As Senate Republicans Delay Health Care Bill Vote, Medicaid MCOs Brace for Cuts

The highly anticipated and secretly crafted Better Care Reconciliation Act — the Senate GOP’s attempt to repeal and replace the Affordable Care Act — appeared to do much to stabilize the exchange marketplace. But deep cuts to Medicaid and other changes that would have led to 22 million more uninsured people by 2026 had too many Senate Republicans coming out against the bill for Senate Majority Leader Mitch McConnell (R-Ky.) to push it to a vote this week as planned. Instead, lawmakers at press time were reportedly working on a revised version that could be voted on after the July 4 recess. Nevertheless, industry experts advise Medicaid managed care organizations to stay close to state decision makers who face drastically reduced federal funding if the GOP succeeds in passing health care reform.

Although Senate Republicans initially vowed to craft their own legislation rather than revise the American Health Care Act that passed the House in May, what they introduced on June 22 was broadly similar with several key changes to Medicaid expansion and funding that were perceived as marginally better than those included in the House bill. Both proposed moving the current federal medical assistance percentage (FMAP) funding structure for Medicaid to fixed per capita allotments beginning on Jan. 1, 2020, and offering states the option to accept a block grant instead.

The per capita payments would be based on states’ per-beneficiary spending for eight quarters, as opposed to fiscal year 2016 as proposed by House Republicans, and would increase each year to match growth in the medical care component of the Consumer Price Index (CPI-M) for nondisabled children and adults. For aged and disabled enrollees, per capita payments would be limited to CPI-M plus 1%, similar to the House bill. But starting in 2025, the rate of growth in per-enrollee payments for all groups would be tied to the much tighter CPI for all urban consumers (CPI-U). continued on p. 7

New MACRA Rule Clarifies ‘All-Payer’ APM Option, Mulls Greater MAO Involvement

In what is the first major update to the Medicare Access and CHIP Reauthorization Act under the new administration, CMS on June 20 introduced a proposed rule containing changes for the second year of the Quality Payment Program (QPP) established under MACRA that are largely aimed at reducing the burden of Part B providers.

The 1,000-plus-page 2018 draft rule, which is slated for Federal Register publication on June 30, doesn’t impose any requirements on Medicare Advantage organizations that share risk with providers. Instead, it provides new clarification on the upcoming “all-payer” option for advanced Alternative Payment Models and floats the idea of a “payer initiated process” through which MAOs could request that their payment arrangements with providers qualify as advanced APMs in the all-payer years.
Established in a final rule last fall, the QPP replaces the Sustainable Growth Rate model used to pay fee-for-service physicians and allows them to seek reimbursement through one of two paths: (1) the Merit-based Incentive Payment System (MIPS), which requires reporting of measures in four performance categories and includes bonuses and penalties depending on performance; or (2) the advanced APM, which applies to provider organizations that accept significant downside risk through specific models, includes an automatic 5% bonus and exempts clinicians from the extensive MIPS reporting requirements (MAN 11/3/16, p. 1). The first QPP performance period opened Jan. 1, 2017, with payment beginning in 2019, although 2017 was considered a “transition year” as CMS gave MIPS providers the chance to pick their own pace for collecting and submitting data to avoid a negative payment adjustment in 2019.

For the second year of the program, CMS is proposing, among other things, to add a “virtual group” reporting option — in which solo practitioners and groups of 10 or fewer eligible clinicians could pool information on how they care for patients to be reported and evaluated under the QPP — and an increase in the low-volume threshold so that more small practices and eligible clinicians in rural and Health Professional Shortage Areas are exempt from MIPS participation.

Beginning with the 2019 performance period, participation in MA, Medicaid and private payer arrangements that meet certain criteria will be included when determining whether eligible clinicians earn the 5% incentive payment and are exempt from the less-profitable MIPS track. “That means MAOs could really have some kind of impact with providers, and their contracts could be taken into account for purposes of qualifying participant thresholds and qualifying provider determinations,” observes Christopher Kunkel, a consulting actuary in the Seattle office of Milliman. In the 2018 draft rule, CMS provides new specifics about this all-payer combination option, such as how and what data will be submitted and other logistics that will determine what’s an advanced APM when factoring in non-Medicare arrangements.

Included in the rule is the option that payers could initiate the process on behalf of providers to identify their arrangements as qualifying alternative APMs. “This could be a great thing for small providers that are engaged with big MAOs because it could help them handle this submission process to get necessary information to CMS,” says Kunkel.

**Process Would Align With Bid Submission**

CMS proposes in the rule that plans submit such information at the same time they submit bids for the coming MA plan year via the Health Plan Management System. “Because this is a process in which many Medicare Health Plans currently participate, we believe it will be the least burdensome approach” for MAOs, suggested CMS. Guidance on the submission process would be made available around the same time as the release of the Part C and D Advance Notice and draft Call Letter.

“In order to qualify as an advanced APM, there are requirements around EHR technology, having quality metrics built into the contracts as well as the nominal risk standard, so we anticipate that there will need to be attestations or submissions regarding each of those components,” suggests Lynn Dong, a principal and consulting actuary in the Seattle office of Milliman.

CAPG, a large association of physician organizations practicing capitated, coordinated care, had strongly advocated that CMS include MA risk contracts between plans and providers beginning in MACRA’s 2019 payment year (MAN 3/16/17, p. 1). CMS did not grant this request in the proposed rule but said it was “considering opportunities” that would allow MA providers to receive credit for that participation in qualifying participant determinations under the Medicare option and solicited feedback on such opportunities, including potential...
models and uses of its waiver and demonstration authorities.

“For me that is a big change in policy, [and CMS’s way of saying], ‘We want to help, we want to look at these arrangements, we do think there’s value there and give us your ideas,’” remarks Mara McDermott, vice president of federal affairs with CAPG. “It’s a step in the right direction.” The “all-payer” option as it is now layers on top of the fee-for-service requirement, so that even in the all-payer years, providers would still have to bear total risk of at least 8% of their Medicare Parts A and B revenue, according to a CMS fact sheet on the 2018 rule.


Contact Dong at lynn.dong@milliman.com, Kunkel at chris.kunkel@milliman.com or McDermott at mmcdermott@capg.org. ♦

MA Plans Seek Healthier Outcomes By Promoting Social Interaction

Loneliness affects more than 43% of adults over the age of 65 and has been linked to numerous serious health conditions, yet it is not systematically diagnosed and discussed in clinical practice, industry experts say. Anthem, Inc.’s CareMore Health System, a physician-led care delivery system and health plan, is working to change that by reaching out to its impacted Medicare Advantage enrollees to encourage socialization and raising broader awareness of the issue of senior loneliness. With a similar goal in mind, another MA plan — Fort Worth-based Care N’ Care — just launched a community outreach initiative that draws on the resources of multiple partners offering senior-related services.

“Loneliness is deeply felt throughout the senior population and has very clear implications for health, mainly because patients who are alone and socially isolated cannot take care of themselves as well as patients who have high levels of social connectedness,” asserts CareMore President Sachin H. Jain, M.D. As a result, the plan earlier this year launched the Togetherness Program, a “first-of-its-kind clinical effort that will address the social challenges aging seniors face on a daily basis.”

CareMore in a recent survey of older adults found that one in five seniors feel isolated from their friends and family, and 27% indicated that they would like their health care provider to offer programs to connect them to people or activities in their community to help them stay healthy. And previous research has identified loneliness as a risk factor for a variety of serious conditions including cognitive decline, the progression of Alzheimer’s disease, recurrent stroke, obesity and early mortality, according to the plan.

Additionally, one of the biggest morbidity underwriting factors in long term care is isolation, which can be removed or reduced by being surrounded by and engaged with others in a nursing home, points out Chris Orestis, executive vice president of GWG Life, which specializes in helping seniors convert life insurance policies that are no longer needed. In his 2016 book, A Survival Guide to Aging, the former Washington, D.C., lobbyist and long-time senior care advocate discusses a patient’s emotional state as one of the “direct investments’” patients need to make in their longevity, he tells AIS Health. “And your emotional state comes from how engaged you are. Family, friends, activities, etc. give you purpose in life and when you’re isolated and alone, it tends to strip you of purpose. Seniors will literally will themselves to die; they’ll just start turning off the switches,” he says.

CareMore Effort Utilizes Existing Supports

Through data collected from first-time appointments with new members at their required Healthy Start visit, CareMore identified about 1,100 members who self-reported potential risk factors for loneliness, such as living alone and without social support. “We felt a need to act and felt a need to build a solution, and one of the paradigms we introduce in this program is the notion that loneliness or social isolation is actually a treatable condition,” says Jain. But physicians and nurse practitioners tend not to ask patients about care barriers such as loneliness for which they have no interventions, and this program aims to equip them with the tools to address it, he tells AIS Health.

Based in California, CareMore’s health system serves more than 100,000 patients in seven states through 54 care center clinics staffed by a variety of providers. Its MA plans cover about 80,000 lives, which include Special Needs Plan enrollees who are dually eligible for Medicare and Medicaid, but the Togetherness Program focuses solely on the needs of MA beneficiaries for now, says Jain.

The company will tailor and expand its offerings based on what it learns from patients about their needs, but the initial model involves connecting them with resources to promote socialization and engagement. While the effort required hiring a “chief togetherness officer” as well as numerous telephonic outreach employees — who build personal connections with those in the program — Jain says it is relatively low cost because it utilizes supports that already exist, such as gyms and senior centers that have the potential to boost their social connectedness and promote healthier behaviors.
CareMore will measure the success of the program by assessing improvements in quality of life and clinical outcomes such as decreased depression and increased socialization. “Our goal is that these folks will become more engaged in their care, use the hospital less, take their medications more, and so on,” adds Jain.

At the same time, the plan recently kicked off the “Be in the Circle: Be Connected” campaign to raise awareness and provide education on the issue of senior loneliness (MAN 6/8/17, p. 8). “We wanted to introduce the concept of loneliness as a disease so that our staff asks [patients] about it…and have now begun to look at ways to elevate the importance and visibility of what we think is an invisible disease, and build a social movement that goes beyond our organization,” he remarks.

Care N’ Care Creates Database of Services

Meanwhile, a regional MA plan based in Fort Worth, Texas, is already taking steps to reduce isolation among seniors and connect them with resources and programs that can help them stay engaged and active. Care N’ Care, a local MA plan serving 11,000 beneficiaries in North Texas, this month launched the Care N’ Community outreach initiative to support existing connections in the community and “create opportunities for very real human interaction,” explains Care N’ Care CEO Wendy Karsten.

“We live in a time when there is a false belief that social media is a solution to loneliness, but I don’t believe it is,” Karsten tells AIS Health. Wanting to enhance Care N’ Care’s “high touch” member model, “The big question was how to [do so] in a meaningful way, and adding social media, while important to our overall health plan communication, just didn’t seem adequate,” she says.

Observing that there were already “loosely organized ‘villages’ in the community,” Care N’ Care is seeking to create a more direct connection for seniors by partnering with senior centers, faith-based organizations, government agencies and other resources that provide senior-related services that can engage and enrich their lives, explains Karsten. The insurer is building a comprehensive database of local senior-related services, so that it can be a “one-stop shop” for reliable service referral, assistance and social opportunities. The plan also hired a community engagement manager whose job is to build on available resources, communicate these options to its MA members and “create opportunities for them to feel loved and know that someone cares, because we do,” says Karsten.

The plan now is working with its existing internal health care concierge team to determine how best to conduct outreach to members and will be “rolling out new dimensions of this program and forging new community relationships over time,” she adds.

Contact Jain via Emily Hackel at emily.hackel@anthem.com, Karsten via Ross Goldberg at ross@kevinross.net or Orestis via Miguel Casellas-Gil at MiguelCG@news-experts.com.

Medicaid MCOs Address Opioid Crisis in Pregnant Women, Babies

As congressional Republicans seek to repeal and replace the Affordable Care Act, funding of resources to combat the nation’s growing opioid epidemic has become part of the debate among lawmakers. On the very same day that the Senate introduced its own version of health reform legislation (see story, p. 1), addiction specialists, beneficiary advocates, Medicaid managed care organizations, physicians and patients convened on Capitol Hill to discuss ways to deliver more integrated and patient-centered care to pregnant women that includes medication-assisted treatment (MAT) when needed. At the same time, panelists at the summit advocated for greater prevention and treatment of neonatal abstinence syndrome (NAS), an opioid withdrawal syndrome that affects newborns and causes lengthy and costly hospital stays.

The number of opioid-related deaths in the U.S. exceeded 33,000 in 2015, an increase of 200% since 2000, according to the U.S. Centers for Disease Control and Prevention (CDC). At the same time, rates of NAS and maternal opioid use are climbing, observes a new report from the Institute for Medicaid Innovation, which hosted the June 22 summit along with the American Society of Addiction Medicine and the March of Dimes. From 2000 to 2009, rates of opioid misuse rose from 1.19 to 5.63 for every 1,000 hospital births each year, while the number of babies born with NAS jumped 300% between 1999 and 2013 in 28 states with publicly available data on opioid addiction.

Although pregnant women who have a substance use disorder are eligible for priority access to MAT, which usually involves either methadone or buprenorphine, only about half of women who need such treatment receive it, observed Mishka Terplan, M.D., professor of obstetrics/gynecology and psychiatry and associate director of addiction medicine at Virginia Commonwealth University. Speaking at the opioid summit, Terplan suggested that this low rate of treatment may be due in part to a lack of access (e.g., shortage of physicians certified to treat opioid use disorder with buprenorphine, a general lack of experience in treating pregnant women with opioid use disorder) and to punitive state policies,
given that 44 states can prosecute women for opioid misuse in pregnancy.

David O’Gurek, M.D., an assistant professor with the Lewis Katz School of Medicine at Temple University who spoke on behalf of the American Academy of Family Physicians, argued that MAT must be integrated into behavioral health services available to pregnant women and that the health care system can’t adequately meet the needs of these patients unless care is integrated across multiple lines (e.g., insurance, employers, hospital/health system, pharmacies, public health and community agencies). Moreover, the health care system needs to reassess the ways it treats pain in general and consider prescribing non-opioid pharmacologic therapy for chronic pain, as recommended in 2016 guidelines from the CDC.

**Centene Unit Deploys Face-to-Face Approach**

To address this problem in Missouri, Centene Corp.’s Home State Health subsidiary operates a case management program that provides wraparound services to pregnant members who are struggling with opioid addiction. Eligible members are identified through available medical and pharmacy data showing a history of narcotic prescription fills or substance use treatment, as well as through referrals from the state’s Comprehensive Substance Treatment and Rehabilitation (CSTAR) program. While all case management provided by Home State has historically been performed telephonically, the MCO felt pregnant members would be better served by face-to-face case management, said Megan Barton, vice president of medical management with the health plan, who also spoke at the summit.

Since Medicaid members tend to move frequently, locating a member is a “collaborative effort” with providers, including pharmacies, and may even involve driving to the most recent address the plan has on file to confirm she lives at that address or speak with a family member who knows where she currently resides, added Barton. Once a member is successfully reached, the in-person meetings can take place anywhere from CSTAR facilities and members’ homes to playgrounds and church parking lots, wherever “a member can get the best experience and build a trusting relationship” with the plan representative, she observed.

The case manager first conducts a comprehensive assessment, looking for any barriers the patient may face that are preventing her from making healthy decisions and what social supports are needed, and formulates an individualized care plan that could include facilitating enrollment into specialized local programs that provide MAT and linking them to community resources. The program involves frequent contact and support, and case managers may even attend medical appointments with the client, all with the goals of guiding them through a healthy pregnancy, increasing the gestational age of the infant at delivery, reducing NICU admissions and hospital stays, and decreasing illicit use of substances such as opioids during and after pregnancy.

A mother of three who was helped by the program explained to summit attendees that she’d struggled on and off with opioid addiction for years after she was prescribed opioids for pain from her second C-section. Home State contacted her after learning that she had been treated for substance use disorder and become pregnant again. When she saw that her insurance company was calling, her initial response was, “‘What do you want?’” she recalled. But once she realized the kind of assistance the case manager would be able to provide, such as initiation of MAT during pregnancy and temporary housing that did not involve having to be separated from her children, that case manager quickly became her “best friend,” the mother attested.

Barton said the program has about 125 members enrolled at any given time, and about 20 (half of its case management team) nurses offer face-to-face assistance to these pregnant women. She added that the MCO is currently looking to enhance the program through peer support.

Because of the siloed way care is currently provided to pregnant Medicaid beneficiaries — resulting in the delivering hospital, for instance, not knowing the patient has been receiving MAT, or the pediatrician not knowing about the mother’s opioid use history — case managers like the ones working with Home State have “become the glue between all the parts of the system,” attested Paul Jarris, M.D., chief medical officer with the March of Dimes Foundation. Jarris argued that states need to work with all stakeholders and parts of the health care system to create more “seamless handoffs” that result in healthier pregnancies, shorter hospital stays and fewer cases of NAS.

Symptoms of NAS include extreme irritability and feeding problems and are not commonly recognized by pediatricians. NAS costs about $66,700 per stay, and leads to hospital stays averaging 16.9 days, compared to an average two-day hospital stay for newborns without

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NAS. Moreover, NAS amounted to total hospital charges of $1.5 billion in 2012, of which Medicaid paid $1.2 billion and private insurance covered $200 million.

MCOs such as Pittsburgh-based Gateway Health have been collaborating with the Pennsylvania Dept. of Human Services (DHS) to establish coordinated care clinics that can provide MAT, counseling and social service support through a team-based approach. Working with all behavioral health and physical health MCOs in the state, local behavioral health providers and social supports, DHS in 2014 piloted the first clinic with the Magee Women’s Hospital of UPMC. With Gateway playing a leadership role, the health plans agreed on a common shared savings model to help fund the first few years of the program and developed a per-member per-month payment methodology that bundled payment for services not typically included in the Medicaid fee schedule, explained Steven Szebenyi, M.D., chief medical officer for Gateway, who also spoke at the summit.

The pilot resulted in more than 50% of patients completing the program and led to lower rates of NAS. Gateway in 2016 launched a similar program with Allegheny Health Network that shows early signs of success and plans to develop additional programs across the Pittsburgh area. And DHS continues to work with the MCOs on establishing another 20 programs across the state, added Szebenyi.


Prevalence of Opioid Use in Medicaid Is Much Higher in Women Than Men

The prevalence of opioid use in the Medicaid population was 68% higher in women than men in 2015, finds a new Express Scripts Holding Co. analysis. That gender gap was much wider than the 13% difference observed by the pharmacy benefit manager across commercial populations in a 2014 report. And while men who used opioids tended to fill slightly more prescriptions per year than women, a larger proportion of women (63%) filled opiate prescriptions than did men (37%), according to the report. Shown by Medicaid enrollment category, the gender gap was widest among dual-eligible members but remained pronounced in all populations, observed Express Scripts. Moreover, the five types of physicians who most commonly prescribed opioids — family medicine, internal medicine, emergency medicine, obstetrics/gynecology and orthopedic surgeon — were responsible for the majority of opioid prescriptions across all Medicaid categories, added the PBM, which analyzed the opioid use of 3.1 million Medicaid members across 14 states in 2015.

Gender Distribution of Opioid Use Across Medicaid Enrollment Categories

<table>
<thead>
<tr>
<th>Enrollment Category</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABD/LTC</td>
<td>41%</td>
<td>59%</td>
</tr>
<tr>
<td>CHIP</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>Dual-eligible</td>
<td>32%</td>
<td>68%</td>
</tr>
<tr>
<td>TANF</td>
<td>37%</td>
<td>63%</td>
</tr>
<tr>
<td>All populations</td>
<td>37%</td>
<td>63%</td>
</tr>
</tbody>
</table>

ABD/LTC=Aged, Blind and Disabled/Long Term Care, CHIP=Children’s Health Insurance Program, TANF=Temporary Assistance for Needy Families.

Senate Revisits Health Care Bill
continued from p. 1

The Congressional Budget Office on June 26 estimated that enacting the recently proposed legislation would result in a net deficit reduction of $321 billion over the next 10 years. The bulk of that savings would come from reductions in federal outlays to Medicaid, which would amount to about $772 billion between 2017 and 2026. For the House bill, CBO had projected an $834 billion cumulative reduction to Medicaid spending. Additionally, CBO estimated that, relative to the number projected under current law, the Senate bill would result in approximately 22 million fewer people with insurance in 2026, compared with 23 million estimated for the House bill. Medicaid enrollment would be an estimated 15 million lower by 2026 vs. current law.

“The Senate bill is marginally better than the House in terms of overall dollars removed from Medicaid in the 10-year budget window,” remarks Jeff Myers, president and CEO of the Medicaid Health Plans of America (MHPA) trade group. “But it’s still a 26% reduction in federal funding over 10 years. And the Senate bill is actually worse in the out years because they drop the inflator from CPI-M to CPI-U — which is less than medical and frankly is never going to be met unless you do one of two things: significantly reduce the services covered to these individuals or significantly reduce the number of individuals covered.”

Rather than focusing on inflators, however, MHPA suggests that Congress consider rebasings Medicaid on a yearly basis “using a two or three-year lookback” so that the growth rate is revisited year after year, Myers tells AIS Health. Because MCOs are on three-to-five-year contract cycles with state Medicaid programs, that would provide more stability than quickly taking money away from states and forcing them to make drastic decisions about coverage or eligibility, he says.

Senate Proposes Longer Expansion Phaseout

The Senate bill would also begin phasing out expanded FMAP funding for Medicaid expansion enrollees beginning in 2021 — one year later than the House proposed — and return federal funding to pre-ACA levels by 2024. The Senate bill also gives states the option to impose work requirements for Medicaid recipients. Non-Medicaid provisions include replacing the House’s age-based advance premium tax credits with tax credits based on age, income and the actual cost of health insurance in particular markets, and repealing penalties under both the individual and employer mandates.

Should the legislation be enacted, Medicaid MCOs would have to “more carefully tailor their strategic growth initiatives based on the state’s use of more limited Medicaid funding,” weighs in Denise Hanna, co-chair of Locke Lord’s Health Care group and managing partner of the law firm’s Washington, D.C., office. To that end, she recommends talking to decision makers in their markets to get a feel for the direction the state will take with fewer funds and enrollees. “That’s where I think there is risk, that states have to make quick decisions [before they] turn their attentions elsewhere, and that could put managed Medicaid plans in a position where they have to overcommit themselves before the funding goes away and dries up, and states are going to be looking more and more to managed Medicaid to help them manage the shortage of dollars,” she suggests.

Would Biggest Medicaid Cuts Come to Pass?

In a June 22 research note from Evercore ISI, securities analyst Michael Newshel observed that although the changes contained in the Senate bill are directionally positive for Medicaid-focused MCOs and hospitals, the bill would still result in sizable coverage losses and increased cost sharing. Nevertheless, the “near-term aid for the individual market and longer phase-out of Medicaid expansion support the shorter-term outlook and raise the possibility that the most significant coverage cuts may never go into effect post the 2020 election even if repeal is passed now,” he suggested.

Pursuing a special budget approach that requires a simple majority of the Senate vote to secure passage, McConnell can afford to lose only two Republican senators; at least nine at press time had indicated that they could oppose a motion to proceed. Two of those were Senators Shelley Moore Capito (R-W. Va.) and Rob Portman (R-Ohio), both from states where the opioid crisis is particularly prevalent, who had requested the inclusion of $45 billion in extra funding over 10 years for substance use disorder treatment. Instead, the bill earmarked $2 billion in federal funds for such services.

Referring to common assertions that the ACA considers health care a right and the repeal-and-replace efforts portray it as a privilege, former Washington, D.C., lobbyist and GWG Life Executive Vice President Chris Orestis remarks that both represent “two classic examples reflecting the values of this country, which is pretty much split right down the middle. At a political horse race level, I think it’s going to be a big challenge to get all the Republican votes necessary.”

View the bill at www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf. Contact Hanna via Kristen Bulgris at kristen.bulgris@lockelord.com, Myers via Joe Reblando at jreblando@mhpao.org or Orestis via Miguel Casellas-Gil at MiguelCG@news-experts.com.
NEWS BRIEFS

♦ Cigna Corp. in a Form 8-K filing to the Securities and Exchange Commission said CMS finally lifted its Medicare Advantage marketing and enrollment sanctions. CMS imposed the sanctions in January 2016 after an audit of Cigna’s Parts C and D operations turned up substantial failures to comply with organization/coverage determinations, appeals and grievances requirements. Cigna said it could resume marketing its MA Prescription Drug and Medicare Part D stand-alone plans immediately, and could begin enrolling beneficiaries with effective coverage dates starting July 1, 2017. View the filing at http://tinyurl.com/yc8gvzuc.

♦ Aetna Inc. on June 21 said it reached a new pact with Community Care Physician Network, LLC (CCPN) aimed at developing innovative ways to transform the delivery of health care in North Carolina. Beginning in January 2018, Aetna will combine its experience with alternative value-based delivery models with CCPN independent physicians’ advanced medical homes in association with the care management expertise of Community Care of North Carolina, Inc. They will collaborate on new ways to serve Aetna’s MA members in rural areas of North Carolina, according to Aetna. This is one of several new partnerships involving insurers in the state, which is planning to transition from fee-for-service Medicaid to managed care in mid-2019 (MAN 5/25/17, p. 4). Contact Aetna spokesperson Anjie Coplin at copлина@aetna.com.

♦ Blue Cross and Blue Shield of Texas said June 1 that it acquired nearly 20,000 MA and commercial members from Allegian Health Plans, Tenet Healthcare’s wholly owned health plan subsidiary. Tenet plans to exit the health plan business in 2017 amid heavy losses. Financial details of the purchase were not disclosed. Previously, Tenet Healthcare and the Texas Blues plan had entered into multiyear Medicare and commercial contracts to provide Blues members with access to Tenet’s hospitals and providers in the state. See the Tenet statement at http://bit.ly/2sGW8HA.

♦ Centene Corp. subsidiary Magnolia Health on June 20 said it was selected by the Mississippi Division of Medicaid to enter into a three-year contract to serve enrollees of the Mississippi Coordinated Access Network (MississippiCAN).

Magnolia Health has been serving the MississippiCAN program since 2011, according to Centene. The new contract, pending regulatory approval, would begin in mid-2018. The award follows a recent win in Washington state, where Centene’s Coordinated Care Corp. was one of three managed care organizations selected to provide fully integrated behavioral and physical health services in the North Central Region (MAN 6/8/17, p. 4). According to a June 19 research note from Cowen & Co., Centene has several large reprocurements coming up, including in Florida, Arizona and Kansas (see brief, below). The securities firm expressed confidence in Centene’s ability to retain key contracts. Visit www.centene.com/investors.

♦ Kansas Medicaid officials have asked CMS for a one-year extension of the KanCare managed Medicaid demonstration while the Kansas Dept. of Health and Environment prepares a new application, according to the Kansas News Service. Kansas is operating its Medicaid program under a five-year Section 1115 waiver that allows three private insurance companies to manage benefits for about 425,000 enrollees in the state. That waiver is set to expire at the end of this year. CMS officials initially denied the extension request in January because of concerns that the state wasn’t providing proper oversight of the three MCOs, Amerigroup, Centene’s Sunflower State Health and United Healthcare of the Midwest. But CMS on May 22 approved the state’s corrective action plan that includes keeping track of the number of grievances and appeals filed by beneficiaries who were denied services. According to Cowen & Co., an RFP for new contracts starting January 2019 is expected to be released in the fourth quarter of 2017.

♦ PEOPLE ON THE MOVE: Cheryl Phillips, M.D., was chosen as the next president and CEO of the SNP Alliance, an initiative of the National Health Policy Group (NHPG). She is currently the senior vice president for public policy and health services at LeadingAge, a national organization of not-for-profit aging service providers. Rich Bringewatt, co-founder and president of the SNP Alliance, will continue to serve as president of NHPG. Jerry Foxhoven was appointed director of the Iowa Dept. of Human Services in the wake of Charles Palmer’s recent retirement. Foxhoven is a lawyer and longtime leader in child protection.
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