on addressing social determinants of health. Applications are due on May 5, 2017. Read More

Managed Care Provider Contract Guidelines. Effective April 1, 2017, all contracts, contract templates, and material amendments between Medicaid managed care plans, including managed long-term care plans and IPA/ACOs and health care providers, must be submitted to the Department of Health for review and approval in accordance with the revised Provider Contract Guidelines. The contract submission and review process was revised to reflect Value Based Payment arrangements pursuant to the New York State Value Based Payment Roadmap and the Regulatory Impact Subcommittee. Final versions of revised contract guidelines and documents can be found here.

Rome Memorial Hospital Affiliates with St. Joseph's Health. Rome Memorial Hospital and St. Joseph's Health have finalized an affiliation agreement entering into a collaborative relationship in pursuit of mutual goals to expand patient access to needed services in the community. Rome Memorial is a 130-bed community hospital located in Rome, New York; St. Joseph's is a 421-bed hospital and health system located in Syracuse. RMH and St. Joseph's announced plans to affiliate less than a year ago and are moving toward creating a regional integrated health care delivery network, with RMH and its affiliated physician practices joining St. Joseph's Accountable Care Organization and Clinically Integrated Network. RMH will continue to operate as an independent, separately licensed hospital. Read More

North Carolina

State Senate Bill Proposes Medicaid Prepaid Dental Plans. *Winston-Salem Journal* reported on March 13, 2017, that a North Carolina state Senate bill (SB 231) is proposing capitated contracts with at least two prepaid dental plans to provide coverage to Medicaid and NC Health Choice enrollees statewide. The North Carolina Department of Health and Human Services would oversee administration of the contracts. Dental services were previously excluded from a waiver to reform the state's Medicaid system in 2015. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Legislature Introduces Bills for Additional Medicaid, SNAP Eligibility Checks. *Cleveland.com* reported on March 8, 2017, that Ohio introduced two bills that would require additional eligibility checks for enrollees in Medicaid and the Supplemental Nutrition Assistance Program to combat fraud. The bills (SB 96 and HB 119) would require officials to perform quarterly eligibility checks against several state and federal databases and expand the data used in the checks. Data would be crosschecked with real estate records, tax records, state lottery winnings, state residency data, incarceration records, and immigration status reports, among other data sources. Inconsistencies would be reported to program officials. Currently, Ohio has 1.5 million individuals receiving SNAP benefits and 3 million receiving Medicaid coverage. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

UPMC and PinnacleHealth Agree to Affiliate. On March 14, 2017, Pennsylvania health systems UPMC and PinnacleHealth System announced an agreement to affiliate. PinnacleHealth, based in Harrisburg, also said it will acquire four Pennsylvania hospitals and medical centers from Community Health Systems in a separate transaction. No financial terms were disclosed for either deal. Read More

Pennsylvania Strengthening Mental Health and SUD Insurance Protection Through Parity Compliance. Four Pennsylvania state agencies, the Insurance Department, the Department of Human Services, the Department of Health, and the Department of Drug and Alcohol Programs, have been selected to participate in the federal Commercial Parity Policy Academy. This program focuses on consumer protection through enforcement of federal laws requiring parity between insurance coverage of mental health and substance use disorders and physical health coverage. Additionally, a $529,000 federal grant will be used for parity implementation and enforcement. Read More

Pennsylvania Proposes Changes to County Assistance Office System. As part of Governor Tom Wolf's budget proposal, elements of "back office" county assistance office (CAO) work will be consolidated into five new regional processing centers. While there are no finalized locations at this time, the Department of Human Services expects to have two centers operational by June 30, 2018. DHS plans to manage the reduction in staff through an early retirement option and routine attrition. The department anticipates $7 million in savings from this initiative. DHS will continue to have a county CAO presence in each county of the commonwealth. Any message to the contrary is incorrect.

Rhode Island

Patrick Tigue Named as New Medicaid Director. *Providence Journal* reported on March 8, 2017, that Rhode Island Governor Gina Raimondo has appointed Patrick Tigue as state Medicaid director, effective March 20. Tigue was formerly director of operations and strategy at Neighborhood Health Plan of Rhode Island. The Medicaid director position has been unfilled for the past six months since Anya Rader Wallack left in September 2016. Read More

Wisconsin

DHS Cancels Family Care/Partnership RFP for Service Areas 2, 3, 11, 12. The Wisconsin Department of Health Services announced on March 10, 2017, that it had cancelled the Family Care and Family Care Partnership RFP for Geographic Service Areas (GSRs) 2, 3, 11, and 12. The RFP was issued on February 22, 2017, and aimed to contract with managed care organizations to provide managed long-term services and supports for the Family Care program in GSRs 2, 3, 11, and 12, and for the Family Care Partnership program in GSRs 3, 11, and 12. The state's procurement website indicates the canceled RFP will be replaced with two separate RFPs in the upcoming weeks.

National

U.S. Senate Confirms Seema Verma as CMS Administrator. *The New York Times* reported on March 13, 2017, that the U.S. Senate confirmed Seema Verma as administrator of the Centers for Medicare & Medicaid Services. Verma previously worked on Indiana's Medicaid expansion, HIP 2.0, along with then-Governor and current Vice President Mike Pence. The Senate approved her appointment on a 55-43 vote. Read More

Trump Administration Indicates Willingness to Work with States on Medicaid Work Requirements, Other Changes. *The Wall Street Journal* reported on March 14, 2017, that President Donald Trump's administration had indicated they are willing to work with states to make modifications to their Medicaid programs, such as imposing work requirements, monthly premiums, and emergency room co-payments. U.S. Health and Human Services Secretary Tom Price and CMS Administrator Seema Verma issued a letter to state governors noting that Medicaid waivers may be approved that impose training or job requirements on some Medicaid enrollees who are physically able to work. Health analysts fear that such waivers can result in coverage losses. Read More

Trump Administration Voices Support For Broader Rules Around 1332 Waivers. *The New York Times* reported on March 13, 2017, that the Trump administration and Health and Human Services Secretary Tom Price have voiced support for Section 1332 of the Affordable Care Act (ACA), which allows states to pursue State Innovation Waivers to implement innovative approaches to providing care. The law requires states to serve the same number of individuals and provide care that is at least as comprehensive and affordable as without a waiver. The waivers, which became available beginning January 1, 2017, are approved for five-year periods and must be budget neutral. While President Obama's administration issued regulatory guidance in 2015 tightening the use of the waivers, the Centers for Medicare & Medicaid Services announced a broadening of the rules around 1332 waivers on March 13, 2017, allowing them to be used to help states obtain funding to help offset costs in the individual marketplace. Read More

House Panel Approves American Health Care Act Bill. *The New York Times* reported on March 9, 2017, that the House Ways and Means Committee approved the American Health Care Act. The panel rejected various Democratic amendments, including requiring that people not lose health coverage under the legislation and that the plan not increase out-of-pocket costs for older people. Groups, like AARP, the American Hospital Association, American Nurses Association, American Medical Association, and others oppose the bill. Read More

House Speaker Ryan Hopes to Push Companion Bill to AHCA. *Modern Healthcare* reported on March 15, 2017, that U.S. House Speaker Paul Ryan is hoping to push a companion bill to the American Health Care Act (AHCA) that would reduce regulations and incentivize private market competition. Specifically, the bill would aim to make it easier to sell insurance across state lines, limit jury awards for pain and suffering in malpractice lawsuits, and allow small businesses to band together to buy lower-premium plans. The bill would likely face hurdles in the Senate. Read More

CBO Estimates AHCA Would Increase Uninsured by 24 Million, Reduce Federal Deficits by $337 Billion by 2026. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) projected on March 13, 2017, that the House GOP-proposed American Health Care Act (AHCA) would result in 14 million more individuals who are uninsured than under current law by 2018, rising to 21 million in 2020, and 24 million in 2026. In total, the number of uninsured in America would nearly double to 52 million in 2026. However, the CBO-JCT estimates project the AHCA would reduce federal deficits by $337 billion over the 10-year period from 2017 to 2026, with savings coming from reductions in Medicaid outlays and ACA tax credit subsidies. CBO-JCT also projects that individual premiums under the AHCA would be 15 percent to 20 percent higher than under current law in 2018 and 2019. Read More

HHS Secretary Price Says House ACA Bill Will Offer Choice, Lower Cost. *Modern Healthcare* reported on March 12, 2017, that U.S. Department of Health & Human Services (HHS) Secretary Tom Price said he believes that no one will be worse off financially under the House Republican plan to replace the Affordable Care Act (ACA). Secretary Price says that the changes would allow individuals to choose their health coverage rather than be forced into what the government tells them to buy, as well as provide coverage at a lower cost. However, the tax credit structure in the current Republican legislation in the House may not be as generous to segments of the population, including older adults, as the current law. Read More

House Republican Bill Would Strain Hospital Finances, per Moody's and S&P. *Modern Healthcare* reported on March 9, 2017, that the current U.S. House Republican bill to replace the Affordable Care Act would put financial strain on hospitals and could lead to debt downgrades, according to Moody's Investors Service and S&P Global Ratings. S&P said that the bill, which would implement per-capita Medicaid funding caps, would lead to a higher uninsured rate, placing more financial pressure on hospital bad debt and charity care expenses. Limiting expansion would also hurt hospitals, which have benefited from newly insured Medicaid patients. While preserving disproportionate-share hospital (DSH) payments for states that did not expand Medicaid could offset some of the costs, they say it would not be enough to compensate for the downsides. Read More

Republican Governors Consider Proposal to Keep Certain Aspects of Medicaid Expansion. *The Wall Street Journal* reported on March 11, 2017, that 16 Republican governors in states that expanded Medicaid under the Affordable Care Act are considering their own proposal to keep certain aspects of expansion in place. The proposal is expected to run counter to Medicaid provisions of the proposed American Health Care Act (ACHA), which would reduce funding to Medicaid expansion states in 2020. Read More

White House Officials Push for Earlier Sunset of Medicaid Expansion Funds. *CNN* reported on March 10, 2017, that White House officials are urging U.S. House Republicans to sunset Medicaid expansion funds, authorized under the Affordable Care Act, earlier than the 2020 date included in proposed replacement legislation. Ending the Medicaid expansion sooner could threaten the bill's prospects in the Senate, given that Republican Governors in expansion states are likely to push back. Furthermore, while the move to end Medicaid expansion earlier would likely gain the support of hardline

conservatives, it could cause a similar number of moderate House Republicans to withdraw their support. Read More

HSA Banks Would Likely Benefit Under Republican Health Care Plans. *Kaiser Health News* reported on March 14, 2017, that Republican plans to expand the use of Health Savings Accounts (HSAs) could mean millions more customers for organizations like HealthEquity and Optum Bank, which offer the savings accounts. The House Republican American Health Care Act supports broad availability of HSAs, which allow individuals to set aside tax-free funds for medical expenses. HSA industry leaders, meanwhile, are hoping to push into new markets, including Medicare and Tricare, which do not currently permit use of HSAs. There are approximately 21 million HSAs in the U.S., with a total of $41 billion in assets. Read More

Medicaid Innovation Accelerator Program National Webinar scheduled for March 27. As part of CMS's Medicaid Innovation Accelerator Program (IAP), the Center for Medicaid and CHIP Services is seeking to improve the care and health for Medicaid beneficiaries and reduce costs by supporting states' ongoing payment and delivery system reforms through targeted technical support. On March 27th, IAP's *Medicaid Beneficiaries with Complex Needs and High Costs* program area will host a webinar for states that highlights several considerations states can take into account as they pursue value-based payment arrangements, including how payment strategies can support improved care coordination for their target populations. In addition, participants will also learn about states that are using various types of alternative payment strategies to drive better outcomes for their Medicaid beneficiaries with complex care needs. This webinar, ***Applying Alternative Payment Strategies to Activities Focused on Medicaid Beneficiaries with Complex Care Needs and High Costs***, is open to states and all interested state Medicaid agencies and 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. Registration Link

Industry Research

Hospital Uncompensated Care Fell 9.3 Percent in 2014, Per MACPAC Report. The Medicaid and CHIP Payment and Access Commission (MACPAC) released its annual *Report to Congress on Medicaid and CHIP* in March 2017. The report found that total hospital uncompensated care for Medicaid and patients who are uninsured fell 9.3 percent to about $4.6 billion in 2014. States that expanded Medicaid saw the largest declines. The report warned that changes to current policies would create a substantially different environment for safety-net providers and likely affect the level of hospital uncompensated care and the ability of hospitals to provide both inpatient and outpatient services to patients who are uninsured or enrolled in Medicaid. If federal disproportionate share hospital (DSH) payments are reduced, hospitals serving the greatest share of low-income patients would experience negative margins. Read More

Industry News

Community Health Systems Announces Agreement to Sell Four Pennsylvania Hospitals. Community Health Systems announced on March 14, 2017, a definitive agreement to sell four Pennsylvania hospitals to subsidiaries of PinnacleHealth System. The hospitals included are Memorial Hospital of York, Lancaster Regional Medical Centers in Lancaster and Lititz, and Carlisle Regional Medical Center. All are part of the 25 planned hospital divestitures announced in the company's year-end 2016 earnings call. Depending on regulatory approvals, the transaction is expected to close in summer 2017. Read More

Active Day Acquires Three Centers from Addus HomeCare in Illinois. Active Day/Senior Care Centers of America, a provider of adult day health services, announced on March 7, 2017, that it has acquired three centers from Addus HomeCare Corporation in Illinois. Active Day has a total of 82 centers in Connecticut, Delaware, Indiana, Massachusetts, Kentucky, Ohio, Maryland, Mississippi, New Jersey, Pennsylvania, South Carolina, and now Illinois. The newly acquired centers will be known as Active Day of Homewood, Active Day of Moline, and Active Day of Marion. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
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 13, 2017	Massachusetts	Proposals Due	850,000
April 14, 2017	Washington (FIMC - North Central RSA)	Proposals Due	66,000
April 27, 2017	Alaska Coordinated Care Demonstration	Proposals Due	TBD
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May 15, 2017	Illinois	Proposals Due	2,700,000
May 22, 2017	Washington (FIMC - North Central RSA)	Contract Awards	66,000
Spring 2017	Virginia Medallion 4.0	RFP Release	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 (GSR 1, 4, 5, 6)	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 HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
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 HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	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 HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	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 states dual eligible financial alignment demonstration status.

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 to Acquire Firm Founded by Seema Verma

On March 13, 2017, Jay Rosen, founder and president of Health Management Associates (HMA), announced the signing of an agreement by which HMA will acquire SVC, a consulting firm which is owned by Seema Verma, founder and president, and recently confirmed Administrator of the Centers for Medicare & Medicaid Services (CMS). SVC will become HMA Medicaid Market Solutions, a new subsidiary of HMA. Read More

HMA's Pat Casanova and Gina Eckart partner with the Urban Institute and NASMHPD Research Institute to Co-Author ASPE Report, *"The Use of 1915(i) Medicaid Plan Option for Individuals with Mental Health and Substance Use Disorders"*

HMA's Pat Casanova and Gina Eckart, both of our Indianapolis office, co-authored a paper for the U.S. Department of Health and Human Services (HHS) Office of the Assistance Secretary for Planning and Evaluation (ASPE), along with Stan Dorn, Rebecca Peters, and Morgan Cheeks of the Urban Institute, and Ted Lutterman of the National Association of State Mental Health Program Directors (NASMHPD) Research Institute, Inc. Created by the Deficit Reduction Act of 2005 and amended by the Patient Protection and Affordable Care Act (ACA), Section 1915(i) of the Social Security Act gives state Medicaid programs the flexibility to cover home and community-based services (HCBS) through a Medicaid state plan amendment (SPA) without the need to seek a federal waiver. This research project analyzed state implementation of 1915(i), including prospects for innovative and more widespread future use. Read More

HMA Upcoming Webinar: *"Building a Community Collaborative"*

April 12, 2017
1:00-2:00 PM Eastern

Registration/More Information

Individuals with complex challenges arising from chronic health conditions, mental health and/or substance-abuse disorders, or involvement in the criminal justice system are among the highest-cost utilizers of the healthcare system. A multi-pronged Community Collaborative can ensure evidence-based interventions that identify and effectively treat high utilizers – helping to keep them out of the emergency room and out of jail. During this webinar, HMA Principal Bren Manaugh and Senior Consultant Amanda Ternan will provide a case study of a successful Community Collaborative in Bexar County, Texas. HMA Senior Consultant Laquisha Grant will discuss similar initiatives in New York. The webinar will offer practical considerations for building and operating a Community Collaborative, ensuring best practices, and creating a shared recognition of the need for trust and coordination among healthcare providers, community-based organizations (CBOs), and the criminal justice system.

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.