HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

July 19, 2017

THIS WEEK

IN FOCUS

FLORIDA RELEASES STATEWIDE MEDICAID MANAGED CARE (SMMC) PROCUREMENT

This week, our *In Focus* section reviews the Invitations to Negotiate (ITNs) issued on July 14, 2017, by the Florida Agency for Health Care Administration (AHCA) to re-procure its managed care vendors. The ITNs will involve separate and simultaneous regional procurements for managed care plans. Currently, approximately 4 million state residents are eligible for Medicaid—the fourth largest Medicaid population in the nation. Of those, around 3.2 million receive services through managed care plans. Medicaid-covered

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populations include older adults, individuals with disabilities, families, pregnant women, and children living below the poverty line. Estimated state fiscal year (SFY) 2017-18 spending for Medicaid managed care is estimated at $18.4 billion.

Respondents may submit a response for one plan type as either a Comprehensive, Managed Medical Assistance (MMA), Long-term Care (LTC), or a Specialty plan. Respondents may submit more than one Specialty plan response, with a separate response for each target population.

Plan Type	Service Type		Recipient Type	
	MMA	LTC	MMA	LTC
Comprehensive plan	✓	✓	✓	✓
Long-term Care (LTC) Plus plan - ***NEW***	✓	✓	X	✓
Managed Medical Assistance (MMA) Plus plan	✓	X	✓	X
Specialty plans	✓	X	*Defined target population	

Eligible Respondents

Several different types of managed care entities will be allowed to respond to the ITN, including:

- Health Maintenance Organizations (HMOs)
- Provider Service Networks (PSNs)
- Exclusive Provider Organizations (EPOs)
- Accountable Care Organizations (ACOs)
- Other insurers that meet the ownership and financial requirements of a PSN

ITN Covered Populations

The ITN covers most Medicaid recipients, with some exclusions such as medically needy, partial duals, those receiving family planning services, individuals in the breast and cervical cancer program, and those in Department of Juvenile Justice commitment facilities. There will also be voluntary members, who are typically covered through a fee-for-service arrangement but have the option to enroll in managed care. Examples of optional populations include those in an Intellectual and Developmental Disabilities (IDD) waiver, those in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), those in group homes, individuals with Prescribed Pediatric Extended Care (PPEC), or those who are age 65 or older and in a residential treatment facility. Several population groups will be transitioning to a mandatory managed care enrollment by January 2018. Those populations in include Project AIDS Care (PAC) waiver, Adult Cystic Fibrosis (ACF) waiver, and Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) waiver enrollees.

The ITN allows respondents to offer a new option for long-term care (LTC) recipients. The 90,000 current LTC recipients will be able to enroll in either a Comprehensive plan or LTC Plus plan if recipients have both options available in their region.

Respondents may also offer Specialty plans. As of July 2017, almost 80,000 individuals were enrolled in specialty plans, meaning that:

1. they met the Specialty plan target population criteria;
2. the Specialty plan was available in their region; and

3. they chose to enroll.

Examples of some populations in specialty plans include children in Child Welfare, individuals with HIV/AIDS and/or serious mental illness, children with complex medical needs, and dual eligibles with certain chronic conditions.

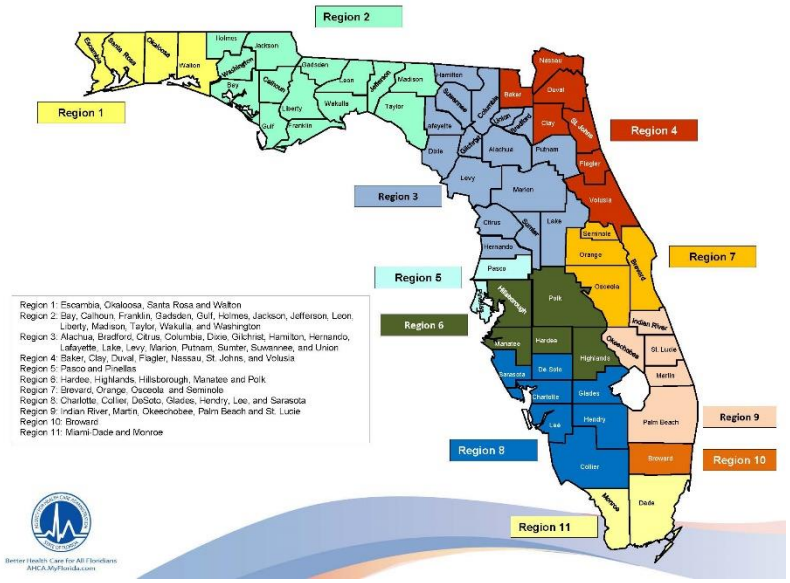
Covered Services

Respondents will need to cover certain managed care services, based on the plan(s) they select.

- MMA: Covers State Plan benefits, including behavioral health, non-emergency medical transportation, and nursing facility services for children 21 and under
- LTC: Covers nursing facility services for individuals over age 21 and home and community based services such as personal care, adult day care, and home-delivered meals
- Enhanced benefits, such as adult dental, vision, and hearing; however, dental services are expected to be carved out no later than March 1, 2019
- Other enhanced benefits, as proposed by the plan

Evaluation Process

Unlike the separate procurements in 2012 and 2013 for LTC and MMA respectively, there will be a single procurement for MMA and LTC. Bidders must submit responses that will include both statewide and regional responses, with a number of completed exhibits. Plans submitting for multiple regions will prepare the same statewide response for certain questions to be used for each regions response, and each statewide response will be reviewed and scored only once. A separate score will be applied to each regional response. Responses will be ranked by plan type, and AHCA will select a predetermined number of top-ranked bidders for each plan type. Selected bidders will enter negotiations with the agency. These negotiations could be concurrent or sequential.



Respondents must use AHCA-provided templates and cannot include flowcharts, graphics, etc., in the templates. Plans may, however, attach documents to the Submission Requirement and Evaluation Criteria (SRC) template.

The ITN has provided maximum scores by plan type and a complex scoring chart in Attachment A on page 29 of the ITN. The scoring has been weighted by category for each plan type. Examples of evaluation categories include agency goals, recipient and provider experience, delivery system coordination, respondent background/experience, oversight and accountability, and statutory requirements.

Plan Type	Maximum Score
Comprehensive plan	6,025.00
LTC Plus plan	4,815.00
MMA Plus plan	5,135.00
Specialty plan	5,282.50

ITN Contract Timing

Interested respondents must submit any questions by August 14, 2017. Proposals are due to the state by November 1, 2017, with awards to be announced April 16, 2018, following expected negotiations. Awarded plans will not begin providing services under the new contracts until January 1, 2019.

Milestone	Date/Time
ITN release	July 14, 2017
Questions due	August 14, 2017
	2 PM Eastern
Answers (anticipated)	September 15, 2017
	2 PM Eastern
Proposals due	November 1, 2017
	9 AM Eastern
Provider comments due	November 20, 2017
	5 PM Eastern
Anticipated date for negotiations	January 16, 2018 - March 30, 2018
Anticipated posting of Intent to Award	April 16, 2018

The ITN indicates that a limited number of plans will be selected for each plan type within each region for negotiation. If AHCA is unable to reach an agreement during the negotiation process or if the bidder withdraws, the agency will select the next highest-ranked respondent for negotiation.

Contracts are anticipated to run from January 1, 2019 through September 30, 2023 with no extension options.

Current Medicaid Managed Care Market

As of July 2017, there are 12 MCOS under contract with AHCA serving MMA members, 6 LTC MCOs, and 6 Specialty MCOs. Enrollment by plan and by region is detailed in the subsequent three tables.

MMA Standard Plan Enrollment - July 2017														
MMA Standard Health Plans	Type	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	TOTAL	Market Share
AMERIGROUP FLORIDA, INC.	MMAC					70,307	123,671	79,359				57,355	330,692	10.9%
BETTER HEALTH	MMAC						23,329				77,415		100,744	3.3%
COVENTRY HEALTH CARE	MMAC											57,188	57,188	1.9%
HUMANA MEDICAL PLAN	MMAC	56,684					38,179			72,933	73,333	83,114	324,243	10.7%
MOLINA HEALTHCARE OF FLORIDA	MMAC	50,392			71,361		23,491	23,555	41,672	78,161		57,564	346,196	11.5%
PRESTIGE HEALTH CHOICE	MMAC		53,504	61,018		23,480	30,260	37,213	51,344	50,518		16,984	324,321	10.7%
SFCCN	MMAC										44,766		44,766	1.5%
SIMPLY HEALTHCARE PLANS, INC.	MMAC											81,284	81,284	2.7%
STAYWELL HEALTH PLAN OF FLORIDA	MMAC		55,066	87,471	65,078	49,279	116,595	138,087	86,802			62,618	660,996	21.9%
SUNSHINE STATE HEALTH PLAN, INC.	MMAC			50,955	85,338	32,188	51,087	58,738	30,385	73,942	69,135	28,303	480,071	15.9%
UNITED HEALTHCARE OF FLORIDA	MMAC			56,665	81,286			53,645				79,290	270,886	9.0%
Total Standard Plans		**107,076**	**108,570**	**256,109**	**303,063**	**175,254**	**406,612**	**390,597**	**210,203**	**275,554**	**264,649**	**523,700**	**3,021,387**	**100.0%**

MMA Specialty Plan Enrollment - July 2017														
MMA Specialty Plans	Type	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	TOTAL	Market Share
AHF / POSITIVE HEALTHCARE	MMASC										803	1,203	2,006	1.3%
FREDOM HEALTH - DUALS CHRONIC CONDS	MMASC			41		15	27	18	13	3	0	0	117	0.1%
MAGELLAN COMPLETE CARE, LLC	MMASC		3,351		9,363	6,709	10,358	10,218		6,696	6,027	12,607	65,329	40.9%
SIMPLY DBA CLEAR HEALTH ALLIANCE	MMASC	217	298	521		783	980	1,104	444	1,408	1,043	2,580	9,378	5.9%
SUNSHINE STATE HEALTH PLAN	MMACC	1,048	945	3,845	4,683	2,393	5,372	3,415	2,168	2,578	3,012	2,727	32,186	20.2%
CHILDREN'S MEDICAL SERVICES NETWORK**	CMSMA	1,274	3,440	4,554	3,760	3,520	6,597	6,570	3,061	4,427	6,109	7,373	50,685	31.7%
Total Specialty Plans		**2,539**	**8,034**	**8,961**	**17,806**	**13,420**	**23,334**	**21,325**	**5,686**	**15,112**	**16,994**	**26,490**	**159,701**	**100.0%**

***CMSN statewide contract not subject to procurement*

LTC Plan Enrollment - July 2017														
Long-term Care	Type	R1	R2	R3	R4	R5	R6	R7	R8	R9	R10	R11	TOTAL	Market Share
AMERIGROUP FLORIDA, INC.	LTCC										2,062	2,862	4,924	5.0%
COVENTRY HEALTHCARE OF FL, INC.	LTCC						911	983		1,527		1,585	5,006	5.1%
HUMANA MEDICAL PLAN, INC./Am Elder Care	LTCC	1,262	1,327	923	2,742	1,845	1,448	1,911	865	1,731	2,332	4,510	20,896	21.4%
MOLINA HEALTHCARE OF FL, INC.	LTCC					1,454	1,606					3,182	6,242	6.4%
SUNSHINE STATE HEALTH PLANH, INC.	LTCC	1,697		4,395	4,422	4,791	4,871	4,267	4,156	4,465	3,103	5,322	41,489	42.5%
UNITED HEALTHCARE OF FL, INC.	LTCC		2,435	1,670	2,072	1,865	1,734	2,034	1,088	1,391		4,792	19,081	19.5%
Total LTC Plans		**2,959**	**3,762**	**6,988**	**9,236**	**9,955**	**10,570**	**9,195**	**6,109**	**9,114**	**7,497**	**22,253**	**97,638**	**100.0%**

Link to ITN Contracts, Procurement Information, and Exhibits

http://ahca.myflorida.com/Procurements/index.shtml

HMA Medicaid Roundup

Arkansas

State Submits Waiver that Rolls Back Medicaid Expansion, Adds Work Requirement. *Modern Healthcare* reported on July 12, 2017 that Arkansas submitted a waiver to the Centers for Medicare & Medicaid Services (CMS) that would limit Medicaid eligibility and add work requirements for certain members. Under the waiver, entitled Arkansas Works, Medicaid expansion eligibility would be reduced from 138% to 100% of the federal poverty level, which is expected to move around 60,000 people from the program. Critics note this could potentially increase uncompensated care in the state by more than $50 million. The waiver proposal is open for public comment until August 10. Read More

California

HMA Roundup – Julia Elitzer (Email Julia)

Medi-Cal Beneficiaries File Lawsuit Over Low Provider Rates. *Los Angeles Times* reported on July 12, 2017, that a group of Medi-Cal beneficiaries has filed a lawsuit against the state of California, alleging that low provider reimbursement rates have resulted in in an unequal health care system that discriminates against Latinos. Many providers are unwilling to see Medi-Cal patients, creating barriers to access and longer waits for appointments. Under the law, California is obligated to provide coverage through Medi-Cal that is equivalent to care under private insurance and Medicare. Currently, Medi-Cal rates are about half of Medicare rates. Read More

Georgia

Georgia Seeks Federal Approval to Reimburse School Nurses through Medicaid. *The Atlanta Journal-Constitution* reported on July 18, 2017, that Georgia is seeking federal approval to reimburse school nurses through Medicaid. The Department of Community Health board voted to approve a nursing services reimbursement program, worth an additional $48.6 million in federal funding, and as a result, the number of school nurses in the state may double. Funding may become available as early as fall, pending Centers for Medicare & Medicaid Services approval. Read More

Massachusetts

Governor Signs Fiscal 2018 Budget, Still Seeks Employer Tax, MassHealth Reforms. *WBUR News* reported on July 17, 2017, that Massachusetts Governor Charlie Baker signed a $40.2 billion state budget for fiscal 2018. Baker returned to the Legislature a $200 million assessment on employers that he initially proposed to help fund MassHealth. Lawmakers had taken out the taxes during budget deliberations. The assessments would increase the Employer Medical Assistance Contribution from $51 to $77 per year and add a $750 penalty for each employee that chooses MassHealth over an employer-sponsored plan. Baker also wants a five-year moratorium on new health insurance mandates; the transition of hundreds of thousands of enrollees from MassHealth to zero-premium plans through the Connector; and approval of an expanded scope of practice for new mid-level dental therapy providers. Read More

Montana

Medicaid Expansion Faces Uncertain Future. *The New York Times* reported on July 17, 2017, the Montana Medicaid expansion faces an uncertain future, no matter how the U.S. Senate ultimately votes on the proposed Better Care Reconciliation Act of 2017. That's because the program requires renewal by state lawmakers to continue beyond 2019. Enrollment in the program has exceeded expectations, raising concerns about its sustainability. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

KPMG Awarded Second Contract for DSRIP Support. *Crain's HealthPulse* reported that KPMG has been awarded a second contract to provide support to the New York Delivery System Reform Incentive Payment (DSRIP) program. KPMG served in that role during the planning phase of the program, providing technical assistance to the Performing Provider Systems, receiving $12.4 million for a 9-month contract. The current contract, valued at $9.2 million, is scheduled to run for 18 months. The Department of Health plans to take over the support role at the end of the contract period. Read More

New York Political Leadership Opposes ACA Repeal. *Gotham Gazette* reported on July 17, 2017, that at a rally in support of the Affordable Care Act (ACA), four of New York's top elected officials participated in a show of force to rally against the Republican-led U.S. Senate's bill to repeal and replace the ACA. Governor Andrew Cuomo, Attorney General Eric Schneiderman, State Assembly Speaker Carl Heastie, and New York City Mayor Bill de Blasio appeared together at the rally, pledging to take legal action should the Senate pass the Better Care Reconciliation Act. Attorney General Schneiderman has threatened to sue the federal government if President Trump signs a bill repealing parts of the ACA citing "multiple constitutional defects" within the House and Senate repeal bills, including a provision that would defund Planned Parenthood for one year and another that would shift Medicaid costs from counties to the state in New York. Read More

Inspector General Audit Identifies Medicaid Overpayments. The New York Office of the Medicaid Inspector General has released findings from an audit of payments to Medicaid managed care plans. For the period October 1, 2010, through September 30, 2016, the Department of Health made 314,287 improper and questionable premium payments totaling about $122 million for 171,936 recipients who were subsequently disenrolled retroactively from a Medicaid managed care plan. During that time period, the Department paid Plans a total of approximately $94 billion in monthly premium payments. An inappropriate payment can occur when a premium payment was made to a plan for a recipient who was later retroactively disenrolled from the plan, and the plan was not "at risk" for the provision of medical services during the disenrollment period. Local Departments of Social Services (LDSS) determine retroactive disenrollment periods and notify Plans to void inappropriate premium payments. OMIG found that officials misinterpreted guidelines governing when plans are considered not at risk and when corresponding premium payments should be recovered. This resulted in improper premium payments being deemed as appropriate when they were not. Read More

HANYS Appoints New Chief Operating Officer. The Healthcare Association of New York State (HANYS) has appointed Courtney Burke as its new Chief Operating Officer (COO). She will oversee all of HANYS' operations and ensure alignment of the Association's various functions, including from healthcare policy and advocacy, quality improvement and data analysis. Ms. Burke most recently served as Senior Vice President and Chief Strategy Officer at Albany Medical Center. Before that, she served as New York State's Deputy Secretary for Health. In that role, Ms. Burke provided oversight for the state's health and mental hygiene agencies, including the Department of Health, Office of Alcoholism and Substance Abuse Services, the Office for the Aging, Office of the Medicaid Inspector General, Office of Mental Health, Office for People with Developmental Disabilities, Developmental Disabilities Planning Council, and the Justice Center. Read More

Medicaid Redesign Waiver Public Comment Days Announced. The Department of Health has announced dates for its annual Public Comment Days on New York's 1115 Waiver programs. New York's 1115 waiver, the Medicaid Redesign waiver, allows the state to use a mandatory managed care delivery system to provide care to most Medicaid recipients. The Delivery System Reform Incentive Payment (DSRIP) Program is a significant waiver initiative, and members of the DSRIP Project Approval and Oversight Panel (PAOP) will join DOH staff in listening to the feedback provided by members of the public and stakeholders on these Public Comment Days. Feedback on all waiver programs is welcomed. The Upstate Public Comment Day will be held on August 14, 2017 from 1:00pm – 4:00pm in Albany at the SUNY Albany School of Public Health. Written public comment may be submitted through August 23, 2017 to 1115waivers@health.ny.gov. The Downstate Public Comment Day has been scheduled for November 16, 2017; more information will be forthcoming. The meetings are open to the public, and will be webcast live. No pre-registration is required. Individuals who wish to provide comment will be asked to register on site, and will speak in their order of registration. All comments will be limited to 5 minutes per presenter. Read More

North Carolina

Aetna, Community Care Sign Medicare Advantage Network Agreement in Rural North Carolina. Aetna announced on June 21, 2017, that it has signed a network agreement with Community Care Physician Network (CCPN) to deliver value-based care to Medicare Advantage members in Rural North Carolina in 2018. CCPN is a clinically integrated network of 2,000 independent physicians in 615 practices. It was formed by North Carolina providers with the assistance of Community Care of North Carolina. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

State Developing 1332 Innovation Waiver. *Cleveland.com* reported on July 14, 2017, that the Ohio Department of Insurance is developing a 1332 Innovation Waiver that will exempt Ohio from the individual and employer mandates established under the Affordable Care Act. Recently enacted House Bill 49, Ohio's biennial operating budget bill, set a deadline for submission to the federal government of January 31, 2018. Read More

CareSource, Cleveland Clinic May Terminate Contract in September. *Cleveland.com* reported on July 17, 2017, that CareSource may terminate its contract with Cleveland Clinic on September 1. CareSource serves 1.3 million Medicaid members in Ohio. It will send letters to members who may be affected with a list of potential new providers, such as MetroHealth, Neighborhood Family, Care Alliance, NEON, and University Hospitals. CareSource and Cleveland Clinic still hope to work out a resolution. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

State House Backs Medicaid Limits Amid Continued Budget Negotiations. *Altoona Mirror* reported on July 16, 2017, that Pennsylvania Governor Tom Wolf allowed a $32 billion spending bill pass into law without his signature earlier this month. As of yet, a corresponding revenue bill has not passed. As part of their consideration of a final mix of $700-$800 million in new taxes and revenues needed to balance the $32 billion 2017-2018 spending plan, majority Republicans in the legislature want more controls on future medical spending, including:

- Instituting a work/ work-search requirement for medical assistance recipients who are "physically and mentally able to";
- Health minders: – a data-driven care management program in an attempt to eliminate treatment errors; and
- Premiums for high-income families

The state House voted narrowly last week to impose new limits and tests on Medicaid recipients. Among several provisions, House Bill 59 would require "able-bodied" adult Medicaid recipients to work or participate in job programs, while higher-income families with children with disabilities would

be required to pay a monthly premium for care. The Pennsylvania House bill would prompt the state to apply for a federal waiver to add work requirements to get Medicaid, although the bill does not detail precisely what those requirements would be. Read More

Texas

STAR+PLUS, STAR, CHIP Operational Start Dates Aligned to September 2019. Texas Health and Human Services announced that the operational start dates of STAR+PLUS, STAR, and CHIP have been moved to September 1, 2019 in order to align the managed care procurement cycles. Read More

State's Largest Medicaid Assisted-living Facility to Close. *The New York Times* reported on July 14, 2017, that the largest assisted-living facility in Texas for Medicaid members is closing. The Westchester Plaza facility in Ft. Worth, which is operated by not-for-profit WGH Heritage, Inc., has experienced financial losses and a decline in the number of residents. WGH Heritage will continue to operate two assisted-living facilities in the state. Read More

Virginia

DMAS Releases Medallion 4.0 Statewide Medicaid Managed Care RFP. The Virginia Department of Medical Assistance Services (DMAS) has released a request for proposals (RFP) for its Medicaid managed care program, MEDALLION 4.0. The program covers approximately 737,000 individuals and will be implemented on a regional basis beginning in August 2018. DMAS anticipates awarding annual contracts to at least three contractors per region. Responses are due September 8, 2017.

National

ACA Repeal May Be Dead Along With Senate Health Bill. *Politico* reported on July 17, 2017, that Senate Majority Leader Mitch McConnell (R-KY) and President Donald Trump have both called for outright repeal of the Affordable Care Act (ACA) without an immediate replacement in the wake of the collapse of the Senate Better Care Reconciliation Act of 2017. Read More. However, that plan may be dead on arrival, according to *The New York Times*. The Senate bill faltered after two more Republican Senators aligned against it, leading to a push for repeal only. At least three Republican Senators immediately said they would not vote for repeal without a replacement. Read More

ACA Repeal Efforts Falter Over Proposed Medicaid Cuts. *Politico* reported on July 19, 2017, that opposition to cutting Medicaid has been a large hurdle for Republican efforts to repeal the Affordable Care Act. Moderate Republican senators and governors believe the cuts to Medicaid proposed by both the House and Senate health care bills go too far. Medicaid covers 70 million individuals nationwide and enjoys wide public support. Read More

Some Health Systems Report Return on Investment from Risk-based Contracts. *Modern Healthcare* reported on July 15, 2017, that certain health systems are seeing financial returns from risk-based contracts. According to Modern Healthcare's Hospital Systems Survey, 19 out of 60 systems responded that they recorded a surplus on risk-based contracts. Systems with the most

substantial infrastructure, resources, and patient populations are able to take on contracts that include full capitation or participation in accountable care, while others are opting for arrangements that include upside risk. Read More

CMS Proposes to Reduce 340B Drug Payments to Hospitals. *Modern Healthcare* reported on July 13, 2017, the Centers for Medicare & Medicaid Services (CMS) has proposed a rule to reduce the percentage paid for drugs under the 340B drug pricing program, thereby reducing payments to hospitals. The agency proposes paying hospitals 22.5 percent less than the average sales price for drugs acquired under the 340B program compared to the current payment formula which is 6 percent above the average sales price. The change is expected to most significantly impact safety-net hospitals. Read More

Hospitals Doubt CMS Will Redistribute Savings Generated from Proposed 340B Rule. *Modern Healthcare* reported on July 18, 2017, hospitals are raising concerns regarding the Centers for Medicare & Medicaid Services (CMS) plan to distribute savings generated from cuts to the 340B drug program. CMS intends to redistribute the savings by increasing Medicare payments to participating hospitals by 1.4 percent in the following year. Read More

Insurers Are Still Leaving Exchanges; States Try to Lure Them Back. *The Wall Street Journal* reported on July 14, 2017, that insurers continue to pull back from the Affordable Care Act Exchanges for the 2018 coverage period, leaving some states with no coverage options in certain areas and others with only one insurer to choose from. Meanwhile, insurers that remain on the Exchanges are seeking significant rate increases. According to the Kaiser Family Foundation, Ohio has 20 counties facing the prospect of having no Exchange plans next year, Nevada has 14, and Indiana has four. States are scrambling to shore up their Exchanges. New York has proposed that insurers must offer Exchange plans in order to keep their Medicaid contracts. Iowa, which only has one insurer participating next year, is seeking federal approval of a proposal that reworks many of the ACA rules. And Alaska just received federal approval for additional funding for its reinsurance program. Read More

Trump Administration Still Considering End to Insurer Subsidy Payments. *Politico* reported on July 18, 2017, that President Donald Trump's administration is still looking to end insurer subsidy payments, according to several aides and advisers. Publicly administration officials say no final decision has been reached. Eliminating the subsidies, worth an estimated $7 billion this year, would potentially destabilize Exchange markets, significantly raise premiums, and force some insurers to exit. Already, there are 44 counties across the nation without any Exchange insurers. Subsidy payments are still expected to be made this month. Read More

US Justice Department Charges Providers with Defrauding Medicaid and Medicare, Illegally Prescribing Opioids. *Reuters* reported on July 13, 2017, that U.S. Attorney General Jeff Sessions announced that the Justice Department has charged 412 people, including 115 doctors and nurses, for defrauding Medicaid, Medicare, and TRICARE of $1.3 billion. Over 120 individuals were accused of illegally prescribing and distributing opioids. In addition, the Department of Health and Human Services has launched suspension procedures against almost 300 medical service providers. Read More

Senator Graham Proposes Alternative ACA Reform Legislation. *Politico* reported on July 13, 2017, that Senator Lindsey Graham (R-SC) will introduce an alternative Affordable Care Act (ACA) reform proposal if the

latest version of the Senate bill fails to pass. The proposal is intended to appeal to both Republicans and Democrats and will likely be introduced as an amendment to the Senate Better Care Reconciliation Act (BCRA). The proposal will keep all the ACA taxes, except for the medical device tax, and block grants approximately $110 billion in federal health care funding to the states. The bill would also end the individual and employer mandates for insurance, but retains protections for people with pre-existing conditions. Read More

Industry News

Magellan to Acquire Senior Whole Health. Magellan Health announced on July 13, 2017, that it will acquire Senior Whole Health for $400 million. Senior Whole Health provides managed long-term care to 22,000 dual eligibles in Massachusetts and New York. The acquisition is expected to close by the end of the first quarter of 2018 with federal regulatory approval. Read More

Mountain States Health Alliance, Wellmont Health System Merger Still Waiting Regulatory Approval. *Modern Healthcare* reported on July 18, 2017, that the proposed merger of Mountain States Health Alliance and Wellmont Health System has been at a standstill for three years now, as the health systems await Certificate of Public Advantage approval from Tennessee and Virginia. The systems maintain that savings generated from the merger would be used to address public health issues and provide mental health and addiction treatment. Both the Federal Trade Commission and health insurer Anthem Inc. argue that the merger would increase health care costs and diminished quality of care. The combined system would have a total 21 hospitals serving 13 counties across the two states. Read More

SSM Health to Acquire Agnesian HealthCare and Monroe Clinic. *Modern Healthcare* reported on July 12, 2017 that SSM Health, a health system based in St. Louis, has agreed to acquire Agnesian HealthCare and Monroe Clinic from the Congregation of Sisters of St. Agnes, a group of Catholic-providers. The purchase of the two Wisconsin-based health systems will include St. Agnes Hospital, Waupun Memorial Hospital, Ripon Medical Center, Monroe Clinic, as well as 12 clinics and home care and hospice agencies. Read More

Individual Market Margins Improve in First Quarter 2017. *Politico* reported on July 13, 2017, that the Affordable Care Act Exchange markets seem to be stabilizing, according to a Kaiser Family Foundation report. In the first quarter of 2017, insurers in the individual market spent 75 percent of premiums on medical claims, compared to more than 85 percent in the same period two years ago. Kaiser's associate director of health reform and private insurance, Cynthia Cox, said there is no evidence of a "death spiral," as many claim. However, despite the improved data, only 141 insurers submitted applications to participate in the 2018 Exchanges due to uncertainty under the new administration. Read More

Long-Term Care Providers Begin Offering Medicare Advantage Plans. *Kaiser Health News* reported on July 13, 2017 that nursing home operators are beginning to offer Medicare Advantage health plans. The companies maintain they offer more coordinated and accessible care by placing providers, such as primary care physicians and nurses, directly in the nursing facilities or retirement communities. Critics of the model claim it can create conflicts of interest when a member's insurer and long-term care provider are owned by the same company. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
July, 2017	Delaware	Contract Awards (Optional)	200,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
August, 2017	Alabama ICN (MLTSS)	RFP Release	25,000
Summer 2017	Illinois	Contract Awards	2,700,000
Summer 2017	Massachusetts One Care (Duals Demo)	Procurement Release	TBD
Summer 2017	Ohio MLTSS	RFA Release	130,000
September 1, 2017	New Mexico	RFP Release	700,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
September 8, 2017	Virginia Medallion 4.0	Proposals Due	700,000
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	Florida Statewide Medicaid Managed Care (SMMC)	Proposals Due	3,100,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
November 15, 2017	New Mexico	Proposals Due	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
March 15, 2018	New Mexico	Contract Awards	700,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
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	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
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	New Mexico	Implementation	700,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	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 (June 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	117,302	33.5%	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	50,064	36.8%	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	16,809	17.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	39,046	39.0%	AmeriHealth Michigan; Coventry (Aetna); Michigan Complete Health; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York*	Capitated	1/1/2015	4/1/2015	124,000	4,566	3.7%	There are 14 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	561	2.8%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	74,347	65.2%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	13,717	54.0%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	7,915	14.8%	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	39,919	23.8%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,194	41.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**391,440**	**31.2%**	

** 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

Number of Registrations for HMA Conference on Future of Medicaid Tops 300; Register Now Before Event is Sold Out

More than 300 leading executives from health plans, providers, state and federal government, and community-based organizations have already registered to attend HMA's conference, *The Future of Medicaid is Here: Implications for Payers, Providers and States*, September 11-12, 2017, at the Renaissance Chicago Downtown Hotel.

This is the second annual conference held by HMA on trends in publicly sponsored healthcare, and registrations have increase significantly.

The event will bring a sharp focus to the opportunities and challenges faced by health care organizations in an evolving Medicaid landscape. A high-level list of 37 industry-leading speakers, including health plan executives and state Medicaid directors, will address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations given the priorities of the new Administration and Congress.

Visit the conference website for details: https://2017futureofmedicaid.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available.