HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 9, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

THIS WEEK

IN FOCUS

NORTH CAROLINA OUTLINES PROPOSED DESIGN FOR MEDICAID MANAGED CARE

This week, our *In Focus* section reviews "North Carolina's Proposed Program Design for Medicaid Managed Care," a draft proposal published this week for public comment, which provides a detailed overview of the planned statewide Medicaid managed care program to be launched in 2019. By 2023, North Carolina estimates it will have transitioned roughly 1.8 million Medicaid

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beneficiaries in the state to managed care. North Carolina's Department of Health and Human Services (DHHS) is encouraging public comment on the program design proposal through September 8, 2017, ahead of a planned request for information (RFI) release later this year.

Current Medicaid Structure

North Carolina's Medicaid program currently covers most beneficiaries through a Primary Care Case Management (PCCM) system, with most services, aside from behavioral health, paid for under a fee-for-service (FFS) structure. The PCCM system is comprised of primary care medical homes (Carolina Access practices) and the Community Care of North Carolina (CCNC) networks. All behavioral health services are currently provided through capitated arrangements with Local Management Entities – Managed Care Organizations (LME-MCOs). However, in 2015, the state legislature enacted legislation, which directed DHHS to transition Medicaid from a FFS to a managed care structure.

Medicaid Managed Care Covered Populations

The Medicaid managed care program will initially aim to enroll around 1.5 million of the state's roughly 2 million Medicaid beneficiaries. The program will initially exclude:

- Dual eligible beneficiaries;
- Program of All-inclusive Care for the Elderly (PACE) enrollees;
- Medically needy beneficiaries;
- Beneficiaries only eligible for emergency services;
- Presumptively eligible, during period of presumptive eligibility; and
- Health Insurance Premium Payment (HIPP) beneficiaries

Certain special populations, including dual eligibles, are scheduled to be shifted to managed care through a phased-in approach after the planned 2019 implementation.

Special Population	Estimated Enrollment	Expected Phase-In (no later than)
Children in foster care, adoptive placements	22,000	1 year after implementation
Certain beneficiaries with a severe mental illness (SMI) or substance use disorder (SUD) diagnosis, individuals with intellectual or developmental disabilities (I/DD), and members in the TBI waiver.	85,000	2 years after implementation
Non-duals receiving long-stay nursing home services	2,000	4 years after implementation
CAP/C and CAP/DA waiver members	3,500	
Dual Eligibles	245,000	

When fully implemented in 2023, North Carolina estimates it will cover 1.8 million Medicaid beneficiaries in Medicaid managed care. This total would increase if the General Assembly passes proposed legislation to implement the Carolina Cares program. Carolina Cares would expand Medicaid, incorporating a number of personal responsibility requirements including work requirements and monthly premiums based on income.

Managed Care Plan Design

North Carolina DHHS will procure and contract with two managed care plan models, known as Prepaid Health Plans (PHPs).

- **Commercials Plans (CPs) –** Per the managed care legislation, DHHS is to contract with three CPs to provide integrated physical, behavioral, and pharmacy services under statewide contracts.
- **Provider-Led Entities (PLEs) –** PLEs will be able to bid on individual regions in the state, and are not required to operate statewide. PLEs must cover a region in its entirety, and may bid for more than one region, provided the regions are contiguous. There are specific statutory rules regulating the ownership structure and governing body of PLEs.

Given that PLEs and CPs will be competing in the same geographies, and PLEs may be directly owned by or have strong ties to providers, DHHS has outlined steps to protect against anticompetitive behavior. Per the program design proposal, "DHHS will prohibit exclusivity provisions in contracts between PHPs and providers and will require providers that partially own or control a PHP to negotiate with rival PHPs in good faith if those rival PHPs seek to contract with them." Additionally, DHHS has the authority to review contracts between PHPs and providers and enforce changes if anticompetitive behavior is found.

Managed Care Product Design

DHHS intends to allow both CPs and PLEs to offer different types of managed care offerings, although this will require legislative amendment of the authorizing statute.

- **Standard Plans:** PHPs will cover physical, behavioral, and pharmacy services for most Medicaid beneficiaries.
- **Tailored Plans:** PHPs may offer targeted managed care plans to serve special populations, including behavioral health and I/DD specific plans, as well as those for individuals with SMI and SUD.

DHHS also leaves open the possibility for future Tailored Plans for other populations, including a specific plan for dual eligible beneficiaries.

Next Steps and Timing

As mentioned above, DHHS is requesting comment on the program design proposal through September 8, 2017, ahead of a PHP RFI scheduled for late fall 2017, and submission of a waiver proposal to the Centers for Medicare & Medicaid Services (CMS) by the end of the calendar year.

Early 2018 will see the release of a formal RFP for PHPs, as well the release of preliminary capitation rates. Assuming the waiver is approved by CMS and procurement and contracting proceed as planned, DHHS is targeting implementation of Medicaid managed care on July 1, 2019.

Link to Managed Care Program Design Proposal

https://files.nc.gov/ncdhhs/documents/files/MedicaidManagedCare_ProposedProgramDesign_REVFINAL_20170808.pdf

HMA Medicaid Roundup

Arkansas

Reorganization of Division of Medical Services Underway, with Focus on Medicaid Innovation, Transformation. The Arkansas Department of Human Services announced on August 3, 2017, that it has begun to restructure its Division of Medical Services (DMS) and has hired Rose Murray Naff as the new DMS Director, effective August 14. Naff was previously the Chief Performance Officer at the State of Florida Department of Business and Professional Regulation and the Executive Director of Florida Healthy Kids Corporation. The reorganization of the division will focus on Medicaid transformation and innovation, including developing a new model of care for high-cost, high-need beneficiaries. Later this year, the division will also launch a new Medicaid Management Information System.

California

Appeals Court Rules Temporary Cuts to Medi-Cal Reimbursements Were Improper. The *Los Angeles Times* reported on August 7, 2017, that the federal government wrongly approved California's request to temporarily cut Medi-Cal reimbursements for hospital outpatient care during the 2008 recession, according to a U.S. Appeals Court ruling. The court found that such approvals can only be granted if evidence indicates that Medicaid recipients will have access to the same services as the general population. Fifty California hospitals brought the case after the state reduced reimbursements by 10 percent between July 2008 and February 2009. If the ruling stands, both the state and federal government would be required to repay hundreds of millions of dollars to California hospitals. Read More

CalOptima in Reimbursement Dispute with Behavioral Health Administrator. *Voice of OC* reported on August 7, 2017, on a contractual dispute between CalOptima and its behavioral healthcare administrator Magellan. The disagreement relates to reimbursement rates for applied behavioral health services. With the involvement of the California Department of Managed Health Care, the parties reached a deal by which Magellan will continue to provide services through the end of August. CalOptima is now considering whether to bring behavioral health administration in-house. Read More

Colorado

Problems Persist with New Medicaid Billing System. *Colorado Public Radio* reported on August 8, 2017, that significant issues remain with Colorado's recently launched Medicaid billing system, Colorado interChange, which is managed by DXC Technology. Chris Underwood, director of the health information office for the Colorado Department of Health Care Policy and Financing, acknowledges that the new system is complex and difficult to navigate, resulting in coding errors. Some providers report they are no longer accepting new Medicaid patients because claims are being improperly rejected. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Medicaid Waiver Receives CMS Approval. The Centers for Medicare & Medicaid Services (CMS) announced on August 3, 2017, approval of a five-year extension of Florida's Managed Medical Assistance (MMA) Section 1115 demonstration. Under the waiver, Florida will be permitted to operate a capitated Medicaid managed care program and a low-income pool (LIP). CMS will allow Florida to choose its own waiver benchmarks to evaluate waiver progress and reporting activities. Read More

Florida Health Choices Insurance Exchange to be Shut Down. *The Florida Times-Union* reported on August 3, 2017, that Florida is shutting down the Florida Health Choices insurance exchange following Governor Rick Scott's veto on funding for the program. The non-Affordable Care Act (ACA) state-run exchange has turned over all of its records to the Florida Agency for Health Care Administration and individuals who have already purchased coverage should not experience any issues. The exchange had struggled to attract enough customers to become self-sufficient. Read More

Idaho

Molina Expresses Interest in Joining Duals Demonstration. The Idaho Department of Health and Welfare announced that Molina Healthcare is interested in participating in the state's Medicare Medicaid Coordinated Plan dual demonstration project, with a projected start date of January 1, 2018. Molina has initiated outreach to Medicare and Medicaid providers in nine counties to establish a provider network to serve dual-eligible members. Read More

Illinois

CountyCare Reportedly Named a Winner in Medicaid Managed Care Procurement. *Crain's Chicago Business* reported on August 4, 2017, that CountyCare was named a winner of a managed care contract under the state's recent Medicaid managed care procurement. Another Cook County health plan, NextLevel Health, was reportedly unsuccessful and plans to appeal the award. There has been no public announcement of any awards outside of the *Crain's* article at this time. Read More

State Opposes Rate Increase for Providers of I/DD Services. *The New York Times* reported on August 4, 2017, that Illinois argued in U.S. District Court against a potential court-ordered increase in rates for providers serving individuals with developmental disabilities. Advocates have argued rates need to increase to ensure access to services, as mandated by a federal consent decree. However, the state says it already lacks enough money to pay off a $14 billion Medicaid claims backlog. The backlog stems from a two-year budget impasse, which was finally resolved last month. Read More

University of Chicago Medicine to End Contract with IlliniCare. *Chicago Tribune* reported on August 3, 2017, that the University of Chicago Medicine will no longer partner with Medicaid managed care organization IlliniCare Health, a Centene company, due to payment issues, effective September 3. IlliniCare CEO Michael Marrah disputes the payment issues, saying that the plan, "has continued to pay all of its providers in well under 30 days and with 99.9 percent accuracy." Northwestern Medicine and Advocate Health Care have also ended Medicaid contracts with IlliniCare. Read More

Iowa

State Seeks Federal Approval to Eliminate Retroactive Coverage. *Modern Healthcare* reported on August 8, 2017, that Iowa is asking federal regulators to allow it to eliminate retroactive Medicaid coverage, which allows individuals to receive coverage when they apply and providers to receive reimbursement for up to three months prior to approval. The request was made through an amendment to the state's Medicaid expansion waiver, submitted for approval to the Centers for Medicare & Medicaid Services (CMS). If approved, Iowa estimates that monthly enrollment would decline by more than 3,000 and annual Medicaid spending would drop approximately $37 million. CMS has granted similar requests to Arkansas, Kentucky, Indiana, and New Hampshire. CMS is accepting public comments on the proposal through September 7. Read More

Maine

Section 1115 Medicaid Waiver Application Calls for Work Requirements, Premiums, Asset Testing. *Think Progress* reported on August 3, 2017, that Maine has submitted an 1115 Medicaid waiver application asking federal regulators to approve work requirements, mandatory premiums, and asset testing for the state's MaineCare program. The work requirements would apply to able-bodied adult Medicaid beneficiaries, according to the application, submitted by the Maine Department of Health and Human Services to the Centers for Medicare & Medicaid Services (CMS). Six other states (Arizona, Arkansas, Indiana, Iowa, Michigan, and Montana) have received approval for Medicaid premiums; however, CMS has yet to approve work requirements for any state. Maine has not expanded its Medicaid program. Read More

Maryland

Evergreen Health Ordered Into Receivership After Investors Back Out. *The Baltimore Sun* reported on August 2, 2017, Evergreen Health. Inc has been ordered into Maryland's receivership program after LifeBridge Health, Anne Arundel Health System, and a group of private individuals pulled out of a deal to acquire the insurance company in July. The Baltimore Circuit Court ordered Risk and Regulatory Consulting LLC to assume control of the insurance company. The firm will continue to pay claims until all members' plans have expired, barring a new buyer. Read More

Massachusetts

Judge Places Insurer Minuteman Health Under State Control. *Boston Business Journal* reported on August 3, 2017, that the Massachusetts Supreme Judicial Court has placed Minuteman Health under state control after the insurer's level of cash reserves fell below state requirements. In 2016, the insurer's risk-based capital fell below the requirement of 150 percent; toward the end of the year, it was at 142 percent. Massachusetts Insurance Commissioner Gary Anderson was appointed to be the receiver of the insurer's assets. The insurer says nothing will change for members despite being under state control. In June 2017, Minuteman Health applied to be a for-profit insurer. Plans will remain in effect until December 31. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

CMS Approves New Jersey Medicaid 1115 Waiver Extension. The Centers for Medicare & Medicaid Services (CMS) has granted an extension of New Jersey's Section 1115(a) demonstration (11-W00279/2) entitled "NJ FamilyCare Comprehensive Demonstration." This approval is effective for five years from August 1, 2017, through June 30, 2022. The approval will enable the state to continue with its Comprehensive Waiver Demonstration for individuals who need long term services and supports (LTSS) and will transform the behavioral health system for adults. New Jersey Medicaid will further clarify the level of care requirements for children seeking long term services and supports under managed care. Children in managed long-term services and supports (MLTSS) today will be grandfathered if they do not meet the new level of care definition as long as they continue to meet other eligibility requirements for the program. The adult level of care criteria will remain unchanged. Further, the state plans to convert the Children with Serious Emotional Disturbance (SED) and Intellectual/Developmental Disabilities with Co-Occurring Mental Health Diagnosis (ID-DD/MI) pilot programs into the Children's Support Services Program (CSSP). It will also transition the Community Care 1915 (c) waiver to the 1115 (a) authority after the state has terminated the 1915 (c) waiver. The Delivery System Reform Incentive Payment (DSRIP) program will continue for an additional three years with plans to phase it out and transition to an alternative payment mechanism by June 30, 2020. The DSRIP program will build more accountability and improve quality metrics during the extension period. A copy of the CMS approval can be found here.

Division of Aging releases MIPPA RFP to fund Medicare Special Benefits Outreach and Enrollment Assistance. The Department of Human Services, Division of Aging Services (DoAS) has released a Request for Proposals (RFP) to fund up to 11 Area Agencies on Aging / Aging and Disability Resource Connections (AAA/ADRC) and State Health Insurance Assistance Program (SHIP) lead agencies. Awardees will be responsible for helping Medicare beneficiaries apply for Medicare Part D, the Part D Extra Help/Low-Income Subsidy (LIS), and the Medicare Savings Programs (MSPs). Funding also covers beneficiary education about free and reduced-cost preventive benefits covered by Medicare Part B. The DoAS will hold a voluntary technical assistance conference call about the RFP on August 16, 2017, at 10:00 am. Email Andrew.biederman@dhs.state.nj.us to register. A letter of interest must be submitted by 3:00 pm on August 14, 2017, with proposals due by 3:00 pm on September 8, 2017.

New Jersey Enacts Peggy's Law to Protect Older Adults Institutions Following Suspected Abuse. On August 7, 2017, Governor Christie signed into law a bill that requires caretakers, providers, and managed care representatives to immediately report to local law enforcement suspected abuse of an older adult living in an institution. In addition, the Ombudsman for the Institutionalized Elderly must ensure that a system is in place to receive complaints 24 hours per day, seven days per week. *NJSpotlight* reported on the bill passage here.

Three New Jersey Hospitals Receive Top Ratings in *U.S. News and World Report's* Annual Ratings. On August 22, 2017, the "Best Hospitals" report by *U.S. News and World Report* identified Hackensack University Medical Center, Morristown Medical Center, and Robert Wood Johnson University Hospital in New Brunswick as the top three best hospitals in the state. Hackensack ranked first in New Jersey and fourth best in the New York metropolitan region. Read more.

Medicaid Managed Care Annual Open Enrollment Period Notice Given. On August 1, 2017, the Department of Human Services, Division of Medical Assistance and Health Services issued a notice about its upcoming 2018 annual open enrollment period. The period begins October 1, 2017, and ends November 15, 2017. During this six-and-a-half week period members in a Medicaid managed care plan can change their current health plan. The new plan will take effect on January 1, 2018. The notice identified five health plan options:

1. **Aetna Better Health of New Jersey** (serving all counties except Cape May, Hunterdon, Monmouth, Ocean and Warren);
2. **Amerigroup Community Care** (serving all counties except Salem);
3. **Horizon NJ Health** (serving all counties);
4. **UnitedHealthcare Community Plan** (serving all counties); and
5. **WellCare Health Plans, Inc.** (serving Bergen, Essex, Hudson, Mercer, Middlesex, Morris, Passaic, Somerset, Sussex and Union counties).

A copy of the notice can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

Fully Integrated Duals Advantage Expands to Region 2. FIDA has expanded to Region 2 (Suffolk and Westchester Counties). As of July 1, two additional plans — Healthfirst and RiverSpring — have been approved to begin enrollment. The New York Department of Health Office of Long-Term Care and CMS co-hosted a meeting on the future of integrated care in New York. The state remains committed to an integrated approach to care for dual-eligible post-FIDA and has launched a stakeholder process to map a strategy to reach integration objectives. They hope to review the lessons learned from FIDA and obtain input into finding the best vehicle to drive one integrated care product, incorporating the best features of existing programs and envisioning the transition process. The state's presentation can be found on the MRT website, along with a presentation from the Integrated Care Resource Center on "Other State Approaches to Integrating Medicare and Medicaid for Dually Eligible Beneficiaries: Implications for the New York State FIDA Demonstration." Read More

New York Launches Regulatory Modernization Initiative. Governor Cuomo's executive budget included a proposal to establish a health care regulation modernization team, meant to review a whole host of regulations governing licensure and oversight of health care facilities. The goals were to increase the speed with which providers can complete construction projects; support the delivery of services across an integrated system of care; modernize regulations that ensure access and protect patient safety; and enhance collaboration between the state and health care providers. The proposal was rejected by the legislature and was not included in this year's budget. Nonetheless, the Department of Health has announced a comprehensive Regulatory Modernization Initiative with the goal of streamlining and updating existing policies and regulations across a range of areas to best meet the needs of payers, providers, and consumers in the years ahead. The Department will be convening a series of Policy Development Workgroup meetings to get input from a broad range of interested parties that will help inform potential policy and regulatory changes. These meetings will be open to the public and will be webcast. The first of the Workgroups to meet will focus on care management models that are emerging as a result of efforts to improve post-acute outcomes and reduce unnecessary hospital inpatient readmissions and emergency department visits. The Post-Acute Care Management Models Workgroup meeting was held on Wednesday, August 9, 2017, from 12:30 to 3:30 pm in Conference Room 6 on the Concourse Level of the Empire State Plaza in Albany. Future Workgroup meetings on other topics will be announced over the next several weeks.

Stony Brook Completes Merger with Southampton Hospital. Stony Brook University has welcomed Southampton Hospital, hereafter known as Stony Brook Southampton Hospital, as a member of the Stony Brook Medicine health system. As such, Stony Brook Southampton Hospital will now provide care under Stony Brook University Hospital's New York State operating license. As reported in *Crain's HealthPulse*, the merger, which was five years in the making, will have Stony Brook University Hospital taking over Southampton Hospital operations and paying Southampton a fee to lease its space. Southampton Hospital will move from its current location to Stony Brook

University's Southampton campus. Southampton Hospital's board will remain intact. Stony Brook Medicine integrates Stony Brook University's health-related initiatives: education, research and patient care. It includes six Health Sciences schools — Dental Medicine, Health Technology and Management, Medicine, Nursing, Social Welfare, and Pharmacy & Pharmaceutical Sciences — as well as Stony Brook University Hospital, Stony Brook Southampton Hospital, Stony Brook Children's Hospital, and more than 90 community-based healthcare settings throughout Suffolk County. Read More

Managed Long Term Care Workforce Investment Program Application Posted. The New York Department of Health has posted its Long Term Care Workforce Investment Organization Application. The Long Term Care Workforce Investment Program includes up to $245 million for initiatives to retrain, recruit, and retain healthcare workers in the long–term care sector. The initiative targets direct care workers, with the goals of supporting the critical long term healthcare workforce infrastructure through retraining, redeployment, and enhancing skillsets. Through the Workforce Investment Program, the Department of Health (DOH) will require MLTC plans to contract with DOH–designated workforce training centers to:

- invest in initiatives to attract, recruit, and retain long term care workers in the areas they serve;
- develop plans to address reductions in health disparities by focusing on the placement of long term care workers in medically underserved communities;
- consistently analyze the changing training and employment needs of the area that the program serves;
- provide for broad participation and input from stakeholders; and
- support the expansion of home care and respite care, enabling those in need of long term care to remain in their homes and communities and reduce New York´s Medicaid costs associated with long term care.

Participation is open to all eligible applicants statewide. Submissions are due by 3:00 pm August 28, 2017. Announcements are expected to be made September 28, 2017; however, all further dates are subject to change. Read More

New York Office for People with Developmental Disabilities Previews Care Coordination Organizations. The Office for People with Developmental Disabilities (OPWDD) hosted a webinar describing its move to "People First Care Coordination." Acting Commissioner Kerry Delaney outlined the reasons for the planned transformation, noting that public expectations have changed and people desire more customized services and a more flexible approach to care planning. She described a service coordination approach that would span multiple service systems, including the OPWDD system but also including physical health, behavioral health, and life support services. Care Coordination Organizations (CCOs), based on a health home model, which will provide multi-agency care coordination, are being established by groups of OPWDD providers in each region across the state. OPWDD envisions CCOs affiliating with managed care plans, ultimately shifting to a mandatory Medicaid managed care system, as most of New York's Medicaid program already requires. Voluntary pilot CCOs may begin operating as soon as next year, but the shift to a mandatory managed care system will happen gradually, with a

five-year transition planned. A recording of the webinar can be found on the OPWDD website. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Exchange Premiums may Rise Steeply in 2018. *Cleveland.Com* reported on August 2, 2017, that Ohio insurers are requesting 2018 Exchange premium increases averaging 20 percent or more. The Ohio Department of Insurance cautioned that the rates are not final and could change. The primary reason cited for the requested hike is increased medical costs. Read More

Disability Financial Assistance Program to End. *Cleveland.com* reported on August 7, 2017, Ohio is ending its Disability Financial Assistance program, which provides cash assistance to about 6,000 individuals waiting to receive federal disability benefits. The state contends that the program is no longer needed because Medicaid managed care plans can now expedite the process to acquire the federal benefit. The state stopped accepting new applications in July and benefits will end this year for anyone already enrolled. The program was aimed at individuals with disabilities who had little to no income. Read More

Cleveland Clinic Forms Partnership with Molina amid CareSource Negotiations. *Cleveland.com* reported on August 2, 2017, the Cleveland Clinic has signed an agreement with Molina Healthcare to provide Molina's Medicaid patients with access to the health system amid a potential contract separation with CareSource, the state's largest Medicaid managed care plan. The agreement marks the first partnership to serve Medicaid beneficiaries between the two organizations. Cleveland Clinic will cease services to CareSource members unless an agreement is reached before September 1, 2017. The Molina partnership is not related to the CareSource negotiations, according to Cleveland Clinic officials. Read More

Oregon

Oregon Health Authority Director Resigns Amid Scandal. Oregon Health Authority (OHA) Director Lynne Saxton resigned on August 8, 2017, at the request of the Governor, in the wake of a scandal involving the Department's proposed plan to discredit one of the 16 Coordinated Care Organizations (CCOs) that serve Medicaid recipients. OHA and the FamilyCare CCO have had a difficult relationship, with FamilyCare suing the state over capitation rates and a sometimes vocal FamilyCare chief publicly criticizing the Department. A public records request revealed that earlier this year OHA put together a plan to damage FamilyCare's reputation by getting outside lobbyists and legislators to pitch anti-FamilyCare stories to the press. The plan wasn't put into place but this reflects poorly on the Department, particularly in the middle a FamilyCare lawsuit in which the CCO is accusing OHA of unfairly disadvantaging the CCO in its rate-setting. Saxton has been the director for three years, and under her watch the state has rolled out an eligibility and enrollment system that was significantly more expensive and bug-ridden than anticipated. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Eases Highmark's Reporting Requirements for Allegheny Health Investments. On July 28, 2017, Insurance Commissioner Teresa Miller approved elements of a request from Highmark to reduce approval/notification requirements regarding its acquisition Allegheny Health Network (AHN). Beginning with Highmark's acquisition of AHN in 2013, state insurance regulators required Highmark to gain approval before investing $250 million or more in AHN in a 12-month period. Highmark also had to notify state regulators of transfers worth $100 million or more. However, Highmark recently requested the requirements be lightened to "respond more quickly to changes in the healthcare landscape, and thus provide more healthcare options to consumers." Under the requirement's modification, Highmark can invest in the AHN system without approval or notification to the state if the expenditure doesn't surpass 10 percent of the payer's surplus. Highmark's surplus totals $3.9 billion. Pennsylvania Insurance Commissioner Teresa Miller said the change "will still require Highmark Inc., at all times, to maintain sufficient risk-based capital to pay all claims submitted by its health insurance customers." Read More

DHS Notifies 100,000 Medicaid Consumers in Region of Pending Changes. On August 4, 2017, the *Pittsburgh Post-Gazette* reported that the Pennsylvania Department of Human Services began mailing flyers to about 100,000 aged and disabled residents in southwestern Pennsylvania. This population, eligible for Medicaid funded long-term services and supports, will be the first in the state to be transferred into the new Community HealthChoices managed care program. Those who qualify will be expected to choose from the three state-contracted managed care organizations to coordinate their health and long-term care services: AmeriHealth Caritas, UPMC Community HealthChoices, and PA Health & Wellness. The state has a large task in educating consumers about the coming changes and decisions. Some 20 public information sessions are anticipated in September and October in the counties affected on January 1, which will be followed by a broader state roll-out that ultimately affects some 400,000 Pennsylvanians. Read More

Tennessee

Correctional Health Contract Could Top $473 Million Due to Rising Hepatitis C Expenditures. The *Tennessean* reported on August 7, 2017, that rising Hepatitis C-related expenses could drive the cost of a newly awarded Tennessee correctional health contract as high as $473 million over five years. The state's Department of Corrections, however, predicts the contract will not top $460 million. Tennessee awarded the new contract to Centurion of Tennessee, a joint venture of Centene Corp. and MHM Services, which has provided correctional health services in the state since 2013 under a three-year deal worth $270 million. The new contract takes effect in September 2017. Concerns over rising costs stem from a class-action lawsuit filed by inmates alleging that the state was not providing adequate treatment for individuals with Hepatitis C. Read More

Texas

House Approves Bill to Reverse Medicaid Cuts to Children's Therapy Services. *The Texas Tribune* reported on August 3, 2017, that the Texas House unanimously passed a bill that would partially reverse a cut to disabled therapy services for children with disabilities. House Bill 25 would restore $160 million in Medicaid reimbursement rates for speech, physical, and occupational therapists, whose rates were cut in 2015 by $350 million. The bill now heads to the Senate. Despite the House's approval, the bill is reportedly not on Governor Greg Abbott's agenda for the special session. Read More

Washington

Federal Evaluation of Duals Demo Show Positive Results in Quality and Cost. *Modern Healthcare* reported on August 2, 2017, that the state's dual eligible demonstration has been found to improve care for dual eligibles and produce significant savings despite struggles locating and enrolling individuals. According to a federal evaluation, Washington, one of the first states to launch a demonstration in 2013, realized $60 million in Medicare savings and saw a $93 million reduction in Medicaid spending on hospital services under the demonstration. Read More

National

CMS Will Provide Hospitals $2.4 Billion Payment Increase and Recalculate Uncompensated Care Payments. *Modern Healthcare* reported on August 2, 2017, that the Centers for Medicare & Medicaid Services (CMS) issued a final rule that increases payments to inpatient hospitals by $2.4 billion and changes the reimbursement method for uncompensated care. The calculation for uncompensated care will use new data to estimate the rate of uninsurance rather than the number of Medicaid, dual-eligible, and patients with disabilities each hospital serves. According to the Medicare Payment Advisory Commission, the rule is expected to more equitably distribute funds to safety net hospitals; however, opponents of the rule estimate that more than 500 hospitals would see at least a 50 percent decrease in uncompensated payments. Read More

CMS Withdraws Proposed Rule Requiring Private Accreditation Organizations to Release Reports Publicly. *Modern Healthcare* reported on August 3, 2017, that the Centers for Medicare & Medicaid Services (CMS) has withdrawn a proposed rule that would have required private accreditation organizations to publicly release their reports on health care facilities. The rule was initially introduced in April and was met with backlash from industry stakeholders, who argue that the rule would confuse consumers, ruin relationships with the providers, and be an administrative burden. The Joint Commission estimated it would cost $3.7 million in the first year and $2.3 million in subsequent years. Patient safety experts, however, said the rule would have encouraged providers to improve quality outcomes due to transparency. Read More

Industry News

Anthem to Exit Nevada Exchange, Reduce Georgia Presence. *CNN Money* reported on August 7, 2017, that Anthem is withdrawing from the Nevada health insurance Exchange and is reducing its presence in Georgia by half. Anthem will remain in about 85 Georgia counties where it is the sole Exchange insurer. Anthem blamed uncertainty over the future of cost-sharing subsidies and the insurer tax. Read More

Judge Grants Molina $52 Million in Risk Corridor Payments. *The Washington Examiner* reported on August 4, 2017, that a U.S. Court of Federal Claims Judge ruled that Molina Healthcare is owed $52 million in federal risk corridor payments. The risk corridor program was deigned to help offset financial losses that health plans might incur on the Affordable Care Act insurance Exchange. Like many participating plans, Molina incurred losses from 2014 to 2015, but never received payment. Read More

All Metro Health Care Acquires Independence Healthcare Corp. One Equity Partners announced on August 9, 2017, that portfolio company All Metro Health Care has acquired Independence Healthcare Corp., a private in-home health care agency based in Worcester, Massachusetts. Independence Healthcare offers home care services to seniors throughout central Massachusetts, including meal preparation, personal care assistance, companion care, and transportation. The terms of the transaction were not disclosed. Read More

Community Health Systems Looks to Sell More Hospitals Following 2Q17 Financial Loss. The *Nashville Business Journal* reported on August 2, 2017, Community Health Systems (CHS) is looking to sell an additional group of hospitals worth $1.5 billion in revenue after reporting a loss of $137 million in the second quarter of 2017. In the previous quarter, the health system sold 20 hospitals and came to an agreement to sell an additional 10 hospitals, bringing its debts down to $14.7 billion. Read More

FDA Approves New AbbVie Hepatitis C Treatment. *ABC News* reported on August 3, 2017, that the Food and Drug Administration (FDA) has approved Mavyret, a new drug from AbbVie Inc. that treats all six forms of Hepatitis C and is priced below other treatment options. Both the federal government and private insurers have been struggling with the cost of Hepatitis C drugs. 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
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
Summer/Fall 2017	Ohio MLTSS	RFA Release	130,000
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 (Centene); 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%**	

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA News

HMA/HMA-MMS to Present World Congress Webinar on Indiana's HIP 2.0 – Thursday, August 10, 2017 – 2 PM Eastern

On Thursday, August 10, 2017, at 2:00 PM Eastern, HMA's Pat Casanova and HMA Medicaid Market Solutions' Amanda Schipp will present a webinar hosted by World Congress on the Health Indiana Plan (HIP) 2.0 waiver and its potential as a model for other state waivers under the current CMS administration. The webinar will cover what has worked well in Indiana and lessons that can be learned from a non-traditional expansion. **Link to Webinar**

Role of Behavioral Health Integration in Medicaid Care Management to Be Topic of Roundtable Discussion at HMA Conference in Chicago

Representatives of health care providers along with a leading insurance company will highlight behavioral health integration efforts that have successfully driven improvement in care management and coordination for Medicaid and other vulnerable populations.

The session will take place at 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**.**

Speakers include Patrick Gordon, associate vice president, Rocky Mountain Health Plan, a UnitedHealthcare company; Tamara Hamlish, executive director, ECHO-Chicago, Project Manager, HepCCATT; Virna Little, senior vice president, Psychosocial Services and Community Affairs, Institute for Family Health; and Joe Parks, MD, medical director, The National Council for Behavioral Health.

More than 350 are already registered to attend the event, which will features 37 industry-leading speakers and address the challenges and opportunities of serving Medicaid and other vulnerable populations given the priorities of the new Administration and Congress

Registration is filling up fast. Visit the conference website for complete details: https://2017futureofmedicaid.healthmanagement.com/ or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates are available.