HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 24, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

NATIONAL HEALTH EXPENDITURE AND ENROLLMENT PROJECTIONS FOR MEDICAID UPDATED THROUGH 2025

This week, our *In Focus* section reviews Medicaid historical and projected expenditure and enrollment data from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary. The Office of the Actuary provides annual updates to historical and projected National Health Expenditure (NHE) data. The latest NHE projections were updated in July of this year, with projections through 2025, while an overall fact sheet on historical and projected data was updated on August 10. NHE projections include enrollment data by program and expenditure data by program and category of service, as well as data on business, household, and government spending. Below, we summarize some key takeaways on the Medicaid and CHIP data, looking at historical data from 2014 (the most recent historical year), and projections of enrollment and spending for 2015, 2020, and 2025. By 2025, NHE projects 85.2 million Medicaid and CHIP beneficiaries to account for just under $1 trillion in annual spending.

Medicaid Enrollment Projections

Medicaid expansion affected enrollment, as would be expected. Medicaid and CHIP enrolled 71.5 million members in 2014; the number was estimated to be 74.9 million in 2015. By 2020, Medicaid and CHIP enrollment is projected to surpass 81 million and will climb to more than 85 million by 2025. For context, Medicare enrollment is for 2025 is projected at 71.6 million, up from 52.8 million in 2014, while private health insurance is projected at 204.4 million, up from 189.9 million in 2014.

Figure 1 – Historical and Projected Medicaid/CHIP Enrollment (Millions)

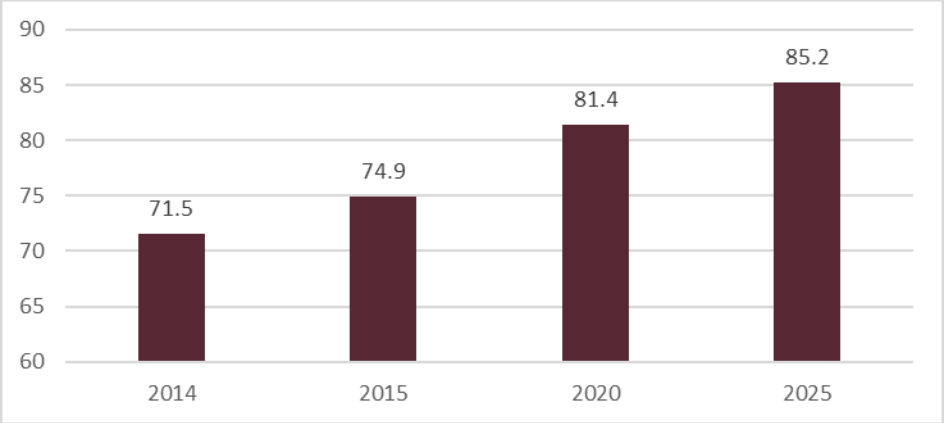

Table 1 breaks down the split between Medicaid and CHIP enrollment projections, showing a compound annual growth rate (CAGR) of 1.6% with Medicaid enrollment growing at a 1.6% annual rate and CHIP projected to grow at a 2.2% annual rate.

Table 1 – Historical and Projected Medicaid/CHIP Enrollment (Millions)

	2014	2015	2020	2025	CAGR
Medicaid	65.9	69	74.7	78.1	1.6%
CHIP	5.6	5.9	6.7	7.1	2.2%
Total Medicaid/CHIP	**71.5**	**74.9**	**81.4**	**85.2**	**1.6%**

Medicaid/CHIP Expenditure Projections

CMS projected that Medicaid and CHIP combined expenditures will grow by $54.3 billion from 2014 to 2015. By 2020, Medicaid and CHIP spending is projected to be nearly $742 billion, with expenditure growth continuing at a little over 6 percent annually for Medicaid and at 5 percent for CHIP, bringing 2025 projected expenditures in just shy of $1 trillion. For context, 2025 spending on Medicare is projected at $1.28 trillion, and private health insurance expenditures are projected at more than $1.75 trillion.

Figure 2 – Historical and Projected Medicaid/CHIP Expenditures ($Billions)

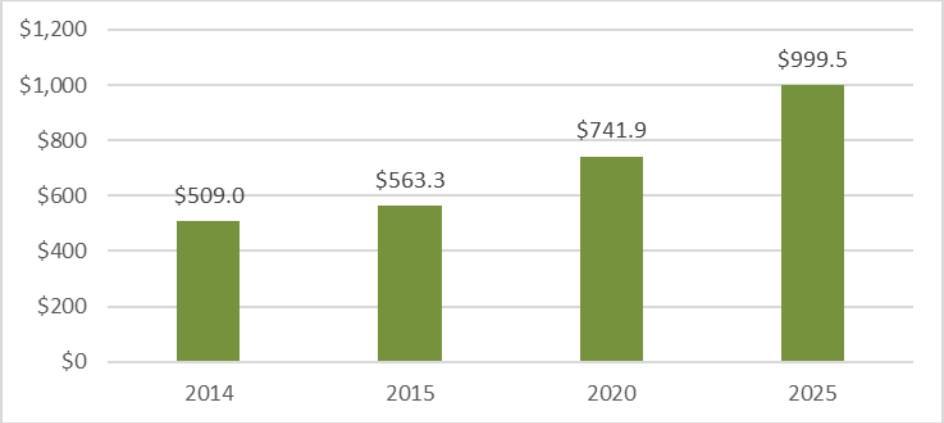

Table 2 breaks out expenditures between Medicaid and CHIP, with both programs projected to nearly double their annual expenditures between 2014 and 2025.

Table 2 – Historical and Projected Medicaid/CHIP Expenditures ($Billions)

	2014	2015	2020	2025	CAGR
Medicaid	$495.8	$548.8	$722.0	$973.8	6.3%
CHIP	$13.2	$14.5	$19.9	$25.7	6.2%
Total Medicaid/CHIP	**$509.0**	**$563.3**	**$741.9**	**$999.5**	**6.3%**

Medicaid Expenditure by Category Projections

CMS provides a historical and projected breakdown of expenditures by category for Medicaid only (CHIP is bundled with Department of Defense and other public spending). Table 3 (on the following page) summarizes the projected change in annual expenditures for several categories of services and other expenditures; it also shows each category's percentage contribution to total Medicaid expenditures and CAGR from 2014 to 2015 for each category of spending.

Hospital spending, residential/personal care/other, and physician/clinical expenditures are projected to continue to be the largest contributors to overall Medicaid expenditures, together equaling around 64 percent of total expenditures. However, residential/personal care/other, along with nursing facility and, to a lesser extent, home health expenditures are projected to decline in their overall share of Medicaid expenditures. Meanwhile, dental, net cost of health insurance (includes Medicaid managed care organization margins), and other professional are projected to see annual growth of more than 8 percent, with durable medical equipment (DME), physician/clinical, and Rx drug expenditures are projected to grow at more than 7 percent annually.

Table 3 – Historical and Projected Medicaid-Only Expenditures by Category, 2014-2025 ($Billions)

	2014	% of Total 2014	2025	% of Total 2025	CAGR 2014-2025
Hospital	$168.0	33.9%	$335.7	34.5%	6.5%
Residential, Personal Care, Other	$83.9	16.9%	$143.2	14.7%	5.0%
Physician/Clinical	$64.0	12.9%	$145.7	15.0%	7.8%
Nursing Facilities	$49.6	10.0%	$70.5	7.2%	3.2%
Home Health	$29.6	6.0%	$50.6	5.2%	5.0%
Net Cost of Health Insurance	$28.3	5.7%	$68.4	7.0%	8.4%
Rx Drugs	$27.3	5.5%	$59.1	6.1%	7.3%
Govt. Admin	$22.6	4.6%	$45.9	4.7%	6.7%
Dental	$10.1	2.0%	$26.0	2.7%	9.0%
Other Professional	$6.3	1.3%	$14.6	1.5%	8.0%
DME	$6.1	1.2%	$14.2	1.5%	7.9%
Total Medicaid Expenditures	**$495.8**	**100.0%**	**$973.8**	**100.0%**	**6.3%**

Link to NHE Data, Additional Information

https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/index.html

HMA MEDICAID ROUNDUP

Alabama

Lottery Bill to Boost Medicaid Funding Possibly Removed from November 8 Ballot. *AL.com* reported on August 23, 2016, that the state House blocked Governor Robert Bentley's lottery bill, intended as a long-term solution to boost funding for the state General Fund and Medicaid, from the general election ballot slated for November 8. The bill, already passed by the Senate, had to be approved by the House committee before a public hearing scheduled for August 24 in order to pass. For it to remain on the ballot in November, lawmakers would have to approve a proposed constitutional amendment during a special legislative session. Although the Governor intends to continue to push for the lottery bill, House Speaker Mac McCutcheon says that a bill allocating oil spill settlement funds will be the main focus of the session. Read More

House Approves Oil Spill Settlement Bill to Fund Medicaid Shortfall. *AL.com* reported on August 17, 2016, that the Alabama House approved a bill to use some of the funds from an oil spill settlement to help fill an $85 million Medicaid budget gap. The money will free up $70 million in state funds that can help avoid Medicaid cuts. The bill now moves to the Senate for approval. Read More

California

Drug Pricing Transparency Bill Pulled from Consideration. *Los Angeles Times* reported on August 18, 2016, California State Senator Ed Hernandez pulled his drug pricing transparency bill from consideration after it was revised by a key Assembly fiscal committee. The bill would have required drug makers to give notice of future price increases above a certain level and forced health plans to report detailed information on pharmaceutical drug costs. The revised version increased the threshold under which drug makers would be required to give notice and delayed the notice requirement for one year. Separately, a ballot initiative addressing drug costs is slated for November. Read More

Connecticut

Advocates Protest Privatization of Group Homes for Individuals with I/DD. *CT Mirror* reported on August 23, 2016 that families and advocates for individuals with intellectual and developmental disabilities (I/DD) are expressing concern over Governor Dannel Malloy's plans to privatize 40 group homes and cut 605 jobs in order to save $70 million annually beginning next year. Critics say private group homes provide insufficient care compared to

state-run ones due to lack of funding, and that high turnover rates negatively affect the ability for clients to bond with their caregivers. Department of Developmental Services (DDS) Commissioner Morna Murray says that the department is working to ensure current service levels are maintained and that the transition goes smoothly for families. Approximately 10 percent of individuals with I/DD are served in community-living settings run by DDS. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Enrollment Opened to More Than 1,000 on HCBS Medicaid Waiver Waiting List. *Foster Folly News* reported on August 18, 2016, that Florida is offering enrollment in its Home and Community-based Services Medicaid Waiver program to more than 1,000 individuals currently on the waiting list. Florida has provided more than $39 million to the state Agency for Persons with Disabilities to address the waiver waiting list, which has already been reduced by 6,000 over the past four years. Read More

Advocacy Group Calls for Medicaid Expansion. *WUSF News* reported on August 18, 2016, that consumer advocacy group Florida CHAIN, released a report calling for the expansion of Medicaid in the state. The report, titled "Expanding Health Coverage for Tampa Bay Will Create Health and Prosperity," states that expansion could cover up to 800,000 uninsured individuals. The report notes that expansion would reduce uncompensated care at a time when changes to the state's Low Income Pool are expected to reduce payments to safety net providers caring for the uninsured. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Rural Hospitals Continue to Struggle Financially. *WABE* reported on August 22, 2016, that the Georgia rural hospital network continues to struggle as officials predict more funding cuts in the future. According to Ethan James, from the Georgia Hospital Association, federal cuts could reduce hospital funding by $1.5 billion annually by 2025. In 2014, 40 percent of the state's hospitals saw net losses. However, a new tax credit program was approved by the Legislature last session, allowing people and companies to make contributions to qualifying hospitals and receive a state tax credit. Total contributions are capped at $50 million in 2017, $60 million in 2018, and $70 million in 2019. A total of 47 rural hospitals qualify. Georgia has yet to expand Medicaid and has the fourth-highest uninsured rate in the country, with 1.5 million individuals. During a hearing focused on the hospital cuts, State Senate Health and Human Services Committee Chairwoman Renee Unterman reiterated her view that Medicaid expansion should be considered during the next legislative session. Read More

Research Reveals Dental Access Issues. *Georgia Health News* reported on August 22, 2016, that an analysis by a Georgia Tech researcher presented to Georgia lawmakers on the House Health and Human Services Committee shows that 500,000 children not eligible for Medicaid and PeachCare, the state's Children's Health Insurance Program, do not have access to dental care. Additionally, some beneficiaries eligible for the state programs have to travel

further than 30 miles in urban areas and 45 miles in rural areas to get dental care. The research is based on a 2012 study sponsored by the Dental Association that showed that the state ranked 49th in the nation in dentists per resident, with only 22 percent accepting Medicaid. The presentation comes months after proposed legislation that would have allowed dental hygienists to provide services in clinics, nursing homes and federally qualified health centers without a dentist present failed. Advocates hope to introduce similar legislation in 2017. Read More

Iowa

Governor Dismisses Medicaid Privatization Criticism. *The Des Moines Register* reported on August 22, 2016, that Iowa Governor Terry Branstad dismissed criticism of the state's transition to Medicaid managed care in his weekly news briefing. Governor Branstad said that managed care is eliminating fraud and abuse while saving taxpayers money. However, hospitals, nursing homes, and mental health agencies have expressed concern to state legislators, asserting that Medicaid managed care plans are inaccurate and delayed in paying providers. Governor Branstad responded that the managed care plans have to verify that the service was provided, which may cause a delay, but ultimately reduces fraud. He said the state is expecting savings of $100 million annually under managed care. Read More

Indiana

HMA Roundup – Pat Casanova (Email Pat)

St. Vincent Health to Expand in Indianapolis Area with "Micro Hospitals." St. Vincent Health, the second largest hospital system in Indiana, is building four micro hospitals in the greater Indianapolis area. The four planned facilities are part of the system's strategy to provide care closer to their patients' homes. Jonathon Nalli, CEO at St. Vincent stated, "We believe this has such an incredible place in the new healthcare delivery world that is shifting from volume to value based environments. This creates more access points where St. Vincent patients and patients wanting St. Vincent care were." The micro facilities will each have seven outpatient beds and eight inpatient beds. Patients requiring more than an overnight stay will be transferred to another facility. The facilities will be located in Noblesville, Castelton, Avon and Plainfield. St. Vincent is working with the Embree Group to build the micro hospitals. Embree is building its own micro hospital in Greenwood, a suburb of Indianapolis.

Kansas

State Signs MMIS Contract with HP. *Kansas Health Institute* reported on August 17, 2016, that the Kansas Department of Health signed a $215 million contract with Hewlett Packard Enterprises to manage its Medicaid Management Information System (MMIS), which tracks Medicaid claims and payments. However, developers are concerned about the MMIS system's ability to communicate with the Kansas Eligibility Enforcement System, which was implemented by Accenture in 2011 and has caused significant delays. The new software, called the Kansas Modular Medicaid System, will enter approved applications into a database of the state's Medicaid recipients, which Medicaid

managed care plans will use to pay claims to providers. Hewlett Packard will work with Cerner to make sure that the new system can aggregate data from different sources into a single record per patient, which the state hopes will help manage patient care and outcomes. Read More

Governor Hopes to Reverse Proposed Medicaid Provider Reimbursement Cuts. *Kansas Health Institute* reported on August 17, 2016, that Kansas Governor Sam Brownback hopes to reverse a proposed 4 percent Medicaid provider reimbursement cut during the next legislative session. Instead, Brownback hopes to address state budget problems by raising a tax on hospitals, currently at 1.83 percent of inpatient revenues. Governor Brownback did not specify how much he is seeking to increase the tax, but federal law prevents the tax from going over 6 percent. Read More

Kentucky

Changes Coming to 1115 Waiver Proposal Following Public Comment Period. *WFPL.com* reported on August 17, 2016, that Kentucky's Cabinet for Health and Family Services plans to make changes to Governor Matt Bevin's Medicaid 1115 waiver proposal after reviewing feedback collected during the public comment period. The draft proposal included premiums between $1 and $15 a month as well as work requirements for many members. The Foundation for a Healthy Kentucky said that the original proposal would make it easier for doctors to join networks, but raised concerns around the collection of proposed premiums from individuals without permanent addresses and bank accounts. The Cabinet's director of communications has said that there have already been some changes to the original proposal, and that more information about the adjustments will be made available once the state submits its final waiver proposal. Read More

Massachusetts

Report Shows High Emergency Room Utilization Due to Preventable Oral Health Conditions. *Worcester Business Journal Online* reported on August 16, 2016, that a new report by the Massachusetts Health Policy Commission shows that 36,000 emergency room visits for preventable oral health issues cost the state between $14.8 and $46 million in 2014. Massachusetts' Medicaid program, MassHealth, paid $11.6 million for such visits between 2008 and 2011. According to the report, sixty percent of the 36,000 visits were made during normal business hours when most dental practices are open, and ninety percent of the visits were for adults, demonstrating the lack of coverage for the age group. Read More

Minnesota

Hospital Charity Costs Declining Following Medicaid Expansion. *Star Tribune* reported on August 22, 2016, that Minnesota hospital charity care costs have declined under the Affordable Care Act (ACA), with $236 million in charity care spending last year, $43 million less than in 2013. The decrease corresponds with a decrease in the uninsured rate, which fell below 5 percent when the state expanded Medicaid under the ACA. However, some hospitals say that those savings are partially negated by rising bad debt costs. While some are calling the hospitals' savings a profitable financial windfall, hospitals argue

that they are losing money on operations and using the savings for community health needs programs. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Medicaid Officials Meet with Stakeholders to Discuss Medicaid 2.0. Staff members at the New Jersey Health Care Quality Institute have been meeting with New Jersey stakeholders and with other states' Medicaid officials (Connecticut, Massachusetts and Ohio) to consider improvements, innovations, and cost containment strategies for New Jersey's Medicaid program. Known as Medicaid 2.0, it is being funded by The Nicholson Foundation and runs from March 1, 2016 through February 28, 2017. The Quality Institute will prepare a report that it has referred to as the "go to" document on Medicaid for the current or a new administration in 2017. Transformation teams will be formed that will develop recommendations for a final report. Additional information about Medicaid 2.0 can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

Oscar Health Insurance Losses Continue. Oscar Insurance Corp., an insurance company startup backed by Silicon Valley investors, continues to post losses in New York. New York is Oscar's biggest market, and saw losses widen from $15.5 million in the first half of 2015 to $52.2 million in the first half of 2016. Oscar also lost $12.9 million in California and $17.9 million in Texas, according to state filings. Oscar continues to increase its market share in the nine downstate New York counties in which it operates. It now covers 14 percent of members in those areas, up from 7 percent in 2015 and 4 percent in its debut year, 2014. But they continue to struggle to manage members' medical costs, spending more on medical costs than it received in member premiums. As part of its cost control strategy Oscar is sharply limiting the number of doctors and hospitals in its New York network for next year. The company says the tighter network — built around Montefiore, Mount Sinai, and Long Island Health Network — will lead to better, more coordinated care for customers. They also got approval from the New York Department of Financial Services to increase premiums by an average of 20 percent for next year. Read More

State to Hold Behavioral Health Value-Based Payment Conference. The New York State Office of Mental Health and Office of Alcoholism and Substance Abuse Services, along with the Health Foundation for Western and Central New York and the Managed Care Technical Assistance Center, will be co-sponsoring a conference on the behavioral health vision for value-based payments, on Tuesday September 27th from 9:30-4:00 pm in Albany. The conference will include key note speakers as well as presentations by NYS OMH and OASAS around the vision for value-based payments in behavioral health as well as future technical assistance offerings for providers. Read More

New York, Healthnow Reach Settlement Over Wrongful Denial of Outpatient Mental Health Treatment. New York Attorney General Eric Schneiderman announced a settlement with HealthNow, New York, Inc., after an investigation uncovered the wrongful denial of claims for outpatient psychotherapy and for

nutritional counseling for eating disorders. The wrongful denials totaled more than $1.6 million in patient claims. Under the agreement, the Buffalo-based company, a not-for profit health service corporation providing health care coverage for approximately 573,700 New Yorkers (including 24,000 Medicaid enrollees), will pay members for the wrongfully denied claims, revise its policies, and will eliminate a company policy that subjected all psychotherapy claims to review after a member's 20th visit. The Attorney General's investigation was launched under Timothy's Law, a mental health parity law that mandates that New York group health plans provide coverage for the diagnosis and treatment of mental, nervous, or emotional disorders or ailments at least equal to the coverage provided for other health conditions. The New York law is similar to the federal mental health parity law, which was enacted in 2008. Read More

Ohio

Medicaid Managed Care Report Card Published. *IndeOnline* reported on August 18, 2016, Ohio released the second annual Medicaid managed care report card, which shows that all five Medicaid plans in the state scored average or better on patient satisfaction and communication. The state used plan data and patient surveys to rate plans on access to care, provider communication, children's health, management of chronic illnesses, and women's care. CareSource ranked highest, receiving 13 of 15 possible stars. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medicaid MLTSS Contract Awards Anticipated this Week. *Modern Healthcare* reported on August 18, 2016, that Pennsylvania is expected to announce the winners of the state's Community HealthChoices Managed Long-Term Supports and Services (MLTSS) procurement this week. The contracts, which are worth over $7 billion annually, were initially scheduled to be awarded in June, but have since been delayed. Fourteen insurers submitted bids. The first phase was scheduled to start on January 1, 2017, but was pushed back to July 1. The second phase will begin in 2018 and the third in 2019. Nearly 421,000 low-income, disabled adults will be covered through the program. Read More

New Health Center Brings Care to Rural Western Pennsylvania's Low-Income and Older Residents. Keystone Healthcare Development Services announced plans to develop a multi-service Federally Qualified Health Center (FQHC) in Transfer, Pennsylvania. Primary Health Network (PHN) will operate this facility in a rural part of the state. The new site will allow PHN to provide 3,400 new patient encounters annually and will serve low-income and older patients. PHN will provide: Primary Care; Behavioral Health Care; Urgent Care; Pharmacy with Retail and Drive thru Services; and Referral with local Surgery Center. Read More

Tennessee

State Officials Meet to Discuss Details of Medicaid Expansion Proposal. *The Tennessean* reported on August 17, 2016, that Tennessee lawmakers and health care officials met again to discuss a proposal for Medicaid expansion in the state. The proposal would initially provide health care to veterans and individuals with a mental illness up to 138 percent of the federal poverty level. A second phase would expand Medicaid to everyone up to 138 percent of poverty. Lawmakers hope to finalize the proposal in the next two weeks. Among those involved in the most recent discussion were Tennessee Medicaid director Wendy Long, Melinda Buntin of the Department of Health Policy at Vanderbilt, and lawmakers on the 3-Star Healthy Task Force. Read More

Insurance Commissioner Approves Rate Increases to Preserve Exchange Options. *The Tennessean* reported on August 23, 2016, that Tennessee Insurance Commissioner Julie Mix McPeak approved premium rate increases on the state's Exchange to ensure there are coverage options in every part of the state during open enrollment this year, warning that the Exchange market is extremely fragile. Currently, BlueCross BlueShield of Tennessee (BCBST) is the only insurer to offer plans statewide. Cigna and Humana are the only other insurers operating on the Exchange. BCBST requested a 62 percent average increase for 2017, Cigna 46 percent, and Humana 44.3 percent. Read More

Texas

Advocates Renew Medicaid Expansion Efforts in Response to Zika. *Texas Tribune* reported on August 19, 2016, Texas Medicaid expansion advocates have renewed their efforts amid rising concerns over Zika and the state's decision to cover non-prescribed mosquito repellent for pregnant women on Medicaid. Groups such as Texans Care for Children and Texas Organizing Project say that the state should not only extend coverage of repellent to all Medicaid beneficiaries, but that the state should expand Medicaid to make additional public health resources available to individuals that currently fall in the coverage gap and do not qualify for Medicaid. "The reality is that if we had Medicaid expansion and people had coverage, you'd have more security," said Tiffany Hogue of the Texas Organizing Project. Public health officials have reported 118 cases of Zika in the state so far. Read More

National

ACA Beneficiaries Filled More Prescriptions, Paid Less Out-of-Pocket. *Kaiser Health News* reported on August 17, 2016, that new research published by Health Affairs shows that individuals who received healthcare coverage through the Affordable Care Act (ACA) are filling more prescriptions and paying less out-of-pocket for those drugs than before the law was enacted. Using data on 6.7 million individuals, one-third of whom were previously uninsured, the study tracked insurance status, number of prescriptions filled, and out-of-pocket spending between January 2012 and December 2014. The study group included members of Exchange plans and those who became eligible for Medicaid because of the ACA. Individuals previously uninsured who enrolled in Medicaid benefited most, filing 13.3 more prescriptions and spending 58 percent less of their own money on prescription drugs. Read More

CMS Considers Rules to Prevent Providers from Steering Individuals Away from Medicaid, Medicare. *Reuters* reported on August 18, 2016, that the Centers for Medicare & Medicaid Services is considering new rules to prohibit providers from steering patients away from Medicaid or Medicare and into insurance Exchange plans in order to receive higher reimbursements. Exchange plans typically pay higher rates than Medicaid and Medicare. In August, Aetna stated that the steering of patients to the individual market was resulting in an unhealthy mix customers in individual plans sold on the Exchanges. Read More

Industry News

Oscar Health to Withdraw from Dallas, New Jersey Marketplaces in 2017. *Bloomberg* reported on August 23, 2016, that health insurance startup Oscar Health is pulling out of the New Jersey and Dallas, Texas Exchange markets next year after reporting total losses of $105 million in 2015. The company reported losses of $83 million in New York, California, and Texas for the first half of 2016. Oscar currently covers 26,000 people in New Jersey and 7,000 in Dallas, with 130,000 customers overall. The company says it is exiting Dallas due to increasing medical costs and uncertainty about other insurers exiting, while it is leaving New Jersey due to broad networks, which make keeping costs down more difficult. However, it will continue to operate in the Los Angeles, New York City, and San Antonio markets as well as begin selling small-group insurance next year. Read More

InnovAge Highlighted in New York Times Report on PACE Conversions. On August 20, 2016, *The New York Times* reported on the growing interest among investment firms in the Medicare Program of All-Inclusive Care for the Elderly (PACE) market after the federal government began allowing private sector investments in this space last year. Attracted to the growing Medicare population and increasing demand for home and community based delivery models for the elderly, private investment firms are looking at opportunities to supply capital to PACE organizations that have historically been required to operate as not for profits. In May, Denver-based InnovAge received $196 million in backing from Welsh, Carson, Anderson & Stowe, a private equity firm, in conjunction with its conversion to a for profit entity. On average, Medicare and Medicaid pay PACE providers $76,728 per member per year, about $5,500 less than the average cost of a nursing home. As of January 2016, around 40,000 individuals were enrolled in PACE nationwide, but recent comments from CMS administrator Andy Slavitt have signaled the federal government's commitment to the growth of the program. Read More

Banner Health Acquires 32 Urgent Care Centers in Arizona. *Modern Healthcare* reported on August 17, 2016, that Phoenix, Arizona-based Banner Health announced the acquisition of 32 urgent care centers from Urgent Care Extra, which will be renamed Banner Urgent Care as of October 1. The health system says its hopes to have 50 urgent care centers in the state by the end of 2017. Banner Health operates hospitals in seven states in the western U.S., as well as Banner Health Network, Banner Medical Group, and long-term care centers, outpatient surgery centers, family clinics, home care, and hospice services. Read More

National MedTrans Network Looks to Expand into Other States After Success in New York. *Crain's New York Business* reported that National MedTrans Network, a New York-based medical transportation coordinator, is looking to expand into other states. MedTrans became successful after New York's decision

to switch to managed long-term care in 2011. While the state continued to manage transportation for fee-for-service enrollees, managed care companies contracted with third-party providers. From 2012 to 2015, MedTrans' revenue grew to $73.7 million from less than $4 million. Since January, the company has partnered with Lyft, making it easier to call for back-up if a patient's transportation has not arrived within 30 minutes. MedTrans already contracts with two plans in California, each with over 200,000 members. In 2017, the company will also begin offering services in Chicago. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
August 25, 2016	Nevada	Proposals Due	420,000
August, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
September 6, 2016	Pennsylvania HealthChoices	Proposals Due	1,700,000
September 12, 2016	Rhode Island	Proposals Due	231,000
September 22, 2016	Nevada	Contract Awards	420,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
September, 2016	Washington, DC	RFP Release	200,000
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Massachusetts	RFP Release	860,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November 1, 2016	Texas STAR Kids	Implementation	200,000
November, 2016	Oklahoma ABD	RFP Release	177,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Massachusetts MassHealth ACO - Full	Selection	TBD
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Implementation	177,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
August, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
October, 2017	Massachusetts	Implementation	860,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

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

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (June 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	119,814	34.2%	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	48,218	35.5%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	13,038	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	38,767	38.8%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	5,480	4.4%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	217	1.1%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	62,009	54.4%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,419	10.1%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	42,069	25.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	26,975	40.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**362,006**	**28.9%**	

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

HMA News

One of Modern Healthcare's 100 Most Influential People in Healthcare to Speak at HMA Conference on Vulnerable Populations in Chicago, October 10-12, 2016

Dr. Ram Raju, the President and CEO of NYC Health+Hospitals, was named this week in Modern Healthcare 2016 100 Most Influential People in Healthcare list. Dr. Raju will be a speaker at HMA's inaugural conference on "*The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*," October 10-12, 2016, in Chicago, Illinois.

This premier event, presented by HMA and HMA's Accountable Care Institute, will address key issues facing health systems, hospitals, clinics and provider practices seeking to integrate care in an environment of rising quality and cost expectations. More than 35 speakers have been confirmed to date. Registration is now open. Visit https://fpsh.healthmanagement.com/ for complete conference details or contact Carl Mercurio at (212) 575-5929 or cmercurio@healthmanagement.com.

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

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