HEALTH MANAGEMENT ASSOCIATES

# HMA Weekly Roundup

Trends in State Health Policy

*July 26, 2017*




RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS


## THIS WEEK



## IN FOCUS

### VIRGINIA RELEASES MEDALLION 4.0 MEDICAID MANAGED CARE RFP

This week, our *In Focus* section reviews the request for proposals (RFP) issued by the Virginia Department of Medical Assistance Services (DMAS) for the Medallion 4.0 Medicaid managed care program. Medallion 4.0 will serve roughly 740,000 children, including those with special health care needs, families, and individuals in foster care and adoption assistance programs, with annual Medicaid managed care spending of more than $3 billion when fully implemented by the end of 2018. Proposals are due to DMAS on September 8, 2017.

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## Medallion 3.0 Shift to Medallion 4.0

The Medallion 3.0 program currently provides Medicaid managed care to around 784,000 members across seven regions in the state. However, around 86,000 current Medallion 3.0 members will shift to the new Commonwealth Coordinated Care Plus (CCC Plus) program on January 1, 2018. CCC Plus, a separate Medicaid managed care program providing managed acute care and long-term services and supports, was procured in the last year under a separate RFP.

When fully implemented, Medallion 4.0 will cover nearly 740,000 Medicaid and Family Access to Medical Insurance Security (FAMIS) eligible members, including infants, children and adults in the low income families with children (LIFC) group, pregnant women, FAMIS MOMS, foster care and adoption assistance, children with special health care needs, and teens. This figure includes roughly 30,000 new Medallion 4.0 members. Based on an average per-member-per-month capitation rate of $349, as provided in the RFP, annual capitation payments to MCOs under the Medallion 4.0 can be estimated at more than $3 billion.

| Medallion 4.0 Region | Potential Enrollment (Based on July 2017 data) |
|---|---|
| Tidewater | 161,421 |
| Central | 189,438 |
| Northern/Winchester | 178,416 |
| Charlottesville/Western | 88,486 |
| Roanoke/Alleghany | 72,827 |
| Southwest | 46,558 |
| **Total - All Regions** | **737,146** |

*Source: DMAS RFP*

Medallion 4.0 excluded categories of eligibility are CCC Plus enrollees, individuals in home and community based services (HCBS) waivers, members in the aged, blind, and disabled (ABD) category of eligibility (including SSI), dual eligibles, Program of All-Inclusive Care for the Elderly (PACE) members, as well as a number of smaller and limited benefit categories.

Medallion 4.0 will also mark the beginning of Medicaid managed care plans covering and coordinating new services, such as Early Intervention and non-traditional behavioral health services, previously carved out of Medallion 3.0.

## Contract Terms, Considerations

DMAS intends to contract with at least three MCOs in each of the six regions. Bidders may propose to serve any number of regions, and do not need to submit separate bids for each region. Initial contracts will run for one year, with annual contract extension/renewal options available up to a maximum term of six years.

In December 2016, the Virginia Joint Legislative Audit and Review Commission (JLARC) released its report, *Managing Spending in Virginia's Medicaid Program*. The RFP encourages bidders to review the report and indicate in their proposals how they will "participate in and comply with all initiatives" DMAS pursues in response to the report. HMA provided a summary of the JLARC report in the December 14, 2016, edition of the HMA Weekly Roundup which is available on our website, www.healthmanagment.com.

Contracted MCOs must maintain a minimum medical loss ratio (MLR) of 85 percent, with adjustment payments to be made to the state if actual MLRs are found to be less than the minimum.

## RFP Timeline

A mandatory preproposal conference will be held this Friday, July 28, 2017, with a deadline for submitting inquiries to follow on July 31. Proposals are due to DMAS on September 8, 2017. No date has been announced for potential contract awards.

Implementation of Medallion 4.0 will begin on August 1, 2018, to be phased in across the six regions through the remainder of the calendar year.

| RFP Milestone | Date |
|---|---|
| Mandatory Preproposal Conference | July 28, 2017 |
| Deadline for Submitting Inquiries | July 31, 2017 |
| Proposals Due | September 8, 2017 |
| Contract Awards | TBD |
| Implementation - Tidewater | August 1, 2018 |
| Implementation - Central | September 1, 2018 |
| Implementation - Northern/Winchester | October 1, 2018 |
| Implementation - Charlottesville/Western | November 1, 2018 |
| Implementation - Roanoke/Alleghany, Southwest | December 1, 2018 |

## Current Medallion 3.0 Market

The Medallion 3.0 program, served by seven MCOs, is dominated by Anthem, Virginia Premier, and Optima Health, with combined market share of more than 80 percent.

| Medallion 3.0 MCO | First Quarter 2017 Enrollment | Market Share |
|---|---|---|
| Anthem HealthKeepers | 265,980 | 34.4% |
| Virginia Premier Health Plan | 197,409 | 25.5% |
| Optima Health Plan | 179,049 | 23.1% |
| INTotal Health | 62,581 | 8.1% |
| Aetna/Coventry | 52,030 | 6.7% |
| Humana | 13,600 | 1.8% |
| Kaiser Foundation Health Plan | 3,385 | 0.4% |
| **Total Medallion 3.0 Enrollment** | **774,034** | |

*Source: HMAIS*

DMAS awarded CCC Plus contracts in February 2017 to six MCOs: Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Health, United Healthcare, and Virginia Premier Health Plan. Aside from United and Magellan Complete Care, all selected plans are incumbents in Medallion 3.0 plan. Beginning in August 2017, DMAS will begin implementation of the new CCC Plus program, which will provide integrated acute care and long-term services and supports (LTSS) to around 214,000 older adults and both children and adults with disabilities.

## Link to Medallion 4.0 RFP

http://www.dmas.virginia.gov/Content_atchs/m4/RFP201703,MEDALLION4FINAL.pdf

HMA Medicaid Roundup

## California

**Kaiser Permanente to Expand Behavioral Telehealth.** *mHealth Intelligence* reported on July 20, 2017, that Kaiser Foundation Health Plan will expand its telehealth platform in California as part of an agreement with state regulators to improve access to behavioral health services. Kaiser and the California Department of Managed Health Care worked together for two years on a plan to improve access to behavioral health care. Read More

## Colorado

**Medicaid Program Puts New Limits on Opioid Prescriptions.** *The Denver Post* reported on July 24, 2017, that Colorado's Medicaid program has placed new limits on opioid prescriptions in hopes of preventing abuse. The policy limits opioid dosages to 250 morphine milligram equivalents per day. It also limits first-time opioid prescriptions to a seven-day supply with two additional refills. Read More

## Indiana

**HIP 2.0 Proposed Medicaid Work Requirements Revised After Public Backlash.** *Modern Healthcare* reported on July 24, 2017, that Indiana has revised an amendment to its Healthy Indiana Plan 2.0 waiver renewal application, which calls for certain Medicaid beneficiaries to have a job or be seeking work in order to receive coverage. Following a public backlash, the state changed the proposed work requirement to exclude students, pregnant women, and individuals who are homeless, among a number of other categories. The state, which filed the revised amendment with the Centers for Medicare & Medicaid Services, estimates that approximately 30 percent of Medicaid enrollees will need to comply. Read More

## Iowa

**Poll Shows 47 Percent of Adult Iowa Residents Favor Return to FFS Medicaid.** *The Des Moines Register* reported on July 19, 2017, that 47 percent of Iowa adults think the state should transition back to Medicaid fee-for-service from managed care, according to a *Des Moines Register/Mediacom* Iowa Poll. Former Governor Terry Branstad's administration implemented statewide Medicaid managed care in April 2016, saying the move would save hundreds of millions of dollars and result in more efficient care. However, the program has faced numerous issues since implementation, with both providers and

insurers citing concerns. The state is still negotiating with insurers on rates, which were originally scheduled to take effect July 1. Read More

## Kansas

**Republicans Differ on Medicaid Expansion, Mirroring National Debate.** *The Kansas City Star* reported on July 21, 2017, that the national rift among Republicans over Medicaid expansion is similar to the one Kansas has experienced for some time. Even as one group of Kansas Republicans has pushed for expansion, the state's more conservative Republicans have opposed it. Likewise, about half of Republican states have expanded Medicaid and half haven't. All of which pose significant challenges for Congressional Republicans trying to limit or end expansion without upsetting Republican governors who have supported it. Read More

## Louisiana

**State Deliberates Extending Medicaid Managed Care Contracts.** *Modern Healthcare* reported on July 20, 2017, that Louisiana's Department of Health is deliberating whether or not to extend contracts with the state's five Medicaid managed care organizations. The three-year Medicaid contracts can be extended by one or two years. The current contracted plans are Aetna Better Health of Louisiana, Amerigroup Louisiana; AmeriHealth Caritas of Louisiana, Louisiana Healthcare Connections, and UnitedHealthcare of Louisiana. A decision on contract extensions is expected by September. Read More

**Amerigroup, BCBS-LA Partner to Serve Medicaid Members Under Healthy Blue Name.** The Louisiana Department of Health announced on July 24, 2017, that Amerigroup Louisiana has entered into a partnership with Blue Cross Blue Shield of Louisiana to serve Medicaid members in the state effective September 1 under the new name Healthy Blue. Amerigroup's network providers will not be affected. Amerigroup has notified its Healthy Louisiana Medicaid program members of the change. Read More

## Mississippi

**Mississippi True, Anthem Protest Medicaid Managed Care Awards.** *The Clarion-Ledger* reported on July 21, 2017, that Anthem/Amerigroup and provider-owned health plan Mississippi True filed separate protests against Mississippi's recent Medicaid managed care contract award. The Mississippi Division of Medicaid awarded contracts in June to Centene/Magnolia, Molina Healthcare, and UnitedHealth. Mississippi True claims the "scoring arbitrarily and capriciously favored out-of-state for-profit corporations." Read More

## Montana

HMA Roundup – Rebecca Kellenberg (Email Rebecca)

**Medicaid Providers Say State Health Department Putting Unfair Share of Cuts on Them.** Montana Department of Public Health and Human Services is proposing to reduce reimbursements to doctors and other providers by nearly 3.5 percent. The department could have to reduce its budget by $14 million

under a law passed by the Legislature this spring requiring mandatory cuts if state revenues came in below what was expected. An announcement is expected Tuesday on how severe cuts will be, but estimates show the state is down $65 million from projected revenue and agencies are preparing for the steepest level of reductions. However, the state legislative committee that oversees the department will file a formal objection to the proposed 3.5 percent rate cuts. As Jon Knokey, A Bozeman Republican on the committee said, "There is incredibly bipartisan support within the Legislature that this is not at all what we intended." Reimbursement rates would go down for physicians, outpatient services, rural critical access hospitals, dialysis, drug reimbursement, dental care, vaccines, home infusion therapy services, screenings and services for infants and babies, midwives, ambulance services, audiology services, occupational, physical and speech therapists, optometrists, chiropractors and lab and imaging fees and more. Additional program cuts include ending the Third Party Administrator Contract with Blue Cross Blue Shield of Montana to administer the HELP Program, Montana's Medicaid expansion program, and bringing these duties in-house. The health department will hold a hearing on the proposed rule this Thursday at 8:30 a.m. in Helena at 111 N. Sanders St. Read More

## Nebraska

**Medicaid Budget Cuts, Rate Formula Could Cost Hospitals $21 Million.** *Omaha World-Herald* reported on July 21, 2017, that Nebraska's 2017-19 biennium budget cuts payments to hospitals, which along with changes made to the Medicaid payment rate formula in 2014 will cost hospitals more than $21 million. Interim state Medicaid director Thomas Thompson said that the cuts were necessary. The state started the year with a budget shortfall of approximately $900 million. The Department of Health and Human Services estimates that Nebraska hospitals will still receive about $508 million in Medicaid payments this year. Read More

## New Hampshire

**Governor Opposes DOI-Planned Waiver for Exchange Plan Reinsurance Program.** *New Hampshire Public Radio* reported on July 20, 2017, that New Hampshire hopes to establish a reinsurance program to shore up the state's Exchange plans. The state Department of Insurance is seeking a federal waiver to reimburse Exchange plans for high-cost medical care, with funding coming from the federal government and from a fee on insurance companies. New Hampshire Governor Chris Sununu opposes the proposed fee, expressing concern it would just be passed along to consumers. Read More

## New Jersey

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

**State Legislators Consider Resolution to Block Transfer of Mental Health and Addiction Services from Department of Human Services to Department of Health.** On July 25, 2017, a joint legislative hearing was held to discuss the Governor's proposal to reorganize the Executive Branch, transferring the Division of Mental Health and Addiction Services from the Department of

Human Services to the Department of Health. *NJ Spotlight* reported that, while most stakeholders testifying agreed with the "whole person" objectives of the proposal, they questioned the timing and approach of such a reform. According to Assemblywoman Valerie Vainieri Huttle, no providers were consulted by the state on the reform plan. *POLITICO New Jersey* reported that the Assembly plans to vote on a resolution, ACR254, on July 31, 2017. Read more

**State Supreme Court Decides in Favor of Hospitals Seeking OMNIA Health Plan Report on its Hospital Network's Tiered Ranking System.** On July 24, 2017, *NJBIZ* reported that the New Jersey Supreme Court ruled in favor of four hospitals requesting that Horizon Blue Cross and Blue Shield to disclose information about its selection process in assigning hospital contractor tiers as a part of its OMNIA plan's value-based care program. The information is a part of a report prepared for Horizon by McKinsey & Company. Hospitals assigned to Tier 2 are in-network, but members who select those hospitals pay higher copays than members who use hospitals assigned to Tier 1. CentraState Healthcare System, Holy Name Medical Center, Valley Health System, and in a separate case, Saint Peter's Healthcare System, are seeking the rates and metrics from the McKinsey report. Horizon has accepted the decision. Read more

# *New York*

## HMA Roundup – Denise Soffel (Email Denise)

**New York Demonstrates Progress in Reducing Avoidable Hospital Use; Launches Children's Initiative.** New York State Medicaid Director Jason Helgerson spoke at the United Hospital Fund annual conference on Medicaid in New York. As part of his review of the state's Medicaid program and its future direction, he reported on progress that has been made in reducing avoidable hospital use. As part of the state's Delivery System Reform Incentive Payment program the state is required to reduce avoidable hospital use by 25 percent over the course of the 5-year program, including avoidable readmission, avoidable emergency department visits, and admission for conditions where appropriate ambulatory care can reduce the need for an inpatient stay. In the first two years of DSRIP Performing Provider Systems have reduced potentially preventable readmissions (PPRs) by 7.7 percent. The most successful PPS, NYU Lutheran, reduced PPRs by almost 30 percent; three PPSs actually saw a slight increase in PPRs. Helgerson noted that if all PPSs maintain their current reduction rates, the state will achieve a 33 percent reduction in PPRs by the end of the DSRIP program. When looking at potentially preventable emergency department visits (PPVs), the reduction was 6.1 percent, with Refuah, the only PPS sponsored by an FQHC, demonstrating the most significant reduction, of over 18 percent. Again, two of the PPSs saw a slight increase in PPVs. The state forecasts that if all PPSs maintain their current rates, the state will achieve a 27 percent reduction overall.

Helgerson also announced a new initiative called "First 1000 days on Medicaid" targeted at improving outcomes and access to services for children during their first 3 years of life. Noting that 59 percent of children under the age of 3 in NY are covered by Medicaid, Helgerson has established a stakeholder process to develop a ten-point plan that works across agencies and systems to improve outcomes for children, with a preliminary focus on

assuring school readiness. The idea is to focus on social determinants that go beyond the scope of traditional health care, ensuring that New York's Medicaid program is working with health, education and other system stakeholders to maximize outcomes. The initiative is chaired by Nancy Zimpher, the Chancellor of the State University of New York; recommendations are due back to the state by the end of October. The group will be built off the Value Based Payment Advisory Group on Children's Health. If you are interested in participating, contact mrtupdates@health.ny.gov.

**Deloitte Consulting Awarded Contract to Administer Insurance Programs.** *Crain's HealthPulse* reports that the New York State Department of Health has awarded a $49.1 million contract to Deloitte Consulting to help the department administer its insurance programs and ensure that the rates it pays to plans are actuarially sound. The five-year contract covers all the managed care programs and products offered by New York's Medicaid program, including the mainstream Medicaid managed care program, HIV Special Needs Plans, the managed long-term care programs, including the duals demonstration, FIDA (Fully Integrated Duals Advantage), HARPS (Health and Recovery Plans, for individuals with serious mental illness and/or substance use disorders), as well as plans for individuals with intellectual/developmental disabilities currently being designed. Many of these programs are part of New York's Care Management for All initiative. According to *Crain's*, Deloitte will also be assisting with value-based payment initiatives.

**Governor Announces Statewide Health Care Facility Transformation Program Awards.** Governor Andrew Cuomo announced $468 million in awards to support 91 projects as part of New York's Statewide Health Care Facility Transformation Program. The funding is meant to improve patient care through the development of high-quality medical facilities and programs serving the inpatient, primary care, mental health, substance use disorder and long-term care needs of communities throughout New York State. New York had sought capital funding as part of its Delivery System Reform Incentive Program, and when that funding was denied by CMS the state established its own capital program. $76 million, or just over 16 percent of the funding, is going to New York City facilities. The single largest award of $65 million was awarded to Montefiore Medical Center for the construction of a medical village in Mt. Vernon, including outpatient and emergency department facilities. Other large awards include Brooklyn Hospital for emergency room modernization ($25 million), Nassau Health Care Corporation to support on-going repairs and upgrades ($25 million), Glens Falls Hospital for the construction of a medical village ($20 million) and Cortland Regional Medical Center to allow the center to retire long-term debt, facilitating consolidation with a larger regional health care system. Despite New York's commitment to building the community-based health care infrastructure and reducing hospital use, the largest awards, and most of the funding, went to hospital systems. About $105 million, or 21 percent of the funds, went to community-based providers and nursing homes, including $59 million to 21 community health centers. The state is soliciting input as it develops the next phase of the Statewide Health Care Facility Transformation Program. The program will provide grants to "support capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including, but not limited to, merger, consolidation, acquisition or other activities intended to create financially sustainable systems of care or preserve

or expand essential health care services." Comments must be submitted via email to statewide.II.input@health.ny.gov by August 17th. Read More

**New York Insurers Concerned About Senate Health Bill.** *Crain's HealthPulse* reports on an analysis of the Better Care Reconciliation Act commissioned by the Coalition of New York State Public Health Plans. The Coalition represents eight plans participating in New York's Medicaid managed care programs, all of which are provider-sponsored. The analysis, prepared by Manatt Health, focuses on the effects of the bill's proposals to end enhanced federal funding for the Medicaid expansion and introduce per capita caps on spending. The report notes that Medicaid covers nearly one in three people in New York—more than 6 million individuals, and the Senate proposal imposes substantial cuts on New York that grow over time. The state is expected to lose $40 billion in federal Medicaid funds through FY 2026, with the reduction in federal funding exceeding 12 percent during FYs 2020-2026 when both expansion and per capita cap changes are in effect: $24 billion due to loss of enhanced funding for expansion—including $1.7 billion over the next three years, before cuts grow substantially starting in FY 2021, and $16 billion due to the new cap on federal Medicaid funding. Finally, the report notes that the Senate plan to continue Medicaid DSH cuts under current law results in an additional $250.4 million federal funding cut to New York in FY 2018, which will increase over time. Read More

# *Pennsylvania*

### HMA Roundup – Julie George (Email Julie)

**Pennsylvania Revenue Plan Still Outstanding.** Pennsylvania is in the fourth week of the 2017-18 fiscal year and still does not have a fully funded budget. While a $32 billion spending plan has been approved by the legislature, a revenue package to pay for it remains unfinished. The state Senate is expected to be called back this week to try to finalize a revenue package, on which the Senate, House Democrats, and the Governor were said to be close to getting an agreement. Read More

**Highmark Seeks 20 Percent Rate Increase on Exchange Plans.** Highmark has requested an average 20 percent rate increase next year from the Pennsylvania Insurance Department. The increase request, the highest in Pennsylvania, will affect Western PA Highmark members. Alexis Miller, a senior vice president, said the request was driven by more than $46 million in 2016 losses in the Exchange market. Read More

# *Texas*

**Three Providers to Exit Early Childhood Intervention Program.** *The Texas Tribune* reported on July 24, 2017, that the University of Texas Medical Branch (UTMB), Hill Country MHDD Centers, and Easter Seals East Texas are withdrawing from the state's Early Childhood Intervention program, leaving Galveston and Hill Country without any state-funded children's therapy providers. A decrease in reimbursement rates for therapy services drove the decision. Texas is seeking other providers to provide children's therapy services in these regions. Read More

## Utah

**State Senator Urges Governor to Reconsider Medicaid Expansion.** *Deseret News* reported on July 20, 2017, that Utah State Senator Jim Dabakis (D-Salt Lake) is urging Governor Gary Herbert to hold a special legislative session to reconsider accepting federal funding for Medicaid expansion. Dabakis said Utah Republicans opposed expansion because of uncertainty over whether federal funding would continue. He said lawmakers should reconsider now that the U.S. Senate has failed to repeal and replace the Affordable Care Act. Utah implemented a limited expansion, offering Medicaid to an additional 3,000 to 5,000 parents and 6,500 childless adults who are homeless, need substance use or mental health treatment, or are in the criminal justice system. Read More

## National

**Medicaid Expansion States See Decline in Unpaid Medical Bills, Higher Financial Satisfaction.** *StarTribune* reported on July 24, 2017, that a recent study suggests Medicaid expansion states saw large declines in unpaid medical bills and an increase in overall financial satisfaction among low-income individuals compared to states that didn't expand. The study, which analyzed data from the National Financial Capability Study, said that unpaid medical bills in expansion states fell seven percent faster than in non-expansion states. Read More

**CMS Seeks New Behavioral Health Payment Models to Drive Quality, Access.** *Modern Healthcare* reported on July 20, 2017, the Centers for Medicare & Medicaid Services (CMS) is seeking new behavioral health payment models in an effort to drive care quality and improved access for Medicaid, Medicare, and Children's Health Insurance Program (CHIP). The effort will be spearheaded by the CMS Innovation Center. Health and Human Services Secretary Tom Price had previously been critical of both the Innovation Center and value-based payments, leading to concerns that CMS would deemphasize value-based models. The Innovation Center will be holding a meeting on September 8th to solicit public comment on behavioral health payment and delivery models. Read More

**Senate Rejects Better Care Reconciliation Act in 43-57 Vote.** *The New York Times* reported on July 25, 2017, that the U.S. Senate has rejected the Better Care Reconciliation Act of 2017 in a 43-57 vote shortly after narrowly approving a procedural motion to begin debate repeal and replacement of the Affordable Care Act (ACA). The Senate will continue to debate, propose amendments, and potentially vote on repealing and replacing certain portions of the ACA, likely through the rest of the week. Read More

**Senate Considers 'Skinny Repeal' Plan that Rolls Back Mandates; Rep. Meadows Pushes for September Vote on Final Bill.** *Politico* reported on July 25, 2017, that the U.S. Senate is considering a new "skinny repeal" plan, which would roll back the Affordable Care Act's (ACA) individual and employer mandates, as well as repeal the medical device tax. The plan would keep all other major parts of the ACA in place for now and would allow the Senate to move a repeal bill into the House if they cannot agree on a more comprehensive plan. Republican leaders are pushing the "skinny repeal" as an

option if the Senate's replacement bill and a straight repeal both fail. Read More. However, according to House Freedom Caucus Chairman Mark Meadows, the "skinny repeal" will not pass the House. Representative Meadows is also calling for a final vote in early September. Read More

**Senate Parliamentarian Frustrates Republican Efforts to Remake Health Law through Reconciliation.** *Kaiser Health News* reported on July 21, 2017, that Senate Parliamentarian Elizabeth MacDonough is frustrating Senate Republican efforts to make major changes to the Affordable Care Act through budget reconciliation. MacDonough, who is charged with enforcing strict Senate parliamentary rules, said that changes made through reconciliation can't include things like temporarily defunding Planned Parenthood, imposing abortion coverage restrictions on health plans purchased with tax credits, imposing a six-month waiting period before individuals with breaks in coverage can purchase a new plan, or eliminating essential benefit and medical loss ratio requirements. Read More

**Senate Parliamentarian Further Frustrates Republican Efforts Modify ACA.** *Modern Healthcare* reported on July 25, 2017, that Senate Parliamentarian Elizabeth McDonough has further frustrated Republicans efforts to repeal and replace portions of the Affordable Care Act, noting that a 60-vote majority will be required on provisions to permit insurers to charge higher premiums for older adults, as well as a provision for small businesses to form association health plans across state lines. Senate Republicans were seeking to potentially pass these proposals through the budget reconciliation process, which requires a simple majority. Read More

**Senate Republicans to Offer $200 Billion to Help Move Medicaid Expansion Members to Commercial Plans.** *Modern Healthcare* reported on July 24, 2017, that Senate Republicans are expected to offer as much as $200 billion to help shift Medicaid expansion members to commercial health plans. The so-called "Medicaid wraparound" proposal is aimed at winning support for the Senate Better Care Reconciliation Act of 2017, especially among moderate Republicans concerned about the bill's potential impact on expansion adults. The funding, which would be available through 2026, would assist individuals with out-of-pocket and co-insurance expenses associated with commercial plans. The proposal mirrors the Arkansas private option Medicaid expansion, in which adults with incomes up to 138 percent of the federal poverty are enrolled in Exchange plans. Read More

**CBO Says ACA Repeal Bill Would Increase Uninsured by 32 Million, Reduce Federal Deficit by $473 Billion.** The Congressional Budget Office (CBO) on July 19, 2017, released its scoring of the Senate Obamacare Repeal Reconciliation Act of 2017, projecting that the legislation would result in an additional 32 million uninsured while reducing the federal deficit by $473 billion by 2026. Premiums in the individual market would double by 2026 and half of the nation's population could live in areas with no individual market insurance choices. Read More

**CBO Scores Revised Senate Health Care Bill with Same Projection for Uninsured.** *Modern Healthcare* reported on July 20, 2017, that a revised version of the Senate Better Care Reconciliation Act of 2017 would increase the number of uninsured individuals by 22 million, while reducing the federal deficit by $420 billion by 2026, according to the Congressional Budget Office (CBO) analysis. The estimate of uninsured is unchanged from the June 26 CBO

score, while the revised bill increases the reduction to the federal deficit. Federal Medicaid spending would decline by 26 percent from 2017 through 2026, largely through rolling back Medicaid expansion. The new bill also retains two Affordable Care Act taxes. Read More

**CMS Ends ACA Enrollment Assistance Contracts with Cognosante, CSRA.** *Bloomberg* reported on July 20, 2017, that the Trump administration chose not to continue contracts with Cognosante and CSRA to help individuals in 18 cities enroll in Affordable Care Act Exchange plans. The contract had one more optional year. A CMS spokeswoman stated that other federal programs to help people enroll will continue. Read More

## *Industry Research*

**Studies Reveal Cost-Sharing in Health Care Reduces Spending, May Worsen Outcomes.** *Philly.com* reported on July 19, 2017, that recent studies suggest that consumers taking a personal stake in their health spending may result in cost savings, but worsen outcomes. The findings run counter to the thinking behind a number of recent Medicaid waivers that include consumer responsibility and cost-sharing provisions. A recent study in the Netherlands revealed that requiring individuals to make co-payments for mental health services resulted in a decrease in utilization and an increase in involuntary institutionalization for mental health crises. Read More


# Industry News

**Centene Raises 2017 Earnings Expectations on Improved Exchange Plan Performance.** The *St. Louis Post-Dispatch* reported on July 25, 2017, that Centene Corp. raised its 2017 earnings outlook after reporting better-than-expected results among Exchange plans. In the second quarter alone, Centene reported net earnings of $254 million, compared to $170 million in the same period a year earlier. Enrollment rose 11 percent to 12.2 million. Exchange enrollment tops 1 million. Read More

**UnitedHealth Group Margins Improve After Exiting Exchanges.** *Forbes* reported on July 20, 2017, that UnitedHealth Group margins improved in the second quarter, driven in part by the company's decision to exit the Exchanges last year. Revenues grew in the company's various segments, with the exception of the employer and individual business, which was directly impacted by the Exchange exits. Read More

**HCA Healthcare Profits Dip in Second Quarter 2017.** *Reuters* reported on July 25, 2017, that HCA Healthcare, a for-profit hospital operator with 172 hospitals and 119 freestanding surgery centers, saw net income fall to $657 million in the second quarter of 2017, compared to $658 million the same period a year earlier. Shares fell on the news. Read More

**HCA to Acquire Florida Hospital from Community Health Systems.** HCA Healthcare announced on July 21, 2017, that it will acquire Florida-based Highlands Regional Medical Center, a subsidiary of Community Health Systems. The transaction is expected to close in the fall of 2017, subject to regulatory approval. Highlands Regional Medical Center will become part of HCA's East Florida Division. Read More

**Active Day Acquires New Jersey-based Casa Manito, Rise & Shine Adult Medical Day Care Centers.** Active Day announced on July 1, 2017, that it had acquired New Jersey-based Casa Manito and Rise & Shine Adult Medical Day Care Centers effective July 1. The centers will be re-branded Active Day at Casa Manito and Active Day of North Bergen. Active Day now operates 14 adult day health centers in New Jersey. Read More

**Anthem May Leave Additional Exchange Markets, Citing Uncertainty on Cost-Sharing Subsidies.** *Forbes* reported on July 26, 2017, that Anthem chief executive Joseph Swedish confirmed the insurer may pull out of additional state Exchange markets if uncertainty on cost-sharing subsidies continues. Anthem has already announced plans to exit the Wisconsin, Ohio, and Indiana Exchanges. Insurers are pushing for cost-sharing subsidies to be continued, arguing the payments are critical to market stability. Read More

**Molina to Cut 1,400 Corporate, Health Plan Jobs.** *Long Beach Post* reported on July 24, 2017, that Molina Healthcare plans to lay off 1,400 employees under a new strategy called "Project Nickel." The goal is to focus on being

"exceptionally strategic in doing more with less" by simplifying management and reducing organizational layers, according to interim chief executive Joe White. The cuts will affect corporate and health plan jobs, but not the company's Pathways behavioral health program. Read More

# RFP Calendar

| Date | State/Program | Event | Beneficiaries |
|---|---|---|---|
| July, 2017 | Delaware | Contract Awards (Optional) | 200,000 |
| August 1, 2017 | Virginia MLTSS | Implementation - Tidewater | 20,000 |
| August, 2017 | Alabama ICN (MLTSS) | RFP Release | 25,000 |
| Summer 2017 | Illinois | Contract Awards | 2,700,000 |
| Summer 2017 | Massachusetts One Care (Duals Demo) | Procurement Release | TBD |
| Summer 2017 | Ohio MLTSS | RFA Release | 130,000 |
| September 1, 2017 | New Mexico | RFP Release | 700,000 |
| September 1, 2017 | Virginia MLTSS | Implementation - Central | 23,000 |
| September 8, 2017 | Virginia Medallion 4.0 | Proposals Due | 700,000 |
| October 1, 2017 | Arizona ALTCS (E/PD) | Implementation | 30,000 |
| October 1, 2017 | Virginia MLTSS | Implementation - Charlottesville/Western | 17,000 |
| October 1, 2017 | Texas CHIP (Rural, Hidalgo Service Areas) | Contract Awards | 85,000 |
| October, 2017 | Alabama ICN (MLTSS) | Proposals Due | 25,000 |
| October, 2017 | Ohio MLTSS | Contract Awards | 130,000 |
| November 1, 2017 | Florida Statewide Medicaid Managed Care (SMMC) | Proposals Due | 3,100,000 |
| November 1, 2017 | Virginia MLTSS | Implementation - Roanoke/Alleghany, Southwest | 23,000 |
| November 2, 2017 | Arizona Acute Care/CRS | RFP Release | 1,600,000 |
| November 15, 2017 | New Mexico | Proposals Due | 700,000 |
| December 1, 2017 | Virginia MLTSS | Implementation - Northern/Winchester | 26,000 |
| December 18, 2017 | Massachusetts | Implementation | 850,000 |
| January 1, 2018 | Delaware | Implementation (Optional) | 200,000 |
| January 1, 2018 | Illinois | Implementation | 2,700,000 |
| January 1, 2018 | Pennsylvania HealthChoices | Implementation (SW, NW Zones) | 640,000 |
| January 1, 2018 | Pennsylvania MLTSS/Duals | Implementation (SW Zone) | 100,000 |
| January 1, 2018 | Alaska Coordinated Care Demonstration | Implementation | TBD |
| January 1, 2018 | Washington (FIMC - North Central RSA) | Contract Awards | 66,000 |
| January 1, 2018 | Virginia MLTSS | Implementation - CCC Demo, ABD in Medallion 3.0 | 105,000 |
| January 25, 2018 | Arizona Acute Care/CRS | Proposals Due | 1,600,000 |
| Winter 2018 | Massachusetts One Care (Duals Demo) | Contract Awards | TBD |
| March, 2018 | North Carolina | RFP Release | 1,500,000 |
| March 1, 2018 | Pennsylvania HealthChoices | Implementation (NE Zone) | 315,000 |
| March 8, 2018 | Arizona Acute Care/CRS | Contract Awards | 1,600,000 |
| March 15, 2018 | New Mexico | Contract Awards | 700,000 |
| April 16, 2018 | Florida Statewide Medicaid Managed Care (SMMC) | Contract Awards | 3,100,000 |
| June, 2018 | North Carolina | Proposals Due | 1,500,000 |
| July 1, 2018 | Pennsylvania HealthChoices | Implementation (SE Zone) | 830,000 |
| July 1, 2018 | Pennsylvania MLTSS/Duals | Implementation (SE Zone) | 145,000 |
| July 1, 2018 | MississippiCAN | Implementation | 500,000 |
| July, 2018 | Alabama ICN (MLTSS) | Implementation | 25,000 |
| July, 2018 | Ohio MLTSS | Implementation | 130,000 |
| August 1, 2018 | Virginia Medallion 4.0 | Implementation | 700,000 |
| September 1, 2018 | Texas CHIP (Rural, Hidalgo Service Areas) | Implementation | 85,000 |
| September, 2018 | North Carolina | Contract awards | 1,500,000 |
| October 1, 2018 | Arizona Acute Care/CRS | Implementation | 1,600,000 |
| January 1, 2019 | Florida Statewide Medicaid Managed Care (SMMC) | Implementation | 3,100,000 |
| January 1, 2019 | Pennsylvania HealthChoices | Implementation (Lehigh/Capital Zone) | 490,000 |
| January 1, 2019 | Pennsylvania MLTSS/Duals | Implementation (Remaining Zones) | 175,000 |
| January 1, 2019 | New Mexico | Implementation | 700,000 |
| January, 2019 | Massachusetts One Care (Duals Demo) | Implementation | TBD |
| July 1, 2019 | North Carolina | Implementation | 1,500,000 |
| September 1, 2019 | Texas STAR+PLUS Statewide | Implementation | 530,000 |
| September 1, 2019 | Texas STAR, CHIP Statewide | Implementation | 3,400,000 |

# Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of state dual eligible financial alignment demonstration status.

| State | Model | Opt- in Enrollment Date | Passive Enrollment Date | Duals Eligible For Demo | Demo Enrollment (June 2017) | Percent of Eligible Enrolled | Health Plans |
|---|---|---|---|---|---|---|---|
| **California** | Capitated | 4/1/2014 | 5/1/2014<br>7/1/2014<br>1/1/2015 | 350,000 | 117,302 | 33.5% | CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore) |
| **Illinois** | Capitated | 4/1/2014 | 6/1/2014 | 136,000 | 50,064 | 36.8% | Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina |
| **Massachusetts** | Capitated | 10/1/2013 | 1/1/2014 | 97,000 | 16,809 | 17.3% | Commonwealth Care Alliance; Network Health |
| **Michigan** | Capitated | 3/1/2015 | 5/1/2015 | 100,000 | 39,046 | 39.0% | AmeriHealth Michigan; Coventry (Aetna); Michigan Complete Health; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan |
| **New York*** | Capitated | 1/1/2015 | 4/1/2015 | 124,000 | 4,566 | 3.7% | There are 14 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website. |
| **New York - IDD** | Capitated | 4/1/2016 | None | 20,000 | 561 | 2.8% | Partners Health Plan |
| **Ohio** | Capitated | 5/1/2014 | 1/1/2015 | 114,000 | 74,347 | 65.2% | Aetna; CareSource; Centene; Molina; UnitedHealth |
| **Rhode Island** | Capitated | 7/1/2016 | 10/1/2016 | 25,400 | 13,717 | 54.0% | Neighborhood Health Plan of RI |
| **South Carolina** | Capitated | 2/1/2015 | 4/1/2016 | 53,600 | 7,915 | 14.8% | Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth) |
| **Texas** | Capitated | 3/1/2015 | 4/1/2015 | 168,000 | 39,919 | 23.8% | Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United |
| **Virginia** | Capitated | 3/1/2014 | 5/1/2014 | 66,200 | 27,194 | 41.1% | Humana; Anthem (HealthKeepers); VA Premier Health |
| **Total Capitated** | **10 States** | | | **1,254,200** | **391,440** | **31.2%** | |

** New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment.*

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

# HMA News

## Pros, Cons of Shared Responsibility in Medicaid to Be Topic of Roundtable Discussion at HMA Conference on Future of Medicaid, September 2017, in Chicago

Health plan executives and policy experts will join in a spirited roundtable discussion on the pros and cons of shared responsibility in Medicaid, with former Indiana Medicaid director Joe Moser kicking things off with a keynote address on the topic.

In addition to Moser, the roundtable discussion will feature Jesse Hunter, executive vice president of products, Centene Corp.; Kristen Metzger, President, Indiana Medicaid, Anthem Blue Cross and Blue Shield; and Christopher Perrone, Director, Improving Access, California Health Care Foundation.

The session will take place during HMA's conference, *The Future of Medicaid is Here: Implications for Payers, Providers and States,* September 11-12, 2017, at the Renaissance Chicago Downtown Hotel**.**

More than 300 are already registered to attend the event, which will features 37 industry-leading speakers and address the challenges and opportunities of serving Medicaid and other vulnerable populations given the priorities of the new Administration and Congress

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