

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... August 2, 2017



[RFP CALENDAR](#)

[DUAL ELIGIBLES
CALENDAR](#)

[HMA NEWS](#)

2017 CONFERENCE



**THE FUTURE OF
MEDICAID IS HERE:**

IMPLICATIONS FOR PAYERS,
PROVIDERS AND STATES

Sept. 11-12

REGISTER NOW

THIS WEEK

- **IN FOCUS: CHRONICLE OF A DEATH FORETOLD: ACA REPEAL AND REPLACE STALLS IN SENATE**
- ALABAMA TO PURSUE AN ALTERNATIVE TO REGIONAL CARE ORGANIZATIONS
- COLORADO ISSUES REGIONAL ACCOUNTABLE ENTITIES RFP
- FLORIDA RELEASES MEDICAID PREPAID DENTAL PROGRAM RFI
- ILLINOIS BEGINS MAKING OVERDUE PAYMENTS TO MEDICAID PLANS
- INDIANA ISSUES RFI FOR FFS MEDICAID PBM
- NEW YORK PROVIDES DSRIP YEAR 2 RESULTS
- PENNSYLVANIA DELAYS HEALTHCHOICES IMPLEMENTATION
- CENTURION RETAINS TENNESSEE CORRECTIONAL HEALTH CONTRACT
- CMS OUTLINES DSH FUNDING REDUCTIONS SET TO BEGIN IN OCTOBER
- LHC GROUP, CHRISTUS HEALTH FORM JOINT VENTURE
- HMA TO SPEAK ABOUT ROLE PUBLIC HEALTH PLAYS IN IMPLEMENTING RETAIL MARIJUANA LEGALIZATION AT NATIONAL CANNABIS SUMMIT

IN FOCUS

CHRONICLE OF A DEATH FORETOLD: ACA REPEAL AND REPLACE STALLS IN SENATE

In deference to Miracle Max, after last week's failed votes on "Repeal and Replace," "Straight Repeal," and "Skinny Repeal," the GOP's efforts to undo the Affordable Care Act (ACA) through budget reconciliation appear to be at least "mostly dead." While it is possible strictly partisan discussions will reaccelerate at some point, it appears that Congress is, for the first time,

considering bipartisan proposals for shoring up the underwriting challenges in the individual market. In light of this change in direction, we are using this week's *In Focus* section to chronicle the events that transpired over the last five months leading to last week's historic vote. Our objective here is to create a reference piece for our readers so that the next time Congress revisits major healthcare legislation we can look back on the strategies and approaches that led to last week's result. Many times over the last eight months, we have reflected on the key dynamics surrounding the passage of the ACA in 2010 as a guide for what factors to watch in the efforts to repeal the ACA - budget reconciliation issues, Congressional Budget Office (CBO) scoring, key proposals to win over recalcitrant legislators, the President's role in pushing the agenda - but our memories were not always up to the task. So in the spirit of having a reference document for future reflection, we record below the key events associated with this effort.

It is worth mentioning that we, the editors of the *HMA Weekly Roundup*, were as unsure of the outcome of last week's votes as anyone. We took some solace in that the experts and our friends in the business of Washington punditry shifted their probabilities of passage from week to week, even day to day, if not hour to hour, as the political momentum swung from one outcome to the other. That said, we were reminded that there was one interested observer who foretold the outcome of the GOP's repeal and replace efforts before the legislative process even started in earnest. Who was this congressional clairvoyant? None other than former House Speaker John Boehner who, two weeks before the House of Representatives introduced the American Health Care Act (AHCA), predicted at a health care conference in Orlando, Florida that "I shouldn't have called it repeal and replace because that's not what's going to happen...Most of the framework of the Affordable Care Act ... that's going to be there. They will never ever agree on what the bill should be. Perfect always becomes the enemy of the good." Boehner concluded, "Republicans never ever agree on health care."¹ Words to remember.

House Actions

- **March 6, 2017** - House Republicans released the American Health Care Act (AHCA) (H.R. 1628), their proposal to repeal-and-replace the Affordable Care Act (ACA). If passed, the AHCA would restrict federal funding for Medicaid, roll back the Medicaid expansion in 2020, and eliminate the individual and employer mandates. States would receive per capita funding amounts for select groups of Medicaid beneficiaries based on historical spending. Annually, the per capita caps would be recalculated based on changes to the Consumer Price Index (CPI). Under the AHCA, children would be able to stay on their parents' insurance plan until age 26 and prohibits insurers from refusing an individual coverage for a preexisting condition. Also, the federal government would continue providing tax credits. Starting in 2020, the tax credits would be determined by household income, age, and limited to \$14,000 per family. Individuals could also contribute to their own health savings accounts (HSA).² House Speaker Paul Ryan (R-WI) issued a press release introducing the AHCA and praising it as

¹ <http://www.politico.com/story/2017/02/john-boehner-obamacare-republicans-235303>

² <http://khn.org/news/house-gop-health-bill-jettisons-insurance-mandate-much-of-medicaid-expansion/>

a plan that will “drive down costs, encourage competition, and give every American access to quality, affordable health insurance.”³ In his statement, he reassured that the bill would also “protects young adults, patients with pre-existing conditions, and provides a stable transition so that no one has the rug pulled out from under them”⁴ The bill was immediately met with opposition from the House Freedom Caucus and the Republican Study Committee (RSC). The RSC drafted a policy memo the same day the bill was passed expressing their opposition to the bill.

- **March 8, 2017** – The House Energy and Commerce Committee and the House Ways and Means Committee approved the AHCA. The bill passed without a nonpartisan economic analysis from the Congressional Budget Office (CBO). The panel rejected various Democratic amendments, including requiring that people not lose health coverage under the legislation and that the plan not increase out-of-pocket costs for older people.⁵
- **March 8, 2017** – In a meeting with House Republicans, President Trump warned that there could be a “bloodbath” in the 2018 midterm elections if they could not meet their seven year promise to repeal and replace Obamacare.
- **March 12, 2017** – The CBO and the Joint Committee on Taxation (JCT) released their budget analysis of the AHCA. They projected that the House GOP-proposed bill would result in 14 million more individuals who are uninsured than under current law by 2018, rising to 21 million in 2020, and 24 million in 2026. In total, the number of uninsured in America would nearly double to 52 million in 2026. However, the CBO-JCT estimates project the AHCA would reduce federal deficits by \$337 billion over the 10-year period from 2017 to 2026, with savings coming from reductions in Medicaid outlays and ACA tax credit subsidies. CBO-JCT also projects that individual premiums under the AHCA would be 15 percent to 20 percent higher than under current law in 2018 and 2019.⁶ Democrats, including U.S. Representatives Frank Pallone (D-NJ) and Richard Neal (D-MA), used the CBO projections to highlight the shortfalls of the AHCA, stating “the Republican plan does absolutely nothing to control costs or protect consumers...Instead, it guts Medicaid, raises costs on older Americans, and pulls billions of dollars from Medicare, all in order to pay for tax cuts for the rich.”⁷
- **March 13, 2017** – Given the internal strife within House Republicans, House Speaker Ryan joined President Trump in warning Republicans that there would be a “bloodbath” in the 2018 elections if they fail in their promise to repeal and replace the ACA.

³ <https://www.speaker.gov/press-release/statement-introduction-american-health-care-act>

⁴ <https://www.speaker.gov/press-release/statement-introduction-american-health-care-act>

⁵ https://www.nytimes.com/2017/03/09/us/politics/health-bill-clears-house-panel-in-pre-dawn-hours.html?_r=1

⁶ See Attachment

⁷ <https://www.advisory.com/daily-briefing/2017/03/14/cbo-report>

- **March 16, 2017** – The House Budget Committee passed the AHCA in a 19-17 vote, sending the AHCA to the House Floor. They also recommended several changes to AHCA, which include prohibiting additional states from expanding Medicaid, establishing Medicaid work requirements, giving states the option to receive block grants or per capita funding, and repealing the Affordable Care Act (ACA) taxes by the end of 2017, among other changes.⁸
- **March 20, 2017** – The House introduced the AHCA to the House Floor. To view this version of the bill, click [here](#).
- **March 23, 2017** – House Republican leaders delayed the vote on the AHCA, originally scheduled for Thursday at 7 p.m., due to opposition from both moderate and conservative House Republicans. According to Representative Mark Meadows, head of the Freedom Caucus, the House did not have enough votes to pass the bill. Instead, the House Republicans held a meeting to discuss next steps.
- **March 24, 2017** – After four hours of debate, House Speaker Paul Ryan pulled the AHCA bill from the House floor before a scheduled vote. Speaker Ryan rushed to the White House to inform President Trump that they did not garner enough support to pass the AHCA. With moderate and conservative Republicans at odds, it became clear early in the day that the bill would be not be passed. According to a leadership aide, President Trump asked Speaker Ryan to pull the bill.
- **April 4, 2017** – Vice President Mike Pence and two White House officials proposed several changes to the AHCA to attract the votes of hardline conservative Republicans. These changes include allowing states to seek waivers to permit insurance companies to deny coverage for certain pre-existing conditions.⁹
- **April 6, 2017** – Representatives Gary Palmer (R-AL) and David Schweikert (R-AZ) added an amendment to the AHCA that would create a federal risk sharing program within the AHCA's Patient and State Stability Fund (PSSF) program. This would provide an extra \$15 billion for insurers to help pay for high-cost customers. The risk-sharing program's goal was to stabilize insurance markets by lowering premiums and, in turn, attracting more individuals to purchase insurance. The measure passed by a party-line vote of nine to two.¹⁰
- **April 11 - 20, 2017 – House Recess** – During the House Recess, U.S. Representatives that called for the ACA to be repealed and replaced were greeted by crowds of angry constituents. Constituents vocally expressed their opposition to the AHCA and even threatened to vote their respective representatives out of office.
- **April 20, 2017** – Representative Tom MacArthur (R-NJ) introduced an amendment to the AHCA, which would allow states to apply for waivers to opt out of many provisions of the ACA, such as charging

⁸ <http://www.modernhealthcare.com/article/20170320/NEWS/170329984>

⁹ <http://www.cnn.com/2017/04/04/white-house-officials-offer-change-to-health-care-bill.html>

¹⁰ <https://www.nytimes.com/2017/04/06/us/politics/health-care-affordable-care-act-house.html>

consumers more based on age and pre-existing conditions, and changing or eliminating the Essential Health Benefits requirement.

- **May 3, 2017** - Senator Fred Upton (R-MI) introduced an amendment, which would create an \$8 billion fund that would be distributed to states that permit insurers to charge individuals with pre-existing conditions higher premiums.
- **May 4, 2017** - The House passed the AHCA without a revised CBO analysis in a 217/213 vote, moving the bill to the Senate.¹¹ To view this version of the bill, click [here](#). Shortly after the House passed the bill, President Trump celebrated its passage in the Rose Garden at the White House. At the event, President Trump provided a prediction that the bill would get better as it moved to the legislative process. The President stated, “most importantly, yes, premiums will be coming down. Yes, deductibles will be coming down.” President Trump also applauded Republican efforts in their accomplishments, particularly House Speaker Paul Ryan, who the President mentioned had concerns about whether the bill would pass earlier in the week. Democrats and several Republicans issued statements in opposition regarding the House’s vote. Senator Chuck Schumer expressed his skepticism that the bill would be as successful in the Senate stating, “This bill is going nowhere fast in the United States Senate,” and advised that Republican Senators try to pass a different bill rather than “follow their House colleagues over a cliff.” Representative Nancy Pelosi painted a grimmer portrait for House Republicans warning that they will “pay the price” in 2018.
- **May 18, 2017** - The AHCA was being held until the CBO issues its final score. Since the bill was being moved through budget reconciliation, the bill needed to save at least \$2 billion in the federal budget. If the CBO analysis found that there was not a net savings in the budget, the House would have to vote on a revised AHCA bill.¹²
- **May 24, 2017** - The CBO released the cost estimate of the AHCA, as passed by the House on May 4, 2017. The estimates detailed budgetary and enrollment impacts of the bill over the 2017 to 2026 time period. The CBO estimated that 23 million more individuals would be uninsured by 2026 as compared to the current baseline estimates, with 14 million more uninsured by 2018. Medicaid enrollment was predicted to be 14 million less than the current baseline by 2026, while Medicaid expenditures over the ten-year period were expected to decrease by \$834 billion, with an overall reduction of \$119 billion to the federal deficit. The CBO also estimated that by 2020, one-sixth of Americans will reside in states that waive provisions such as essential health benefits and lifetime coverage limits. However, the CBO also found that community-rated premiums could likely rise over time.¹³ In an interview with *Politico*, former CBO Director Douglas Elmendorf stated that the House decision “to go ahead with a vote before you know the effects of what you’re voting for is a terrible mistake.”

¹¹ <http://www.reuters.com/article/us-usa-healthcare-idUSKBN18014F>

¹² <http://www.businessinsider.com/gop-health-care-bill-re-vote-obamacare-cbo-score-2017-5>

¹³ <https://www.cbo.gov/publication/52752>

Senate Actions

- **May 4, 2017** – Senate Republicans announced that they will be drafting their own repeal-and-replace health bill.
- **May 9, 2017** – Senate Republicans created a 13-person working group tasked with drafting a new bill. The members consisted of conservative foes of the ACA and the decision to exclude women from the working group was widely criticized. The members of the working group were:
 1. Senator Mitch McConnell (R-KY), Senate Majority Leader
 2. Senator Orrin Hatch (R-UT), Senate Finance Committee Chair
 3. Senator Lamar Alexander (R-TN), Senate HELP Committee Chair
 4. Senator Mike Enzi (R-WY)
 5. Senator John Thune (R-SD), Chair of the Republican Conference
 6. Senator Mike Lee (R-UT), Chair of the Senate Republican Steering Committee
 7. Senator Ted Cruz (R-TX)
 8. Senator Tom Cotton (R-AR)
 9. Senator Cory Gardner (R-CO), Chair of the National Republican Senatorial Committee
 10. Senator John Barrasso (R-WY), Chair of the Senate Republican Policy Committee
 11. Senator John Cornyn (R-TX), Senate Majority
 12. Senator Rob Portman (R-OH)
 13. Senator Pat Toomey (R-PA)
- **June 19, 2017** – Senate Majority Leader Mitch McConnell (R-KY) announced that the draft Senate health bill was sent to the CBO. Senate Republicans announced that they plan to vote on the bill by June 30.
- **June 22, 2017** – Following weeks of criticism from both Senate Republicans and Democrats over the secretive process in drafting the bill, Senate Majority Leader McConnell released a discussion draft of its ACA repeal-and-replace bill, called the Better Care Reconciliation Act of 2017 (BCRA). The bill would phase out enhanced federal funding for Medicaid expansion, limit tax subsidies for Exchange plans to individuals with incomes below 350 percent of poverty, and shift Medicaid to a per capita cap funding model with a state option to take block grants. The bill would also fund a temporary federal reinsurance program to stabilize the individual insurance market. States would then have to implement their own reinsurance programs with federal assistance through 2026.¹⁴ Senator Rand Paul (R-KY) called the BCRA “Obamacare lite.”

¹⁴ <http://www.modernhealthcare.com/article/20170622/NEWS/170629968>

- **June 22, 2017** - Senator Mitch McConnell encountered protests after releasing the draft bills. Individuals with disabilities protesting the bill were forcibly removed from the Senator's office and arrested.
- **June 26, 2017** - The Senate revised the BCRA to prohibit individuals from purchasing insurance for six months if they had a gap in coverage of 63 days or longer in the previous year. The rule, which would take effect in 2019, would apply to individuals attempting to purchase insurance during open enrollment or because of a qualifying event. The rule, which is designed to encourage people to purchase insurance, offers an alternative to the insurance mandates. To view this version of the bill, click [here](#).
- **June 26, 2017** - The CBO released its scoring of BCRA, estimating that the legislation would cause 22 million more individuals to be uninsured by 2026, compared to 23 million under the House bill passed in May. The cumulative federal deficit would be reduced by \$321 billion over the 2017-2026 period.¹⁵ The CBO estimated the largest savings would come from Medicaid, which would see a 26 percent decline in 2026. Following the CBO analysis, Tom Perez, Democratic National Committee Chairman declared the BCRA a "disaster for women, older Americans, and people with pre-existing conditions."¹⁶
- **June 27, 2017** - Senate Majority Leader McConnell (R-KY) delayed a planned vote on the BCRA until after the July 4th recess. The decision comes as Senators Susan Collins (R-ME), Dean Heller (R-NV), Mike Lee (R-UT), and Ron Johnson (R-WI) indicated they would vote against the bill. In response, Senate leaders decided to push for a vote by the end of July.¹⁷
- **June 30, 2017** - Growing frustrated with the legislative process, President Trump changes his stance on repealing and replacing the ACA simultaneously, tweeting, "If Republican Senators are unable to pass what they are working on now, they should immediately REPEAL, and then REPLACE at a later date!"
- **July 3 - 7, 2017 Recess** - During the July 4th Recess, Senate Republicans opted not to hold listening sessions with their constituents. Representative Jerry Moran (R-KS) and Bill Cassidy (R-LA) were the only Senate Republicans to host town hall meetings.
- **July 11, 2017** - Senate Majority Leader McConnell (R-KY) delayed the start of the Senate's August recess until the third week in August to allow more time to amend the BCRA.
- **July 13, 2017** - Senator Ted Cruz (R-TX) introduced an amendment that would permit insurers that offer a Gold, Silver, and Bronze plan on the Exchange market to also offer plans that do not comply with the ACA requirements. Additionally, states would be permitted to apply for block grant funding for the Medicaid expansion population and

¹⁵ <http://www.modernhealthcare.com/article/20170626/NEWS/170629913>

¹⁶ <https://www.cnbc.com/2017/06/26/cbo-to-release-crucial-report-on-senate-obamacare-replacement-bill.html>

¹⁷ <http://www.modernhealthcare.com/article/20170627/NEWS/170629901>

exceed block grant caps in the event of a public health emergency. To view this version of the bill, click [here](#).

- **July 13, 2017** - Senators Susan Collins (R-ME) and Rand Paul (R-KY) announced their opposition to the BCRA.
- **July 17, 2017** - The Senate postpone the vote on BCRA after Senators Mike Lee (R-UT) and Jerry Moran (R-KS) announced their opposition to the bill. In response, President Trump tweeted, "Republicans should just REPEAL failing ObamaCare now & work on a new Healthcare Plan that will start form a clean slate. Dems will join in!"
- **July 18, 2017** - Senate Republicans propose a plan to introduce a bill to repeal the ACA, but the proposal was dropped after Senators Susan Collins (R-ME), Shelley Moore Capito (R-WV), and Lisa Murkowski (R-AK) announced their opposition to the bill. President Trump told reporters that he intends to let the ACA fail as it would be easier, stating, "let Obamacare fail. It would be a lot easier...We're not going to own it. I'm not going to own it...I can tell you the Republicans are not going to own...We'll let Obamacare fail, and then the Democrats are going to come to us."
- **July 18, 2017** - Senate Majority Leader McConnell announced that the Senate will hold a vote on BCRA on the week of July 24.
- **July 19, 2017** - President Trump hosted a White House lunch for Senate Republicans, urging an alternative plan to replace the ACA before leaving for the August recess.
- **July 19, 2017** - After a strong push by Senator Rand Paul (R-KY), the Senate posted the Obamacare Repeal Reconciliation Act ("ORRA"), which would repeal the ACA without replacement. ORRA is identical to the bill passed in 2015 by the House and Senate. The bill was eventually vetoed in 2016 by President Obama.
- **July 19, 2017** - The CBO released its score of ORRA. The CBO reported that by 2018, 17 million more people would be uninsured than would be under current law. That number would increase to 27 million in 2020, and finally to 32 million in 2026. The agency also projected that the ORRA would decrease the federal deficit by \$473 billion from 2017 to 2026.
- **July 20, 2017** - Senate Republicans released the latest version of the BCRA, which was sent to the CBO for scoring. This version of the BCRA incorporated the July 13, 2017, Amendment and excluded the amendments made by Senator Cruz (R-TX). To view this version of the bill, click [here](#).
- **July 20, 2017** - The CBO released its report on the July 20th version of the BCRA. According to the CBO's analysis, the BCRA was projected to reduce the federal deficit by \$321 billion between 2017 and 2026. The CBO also projected that the bill would increase the number of uninsured Americans, and that, by 2018, 15 million more individuals would be uninsured than would be under current law. By 2020, that difference would reach 19 million more people, and in 2026, 21 million more people would be left uninsured compared to current law.

- **July 25, 2017** - Senate Majority Leader McConnell announced after 20 hours of debate, he would call for a vote on ORRA. If it fails, he will call for a vote on the July 20th version of the BCRA. Senate leadership will introduce a “skinny repeal” bill. This bill would leave almost all of the ACA in place, but it would eliminate the individual mandate, the employer mandate, and the medical device tax.
- **July 25, 2017** - The Senate voted to debate BCRA. The vote was called upon Senator John McCain’s (R-AZ) return to Washington, less than two weeks after having a procedure done to remove a major blood clot from his brain and being diagnosed with a brain tumor. The motion to proceed on debate passed after Vice President Mike Pence broke a Senate 50-50 vote. Senators Susan Collins (R-ME) and Lisa Murkowski (R-AK) voted against the motion. Following the vote, McCain gave an impassioned speech on the Senate floor imploring colleagues to consider bipartisan compromise and a return to regular order, noting “We’ve tried to do this by coming up with a proposal behind closed doors in consultation with the administration, then springing it on skeptical members, trying to convince them it’s better than nothing, asking us to swallow our doubts and force it past a unified opposition. I don’t think that is going to work in the end. And it probably shouldn’t.”
- **July 25, 2017** - The Senate introduced a new version of the BCRA that incorporated the Cruz and Portman amendments. The Portman amendment would provide \$100 billion intended to lower insurance costs and stabilize the marketplace.
- **July 26, 2017** - The Senate voted to reject BCRA in a 43-57 vote. The Senate will continue to debate, propose amendments, and potentially vote on repealing and replacing certain portions of the ACA. Three Republican Senators that voted against the bill: Senator Susan Collins (R-ME), Senator Lisa Murkowski (R-AK), and Senator John McCain (R-AZ). Following the vote, President Trump shamed Republican Senators that voted against the bill, tweeting, “Senator @lisamurkowski of the Great State of Alaska really let the Republicans, and our country, down yesterday. Too bad!”
- **July 27, 2017** - Senators Lindsey Graham (R-SC), Ron Johnson (R-WI), and John McCain (R-AZ) announced that they would not vote for the “skinny bill.” House Republicans considered enacting “martial law,” which would waive chamber rules that mandate they wait three days after a bill is made public to vote on BCRA. If the bill were passed, this would allow House Republicans the opportunity to take up the Senate bill immediately and enact the bill.
- **July 27, 2017** - President Trump tweeted, “3 Republicans and 48 Democrats let the American people down. As I said from the beginning, let ObamaCare implode, then deal. Watch!”

Next Steps

- **July 31, 2017** - With the failure to repeal and replace the ACA, a bipartisan coalition of 40 Representatives announced they hope to introduce legislation aimed at stabilizing the health insurance Exchanges. The “Problem Solvers” coalition, which is led by Tom Reed

(R-NY) and Josh Gottheimer (D-NJ), are seeking to ensure funding for insurance cost-sharing subsidies, modify the employer mandate, create a federal stability fund for individuals with high-cost medical conditions, eliminate the medical-device tax, and allow for greater state innovation.



HMA MEDICAID ROUNDUP

Alabama

State to Pursue an Alternative to Regional Care Organizations. The Alabama Medicaid Agency will pursue an alternative to provider-led risk-based Regional Care Organizations (RCOs), according to a July 27, 2017, Agency press release. The Medicaid commissioner cited major federal changes, including new opportunities in state flexibility, as a key factor in the decision. Previously, approximately two-thirds of the state's Medicaid members were anticipated to be enrolled in RCOs beginning October 2017.

Alaska

Premera BCBS Files for 22 Percent Rate Decrease on Exchange. *The New York Times* reported on August 1, 2017, that Premera Blue Cross Blue Shield filed for an average 22 percent rate decrease on Alaska's insurance Exchange. Premera, which is the only insurer on the Exchange, attributes the rate drop to lower use of medical services and payment of high-cost claims through a state-based reinsurance program intended to stabilize the market. Previously rate increases reached as high as 40 percent. [Read More](#)

Arkansas

Waiver Aims to Expand Medicaid Coverage to Marshallese, Other Children. *U.S. News* reported on July 26, 2017, that Arkansas hopes to expand Medicaid coverage to Marshallese children and to eliminate a requirement that children who are legal immigrants must live in the country for five years prior to becoming eligible for Medicaid. Arkansas has a significant population of citizens from the Marshall Islands, who are federally barred from Medicaid coverage. The proposal would impact an estimated 2,000 Marshallese children. The Arkansas Department of Human Services (DHS) is submitting the proposal to the Centers for Medicare & Medicaid Services for approval. DHS will be accepting public comments on the proposal until August 21. [Read More](#)

California

HMA Roundup - Julia Elitzer ([Email Julia](#))

Medi-Cal to Launch Diabetes Prevention Program. *Public Health Advocates* reported on July 10, 2017, that Governor Jerry Brown signed a new bill into law allocating \$5 million for a program to help prevent people with prediabetes from developing diabetes. Senate Bill 97 is a fiscal 2018 budget

trailer bill that allocates funding for a new Diabetes Prevention Program that could potentially save California up to \$45 million per year in long-term healthcare costs. State health officials will seek nearly \$8 million in federal matching funds for the program. The program aims to enroll 25,000 members in 2018. [Read More](#)

Colorado

HMA Roundup – Alana Ketchel ([Email Alana](#))

Colorado Issues Regional Accountable Entities RFP. On May 11, 2017, Colorado issued a request for proposals (RFP) to procure Regional Accountable Entities (RAE) for the Accountable Care Collaborative, the core of the state’s Medicaid program, Health First Colorado. The RFP solicits approaches for population health management by contracting with a single entity in each of the seven regions that will be responsible for coordinating physical and behavioral health services. Previously separate entities took on these roles, the Regional Care Collaborative Organizations (RCCOs) and Behavioral Health Organizations (BHOs). The Colorado Department of Health Care Policy and Financing (HCPF) reported that 11 bidders responded to the state’s RFP. Bidders could bid on up to three regions but can only operate in two regions; therefore, bidders were asked to rank their preferences. Incumbent plans are indicated with an asterisk.

Region	Counties	Bidder(s)
1	Archuleta, Delta, Dolores, Eagle, Garfield, Grand, Gunnison, Hinsdale, Jackson, La Plata, Larimer, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel, Summit	<ul style="list-style-type: none"> Reunion Health in Partnership with Rocky Mountain Health Plans*
2	Cheyenne, Kit Carson, Lincoln, Logan, Morgan, Phillips, Sedgwick, Washington, Weld, Yuma	<ul style="list-style-type: none"> Northeast Health Partners <p><i>Incumbent did not bid</i></p>
3	Adams, Arapahoe, Douglas, Elbert	<ul style="list-style-type: none"> Colorado Access* Colorado Community Health Alliance
4	Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, Fremont, Huerfano, Kiowa, Lake, Las Animas, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache	<ul style="list-style-type: none"> Health Colorado Inc. Peaks and Prairies in partnership with Rocky Mountain Health Plans <p><i>Incumbent split across bidders.</i></p>
5	Denver	<ul style="list-style-type: none"> Colorado Access*
6	Boulder, Broomfield, Clear Creek, Gilpin, Jefferson	<ul style="list-style-type: none"> Foothills Health Solutions in partnership with Rocky Mountain Health Plans

		<ul style="list-style-type: none"> • Colorado Community Health Alliance*
7	El Paso, Park, Teller	<ul style="list-style-type: none"> • Community Care of Central Colorado* • New Health Ventures • Mountain Springs Healthcare • Colorado Community Health Alliance

The following background on select bidders is based on Articles of Incorporation filed with the Colorado Secretary of State and information published on entities’ websites.

- **Rocky Mountain Health Plans** is an existing RCCO that services Region 1. They have proposed to partner with safety net provider networks **Reunion Health, Peaks and Prairies, and Foothills Health Solutions** on their respective three bids.
- **Northeast Health Partners** is a new LLC registered to addresses affiliated with North Range Behavioral Health, Sunrise North Range Clinic, Centennial Mental Health Center, and Salud Family Health Centers.
- **Colorado Access** is an existing RCCO that serves Regions 2, 3, and 5.
- The **Colorado Community Health Alliance (CCHA)** is a partnership between Physician Health Partners (PHP), Centura Health, and Primary Physician Partners.
- **Health Colorado, Inc.** is a new LLC registered to addresses affiliated with SyCare, which oversees health care providers in 19 counties specializing in behavioral and primary healthcare services, and to Colorado Health Partnerships, a collaboration between eight community mental health centers and Beacon Health Options.
- **Community Care of Central Colorado** is an existing RCCO in Region 7 that has partnered with Envolve, Inc., which is a wholly-owned subsidiary of Centene Corporation.
- **New Health Ventures** is a subsidiary of Colorado Access.
- **Mountain Springs Healthcare** is a new LLC registered to an address affiliated with Colorado Health Partnerships.

Awards are expected to be announced in the fall of 2017, with contracts signed in February 2018 for a July 2018 implementation.

Florida

HMA Roundup – Elaine Peters ([Email Elaine](#))

AHCA Releases Statewide Medicaid Prepaid Dental Program RFI. Florida’s Agency for Health Care Administration (AHCA) released a Request for Information (RFI) for the Statewide Medicaid Prepaid Dental Program on July 26, 2017. The procurement is expected to be released in the fall of 2017. AHCA is seeking information from providers, including a specific request for ideas on the provision of dental services to individuals with complex needs (e.g.,

individuals with disabilities, in long-term care settings, or in need of specialized services). The dental plan will coordinate with health plans in the Statewide Medicaid Managed Care (SMMC) Managed Medical Assistance program.

AHCA Begins 30-day Public Comment Period for MMA, LTC Waiver Transitions. The Florida Agency for Health Care Administration (AHCA) announced the start of a 30-day public notice and comment period through August 30, 2017, on a plan to transition additional populations to the state's 1115 Managed Medical Assistance (MMA) Waiver and 1915(b)/(c) Long-Term Care (LTC) Waiver by January 1, 2018. The Agency is seeking to transition 1915(c) Traumatic Brain and Spinal Cord Injury (TBI/SCI), Adults with Cystic Fibrosis (ACF), and Project AIDS Care (PAC) waivers, and the 1115 MEDS-AD Waiver, all of which would end once the transitions are complete. [Read More](#)

State Employee Charged in \$1 Billion Medicaid, Medicare Fraud Case. The *Miami Herald* reported on July 29, 2017, that Bertha Blanco, an administrator with the Florida Agency for Health Care Administration (AHCA), was charged with accepting bribes in a \$1 billion Medicaid and Medicare fraud scheme. Philip Esformes, who owns 20 nursing facilities, was charged last year for filing false Medicare and Medicaid claims for 14,000 patients. Blanco, the first AHCA employee ever to be charged with accepting bribes, is accused of taking tens of thousands of dollars in exchange for tipping off Esformes about violations in advance of state inspections. Bianco is considered a "small cog" in the alleged scheme. [Read More](#)

Georgia

Lawmakers Consider Medicaid Waivers to Cut Costs. The *Atlanta Journal-Constitution* reported on July 31, 2017, that conservative lawmakers in Georgia are considering Medicaid waivers to cut state costs by imposing new standards on recipients. Governor Nathan Deal said he is open to waivers; however, some lawmakers worry that the waivers could increase the state's dependency on federal funding. [Read More](#)

Illinois

State Begins Making Overdue Payments to Medicaid Plans. *Chicago Tribune* reported on July 27, 2017, that Illinois made overdue payments of \$740 million to Medicaid managed care organizations this week. The state's ability to make payments had been hampered by a two-year budget impasse, which was finally overcome when the state passed a budget this month. The state still owes plans \$3.5 billion, hampering their ability to pay claims. Providers have warned of deteriorating financial stability, and some are refusing to see additional Medicaid patients, impacting access. [Read More](#)

Indiana

State Issues RFI for FFS Medicaid Pharmacy Benefits Management. On July 27, 2017, Indiana released a Request for Information (RFI) for the state's fee-for-service Medicaid Pharmacy Benefits Management (PBM) Services program. Responses are due September 8, 2017. The current contract, held by OptumRx,

was recently extended through May 2019. The vendor will work under the Office of Medicaid Policy and Planning (OMPP) to manage the Indiana Health Coverage Program (IHCP).

Maryland

Proposed Acquisition of Evergreen Health Falls Through. *The Baltimore Sun* reported on July 26, 2017, that investors LifeBridge Health, Anne Arundel Health System, and JARS Health Investments have backed out of a deal to acquire Maryland-based co-op plan Evergreen Health. Investors cited concerns over new financial information that came to light. Evergreen converted to for-profit status this year to facilitate the acquisition. Founder Peter Beilenson warned that the plan may not be able to remain in business without a deal. [Read More](#)

Massachusetts

Legislature Approves Employer Medicaid Fee, Nixes Plan to Move Certain Adults Off MassHealth. *The Boston Globe* reported on July 26, 2017, that Massachusetts legislators approved a plan to impose \$200 million in fees on employers to help fund the state's MassHealth Medicaid program, while rejecting a proposal to shift 140,000 adults from MassHealth to the state's Exchange. The proposals have been pushed as a package by Massachusetts Governor Charlie Baker, who now has the option to either accept or veto the Legislature's decision. [Read More](#)

New Jersey

HMA Roundup – Karen Brodsky ([Email Karen](#))

Medical Assistance Advisory Council (MAAC) Updates. *Update on Transition of Mental Health Services to FFS:* On July 20, 2017, the New Jersey Medical Assistance Advisory Council (MAAC) received an update from Roxanne Kennedy, Director of Behavioral Health Management at the Department of Human Services on the shift of mental health services from contract based to fee-for-service (FFS). The transition is occurring in three phases, two of which are complete. The third phase will be completed by January 2018. Between January and June 2017, there were 1183 consumers in FFS in the following programs: Room and Board (36 percent), Integrated Case Management Services (ICMS) (30 percent), Residential (9 percent), Outpatient (9 percent), Supported Employment (8 percent), Partial Care (7 percent), and Community Support Services (CSS) (1 percent). FFS claims totaled \$4.74 million for the same period, with residential services accounting for nearly 50 percent. Seventy-nine providers have transitioned to mental health FFS contracts so far. As part of the rollout, DMAHS will continue to move the remaining CSS providers into FFS contracts, enhance the NJ Mental Health Application for Payment Processing (NJMHAPP), and conduct an evaluation of the first year of implementation.

Medicaid Director Davey Provides NJ FamilyCare Update: The NJ FamilyCare program, which includes individuals on Medicaid, Medicaid Expansion and CHIP, has a total of 1,773,206 people enrolled as of June 2017. This accounts for approximately 19.8 percent of the New Jersey residents.

Division of Developmental Disabilities (DDD) Provides Update on System Reform: Elizabeth Shea, Assistant Commissioner, provided an update on the Division of Developmental Disabilities (DDD) system reform over the past five years, with a focus on the Supports Program, the Community Care Waiver (CCW), and the fee-for-service implementation. DDD has 26,000 individuals in their system of which about 12,000 receive services. Currently, there are 3,000 individuals enrolled in the Supports Program and DDD plans to enroll an additional 9,500 individuals by the end of December 2017. There are approximately 45 individuals enrolled or enrolling in Supports Program + Private Duty Nursing (SP+PDN), a specialized program for people coming out of school who require PDN.

Assistant Commissioner Shea informed the MAAC that CMS approved CCW on March 30, 2017, and discussions to incorporate CCW into the 1115(i) waiver are ongoing. In terms of the FFS implementation, DDD approved 90 Support Coordination Agencies and 334 Service Providers. More than 21,000 individuals have completed the New Jersey Comprehensive Assessment Tool (NJ CAT).

Managed Care Update: Carol Grant, Medicaid Deputy Director, provided an overview of the changes to the appeal process to comply with the federal Medicaid managed care final rule and to better align with Medicare Advantage and federal Marketplace rules. These changes include the following:

- Medicaid managed care plan members must exhaust their health plan's appeal process before proceeding to a state fair hearing.
- The number of days in which a member can file an appeal for the internal appeal, previously known as Stage 1, was reduced from 90 to 60 days and MCOs now have 30 days to reach a decision (72 hours for expedited appeals).
- CMS no longer permits Medicaid MCOs to have more than one stage of internal appeal.
- Members have within 120 days of the outcome of the internal appeal to pursue a state fair hearing concurrent with or instead of an external appeal by an Independent Utilization Review Organization (IURO) through the Department of Banking and Insurance, Consumer Protection Services, Office of Managed Care.
- Benefits will continue automatically while the Internal Appeal or External Appeal is pending if the member requests an appeal within a defined timeframe. Members must submit in writing within a certain timeframe to continue receiving benefits during a state fair hearing.

The changes to the appeals process went into effect July 1, 2017.

Laura Otterbourg, Director, Division of Aging Services, provided an update on the MLTSS implementation. As of June 2017, there were 51,793 long term care recipients in New Jersey, a nearly 20 percent increase from July 2014. Of those enrolled, 70 percent are in MLTSS, 28 percent in FFS, and 2 percent in PACE. Since December 2016, there has been 2,141 additional HCBS recipients, 21 fewer PACE recipients, and 718 fewer recipients in nursing facilities.

In addition, DMAHS is transitioning the MLTSS Any Willing Provider (AWP) policy to an Any Willing Qualified Provider (AWQP) Program under a nursing facility (NF) quality improvement initiative. In doing so they are setting the

stage for value-based purchasing (VBP) for MLTSS, improving NF quality for long-stay NF residents and providing managed care organizations with a means to build stronger network management. The AWQP Program, led by Assistant Director Elizabeth Brennan, is a joint effort between the Division of Aging Services, the Division of Medical Assistance and Health Services, the DMAHS Offices of Managed Health Care, and Business Intelligence. Seven quality nursing facility measures have been selected to date. The National CoreQ survey tool will be used to measure NF resident and family satisfaction in NFs, and administered by Dr. Nick Castle of the University of Pittsburgh. The first NF AWQP designation will be provided in the second quarter of 2019. NF AWQP designations will occur annually thereafter. Last, in October 2017, a new PACE site will open in Atlantic City called Atlantic Care Life Connection.

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

New York Department of Health Provides DSRIP Year 2 Results. The New York Department of Health circulated an email providing statewide performance results for the second year of the Delivery System Reform Incentive Payment program (DSRIP). The email notes that DSRIP Year 2 (DY2), which ended March 31, 2017, closed with positive statewide performance results. Through DY2, PPS have earned a total of \$2.4 billion, which is 95 percent of all available incentive payments. Progress towards the DSRIP program requirement of achieving a 25 percent reduction in avoidable hospital use by DSRIP Year 5 was demonstrated through two measures: a 14.9 percent reduction in Potentially Preventable Readmissions and an 11.8 percent reduction in Potentially Preventable ED Visits. If the current reduction rates are maintained, New York will achieve the goal of a 25 percent preventable Readmission and ED reduction by DSRIP Year 5. Additionally, Performing Provider Systems have successfully met all requirements for 31 projects in total and have successfully implemented 95 percent of all DY2 project requirements.

Public Hospitals Provides Disproportionate Share of Inpatient Mental Health Services in NYC. A report from the New York City Independent Budget Office finds that, in contrast to systemic reductions in hospitalization across New York City, which have been evident for some time, the public hospital system, NYC Health + Hospitals, has seen significant increases in hospitalizations for patients with mental illness. Hospitalizations related to mental illness at NYC H + H rose 20 percent from 2009 to 2014, while voluntary hospitals in the city saw a 5 percent decline in hospitalizations due to a mental health condition. Hospitalizations for mental health care were the single most common reason for hospitalization across the NYC H + H system in 2014, accounting for 13 percent of all hospitalizations in the public system, and 43 percent of all inpatient care for mental health across all NYC hospitals. This is due in part to the fact that Health + Hospitals has dedicated a greater portion of its beds to psychiatric care, with about half of all psychiatric beds in NYC within the public system. [Read More](#)

Department of Health Launches Value Based Payment (VBP) Learning Resources. The NY Department of Health has launched an on-line learning program they call VBP University. VBP University is an educational resource designed to raise awareness, knowledge and expertise in the move to Value Based Payment (VBP). VBP University combines informational videos and

supplemental materials that stakeholders interested in VBP can use to advance their understanding of topic. The program consists of four semesters, and individuals who successfully complete all four semesters will be awarded a certificate of completion.

- Semester One: Background and foundational information on VBP
- Semester Two: Topic specific information such as governance, business strategy, stakeholder engagement, finance, and data
- Semester Three: VBP Contracting
- Semester Four: VBP Bootcamps

Participation in a VBP bootcamp is required in order to complete the certification process. Bootcamps will be scheduled for October and November of this year. The Department currently has posted the curriculum for the first semester of VBP University. Semester 1 is designed to be a foundational curriculum for VBP. This semester gives an overview of the different levels of risk within VBP and the different VBP contract arrangement types. The curriculum consists of a series of short videos (1 - 3 minutes), and a quiz to demonstrate mastery of the material. [Read More](#)

New York Developing Care Coordination Initiative for Individuals with Intellectual/Developmental Disabilities. New York is developing an initiative aimed at enhancing care coordination for people with developmental disabilities. The initiative, People First Care Coordination, will coordinate healthcare, behavioral health, and other community services in conjunction with the services a person receives through the Office for People with Developmental Disabilities (OPWDD) in a single "Life Plan." People First Care Coordination builds on the current service coordination model to offer greater simplicity, improved follow-up, and a person-centered planning approach that considers the whole person. OPWDD is hosting a webinar for individuals and families served through the OPWDD system that will describe plans for the move to enhanced care coordination, as well as provide the reasons for this shift and a timeline of anticipated next steps. The webinar will be held on Monday, August 7, 1-2 pm. Advance registration is required. [Link to Webinar Registration](#). A recording of the webinar will be posted to the OPWDD website.

Northwell Health Expands as Mather Memorial Signs LOI. John T. Mather Memorial Hospital in Port Jefferson, NY has entered into a letter of intent to join Northwell Health as part of a long-term strategy to ensure advanced healthcare for Mather's communities and the future growth of the hospital. Over the next few months, Mather and Northwell Health will work together in good faith to develop a final agreement which will require approval from both the Mather and Northwell Board of Directors as well as governmental regulatory authorities. If the process is successful, the approvals could take place by the end of 2017. The NY hospital market continues to see consolidation and affiliations across the state, including on Long Island. Prior to this decision, Mather was one of only two hospitals on Long Island that had not joined or announced plans to join a larger system: Brookhaven Memorial Hospital in Patchogue is the only remaining private hospital on Long Island that is not part of a system and has not announced plans to join one. Mather is an accredited 248-bed, non-profit community teaching hospital. Northwell Health is New York State's largest health care provider and private employer,

with 22 hospitals and over 550 outpatient facilities. The system provides care for more than two million people annually in the metro New York area, and has 62,000 employees, including 15,000 nurses and about 3,900 physicians, including more than 2,800 members of Northwell Health Physician Partners. They are partners with Hofstra Northwell School of Medicine and the School of Graduate Nursing and Physician Assistant Studies, and also offer health insurance through CareConnect. [Read More](#)

Ohio

Access to Exchange-based Health Insurance Restored in 19 Ohio Counties. *The Ohio Department of Insurance* announced on July 31, 2017 that residents in 19 Ohio counties have had their access to health insurance through the Exchange restored. Five major health care insurers, Buckeye Health Plan, CareSource, Medical Mutual of Ohio, Molina Health Care of Ohio and Paramount Health Care will ensure coverage is available in these counties on the Exchange in 2018. The Ohio Department of Insurance is working to restore coverage in the 20th county. [Read More](#)

Oklahoma

State Terminates Shadow Mountain Behavioral Contract Following Judge's Ruling. *Tulsa World* reported on August 2, 2017, that the Oklahoma Health Care Authority (OHCA) terminated its SoonerCare contract with Shadow Mountain Behavioral Health System, a Tulsa-based youth psychiatric hospital, effective July 31. Shadow Mountain had filed for an injunction to block the move, but Oklahoma County District Judge Thomas Prince denied the request. The state cited compliance and regulatory deficiencies for the decision. [Read More](#)

Pennsylvania

HMA Roundup - Julie George ([Email Julie](#))

State Senate and House GOPs Agree on Work/Work Search Requirement for Medicaid. On July 28, 2017, *The Harrisburg Patriot-News* reported, Pennsylvania's state Senate has approved a budget-related bill that would require state officials to seek a work requirement for some Medicaid beneficiaries. The measure was included in the Human Services Code (HB 59), one of a number of budget-related code bills that must be passed to enact the state budget. HB 59 would require the state to request a waiver from the federal government "for approval of design options or reforms that require reasonable employment and job search requirements nondisabled, nonpregnant, nonelderly Medicaid eligible adults as well as appropriate limits on nonessential benefits." The bill passed the Republican-controlled state Senate in a mostly partly line vote, 35-15, with no debate. The bill passed the House earlier this month but must return to the House for another vote because of changes in the Senate. Senators removed a provision that would have required the state request a waiver from the federal government so it could charge premiums in Medicaid to families with disabled children whose income is above 1,000 percent of the federal poverty income limit. It is unclear if Democratic Gov. Tom Wolf would sign the bill. Governor Wolf allowed a

nearly \$32 billion spending plan to lapse into law without his signature for the fiscal year that began July 1. Senators passed a revenue package Thursday, though its fate in the House is unclear. [Read More](#)

Pennsylvania Senate Approves Higher Taxes to Balance Budget. Pennsylvania's \$32 billion spending bill for 2017-18 is now law, but out of balance. On July 27, 2017, the Pennsylvania Senate voted on and passed a plan to eliminate a \$2.2 billion budget deficit that included \$530 million in new taxes, borrowing \$1.3 billion against future tobacco settlement payments and a not yet finalized expansion of legalized gambling. One of the new taxes in the Senate plan was a severance tax on natural gas drillers. Pennsylvania currently has an impact fee, but no severance tax. Pennsylvania risks a credit downgrade if it doesn't balance the budget, which would increase its borrowing costs. It could also force Governor Wolf to freeze some government spending, potentially affecting schools, grant programs, tax credits and counties that administer social service programs. Governor Wolf has indicated support for the Senate's revenue plan, but the bill now returns to the House, which appears to be in no rush to come back to the Capitol to debate the Senate's revenue package. In a letter to their members on July 27th, GOP leaders said to expect to return sometime before the end of August. [Read More](#)

PA Medical Assistance Advisory Committee July 27th Meeting. *Office of Medical Assistance Programs (OMAP) Update:* The Department of Human Services (DHS) is still in a stay regarding the HealthChoices physical health procurement. DHS has requested an expedited review from the Commonwealth Court, but there will be not be a January 2018 implementation. A new timeline for implementation will be developed once the Department hears from the court. In the interim, the current HealthChoices contracts are being amended and extended for 2018. The amended 2018 contracts will be in effect through December 2018, unless the Department gets approval to move forward sooner. *Office of Long Term Living (OLTL) Update:* Pennsylvania has received approval from CMS on its 1915 (b) and 1915 (c) waivers and for its amendments to its Independence Waiver. The COMM CARE waiver will be transitioned to the Community HealthChoices waiver and COMM CARE waiver recipients can now be moved to the Independence Waiver. The Independent Enrollment Broker RFP is still in a stay. *Office of Developmental Programs (ODP) Updated:* ODP announced a new Community Living Waiver. The waiver will serve as an intermediate waiver for services to 1,000 individuals with an intellectual disability, autism, and children under age nine with a disability who have a high probability of resulting in an intellectual disability or autism. There will be a limit on services of \$70k/year excluding service coordination. Many services are identical to the Person/Family Directed Support waiver, with the significant addition of residential services. The public comment period is likely to start late August 2017. ODP plans to submit to CMS in early October 2017 and there is a target effective date of September 1, 2018.

DHS Office of Long-Term Living Makes Waiver Amendments Available for Public Comment. In September 2017, the Department of Human Services (DHS) Office of Long-Term Living (OLTL) will be submitting amendments to the Aging, Attendant Care, Independence, and OBRA waivers. A side-by-side comparison of the current and revised language, and access the amendments in their entirety, are available on the department's website. OLTL is seeking public comment on the Aging, Attendant Care, Independence, and OBRA

waiver amendments. The public comment period ends on August 31, 2017. The Office of Long-Term Living will offer two webinars in August for public input and discussion. The webinars will be held on August 7, 2017 10:00-11:00am and August 16, 2017 1:30-2:30pm. [Read More](#)

Tennessee

Centurion Retains Correctional Health Contract. Centene Corp. announced on August 1, 2017, that its Centurion joint venture with MHM Services has again been awarded a contract to provide inmate health services to the Tennessee Department of Corrections. The latest contract will be effective in the third quarter of 2017. Centurion has been providing correctional health services in Tennessee since 2013. The company also serves Florida, Massachusetts, Minnesota, Mississippi, New Mexico, Tennessee, and Vermont; and provides administrative services in California. [Read More](#)

Texas

Senate Approves Teacher Bonuses Funded by Delay in Medicaid MCO Payments. *Austin American-Statesman* reported on July 27, 2017, that the Texas Senate passed a \$405 million bill that would delay payments to Medicaid managed care plans in order to fund bonuses for active teachers and reduce health care deductibles for retired teachers. A portion of payments to plans would be pushed from the 2018-19 biennium to the following biennium. The House also passed its version of the bill, which instead taps the state's rainy day funds, rather than MCO payments. [Read More](#)

National

CMS Outlines DSH Funding Reductions Set to Begin in October. *Modern Healthcare* reported on July 27, 2017, that the Centers for Medicare & Medicaid Services (CMS) will begin cutting federal funding for uncompensated care in fiscal year 2018. Under the Affordable Care Act, Medicaid disproportionate-share hospital funds (DSH) were to be cut by \$43 billion between fiscal 2018 and 2025, with the assumption that the Medicaid expansion and Exchanges would reduce the need for funds. DSH reductions were intended to begin in 2014, but Congress delayed the cuts until September 30, 2017. In fiscal 2018, the DSH cuts will start at \$2 billion. [Read More](#)

States Can Intervene to Defend ACA Cost-sharing Subsidies. *Modern Healthcare* reported on August 2, 2017, that a U.S. Court of Appeals in Washington has ruled that states can intervene in the *House v. Price* lawsuit to defend the Affordable Care Act cost-sharing subsidies. The ruling may make it harder for the Trump administration to unilaterally terminate the payments. The court said that states showed that there would be a substantial risk of premium hikes and an increase in the number of individuals who are uninsured if the subsidies are terminated. President Trump has called the subsidies "insurer bailouts." [Read More](#)

Top Senate Republicans Support Cost-sharing Subsidies for Exchange Plans. *CQ News* reported on July 31, 2017, that top Senate Republicans support keeping cost-sharing reduction (CSR) subsidies to help stabilize Exchange

markets despite new threats from President Trump to cut them. The threats came after Affordable Care Act repeal and replace legislation failed to pass. The federal government is expected pay \$10 billion in CSR subsidies next year. Insurers argue the payments are necessary to keep Exchange markets from collapsing. Senators John Cornyn (R-TX) and John Thune (R-SD) have both come out in support of continuing the payments. [Read More](#)

Senators Alexander, Murray to Hold Bipartisan Hearings on ACA. *Politico* reported on August 1, 2017, that the Senate Committee on Health, Education, Labor, and Pensions, led by Senators Lamar Alexander (R-TN) and Patty Murray (D-WA), will hold bipartisan hearings on the Affordable Care Act. The sessions will host health policy experts, including state insurance commissioners, patients, and insurance industry representatives. Senator Alexander has pushed President Donald Trump to keep cost-sharing subsidies and to give Congress time to create a stabilization plan. [Read More](#)

Cassidy-Graham Proposal Faces Tough Odds. *Politico* reported on August 1, 2017, that the latest Affordable Care Act (ACA) repeal and replace legislation, proposed by Senators Bill Cassidy (R-LA) and Lindsey Graham (R-SC), may face long odds given internal divisions among Senate Republicans. The proposal would give states annual funding, similar to block grants, and significant flexibility over how to use the funds. States could direct funding to Medicaid, Exchanges, or new coverage programs. The bill would preserve the bulk of the ACA taxes. [Read More](#)

Presidential Commission Reports on National Opioid Crisis. *ABC News* reported on July 31, 2017, that a Presidential drug commission said the nation's opioid epidemic, which claims 142 lives daily, is "equal to September 11 every three weeks" and urged President Trump to declare a national emergency. The commission, which is led by New Jersey Governor Chris Christie, also recommended enforcing mental health parity regulations, making overdose drug naloxone available to law enforcement officers, and requiring providers in FQHCs to get waivers to prescribe buprenorphine. [Read More](#)



INDUSTRY NEWS

LHC Group, Christus Health Form Joint Venture. *The Acadiana Advocate* reported on August 1, 2017, LHC Group will acquire majority ownership and assume management responsibility of 21 Christus Health facilities in Louisiana, Texas, Arkansas, and Georgia through a joint venture agreement. The agreement includes five hospice programs, seven home health agencies, two-community-based home care services, one inpatient hospice unit and six long-term care acute-care hospitals. With the addition of the Christus Health joint venture, LHC Group will have partnerships with 75 health systems that consist of more than 250 hospitals nationwide. [Read More](#)

Molina Announces Restructuring Plan, Posts Second Quarter Net Loss of \$230 Million. Molina Healthcare reported on August 2, 2017, a net loss of \$230 million for the second quarter of 2017, adding that the company is implementing a restructuring plan to reduce expenses by up to \$400 million. Molina also announced it would exit Exchange markets in Utah and Wisconsin. Interim chief executive Joseph White attributed the financial performance largely to the company's health plans in Florida, Illinois, New Mexico, and Puerto Rico. [Read More](#)

Centene Hires Kevin Counihan for Midwest Market. *Vox* reported on August 2, 2017, that Kevin Counihan, a top health care official in the Obama administration, will join Centene to focus on the Midwestern market. Counihan served as chief executive of *Healthcare.gov*, from August 2014 through January 2017. Centene plans to expand in six states where it already offers Exchange coverage: Florida, Georgia, Indiana, Ohio, Texas, and Washington. [Read More](#)

Community Health Systems to Post Second Quarter 2017 Loss. *Modern Healthcare* reported on July 26, 2017, that Community Health Systems (CHS) is expected to post second-quarter operating losses of \$131 million, driven by a decline in hospital admissions and revenues. In the same period last year, the company posted a loss of \$1.4 billion, largely because of a one-time charge. [Read More](#)

Mednax Misses Second Quarter Earnings, Revenue Projections. *Modern Healthcare* reported on July 28, 2017, that Florida-based physician staffing company Mednax missed its second-quarter 2017 earnings and revenue forecast, in part because of a decline in hospital admissions. The company reported second-quarter net income of \$63.7 million on revenues of \$842.9 million. [Read More](#)

Anthem Hints at Medicaid, Medicare Acquisitions. *Modern Healthcare* reported on July 26, 2017, that Anthem enjoyed membership growth in its Medicaid and Medicare Advantage lines of business, and company CEO Joseph Swedish hinted at acquisitions to further build scale. Meanwhile, the

company said it may withdraw from additional state Exchange markets unless the business stabilizes. [Read More](#)

Company Announcements

"MCG Certifies MedVision QuickCAP 7.0" [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
TBD	Delaware	Contract Awards (Optional)	200,000
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 currently 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

HMA to Speak about Role Public Health Plays in Implementing Retail Marijuana Legalization at National Cannabis Summit

The 2017 National Cannabis Summit will feature the workshop, *Implementing Retail Marijuana Legalization: Public Health's Role in Implementation of Prevention and Education Efforts Following Legalization of Retail Marijuana*. During this workshop, HMA Principal Shannon Breitzman will share her unique expertise on how state agencies begin the complex implementation process of regulatory and programmatic needs after retail marijuana is legalized.

Shannon was part of the leadership team that implemented policies, programs, and procedures for the legalization of marijuana in Colorado. Her role focused on establishing the budget and strategy for education of Colorado laws and the prevention of marijuana abuse by high-risk groups. Shannon has extensive knowledge about the impact and complexities of legalizing recreational marijuana including the research on the health impacts of marijuana. She has developed and evaluated public education and messaging strategies established cross sector, cross agency collaboration, and dealt with unforeseen outcomes post-legalization.

The workshop will include an overview of Colorado's experience creating and implementing a prevention and education program to ensure safe and responsible adult use while preventing harm to vulnerable populations like children and adolescents. Attendees will hear about lessons learned, including:

- Making data driven decisions
- Engaging diverse stakeholders on opposite sides of the issue
- Collaborating with other state and local agencies
- Developing effective education campaigns for different audiences

The 2017 National Cannabis Summit is hosted by Advocates for Human Potential, Inc. (AHP), National Council for Behavioral Health, and the Addiction Technology Transfer Center Network (ATTC) in Denver, August 28-30. For more information, please visit www.NationalCannabisSummit.org

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

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

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