HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 29, 2017

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THIS WEEK

IN FOCUS

PUERTO RICO HEALTH CARE UPDATE

This week, our *In Focus* section comes to us from HMA Principal Juan Montanez, of our Washington, D.C. office. Juan provides an update on the fiscal crisis in Puerto Rico, the relationship between the fiscal crisis and Puerto Rico's Government Health Plan (GHP), as well as what may lie ahead for the GHP. Puerto Rico has been in the news over the last couple of years, primarily because of the central government's inability to meet its debt obligations. In 2015 the central government's finances reached a point where it could have literally run out of cash to service its debt and fund regular operations. A significant contributor to this fiscal crisis is the cost of and associated funding for the GHP, known colloquially on the island as Mi Salud ("My Health"). This

article provides some history and context on the GHP, in addition to outlining current proposals for addressing the program's impending funding "cliff."

About the GHP

The GHP in its current form originated in the 1990s, when then Governor Pedro Rossello (a physician) devised a major reform of the island's public healthcare system. Using proceeds from the sale of numerous health care facilities previously owned by the central government as "seed funding," in conjunction with matched federal Medicaid funding, the Pedro Rossello administration pursued what is still referred to as "Reforma" – a managed care program whereby individuals below a locally set poverty level could access health care services. The program has undergone changes over time, but key elements have remained constant:

- A fairly comprehensive package of physical, behavioral and oral health services for both children and adults.
- No choice of plans or benefit packages.
- No coverage of long-term services and supports.
- No coverage of non-emergency medical transportation.
- No coverage of non-emergency services outside of Puerto Rico.

These elements are driven by local policy, the reality that federal Medicaid funding is capped - i.e. not entitlement level funding as in the U.S. mainland - and the fact that U.S. territories are exempt from the *provider freedom of choice* provisions of the Social Security Act (SSA).

Currently the GHP is a full-risk capitated managed care program where five MCOs are responsible for all covered benefits to GHP members residing in one of nine regions; only one MCO operates in each region. At present the GHP has approximately 1.3 million members (this figure does not include approximately 250,000 Medicaid-Medicare duals). Current spend on the GHP (excluding duals) is approximately $2.6 billion per year, or about $170 per member per month. This figure is quite low compared to Medicaid program spending in the mainland for two major reasons - the difference in covered benefits between the GHP and Medicaid programs in the U.S. and the difference in costs, particularly labor costs, between the Puerto Rico and the U.S.

At present GHP funding is dependent on three distinct federal funding pools:

1. Puerto Rico's CHIP allotment, which is approximately $180 million per year.
2. The aforementioned capped Medicaid funding, which is statutorily prescribed in the SSA, and amounts to approximately $360 million per year.
3. A non-recurring Medicaid allotment, which was earmarked to Puerto Rico in the ACA. This funding, which totals approximately $6.3 billion, was designated for Puerto Rico to access between 2011 and 2019.

The GHP has approximately the same level of membership it had prior to the ACA. Even so, the GHP is projected to exhaust the newly available revenue provided in funding pool 3 this year. This impending "Medicaid funding cliff" has received significant news coverage. Prior to these funds being available,

the Puerto Rican government was employing general funds to supplement federal funds and maintain a high level of GHP membership – over 40 percent of the island's population. This placed considerable pressure on the local budget, and has been cited as one of the major contributors to the island's current debt situation. Upon the exhaustion of funding pool 3, the government will have to substitute general funds for these federal funds – which technically it does not have – or make drastic cuts in GHP benefits and/or membership.

The GHP's Future

As part of a cost control plan required by the Fiscal Oversight Board currently overseeing Puerto Rico government finances, current Governor Ricardo Rossello – Pedro Rossello's son – proposed a series of initiatives aimed at controlling the rate of growth in GHP spending:

- Establishment of uniform fee schedules anchored to Medicare reimbursement
- Changes in the current "profit-sharing" arrangement between the government and the GHP MCOs
- Implementation of program integrity policies and associated information systems
- Reductions in prescription drug spending through increased discounts on brand drugs, enforcement of generic drug dispensing, updates to the GHP's preferred drug list and implementation of shared-savings initiatives
- Adjustments to the GHP benefit package, which could include differential benefit packages for different types of members
- Changes in the GHP's operating model which may include moving to a single region where multiple entities compete for members and alternative entities to MCOs including ACO-like entities

While the Fiscal Oversight Board approved the cost control plan, details on the aforementioned proposals have not been provided. HMA will closely monitor the evolution of these proposals. For more information, please contact Juan Montanez at jmontanez@healthmanagement.com.

HMA Medicaid Roundup

Florida

HMA Roundup – Elaine Peters (Email Elaine)

House, Senate Subcommittees Propose Medicaid Cuts in Budget Drafts. *Miami Herald* reported on March 28, 2017, that Florida state legislators in the House and Senate health care budget subcommittees proposed Medicaid cuts in their initial budget drafts. The House recommended cutting Medicaid by $238.6 million, which would result in a total reduction of $621.8 million including federal matching funds. Meanwhile, the Senate recommended a $99.3 million budget cut or $258.6 million including federal matching. Hospitals, specifically those serving Medicaid patients and the uninsured, have expressed concerns about the potential cuts. Meanwhile, lawmakers are hoping the federal government reinstates the Low Income Pool to reimburse hospitals for unpaid care. Read More

Advocates Express Concerns on Proposed Changes to Medicaid Program. *Health News Florida* reported on March 26, 2017, that health advocacy groups are reportedly concerned about proposed changes to Florida's Medicaid program. The changes include a block grant structure for Medicaid funding and waiving certain federal regulations on medical care access, which advocates argue could leave millions of people without access to medical providers. Some policy experts have said the proposed changes could lead to provider rate reductions and new eligibility limits, which in turn could raise uncompensated care costs. Advocates also fear a provision that would eliminate retroactive Medicaid coverage, which allows individuals who have a medical crisis to get help with medical costs up to three months before they are enrolled in Medicaid. The state has not yet made the proposal open for public comment. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Governor Says State to Explore Changes to Medicaid Program. *Online Athens* reported on March 27, 2017, that Georgia Governor Nathan Deal said that the state will explore modifications to its Medicaid program, possibly through a waiver. A specific proposal has not yet been developed, however, the Governor plans to work with the legislature to evaluate options. Georgia did not expand Medicaid, and the legislature passed a law in 2014 that requires legislative approval to make any changes related to expanded eligibility.

Former Georgia Congressman Tom Price is now the Secretary of the U.S. Department of Health and Human Services. Read More

Illinois

State Supreme Court Upholds Property Tax Exemption for Not-for-Profit Hospitals, Sends Case Back to Lower Court. *Modern Healthcare* reported on March 23, 2017, that the Illinois Supreme Court unanimously voted to preserve a law exempting not-for-profit hospitals from property taxes. In January 2016, the 4th District Appellate Court ruled that the law was unconstitutional after the Carle Foundation Hospital sued the city of Urbana, Illinois, and local tax authorities, alleging that it made millions in unnecessary property tax payments. The Illinois constitution exempts property from taxes if used exclusively for charitable purposes. The Supreme Court said that the Appellate Court did not have the jurisdiction to make the ruling and returned the case to a lower court. State not-for-profit hospitals were hoping the Supreme Court would clarify the meaning of the term "charity" in the constitution. However, the court did not comment on the constitutionality of the law, nor clarify any terminology. Read More

Iowa

State to Implement MCO Risk-Corridor Payments to Offset Losses. *The News & Observer* reported on March 25, 2017, that the Iowa Department of Human Services (DHS) has amended its contracts with Medicaid managed care organizations (MCOs) to include risk-corridor agreements meant to help offset financial losses. Under the agreement, DHS would help cover MCO financial losses if they grow beyond a certain point. DHS spokesperson Amy McCoy said that the payments would not be made for at least a year, and that they are expected to cost the state around $10 million. The state's share of the risk-corridor payments would come from its fiscal 2019 budget, which begins on July 1, 2018. MCOs are also expecting increases in rates for the upcoming budget year, negotiations for which will begin shortly. Read More

Kansas

Senate Passes Medicaid Expansion Bill. *Reuters* reported on March 28, 2017, that the Kansas Senate passed a bill to expand Medicaid. The legislation, which had already passed in the House, now moves to Governor Sam Brownback, who has signaled a veto is likely. According to the Governor's office, expanding Medicaid when the Affordable Care Act "is in a death spiral is not responsible policy." The Senate voted 25-14 on expansion and the House voted 81-44 last month. The total votes fall short of veto-proof margins. Read More

Massachusetts

Governor Says AHCA Could Cost State $1.9 Billion; 495,000 at Risk of Losing Coverage. *The Boston Globe* reported on March 21, 2017, that Massachusetts Governor Charlie Baker said that the American Health Care Act (AHCA) could cost the state between $1.1 billion and $1.9 billion in federal funding annually, putting approximately 495,000 individuals at risk of losing

coverage. The Governor fears the bill will unravel Massachusetts' decade-long effort toward providing universal health care coverage. Approximately 300,000 individuals who are enrolled in the state's MassHealth Medicaid program could be at risk of losing coverage and 195,000 who get insurance through the Massachusetts Exchange could lose their subsidies. Additionally, Massachusetts Health and Human Services Secretary Marylou Sudders said the state could lose up to $475 million annually in payments to hospitals serving Medicaid patients and $19 million in grants to the Department of Public Health, which could ultimately force the state to limit Medicaid eligibility. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Division of Developmental Disabilities update. On March 21, 2017, the New Jersey Department of Human Services (DHS), Division of Developmental Disabilities (DDD) held a quarterly meeting for families and providers that included information about DDD's new fiscal intermediary, Public Partnerships, LLC (PPL). Highlights from the meeting are provided.

1. ***FY18 proposed DDD budget.*** The budget includes proposed increase of $89.7 million in community spending, which includes:
    a. $10 million to fund community-based services for individuals on the Community Care Waiver (CCW) waiting list
    b. $8.6 million to fund community-based residential placements (54 individuals)
    c. $1 million to fund 125 new housing vouchers
    d. $46.2 million to fund service expansion for Supports Program participants
    e. $23.9 million to fund general Division growth
2. ***Supports Program.*** There are currently 1,440 individuals enrolled in the Supports Program.
3. ***Community Care Waiver Renewal.*** CMS committed to approving the CCW renewal by March 31, 2017.

Additional information about recent policy changes, fee-for-service provider readiness plans and quality improvement can be found here.

4. ***Public Partnerships for the Self-Directed Employee Option.*** PPL supports individuals with Intellectual/Developmental Disabilities (I/DD) in 13 states and has served as the fiscal intermediary for New Jersey's Division of Aging Services since 2006. DHS contracted with PPL as the fiscal intermediary for the self-directed employee option. It will work closely with DDD to support the transition from an "Agency with Choice" model of self-direction (under Easter Seals of New Jersey) to a "Vendor Fiscal/Employer Agent" model. PPL distinguished the role of PPL as compared to the existing Easter Seals model as follows:

ROLE/RESPONSIBILITY	AGENCY WITH CHOICE	VENDOR FISCAL/ EMPLOYER AGENT
Serving as an Employer of Record	The Agency	The Individual
Hiring a Self-Directed Employee	The Agency	The Individual
Setting the pay rate for the employee	The Agency	The Individual
Workers Compensation Brokerage	The Agency	Fiscal Intermediary will broker
Employee Performance Assessment	The Agency	The Individual

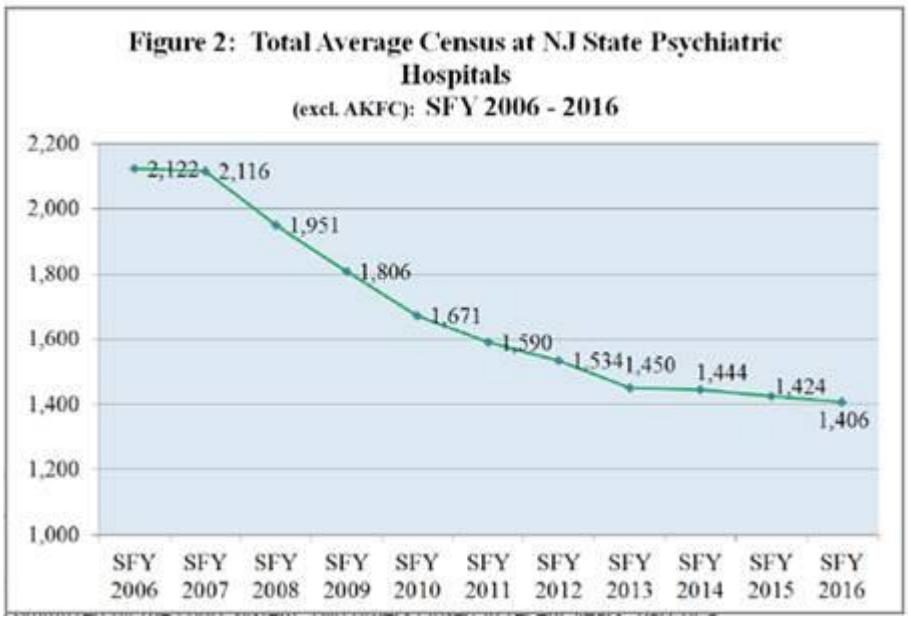
PPL further summarized its role for the individual acting as employer as the entity that will:

- Process enrollment forms including state and federal tax forms establishing the individual/authorized representative as the employer;
- Process enrollment forms, including state and federal tax forms, that establish the individual/authorized representative as the employer;
- Coordinate the administration of fingerprinting for Self-Directed Employees, complete required criminal background checks and ensure employee candidates are not on the NJ Central Registry of Offenders against Individuals with Developmental Disabilities;
- Register Self-Directed Employees for training through the College of Direct Support;
- Provide online access for timesheet submission and individualized budget management.

PPL will begin reaching out to individuals currently self-directing services in late March 2017 and will begin paying on behalf of any fully enrolled individuals on June 1, 2017. Complete details about the transition to PPL can be found here beginning on slide 14.

Moody's Downgrades New Jersey's Credit Rating for 11th time Under Governor Christie. On March 27, 2017, *NorthJersey.com* reported that Moody's Investors Service reduced the state's bond rating from A2 to A3 following Governor Christie's FY18 state budget unveiling. The downgrade was attributed to the state's poorly managed budget and ailing pension system for public workers. The state has the second lowest credit rating among states. Read more

New Jersey Shifts More Care for Adults with Mental Illnesses from State Psychiatric Hospitals to Community-Based Facilities. On March 28, 2017, *NJ Spotlight* reported that the Department of Human Services is exceeding its goals to expand local programs for adults with mental illness and transfer qualified individuals in state hospitals to community facilities. The average New Jersey State psychiatric hospital total census over 10 years dropped from over 2,100 to about 1,400.



Despite these gains, acute care hospitals and county psychiatric facilities are reporting an increase in mental health-related emergencies, and insufficient community options for transitioning patients out of these settings. Read more

New Jersey Medicaid ACOs share progress at Good Care Collaborative gathering. On March 23, 2017 a coalition of providers, advocates and policy leaders across the state convened to discuss the early impact and future implications of the state's Medicaid ACOs and similar ACOs across the country. Legislation authorized the NJ Medicaid ACOs in August 2011, final rules were published in May 2014 and three Medicaid ACOs were certified by the Department of Human Services in July 2015. The three NJ Medicaid ACOs include the Camden Coalition, Trenton Health Team and Healthy Greater Newark. The Camden Coalition's Director of Population Health Initiatives reported that its work is beginning to "see a positive savings trend…despite significant increases in pharmacy, outpatient and pediatric care costs across the state." The Healthy Greater Newark ACO shared a utilization overview of its adult and pediatric target populations. The Rutgers Center for State Health Policy (CSHP) summarized five major themes from early ACO operations, while noting that the ACOs are starting from very different positions and progressing differently:

ACO THEME	DESCRIPTION
1	ACO arrangements are part of larger population health improvement strategies in each community
2	ACOs must prove their value to largely skeptical MCOs
3	ACOs continually rethink & refine key target populations
4	ACOs are developing precisely targeted strategies to engage providers and improve specific quality measures
5	ACOs rely on multiple unstable funding sources. Uncertainty limits future planning

Source: DeLia, Yedidia, & Lontok, 2017

Rutgers CSHP will complete a quantitative analysis of the Medicaid ACO activities by Fall 2017. A qualitative data collection for Year 2 of the Medicaid ACO demonstration will completed in late spring 2017 with a report in late 2017 or early 2018. Read more

New York

HMA Roundup – Denise Soffel (Email Denise)

NYC Health + Hospitals Transformation Agenda. New York City Mayor Bill deBlasio has released the report of the Commission on Health Care for Our Neighborhoods, a Blue Ribbon commission established by the Mayor in response to the on-going financial challenges of New York City's public hospital system, NYC Health + Hospitals. NYC H + H operates 11 acute care hospitals, 6 Diagnostic and Treatment Centers, 4 long-term care facilities, a certified home health care agency and more than 80 community health clinics. H + H has an annual budget of roughly $7 billion; they reported a $776 million operating loss for the first half of fiscal year 2017. The Commission report highlights three areas for transformation: clinical infrastructure, building clinical partnerships, and sustaining the safety net. The commission recommends a significant restructuring of clinical services, including new investments to expand ambulatory care. They also recommend that the system foster stronger partnerships with other hospitals and providers, and pursue multiple strategies to ensure adequate resources, including preserving Disproportionate Share Hospital (DSH) funding and addressing the need for changes in state DSH funding to ensure equity in its distribution. Read More

Political Tensions Surround New York Medicaid Funding Formula. Negotiations over the American Health Care Act (AHCA) highlighted on-going tensions between Republican House members representing non-urban counties and New York's Democratic Governor Andrew Cuomo. An amendment to the AHCA submitted by Representatives John Faso and Chris Collins, which only impacted New York State, would have ended the county role in paying for Medicaid. New York is unusual in the role counties play in financing the state's Medicaid program, which historically had counties providing 25 percent of the cost (along with the state's 25 percent share and the federal 50 percent match). Recognizing that the growth in Medicaid costs was outpacing the ability of counties to generate tax revenue to finance those costs, the state has gradually been taking on a greater share of those costs. The Collins-Faso amendment would have effectively barred the state government from sharing Medicaid costs with the counties (with the exception of New York City). The Cuomo administration worried about the $2.3 billion the state would have to find if counties no longer shared the cost of Medicaid. The governor threatened to sue the federal government, threatened to raise taxes, and threatened to close hospitals, as well as launching a public relations campaign attacking New York's Republican members of Congress. Representative Collins has promised to keep advocating for the amendment and to look for ways to get it passed, arguing it will help slow the growth of property taxes. Read More

Report Finds Funding for Hospital Charity Care Misaligned With Need. A recent report released by the New York State Health Foundation documents a misalignment between hospital charity care funding and the actual provision of hospital uncompensated care. New York utilizes an Indigent Care Pool,

which is financed through Medicaid Disproportionate Share Hospital payments as well as a taxing mechanism known as the Health Care Reform Act. The money is distributed according to a formula that is based on care to uninsured patients, adjusted for a number of factors. Despite changes to the allocation methodology, Indigent Care Pool allocations are not proportional to the provision of care to uninsured patients. Currently, hospitals that provide limited services to the uninsured receive more funding per unit of service than hospitals that provide the most services to the uninsured. The report notes that the New York City public hospital system, NYC Health + Hospitals, provides a disproportionate amount of care to uninsured New Yorkers, yet due to a provision that caps Indigent Care Pool funding to public hospitals, their payments are far below funding available to private hospitals. Read More

Office of Mental Health Statewide Comprehensive Plan 2016 – 2020. The New York Office of Mental Health has released an update to its Statewide Comprehensive Plan. The report provides a snapshot of the current state of the public mental health system in New York, including a profile of populations served, a description of the principal initiatives transforming the mental health system, and a review of the workforce challenges and opportunities for serving a diverse and growing population. In 2015, the New York State public mental health system served an estimated 772,000 individuals, a significant increase from prior estimated annual service numbers of 729,000 in 2013 and 717,000 in 2011. Statewide mental health expenditures totaled $6.8 billion in 2015. Read More

New York State Department of Health Request for Applications. The New York State Department of Health Office of Quality and Patient Safety, in conjunction with the Office of Primary Care and Health Systems Management, and Health Research, Inc. (HRI) has released a Request for Applications to implement and/or expand the Project ECHO (Extension for Community Healthcare Outcomes) model in health care settings in New York State. Project ECHO is a tele-mentoring model that develops the capacity of the frontline primary care workforce to treat complex, chronic medical conditions by using video-conferencing technology to establish a virtual "knowledge network" between a "hub" (team of inter-disciplinary specialists located at a medical center) and multiple "spokes" (primary care clinicians located at sites in underserved communities) for training and mentoring. Under the terms of the RFA, awardees will be expected to operate a Project ECHO "hub" site, implementing a guided practice model. Awards will be made to support up to four Project ECHO hub sites over a 20-month period from June 1, 2017 to January 31, 2019. Final award amounts will be determined based upon successful applications and available funding. Applications are due by May 5, 2017. Read More

Ohio

Counties Urge Legislature to Take Action on Loss of MCO Sales Tax Revenues. *The News-Herald* reported on March 24, 2017, that Ohio county officials are voicing their concerns over the expected loss of funding when the state eliminates the requirement that Medicaid managed care organizations (MCOs) pay sales taxes, effective July 1, 2017. Changes in federal regulation preclude the state from using the Medicaid MCO sales tax to draw down additional federal Medicaid matching funds. Lake County, for example, says it

stands to lose $1.7 million annually from the change. In response, Lake County commissioners passed a resolution at their last meeting encouraging legislators to take action to protect counties against the loss of the Medicaid MCO sales tax revenues during the biennial budget process. The County Commissioners Association of Ohio is encouraging all counties to pass similar resolutions. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Updates from March 23 Meeting of Medical Assistance Advisory Committee. *Office of Medical Assistance (OMAP) Update:* Leesa Allen, Deputy Secretary of OMAP, informed the committee there was still a blackout period for the HealthChoices reprocurement due to unresolved protests which have delayed June 1 implementation. She outlined new projections for implementation in each region: January 2018 for the Northwest and Southwest zones; March 2018 for Northeast; July 2018 for Southeast and January 2019 for Lehigh/Capital zone.

Office of Long Term Living (OLTL) Update: Kevin Hancock, OLTL Chief of Staff, provided an update for Community HealthChoices. The department moved from the Planning stage to the Implementation stage and is engaging with MCOs for agreement and rate negotiations, as well as conducting the review process. Commencement meetings with MCOs and a kickoff event will be held in the next two weeks. The current rollout schedule is for the southwest region to begin on January 1, 2018, southeast zone on July 1, 2018, and the remainder of the state on January 1, 2019. Hancock also announced that the RFP for the Independent Enrollment Broker (IEB) will be released in the next two weeks. The IEB will provide choice counseling for managed care selection as well as providing peer plan selection for people who need long term services and supports. The related Fiscal Management Services RFP will be released in two to three weeks, changed from original plans to release the RFP before the independent enrollment broker RFP.

Office of Mental Health and Substance Abuse Services (OMHSAS) Update: Deputy Secretary Dennis Marion provided an overview of the governor's FY 2017-18 budget for the office. The overall budget of $4.82 billion is attributed as follows:

- HealthChoices Behavioral Health Managed Care: $3.674 billion;
- Community Based Grants: $625.7 million;
- OMHSAS State Facilities: $433.3 million;
- Behavioral Health Services Initiative: $53.2 million;
- Medical Assistance Fee-for-Service: $34.1 million.

Office of Developmental Programs (ODP) Update: Kristin Ahrens, Deputy Secretary for ODP, announced the Autism Waiver amendments are out for public comment until April 3. ODP hopes to get the waiver finalized in the next two months. Ahrens indicated that after the renewal waivers are completed, ODP will be working on the Community Living Waiver. This new waiver is the funding vehicle for the governor's proposal to remove 1,000 individuals from the autism waiting list.

Texas

Senate Approves Budget With $400 Million in Cuts to Health and Human Services. *The Texas Tribune* reported on March 28, 2017, that the Texas Senate has approved a two-year, $218 billion budget that includes $400 million in reductions to Health and Human Services, the department that manages the state's Medicaid program. State tax cuts and highway building investments in 2015, as well as lower than expected revenues left the legislature with less funding for the upcoming budget. Read More

Virginia

Governor Renews Push for Medicaid Expansion. ***WTVR*** reported on March 27, 2017, that Virginia Governor Terry McAuliffe is pushing Medicaid expansion following the failure of American Health Care Act. McAuliffe, who is a Democrat, is requesting a budget amendment that would allow him to expand Medicaid, a request that has been turned down by Republicans in the state legislature in the past. Virginia House Delegates Speaker William Howell and four other Republican lawmakers released a statement on March 27 rejecting the Governor's request and arguing that expanding Medicaid would take resources away from other priorities such as education and transportation. Read More

Wisconsin

DHS Reissues Separate Family Care, Partnership RFPs for Service Regions 2, 3, 11, and for Service Region 12. The Wisconsin Department of Health Services (DHS) issued a request for proposals (RFP) on March 23, 2017, for managed care organizations to deliver services through the Family Care and Family Partnership programs in geographic service regions (GSR) 2, 3, 11 and, through a separate RFP, GSR 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. DHS is aiming to increase choice within GSAs by having more than one MCO available to enrollees within each region. Proposals for the RFP covering GSAs 2, 3, and 11 are due April 27, 2017, and proposals for the RFP covering GSA 12 are due May 11, 2017. The RFPs were originally released as a single RFP that covered the four GSAs on February 22, 2017, but on March 10, the state canceled that procurement and announced that it would be replaced by two separate RFPs.

Governor Proposes Medicaid Drug Screening, Work Requirements. *The Journal-Sentinel* reported on March 27, 2017, that Wisconsin Governor Scott Walker is still planning to request changes to the state's Medicaid program, including drug screening and work requirements, through a waiver proposal to the Centers for Medicare & Medicaid Services (CMS). The proposal, which is projected to cost $48 million in state and federal funds, would screen certain Medicaid applicants for illegal drug use; include monthly premiums ranging from $1 to $10 a month, based on income, for single adults; give premium breaks to individuals who complete a health risk assessment and avoid certain behaviors such as smoking; and limit the amount of time some enrollees ages 19 to 49 can be on Medicaid to 47 months. Governor Walker plans to release his full waiver proposal for public comment towards the end of April. Read More

National

AHCA Bill Pulled Before Scheduled Vote. *Politico* reported on March 24, 2017, that House Speaker Paul Ryan pulled the American Health Care Act bill from the House floor before a scheduled vote. With moderate and conservative Republicans in opposition, it became clear early in the day that the bill would be defeated. According to a leadership aide, President Trump asked Ryan to pull the bill on a phone call around 3 p.m. ET. Read More

States Reconsider Medicaid Expansion Following AHCA. *The Wall Street Journal* reported on March 28, 2017, that more states are considering Medicaid expansion following the demise of the American Health Care Act. The Kansas legislature voted to expand Medicaid this week even though Republican Governor Sam Brownback will likely veto the bill. Virginia, Maine, and North Carolina are also exploring the possibility of expansion. Health policy analysts say other states likely to consider expansion include Idaho, Florida, Georgia, Missouri, Utah, and Wyoming. Read More

Governors in Medicaid Expansion States Welcome AHCA Setback. *Associated Press/The Washington Times* reported on March 25, 2017, that governors across the country, specifically those in states that expanded Medicaid, applauded the withdrawal of the proposed American Health Care Act (AHCA). Governors feared that the legislation would increase state costs and potentially increase the number of uninsured. Massachusetts Governor Charlie Baker, a Republican, said the bill did not reflect the needs of states. California Governor Jerry Brown, a Democrat, estimated that the legislation would cost his state $6 billion annually starting in 2020. Read More

Executive Budget Calls for Cuts in Grant Funding for Meals on Wheels. *Bloomberg* reported on March 17, 2017, that President Donald Trump's proposed budget would cut grant funding often used for Meals on Wheels. The program, which delivers 218 million meals annually to more than 2.4 million seniors in their homes or senior centers, is aimed at reducing hospitalizations and has been found to reduce Medicare and Medicaid costs. The plan would reduce two grants that Meals on Wheels relies on, as well as other federal funds. Community Development Block Grants, which help fund affordable housing, low-income services, and community development, are often used by states for Meals on Wheels. The Trump administration states these grants have not shown results. Meals on Wheels chief executive Ellie Hollander says the cuts would put additional pressure on the program, which is already suffering from funding shortfalls. Read More

National Coalition of Health Care Pushes Congress for Extension of Funds for Community Health Centers. *Modern Healthcare* reported on March 28, 2017, that The National Coalition of Health Care, a trade association representing unions, health funds, and providers, is urging Congress to renew federal funding to prevent closing of community health centers that serve a high proportion of low-income patients. The Affordable Care Act and Medicare Access and CHIP Reauthorization Act provided a combined $3.6 billion in annual funding to over 1,200 community health centers across the country, which accounts for 70 percent of their total federal funding. Read More

Industry News

Trusted Health Plan Completes Acquisition of Harbor Health Plan. *The PE Hub Network* reported on March 27, 2017, that District of Columbia-based Trusted Health Plan, a managed care organization with 35,000 members, has completed its acquisition of Michigan-based Harbor Health Plan from Tenet Healthcare. The deal is valued at $16 million. Trusted plans to expand Harbor in 2017, including adding wellness centers in Wayne, Oakland, and Macomb counties, as well as establishing value-based contracts with providers. Read More

CareSource Anticipates at Least 200,000 Medicaid Managed Care Members in Georgia. *Georgia Health News* reported on March 28, 2017, that CareSource has been promised at a minimum of 200,000 Medicaid managed care members in the Georgia market effective July 1. CareSource, a new entrant to the Georgia market, will act as one of four Medicaid care management organizations, along with incumbents Peach State (Centene), WellCare, and Amerigroup (Anthem). Georgia's Medicaid managed care business is worth a total of $4 billion over six years. Open enrollment is ongoing, and individuals who do not select a plan will be auto-enrolled. Read More

Advisory Board to Consider Merger with Evolent Health. *Modern Healthcare* reported on March 27, 2017, that the Advisory Board Co. is considering a merger with consulting firm Evolent Health, which was founded in part by the Advisory Board in 2011. Washington, DC-based Evolent announced that it was considering a potential sale, following lower-than-expected revenues in 2016. Press Ganey has reportedly also expressed interest in the company. Read More

Addus HomeCare Growth Will Include Focus on EVV, Managed Care. *Home Health Care News* reported on March 22, 2017, that Addus HomeCare hopes to drive growth in 2017 through the implementation of electronic visit verification (EVV) and a focus on managed care referrals. Chief executive Dirk Allison said that Addus' scale will help the company comply with the complex EVV mandate rules and provide other companies with electronic billing systems. In addition, Addus has added managed care contracting resources for the year ahead. Read More

Baptist Health CEO Steve Hanson Resigns. *Modern Healthcare* reported on March 23, 2017, that Baptist Health chief executive Steve Hanson resigned this week. The health system reported a $41 million operating loss in 2016. Earlier this month, Baptist Health also announced it would lay off 288 employees. Vice President and Chief Legal and Regulatory Affairs Officer Janet Norton and Chief Financial Officer Steve Oglesby will serve in interim leadership roles. 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 state 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

Focus on New Models of Care in Correctional Health

CorrectCare featured on the cover of its Winter 2017 issue the second article in a three-part series developed to bring attention to new models of care in correctional health. The article focuses on California's Complete Care Model, which is designed to improve patient safety and increase the effectiveness and efficiency of prison-based primary care. Authors are Donna Strugar-Fritsch of HMA along with John Dunlap, DO, and Jorge Gomez of California Correctional Health Care Services. HMA is collaborating on the series with the National Commission on Correctional Health Care. Read More

Celebrating Doctors' Day at HMA

As most of our readers know, HMA was founded by a visionary group of individuals who fostered innovation in government systems that managed healthcare. Over the years the company has grown to include colleagues who represent nearly every facet of the healthcare environment, including direct clinical services. This evolution parallels the movement in our country toward models of integrated healthcare, whole person care, and team-based approaches to help organizations successfully embrace the triple aim. Our clinicians are embedded in a much larger cadre of HMA policy wonks, healthcare administrators, IT wizards, past government officials and health plan executives, community strategists and entrepreneurs with backgrounds in foundations, advocacy groups, industry and the private healthcare sector. HMA Principal Jean Glossa, MD, celebrates Doctors' Day in a blog post, available here.