HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 9, 2016

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

QUARTERLY MEDICAID MANAGED CARE ENROLLMENT UPDATE – Q3 2016

This week, our *In Focus* section reviews recent Medicaid enrollment trends in capitated, risk-based managed care in 24 states.[1] Many state Medicaid agencies elect to post monthly enrollment figures by health plan for their Medicaid managed care population to their websites. This data allows for the timeliest

[1] Arizona, California, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, New Mexico, New York, Ohio, Pennsylvania, South Carolina, Tennessee, Texas, Washington, West Virginia, Wisconsin.

analysis of enrollment trends across states and managed care organizations. Nearly all 24 states have released monthly Medicaid managed care enrollment data through the third quarter (Q3) of 2016. This report reflects the most recent data posted.

Sixteen of the 24 states in Table 1 (below) – Arizona, California, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New Mexico, New York, Ohio, Pennsylvania, Washington, and West Virginia – expanded Medicaid under the Affordable Care Act and have seen increased Medicaid managed care enrollment throughout 2014, 2015, and the first three quarters of 2016.

- The 24 states in this report account for an estimated 46.9 million Medicaid managed care enrollees as of the end of Q3 2016. Based on HMA estimates of MCO enrollment in states not covered in this report, we believe that, nationwide, Medicaid MCO enrollment has surpassed 52 million in the first three quarters of 2016. As such, the enrollment data across these 24 states represents between 85 percent and 90 percent of all Medicaid MCO enrollment.
- Across the 24 states tracked in this report, Medicaid managed care enrollment is up 4.5 percent year-over-year as of September 2016, adding just over 2 million net new enrollees since September 2015, with nearly 1.4 million of those added since January 1, 2016.
- The sixteen expansion states listed above have seen Medicaid managed care enrollment increase by more than 1.6 million members, or 5.0 percent, in the past year, at 34.2 million at the end of Q3 2016, up from 32.5 million as of Q3 2015.
- The eight states that have not yet expanded Medicaid have seen Medicaid managed care enrollment increase by more than 380,000 members, roughly 3.1 percent, surpassing 12.7 million at the end of Q3 2016, up from less than 12.4 million as of Q3 2015.

Table 1 - Monthly MCO Enrollment by State – April 2016 through September 2016

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Arizona	**1,554,075**	**1,554,282**	**1,560,509**	**1,563,499**	**1,576,807**	**1,592,523**
+/- m/m	(7,020)	207	6,227	2,990	13,308	15,716
% y/y	10.4%	9.3%	8.0%	6.1%	6.6%	4.9%
California	**10,457,404**	**10,480,290**	**10,572,440**	**10,574,940**	**10,606,412**	**10,580,743**
+/- m/m	42,700	22,886	92,150	2,500	31,472	(25,669)
% y/y	9.9%	8.3%	8.5%	7.4%	7.4%	6.0%
Florida	**3,318,698**	**3,338,639**	**3,354,458**	**3,352,307**	**3,383,110**	**3,377,101**
+/- m/m	(5,888)	19,941	15,819	(2,151)	30,803	(6,009)
% y/y	5.4%	5.5%	5.3%	5.1%	4.9%	4.0%
Georgia	**1,321,840**	**1,318,412**	**1,323,697**	**1,316,171**	**1,317,071**	
+/- m/m	5,571	(3,428)	5,285	(7,526)	900	*N/A*
% y/y	2.1%	1.4%	1.1%	-0.3%	-0.1%	
Hawaii	**350,307**	**349,579**	**350,358**			
+/- m/m	963	(728)	779	*N/A*	*N/A*	*N/A*
% y/y	6.2%	5.6%	5.0%			
Illinois	**2,052,544**	**2,069,269**	**2,077,898**	**2,019,892**	**2,069,915**	**2,124,935**
+/- m/m	(3,654)	16,725	8,629	(58,006)	50,023	55,020
% y/y	2.4%	-1.0%	-0.7%	-5.0%	-2.5%	0.5%

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Indiana	**1,088,227**	**1,089,674**	**1,094,268**	**1,097,345**	**1,105,139**	**1,109,587**
+/- m/m	2,801	1,447	4,594	3,077	7,794	4,448
% y/y	23.6%	20.1%	16.6%	9.6%	9.4%	8.7%
Kentucky	**1,217,166**	**1,206,450**	**1,229,902**	**1,219,630**	**1,191,004**	**1,211,761**
+/- m/m	18,741	(10,716)	23,452	(10,272)	(28,626)	20,757
% y/y	4.5%	2.7%	11.9%	10.5%	3.3%	-1.1%
Louisiana	**1,080,462**	**1,072,132**	**1,070,519**	**1,292,032**	**1,337,465**	**1,354,339**
+/- m/m	(5,609)	(8,330)	(1,613)	221,513	45,433	16,874
% y/y	12.8%	11.8%	11.0%	33.8%	38.1%	38.9%
Maryland	**1,061,396**	**1,077,622**	**1,087,450**	**1,098,271**	**1,107,564**	**1,108,461**
+/- m/m	19,431	16,226	9,828	10,821	9,293	897
% y/y	3.1%	5.0%	7.8%	8.8%	10.1%	12.5%
Michigan	**1,720,386**	**1,734,591**	**1,744,002**	**1,736,669**	**1,729,462**	**1,738,389**
+/- m/m	4,901	14,205	9,411	(7,333)	(7,207)	8,927
% y/y	6.9%	4.9%	4.1%	3.7%	3.8%	5.2%
Minnesota	**894,708**	**913,029**	**913,570**	**914,933**	**911,559**	**934,682**
+/- m/m	34,280	18,321	541	1,363	(3,374)	23,123
% y/y	12.6%	14.9%	14.9%	15.1%	14.7%	17.6%
Mississippi	**503,546**	**508,893**	**507,173**	**502,276**	**496,561**	**491,661**
+/- m/m	(3,858)	5,347	(1,720)	(4,897)	(5,715)	(4,900)
% y/y	140.7%	59.2%	19.1%	-0.5%	-0.9%	-1.3%
Missouri	**491,695**	**493,612**	**495,383**	**509,784**	**513,635**	**517,065**
+/- m/m	2,978	1,917	1,771	14,401	3,851	3,430
% y/y	9.7%	7.7%	7.0%	9.5%	11.0%	11.7%
New Mexico	**666,145**	**669,502**	**672,558**	**674,657**	**680,536**	**683,219**
+/- m/m	(59)	3,357	3,056	2,099	5,879	2,683
% y/y	7.6%	7.3%	7.0%	6.1%	6.0%	5.8%
New York	**4,653,676**	**4,678,143**	**4,660,909**	**4,667,284**	**4,660,170**	**4,662,560**
+/- m/m	4,775	24,467	(17,234)	6,375	(7,114)	2,390
% y/y	-1.4%	-1.8%	-2.5%	-2.7%	-2.9%	-3.1%
Ohio	**2,446,651**	**2,472,466**	**2,471,005**	**2,462,370**	**2,471,159**	**2,471,104**
+/- m/m	931	25,815	(1,461)	(8,635)	8,789	(55)
% y/y	5.5%	5.5%	5.8%	4.2%	2.1%	1.7%
Pennsylvania	**2,202,006**	**2,211,254**	**2,218,321**	**2,227,383**	**2,236,624**	**2,245,656**
+/- m/m	9,731	9,248	7,067	9,062	9,241	9,032
% y/y	29.3%	27.4%	17.2%	15.1%	13.1%	8.2%
South Carolina	**731,431**	**736,926**	**747,178**	**753,559**	**760,548**	**761,034**
+/- m/m	12,304	5,495	10,252	6,381	6,989	486
% y/y	0.7%	-0.9%	-2.5%	-0.1%	4.1%	7.9%
Tennessee	**1,534,066**	**1,543,757**	**1,549,585**	**1,557,955**	**1,553,726**	**1,551,984**
+/- m/m	8,518	9,691	5,828	8,370	(4,229)	(1,742)
% y/y	9.7%	9.6%	9.0%	8.7%	7.4%	6.3%
Texas	**3,849,575**	**3,893,388**	**3,887,530**	**3,875,942**	**3,916,936**	**3,927,352**
+/- m/m	10,017	43,813	(5,858)	(11,588)	40,994	10,416
% y/y	2.0%	2.6%	2.2%	N/A	N/A	1.1%
Washington	**1,517,512**	**1,564,045**	**1,567,641**	**1,566,693**	**1,565,937**	**1,568,256**
+/- m/m	8,153	46,533	3,596	(948)	(756)	2,319
% y/y	7.8%	10.3%	9.6%	9.4%	9.0%	8.8%
West Virginia	**384,197**	**385,730**	**387,123**	**390,335**	**389,137**	**389,858**
+/- m/m	9,228	1,533	1,393	3,212	(1,198)	721
% y/y	87.2%	85.7%	85.9%	85.9%	79.2%	7.0%
Wisconsin	**801,595**	**803,458**	**802,390**	**800,533**	**795,966**	**799,091**
+/- m/m	(5,103)	1,863	(1,068)	(1,857)	(4,567)	3,125
% y/y	1.1%	1.3%	1.8%	1.2%	0.6%	1.4%

Note: In Table 1 above and the state tables below, "+/- m/m" refers to the enrollment change from the previous month. "% y/y" refers to the percentage change in enrollment from the same month in the previous year.

Below, we provide a state-specific analysis of recent enrollment trends in the states where HMA tracks data.

It is important to note the limitations of the data presented. First, not all states report the data at the same time during the month. Some of these figures reflect beginning-of-the-month totals, while others reflect an end-of-the-month snapshot. Second, in some cases the data is comprehensive in that it covers all state-sponsored health programs for which the state offers managed care; in other cases, the data reflects only a subset of the broader managed Medicaid population. This is the key limiting factor in comparing the data described below and figures reported by publicly traded Medicaid MCOs. Consequently, the data we review in Table 1 and throughout the *In Focus* section should be viewed as a sampling of enrollment trends across these states rather than a comprehensive comparison, which cannot be developed based on publicly available monthly enrollment data.

State-Specific Analysis

Arizona

Medicaid Expansion Status: Expanded January 1, 2014

Enrollment in Arizona's two Medicaid managed care programs has seen growth in the second and third quarters of 2016, adding a net 31,400 members. At the end of Q3 2016, Arizona's MCO enrollment stands at more than 1.59 million, up roughly 5 percent year-over-year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Acute Care	1,496,248	1,496,248	1,502,255	1,505,163	1,518,403	1,534,014
ALTCS	57,827	58,034	58,254	58,336	58,404	58,509
Total Arizona	**1,554,075**	**1,554,282**	**1,560,509**	**1,563,499**	**1,576,807**	**1,592,523**
+/- m/m	*(7,020)*	*207*	*6,227*	*2,990*	*13,308*	*15,716*
% y/y	*10.4%*	*9.3%*	*8.0%*	*6.1%*	*6.6%*	*4.9%*

California

Medicaid Expansion Status: Expanded January 1, 2014

Medi-Cal managed care enrollment data through September 2016 shows an overall trend of enrollment growth, with membership up more than 166,000 over the last six months. As of September 2016, enrollment in managed care is approximately 10.6 million, a 6 percent increase over the previous year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Two-Plan Counties	6,693,521	6,715,416	6,780,241	6,757,482	6,787,494	6,756,969
Imperial/San Benito	81,119	81,715	82,005	82,424	82,292	82,408
Regional Model	299,700	299,642	299,985	301,146	300,824	300,817
GMC Counties	1,106,174	1,110,322	1,116,107	1,135,606	1,143,618	1,151,184
COHS Counties	2,154,803	2,152,224	2,174,288	2,178,928	2,174,814	2,173,629
Duals Demonstration	122,087	120,971	119,814	119,354	117,370	115,736
Total California	**10,457,404**	**10,480,290**	**10,572,440**	**10,574,940**	**10,606,412**	**10,580,743**
+/- m/m	*42,700*	*22,886*	*92,150*	*2,500*	*31,472*	*(25,669)*
% y/y	*9.9%*	*8.3%*	*8.5%*	*7.4%*	*7.4%*	*6.0%*

Florida

Medicaid Expansion Status: Not Expanded

Although not currently electing to expand Medicaid, Florida's statewide Medicaid managed care program continues to grow. As of September 2016, enrollment is nearing 3.4 million, up 4 percent from a year ago. (*Note that the managed LTC enrollment figures listed below are a subset of the Managed Medical Assistance (MMA) enrollments and are included in the MMA number; they are not separately added to the total to avoid double counting*).

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
MMA	3,012,140	3,027,859	3,038,489	3,034,719	3,064,639	3,056,190
LTC (Subset of MMA)	*90,982*	*91,311*	*91,718*	*92,350*	*93,179*	*93,397*
SMMC Specialty Plan	146,354	149,192	151,743	151,792	151,936	152,755
FL Healthy Kids	160,204	161,588	164,226	165,796	166,535	168,156
Total Florida	**3,318,698**	**3,338,639**	**3,354,458**	**3,352,307**	**3,383,110**	**3,377,101**
+/- m/m	*(5,888)*	*19,941*	*15,819*	*(2,151)*	*30,803*	*(6,009)*
% y/y	*5.4%*	*5.5%*	*5.3%*	*5.1%*	*4.9%*	*4.0%*

Georgia

Medicaid Expansion Status: Not Expanded

As of August 2016, Georgia Medicaid managed care enrollment stands at more than 1.31 million, down just slightly from a year prior. Georgia has not reported enrollment figures for September 2016 as of publication.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Georgia	**1,321,840**	**1,318,412**	**1,323,697**	**1,316,171**	**1,317,071**	
+/- m/m	*5,571*	*(3,428)*	*5,285*	*(7,526)*	*900*	
% y/y	*2.1%*	*1.4%*	*1.1%*	*-0.3%*	*-0.1%*	

Hawaii

Medicaid Expansion Status: Expanded January 1, 2014

In 2015, Hawaii implemented its integrated Medicaid managed care program, combining QUEST managed Medicaid and QUEST Expanded Access, which provides managed Medicaid to the aged, blind, and disabled populations. Through June 2016, enrollment in the new program stands at more than 350,000, up 5 percent from Q2 2015. Hawaii has not reported Q3 2016 enrollment figures at the time of publication.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Hawaii	**350,307**	**349,579**	**350,358**			
+/- m/m	*963*	*(728)*	*779*			
% y/y	*6.2%*	*5.6%*	*5.0%*			

Illinois

Medicaid Expansion Status: Expanded January 1, 2014

Illinois enrollment across the state's four managed care programs sits at more than 2.1 million as of September 2016, up just slightly year-over-year. In the third quarter of 2016, Illinois began enrolling dual eligible members who opt out of the duals demonstration in mandatory Managed Long Term Supports and Services (MLTSS) in the Greater Chicago region.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Family Health Program	1,883,909	1,900,700	1,907,692	1,850,984	1,898,536	1,944,389
Integrated Care Program	119,984	121,234	121,988	121,330	121,524	120,064
Duals Demonstration	48,651	47,335	48,218	47,363	47,420	49,586
MLTSS				215	2,435	10,896
Total Illinois	**2,052,544**	**2,069,269**	**2,077,898**	**2,019,892**	**2,069,915**	**2,124,935**
+/- m/m	*(3,654)*	*16,725*	*8,629*	*(58,006)*	*50,023*	*55,020*
% y/y	*2.4%*	*-1.0%*	*-0.7%*	*-5.0%*	*-2.5%*	*0.5%*

Indiana

Medicaid Expansion Status: Expanded in 2015 through HIP 2.0

As of September 2016, enrollment in Indiana's managed care programs—Hoosier Healthwise, Hoosier Care Connect, and Healthy Indiana Program (HIP)—has surpassed 1.1 million, up 8.7 percent from the prior year. Indiana managed care plans added more than 24,000 members in the past six months.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Hoosier Healthwise	602,818	601,649	601,012	598,567	601,609	601,300
Hoosier Care Connect	97,985	97,935	97,988	96,860	96,500	95,887
HIP	387,424	390,090	395,268	401,918	407,030	412,400
Indiana Total	**1,088,227**	**1,089,674**	**1,094,268**	**1,097,345**	**1,105,139**	**1,109,587**
+/- m/m	*2,801*	*1,447*	*4,594*	*3,077*	*7,794*	*4,448*
% y/y	*23.6%*	*20.1%*	*16.6%*	*9.6%*	*9.4%*	*8.7%*

Kentucky

Medicaid Expansion Status: Expanded January 1, 2014

As of September 2016, Kentucky enrolled more than 1.2 million beneficiaries in risk-based managed care. Total enrollment is down just over 1 percent from a year prior.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Kentucky	**1,217,166**	**1,206,450**	**1,229,902**	**1,219,630**	**1,191,004**	**1,211,761**
+/- m/m	*18,741*	*(10,716)*	*23,452*	*(10,272)*	*(28,626)*	*20,757*
% y/y	*4.5%*	*2.7%*	*11.9%*	*10.5%*	*3.3%*	*-1.1%*

Louisiana

Medicaid Expansion Status: Expanded July 1, 2016

Medicaid managed care enrollment in Bayou Health stands at more than 1.35 million as of September 2016, up 39 percent from the previous year. Louisiana recently authorized Medicaid expansion, with an effective enrollment date that began on July 1, 2016.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Louisiana	**1,080,462**	**1,072,132**	**1,070,519**	**1,292,032**	**1,337,465**	**1,354,339**
+/- m/m	*(5,609)*	*(8,330)*	*(1,613)*	*221,513*	*45,433*	*16,874*
% y/y	*12.8%*	*11.8%*	*11.0%*	*33.8%*	*38.1%*	*38.9%*

Maryland

Medicaid Expansion Status: Expanded January 1, 2014

Medicaid managed care enrollment declined in Maryland throughout 2015, and then reversed course in 2016. Month-over-month enrollment increases have continued through Q3, with September 2016 enrollment coming in at more than 1.1 million, up 12.5 percent from the prior year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Maryland	**1,061,396**	**1,077,622**	**1,087,450**	**1,098,271**	**1,107,564**	**1,108,461**
+/- m/m	*19,431*	*16,226*	*9,828*	*10,821*	*9,293*	*897*
% y/y	*3.1%*	*5.0%*	*7.8%*	*8.8%*	*10.1%*	*12.5%*

Michigan

Medicaid Expansion Status: Expanded April 1, 2014

Michigan's Medicaid and CHIP managed care growth trends over the past year have continued, despite two months of negative growth in July and August. As of September 2016, managed care enrollment has surpassed 1.7 million, up 5.2 percent from the previous year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Medicaid	1,688,620	1,703,778	1,705,235	1,698,888	1,692,375	1,701,497
MI Health Link (Duals)	31,766	30,813	38,767	37,781	37,087	36,892
Total Michigan	**1,720,386**	**1,734,591**	**1,744,002**	**1,736,669**	**1,729,462**	**1,738,389**
+/- m/m	*4,901*	*14,205*	*9,411*	*(7,333)*	*(7,207)*	*8,927*
% y/y	*6.9%*	*4.9%*	*4.1%*	*3.7%*	*3.8%*	*5.2%*

Minnesota

Medicaid Expansion Status: Expanded January 1, 2014

As of September 2016, enrollment across Minnesota's multiple managed Medicaid programs sits at more than 934,000, up 17.6 percent from the prior year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Parents/Kids	530,521	541,648	549,632	553,120	549,037	564,062
Expansion Adults	157,531	160,656	163,019	162,747	163,057	167,571
Senior Care Plus	13,567	13,669	13,895	14,186	14,163	14,357
Senior Health Options	35,459	35,619	35,796	36,016	36,179	36,498
Special Needs BasicCare	51,308	51,456	51,241	51,023	51,227	51,071
PIN Program	380	380	371	371	364	363
Minnesota Care	105,942	109,601	99,616	97,470	97,532	100,760
Total Minnesota	**894,708**	**913,029**	**913,570**	**914,933**	**911,559**	**934,682**
+/- m/m	*34,280*	*18,321*	*541*	*1,363*	*(3,374)*	*23,123*
% y/y	*12.6%*	*14.9%*	*14.9%*	*15.1%*	*14.7%*	*17.6%*

Mississippi

Medicaid Expansion Status: Not Expanded

MississippiCAN, the state's Medicaid managed care program grew significantly in 2015. However, net enrollment declines over the past six months have reversed some of this growth. Medicaid managed care membership stands at more than 491,000 as of September 2016, down just slightly from last year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Mississippi	**503,546**	**508,893**	**507,173**	**502,276**	**496,561**	**491,661**
+/- m/m	*(3,858)*	*5,347*	*(1,720)*	*(4,897)*	*(5,715)*	*(4,900)*
% y/y	*140.7%*	*59.2%*	*19.1%*	*-0.5%*	*-0.9%*	*-1.3%*

Missouri

Medicaid Expansion Status: Not Expanded

Missouri managed care enrollment in the Medicaid and CHIP programs sits at more than 517,000 as of September 2016. Although the state has not expanded Medicaid, Missouri has seen steady growth in managed care membership, with the September 2016 enrollment up more than 11 percent from the previous year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Medicaid	475,385	477,432	479,390	493,906	497,561	500,975
Total CHIP	16,310	16,180	15,993	15,878	16,074	16,090
Total Missouri	**491,695**	**493,612**	**495,383**	**509,784**	**513,635**	**517,065**
+/- m/m	*2,978*	*1,917*	*1,771*	*14,401*	*3,851*	*3,430*
% y/y	*9.7%*	*7.7%*	*7.0%*	*9.5%*	*11.0%*	*11.7%*

New Mexico

Medicaid Expansion Status: Expanded January 1, 2014

As of September 2016, the state's Centennial Care program had enrolled more than 683,000 members, with steady enrollment growth throughout 2015 and 2016, a 5.8 percent increase over the prior year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total New Mexico	**666,145**	**669,502**	**672,558**	**674,657**	**680,536**	**683,219**
+/- m/m	*(59)*	*3,357*	*3,056*	*2,099*	*5,879*	*2,683*
% y/y	*7.6%*	*7.3%*	*7.0%*	*6.1%*	*6.0%*	*5.8%*

New York

Medicaid Expansion Status: Expanded January 1, 2014

New York's Medicaid managed care programs collectively enrolled 4.66 million beneficiaries as of September 2016, down 3.1 percent from the previous year. After positive enrollment growth throughout 2015, the first nine months of 2016 have seen a trend of declining enrollment.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Mainstream MCOs	4,439,785	4,462,472	4,442,644	4,436,994	4,405,284	4,405,725
Managed LTC	154,333	157,067	159,942	162,600	165,099	167,490
Medicaid Advantage	8,462	8,568	8,727	8,599	7,504	8,539
Medicaid Advantage Plus	5,728	5,759	5,838	5,963	6,055	6,220
HARP	39,751	38,907	38,278	47,707	70,908	69,286
FIDA/FIDA-IDD (Duals)	5,617	5,370	5,480	5,421	5,320	5,300
Total New York	**4,653,676**	**4,678,143**	**4,660,909**	**4,667,284**	**4,660,170**	**4,662,560**
+/- m/m	*4,775*	*24,467*	*(17,234)*	*6,375*	*(7,114)*	*2,390*
% y/y	*-1.4%*	*-1.8%*	*-2.5%*	*-2.7%*	*-2.9%*	*-3.1%*

Ohio

Medicaid Expansion Status: Expanded January 1, 2014

Ohio's Medicaid managed care enrollment has seen significant growth in the past two years, due to Medicaid expansion ("Group 8" enrollees) and the launch of MyCare Ohio, the state's dual eligible financial alignment demonstration. As of September 2016, enrollment across all four programs is nearing 2.5 million, up less than 2 percent from the prior year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
CFC Program	1,618,224	1,635,604	1,632,975	1,621,712	1,627,499	1,622,636
ABD Program	120,844	117,397	113,787	110,472	111,317	112,627
Group 8 (Expansion)	615,742	627,518	632,328	637,847	641,597	642,151
MyCare Ohio (Duals)	91,841	91,947	91,915	92,339	90,746	93,690
Total Ohio	**2,446,651**	**2,472,466**	**2,471,005**	**2,462,370**	**2,471,159**	**2,471,104**
+/- m/m	*931*	*25,815*	*(1,461)*	*(8,635)*	*8,789*	*(55)*
% y/y	*5.5%*	*5.5%*	*5.8%*	*4.2%*	*2.1%*	*1.7%*

Pennsylvania

Medicaid Expansion Status: Expanded as of 2015

At the end of Q3 2016, Pennsylvania's Medicaid managed care enrollment sits at nearly 2.25 million, up more than 8 percent in the past year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Pennsylvania	**2,202,006**	**2,211,254**	**2,218,321**	**2,227,383**	**2,236,624**	**2,245,656**
+/- m/m	*9,731*	*9,248*	*7,067*	*9,062*	*9,241*	*9,032*
% y/y	*29.3%*	*27.4%*	*17.2%*	*15.1%*	*13.1%*	*8.2%*

South Carolina

Medicaid Expansion Status: Not Expanded

After declines in enrollment in 2015, 2016 has been a year of growth in South Carolina. September 2016's 761,000 members represent 7.9 percent growth in the past year. South Carolina has so far seen only limited enrollment in the state's duals demonstration program.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Medicaid	725,477	731,230	741,759	744,119	751,546	752,878
Total Duals Demo	5,954	5,696	5,419	9,440	9,002	8,156
Total South Carolina	**731,431**	**736,926**	**747,178**	**753,559**	**760,548**	**761,034**
+/- m/m	*12,304*	*5,495*	*10,252*	*6,381*	*6,989*	*486*
% y/y	*0.7%*	*-0.9%*	*-2.5%*	*-0.1%*	*4.1%*	*7.9%*

Tennessee

Medicaid Expansion Status: Not Expanded

As of September 2016, TennCare managed care enrollment totaled 1.55 million, up 6.3 percent from the prior year. TennCare enrollment has seen an overall trend of growth in the past year, although enrollment declined in both August and September. Despite this, TennCare has added more than 26,000 members in the past six months alone.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Tennessee	**1,534,066**	**1,543,757**	**1,549,585**	**1,557,955**	**1,553,726**	**1,551,984**
+/- m/m	*8,518*	*9,691*	*5,828*	*8,370*	*(4,229)*	*(1,742)*
% y/y	*9.7%*	*9.6%*	*9.0%*	*8.7%*	*7.4%*	*6.3%*

Texas

Medicaid Expansion Status: Not Expanded

As of September 2016, Texas managed care enrollment stands at more than 3.9 million across the state's five managed care programs, roughly flat from last year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
STAR	2,839,454	2,875,902	2,870,029	2,859,349	2,899,420	2,910,741
STAR+PLUS	537,512	540,194	541,348	542,297	542,763	543,978
STAR HEALTH	31,380	31,666	31,669	31,721	31,897	32,086
Duals Demo	43,298	41,556	40,428	39,370	38,064	37,157
CHIP	397,931	404,070	404,056	403,205	404,792	403,390
Total Texas	**3,849,575**	**3,893,388**	**3,887,530**	**3,875,942**	**3,916,936**	**3,927,352**
+/- m/m	*10,017*	*43,813*	*(5,858)*	*(11,588)*	*40,994*	*10,416*
% y/y	*2.0%*	*2.6%*	*2.2%*	*N/A*	*N/A*	*1.1%*

Washington

Medicaid Expansion Status: Expanded January 1, 2014

Washington's Medicaid managed care enrollment as of September 2016 is nearing 1.6 million. This represents an 8.8 percent increase from the prior year.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total Washington	**1,517,512**	**1,564,045**	**1,567,641**	**1,566,693**	**1,565,937**	**1,568,256**
+/- m/m	*8,153*	*46,533*	*3,596*	*(948)*	*(756)*	*2,319*
% y/y	*7.8%*	*10.3%*	*9.6%*	*9.4%*	*9.0%*	*8.8%*

West Virginia

Medicaid Expansion Status: Expanded January 1, 2014

As of September 2016, West Virginia's managed care program enrolls nearly 390,000 members, up 7 percent from September 2015. Enrollment began to grow significantly in September 2015 after a court ruling allowed the state to proceed with plans to expand managed care.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Total West Virginia	**384,197**	**385,730**	**387,123**	**390,335**	**389,137**	**389,858**
+/- m/m	*9,228*	*1,533*	*1,393*	*3,212*	*(1,198)*	*721*
% y/y	*87.2%*	*85.7%*	*85.9%*	*85.9%*	*79.2%*	*7.0%*

Wisconsin

Medicaid Expansion Status: Not Expanded

Across the state's three managed care programs, September 2016 enrollment totals nearly 800,000, up 1.4 percent from the year before.

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
BadgerCare+	718,481	719,994	718,576	716,369	711,575	714,447
SSI	36,425	36,623	36,821	37,019	36,333	36,348
LTC	46,689	46,841	46,993	47,145	48,058	48,296
Total Wisconsin	**801,595**	**803,458**	**802,390**	**800,533**	**795,966**	**799,091**
+/- m/m	*(5,103)*	*1,863*	*(1,068)*	*(1,857)*	*(4,567)*	*3,125*
% y/y	*1.1%*	*1.3%*	*1.8%*	*1.2%*	*0.6%*	*1.4%*

More Information Available from HMA Information Services

More detailed information on the Medicaid managed care landscape is available from HMA Information Services (HMAIS), which pulls together Medicaid enrollment data, health plan financials, and the latest on expansions, waivers, duals, ABD populations, long-term care, accountable care organizations, and patient-centered medical homes. There is also a public documents library with copies of Medicaid RFPs, responses, model contracts, and scoring sheets.

HMA enhances this publicly available information with an overview of the structure of Medicaid in each state, as well as a proprietary HMA Medicaid Managed Care Opportunity Assessment.

For additional information on how to subscribe to HMA Information Services, contact Carl Mercurio at 212-575-5929 or cmercurio@healthmangaement.com.

HMA Medicaid Roundup

Alabama

Medicaid Commissioner Urges Lawmakers to Continue Transition to Regional Care Organizations. *AL.com* reported on November 3, 2016, that Alabama Medicaid Commissioner Stephanie Azar is urging state lawmakers to continue to fund the planned transition of the state's Medicaid program to provider-led Regional Care Organizations (RCOs). Citing "sticker shock," a key state legislative committee temporarily blocked the renewal of a one-year contract with Navigant, a consulting firm that is helping with the transition. The uncertainty has caused three of 11 RCOs to withdraw from the program, which is expected to start in July 2017. Read More

California

Voters Extend Medi-Cal Hospital Fee Program, Defeat Drug Pricing Measure. *California Healthline* reported on November 9, 2016, that California voters passed a series of health care-related measures on November 8, including an indefinite extension of the Medi-Cal hospital fee program to help fund Medi-Cal, legalization of recreational marijuana, and a cigarette tax increase. However, a measure to cap prescription drug prices, the California Drug Price Relief Act, was defeated 54 percent to 46 percent. Read More

Colorado

Accountable Care Collaborative Phase II Draft RFP Released for Public Comment. The Colorado Department of Healthcare Policy and Financing released a draft request for proposal (RFP) on November 4, 2016, for Regional Accountable Entities to operate in phase two of the state's Accountable Care Collaborative. Phase two will focus on integrating physical and behavioral health, strengthening team-based care, and value-based incentives. Comments are due January 13, 2017, and the final RFP is expected to be released in the spring of 2017. Contracts are anticipated to begin on February 1, 2018, and end on June 30, 2018. Read More

Universal Health Care Ballot Measure Defeated. *The Denver Post* reported on November 9, 2016, that Colorado voters defeated the ColoradoCare ballot measure, which would have provided universal health care in the state. Nearly 80 percent of votes went against the measure, which would have replaced most private insurance with taxpayer-funded coverage for every resident. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Department of Community Health Names New Commissioner. *Georgia Health News* reported on November 2, 2016, that Governor Nathan Deal has appointed Frank Berry as the new commissioner for the Georgia Department of Community Health (DCH). Berry has led the Department of Behavioral Health and Developmental Disabilities (DBHDD) for the past four years. Current DBHDD chief of staff Judy Fitzgerald will assume the role of department commissioner beginning December 1. The announcements were made after current DCH commissioner Clyde Reese announced his departure to work as a judge for the Georgia Court of Appeals. Read More

Iowa

Anthem Says Medicaid Managed Care Rate Increases Insufficient. *The Gazette* reported on November 4, 2016, that Anthem Inc. believes that recent rate increases for Iowa Medicaid managed care plans are not actuarially justified. In April 2016, Iowa awarded its Medicaid managed care program, with nearly 600,000 members, to Amerigroup (Anthem), AmeriHealth Caritas, and UnitedHealthcare. In November, the state retroactively increased capitation rates by $33 million for the period ending June 30, 2017. The increase also comes with $94.5 million from the federal government. Read More

Louisiana

Department of Health Expects $2.85 Million Surplus in Fiscal 2017. *The Advocate* reported on November 3, 2016, that after five straight years of deficits, the Louisiana Department of Health (LDH) is expected to close out fiscal 2017 with a $2.85 million surplus, attributed to the state's decision to expand Medicaid. According to an LDH report, federal Medicaid dollars tied to expansion are expected to make up for a state funding shortfall tied to higher-than-expected costs among expansion members. The state has enrolled 331,763 additional individuals in Medicaid since expanding the program and is expected to end the fiscal year with 402,333 new enrollees. Read More

Massachusetts

CMS Approves MassHealth Waiver to Implement ACO Models. *The Boston Globe* reported on November 4, 2016, that the federal government approved Massachusetts' waiver to launch Accountable Care Organization models (ACOs) in the state's Medicaid program, MassHealth. The approval authorizes $52.4 billion in spending over five years, including $29.2 billion from the federal government. Full implementation of the model is set to begin in December 2017. The overhaul will aim to better coordinate care and control costs for Massachusetts' nearly 2 million Medicaid recipients. Provider-led entities will have three possible ACO models to choose from. Model A will be capitated through direct contracts with the state, fully integrating ACOs with MCOs to provide services. Model B will have ACOs contract directly with MassHealth and will be paid FFS with a shared savings/loss arrangement. Finally, Model C will have MCO-administered ACOs with various levels of risk. State officials

hope the new care model will result in closer communication with primary care physicians and care managers, who will help coordinate the full spectrum of medical, behavioral health, and social services. Read More

Nevada

Medicaid Managed Care Awards Announced. The Nevada Department of Administration announced on November 3, 2016, it had awarded Medicaid managed care contracts to four health plans: Aetna Better Health of Nevada, Amerigroup Nevada (Anthem), Health Plan of Nevada (UnitedHealthcare), and SilverSummit Healthplan (Centene). UnitedHealth and Anthem were incumbents. The procurement, issued in July 2016, covered existing managed care populations, including Family Medical Coverage and Nevada Check Up (CHIP), and children who have aged out of foster care.

New Hampshire

Waiver Request for Medicaid Work Requirements Denied by CMS. *New Hampshire Union Leader* reported on November 6, 2016, that the Centers for Medicare & Medicaid Services (CMS) has rejected New Hampshire's waiver amendment requesting a work requirement for 50,000 adults covered under the state's Medicaid expansion. CMS also denied parts of the 2015 New Hampshire Health Protection Program, which would increase citizenship requirements for eligible individuals, including providing two forms of identification to be eligible for coverage. Advocacy and consumer groups have criticized any sort of work requirement. Republican lawmakers said they were not optimistic about CMS approving a work requirement, given that similar proposals in Arizona and Ohio were also denied. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Public Notice for Comments on Proposed Access Monitoring Review Plan. The Department of Human Services, Division of Medical Assistance and Health Services issued a public notice to invite comments on its proposed Access Monitoring Review Plan for the NJ FamilyCare fee-for-service enrollment. The Access Monitoring Review Plan was prepared to comply with federal rule, 42 CFR 447.203 to specify requirements and processes for states to review data and trends to evaluate beneficiary access to Medicaid services. The Access Monitoring Review Plan defines data sources, methodologies, baselines, assumptions, trends, factors and thresholds for analyzing provider access. Comments will be accepted until November 24, 2016. Read More

RFP Released for Opioid Overdose Recovery Program. On November 7, 2016 the Department of Human Services, Division of Mental Health and Addiction Services (DMHAS) released a request for proposals (RFP) to develop an Opioid Overdose Recovery Program "to respond to individuals reversed from opioid overdoses and treated at hospital emergency departments as a result of the reversal. One contractor will be selected in either Burlington or Mercer County. Bidders may apply to serve more than one county but must submit separate proposals for each county. A mandatory bidders conference will be held on

November 21, 2016. Proposals are due by December 19, 2016. A copy of the RFP can be found here.

New York

HMA Roundup – Denise Soffel (Email Denise)

Duals Demonstration Extended Through 2019. New York has received approval from the Centers for Medicare & Medicaid Services (CMS) to extend its duals demonstration program, Fully Integrated Duals Advantage (FIDA), through December 31, 2019. The FIDA demonstration was originally approved to run from January 1, 2015, through December 31, 2017. Last year, CMS offered states an opportunity to extend their demonstrations, and the New York State Department of Health (NYSDOH) has now formally accepted the opportunity from CMS and has officially committed to the two-year extension. According to the Director for the Office of Long-Term Care, the extension will "allow NYSDOH and CMS to maximize our experience with fully integrated care and assess the demonstration's impact on quality and cost while engaging stakeholders in planning for the future." The Director also announced the expectation that FIDA will expand into two additional counties (Suffolk and Westchester) at some point in 2017, pending final review of Medicare provider networks. That expansion was originally scheduled for March 2015. Participation in FIDA remains limited. Three additional Fully Integrated Duals Advantage (FIDA) plans are withdrawing from the demonstration program as of January 2017. Twenty-three plans were initially approved to operate a FIDA plan; 14 plans will remain in the program in 2017. A total of 5,128 dual eligibles were enrolled in FIDA plans as of September 2016, although the state estimates that as many as 140,000 individuals are eligible. In an attempt to increase enrollment the state launched an advertising campaign in September, 2016, encouraging dual-eligibles to "take another look" at FIDA.

Fully Integrated Duals Advantage Plans Withdrawing from Market in 2017. Three additional Fully Integrated Duals Advantage (FIDA) plans are withdrawing from the demonstration program as of January 2017: Alphacare (36 enrollees), Centerlight (169 enrollees) and WellCare (155 enrollees). Individuals who do not actively choose a plan will be auto-enrolled into another FIDA plan. Twenty-three plans were initially approved to operate a FIDA plan; 14 plans will remain in the program in 2017. A total of 5,128 dual-eligibles were enrolled in FIDA plans as of September 2016.

State Requests Medicaid Funds for Certain Inmate Health Services. *Modern Healthcare* reported on November 2, 2016, that New York is seeking a federal waiver to receive Medicaid matching funds for certain inmate health care services. The New York State Health Department submitted a waiver proposal to the Centers for Medicare & Medicaid Services (CMS) to provide Medicaid-funded care management, clinical consultation services, and certain prescription drugs, primarily for individuals with behavioral health needs or substance use disorders. Funding would only apply to eligible individuals in the 30 days prior to their release. CMS is taking public comments on the waiver proposal through November 20, 2016. Read More

Behavioral Health Value-Based Payment Draft Recommendations. As part of New York's Delivery System Reform Incentive Payment program, the state is committed to moving Medicaid payment away from fee-for-service payment

and into value-based arrangements. The Department of Health established a number of Clinical Advisory Groups (CAGs) to develop recommendations for diagnosis-specific bundled payments. The Behavioral Health Value-Based Payment CAG has produced the Behavioral Health Chronic Conditions Recommendation Report, which was recently released for public comment. The CAG identified four behavioral health chronic conditions where a bundled payment was appropriate: Depression and Anxiety Disorder; Substance Use Disorder; Bipolar Disorder; and Trauma and Stressor Disorder. Each bundle includes specific episode triggers and timelines, covered services, exclusions, and potentially avoidable complications. Each condition further includes a set of quality measures for evaluating treatment. The proposed quality measures are exclusively clinical, and do not incorporate broader measures of well-being that are typically part of a recovery model of care. The public comment period for the Behavioral Health Chronic Conditions Recommendation Report will run through November 28, 2016. Read More

Impact of the Affordable Care Act on Health Insurance Markets. The United Hospital Fund released a report that reviews the impact of the Affordable Care Act on New York's health insurance markets during the first year of implementation. Enrollment in individual health insurance coverage increased sharply in 2014, but overall net income for New York health plans dropped significantly compared to 2013, as noted below. Individual coverage grew significantly in both the commercial and Medicaid markets, but Medicaid provided more positive financial returns to the health plans. Enrollment in fully insured employer-sponsored coverage declined significantly, as coverage among public employees shifted to self-funded arrangements. Employers were not dropping coverage and paying ACA penalties, as some analysts feared before the implementation of the ACA. Total net income for all New York health plans in 2014 was $516 million, down by more than $1 billion from the totals in 2013 ($1.6 billion) and 2012 ($1.7 billion). Much of that decline was experienced by EmblemHealth, which lost almost $500 million in 2014. Medicaid managed care was the most positive line of business in 2014, while Medicare Advantage generated significant losses for most health plans. Read More

NYC Health and Hospital President Ram Raju to Step Down. *Modern Healthcare* reported on November 7, 2016, that NYC Health and Hospitals president Ram Raju will step down on November 30. Stanley Brezenoff, who previously served in the same role, has been named acting president until a permanent replacement is found. Raju has run the embattled 11-hospital system since 2014. Read More

Health Home Criminal Justice Workgroup. New York is in the process of developing a waiver to allow for the coverage of services to incarcerated individuals within 30 days prior to discharge from criminal justice facilities. Details were presented to the Health Home Criminal Justice Workgroup. The categories of services include Health Home services, medical and behavioral health consultations, and certain pharmaceuticals. The minutes and presentation from the August 25, 2016, meeting are posted on the Health Home website. Read More

Decline in Number of Uninsured Children in New York. A study from the Georgetown University Center for Children and Families shows that New York State reduced the number of uninsured children by nearly 40 percent in two years, the fifth largest decline of its kind in the nation. The report shows that between 2013 and 2015, the number of children without health insurance in New

York dropped by 67,000, with 97.5 percent of New York's children insured. The national average of insured children is 95.2 percent. The study attributes the Affordable Care Act, which maintained and enhanced existing Medicaid and CHIP coverage for children, to the widespread declines in the number and rate of uninsured children during these two years. Read More

HIV Special Needs Plan to Establish an Accountable Care Organization. Amida Care, which was founded by seven community-based HIV service organizations, is the state's largest Medicaid HIV special needs plan, with 6,180 enrollees. Amida Care is now enlisting providers to form a statewide HIV accountable care organization. An HIV accountable care organization would allow Amida Care to develop value-based payment arrangements with providers that would make the delivery system more financially stable. According to *Crain's HealthPulse*, Amida Care plans to launch the group through the Value-Based Payment Innovator Program, part of the state's roadmap for moving Medicaid spending away from fee-for-service and into value-based payments by 2020. Amida Care's planned accountable care organization would include community-based organizations, and would offer all members the opportunity to share ownership of the organization. Read More

Office of Mental Health Virtual Town Hall. The Office of Mental Health (OMH) is conducting a Statewide Virtual Town Hall on November 16, 2016, from 1:00 p.m. to 3:00 p.m. with Commissioner Ann Marie Sullivan, M.D., presenting the "Commissioner's Transformation Agenda for a Changing Healthcare Environment." It will be held online via WebEx in order to maximize public participation, with three sites (Albany, New York City and Rochester) for attendees who are unable to access the event online. The Town Hall will provide the public an opportunity to learn more about the OMH vision for the future, including the Commissioner's top policy and planning priorities. All public comments will be considered in the development of the OMH Statewide Comprehensive Plan. Written comments can be submitted up to three weeks following the event. Read More

Provider Contract Guidelines. The Department of Health has published a draft version of the revised New York State Department of Health Provider Contract Guidelines for managed care plans, accountable care organizations and Independent Practice Associations for public comment. The Guidelines are being revised to reflect value-based payment arrangements pursuant to the New York State Value-Based Payment Roadmap. Read More

Children's Health Homes and Early Intervention. In December 2016, New York's Medicaid Health Home Program will begin serving children. The Health Home Program provides comprehensive case management services for children enrolled in Medicaid who meet Health Home eligibility and appropriateness criteria. It is anticipated that some children currently in the Early Intervention Program (EIP) or who might be potentially eligible for the EIP, may also be eligible for Health Home. The EIP also includes service coordination. As a result, guidelines need to be developed and implemented to coordinate the provision of care coordination and management for children enrolled in both the Health Home and EIP. To provide the time needed to develop guidelines and engage stakeholders in the development and implementation of those guidelines, the enrollment of children in the Health Home Program who are also enrolled in EIP will be delayed until March 2017.

Waiver Program Transition Timeline. As part of its Care Management for All strategy, New York's Medicaid program will transition individuals currently enrolled in two 1915(c) waiver programs into managed care plans. Individuals currently enrolled in the Nursing Home Transition and Diversion waiver and the Traumatic Brain Injury waiver will transition into Medicaid managed care beginning in 2017. A new timeline published by the Department of Health indicates that the state plans to submit an amendment to its 1115 waiver to CMS in June 2017; new referrals into the two waiver programs will end on January 1, 2018, and the comprehensive Medicaid mainstream managed care plans will fully incorporate all previous waiver services, including those offered through the Community First Choice Option, effective April 1, 2018. Read More

Community First Choice Option. The Department of Health (DOH) has received approval from the Centers for Medicare and Medicaid Services (CMS) to amend the State's Medicaid Plan to effectuate the Community First Choice Option (CFCO). CFCO will incorporate enhanced services and supports into the Medicaid State Plan for eligible individuals who need assistance with everyday activities due to a physical, developmental or behavioral disability. The DOH anticipates implementing CFCO for both fee-for-service and managed care enrollees on April 1, 2017. Medicaid beneficiaries must meet certain setting and needs-based criteria in order to be eligible for CFCO services. Local departments of social services and managed care organizations will be required to assess the need for as well as authorize CFCO services. CFCO services must be provided pursuant to a Person Centered Service Plan. CFCO State Plan services and supports include:

- Assistive technology beyond the scope of durable medical equipment
- Activities of daily living and instrumental activities of daily living skill acquisition, maintenance, and enhancement
- Community transitional services (assistance to consumers who are transitioning from an institutional setting to a home in the community)
- Moving assistance (costs of physically moving the consumer's furnishings and other belongings to the community-based setting)
- Environmental modifications (internal and external adaptations necessary to ensure the consumer's health, welfare and safety)
- Vehicle modifications
- Non-emergent transportation (social)
- Congregate and/or home-delivered meals.

Many of these services are subject to cost limitations. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Highmark Pulls out of ACA Marketplace in 27 Counties for 2017. *The Tribune-Review* reported on November 4, 2016, that Highmark is reducing its participation in Pennsylvania's ACA marketplace by more than 50 percent for 2017. Roughly 70 percent of Highmark customers will lose their plans. Pennsylvania's Department of Insurance Commissioner, Teresa Miller, told the media she approved premium increases averaging 50 percent for Highmark's

2017 plans to keep it from walking away entirely. Highmark is leaving 17 Western Pennsylvania counties in 2017. UPMC Health Plan will be the only insurer selling marketplace plans in 11 of these: Greene, Fayette, Indiana, Armstrong, Lawrence, Mercer, Crawford, Warren, Forest, Clarion and Elk. Highmark has sued the federal government over a risk program meant to protect insurers from runaway losses, saying the government owes $223 million for 2014 and owes more for subsequent years. Commissioner Miller has requested the court's permission to file an amicus brief supporting Highmark in the lawsuit, and is encouraging federal lawmakers to improve the marketplace. Read More

Vermont

DVHA Begins Reallocating $4 Million in Medicaid Funds to Primary Care. *VTDigger.com* reported on November 3, 2016, that the Department of Vermont Health Access will reduce payments to academic hospitals by $4 million and reallocate the funds to primary care providers under an approved spending bill from the 2016 legislative session. The University of Vermont Medical Center will see a reduction of $2.9 million, Dartmouth-Hitchcock Medical Center $1 million, and out-of-state academic medical centers $100,000. Primary care doctors will see reimbursements rise by 8.9 percent. Read More

National

Medicaid Personal Care Services Fraud Prevalent, OIG Report Finds. *Kaiser Health News* reported on November 7, 2016, that Medicaid personal care services programs are rife with financial fraud and safety issues, according to a new report from the Department of Health and Human Services (HHS) Office of lnspector General (OIG). The federally financed, state-run programs provide individuals with non-medical assistance at home, with personal care attendants being paid around $10 an hour. The OIG says it has investigated over 200 accounts of fraud in the $14.5 billion program since 2012 and is urging federal action, including standardized training, background checks, and documentation of personal care attendants. The federal government has granted $50 million to 26 states to establish background checks and has offered states guidelines for basic caretaker training. Read More

Federal Judge Blocks CMS Rule on Nursing Home Disputes with Residents. *The Hill* reported on November 7, 2016, that a federal judge in Mississippi has temporarily blocked a new rule put forward by the Centers for Medicare & Medicaid Services (CMS) aimed at protecting the right of nursing home residents to settle disputes in court. The rule, which was supposed to take effect November 28, would prohibit nursing homes from including pre-dispute arbitration clauses in resident contracts. These clauses require residents to settle disputes privately with an arbitrator rather than in court. Nursing homes argue that CMS is overstepping its authority by attempting to block arbitration agreements. Read More

Industry News

Centene, Kentucky Reach Settlement on Contract Dispute. Centene Corporation announced on November 4, 2016, that its subsidiary Kentucky Spirit Health Plan will receive a cash payment after agreeing to settle a contract dispute with the Commonwealth of Kentucky. The parties agree that neither acted in bad faith, and both agreed to dismiss all claims. Read More

Amedisys Acquires Visiting Nurse Association of Long Island. *Crain's HealthPulse* reports that Tender Loving Care Health Care Services of Nassau Suffolk, a subsidiary of the national home health and hospice company Amedisys, has finalized its acquisition of the nonprofit Visiting Nurse Association of Long Island for $4.6 million. The deal represents Amedisys' first foray into New York City. The Visiting Nurse Association filed for bankruptcy in June 2015, citing insufficient reimbursement rates from long-term managed-care plans. Read More

Attorney General Files Suit Against Skilled Nursing Home Chain. On November 4, 2016, Pennsylvania Attorney General Bruce Beemer announced the filing of a consumer protection lawsuit against Grane Healthcare Company for misrepresenting the level of care it can provide patients, given alleged chronic understaffing. The lawsuit alleges that Grane violated the commonwealth's Unfair Trade Practices and Consumer Protection Law by making misrepresentations on its websites, and in marketing materials, regarding staffing and basic care provided to the residents of its facilities. Grane is also accused of billing consumers and the state for services that were not provided. Mark Grane, president of Grane Healthcare, said in a statement Friday that his firm "has not had the opportunity to review the specific allegations in the complaint but believes the lawsuit is completely unfounded." The AG's office is seeking refunds for customers and the state, as well as up to a $3,000 fine for every violation of the consumer protection law involving a person 60 years or older. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November, 2016	Washington, DC	RFP Release	200,000
November 9, 2016	Wisconsin Family Care/Partnership (MLTSS)	Proposals Due	14,000
November 30, 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	RFP Release	860,000
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
December, 2016	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
January 23, 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	Contract Awards	177,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
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
April, 2018	Oklahoma ABD	Contract Awards	177,000
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 (Sept. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	115,736	33.1%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	46,330	34.1%	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	13,012	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,982	37.0%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	4,990	4.0%	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	310	1.6%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	61,651	54.1%	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	8,156	15.2%	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	38,658	23.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,477	41.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**353,302**	**28.2%**	

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

HMA WELCOMES…

Florence "Missy" Garrity, Senior Consultant – Boston, Massachusetts

Missy Garrity comes to HMA most recently from the Commonwealth Care Alliance where she served as Senior Director of the Enterprise Project Management Office over the past two years. In this role, Missy facilitated the annual business planning process to define strategic objectives. She evaluated strategic project portfolio performance and engaged with executives and business owners to resolve barriers and promote project success. Missy also served as an Independent Consultant for Commonwealth Care Alliance and BMC Health Plan where she supported the implementation of the Medicaid-Medicaid Dual Eligible Demonstration project.

Prior to her role as an independent consultant, Missy served as a Program Director for Freedman Healthcare where she led strategic projects that assisted stakeholders in developing and implementing policies and procedures that drive cost containment and quality improvement. Select projects include a Signature Health PCMH Readiness Assessment and a Medical Cost Driver Analysis for the state of Rhode Island. Missy also served as a Director of Health Management Programs with Blue Cross Blue Shield of Massachusetts where she supported clinical and operational health management leadership by successfully leading teams.

Missy held a number of project management and department leadership roles at Tufts Health Plan, including Manager of Reporting and Analytics, Project Manager for the finance and reporting components of a legacy system replacement project and Director of the Corporate Project Management Office.

Missy received her Master of Business Administration from Northeastern University and her Bachelor of Arts in Biology from Regis College. Missy has her Project Management Professional (PMP) Certification from the Project Management Institute.

Myra Sessions, Senior Consultant – Boston, Massachusetts

Myra Sessions comes to HMA most recently from Commonwealth Care Alliance where she served as a Program Manager for Business Development for the past three years. In this role, Myra implemented a collaborative clinical program for Senior Care Options and One Care programs by building partnerships between primary care practices and health plan care managers. She also managed relationships and facilitated meetings to define shared expectations, communication processes, growth strategies and workflows.

Prior to her role as a Program Manager, Myra served as a Senior Project Manager and Coach with Brigham and Women's Hospital's Department of Primary Care. Myra collaborated with medical and administrative leadership teams to support transformation toward team-based care and the patient-centered medical home model. She also provided expertise in change management approaches, communication strategies, organizational tools and measuring progress.

Additional positions that Myra has held include Project Manager with the Urban Medical Group, Program Coordinator with the Center for Global Development, and Population Reference Bureau Policy Fellow with the USAID Office of Population and Reproductive Health.

Myra received her Master of Science degree in Health Policy and Management from Harvard's School of Public Health. She received her Bachelor of Arts degree in American Studies from Wesleyan University.

Caryn Swartz, Senior Consultant – Harrisburg, Pennsylvania

Caryn Swartz comes to HMA most recently from MAXIMUS, Inc., where she served as a Project Manager for their Pennsylvania Independent Enrollment Broker Contract. In this role, Caryn managed the statewide contract with the Department of Human Services and worked closely with the Commonwealth of Pennsylvania in the development of their MLTSS program implementation plan. Caryn facilitated community outreach to program stakeholders, consumers and advocacy groups, and she provided budgetary oversight, staff management and program development. Caryn also previously served as a Systems Implementation Project Manager and Business Analyst with MAXIMUS, Inc.

Prior to her role as a Project Manager, Caryn served as a Healthcare Analyst and Audit Lead with InGenesis (previously Liberty Healthcare), working on the Commonwealth of Pennsylvania's Office of Medical Assistance Programs' Electronic Health Record (EHR) Incentive Program. In this role, Caryn designed and carried out audit strategies for the incentive program, identifying risk and a mitigation process. Additionally, Caryn assisted with the monitoring and development of the Medical Assistance Health Information Technology initiative program.

Additional positions Caryn has held include Program Specialist and Social Worker with Liberty Healthcare and Director of Admissions and Social Services with Palmyra Nursing Home.

Caryn received her Master of Business Administration in Health Administration from Eastern University. She also received her Bachelor of Science in Psychology with a concentration in Gerontology from Eastern University.

Julia Elitzer, Senior Consultant – San Francisco, California

Julia Elitzer comes to HMA most recently from the Brod Group where she served as a Senior Research Associate. In this consulting role, Julia analyzed patient reported outcomes for late-phase chronic disease-related pharmaceuticals. Prior to the Brod Group, Julia served as a Community Affairs Liaison at Cambridge Health Alliance, where she analyzed the utilization of hospital services and streamlined outpatient care in the El Salvadoran community.

Prior to her role at Cambridge Health Alliance, Julia served as a an Acting General Manager for the U.S.-Mexico Border Health Commission for the U.S. Department of Health and Human Services' Office of the Americas. Julia coordinated appointed members and delegates to the Border Health Commission around border health policy. She also facilitated binational working groups and optimized international leadership for binational actions along the U.S.-Mexico border.

Additional positions that Julia has held include J. William Fulbright Research Grantee with the United States-Mexico Foundation for Science, Global Health Analyst for the National Institutes of Health, and Multilateral International Public Health Analyst for HHS' Office of the Secretary.

Julia received her Doctorate of Public Health degree from Boston University. She received her Master of Public Health degree and Bachelor of Arts degree in Community Health and Spanish from Tufts University.

Rachel Patterson, Senior Consultant – Washington, D.C.

Rachel Patterson comes to HMA most recently from the Christopher and Dana Reeve Foundation, where she served as Director of Public Policy since 2015. In this role, Rachel created and implemented a new policy agenda focused on health, access to rehabilitation, long-term services and supports (LTSS) and family caregiver support. She built a new partnership with the National Council on Disability around civil rights of parents with disabilities. She also served as Co-Chair for the Consortium for Citizens with Disabilities Long-Term Services and Supports and Health Task Forces.

Prior to her role as Director of Public Policy, Rachel served as a Policy Manager with the Association of University Centers on Disabilities (AUCD). In this role, Rachel led AUCD's health and long-term services and supports policy efforts. She launched an online resource to support state and national advocacy coalitions implement the home and community-based services settings regulation. Rachel's previous roles with AUCD include Policy Analyst and Program Specialist of University Centers for Excellence in Developmental Disabilities (UCEDDs).

Additionally, Rachel served as a Research Assistant with the Burton Blatt Institute at Syracuse University where she monitored the Medicaid redesign and transition to managed care in New York State and contributed to national and international disability projects with research and literature reviews.

Rachel received her Master of Public Administration from the Maxwell School of Citizenship and Public Affairs at Syracuse University where she was a Brian McLane Fellow for disability policy. She received her Bachelor of Arts in Politics from Whitman College. She currently serves on the board of the Sibling Leadership Network.