HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

Annie Melia
Email

THIS WEEK

IN FOCUS

CMS PUBLISHES CHECKLIST FOR STATES PURSUING SECTION 1332 INNOVATION WAIVERS

This week, our *In Focus* section reviews a checklist published on May 11, 2017, by the Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) providing states with a guide to applying for a Section 1332 State Innovation Waiver. The 1332 Waiver was authorized under Section 1332 of the Affordable Care Act (ACA) and allows states to "pursue innovative strategies for providing… access to high quality, affordable health coverage." The checklist, as well as a March 13, 2017, letter to state governors from Health and Human Services (HHS) Secretary Tom Price and Secretary of the Treasury Steven Mnuchin, are specifically encouraging states to pursue approval of 1332 Waivers that include high-risk pool and state-operated reinsurance programs. The move comes in response to President Donald Trump's Executive Order directing agencies to "alleviate the burdens of the ACA." The checklist specifically notes that if state-operated reinsurance

programs demonstrate a reduction in federal spending on premium tax credits, a state could receive federal pass-through funding to help fund the reinsurance program.

Section 1332 State Innovation Waiver Overview

Section 1332 of the ACA provides significant flexibility for state innovation through the waiver process to test models of care that modify or waive provisions of the ACA, provided that the waived provisions are budget neutral and do not contribute to the federal deficit. While the ACA was passed in 2010, the law set January 1, 2017, as the earliest date of implementation for a 1332 Waiver.

So far, Hawai'i is the only state to receive approval for a 1332 Waiver, which the state used to waive the requirement that it operate a Small Business Health Options Program (SHOP). Three additional states, Alaska, California, and Vermont, have submitted 1332 Waiver applications to CMS, with both Alaska and California receiving preliminary determinations of completeness, although review and approval of both is pending. According to the National Conference of State Legislatures (NCSL), at least 18 states have introduced or enacted legislation to pursue the 1332 Waiver application process.

Alaska Reinsurance Program

Alaska is the first state to apply for a Section 1332 Waiver to operate a state-operated reinsurance program. The proposed Alaska Reinsurance Program (ARP) is estimated to save the federal government $51.6 million in premium tax credit expenditures in 2018, increase enrollment relative to baseline projections by more than 1,600 members, and potentially decrease individual market premium rates by up to four percent. The ARP would be partially funded by federal pass-through payments based on these savings, with the remainder funded by the state.

1332 Waiver Checklist Summary

The checklist published by CMS on May 11 contains eight elements states must address in the development and application process. The checklist also specifically highlights elements related to high-risk pool/state-operated reinsurance Section 1332 Waivers.

1. **Application Timing.** States must submit an application with a timeline that allows for a 45-day period to determine completeness, and a final decision in the following 180 days.
2. **Compliance with Public Notice and Comment Requirements.** States must provide written evidence of compliance with public notice and comment period requirements, including a 30-day public comment period, a minimum of two public hearings, reporting on issues raised, and documentation of Tribal consultation.
3. **Legislative Authority.** States must include legislation establishing authority to pursue a Section 1332 Waiver. *For states pursuing high-risk pool/state-operated reinsurance programs, legislation must provide that programs are contingent upon federal approval of the 1332 Waiver.*
4. **Waiver Provision Reasoning.** States must describe and justify the provisions to be waived. . *For states pursuing high-risk pool/state-operated reinsurance programs, the application should describe how the provisions to*

be waived are related to the state's plan for a reinsurance program, how the waiver would result in a reduction in federal spending on premium tax credits, and how the state would use federal pass-through funding if applicable.

5. **Actuarial, Economic, and Other Data and Assumptions.** States must provide actuarial and economic analysis documenting how the waiver complies with requirements for coverage, comprehensiveness, and affordability, as well as analysis detailing that the waiver will not increase the federal deficit over the five-year waiver period of ten-year budget period. *For states pursuing high-risk pool/state-operated reinsurance programs, states are directed to use a baseline in which there is no state or federal funding for a state reinsurance program and should compare premiums and coverage under the baseline for each year projected under the waiver.*

6. **Timeline for Implementation.** States must provide a timeline for implementation. *For states pursuing high-risk pool/state-operated reinsurance programs, this should include:*

    i. *How the state will implement a reinsurance program.*

    ii. *The data collection timing and mechanism for collecting claims information and generally for pay-out.*

    iii. *Whether the state is using a conditions-based list for reinsurance and/or an attachment point model.*

    iv. *Whether the reinsurance program includes incentives for providers, enrollees, and plan issuers to continue managing health care cost and utilization for individuals eligible for the described reinsurance (if any).*

    v. *Whether the state is specifying a co-insurance amount, or a cap, based on available funds, similar to the federal program.*

    vi. *Any legislation and/or regulations related to the state reinsurance program.*

7. **Additional Relevant Information.** States should include an additional information that is relevant to the waiver proposal, including impacts on administrative burdens, impacts on other ACA provisions, and how the waiver addresses compliance, fraud, waste, and abuse.

8. **Reporting Target.** States must propose a plan for regular reporting on compliance with scope of coverage, affordability, comprehensiveness, and deficit requirements. *For states pursuing high-risk pool/state-operated reinsurance programs, this must include a comparison of actual Second Lowest Cost Silver Plan premiums as compared to a without-waiver scenario.*

Link to Section 1332 Waiver Checklist

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf

HMA Medicaid Roundup

California

HMA Roundup – Julia Elitzer (Email Julia)

DHCS Releases Medi-Cal Managed Care RFP/RFA Schedule. The California Department of Health Care Services (DHCS) on May 17, 2017, released a timeline for re-procurement of the state's Medi-Cal managed care program. The schedule includes request for proposal (RFP) and request for application (RFA) release dates and potential implementation dates for each county and model type. The state plans to release RFPs/RFAs between late 2019 and early 2021 for implementation between July 2021 and January 2024. The counties covered under RFP/RFA schedule encompass more than 8.5 million Medi-Cal managed care member; however, only the commercial Medi-Cal contracts will be reprocured. Counties under the two-plan model, which account for nearly 7 million Medi-Cal managed care members, have both a commercial and a Local Initiative health plan. Local Initiative health plans generally have a significantly higher share of enrollment. The timeline will be updated as additional RFP/RFAs are planned. Read More

Governor Brown's 2017-18 Budget Revisions. On May 11, 2017, Governor Jerry Brown released May Revision of the 2017-2018 California's budget. The budget includes a total of $158.7 billion ($33.7 billion General Fund and $125.1 billion other funds) for all health and human services programs, a decrease of $324.8 million in General Fund allocations compared to the January, 2017 Governor's Budget. The Governor's January 2017 budget sought to cancel the state's participation in the Coordinated Care Initiative, which allows Medi-Cal, Medicare and in-home support services (IHSS) to be offered through a single delivery system. As a result, IHSS benefits are removed from Medi-Cal managed care capitation rates, and there is a return to the share-of-cost structure for counties. The updated estimate of the return to the share-of-cost structure for counties in the May Revise is $592.2 million. The May Revision includes $400 million in General Fund assistance, which will gradually decrease to $150 million by 2020-21, to help counties offset their costs while transitioning back to the share-of-cost structure. Additionally, there is an increase of $19.8 million in the California Healthcare, Research and Prevention Tobacco Tax Act of 2016 (Proposition 56) allocation to Medi-Cal based on updated revenue projections. Overall revenue from Proposition 56 increased by $23.3 million compared to the January 2017 budget. The revised budget includes a total of $108.4 billion for the support of Department of Health Care Services (DHCS) programs and services. Of that amount, $652 million funds state operations, while $107.7 billion supports local assistance. The Governor's revised budget raised revenue projections from his January 2017 plan by $2.5 billion. Improved tax collection shrunk the overall budget shortfall to $400

million from a projected $1.6 billion deficit in the January 2017 budget. Read More

DHCS Receives $90 Million Grant to Combat Opioid Addiction. *The California Medical Association* reported on May 13, 2017, that DHCS received a $90 million Substance Abuse and Mental Health Services Administration (SAMHSA) grant to expand efforts to curb opioid-related deaths and opioid addiction in California. The initiative will target regions of the state that have high rates of opioid-related overdoses and establish new medication-assisted programs to help people break their addiction to opioids. Read More

Study Shows Demand for Emergency Department Beds Outpacing Supply. *HealthFax* reported on May 15, 2017, that the number of emergency department (ED) beds in the state is not keeping pace with demand for acute care services and that EDs are seeing an increasing number of visits from psychiatric patients. Researchers from UC San Francisco looked at the California Office of Statewide Health Planning and Development (OSHPD) from 2005 to 2014 and found that ED visits increased 35 percent during the study period while the number of ED beds increased only 29.8 percent. Read More

Bill Would Mandate Dialysis Center Nurse-to-Patient Ratios. *Nephrology News and Issues* reported on April 17, 2017, that Senate Bill 349, the Dialysis Patient Safety Act authored by Ricardo Lara (D-Bell Gardens), is awaiting further action in the State Senate after clearing the Senate Health Committee. The bill would require higher staffing levels at dialysis centers and mandate annual inspections. Currently, dialysis centers do not have minimum staffing ratios; the bill would require dialysis centers to staff one nurse for every eight patients on dialysis, one technician for every three patients, and one social worker for every 75 patients. The bill sets standards for cleaning and disinfecting practices, among other provisions. Read More

Colorado

Medicaid Regional Accountable Entity RFP Released. The Colorado Department of Health Care Policy & Financing released a request for proposals (RFP) on May 11, 2017, for seven Regional Accountable Entities (RAE) for Phase II of the Accountable Care Collaborative (ACC), the core of the State's Medicaid program, Health First Colorado. The RFP will integrate behavioral and physical health under one RAE in each of the State's seven regions. Currently, physical and behavioral health are managed separately by seven Regional Care Collaborative Organizations and five Behavioral Health Organizations. Proposals are due July 28, 2017. The contract begins February 1, 2018 and runs through June 30, 2019, with an operational start date of July 1, 2018. With extension years, the total length of the contract is not anticipated to exceed seven years. As of March 2017, 1,022,445 or approximately 76 percent of Health First Colorado members were enrolled in the ACC program, which is an enhanced Primary Care Case Management model of managed care.

District of Columbia

Insurers Request Premium Increases for 2018 Exchange Plans. *WTOP.com* reported on May 9, 2017, that insurers offering health plans in 2018 on the District of Columbia Health Link Exchange are seeking premium

increases ranging from 13 percent to 40 percent. Aetna, CareFirst BlueCross BlueShield, Kaiser Permanente, and United Healthcare all filed requests for rate increases with the DC Department of Insurance, Securities, and Banking. Rate requests can be viewed here. Read More

Illinois

HFS Publishes Medicaid Managed Care RFP Bidders List. *The Chicago Tribune* reported on May 15, 2017, that Illinois has released the list of bidders for the statewide Medicaid managed care program procurement. Aetna Better Health, Blue Cross Blue Shield of Illinois, County Care Health Plan, Harmony Health Plan (WellCare), IlliniCare Health Plan (Centene), Meridian Health, Molina Healthcare of Illinois Inc., NextLevel Health, and Trusted Health Plan (District of Columbia) Inc. submitted proposals in response to the RFP. Four of the state's 12 current MCOs – Family Health Network (FHN), Community Care Alliance of Illinois (a FHN subsidiary) Humana, and Cigna/HealthSpring – did not submit a bid. The state will award no more than seven contracts in total. Following the procurement, managed care will cover 80 percent of Medicaid recipients, up from about two-thirds currently, in part by expanding the program statewide. Read More

Home Care Worker Shortage Worsens; Senate Passes Bill to Increase Minimum Wage. *The Chicago Tribune* reported on May 12, 2017, that a continuing shortage of caregivers for individuals with disabilities has led the Illinois Senate to again pass legislation in an attempt to increase the minimum wage for home care workers. The bill now heads to the House for consideration with only weeks left in the legislative session. Illinois Governor Bruce Rauner vetoed a similar bill last year, which would have raised the minimum wage for these caregivers to $15 an hour; on average, they now make about $9.35. Advocates say the shortage means that individuals with disabilities are moving into private group homes that are often inadequately staffed. Read More

Kentucky

KentuckyOne Health to Sell Louisville Hospitals, Focus on Central Kentucky. *Lexington Herald Leader* reported on May 12, 2017, that KentuckyOne Health is planning to sell its Louisville and Eastern Kentucky hospitals and medical centers. The health system will instead focus on Central Kentucky. There is no potential buyer or a definite timeline for divestiture, a KentuckyOne spokesman said. Catholic Health Initiatives, KentuckyOne's parent company, posted a $76 million operating loss in 2016. Read More

Massachusetts

Partners HealthCare to Cut $600 Million in Costs Over Next Three Years. *The Boston Globe* reported on May 12, 2017, that hospital system Partners HealthCare is planning to cut $600 million in costs over the next three years. The initiative will target areas such as revenue collection, the supply chain, care delivery, and research, with cuts set to begin in the fiscal year that starts October 1, 2017. Partners reported losses of $108 million in 2016, and

executives say the system's expenses are growing faster than revenues. Read More

Nebraska

Behavioral, Home Health Providers Concerned Over Unpaid Medicaid Claims. *Omaha World-Herald* reported on May 15, 2017, that behavioral and home health providers in Nebraska are concerned over unpaid claims and problems obtaining authorization for care, stemming from the state's newly implemented integrated Medicaid managed care program, Heritage Health. Some providers have stated that these issues are threatening their ability to participate in the program. Heritage Health administers around $1.2 billion in physical, behavioral, and pharmacy services to nearly 227,000 beneficiaries across the state. The state's three managed care companies are working to identify and remedy reported issues. Read More

State Supreme Court Rules Medicaid Can Collect from Nursing Home Resident Estates. *Omaha World-Herald* reported on May 14, 2017, that the Nebraska State Supreme Court ruled that Medicaid could bill the estate of a deceased nursing home resident for non-medical room-and-board costs. Judge William Cassel said that the state does not profit from collecting such funds, but rather uses the money to pay costs owed to the federal government. "The beneficiaries of a recipient's estate are not entitled to an inheritance at the public's expense," Cassel wrote. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Value-Based Payment Pilot Projects Launched. New York announced the launching of its first value-based payment pilot projects. The Pilot Program is a two-year program intended to create momentum in the transition from a fee-for-service to a value-based payment environment. Seven provider organizations and eight Managed Care Organizations located throughout the State will be working together as part of the Pilot Program on 13 distinct contracts. These contracts will pilot three types of value based payment arrangements: Health and Recovery Plan (HARP) Subpopulation, Integrated Primary Care (IPC), and Total Care for the General Population (TCGP). Read More

Affinity Health Plan Names Michael Murphy as President and CEO. Affinity Health Plan announced the selection of Michael Murphy as its new President and Chief Executive Officer. Murphy comes to Affinity with extensive experience leading public and private healthcare organizations. He was most recently at Aetna, and previously served as CEO of Coventry Health Care Plans across multiple states. He succeeds former CEO Glenn MacFarlane, who resigned in June of 2016, and James Hooley, who stepped down as Chair of Affinity's Board in 2016 in order to serve as interim CEO while the search for a new leader was conducted. Read More

Budget Side Letter Agreement Codifies Agreements Between Department of Health, Lawmakers. The state budget that was approved in April included a side letter between the Department of Health and the Chairs of the Health Committees of the Assembly and the Senate, Assemblymember Richard

Gottfried and Senator Kemp Hannon. The side letter codifies a number of agreements between the Department of Health and the respective legislators. Some of the items addressed in the side letter are:

- *Separate Rate Cells or Risk Adjustments for Specific Populations:* The letter commits to exploring separate rate cells or risk adjustments for the nursing home, high cost / high need home and personal care, and Health and Recovery Plan (HARP) populations. The Department will re-engage the Centers for Medicare and Medicaid Services (CMS) regarding this reimbursement methodology with the assistance of health care industry stakeholders impacted by these changes (e.g. advocates, providers and managed care organizations).
- *Quarterly Meetings on Medicaid Managed Care Rates:* The Executive commits to providing quarterly updates to the Legislature regarding Medicaid Managed Care rates. In the spirit of transparency, the Department, in conjunction with the Division of the Budget (DOB), will hold quarterly meetings with the chairpersons of the Senate and Assembly Health Committees, the Senate Finance Committee and the Assembly Ways and Means Committee.
- *Monthly Meetings on the Medicaid Global Cap:* The Executive commits to monthly meetings with the Legislature to provide an update on actual spending to-date and potential changes to projections for the remainder of the year.
- The Executive commits to analyzing and formulating recommendations regarding the Universal Assessment Tool (UAT) with the health care community.

Read More

All-Payer Database Nears Completion. *Crain's HealthPulse* reported on a stakeholder meeting convened by the Department of Health to provide an update on planning to create an all-payer database. The project is driven by an awareness that advancing health care transformation in an effective and accelerated manner requires population based data to support decision making into the challenges of access, quality, and affordability. An APD that includes not only health care claims data, but other health-related data, will allow a broad range of stakeholders to monitor efforts to improve quality of care, conduct population health research and reduce health care costs. New York's APD will serve as a comprehensive data and analytical resource for supporting policy and decision making and research. The database will include information from public and private insurers on benefits, enrollment, patient encounters and claims. That data on cost and utilization will be supplemented with information about provider networks and public health statistics, including disease mortality rates. The state is proposing an APD Advisory Group comprised of representatives that have both short- and long-term vested interests in the success of the APD. Activities of the Advisory Group include strategic planning functions, fiscal sustainability planning, data sharing and privacy protections, consumer utility framework and cross-agency resource coordination and communication. Read More

Oscar Health Introduces a Small Business Product. Oscar Health, a startup established to participate in New York's Exchange market, has introduced a new product for small businesses called Oscar for Business. As reported in

TechCrunch, Oscar continues to struggle in the individual insurance market, and reportedly lost $128 million in the first three quarters of last year and was down $105 million in 2015. In response, the company trimmed operations, boosted pricing and shut down operations in Texas and New Jersey. Oscar for Business rolled out in NY in April. The product is intended for small business owners with 100 employees or less and will offer the same services as the individual plans. Oscar plans to extend its small business product to other states as it works through regulatory issues. Read More

Behavioral Health Integration Remains a Challenge. New York Medicaid Director Jason Helgerson addressed the challenges of behavioral health integration at a recent event sponsored by the New York Association of Psychiatric Rehabilitation Services. He noted that behavioral health has an integral role in New York's health system transformation efforts as embodied in the Delivery System Reform Incentive Payment program and the move to value-based payment. He noted that 750,000 Medicaid recipients are served by the public behavioral health system, and that the per-member-per-month cost for Medicaid members with a behavioral health diagnosis is 2.6 times higher than the overall Medicaid population. He emphasized that improving behavioral health is a major factor in achieving DSRIP goals statewide. He noted that Health and Recovery Plans have struggled to link their members with health homes, which are the entry point for the enhanced home and community-based services that are at the heart of the HARP model. Currently, only 31 percent of HARP members are enrolled in health homes. The state has undertaken a series of steps to facilitate this connection, including eliminating the complex assessment process; flagging HARP members in the Psychiatric Services and Clinical Knowledge Enhancement System (a statewide database derived from Medicaid claims to generate quality indicators and summarize treatment histories); and increasing consumer education initiatives and provider trainings. Read More

New York State of Health 2017 Open Enrollment Report Released. New York has released its report on the experience of the health plan marketplace, New York State of Health (NYSOH), during the 2017 open enrollment period that ended on January 31, 2017. More than 3.6 million people, or 18 percent of the state's population, were enrolled through NYSOH. This is a net increase of almost 800,000 since last year's open enrollment. Since NYSOH began operations in 2013, the rate of uninsured New Yorkers has dropped from 10 percent to five percent. The largest number of individuals who applied for coverage through NYSOH were enrolled in Medicaid, representing about two-thirds of total enrollment. Since New York's eligibility levels had already been expanded prior to the Affordable Care Act, most of these are individuals who had already been eligible for Medicaid coverage in New York. Approximately nine percent of Medicaid enrollees are part of the ACA expansion population, that is, childless adults with incomes between 100 and 138 percent FPL. The report includes information on the demographic and geographic breakdown of enrollment, as well as plan-specific enrollment by county. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Introduces Bill to oversee Medicaid MCOs to address network adequacy. On May 11, 2017, Assemblywoman Huttle introduced A4769, which

establishes a Medicaid Managed Care Organization (MCO) Oversight Program (Oversight Program). This bill is a result of the New Jersey State Audit Report on the Division of Medical Assistance and Human Services (DMAHS), which recommended that DMAHS take appropriate action to ensure that the Medicaid MCOs meet their contractual obligations regarding access to care and network adequacy. The bill consists of four major components:

- MCOs must submit quarterly, updated provider data and beneficiary data to the Oversight Program. The updated beneficiary information is required to be shared with the county welfare offices or any other entity that is responsible for the enrollment and re-enrollment of Medicaid beneficiaries.
- The Oversight Program would be responsible for establishing an independent verification system to annually verify the accuracy of at least 20 percent of the information that the MCOs share with the oversight program and 100 percent of the information about listed Medicaid providers.
- As suggested by the audit report, the bill would require that MCOs submit claims inactivity reports for all providers that meet the Oversight Program's claims inactivity criteria.
- MCOs would be required to verify that all the participating providers' panel sizes not exceed the Oversight Program's criteria, which is to include all patients regardless of the patient's health insurance carrier.

Governor Christie establishes advisory panel to oversee mental health payment reform. On May 12, 2017, *NJSpotlight* reported that Governor Chris Christie signed legislation that would establish an advisory board to monitor the mental health payment reform process in New Jersey. As part of the transition, the State directed an additional $127 million in federal funding, which allowed the Department of Human Services (DHS), Division of Mental Health and Addiction Services to increase rates for 90 different Medicaid treatments. Additionally, Senator Robert Gordon introduced S3121 last month that would provide an additional $90 million for the state to reimburse providers. Despite additional funding support, mental health organizations continue to express concern that the transition may force some providers out of business and limit treatment options. To facilitate the payment reform, the advisory board will be assessing whether the state's payment rates are appropriate and will be tasked with making recommendations for future reform. As part of the legislation, DHS will also be contracting with an independent contractor to evaluate the transition and report back to the Legislature on a regular basis. The evaluation will allow the advisory panel to focus on the new rates' impact on provider sustainability and patient care. Read more

Ohio

HMA Roundup – Debra Moscardino (Email Debra)

Stakeholders Support Ohio Medicaid Move to Managed Long Term Services and Supports. *Gongwer* reported on May 16, 2017, that representatives from nursing facilities, home care agencies, and area agencies on aging signaled a willingness to work with the Kasich administration on moving long term

services and supports into Medicaid managed care. Groups representing providers who offer home and community based services also pushed for increased funding in the biennial budget bill. LeadingAge Ohio, which includes non-profit nursing facilities, indicated an openness to MLTSS as long as it includes sufficient protections for providers. The representative acknowledged that conversations with the Department of Medicaid and other stakeholders have led them to believe MLTSS could be a vehicle for improving quality. Stakeholders seemed mostly concerned about avoiding significant provider payment problems that plagued the initial implementation of Ohio's dual demonstration program, MyCare, three years ago. Group representatives agreed that MLTSS offers increased opportunities for value and improved outcomes. Read More

Office of Health Transformation Releases Nursing Home Data. *Cleveland.com* reported on May 11, 2017, that the Office of Health Transformation released ratings and payment data for over 930 nursing homes in Ohio in the latest push by Governor John Kasich's administration to establish quality-based nursing home payments under Medicaid managed care. Kasich included language in his budget proposal that would replace current nursing home payments with payments tied to higher quality care under a managed long-term services and supports (MLTSS) program. The Ohio House passed a budget without the Governor's proposal and suggested delaying MLTSS implementation until 2021. The data, from the Centers for Medicare & Medicaid Services (CMS) Star Ratings metrics, is meant to show which nursing homes would benefit from linking payments based on quality measures. Read More

Oregon

Lawmakers Propose Taxes to Close Medicaid Budget Gap. *The Oregonian* reported on May 12, 2017, that Governor Kate Brown and lawmakers are considering hospital and insurance taxes to fund Oregon's Medicaid program in the upcoming two-year budget. The state is currently facing a $1.6 billion budget gap, including an $882 million shortfall for the Oregon Health Authority, the state's Medicaid agency. Legislators on both sides of the aisle are still debating exactly how much additional funding will be needed. Read More

115,000 Medicaid Beneficiaries May No Longer Be Eligible; Could Cost State Millions. *The Oregonian* reported on May 16, 2017, that 115,000 Medicaid beneficiaries in Oregon may no longer be eligible because of technological issues with the Medicaid agency's computer systems and a lack of regularly eligibility redeterminations. Improper Medicaid reimbursements made for these members could amount to as much as $72 million annually. The state is currently in the process of terminating enrollment for 14,000 ineligible members and analyzing 17,000 more. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Announces Medicaid Policy Change for Individuals with Hepatitis C Virus. On May 16, 2017, Pennsylvania's Department of Human Services (DHS) announced expanded drug coverage of Hepatitis C virus

(HCV) therapies in its Medicaid program. Beginning on July 1, the Department will begin phasing in coverage for individuals who have liver function test scores less severe than previously required. The policy change follows the clinical recommendations presented by the Department's Pharmacy & Therapeutics Committee. Read More

Geisinger and Highmark Partner in Central Pennsylvania. Highmark Inc. and Geisinger Health System have signed a letter of intent on a clinical joint venture in north central Pennsylvania. The joint venture, the first of its kind for both parties, will be based in four counties, with plans to possibly establish a new "comprehensive health campus" in Lycoming County. In a conference call to brief the media Wednesday, officials said the intent is to develop a clinical network model of patient care and reimbursement model that will be a better-value alternative to traditional inpatient hospital stays and outpatient visits. Many details of the joint venture remain unknown, including specific terms of the agreement and whether it will require state regulatory approval. Deb Rice-Johnson, Highmark Health Plan president, said the collaboration will not discriminate against consumers of other insurers nor will it bar its own members from using other healthcare facilities. Highmark's plan to enhance its presence in that region comes just two months after executives from its rival, UPMC, said they plan to pursue an affiliation with Harrisburg-based PinnacleHealth System. Lynn Miller, executive vice president and chief administrative officer at Geisinger, said that, while Geisinger is not intentionally competing with UPMC Susquehanna, she can't deny that there is competition. Read More

National

Trump Administration Selects Psychiatrist Specializing in Opioid Abuse to Lead SAMHSA. *STAT News* reported on May 11, 2017, that President Donald Trump's administration has nominated Elinore McCance-Katz, MD, to lead the Substance Abuse and Mental Health Services Administration (SAMHSA). Dr. McCance-Katz is a psychiatrist specializing in opioid abuse. She will be the first person to take the title of Assistant Secretary for Mental Health and Substance Abuse, a post that reports to Health and Human Services Secretary Tom Price. The Senate must confirm Dr. McCance-Katz's nomination. Read More

U.S. Supreme Court Allows Nursing Home Arbitration Agreements. *The Hill* reported on May 15, 2017, that the U.S. Supreme Court ruled 7-1 that nursing homes can enforce arbitration agreements that prohibit individuals from disputing grievances in court, overturning an earlier decision by the Kentucky State Supreme Court. The lawsuit was originally filed by relatives of two individuals who died at a Kindred Nursing Center in Kentucky. The Supreme Court justices agreed with Kindred that the Federal Arbitration Act allows nursing homes to use arbitration over litigation to settle disputes with residents and their families. Read More

States Look to Regulate Drug Pricing, Curb Costs. *The Wall Street Journal* reported on May 17, 2017, that legislatures in about 30 states are considering legislation to regulate prescription drug prices and curb costs, which lawmakers say are putting significant pressure on Medicaid budgets, state employee health plans and correctional health programs. Proposals include requiring manufacturers to justify price increases, forming purchasing groups

to negotiate lower prices, capping patient out-of-pocket costs, and pegging drug prices to what the U.S. Department of Veterans Affairs pays. The pharmaceutical industry maintains that price controls and other regulations would distort markets and discourage innovation. Read More

Senate Republicans Consider Repeal of Essential Health Benefits Mandate. *The Hill* reported on May 11, 2017, that Senate Republicans are discussing a proposal to repeal the essential health benefit mandate as part of a broader overhaul of the Affordable Care Act (ACA). The mandate requires insurers to cover a minimum set of benefits, including prescription drugs and behavioral health services. Republicans say this is driving up costs, adding that individuals should be able to buy the coverage they need. One idea being considered is to let states opt in to ACA regulations, rather than opt out of them. Read More

Senate Eyes More Generous Subsidies in Initial ACA Repeal, Replace Discussions. *Politico* reported on May 12, 2017, that Senate Republicans have singled out subsidy levels as a potential area of compromise on an Affordable Care Act replacement bill. Senators are discussing more generous tax credits for low-income individuals than in the American Health Care Act, which the House recently passed. The Senate version would also tie subsidies to income rather than age. An initial proposal suggests phasing out tax credits at more than 600 percent of the federal poverty level, lower than the House bill, but the credits themselves would be larger. Read More

Senate Finance Committee Seeks Industry Input on ACA Repeal, Replacement. *Modern Healthcare* reported on May 15, 2017, that Senate Finance Committee Chairman Orrin Hatch (R-UT) has asked health care industry groups to offer ideas by May 23 on the potential repeal and replacement of the Affordable Care Act (ACA). Since Democrats are unlikely to support an ACA replacement bill, the Senate will need all but two Republicans to vote in favor of any legislation to reach a majority. This means it will need to win the support of conservative Senators. Analysts say Senate Republicans hope to pass the bill before July 4. Read More

Maine High-Risk Pool Emerges as Potential Model Under ACA Replacement. *Kaiser Health News* reported on May 17, 2017, that House Republicans have suggested using Maine's "invisible high-risk pool" as a model for providing healthcare coverage to individuals with preexisting conditions. The pool is funded by a $4-per-month surcharge on all policyholders in the state. Individuals would be enrolled in the pool based on responses to a questionnaire regarding certain high-cost medical conditions. Senator Susan Collins (R-ME) raised concerns over the cost of the program, noting that implementation would cost $15 billion nationwide in the first year; the House American Health Care Act only designated $3 billion for high-risk pools. Read More

School Districts Raise Concerns Over Potential Medicaid Funding Cuts. *The New York Times* reported on May 15, 2017, that school districts around the country are growing increasingly concerned about the potential for Medicaid funding cuts. Schools receive about $4 billion in Medicaid funds annually, which mostly goes to school nurses, social workers, speech pathologists, and other specialists. School administrators worry that the shift to per capita funding under legislation like the American Health Care Act could put various programs at risk. Read More

Industry News

Florida Expands Correctional Health Relationship with Centurion. Centene Corporation announced on May 11, 2017, that the Florida Department of Corrections has chosen Centurion, a joint venture between Centene and MHM Services, to provide correctional health in south Florida for nine institutions and associated satellite facilities, covering more than 15,600 inmates. Centurion already provides services to about 70,000 Florida inmates in three regions of the state. Centurion's contract runs through January 2018 when the Department is expected to issue a formal procurement. Read More

Anthem Ends Effort to Acquire Cigna. *Modern Healthcare* reported on May 12, 2017, that Anthem, Inc. has officially ended its effort to merge with Cigna Corp., after a Delaware judge ruled Cigna could pull out of the deal. Read More The merger had been opposed by federal regulators. Read More

UnitedHealthcare's Harken Health to Cease Operations Amid Heavy Losses. *Chicago Tribune* reported on May 15, 2017, that Harken Health, a subsidiary of UnitedHealthcare that offers a staff-model health plan in Illinois and Georgia, will shut down after two years amid heavy losses. Individual coverage will remain in effect through year-end, while group coverage will stay in effect until the end of employer contracts. Harken, which launched in 2015, provides members with insurance coverage, unlimited primary care visits at its health centers, and wellness programs. The company posted losses of $64 million in 2016, and had already pulled out of the Illinois and Georgia Exchange markets for 2017, though continued to offer off-Exchange plans. Harken Health had approximately 26,000 members in Illinois at the end of 2016 before the insurer decided to exit the Exchange. Read More

Kaiser Permanente to Remain on Exchanges, CEO Says. *The Wall Street Journal* reported on May 12, 2017, that Kaiser Permanente will remain committed to the Affordable Care Act Exchanges, according to chief executive Bernard Tyson. Kaiser has 11.7 million Exchanges members in California, Colorado, the District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. Read More

Kaiser Permanente Raises $4.4 Billion for Expansion through Bond Offerings. *Modern Healthcare* reported on May 10, 2017, that Kaiser Permanente raised $4.4 billion through three hospital bond offerings. Chief Financial Officer Kathy Lancaster said the money will be used for expansion, including increasing hospital capacity, adding physician offices, and technology enhancements. Kaiser has a total of 11.7 million members, up about 2.5 million over the past three years, largely from the acquisition of Group Health in Seattle, Washington. Read More

CareCore National to Pay $54 Million Settlement for Medicaid, Medicare Overbilling. *Modern Healthcare* reported on May 12, 2017, that utilization management company CareCore National has agreed to pay a $54 million

settlement over allegations that it inappropriately overbilled for Medicare and Medicaid services. Of the total, $18 million will go to state Medicaid programs, and the remainder will go to the Centers for Medicare & Medicaid Services. CareCore admitted to improperly approving prior authorization requests for Medicare Part C and Medicaid without physician review. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
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 15, 2017	Delaware	Proposals Due	200,000
June 30, 2017	Illinois	Contract Awards	2,700,000
June, 2017	Oklahoma ABD	Contract Awards	155,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Georgia	Implementation	1,300,000
July 10, 2017	Delaware	Contract Awards (Optional)	200,000
July 17, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
July, 2017	Ohio MLTSS	RFA Release	130,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
August, 2017	Alabama ICN (MLTSS)	RFP Release	25,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
Summer 2017	Florida	RFP Release	3,100,000
Summer 2017	Massachusetts One Care (Duals Demo)	Procurement Release	TBD
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October, 2017	Alabama ICN (MLTSS)	Proposals Due	25,000
October, 2017	Ohio MLTSS	Contract Awards	130,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Delaware	Implementation (Optional)	200,000
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 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
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
July, 2018	Alabama ICN (MLTSS)	Implementation	25,000
July, 2018	Ohio MLTSS	Implementation	130,000
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
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
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.

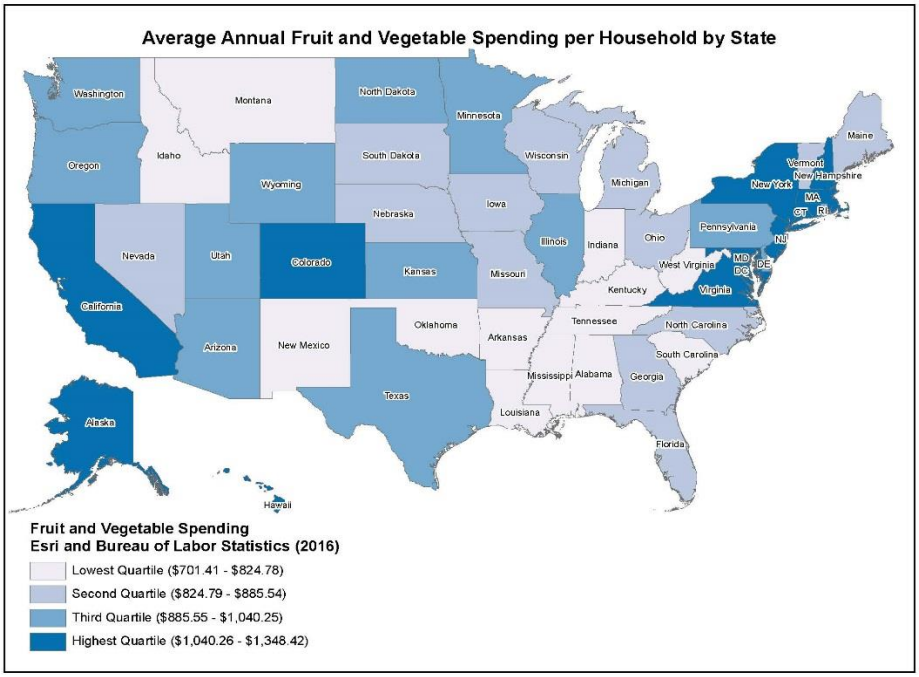
State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Jan. 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	114,804	32.8%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; 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

Over the next few weeks, the HMA Weekly Roundup and HMA Information Services (HMAIS) will showcase a series of maps and other key informatics. Our sixth map in the series highlights data on **the average annual fruit and vegetable spending per household by state**. Fruits and vegetables as part of an overall healthy diet are essential for optimal child growth, weight management, and chronic disease prevention.



What does your service area look like? HMA can drill down to county, zip code, or census tract - adding to the depth and breadth of knowledge around the health indicators affecting your community. For more information, contact **Anissa Lambertino** at alambertino@healthmanagement.com or (312)641-5007.

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.

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