HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

GRAHAM-CASSIDY AFFORDABLE CARE ACT (ACA) REPEAL-AND-REPLACE BILL

This week, our *In Focus* section reviews the bill put forward last week by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) to repeal and replace the Affordable Care Act (ACA). General consensus, the HMA Roundup included, viewed ACA repeal-and-replace efforts as largely defeated at the end of July, with the Senate's failure to pass the Better Care Reconciliation Act. There is, however, an emerging view, which was shared by several speakers at

last week's HMA conference, that the Graham-Cassidy bill has a real chance of passing the Senate ahead of the September 30 deadline, at which point the reconciliation process expires and a bill would require 60 votes to pass the Senate. Below, we highlight key provisions of the Graham-Cassidy bill that impact federal funding to states, state Medicaid programs, and the Exchange and individual insurance markets, including both a block grant program targeted at higher-income and Medicaid expansion populations and a Medicaid per capita cap funding structure.

Block Grant Program

The Graham-Cassidy bill proposes eliminating funding for the Medicaid expansion, Exchange tax credits and cost-sharing reduction (CSR) payments, and basic health plan by 2020. Instead, the funding from these programs would be replaced by block grants aimed at providing state flexibility under a capped funding structure. The bill sets a capped amount of funds ($200 Billion by 2026) to be distributed among states through the block grant mechanism. The initial allocation to states would be based on current spending, grown forward to 2020. This base amount would then be adjusted by one-sixth of the difference between the 2020 base amount and the 2026 targeted amount. As a result, over the six year period, block grant funding allocations would gradually shift to states proportionate to their total share of the population between 50 and 138 percent FPL. Block grants are not contingent on state matching funds. States can apply for waivers with significant flexibility in how they utilize block grant dollars, including:

- Providing premium support to purchase coverage;
- Contracting with insurers and managed care plans to encourage market participation;
- Providing direct payment to providers for health care services;
- Establishing high-risk pools and reinsurance programs;
- Providing funding to reduce out-of-pocket costs for consumers; and
- Utilizing up to 20 percent of the block grant to fund the state's traditional Medicaid program.

The block grants under Graham-Cassidy aim to provide funding parity across states for individuals between 50 and 138 percent FPL on a per capita basis. The bill would also include a risk-adjustment formula, which can adjust per beneficiary funding to states to account for higher cost population variation across states. The Senators have published an illustrative model of the impacts on per member funding, which shows several states with higher per capita spending (including Massachusetts and Oregon) losing funding on a per beneficiary basis, and the majority of states receiving increased funding on a per beneficiary basis by 2026. However, the model may not fully capture the impact of block grants on reduced federal funding to states, and does not include the impact of the Medicaid per capita payment reforms to be implemented alongside the block grants, as detailed below.

Medicaid Per Capita Payment Reforms

While the block grants described above target the Medicaid expansion and expansion-like population, Graham-Cassidy would also implement a Medicaid per capita cap funding structure as was proposed under the Better Care Reconciliation Act. However, Graham-Cassidy would increase growth rates in

per capita funding, utilizing the CPI-Medical inflator through 2024, for older adults and individuals with disabilities.

Options to Mitigate Funding Shortfalls

The Graham-Cassidy bill provides several options to states to address funding shortfalls under the new structures.

- States may restore penalties associated with the employer and individual coverage mandates, which are both repealed under the bill.
- States may continue to provide funding that would have otherwise been in place under a federal matching fund structure.
- Any state that faces a budget shortfall under the Graham-Cassidy bill as compared to the BCRA bill's structure grown by CPI-M, may continue to receive scheduled Disproportionate Share Hospital (DSH) funding cuts under the ACA. States must provide matching funds on any DSH dollars received.
- In early years of implementation, 2020 through 2024, states may effectively borrow funds from 2025 and 2026 allotments to support transition to the new funding structure.

Additional Provisions of Graham-Cassidy

The bill includes a number of additional provisions, including:

- Repealing a number of ACA taxes, including the Medical Device Tax, a tax on health savings accounts, and a tax on over-the-counter medications;
- Repealing the ACA's Prevention and Public Health Fund;
- Eliminating the option for states to expand Medicaid as of September 1, 2017;
- Granting flexibility to states to institute work requirements in Medicaid and increase frequency of eligibility redeterminations;
- Phasing down the Medicaid provider tax threshold from the current level of 6 percent to 4 percent by fiscal year 2025;
- Providing states the option to cover inpatient psychiatric hospital services to individuals between 21 and 65 as of October 1, 2018; and
- Allowing individuals to purchase catastrophic health plan coverage, and include catastrophic coverage in the individual and small group market risk pools.

Graham-Cassidy to Receive Limited CBO Assessment Next Week

The Congressional Budget Office (CBO) announced on September 18 that it would provide a limited assessment of the Graham-Cassidy bill early next week, the week of September 25. The CBO's analysis will address budgetary impacts and compatibility with the reconciliation process, but will not address coverage and premium impacts or the longer-term impact on the federal deficit. As noted above, the Senate's ability to use the reconciliation process to pass an ACA repeal-and-replace bill expires after September 30.

HMA Medicaid Roundup

California

State Senate Passes Bill Requiring Insurers to Report on Frequently Prescribed Drugs. The *Los Angeles Times* reported on September 13, 2017, that the California Senate approved a bill that would require health plans to report to the state on the 25 drugs that are identified as frequently prescribed, costly, and having the highest year-to-year price increases. SB 17, which was introduced by state Senator Hernandez (D-West Covina), would also require insurers to provide notice if they plan to increase drug prices beyond a certain threshold. The bill now heads to Governor Jerry Brown's desk. Read More

District of Columbia

District Wins Ruling in Class Action Suit Filed by Nursing Home Residents Over HCBS. *The Washington Post* reported on September 13, 2017, that Washington, DC, did not violate a federal mandate to move nursing home residents into community-based settings, according to a federal judge. In dismissing a class action lawsuit brought by nursing home residents, U.S. District Judge Ellen Segal Huvelle pointed to various barriers preventing the District from complying with the mandate. Chief among these was lack of affordable housing. "Plaintiffs have failed to demonstrate the existence of a concrete, systemic failure that entitles them to class-wide relief," she noted. Read More

Florida

AHCA Removes Rehabilitation Center from Medicaid Program After Eight Deaths. *The New York Times* reported on September 15, 2017, that the Rehabilitation Center in Hollywood Hills, Florida was suspended from the state Medicaid program after eight patients died in the aftermath of Hurricane Irma. Approximately 140 residents were evacuated from the nursing home on Wednesday after a number of residents were admitted to a nearby hospital for dehydration, heat stress, and difficulties breathing. The Rehabilitation Center is currently under criminal investigation. Read More

Indiana

Nursing Home Management Firm Files RICO Lawsuit Against Former Executives. *The New York Times* reported on September 18, 2017, that nursing home management firm American Senior Communities has filed a federal lawsuit in Indiana against several former executives and 16 shell companies for

allegedly violating the Racketeer Influence and Corrupt Organizations Act. Some executives named in the suit had already been charged criminally for allegedly embezzling $16 million. They were also charged with conspiracy to defraud Medicaid, Medicare, and the Health & Hospital Corp. of Marion County. The executives have pleaded not guilty. American Senior Communities manages nearly 100 senior care facilities. Read More

Iowa

Iowa Medicaid Considering Managed Care Exemption for Individuals with Serious Disabilities. *The Des Moines Register* reported on September 14, 2017, that Iowa is considering exempting individuals with serious disabilities from Medicaid managed care, according to Jerry Foxhoven, director of the state Department of Human Services. Instead, these individuals would transition back into fee-for-service Medicaid. Foxhoven stated that there is little managed care organizations can do to save costs or improve the health of individuals with serious disabilities. Read More

Minnesota

Governor Asks CMS to Approve 1332 Waiver, Reverse Penalty to Basic Health Plan. *Politico* reported on September 20, 2017, that Minnesota Governor Mark Dayton is criticizing the federal government for its process of evaluating Affordable Care Act 1332 waivers for approval. Minnesota had requested a waiver for federal funding to support a state-based reinsurance program. The waiver was expected to be approved in August. However, Dayton says the Centers for Medicare and Medicaid Services (CMS) told the state that funding for the Basic Health Plan for MinnesotaCare would be reduced. Dayton is asking CMS to approve the waiver and reverse the penalty to the Basic Health Plan. Read More

Mississippi

MississippiCAN Contracts Move Forward Following Review Board's Non-Vote. *The Clarion-Ledger* reported on September 20, 2017, that MississippiCAN Medicaid managed care contracts worth $2 billion will move forward after the Public Service Contract Review Board declined to take up the matter. A state Medicaid spokesperson said the contracts will be submitted to the Centers for Medicare & Medicaid (CMS) for approval. The state is currently three months behind schedule, but still hopes to go live July 1, 2018. Mississippi True, one of the losing bidders, believes that the contracts should be voided because changes were not approved by the board. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Governor Announces $200 Million Plan to Reduce Drug Addition. *NJSpotlight* reported on September 201, 2017, that Governor Chris Christie announced a $200 million plan to expand existing programs and create new performance-based programs to reduce drug addiction and substance use disorders (SUD). A large portion of the budget has been allocated towards

expanding care for adults with Medicaid or no insurance, Recovery Coach Programs throughout the state, supportive housing for adults in recovery, and a Department for Children and Families program that offers housing and other assistance to families. Additionally, the funding will be used to create and expand current programming across various state agencies; hire new staff for juvenile justice facilities; offer trainings in the use of narcan; improve screening and intervention; and expanding medication-assisted treatment in correctional facilities. Funding for this plan will be reallocated from state department budgets and "lapsed" dollars. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

State Blames Correctional Health Company for Death of Three Inmates. *NBC* reported on September 17, 2017, that the death of three inmates last year at Nassau County Jail was a result of Armor Correctional Health Services failing to provide adequate medical treatment, according to the New York State Commission of Corrections. The Florida-based medical vendor has denied the state oversight agency's findings. Read More

Fidelis Care to be Acquired by Centene. Centene Corporation announced that it has signed a definitive agreement under which Fidelis Care will become Centene's health plan in New York State. Under the terms of the agreement, Centene will acquire substantially all of the assets of Fidelis Care for $3.75 billion, subject to certain adjustments. The agreement has been described as an asset purchase. Fidelis Care operates the largest Medicaid managed care plan in New York, with 1.3 million members. Fidelis Care is the only Medicaid managed care plan with a presence in every county across the state. Fidelis Care is a not-for-profit provider-sponsored plan operated by the Diocesan Bishops of the State and Ecclesiastical Province of New York and Catholic health care providers. As such, the transaction will require approval by the Charities Bureau of the New York Attorney General, as well as approval by the Department of Health and the Department of Financial Services. It is unclear whether Centene has begun discussions with state regulators, or how long the approval process might take, although Centene has said they expect the deal to close early in 2018. When Empire Blue Cross began the process for conversion from a not-for-profit to a for-profit entity, multiple stakeholders raised concerns, leading to a series of public hearings, extensive stakeholder input, and many months of negotiations. Although this is a an asset purchase and not a conversion, it is likely to be subject to similar scrutiny. Read More

Court Rules that Home Care Agencies Must Pay Staff for 24-Hour Care. A state Appellate Court has ruled that home care agencies must pay live-in home health aids 24 hours per day, and not the 13 hours that is the industry standard. The 13-hour standard is based on the notion that live-in aids sleep 8 hours, and spend 3 hours/day for meals, and are therefore only working 13 hours. As reported in Politico, the case was brought by two workers who argued that New York's minimum wage law requires that workers be paid for the time an employee is required to be available for work. If the decision stands, it means that agencies must pay for an additional 11 hours of care per day, almost doubling the cost of care. It is estimated that it will increase costs for home care by tens of millions of dollars. Further, the court has allowed a

class action suit to move forward that could potentially leave home care agencies liable for up to six years of back pay for thousands of employees. Read More

Children's Medicaid System Transformation Overview. The New York State Department of Health has posted slides from its recent webinar on the Children's Medicaid System Transformation. Due to overwhelming interest the state was not able to respond to all the questions it received, and is planning to release FAQs to answer questions around the Transformation to provide further clarity and responses to feedback. The state intends to bring six different 1915-c waivers under its 1115 waiver so that all children in the state's Medicaid program are eligible for the same set of home and community based services (HCBS). Care management that is currently provided under the 1915-c programs will be shifted to health homes, and current care managers will be absorbed by the 16 children's health homes. The state is adding six new state plan services for children, some of which are currently offered through waiver programs. The state intends to determine eligibility for HCBS under a Level of Need standard rather than the current Level of Care standard (i.e., needing institutional support) so they can provide services to children both before they deteriorate to the level of needing institutional services, and to support bringing them back to the community when an institutional level of care is no longer necessary. During the webinar the state noted that it has submitted various amendments to New York's 115 waiver, the Medicaid Redesign Team waiver, to CMS, which are being reviewed, but have not yet been approved. Read More

Indigent Care Funding Continues to Skew Payments Away from Safety Net Hospitals. A recent issue brief released by the Empire Center reviews the distribution of New York's indigent care pool dollars for 2015. The Indigent Care Pool distributes over $1 billion to reimburse them for providing free care to the poor and uninsured. But due to a quirk in the distribution formula, how much money a hospital receives bears limited relation to how much charity care it delivers. Safety-net institutions serving large numbers of poor and uninsured patients get significantly fewer pennies on the dollar for the care they deliver, while some hospitals serving affluent communities receive payments in excess of the charity care provided. This is the result of a political compromise that was achieved when the charity care distribution formula was revised in 2013, with a goal of linking charity care payments directly to the amount of care provided to the uninsured. In order to prevent large fluctuations in indigent care payments, however, the formula included a "transition adjustment" that sharply limited how much each hospital's grant could increase or decrease in a given year. This adjustment effectively overrides the need-based calculation for the majority of hospitals, resulting in a disconnect between need and funding. Read More

Value Based Payment Clinical Advisory Group Recommendations for Managed Long-Term Care, Children. As part of its Delivery System Reform Incentive Payment program (DSRIP), New York is committed to shifting payments made by Medicaid managed care plans to providers away from fee-for-service arrangements and toward value-based payment methodologies. As part of the transition the state has convened a series of clinical advisory groups to develop recommendations that are specific to a given clinical condition or population. Each report provides definitions and associated quality measures

for each VBP arrangement. The Recommendations Reports are meant to inform providers and payers of the details of each arrangement, further supporting their transition to VBP. Two new recommendation reports, on managed long-term care and on children, have recently been released for review and public comment.

The MLTC report focuses on the longer term clinical and functional care goals for MLTC members in an MLTC VBP Arrangement in order to identify any gaps or oversights. The work group identified five themes that were missing from the measure set that should be represented with added measures in future measurement years:

- Critical Prevention – Captures aspects of care related to preventing adverse events or occurrences likely to hasten decline for MLTC members
- Functional Improvement – Captures aspects of care related to supporting and improving self-care skills and maintaining independence
- Personal Choice/Satisfaction – Captures aspects of care related to following individual preferences and experience of care
- Quality of Life – Captures aspects of care related to happiness, enjoyment, consciousness, and social and emotional well-being
- Medication Review – Captures aspects of care related to monitoring prescription medications and preventing adverse drug interactions in members with multiple prescriptions

The Children's report has developed recommendations in three areas:

- VBP Principles and Payment Model - The committee proposes the State use the "North Star" Framework as a guide to create an additional, voluntary VBP arrangement for the Roadmap focused on generating health improvements for the 90 percent of children that are considered "low-cost" in Medicaid.
- Quality Measures - The committee suggests that the same metrics apply for all children, regardless of the underlying VBP arrangement, creating a Universal Child Measure Set applicable to all VBP arrangements. To address known disparities in children's health, all measures in this universal set should be reported with relevant race/ethnicity data to the fullest extent possible.
- Additional Work/Deliberation - Committee members recommend further deliberative work in a few areas, especially in analyzing the appropriateness and potential opportunities of value based payment for vulnerable subpopulations of children and adolescents.

Comments and questions on both reports are welcome through September 25 at vbp@health.ny.gov .

Department of Health Releases Report on Health Care Delivery Models. The New York State Department of Health released a report addressing innovative forms of care delivery that are not presently required to undergo state Certificate of Need processes nor required to obtain authorization to conduct office-based surgery ("OBS"). The report examines retail clinics, urgent care

providers and major physician practices whose physicians are linked directly or indirectly in an economic relationship. The report explores the impact of these respective types of entities on the delivery, quality and cost of health care in the respective communities and regions in which they are found. While conclusions regarding the impact of these entities on health care delivery, quality and cost are very limited, the report concludes that these models have the potential for creating a beneficial impact by increasing access to services in convenient, community-based settings, using evidence-based methods, and in some cases providing care at lower cost than traditional alternatives. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

House Reconsiders Overriding Governor Kasich's Veto to Protect Medicaid Expansion. *Cleveland.com* reported on September 17, 2017, that the Ohio House of Representatives is reconsidering whether to override Governor John Kasich's veto of a budget provision that would freeze enrollment in the state's Medicaid expansion program. House Republicans had until September 17 to respond to House Speaker Cliff Rosenberg's memo inquiring about their stance on overriding Kasich's veto. The Medicaid expansion freeze would have taken effect on July 1, 2018, and prevented individuals that drop out of Medicaid from re-enrolling. The House decided not to override the veto back in July as the lawmakers wanted to see how things played out in Congress. Read More

Study Says Residents with Developmental Disabilities Receive Poorer Care. *The Columbus Dispatch* reported on September 16, 2017, that individuals with intellectual or developmental disabilities (I/DD) in Ohio fare worse in terms of health status, quality of care, access to care, unmet health care needs and number of hospitalizations and emergency department visits, according to a study funded by the Ohio State College of Medicine Roessler Research Scholarship, the Centers for Disease Control and Prevention (CDC), and the Maternal and Child Health Bureau. An analysis of the 2015 Ohio Medicaid Assessment Survey found that 14 percent of children with I/DD reported problems receiving care and more than half of seniors with I/DD reported at least one unmet health care need. The study recommends medical schools better prepare students to care for individuals with I/DD. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Governor Wolf Delays More Than $1B in Medicaid Payments. *The Inquirer* reported on September 15, 2017, that Pennsylvania will delay more than $1.7 billion in payments due mainly to Medicaid insurers and school districts because of unprecedented dwindling cash reserves and a fight in the General Assembly over how to address a projected $2.2 billion budget hole. Governor Tom Wolf's office issued a brief statement acknowledging the delays on Friday, September 15th, the day the state's main bank account was projected to hit zero. It is the first known time that the Pennsylvania state government has missed a payment as a result of not having enough cash. Medicaid plans serving 2.2 million members say the delayed payments will force plans to borrow money to make timely payments to hospitals, physicians

and pharmacies as required by federal law. The cost to borrow can contractually be charged to the state. Read More

Pennsylvania House Passes Revenue Plan Built on Borrowing, No New Taxes. *Trib Live/The Associated Press* reported on September 13, 2017, that the Pennsylvania House passed a no-new-taxes borrowing package to address a $2.2 billion budget gap. The package, approved 103-91, includes a $1 billion loan and fund transfers from off-budget programs, including accounts for mass transit, environmental protection and economic development. The plan is opposed by Democratic Governor Tom Wolf and will likely face pushback from the state Senate, which passed a $500 million-plus tax package in July to fully fund a $32 billion spending agreement. Read More

Texas

Draft STAR+PLUS RFP Released. The Texas Health and Human Services Commission released on September 15, 2017, a draft Request for Proposals (RFP) for its STAR+PLUS managed care services procurement. The state intends to award contracts to two managed care organizations in each service area (Bexar, Central Texas, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Northeast Texas, Nueces, Tarrant, Travis, and West Texas). Services are expected to begin September 1, 2019. Future legislatively mandated carve-ins may include:

- Texas Home Living (TxHmL) waiver program, September 2020;
- The Home and Community-based Services (HCS) waiver program, September 2021;
- Community Living Assistance and Support Services (CLASS) waiver program, September 2021;
- Individuals in the Deaf Blind with Multiple Disabilities (DBMD) program, September 2021; and
- Community-based Intermediate Care Facilities for Individuals with Intellectual Disabilities or Related Conditions (ICF/IID), September 2021.

The RFP is expected to be released November 17, 2017. Proposals will be due January 10, 2018, and contracts will be awarded January 2019.

National

Graham-Cassidy ACA Repeal Bill Gains Momentum, Vote Set for Next Week. *Politico* reported on September 18, 2017, that an Affordable Care Act repeal and replacement bill sponsored by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) is gaining momentum. Three "no" votes from Republicans would kill the bill; however, only Senators Rand Paul (R-KY) and Susan Collins (R-ME) have explicitly said they would vote "no." Supporters hold out hope that some undecided Senators may end up supporting the bill. John McCain (R-AZ), who was the deciding vote against a prior repeal and replace effort, has not explicitly said he would vote "no" this time around. Senators have until September 30 to pass the bill with 50 votes. Read More. On

September 20, 2017, Senate Majority Leader Mitch McConnell confirmed that the Senate will vote on the bill next week. Read More

Avalere Says Graham-Cassidy Would Reduce Federal Funding to States by $215 Billion. Avalere announced on September 20, 2017, that the Graham-Cassidy bill to repeal and replace the Affordable Care Act (ACA) would reduce federal funding to states by approximately $215 billion by 2026 and more than $4 trillion in the next twenty years. Cuts in federal funding would vary significantly across states, Avalere said, with Medicaid expansion states being hit the hardest over the long term. Read More

Graham-Cassidy Bill Faces Opposition from Industry, Consumer Groups. *Modern Healthcare* reported on September 18, 2017, that opponents are mobilizing against the latest Republican effort to repeal and replace the Affordable Care Act. Groups opposed to the legislation, sponsored by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) are planning protests, digital ads, social media campaigns, and phone bank efforts targeting key Republicans, including Senators John McCain (R-AZ) and Susan Collins (R-ME). Senate Republicans hope to vote on the bill next week. Read More

Senate HELP Committee Announces End of Bipartisan Effort to Fix the ACA. *The Hill* reported on September 19, 2017, that a Republican push to vote on the Graham-Cassidy bill to repeal the Affordable Care Act has put an end to bipartisan efforts to stabilize the individual health insurance market. The decision was made after House Speaker Paul Ryan (R-WI) and the White House announced that they would not support a bipartisan bill. Senator Lamar Alexander (R-TN), chairman of the Senate Health, Education, Labor and Pensions Committee, attributes the failure to Republicans and Democrats being unable to reach a consensus, while Senator Charles Schumer (D-NY) pointed toward partisan efforts being made by both sides. Read More

Senators Hatch, Wyden Introduce CHIP Funding Bill. *CQ* reported on September 18, 2017, that Senators Orrin Hatch (R-UT) and Ron Wyden (D-OR) introduced a bill (S1827) to extend funding for the Children's Health Insurance Program (CHIP) for an additional five years. The bill, introduced in the Senate Finance Committee, where Senator Hatch is chair, would maintain a 23 percent enhanced federal funding match through 2019 and an 11.5 percent enhanced match in 2020. Read More

CBO Lowers ACA Exchange Enrollment Projection for 2018. *The New York Times* reported on September 14, 2017, that the U.S. Congressional Budget Office (CBO) predicts that enrollment in Affordable Care Act Exchange plans will be less than previously predicted for 2018. President Donald Trump's administration shortened the enrollment period, cut back advertising funding, and reduced outreach efforts, likely contributing to lower enrollment. The administration has also refused to commit to insurer subsidies beyond a month-to-month approach. The CBO estimates that the average monthly enrollment on the Exchanges will be 11 million. Read More

Trump Administration Moves to Rollback Obama-Era Health Care Rules, Regulations. *Politico* reported on September 13, 2017, that the Trump administration is moving forward administratively to rollback Obama-era health rules and regulations, including a slowdown in the transition to provider payments based on quality of care rather than quantity of services performed. Other changes would include amending federal requirements for Medicaid managed care plans; loosening oversight over residential care

facilities; ending mandatory programs that hold hospitals more accountable for patient health; delaying a Medicare competitive bidding program for medical equipment; and undoing a rule that prevents nursing homes from forcing residents to sign away their right to sue. Read More

Sanders Unveils 'Medicare For All' Bill With Support of 16 Democratic Senators. *Politico* reported on September 13, 2017, that Senator Bernie Sanders (I-VT) has unveiled a "Medicare For All" bill with the support of 16 Democratic Senators, the largest number to ever support a single-payer bid. Sanders has proposed similar plans for a single-payer system in previous years, but failed to gain meaningful support. The bill would transform the Medicare program into a universal health insurance program. Read More

Industry News

Anthem Backs Off Plan to Exit Virginia Exchange Market. *The New York Times* reported on September 15, 2017, that Anthem will no longer exit the Virginia Affordable Care Act Exchange in 2018 upon learning that no other insurer had stepped in to serve numerous counties that would have been left without an Exchange plan. Read More

Anthem to Acquire Florida-based HealthSun. Anthem Inc. announced on September 20, 2017, that it has entered into an agreement to acquire Florida-based HealthSun from Summit Partners. HealthSun is an integrated Medicare Advantage plan serving 40,000 individuals in Miami-Dade and Broward counties. Its network includes 19 wholly owned primary care and specialty centers. The acquisition is expected to close by the end of 2017. Read More

Catholic Health Initiatives Posts $585.2 Million Operating Loss in 2Q17. *Modern Healthcare* reported on September 15, 2017, that Colorado-based Catholic Health Initiatives (CHI) posted an operating loss of $585.2 million in the second quarter of 2017. CHI is currently in merger talks with Dignity Health. Under the merger, CHI would also sell its hospitals in Louisville, KY, and exit the insurance business. The company already has an undisclosed buyer for its Medicare Advantage plans, but is delaying action regarding QualChoice Health, the company's Exchange plan. CHI operates 103 hospitals across 18 states. Read More

HCA Emerges as Potential Tenet Buyer, Antitrust Concerns Remain. *Modern Healthcare* reported on September 15, 2017, that Tennessee-based HCA has emerged as a potential buyer for Tenet Healthcare. Tenet is considering a possible sale following a net loss of $56 million in the second quarter of this year. The deal must clear antitrust regulatory barriers, given that HCA and Tenet each have a strong presence in south Florida. HCA already purchased three hospitals in Houston, TX, from Tenet for $750 million. Read More

Epic to Make Electronic Medical Records Available Through Internet Browser. *Modern Healthcare* reported on September 13, 2017, that Epic Systems Corp. has unveiled technology that will allow patients to send their electronic medical records to physicians for access through an internet browser, rather than solely through an EMR system. The product, called Share Everywhere, will be released in a November update of the company's MyChart product. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
TBD	Delaware	Contract Awards (Optional)	200,000
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
September 22, 2017	Massachusetts	Contract Awards	850,000
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
Timeline to be Revised	Alabama ICN (MLTSS)	Proposals Due	25,000
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 3, 2017	New Mexico	Proposals Due	700,000
November 17, 2017	Texas STAR+PLUS Statewide	RFP Release	530,000
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 10, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
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 1, 2018	Massachusetts	Implementation	850,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 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
Timeline to be Revised	Alabama ICN (MLTSS)	Implementation	25,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
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	Texas STAR+PLUS Statewide	Contract Awards	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
September 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

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

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

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

HMA NEWS

Webinar Replay: *Managing Social Determinants of Health: A Framework for Identifying, Addressing Disparities in Medicaid Populations*

Link to Webinar Replay

On September 7, 2017, HMA hosted the webinar, "Managing Social Determinants of Health: A Framework for Identifying, Addressing Disparities in Medicaid Populations," in partnership with the Disability Policy Consortium. Social determinants of health are increasingly recognized by Medicaid programs as important drivers of poor health outcomes and disparities that lead to higher costs. In response, Medicaid programs are beginning to analyze social determinants of health as potential causes of health disparities.

During this webinar, Ellen Breslin and Anissa Lambertino of HMA, Dennis Heaphy of the Disability Policy Consortium, and independent consultant Tony Dreyfus presented an analytical framework for understanding the impact social determinants of health have on Medicaid populations. Leveraging work done by the Institute of Medicine, the framework includes measures and statistical methods that Medicaid programs, health plans, and accountable care organizations can use to generate the type of information needed to develop interventions that improve health outcomes. Listen to the recording and:

- Understand why social determinants of health are key to addressing health disparities and achieving the goals of payment and delivery system reform.
- Learn about the value of population-based approaches for examining the relationship between social determinants of health and health disparities.
- Find out what it takes to implement the type of framework, measures and statistical methods needed to effectively examine the importance of social determinants of health on health outcomes.