HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 8, 2017

RFP CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

ARIZONA, KANSAS MEDICAID MANAGED CARE RFPS REVIEWED

This week, our *In Focus* section reviews two Medicaid managed care requests for proposals (RFPs) released on November 2, 2017. The Arizona Health Care

Cost Containment System (AHCCCS) issued an RFP for the "Complete Care" program, which will integrate Medicaid managed care for physical and behavioral health as well as replace the state's long-standing Acute Care Medicaid managed care program. It will cover approximately 1.5 million Medicaid members. Meanwhile, the Kansas Department of Health and Environment and Department for Aging and Disability Services issued an RFP for KanCare 2.0 Medicaid and Children's Health Insurance Program (CHIP) Capitated Managed Care, which will serve approximately 403,000 members.

Arizona "Complete Care" RFP

Arizona will integrate Medicaid managed care for physical and behavioral health and replace the state's long-standing Acute Care Medicaid managed care program on or after October 1, 2018. Long-term services and supports are not included under this RFP and are managed separately under Arizona's Long Term Care System (ALTCS) managed care program. Under the RFP, annual capitation payments to MCOs are expected to be approximately $4.5 billion and plans are expected to collectively enroll roughly 1.5 million Medicaid members. The RFP covers the three Geographic Service Areas (GSAs) that comprise all fifteen Arizona counties.

Covered Populations

AHCCCS Complete Care contractors will cover most Medicaid-eligible adults and children, including children with special health care needs, as well as members with a serious mental illness who opt out of the existing Regional Behavioral Health Authorities (RBHAs). The Complete Care contractors will not enroll foster children enrolled in the Comprehensive Medical & Dental Program or individuals with developmental disabilities (IDD). A separate IDD integrated care RFP is expected in spring 2018.

Contract Term

The initial term of the contract is three years with two two-year optional extensions, for a full potential term of seven years. Implementation of the contracts is expected on or after October 1, 2018.

Risk Corridors and Quality Withhold

Under the RFP, contractors will retain all profits less than or equal to 2 percent of revenue; half of profits more than 2 percent and less than or equal to 6 percent of revenue; and none of the profits greater than 6 percent of revenue. Contractors are responsible for all losses less than or equal to 2 percent of revenue and none of the losses greater than 2 percent of revenue.

Arizona Complete Care Risk Corridors		
Profit	MCO Share	State Share
<= 2%	100%	0%
>2% and <=6%	50%	50%
>6%	0%	100%
Loss	MCO Share	State Share
<= 2%	100%	0%
>2%	0%	100%

Contracts will include a quality-based withhold of 1 percent of an MCO's capitation rates. Additionally, MCOs may receive incentive payments up to 5 percent of capitation rates.

Additional RFP Details

- **D-SNP Requirement:** Contractors are required to have a Dual Eligible Special Needs Plan (D-SNP) for all counties in the contracted Geographic Service Area.
- **Contract changes based on Federal actions:** Arizona may alter contracts that result from this RFP based on Federal changes to Medicaid and CHIP. Changes could result from the following:
    - Creation of a new, non-Medicaid program to insure individuals currently covered through Medicaid expansion and the Exchange.
    - Adding work requirements to Medicaid. Arizona plans to submit an 1115 waiver adding work requirements in their Medicaid program to the Centers for Medicare & Medicaid Services by the end of 2017.
- **Regional Behavioral Health Authorities' (RBHAs) Option to Become a Complete Care Contractor:** The state intends to allow RBHA contractors the option to become a complete care contractor if they are not affiliated with an awardee in the same GSA. The term of expanded services would be the remaining RBHA contract term. Additionally, if a successful bidder is awarded a contract in the same GSA as an affiliated organization at the time of the award, a single legal entity must be established.

Scoring and Number of Anticipated Contractors

The *Capitation – Non-Benefit Costs* proposal section will be scored by GSA and the *Programmatic* proposal portion of the proposal, which includes the narrative submission requirements and oral presentations, will be scored statewide. Each of these scores will be weighted separately then added for a final score by GSA. A successful offeror must accept or decline all awarded GSAs. Prospective offerors are not required to include all GSAs in their proposals.

The state anticipates awarding Complete Care contracts as follows.

Anticipated # of Awards by GSA		
GSA	Counties Included	# of Awards
North GSA	Mohave Coconino Apache Navajo Yavapai (excludes zip codes 85542, 85192, and 85550)	2
South GSA	Cochise Graham Greenlee La Paz Pima Santa Cruz Yuma (includes zip codes 85542, 85192, and 85550)	Entire GSA - 2; At least 1 additional award in Pima County only
Central GSA	Maricopa Gila Pinal	At least 4

RFP Timeline

A pre-proposal bidders conference is scheduled for November 8, 2017. Proposals are due January 25, 2017.

RFP Activity	Date
Issue Request for Proposal	November 2, 2017
Pre-proposal Prospective Offerors Conference	November 8, 2017
First Set of Questions Due	November 14, 2017
Second Set of Questions Due	December 8, 2017
Proposal Due Date	January 25, 2017
Contract Awards	On or Before March 28, 2018
Implementation	On or After October 1, 2018

Current Market

Arizona currently has separate Medicaid managed care programs for acute care and behavioral health. Seven acute care plans serve 1.6 million Medicaid members. As of September 2017, UnitedHealth, Mercy Care Plan, and Health Choice held the largest market share, with 34 percent, 25.4 percent, and 16.7 percent, respectively.

While the state's three RBHAs manage behavioral health for most members, these organizations manage both behavioral health and physical health for individuals with a serious mental illness. Cenpatico Integrated Care (Centene), Health Choice Integrated Care, and Mercy Maricopa Integrated Care currently hold RBHA contracts.

The Children's Rehabilitative Services (CRS) program currently serves children with qualifying serious medical conditions. The contract is held by United.

With the implementation of contracts resulting from the RFP, the terms "acute care contractor," "CRS contractor," and "RBHA contractor" will be replaced by "AHCCS Complete Care Contractor."

Arizona Managed Acute Care and CRS Enrollment Share by Plan, 2011-16, September 2017	
Plan	Sep-17
UnitedHealth/Maricopa Health Plan/CRS Total	529,022
UnitedHealth/Maricopa Health Plan	512,439
CRS	16,583
% of total	*34.0%*
(Dignity) Mercy Care Plan/Mercy Maricopa Integrated Care[1]	395,067
% of total	*25.4%*
Health Choice/Health Choice Integrated	259,431
% of total	*16.7%*
UPH (Univ. Family Care)	135,000
% of total	*8.7%*
Care 1st Arizona (WellCare)	151,064
% of total	*9.7%*
DES Foster Care (CMDP)[2]	15,228
% of total	*1.0%*
Centene/Cenpatico Integrated Care/Health Net	72,719
% of total	*4.7%*
Total	1,557,531

1. Aetna has an ASO management agreement with Mercy Care/Dignity Health.
2. Governmental entity

Source: AHCCCS, HMA

Link to RFP/Bidders Library

https://www.azahcccs.gov/PlansProviders/HealthPlans/YH19-0001.html

KanCare 2.0 Managed Care RFP

As of January 1, 2019, Kansas will contract with Medicaid managed care organizations to provide coverage to the state's Medicaid and CHIP beneficiaries. The RFP will ensure coordination of care and integration of physical, behavioral, long term services and supports (LTSS), and home and community-based services (HCBS). When fully implemented, annual spending is estimated to be at least $3 billion across all MCOs. The contract will be effective through December 31, 2023. The RFP was initially expected to be released in 2016, but the state delayed it to see what policy changes the Trump Administration might make.

Pending CMS approval, Kansas is considering adding a work requirement for able-bodied adults in KanCare 2.0. This work requirement will be implemented as soon as possible on or after January 1, 2019, and no later than July 1, 2020.

Covered Populations and Market Size

The KanCare 2.0 program will continue to cover parents, pregnant women, children, individuals with intellectual/developmental disabilities (IDD), individuals with physical disabilities (PD), individuals with Severe and Persistent Mental Illness, and the older adults. Almost all Medicaid beneficiaries and 100 percent of CHIP beneficiaries will enroll in a MCO of their choosing. Approximately 323,000 parents, pregnant women, and children; 44,000 individuals with disabilities; and 67,000 older adults will be covered. Under a 1915(c) HCBS waiver, KanCare covers:

- Children with autism;

- Children and adults with intellectual and developmental disabilities (IDD);
- People ages 16–64 with PD;
- Medically fragile children ages 0–22 dependent on intensive medical technology (TA);
- People ages 16–64 with traumatic brain injuries (TBI);
- People ages 65 and older who are functionally eligible for nursing facilities (NF); and
- Children with a serious emotional disturbance (SED).

MCOs will be required to report separately on expenditures and utilization for behavioral health, physical health, LTSS, and HCBS. They must also report performance measurement data, including performance measures relating to quality of life, rebalancing, and community integration activities for LTSS members.

Certain Medicaid beneficiaries including dual eligibles (Medicare and Medicaid), foster care children, and children with disabilities may be voluntarily enrolled.

RFP Requirements

MCOs are required to bid for all populations, services, and regions of the state. The state is also requiring bidders to implement Value Based Purchasing (VBP) models and strategies, including helping members access affordable housing, food security, employment, and other Social Determinants of Health and Independence; increasing employment and independent living supports for members with behavioral health needs or who have IDD/TBI; and providing service coordination for all youth in foster care.

RFP Timeline

Contracts will be effective January 1, 2019, through December 31, 2023, with enrollment beginning prior to November 1, 2018. Proposals are due January 5, 2018.

RFP Milestone	Date
RFP Released	November 2, 2017
Pre-Proposal Conference	November 20, 2017
Proposals Due	January 5, 2018
Contract Awards	TBD
Implementation	January 1, 2019

Current KanCare Market

Kansas currently contracts with three Medicaid plans: Centene/Sunflower State Health plans, Anthem/Amerigroup, and UnitedHealthcare. Enrollment was nearly 381,000 as of September 2017.

KanCare MCO	Sep-17 Enrollment	Market Share
Centene/Sunflower State Health Plan	127,193	33.4%
UnitedHealthCare of the MW	131,796	34.6%
Anthem/Amerigroup/UniCare	121,824	32.0%
Total KanCare Enrollment	**380,813**	

RFP, 1115 Waiver Request Links

Link to RFP EVT0005464

Link to 1115 Waiver

HMA Medicaid Roundup

Alabama

State Chooses Not to Award Contract for Medicaid Dental Benefit Manager. The Alabama Medicaid Agency announced on October 31, 2017, that it will not award a contract for a dental benefit manager (DBM). The announcement comes more than three months after the state issued a request for proposal on July 27, 2017, for a DBM to administer dental benefits as a risk-bearing Prepaid Ambulatory Health Plan. The Alabama Medicaid Dental Program currently pays for routine dental care for children under the age of 21.

California

Medi-Cal Officials Want to Recoup Some Insurer Profits Under ACA. The *Los Angeles Times* reported on November 5, 2017, that health insurers serving the Medi-Cal program profited approximately $5.4 billion under the Affordable Care Act (ACA), with some insurers making two or three times more than predicted targets. The unanticipated high profits are being attributed to lower-than-expected Medicaid costs for newly insured members, as well as poor quality performance on the insurer end. California officials intend to recoup some of the money within the next year. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Medicaid Managed Care ITN Respondents Identified. The Florida Agency for Health Care Administration (AHCA) publicized respondents to the recent Invitation to Negotiate (ITN) for the statewide Medicaid managed care (SMMC) program. Aetna Better Health of Florida, Clear Health Alliance, Coral Care, Florida Community Care, Health Advantage Florida, Horizon Health Plan, Humana Medical Plan, Lighthouse Health Plan, Magellan Complete Care, Miami Children's Health Plan, Molina Healthcare of Florida, Our Children PSN of Florida, PHC Florida, Prestige Health Choice, Simply Healthcare Plans, Staywell Health, Plan of Florida (WellCare), Sunshine Healthcare Plans (Centene), UnitedHealthcare of Florida, and Wellmerica all submitted a response.

Legislature Cuts $521 Million in Medicaid Funding for Hospitals. *Health News Florida* reported on November 3, 2017, that the Florida legislature agreed to cut $521 million in Medicaid funding for hospitals. The Agency for Health Care Administration also proposed additional funding cuts for hospitals, including the elimination of automatic rate enhancements. Read More

Georgia

State May Seek 1332 Innovation Waivers Next Year. *Rome-News Tribune* reported on October 31, 2017, that Georgia may seek waivers to alter some of Affordable Care Act (ACA) mandates, including alternatives to Medicaid expansion and improved preventive care and disease management. Georgia's Health Care Reform Task Force is expected to recommend that the General Assembly seek waivers from the Trump administration in the legislative session next year. Read More

Idaho

State Seeks Waivers to Expand Coverage, Create Complex Needs Program. *CQ Healthbeat News* reported on November 6, 2017, that Idaho plans to submit two federal waiver requests, one Section 1332 waiver and one Section 1115 waiver, to the Centers for Medicare & Medicaid Services (CMS) that would expand Exchange eligibility for working residents, as well as create a complex needs program. The 1332 waiver proposal would expand Exchange tax credit and cost-sharing reduction (CSR) payment eligibility for 78,000 working residents with incomes below 100 percent of the federal poverty level (FPL). The proposed 1115 waiver would create a complex needs program for Medicaid beneficiaries with incomes below 400 percent of the FPL with certain chronic conditions. The state contends that moving this population from the Exchange to Medicaid would save the state money through federal subsidies. The federal waiver applications are open to public comment.

Illinois

Cook County Health and Hospital System Proposes $12 Million in Reductions, Considering Additional Cuts. *The Chicago Sun Times* reported on November 7, 2017, that Cook County Health and Hospital System has proposed approximately $12 million in reductions in the FY2018 executive budget recommendation. The proposed cut, which is seeking to fill part of a $200 million budget hole, is short $15 million of the county commissioner's target. Cook County is contemplating further actions to address the budget shortfall. Read More

Indiana

Allison Taylor Named New Medicaid Director. The Indiana Family and Social Services Administration (FSSA) announced on November 6, 2017, that Allison Taylor, J.D., will become Indiana's new Medicaid Director. Since May of this year, Taylor has been acting as the interim Medicaid Director. Read More

Iowa

State to Pay Additional $60 Million to Continue Medicaid Managed Care Program. *Associated Press/Miami Herald* reported on November 2, 2017, that Iowa will pay an additional $60 million to continue the state's Medicaid managed care program. Using the surplus from the previous budget year, the

state's Department of Human Services (DHS) will pay the two remaining insurers in the program approximately $20 million in direct capitation rates, with the remainder to be used for carved-out drug expenses and the implementation of internal cost savings strategies. The federal government will contribute an additional $80 million, adding up to $140 million in additional funds. Read More

Louisiana

House Republicans Block Medicaid MCO Contract Extensions. *The Advocate* reported on November 3, 2017, that Louisiana House Republicans have blocked Medicaid managed care contracts from being extended for an additional 23 months in an 18-6 vote. Lawmakers cited the $15.4 billion cost in federal and state funding, accounting for approximately one-quarter of the state's operating budget. The contracts are slated to expire in January. Another meeting on the proposals is expected in December. Lawmakers say contract approval will still likely pass, but Republican members hope it will be with cost-saving changes. Read More

Maine

Voters Approve Ballot Initiative to Expand Medicaid. *Bangor Daily News* reported on November 7, 2018, that Maine will expand Medicaid after nearly 60 percent of voters approved the expansion ballot initiative. The Legislature's Office of Fiscal and Program Review estimates that Maine will require an annual state appropriation of nearly $55 million and an annual federal appropriation of $525 million to cover the 70,000 people that would now be covered. Governor Paul LePage (R-ME) announced that he will not expand Medicaid in Maine unless it is fully funded by the state legislature at the levels calculated by the state's Department of Health and Human Services (DHHS). Read More

Montana

HMA Roundup – Rebecca Kellenberg (Email Rebecca)

Governor Calls Special Session to Address Budget Shortfall. Governor Steve Bullock has called the Montana Legislature into special session to address a projected $227 million budget shortfall. The legislature will convene on Tuesday, November 14. Committee hearings will be held next Monday to consider the Governor's proposed solutions. The Governor is recommending cutting $76.6 million in general fund spending, including $49 million in cuts from the Department of Public Health and Human Services. The proposal also includes temporarily raising some taxes, and other costs savings measures to cover shortfall in tax revenues and the most expensive wildfire season in state history. Read More

New Hampshire

State Submits 1115 Waiver Application, Includes Medicaid Work Requirements. *Modern Healthcare* reported on November 3, 2017, that New Hampshire submitted a Section 1115 waiver application to the Centers for

Medicare & Medicaid Services (CMS) that would add work requirements to the state's Medicaid program. New Hampshire previously submitted a similar waiver that was rejected by the Obama administration. The waiver, if approved, would require adult Medicaid beneficiaries to be working, training for a job, actively searching for a job, or participating in other work-related activities for up to 30 hours per week in order to continue to receive coverage. Arkansas, Arizona, Kentucky, Maine, Indiana, Utah, and Wisconsin are also seeking to implement work requirements for Medicaid members. Read More

North Carolina

State Releases Managed Care RFIs. The North Carolina Department of Health and Human Services released on November 2, 2017, two Requests for Information (RFIs) on transitioning the state's Medicaid and NC Health Choice programs to managed care, as mandated by the general assembly in 2015. One RFI addresses managed care operations and the other addresses the financial aspects of managed care. Responses to the Managed Care Program Operations RFI are due November 22, 2017, and a non-binding statement of interest is due December 1. Responses to the Managed Care Program Actuarial RFI are due December 1, 2017. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Owes $29.5 Million to Federal Government For Unallowable Bonus Payments. The *Columbus Dispatch* reported on November 7, 2017, that the Office of the Inspector General of the Department of Health and Human Services has issued a finding of $29.5 million to the Ohio Department of Medicaid. From 2010 through 2013, Ohio received bonus payments for enrolling children in the Medicaid Program. The report found that Ohio overstated the number of children enrolled by including children who are blind or disabled in the count. Read More

Oregon

Governor Seeks $64 Million Medicaid Repayment. *The Oregonian* reported on November 7, 2017, that Oregon Governor Kate Brown is seeking $64 million in Medicaid repayments from the state's coordinated care organizations (CCOs). The governor's office became aware of overpayments to CCOs in mid-October. In a public statement on the issue last week, Governor Brown initially did not call for repayments, but has since changed her stance, after State Representative Knute Buehler wrote a letter calling for action on repayment. Governor Brown asked Patrick Allen, acting director of the Oregon Health Authority, to "take swift action and have zero tolerance for the waste of their taxpayer dollars." She also requested Allen to submit a written report on the issue every two weeks and build a transparency website with public documents related to the matter. The overpayments occurred because the state incorrectly enrolled Medicare-eligible individuals into Medicaid between 2014 and 2016. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Postpones Phase 2 and Phase 3 Rollout of Community HealthChoices. Pennsylvania Department of Human Services (DHS) Acting Secretary Teresa Miller and Department of Aging Secretary Teresa Osborne sent a message to stakeholders updating the Community HealthChoices (CHC) implementation timeline. CHC is the commonwealth's new managed long-term services and supports program for older Pennsylvanians and individuals with physical disabilities and is being implemented in three phases. For Phase 1, notices have been mailed to participants in the 14 counties in the Southwest Zone to inform them that they will move to CHC on January 1, 2018. Phase 1 is expected to include approximately 80,000 people. The deadline for Phase 1 participants to select an MCO is November 13th; currently around 25 percent of eligible members have already made a plan choice. Secretaries Miller and Osborne say they are "confident" in the Phase 1 rollout, but would prefer more time to adjust based on lessons learned for Phases 2 and 3. The commonwealth has decided to shift the implementation dates for the next two phases of CHC. The new start dates are as follows: Phase 2 will now begin on January 1, 2019, instead of July 1, 2018; Phase 3 will now begin on January 1, 2020, instead of January 1, 2019.

Puerto Rico

Puerto Rico Asks Trump Administration for $1.6 Billion in Annual Medicaid Funding. *The New York Times* reported on November 2, 2017, that Puerto Rico Governor Ricardo Rossello has asked the Trump administration for $1.6 billion annually for at least five years to help fund Medicaid. Puerto Rico is expected to run out of Medicaid funding in early 2018, which could leave 900,000 individuals without health care coverage. A dozen Democratic senators and Senator Marco Rubio (R-FL) have expressed support for additional funding. Separately, the Trump administrations is working on a longer term plan for Medicaid in Puerto Rico. Read More

Utah

Medicaid Expansion Waiver Approved. *The Salt Lake Tribune* reported on November 1, 2017, that a Medicaid expansion waiver submitted by Utah was approved by the Centers for Medicare & Medicaid Services (CMS). The waiver will allow the state to cover an additional 6,000 low-income adults without children who earn no more than five percent of the federal poverty level and are deemed "chronically" homeless or in the criminal justice system. It is the first time adults without dependents will be able to get Medicaid in the state. Utah submitted the waiver in July 2016, originally expecting to enroll individuals beginning January 1, 2017. The expansion includes $70 million in annual federal funding and $30 million in state funding. Read More

Virginia

Medicaid Costs to Rise $670.6 Million Over Three Years. *The Richmond Times-Dispatch* reported on November 6, 2017, that Virginia's Medicaid costs are

expected to rise $670.6 million over three years, and, unless federal Children's Health Insurance Program (CHIP) funding is restored, this cost may rise an additional $195.3 million. Virginia's CHIP program is called Family Access to Medical Insurance Security (FAMIS), which covers 67,000 children and almost 1,100 pregnant women. It is currently slated to end unless funding is restored. Overall Medicaid growth is expected to slow once the state moves ahead with reforms to expand Medicaid managed care. Costs will rise 2.5 percent in the first year and 3.4 percent in the second, compared with a 7.8 percent increase in costs in the current fiscal year. Read More

National

CMS Issues New Guidelines to Expedite Medicaid Waiver, State Plan Amendment Approval Process. *CQ* reported on November 6, 2017, that the Centers for Medicare & Medicaid Services (CMS) issued new guidelines in order to expedite the approval process of Medicaid waivers and state plan amendments (SPAs). CMS will establish a fast track process and make improvements in the review, approval, monitoring, and evaluation process of 1115 waivers. It will also work to reduce the SPA backlog; expand the use of MACPro, a web-based system for the submission, review, and disposition of SPAs; provide earlier waiver and SPA review; and provide a toolkit of preprints, templates, checklists, and other guidance. CMS hopes to increase efficiency and transparency. Read More

Verma Announces Administration's Support for Medicaid Work Requirements. *CQ* reported on November 7, 2017, that Seema Verma, Centers for Medicare & Medicaid Services (CMS) administrator, announced President Donald Trump's administration's support for Medicaid work requirements at the annual National Association of Medicaid Directors (NAMD) conference. Verma emphasized providing states more flexibility to run their programs and said, "we will approve proposals that promote community engagement activities." Under the new guidelines released by CMS, states can request approval for certain Section 1115 waiver demonstrations for up to 10 years. Meanwhile, the agency will work to expedite the approval process. Verma also stated that CMS will develop quality scorecards to track and publish state and federal Medicaid outcomes. Read More

House Passes CHIP, FQHC Funding Bill. *Modern Healthcare* reported on November 3, 2017, that the House voted to pass the Healthy Kids Act, extending funding for the Children's Health Insurance Program (CHIP) for five years. The program provides care to 8.9 million children and 370,000 pregnant women. The bill, which now moves onto the Senate, also extends funding for federally qualified health centers (FQHCs) for two years. Read More

Early Exchange Enrollment Reportedly Sets Record High Compared to Prior Years. *The Hill* reported on November 6, 2017, that a record number of individuals have reportedly signed up for Exchange coverage in the first few days of the open enrollment period this year compared to the same period in previous years. This enrollment surge comes despite cuts in funding for outreach and advertising. On the first day of open enrollment, more than 200,000 people selected a plan for next year and 1 million people visited the healthcare.gov website. In 2016, 100,000 people enrolled in a plan and 750,000 people visited the site. However, it remains uncertain how final enrollment

numbers will be affected by the cut in funding and shortened enrollment period as early signups are often people renewing coverage. Read More

House Unlikely to Repeal ACA Individual Mandate in Tax Bill. *The Hill* reported on November 6, 2017, that House Republicans are unlikely to repeal the Affordable Care Act individual mandate in the tax-reform bill. House Ways and Means Committee Chairman Kevin Brady (R-TX) stated that lawmakers are worried about jeopardizing the broader tax-reform bill. However, no final decision has been made. Some lawmakers say the mandate may still be repealed in the future, possibly through the Senate. President Donald Trump is also considering taking executive action if Congress does not repeal it. Read More

Republicans Criticize CBO for Revised Individual Mandate Repeal Score. *The Hill* reported on November 7, 2017, that the Congressional Budget Office (CBO) has changed its savings estimate of the Affordable Care Act (ACA) individual mandate repeal in a revised analysis expected later this week. Congressional Republicans hoping to repeal the mandate are already criticizing the CBO over the revisions, with Senator Mike Lee (R-UT) proposing the "CBO Show Your Work Act of 2017," which would require the CBO to publish information on how it comes up with its analyses. However, Senator Tom Cotton (R-AR), said that the newest score would reflect recent changes, and estimates savings would still be over $300 billion. The previous CBO score of the repeal projected $416 billion in savings and 15 million more uninsured people. Read More

Industry News

Swedish to Step Down as Anthem CEO, Boudreaux Named as New President and CEO. Anthem announced on November 6, 2017, that Gail K. Boudreaux will be named president and CEO of Anthem and appointed to the company's board of directors, effective November 20. Joseph R. Swedish, the current chairman, president, and CEO, will serve as executive chairman of the board of directors until May 2018, at which point he will act as a senior advisor through May 2020. Read More

McLaren to Acquire MDwise. *Crain's Detroit Business* reported on November 2, 2017, that Michigan-based McLaren Health Care Corp. will acquire Indiana-based MDwise. Collectively, MDwise and McLaren Health Plan will serve over 620,000 individuals. The deal is expected to close at the end of the year. Financial details were not disclosed. The move is part of McLaren's push to acquire health plans, physician groups, and hospitals in Ohio and Indiana in the coming years. Read More

Molina Restructuring Shows Progress. *Modern Healthcare* reported on November 2, 2017, that Molina Healthcare is showing improved results from a restructuring effort. In the third quarter of 2017, Molina reported a decline in medical cost ratio, higher reserves, and improvement in challenging markets like the Exchanges and Illinois, New Mexico, and Puerto Rico. Overall, Molina reported a net loss of $97 million in the third-quarter. Read More

Baptist Health to Acquire Kentucky-Based Hardin Memorial Health. *Modern Healthcare* reported on November 6, 2017, that Baptist Health has signed a letter of intent to acquire Kentucky-based Hardin Memorial Health, which Baptist Health has been managing day-to-day operations for since 1997. Terms of the deal were not disclosed. Baptist Health operates seven other hospitals in Kentucky and one in Indiana that it acquired last year. Read More

Virginia Health Commissioner Approves Mountain States, Wellmont Merger Despite FTC Opposition. *Modern Healthcare* reported on November 3, 2017, that the Virginia health commissioner has approved the Mountain States Health Alliance merger with Wellmont Health System despite opposition from the Federal Trade Commission (FTC). The companies' initial letter of intent was issued in September 2015. The FTC said that the organizations, "fail to provide sufficient additional information or analysis to demonstrate by clear and convincing evidence that the purported benefits of this merger would outweigh the serious competitive harm that would likely result from creating a near-monopoly." However, Tennessee, and now Virginia, both approved the organizations' certificate of public advantage (COPA), which allows the merger to bypass federal approval by demonstrating that the public benefit outweighs potential anti-competitive consequences. The companies said that they would use over $200 million from the savings resulting from the merger

to provide mental health counseling, addiction treatment, managed care services, and pediatric specialty centers. Read More

Ensign's Cornerstone Healthcare Acquires Excell's Home Care and Hospice, Private Care Services. The Ensign Group announced on November 7, 2017, that its health home and hospital subsidiary, Cornerstone Healthcare, Inc., has acquired the assets of Excell Home Care and Hospice and Excell Private Care Services in Oklahoma effective November 1, 2017. Cornerstone, which now operates 20 home health operations, 22 hospice operations, and 4 home care operations in 11 states, is seeking additional opportunities to acquire home health, hospice, and home care operations. Read More

Epic Sued Over Medicaid, Medicare Fraud. *Modern Healthcare* reported on November 3, 2017, that Epic Systems Corp. was sued for violating the False Claims Act after its billing software company double-billed Medicare and Medicaid for anesthesia claims. The suit was first filed in 2015 by Geraldine Petrowski, who worked at WakeMed Health in Raleigh, North Carolina, and remained sealed until last week. According to an Epic spokesperson, the U.S. Justice Department previously reviewed Petrowski's case and declined to intervene. Epic refutes the allegations. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
November 3, 2017	New Mexico	Proposals Due	700,000
November 17, 2017	Texas STAR+PLUS Statewide	RFP Release	530,000
November, 2017	Kansas KanCare	RFP Release	380,000
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 5, 2018	Iowa	Proposals Due	600,000
January 10, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
January, 2018	Kansas KanCare	Proposals Due	380,000
February 27, 2018	Iowa	Contract Awards	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 1, 2018	Massachusetts	Implementation	850,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
June, 2018	Kansas KanCare	Contract Awards	380,000
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 1, 2018	Iowa	Implementation	600,000
Timeline to be Revised	Alabama ICN (MLTSS)	Implementation	25,000
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
November 1, 2018	New Hampshire	Proposals Due	160,000
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 1, 2019	New Hampshire	Contract Awards	160,000
January, 2019	Texas STAR+PLUS Statewide	Contract Awards	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
January, 2019	Kansas KanCare	Implementation	380,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000

HMA WELCOMES…

Glenn Stanton, Principal - Atlanta, Georgia

Glenn Stanton joins HMA most recently from Magellan Health, Inc. where he served as Senior Vice President, Business Development for Public and Emerging Markets. In this role, Glenn led new business development for public sector governmental contracts, including partnership building at state and local levels, strategic messaging and positioning, RFP proposal development, and new product development. He worked with public purchasers to utilize Magellan's behavioral and specialty health expertise to improve health outcomes for individuals with disabilities and their families. Glenn played an integral role in contributing to the company's revenue growth from $1.5 billion in 2003 to $4.8 billion in 2017. He led Magellan's expansion in the Medicaid behavioral health marketplace and played a key role in expanding into adjacent markets, including long-term services and supports (LTSS) for persons with disabilities and services for youth in child welfare.

Glenn was selected as a key member of a strategic team that identified alternative markets to capitalize on emerging opportunities in the Medicaid market. He led proposal development efforts to win publicly-funded children's services in three state markets and led the proposal development process to win Magellan's first contract in the Managed LTSS market.

Prior to Magellan Health, Glenn served as Acting Director and Deputy Director, Disabled and Elderly Health Programs Group at the Center for Medicaid Services (CMS), U.S. Department of Health and Human Services. In this role, Glenn provided leadership for CMS's self-directed health care initiative Independence Plus, which resulted in a new Medicaid waiver template for self-directed care for persons with disabilities, making it easier for states to submit and receive waiver approval. He identified viable financing strategies for comprehensive systems of care by convening and facilitating meetings with state Medicaid and mental health directors, and helped develop solutions to complex Medicaid policy and financing issues, which emerged through Medicaid State Plan Amendments, managed care waivers, demonstrations, and beneficiary outreach activities. He directed efforts that resulted in the transformation of a CMS Quality Framework for home and community-based services (HCBS) and provided leadership and support to multiple aspects of then-President Bush's New Freedom initiative, focused on improving the ability for disabled persons to live at home.

In addition, Glenn has held multiple director-level positions at the Michigan Department of Community Health and the Clinton-Eaton-Ingham Community Mental Health Board. He has been recognized year after year for his outstanding leadership and managerial performance, receiving the U.S. Department of Health and Human Services Secretarial Honor Award (2004), CMS Leadership Development and Recognition Board's Excellence in Leadership Award (2003), CMS Administrator's Achievement Award (2003), and many more.

Glenn earned his Master's Degree in Community Psychology from Michigan State University and his Bachelor's Degree in Psychology from State University of New York at Buffalo.

Dr. Craig Thiele, Principal - Columbus, Ohio

Dr. Craig Thiele joins HMA most recently from CareSource, a multistate, multiproduct, nonprofit managed care plan, where he served as Chief Medical Officer. In this role, Dr. Thiele was responsible for providing leadership and direction for the clinical, quality, and utilization/cost management functions of the company. He developed and led innovative initiatives focused on high-quality, efficient care for highly-vulnerable citizens. Dr. Thiele was instrumental in shifting business from a primarily Ohio-based Medicaid focus to a comprehensive, member-centric health and life services entity serving 1.7 million members in multiple states and products, including Medicaid, Medicare, dual eligibles, and the Marketplace. He championed and authored a value reimbursement contracting model, infrastructure, and environment now serving over 50 percent of membership. Dr. Thiele managed a $1.7 billion pharmacy department that generated $200 million in annual savings. Additionally, he restructured clinical and reimbursement policy development, supporting 11 lines of business projecting $40 million in savings in 2017.

Dr. Thiele reduced opioids dispensed by CareSource healthcare providers by 30 percent and initiated a medication therapy management program that generated a 3-to-1 return on investment savings through improved adherence to chronic medications and reduced emergency room and inpatient admissions. He instituted primary care relationships in commercial retail settings, now serving over 7,000 members, and established relationships and operationalized clinical data sharing with Ohio's two Health Information Exchanges. He created an integrated nurse advice line with a virtual telemedicine program for Medicaid and Marketplace products and implemented automated care management and pharmacy systems, reducing administrative structure and improving health plan and provider efficiency.

Prior to CareSource, Dr. Thiele served as National Medical Executive, Clinical Programs, at Optum, a division of UnitedHealth Group. In this role, he directed clinical program design and led medical directors in the support of utilization review and case management.

Dr. Thiele has nearly 15 years of clinical practice experience, serving as Chair of the Department of Internal Medicine at Premier Integrated Medical Specialists, Hospitalist at South Dayton Acute Care Consultants, and in several Medical Director roles.

Dr. Thiele earned his Doctor of Medicine from Wright State University Boonshoft School of Medicine and his Bachelor's degree in Chemistry from Miami University in Ohio. He completed an Internal Medicine Internship and Residency at Wright State University Department of Internal Medicine. He is a board-certified internist.

Xavior Robinson, Senior Consultant - Washington, DC

Xavior Robinson joins HMA most recently from the National Council for Behavioral Health where he served as Senior Advisor of Practice Improvement. In this role, Xavior promoted behavioral health integration across a variety of national public health initiatives, including the National Council's Opioid Epidemic Impact Initiative and the National Behavioral Health Network for Tobacco and Cancer Control. He led a national training and technical assistance initiative that advised payers, state government agencies, and provider organizations on opportunities to improve benefit designs, provider

engagement, managed care contracts, and processes that expanded access to opioid use disorder treatment and prevention services. He provided ongoing technical assistance to Medicaid programs and state provider associations on clinical, operational, technological, and financial opportunities to address the opioid epidemic. He served as subject matter expert for the behavioral health workforce, HIV, health financing, and insurance initiatives for the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Financing Reform and Innovation. He directed a national campaign to expand access to tobacco cessation and cancer treatment and prevention services aimed at state Medicaid officials, managed care organizations (MCOs), and state public health officials.

Prior to the National Council for Behavioral Health, Xavior served as Senior Manager of Health Systems Integration at the National Alliance of State and Territorial AIDS Directors (NASTAD). In this role, he led health insurance financing technical assistance initiatives geared toward state public health departments around HIV treatment and prevention. He advised AIDS Drug Assistance Programs (ADAPs) on opportunities to maximize access to HIV treatment and prevention services and prescription drugs by leveraging Medicaid, Medicare, and health insurance marketplaces. He wrote regulatory policy comments that advocated for expanded access to HIV and Hepatitis C treatments on behalf of NASTAD, the HIV Health Care Access Workgroup, and the HCV Treatment Access Workgroup regarding Medicaid MCO parity and the health insurance marketplace benefit and parameters notice. He spearheaded provider sustainability that leveraged public health systems data, insurance reimbursement models, and financial modeling to support the viability of public health providers.

Prior to NASTAD, Xavior worked on healthcare access issues for multiple organizations, including Unity Health Care, one of the largest Federally Qualified Health Centers (FQHCs) in the country; El Pomar Foundation, a private charitable foundation dedicated to improving the well-being of the people of Colorado; and in the Office of United States Senator Michael Bennet. While serving as Senator Bennet's local liaison to the military and veterans community, he partnered with community agencies to enhance healthcare access for returning veterans. Xavior also served in the U.S. Army between 2002 and 2008, completing tours of service in Fort Carson, Colorado, the Republic of Korea, and Iraq.

Xavior earned his Master of Health Services Administration degree from The George Washington University and his Bachelor of Science degree in Sociology from Colorado State University-Pueblo. He received a Graduate Certificate in Nonprofit Management from the University of Colorado – Colorado Springs.

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; Raleigh, North Carolina; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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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.