HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 8, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

MISSISSIPPI DIVISION OF MEDICAID ISSUES RFP TO REBID MISSISSIPPICAN PROGRAM

This week, our *In Focus* section reviews the request for proposals (RFP) issued by the Mississippi Division of Medicaid (DOM) for the reprocurement of Mississippi Coordinated Access Network (MississippiCAN) Medicaid managed care plans. Under the RFP, the DOM is adding 1915(i) Intellectual/Developmental Disabilities Community Support Program (IDD CSP) and Mississippi Youth Programs Around the Clock (MYPAC) services to the MississippiCAN benefit package. As of February 2017, MississippiCAN enrolls roughly 490,000 Medicaid members across all 82 counties in the state, with annual managed care spending of more than $2.7 billion.

MississippiCAN Overview

MississippiCAN has undergone a significant expansion in recent years. Legislation passed in 2012 allowed the program to expand to enroll up to 45 percent of the state's Medicaid beneficiaries in managed care, with additional expansions approved in 2014 and 2015. Roughly 490,000 out of 690,000 total Medicaid beneficiaries (70 percent) are enrolled in one of two MississippiCAN managed care plans.

MississippiCAN allows for optional disenrollment for the following eligibility groups:

- Children with SSI aged 0 to 19;
- Children ages 0 to 19 with disabilities who live at home
- DHS-Foster Care children and individuals receiving Adoption Assistance, ages 0 to 19; and
- Native Americans, regardless of age.

Members are excluded from MississippiCAN if they are:

- Residing in a nursing home (excluding those residing in a Psychiatric Residential Treatment Facility (PRTF) or in a intermediate care facility for individuals with intellectual or development disabilities (ICF/IID);
- Enrolled in a waiver program; or
- Dual eligible for Medicaid and Medicare.

Estimated Capitation Rates

Projected membership and capitation rate data for July 2016 through June 2017 is provided in the RFP documents. Based on projected average monthly membership of 494,000, and a blended per-member-per-month capitation rate of $473, projected fiscal year (FY) 2017 spending for MississippiCAN should surpass $2.8 billion. It is likely that the inclusion of IDD CSP and MYPAC services to the benefit package would increase overall spending and the average blended capitation rate.

	Projected Average Members FY 2017	July 2016-June 2017 Capitation Rates	Projected FY 2017 Annual Spend
Children	305,372	$276.10	$1,011,759,000
SSI/Disability (Non-Newborn)	64,087	$1,117.69	$859,553,000
Adults	51,011	$546.81	$334,720,000
Non-SSI Newborns	28,473	$637.99	$217,985,000
Quasi-CHIP Children	28,226	$287.76	$97,468,000
Pregnant Women	11,525	$651.29	$90,073,000
Foster Care	4,886	$465.20	$27,276,000
SSI/Disability (Newborn)	529	$7,309.02	$46,398,000
Breast and Cervical Cancer	100	$3,561.29	$4,274,000
Total - All Rate Cells	**494,209**	**$472.93**	**$2,804,742,262**

Note: Total projected annual spending includes delivery kick payment
Source: SFY 2017 MississippiCAN CCO Rate Calculation and Certification

RFP, Contract Timing

Interested bidders must submit a mandatory letter of intent (LOI) to the Mississippi DOM by February 24, 2017, to be considered for a contract award. Proposals are due to the state on April 7, 2017, with awards to be announced in June and contracts to be in effect by July 1, 2017, when current MississippiCAN contracts expire. However, awarded plans will not begin providing services under the new contracts until July 1, 2018.

RFP Event	Date
RFP Released	February 3, 2017
Mandatory Letter Of Intent (LOI) Due	February 24, 2017
Proposals Due	April 7, 2017
Contract Awards	June 12, 2017
Contract Start Date	July 1, 2017
Implementation	July 1, 2018

The RFP provides no indication of the number of contract awards that will be made. Contracts run from July 1, 2017 through June 30, 2020, with two one-year extension options.

Evaluation Criteria

Bidders will be primarily evaluated on the "methodology and work statement" section of the response. This section includes:

- Processes and requirements for completion of the project.
- Data management plan, including hardware, software, communications links, and data needs and proposed coordination plan.
- Processes for maintaining confidentiality of patient health information.
- Processes for development and submission of required deliverables.
- Scope of services provided through partnerships or subcontractors.
- Quality Assurance processes.

Proposal Element	Maximum Score	% of Total
Transmittal Letter	Pass/Fail	
Executive Summary/Understanding of Project	5	5%
Corporate Background and Experience	10	10%
Ownership and Financial Disclosures	Pass/Fail	
Organization and Staffing	10	10%
Methodology and Work Statement	55	55%
Management and Control	10	10%
Work Plan and Schedule	10	10%
Total Points Available	100	

Current MississippiCAN Market Summary

As noted above, there are two plans currently under contract and serving the MississippiCAN program – Centene's Magnolia Health Plan and UnitedHealthcare. Each has a roughly 50 percent market share of the roughly 489,000 members as of February 2017 and operates across all 82 counties statewide.

MississippiCAN Health Plan	February 2017 Enrollment	Percent Market Share
Magnolia Health Plan (Centene)	251,682	51.4%
UnitedHealthcare	237,911	48.6%
Total Enrollment	**489,593**	

Link to MississippiCAN RFP, Appendix Documents

https://medicaid.ms.gov/mississippi-coordinated-access-network-mississippican-rfp-20170203/

HMA Medicaid Roundup

Arizona

AHCCCS to Request Waiver Approval for Medicaid Work Requirement, Eligibility Cap. *AZCentral.com* reported on February 1, 2017, that the Arizona Health Care Cost Containment System (AHCCCS), which administers the state's Medicaid program, is considering requiring many Medicaid recipients over age 19 to be employed or actively seeking work as a prerequisite for enrollment. The new eligibility requirements, which would require federal approval, would also cap lifetime eligibility for Medicaid at five years. Adults who failed to report a change in income or employment would be barred from Medicaid for one year. Those who attend high school, are sole caregivers for children under age six, or are on temporary disability would be excluded. The state is collecting public comments on the proposal through February 28, 2017. Read More

Arkansas

Medicaid Dental Managed Care Contract Awards Announced. *ArkansasOnline* reported on February 4, 2017, that Arkansas has selected Managed Care of North America and Delta Dental to manage dental benefits for the state's Medicaid program. Two other bidders were disqualified for failing to disclose lawsuits involving similar services in other states. The contracts must still go to the state legislature for approval. Managed Care of North America originally ranked fourth and Delta Dental ranked second out of four bidders. The contracts are estimated to be worth $300 million over two years and are expected to save the state $5 million in annual dental spending and generate over $3 million annually in state premium taxes. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA Announces Reprocurement Process for Statewide Medicaid Managed Care. The Florida Agency for Health Care Administration (AHCA) announced on February 3, 2017, that it plans to issue invitations to negotiate for the Statewide Medicaid Managed Care (SMMC) program during the summer of 2017. The agency is currently accepting voluntary, non-binding letters of intent (LOIs) to bid, due February 13, 2017. As of January 2017, there are more than 3 million SMMC members enrolled in a Medicaid health plan.

Bill Would Reduce the Number of Medicaid Managed Care Regions Ahead of Re-Bid. *Politico* reported on February 6, 2017, that Florida lawmakers are considering several changes to the state's Medicaid managed care program,

including a reduction in the number of contract regions and an increase in the number of plans that can be selected in a given region. The changes are being considered as the Florida Agency for Health Care Administration prepares to put the Medicaid managed care program out to rebid. According to draft legislation, the state would reduce the number of regions from 11 to eight. For example, it would combine Regions 1 and 2 into Region A and contract with up to four managed care plans in the region. It would also combine 23 counties into Region B and contract with three to five plans. Each region would still be required to have a minimum of two contracted plans unless a provider-sponsored network does not bid in a certain region; then the state could contract with one plan in that region. Read More

Florida Medical Care Advisory Committee Update. The Medical Care Advisory Committee (MCAC) met on February 1, 2017, and received updates from Agency staff on the 2017 Comprehensive Quality Strategy Report (CQS), Medicaid Grievance, Appeals and Fair Hearing Process and Home and Community Based Waiver consolidation.

- ***Comprehensive Quality Strategy (CQS)***: The Agency is required to submit a Comprehensive Quality Strategy Report to the Centers for Medicare & Medicaid Services (CMS) every three years. The report describes strategies for assessment and continuous improvement of the quality of health care and services provided by MCOs and other providers through Florida Medicaid Statewide Medicaid Managed Care (SMMC). A draft of the 2017 Comprehensive Quality Strategy report that reviews and outlines the goals of SMMC is located here.
- ***Medicaid Grievance, Appeals and Fair Hearing Process:*** The Grievance and Appeal System requirements for SMMC and the requirements for filing complaints and requesting a Medicaid Fair Hearing were reviewed. It was noted that there were legislative changes made in 2016 that will transition responsibility for Medicaid fair hearings directly related to Medicaid programs administered by the Agency from the Department of Children and Families (DCF).
- ***Community Based Waiver consolidation:*** The Agency reviewed their 2017 Legislative issue that transitions individuals currently enrolled in the Traumatic Brain and Spinal Cord Injury (TBI/SCI) Waiver, Adult Cystic Fibrosis (ACF) Waiver and Project AIDS Care (PAC) Waiver into SMMC home and community-based services (HCBS). Read More

Senator Proposes Bill to End Certificate of Need Requirements. *Health News Florida* reported on February 5, 2017, that State Senator Rob Bradley (R-Fleming Island) introduced a bill to eliminate the state's certificate of need (CON) regulatory process, which is currently required for the construction of hospitals, nursing homes, and hospice facilities. Governor Rick Scott and House Republicans have long supported efforts to end CON requirements, which they argue will increase competition and decrease cost. However, the measure has been opposed by the state Senate. The bill, SB 676, will be reviewed during the legislative session beginning March 7. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Senate Approves Hospital Assessment to Fill $900 Million Medicaid Budget Gap. *Georgia Health News* reported on February 2, 2017, that the Georgia Senate approved a renewal of the state's hospital provider assessment program to help remedy a $900 million Medicaid budget gap. The program will bring in an estimated $310 million in hospital assessments, which will be matched with $600 million in federal money. During the debate around the renewal, Democrats in the state Senate made a push for Medicaid expansion, but Republican leadership turned it down, calling expansion fiscally unsound. The provider assessment bill now heads to the state House for consideration. Read More

Indiana

Medicaid to Continue Covering Film Form of Addiction Drug Suboxone. *Indystar.com* reported on February 3, 2017, that more than 100 public safety officials signed a letter to Indiana Medicaid Director Joe Moser asking the state to stop covering the film form of the addiction drug Suboxone in an effort to limit the drug's illicit use in prisons. However, the committee that provides recommendations to Indiana Medicaid on which drugs to cover voted to continue covering the drug until there is testimony and further evidence that contraband Suboxone is making its way into jails through prescriptions originated by Medicaid. Some say that removing Suboxone film could negatively impact individuals on Medicaid who are trying to get over addiction. Read More

Iowa

Medicaid Plan Leadership Optimistic About Payments Under New Governor. *The Des Moines Register* reported on February 1, 2017, that Anthem is hopeful it can receive higher Medicaid managed care payments in Iowa assuming Kim Reynolds takes over as governor. Reynolds is currently Lieutenant Governor, but would take over assuming current Governor Terry Branstad is confirmed as Ambassador to China. Branstad led the state's shift to Medicaid managed care. Anthem CEO Joseph Swedish stated that the company has been losing 15 to 20 percent on the Iowa Medicaid contract and is hopeful there will be improvements in the next fiscal year, which begins July 1, 2017. Read More

Hospital Uncompensated Care Decreased Under ACA, Raising Concerns About Repeal. *The Des Moines Register* reported on February 5, 2017, that Iowa hospitals are concerned about the potential repeal of the Affordable Care Act (ACA), especially since both uncompensated care and bad debt have declined significantly since the law was enacted, with uncompensated care alone down 38 percent. About 200,000 people have gained insurance coverage in Iowa because of the ACA, including 150,000 through Medicaid and 50,000 via the Exchange. The Iowa Hospital Association says that hospitals are concerned that if ACA is repealed, they would be even worse off financially than before the law was passed. U.S. Senator Chuck Grassley (R-Iowa) and state lawmakers say they plan to continue conversations with hospitals and other stakeholders to ensure a smooth transition under any repeal and replacement plan. Read More

Kansas

State Submits Corrective Action Plan for KanCare HCBS Services. *KCUR.org* reported on February 2, 2017, that Kansas Medicaid officials have submitted a corrective action plan to federal regulators to address problems in home and community based services (HCBS) provided to individuals with disabilities in the KanCare Medicaid managed care program. The Centers for Medicare & Medicaid Services (CMS) ordered corrective action in December after uncovering deficiencies in an audit of the program. In January, CMS also denied the state's request for a one-year extension of the KanCare program; the contracts expire at the end of 2017 unless the extension is revisited or Kanas reprocures the program. Kansas Department for Aging and Disability Services spokeswoman Angela de Rocha said that the state was already working to make improvements to HCBS services before the CMS audit. Read More

Legislators Debate Increasing HMO Fee to Restore Provider Cuts. *KCUR.org* reported on February 1, 2017, that Kansas legislators are debating whether or not to increase a fee assessed on HMOs in Kansas in order to restore cuts to Medicaid providers, even though providers would likely not see increases until 2018 or 2019. The fee would apply to Medicaid managed care plans as well as private insurers licensed as HMOs. If passed, the bill could be retroactive to the beginning of 2017; although Medicaid providers would not realize the increase until 2018. Chad Austin, vice president of government relations for the Kansas Hospital Association, says that the bill could provide reassurance to providers to stay in the Medicaid program. Read More

Governor's Budget Calls for $20 Million in Cuts for State Psychiatric Hospitals. *KCUR.org* reported on February 3, 2017, that Kansas Governor Sam Brownback is proposing $20 million in funding cuts for two state-run psychiatric hospitals in fiscal 2018: $11.6 million at Osawatomie State Hospital and $8 million at Larned State Hospital. Administration officials say that the two hospitals can make up the shortfall in part by cutting overtime and by maintaining the number of budgeted staff positions. In addition, Osawatomie is expected to regain certain federal Medicare funding that was lost in the wake of patient safety concerns. Read More

Minnesota

Legislature Passes Bill Opening Medicaid, Individual Markets to For-Profit HMOs. *TwinCities.com* reported on February 3, 2017, that Minnesota legislators passed a law last month that allows for-profit insurers to operate health maintenance organizations (HMOs) in the state. Minnesota has only allowed not-for-profit HMOs since 1973 and was the only state to still have the limitation. The change will open the Medicaid managed care market to for-profit entrants, and at least one has already expressed interest in bidding to participate in the program. Read More

Missouri

Governor Proposes Medicaid Provider Cuts in Fiscal Year 2018 Budget. *The Kansas City Star* reported on February 2, 2017, that Missouri Governor Eric Greitens proposed a 3 percent Medicaid provider reimbursement cut in the state's fiscal 2018 budget. The state's Medicaid costs are expected to continue to rise from $10.3 billion in fiscal 2017 to $10.7 billion in fiscal 2018. The proposed budget would generate savings by making it more difficult for more than 20,000 individuals with disabilities to qualify for in-home care and nursing home services. Read More

Nebraska

Lawmaker Proposes Oversight of Medicaid Managed Care Program. *Lincoln Journal Star* reported on February 1, 2017 that Nebraska State Legislator Kate Bolz (D-Lincoln) has proposed a bill to create oversight of the state's new Medicaid managed care program, Heritage Health. Bolz cited the program's estimated $1.2 billion in annual expenditures as a reason for the need for committee oversight. The legislative committee would analyze quality of care, integration and coordination of care, accessibility and spending, consumer satisfaction, and other measures. The measure is opposed by state Senator Merv Riepe (R-Omaha) and others who argue there is already adequate oversight. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Self-Direction Program and Fiscal Intermediary Update. On February 2, 2017 the New Jersey Department of Human Services, Division of Developmental Disabilities (DDD) provided an update on questions it received about the new Department-wide Fiscal Intermediary (Public Consulting Group's Public Partnerships, LLC (PPL)) and DDD's policy on training for self-directed employees (SDE). The transition from the current fiscal intermediary, Easter Seals, to PPL will take up to five months. A timeline for the transition will be shared with stakeholders soon. PPL was chosen to serve as a Fiscal/Employer Agent for fiscal management services for the state's self-directed programs. SDEs will be required to participate in a training to transition from Easter Seals to PPL. DDD will offer print versions of online courses, pay for the training and the time individuals spend attending the training, and will waive continuing education requirements. In addition, families will no longer be subject to a $15 per-hour payment cap, giving them discretion to pay SDEs a higher hourly rate, and family members other than parents, legal guardians, or spouse may be hired as SDEs. Read More

Camden Coalition and UnitedHealthcare Form Strategic Partnership. On January 31, 2017, *NJBIZ* reported that the Camden Coalition of Healthcare Providers will enter into a three year, $15 million strategic partnership with UnitedHealthcare. The arrangement will focus on scaling new models of care based on social determinants of health. Dr. Jeffrey Brenner, the Camden Coalition's founder and executive director will transition to lead United's myConnections services model as their senior vice president of integrated health

and human services. The partnership increases the coalition's funding by 50 percent. Read more

State Doubles Medication Assisted Therapy Rates to Help Address Opioid Addiction. On February 6, 2017, *NJSpotlight* reported on an adjustment by the Department of Human Services, Division of Mental Health and Addiction Services to the fee-for-service reimbursement rates for behavioral health services associated with medication management. The change will reimburse psychiatrists effectively double what they had been paid to manage patients in outpatient settings who are taking prescriptions that contribute to opioid use. Payment for medication evaluation and management services will increase from $24.63 for 10 minutes to $49.06, and from $81.40 to $161.02 for 40 minute sessions. Read more

Audit Report of Mental Health Program: State and Provider Performance See Mixed Results. The New Jersey Office of Legislative Services (OLS), Office of the State Auditor released an audit report on January 26, 2017, of its findings on three mental health programs: 1) Integrated Case Management Services (ICMS); 2) Program for Assertive Community Treatment (PACT); and 3) Intensive Outpatient Treatment and Support Services (IOTSS). The report concludes that the Division of Mental Health and Addiction Services (DMHAS) had inadequate procedures for monitoring and evaluating the performance of the ICMS and PACT programs. The report also concludes that IOTSS providers did not consistently meet their contracted level of service. Details and additional findings may be found here.

Governor Christie Signs Law to Improve Lead-screening Standards to Meet CDC Levels. *NJ Spotlight* reported on February 6, 2017, that New Jersey Governor Chris Christie signed into law a bill (S-1830) that will require additional testing for children under 6 years of age who have more than 5 micrograms of lead/deciliter of blood. The state has been operating with a 10 micrograms/deciliter threshold. About 200,000 children were tested for lead in 2015 and less than 900 met the 10 micrograms/deciliter threshold whereas about 3,000 children tested higher than 5 micrograms/deciliter. The state projects that the new threshold will result in an additional 4,000 children who will be identified for follow-up. The Department of Health is adopting regulations to support the law, which goes into effect immediately. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Marketplace Enrollment Increases. NY State of Health, the state's official health plan Marketplace, announced that more than 3.6 million New Yorkers enrolled in comprehensive health coverage through NY State of Health, a 28 percent increase from 2016. In the final two days of the 2017 Open Enrollment period, NY State of Health enrolled 45,807 people in coverage bringing the total number of people who receive coverage through the Marketplace to more than 3.6 million- an increase of more than 800,000 people since the end of 2016 Open Enrollment. As of January 31, more than 1.2 million people enrolled in a non-Medicaid program through the Marketplace: 242,880 people enrolled in a Qualified Health Plan, and 665,324 people enrolled in the Essential Plan, Affordable Care Act's Basic Health Plan option. In addition, 299,214 children enrolled in Child Health Plus. A total of 2,427,375 people

enrolled in Medicaid as of January 31 through the NY State of Health Marketplace. Total Marketplace enrollment increased in every county of the state, ranging from an increase of 16 percent in New York County to over 68 percent in Rockland County. Read More

Medicaid Global Cap Pressured by MLTC, Drug Costs. *Crain's Health Pulse* reported on February 8, 2017, that rising Medicaid managed long-term care (MLTC) and prescription drug spending is putting pressure on New York's Medicaid global spending cap, according to Jason Helgerson, New York's Medicaid director. Medicaid spending has already exceeded the state's fiscal year 2017 budget by $26 million, mostly from cost overruns of $18 million for MLTC on top of $34 million in fee-for-service long-term care. In addition, prescription drug costs have grown annually by approximately $1 billion. To control costs, Governor Andrew Cuomo has proposed setting a price ceiling for high-cost drugs, among other initiatives. The state has also cut $15 million in MLTC quality payments and $5 million in hospital quality payments.

Primary Care Development Corporation to Administer $19.5 Million Community Health Care Revolving Capital Fund. The Primary Care Development Corporation (PCDC) has been named the administrator for a new $19.5 million Community Health Care Revolving Capital Fund in New York State. The loan fund was established in the New York State 2015-16 enacted budget under the authority of the New York State Department of Health (NYSDOH) and Dormitory Authority of the State of New York (DASNY) to improve access to affordable capital to expand and improve preventive or primary care capacity. The Fund, a financing program created through a public-private partnership between PCDC and the State of New York, is intended to facilitate investment to expand and improve primary care capacity in the state by providing affordable loan capital for eligible community-based health care providers to support quality primary care expansion and integration in NY. Projects will be selected for financing based on underwriting criteria that include creditworthiness, community impact, and demonstrated ties the community. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Releases Medicaid Expansion Report. Governor Tom Wolf's administration released a report on the first year impact of Medicaid expansion on Medicaid enrollment, uninsured rates, the Commonwealth's budget, and the overall economy from January 2015 to December 2015. Utilization of health care services was also analyzed from April 2015 to March 2016. According to data compiled by the Pennsylvania Cost Containment Council, uncompensated care for Pennsylvania's general acute care hospitals has increased every year from 2001 until 2015. This trend was reversed in 2015, when Medicaid was expanded, with the dollar amount decreasing by $92 million or 8.6 percent. The federal government provided 100 percent health care expenditures for individuals meeting the federal definition of a Medicaid expansion enrollee, which were approximately $2.8 billion in 2015 and represented approximately 11 percent of the total Medicaid expenditures. Read More

Pennsylvania Implements ABLE Program. Pennsylvania is slated implement the ABLE (Achieving a Better Life Experience) Act of 2014. This program allows people with disabilities to save up to $14,000 a year without losing government benefits. Without the program, recipients can't have more than $2,000 in savings. The limit had not been changed in nearly three decades. To qualify for an ABLE account, the account owner must have had a disability before their 26th birthday. Anyone can put money in it and the funds can be used for anything that improves the life of the person with a disability, such as rent payments, school tuition or groceries. If the account goes above $100,000, the individual loses monthly government cash benefits until it drops below that level again. When the person dies, the Medicaid program can claim any leftover money to offset the cost of Medicaid services rendered after the account was opened. Read More

DHS Officials Selected to Speak at National Medicaid Association Workshop. Officials from Pennsylvania's Department of Human Services' (DHS) Office of Medical Assistance Programs were selected to participate in a two-day National Association of Medicaid Directors (NAMD) workshop in New Orleans. Pennsylvania was one of nine states chosen to participate and lead various discussions during the workshop. Pennsylvania led a discussion on strategies used to establish the state's Alternative Payment Model (APM) contracting strategies including how data sharing among managed care plans and providers will shape the way providers and managed care organizations serve patients. Read More

Texas

Governor Abbott, House, and Senate Unveil FY 2019-2019 Budget Proposals. At the end of January 2017, Texas Governor Greg Abbott, published his proposed Fiscal Year 2018-2019 budget. Key highlights include:

- A recommendation for the federal government to implement block grants for Medicaid to allow states to effectively manage Medicaid costs and mitigate the impact of Medicaid on state budgets. Specifically, Governor Abbot said:
    - Texas needs flexibility to administer a Medicaid program that delivers cost-effective care to low-income children, the elderly, pregnant women and persons with disabilities. Block grants should be used for the administration of state-managed Medicaid programs, and Congress should act to authorize this important reform. The block grants should be designed in a way that protects states from cost growth due to population growth or the economy and should be accompanied by reforms that significantly reduce or eliminate federal requirements.
    - The reformed Texas Medicaid program would include personal responsibility requirements for certain populations, reduced administrative burdens for providers and other reforms to ensure the program's long-term sustainability in serving the neediest Texans. Such changes would fundamentally shift the budget process moving forward and allow the Texas model of fiscal conservatism to rein in excessive spending growth.

- As part of a recommendation in his budget to the minimum hourly wage for personal attendants assisting individuals with disabilities, Governor Abbot also emphasized the goal in Texas to continue to shift individuals with disabilities from institutional settings into home-and community-based settings in the state.

In addition, Texas House and Senate leaders also unveiled their budget proposals at the beginning of the 85th Legislative Session in January. The starting budgets are nearly $8 billion apart, which signifies significantly different policy priorities between the two chambers in the Texas Legislature. The Senate's proposed a two-year base budget of $213.4 billion and the House outlined a two-year budget of $221.3 billion. These budgets are a starting point for negotiations between the House and Senate about how to spread limited state funds across state agencies. The House proposal for state spending on health and human services is about $2 billion larger than the Senate's. This session's gap is in the beginning budgets is much larger than it was in the previous session two years ago, when less than $3 billion separated the beginning House and Senate proposals. This session's Senate's base budget provides for $61.2 billion for Medicaid funding in federal and state funds. That's about $0.8 billion less than Medicaid's allotment for the current 2016-2017 budget, according to the Texas Legislative Budget Board. The Senate's proposed budget also does not set aside money to pay for projected growth in the number of Texans receiving Medicaid coverage, nor does it account for anticipated cost growth due to medical inflation. The House's base budget offers about $0.9 billion more funds for Medicaid than were allocated for 2016-2017, totaling about $65.1 billion, which is about $4 billion more in combined federal and state funding than what the Senate set aside. Budget negotiations typically last throughout the legislative session.

Utah

Department of Health to Move Ahead on Limited Medicaid Expansion. *Deseret News* reported on February 3, 2017, that the Utah Department of Health is going forward with an expansion of Medicaid for 3,000 to 5,000 low-income parents. The original proposal also included 6,500 childless adults who are homeless, involved in the criminal justice system, or in need of mental health or substance abuse treatment. Health department spokesman Tom Hudachko stated that officials still want to get childless adults covered but it will be a longer and more complicated process. The expansion waiver requires federal approval. If approved, it would cost approximately $5 million to $7 million annually in state funding. Read More

National

Medicaid Block Grants Could Save Federal Government $150 Billion Over Five Years, Reduce Funding to States, Says Study. *The Hill* reported on February 6, 2017, that Medicaid block grants and per capita caps could cut federal Medicaid spending, according to a study published by a health care consulting firm. According to the analysis, block grants could save the federal government $150 billion over five years, while per capita caps could save $110 billion. Under the block grant model, nearly all states could see a reduction in federal funding, ranging from four percent to more than 60 percent. Analysis of

a per capita funding model determined that 26 states and DC could see federal funding decrease up to 30 percent, while 24 states could see an increase in federal funds. Read More

Trump Administration Submits Rule to OMB to Stabilize Exchanges. *Modern Healthcare* reported on February 2, 2017, that President Donald Trump's administration has submitted a rule to the Office of Management and Budget (OMB) aimed at stabilizing the Affordable Care Act health insurance Exchanges. The content of the rule has not been publicly released, but it likely tightens eligibility standards for Exchange coverage and limits special enrollment periods, according to a former Trump health policy advisor. Health plans have been calling for changes like these to help bolster the Exchanges and prevent people from signing up for coverage only when they're sick. The OMB has up to 90 days to review the proposal. Read More

Republicans Identify Four ACA Replacement Measures to Include in Repeal Legislation. *Politico* reported on February 7, 2017, that Congressional Republicans have identified at least four Affordable Care Act (ACA) replacement measures that could be included in repeal and replace legislation. The measures include Health Savings Accounts, high-risk pools, Medicaid per capita caps, and refundable tax credits. Confirmation of U.S. Department of Health and Human Services Secretary nominee Tom Price, which is expected this week, could speed the legislative process. Read More

Hospitals Tightening Labor, Capital Investments in Response to ACA Uncertainty. *HFMA News* reported on February 7, 2017, excerpts from an interview with former Centers for Medicare & Medicaid Services (CMS) Acting Administrator Andy Slavitt, who indicates that hospitals are likely to tighten hiring and capital investments given uncertainty over the future of the Affordable Care Act (ACA). In the interview, Slavitt shares his opinions and anecdotes from conversations with numerous hospital executives and other providers in the past several weeks around potential repeal of the Affordable Care Act (ACA), particularly the Medicaid expansion. Based on these conversations, Slavitt concludes that until hospitals and large provider systems are given clarity on how the ACA repeal, replacement, or modification will unfold, they are responding with a conservative approach around the two areas over which providers have the most control: labor and capital investment. First, many are likely to look at reducing or freezing hiring; and second, systems may reduce or delay capital projects and investment of capital dollars. Read More

Arizona, Texas Hope Trump Administration Approves Alternative Medicaid Waivers. *Modern Healthcare* reported on February 6, 2017, that Arizona and Texas are both hoping the Trump administration will approve Medicaid waivers that were previously opposed by federal regulators. Arizona is seeking a waiver that would put a five-year cap on Medicaid eligibility for certain members, as well as require beneficiaries to participate in job-search programs. Arizona also plans to submit a new request to allow fee-for-service Medicaid beneficiaries to have access to inpatient psychiatric services. Texas is seeking a 21-month waiver extension that continues funding of the state's uncompensated care pool, called the Texas Healthcare Transformation and Quality Improvement Program, and funds a Delivery System Reform Incentive Payment (DSRIP) program. Texas is asking for current funding levels through September 30, 2019. The Obama administration opposed this proposal, arguing that Medicaid expansion would make the uncompensated pool obsolete. Read More

Trump Administration Considers ACA Rule Changes Proposed by Health Plans. *Politico* reported on February 6, 2017, that the Trump administration is considering rule changes to the Affordable Care Act (ACA) submitted by the health insurance industry. The proposals include charging higher premiums for patients who are older, increasing out-of-pocket payments, and restricting who can enroll outside the standard enrollment period. Several insurers announced that they may withdraw from the Exchanges in 2018 if short-term changes to stabilize markets are not implemented. The administration may look into raising the premium ratio between older and younger customers, as well as shortening the 2018 enrollment period and requiring documentation for individuals who try to sign up during special enrollment periods. The administration may also consider increasing the range for out-of-pocket costs and tightening rules around the 90-day grace periods for individuals who did not pay premiums. Read More

Exchange Uncertainty May Threaten Health Plan Participation in 2018. *The New York Times* reported on February 1, 2017, that uncertainty around the stability of the Affordable Care Act (ACA) Exchanges is causing major health insurers to consider their participation for 2018 and beyond. Anthem Inc., which sells Exchange products in 14 states, indicated that it will wait and see whether the federal government commits to stabilizing Exchange markets before deciding whether to participate for 2018. Among the short-term fixes many in the industry would like to see are fewer special enrollment periods, improved eligibility verification, and elimination of the health insurance tax. While Congressional Republicans have promised to preserve coverage options for Exchange members under an ACA repeal and replacement, they have not yet coalesced around a detailed plan of how to do so. Insurers have to decide by April 2017 whether they will apply to participate in the Exchanges in 2018. Read More

Two Key Republicans Open to Modifying ACA Instead of Repealing. *The Washington Post* reported on February 2, 2017, that key Republican Senators Orrin Hatch (R-Utah) and Lamar Alexander (R-Tennessee) announced that they may be open to modifying the Affordable Care Act instead of repealing it outright. Alexander, who chairs the Senate Committee on Health, Education, Labor and Pensions, stated that "no one is talking about repealing anything until there is a concrete practical alternative to offer Americans in its place." Hatch, who chairs the Senate Finance Committee, said he is open to anything that will improve the system. Meanwhile, House Speaker Paul Ryan (R-Wisconsin) and other Republicans are still calling for repeal. Read More

House Subcommittee Passes Bill to Limit Medicaid Eligibility Among Lottery Winners. *Morning Consult* reported on February 7, 2017, that a U.S. House of Representatives subcommittee cleared two bills that would limit Medicaid eligibility. The first would adjust the way that lottery winnings and other lump payments are assessed when determining Medicaid eligibility. The other would close a loophole that impacts long-term care eligibility when married couples purchase annuities. Both bills passed the House Energy and Commerce committee's Health subcommittee. Read More

Industry News

Kaiser Permanente Completes Acquisition of Group Health Cooperative. *Becker's Hospital Review* reported on February 3, 2017, that Kaiser Permanente has completed its $1.8 billion acquisition of Washington-based Group Health Cooperative. The operation will be rebranded Washington Permanente Medical Group. Kaiser now serves 11.3 million individuals in eight states and the District of Columbia. Read More

LogistiCare Announces Partnership With Lyft. *Atlanta Business Chronicle* reported on February 7, 2017, that Atlanta, Georgia-based non-emergency medical transportation (NEMT) provider LogistiCare has launched a partnership with Lyft to expand its services in 276 cities. LogistiCare, which operates in 39 states, will work with Lyft to expand transportation options for patients with same-day ride requests or in instances of traffic delays due to weather or other conditions. The partnership with Lyft will be the largest between a NEMT provider and a ride-sharing company, according to LogistiCare. Read More

Centauri Health Solutions Announces Acquisition of Human Arc. Centauri Health Solutions, Inc., announced on February 7, 2017, that it has acquired Cleveland, Ohio-based Human Arc, a provider of enrollment, outreach, and revenue cycle services. Centauri Health Solutions provides products and services for risk adjustment and quality-based revenue programs to health plans and at-risk providers. The combined firm will serve more than 20 million Medicare and Medicaid beneficiaries in 2017, with a national client base that includes eight of the top 10 Medicaid plans, five of the top 10 Medicare Advantage plans, as well as a number of large, integrated hospital systems. The investment was led by Silversmith Capital Partners, a Boston-based growth equity firm. Robert W. Baird & Co. acted as the financial advisor to Human Arc. Financial terms of the acquisition were not disclosed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February 16, 2017	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
February 21, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	RFP Release	83,000
February 24, 2017	MississippiCAN	Mandatory LOI Due	500,000
February 28, 2017	Oklahoma ABD	Proposals Due	155,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
March 15, 2017	Massachusetts	Proposals Due	850,000
March, 2017	Washington, DC	Contract Awards	190,000
April 7, 2017	MississippiCAN	Proposals Due	500,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
June 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
July 1, 2017	Georgia	Implementation	1,300,000
September 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	83,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	83,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Nov. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	112,468	32.1%	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	46,216	34.0%	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	13,857	14.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,656	36.7%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	4,860	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	384	1.9%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	70,315	61.7%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	4,086	16.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	9,611	17.9%	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	36,736	21.9%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	29,186	44.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**364,375**	**29.1%**	

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

HMA News

HMA's Donna Cohen Ross Co-Authors KFF Paper on Linking Medicaid and Supportive Housing

On January 27, 2017, the Kaiser Family Foundation (KFF) published an issue brief co-authored by HMA Principal Donna Cohen Ross and KFF's Julia Paradise. The brief, *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*, outlines ways in which Medicaid can support integrated strategies to provide wide range of housing-related services and activities for individuals enrolled in Medicaid. Additionally, the brief profiles three current initiatives that illustrate distinctly different approaches to linking Medicaid and supportive housing. The three initiatives include one launched by a city (Philadelphia), one by a state (Louisiana), and one by a Medicaid MCO (Mercy Maricopa Integrated Care in Phoenix, Arizona). They target special populations including homeless individuals, people with a wide range of disabilities, and adults with mental health and/or substance use problems. Link to Issue Brief

HMA's Ellen Breslin to Present at World Congress Workshop

February 27, 2017
Arlington, Virginia

The World Congress 10th Annual Medicaid Managed Care Summit coming up on February 27-28, 2017. Visit www.worldcongress.com/MMC for more information.

HMA Upcoming Webinars:

Outlook for Medicare: An Assessment of Potential Healthcare Policy Changes that Could Impact Original Medicare and Medicare Advantage

Wednesday, February 15, 2017
1 to 2 p.m. EST

Registration Link

Throughout his campaign, President Trump indicated he would not make cuts to the Medicare program. But the reality is that the repeal of the Affordable Care Act could have a significant impact on several important Medicare benefits. Furthermore, many Republican legislators are considering a number of reforms that could drastically change the Medicare program, including the potential transition of Medicare to a premium support program. During this webinar, HMA Principal Mary Hsieh and Senior Consultants Aimee Lashbrook and Jason Silva will outline some of the key Medicare reforms being considered, which – if any – are likely to make it to the President's desk, and how healthcare organizations can best navigate the evolving Medicare business and regulatory environment.

Relationship-Centered Care: A Healthcare Provider's Guide to Patient Engagement, Shared Decision Making, and Improved Outcomes

Thursday, February 16, 2017
1 to 2 p.m. EST

Registration Link

Relationship-centered care is more than just a good bedside manner. It's an entire primary and behavioral care construct designed to foster patient engagement, shared decision making, and a deep collaborative approach between healthcare providers and patients. During this webinar, HMA experts Margaret Kirkegaard, MD, Family Physician, and Jeffrey Ring, PhD, Health Psychologist, will provide a deep appreciation of the value of relationships in the provision of medical care, including data that illustrates the efficacy of the relationship-centered approach. The webinar will also provide a roadmap for provider organizations striving to enhance relationship-centered care initiatives that involve providers, patients, and the entire medical and administrative staff.

HMA Welcomes…

Melisa Byrd, Senior Consultant – Washington, D.C.

Melisa joins HMA from the District of Columbia Department of Health Care Finance (DHCF) where she most recently served as Chief of Staff. In this position, Melisa supported the transition to value based purchasing across the Medicaid program, including a new managed care pay-for-performance program and the development and implementation of health homes programs. She oversaw the annual preparation and justification of the agency's nearly $3 billion budget and advised the Agency Director on all major policy initiatives. Melisa served as the point of contact with the Mayor's policy office and the council on all policy and legislative matters. During her tenure, Melisa maintained an average agency vacancy rate of 15 percent – down from a high of nearly 50 percent when she took the position in 2011. Additional positions Melisa held with DHCF include Special Projects Officer and Associate Director of the Health Care Policy and Planning Administration.

Prior to DHCF, Melisa served as a Policy Advisor with Louisiana Department of Health and Hospitals (DHH). In this role, Melisa executed the Secretary's policy initiatives, including leading Medicaid waiver negotiations between state and federal governments. She advised the Secretary and other executive staff on state and national policy issues and short and long-term strategic planning for the department. Melisa managed state efforts to expand health insurance coverage through Medicaid waivers and supported the Louisiana Health Care Redesign Collaborative in the development of a plan to redesign the New Orleans area healthcare system through coverage expansion, health information technology and quality improvement. She also held the positions of Program Coordinator and Program Specialist with DHH's Bureau of Policy Research and Program Development.

Previously, Melisa served as a Policy Analyst for the National Governors Association (NGA) where she advised health policy advisors on emerging health issues and identified key issues related to chronic disease prevention and management, the health workforce, Medicaid and long-term care policy. Melisa also served as an Administrative Coordinator for NGA.

Melisa received her Bachelor of Arts degree in Government from Wofford College in Spartanburg, South Carolina.

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

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

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