HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

February 15, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION ENROLLMENT UPDATE

This week, our *In Focus* section reviews publicly available data on enrollment in capitated financial and administrative alignment demonstrations ("Duals Demonstrations") for beneficiaries dually eligible for Medicare and Medicaid (duals) in 10 states: California, Illinois, Massachusetts, Michigan, New York,

Ohio, Rhode Island, South Carolina, Texas, and Virginia. Each of these states has begun either voluntary or passive enrollment of duals into fully integrated plans providing both Medicaid and Medicare benefits ("Medicare-Medicaid Plans," or "MMPs") under three-way contracts between the state, the Centers for Medicare & Medicaid Services (CMS), and the MMP. As of January 2017, more than 386,000 duals are enrolled in an MMP, according to state and CMS enrollment reports, the highest monthly enrollment total since the demonstrations began in late 2013. Additionally this week, we highlight key takeaways from the 2017 update to the data book, *"Beneficiaries Dually Eligible for Medicare and Medicaid,"* published in January 2017 by the Medicaid and CHIP Payment and Access Commission (MACPAC) and the Medicare Payment Advisory Commission (MedPAC).

Note on Enrollment Data

Six of the ten states (California, Illinois, Massachusetts, Michigan, New York, and South Carolina) report monthly on enrollment in their Dual Demonstration plans, although there is often a lag in the published data. Other states publish intermittent enrollment reports.

Duals Demonstration plan enrollment is also provided in the CMS Medicare Advantage monthly enrollment reports, which are published around the middle of each month. In the table below, we provide the most current state-reported data, with CMS data supplementing where needed. Historically, we have seen minor inconsistencies between state-reported data and the CMS enrollment report, potentially due to discrepancies in the timing of reports.

Dual Demonstration Enrollment Overview

As of January 2017, more than 386,600 dual eligibles were enrolled in a demonstration plan across the ten states below. Since January 2016, enrollment in Dual Demonstrations across these ten states is up more than 13,700 members or 3.7 percent. As noted in the introduction, January 2017 represents the highest ever duals demonstration enrollment total, due primarily to the launch of Rhode Island's demonstration in late 2016, as well as a significant uptick in Texas enrollment in January 2017.

Table 1 – Dual Eligible Financial Alignment Demonstration Enrollment by State – August 2016 to January 2017

State	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
California	117,370	115,736	114,337	112,468	113,601	114,804
Illinois	47,420	46,330	45,070	46,591	46,669	45,469
Massachusetts	12,974	13,012	13,718	13,857	14,036	16,039
Michigan	37,087	36,892	37,005	36,656	36,837	36,752
New York	5,073	4,990	4,920	4,860	4,922	4,827
New York - IDD	247	310	365	384	430	448
Ohio	62,729	61,651	63,541	70,315	69,074	69,634
Rhode Island		395	1,335	4,086	7,958	9,934
South Carolina	9,002	8,156	7,862	9,611	9,434	8,981
Texas	39,867	38,658	37,855	36,736	35,514	50,924
Virginia	27,576	27,477	29,367	29,186	29,139	28,835
Total Duals Demo Enrollment	**359,345**	**353,607**	**355,375**	**364,750**	**367,614**	**386,647**

Sources: State Enrollment Data, CMS Enrollment Data

So far, enrollment in these nine states represents just over 30 percent of the potential enrollment of more than 1.2 million across all ten capitated

demonstration states. Participation rates range from a low of less than 4 percent in New York to more than 61 percent in Ohio.

Table 2 – Dual Eligible Financial Alignment Demonstration Enrollment Timing; Current Potential Enrollment - As of January 2017

	Opt-In Enrollment Date	First Passive Enrollment Date	Current Enrollment	Potential Enrollment	% Enrolled (Full Potential)
California	4/1/2014	5/1/2014	114,804	350,000	32.8%
Illinois	4/1/2014	6/1/2014	45,469	136,000	33.4%
Massachusetts	10/1/2013	1/1/2014	16,039	97,000	16.5%
Michigan	3/1/2015	5/1/2015	36,752	100,000	36.8%
New York	1/1/2015	4/1/2015	4,827	124,000	3.9%
New York - IDD	4/1/2016	No Passive	448	20,000	2.2%
Ohio	5/1/2014	1/1/2015	69,634	114,000	61.1%
Rhode Island	7/1/2016	10/1/2016	9,934	25,400	39.1%
South Carolina	2/1/2015	4/1/2016	8,981	53,600	16.8%
Texas	3/1/2015	4/1/2015	50,924	168,000	30.3%
Virginia	3/1/2014	5/1/2014	28,835	66,200	43.6%
Total (All States)			**386,647**	**1,254,200**	**30.8%**

Sources: State Enrollment Data, CMS Enrollment Data, HMA Estimates.

Dual Demonstration Enrollment by Health Plan

As of January 2017, more than half (54.4 percent) of all duals in the demonstrations are enrolled in a publicly-traded MMP. Molina and Centene are the largest in terms of enrollment with roughly 54,800 and 47,800 demonstration enrollees, respectively. Centene's enrollment was bolstered by its acquisition of Health Net at the end of March 2016.

Table 3 – Dual Eligible Financial Alignment Demonstration Enrollment by Health Plan (Publicly Traded) - February 2016 to January 2017

Health Plan	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Molina	50,699	50,201	50,173	51,145	50,751	54,795
Centene	45,284	44,395	43,571	45,667	45,066	47,768
Anthem	31,723	31,155	31,661	31,142	30,709	36,580
Aetna	26,787	26,346	26,652	28,211	28,053	27,929
United	16,824	16,373	16,608	17,751	17,208	19,976
Humana	16,561	16,335	17,124	17,131	16,976	16,575
CIGNA/HealthSpring	7,897	7,679	7,445	7,253	7,044	6,823
WellCare	1,857	141	141	133	121	12
Health Net						
Total Publicly Traded Health Plans	**197,632**	**192,625**	**193,375**	**198,433**	**195,928**	**210,458**

Sources: State Enrollment Data, CMS Enrollment Data

Among non-publicly traded health plans, Inland Empire in California is the largest, with more than 22,000 members, making it the fifth largest MMP nationwide. CareSource (Ohio), CalOptima (California), BCBS of Illinois (Illinois), LA Care (California), Commonwealth Care Alliance (Massachusetts), and Meridian (Illinois and Michigan) all have more than 10,000 enrolled members as of January 2017. Enrollment by non-publicly traded health plans for the past six months is detailed below.

Table 4 – Dual Eligible Financial Alignment Demonstration Enrollment by Health Plan (Local/Other Plans) - February 2016 to January 2017

Health Plan	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
Inland Empire (CA)	21,356	21,405	21,447	21,503	21,872	22,286
CareSource (OH)	16,273	16,085	16,559	17,985	18,030	18,352
CalOptima (CA)	18,330	17,691	17,350	16,413	16,745	16,463
BCBS of Illinois (HCSC) (IL)	13,653	13,762	13,609	13,782	13,926	13,803
LA Care (CA)	12,449	12,452	12,481	12,458	12,484	12,850
Commonwealth Care Alliance (MA)	10,265	10,380	11,134	11,309	11,498	12,609
Meridian Health Plan (IL, MI)	10,983	10,659	10,519	11,045	11,097	10,770
Neighborhood Health Plan of Rhode Island (RI)		395	1,335	4,086	7,958	9,934
Health Plan of San Mateo (CA)	9,333	9,314	9,299	9,276	9,391	9,529
AmeriHealth Caritas (MI, SC)	7,034	7,357	7,195	7,773	7,677	7,437
Santa Clara Family Health Plan (CA)	7,740	7,601	7,381	7,323	7,309	7,377
Care 1st (CA)	6,695	6,539	6,356	6,227	6,209	6,376
Virginia Premier (VA)	5,716	5,679	5,690	5,704	5,750	5,657
HAP Midwest Health Plan (MI)	5,279	5,190	5,185	5,112	5,074	5,095
Community Health Group Partner (CA)	4,773	4,750	4,774	4,704	4,925	4,949
Upper Peninsula Health Plan (MI)	3,983	3,965	3,990	3,993	4,016	4,053
Network Health (MA)	2,709	2,632	2,584	2,548	2,538	3,430
VNS Choice (NY)	1,876	1,831	1,792	1,752	1,705	1,697
Managed Health Inc. (NY)	1,026	1,004	996	986	986	1,003
GuildNet (NY)	798	790	790	778	772	800
Partners Health Plan - IDD (NY)	247	310	365	384	430	448
The New York State Catholic Health Plan (NY)	309	300	299	300	298	341
Elderplan (NY)	276	275	283	291	309	339
MetroPlus Health Plan (NY)	182	174	167	170	163	173
Independence Care System (NY)	151	150	151	151	150	153
Senior Whole Health (NY)	76	100	104	108	124	137
AgeWell New York (NY)	14	16	16	16	39	38
North Shore-LIJ (NY)	17	18	15	16	26	26
Centers Plan for Healthy Living (NY)	12	12	11	11	23	22
Village Senior Services Corp. (NY)					23	22
Centerlight Healthcare (NY)	138	128	105	94	105	8
Elderserve Health (NY)					7	8
AlphaCare of New York (NY)	20	18	18	19	27	4
Total Local/Other Plans	**161,713**	**160,982**	**162,000**	**166,317**	**171,686**	**176,189**

Sources: State Enrollment Data, CMS Enrollment Data

Looking Ahead

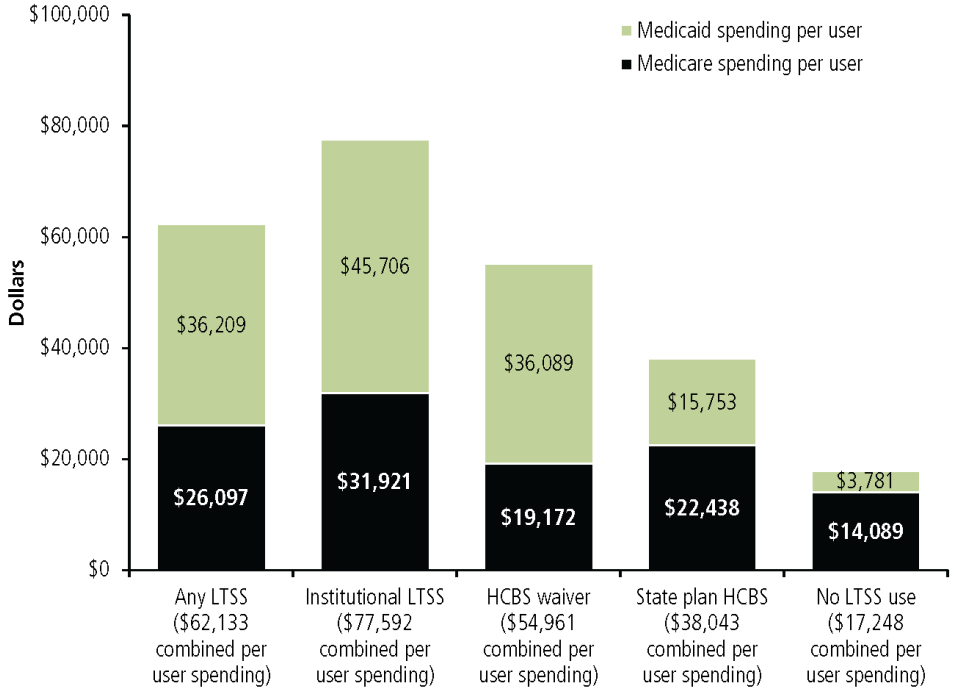
On January 19, 2017, CMS sent a letter to Massachusetts, as well as Minnesota, (operates an alternative demonstration model in agreement with CMS) and Washington (operates a managed fee-for-service demonstration model), to extend their agreements beyond the scheduled end dates of December 31, 2018. If agreed, Massachusetts would continue operating its capitated duals demonstration for an additional two years, through December 31, 2020. The letter also notes that it may also consider extensions within the next year for the five demonstration states slated to end on December 31, 2019. This opens up the potential for additional states to continue their duals demonstrations through at least 2011 or 2022, with the exception of Virginia, who has announced their intentions to end their Commonwealth Coordinated Care demonstration at the end of 2018, transitioning members into a new managed long term services and supports (MLTSS) and dual eligible managed care program.

MACPAC/MedPAC Data Book Update

The January 2017 edition MACPAC/MedPAC data book, "*Beneficiaries Dually Eligible for Medicare and Medicaid,*" includes updated data for calendar year (CY) 2012 on dual eligible beneficiaries, primarily providing aggregated national data, but with some breakouts of state-specific data. The data book

provides a wide range of data around enrollment, spending, service utilization, and conditions, often with comparisons to non-dual Medicare and Medicaid populations. The data provided is primarily for the FFS dual eligible population, but does include some data on duals who are FFS Medicare but enrolled in Medicaid managed care. Below, we highlight a few tables of interest from the report.

Table 6 – Per User Medicare and Medicaid Spending on FFS Full-Benefit Dual Eligible Medicaid LTSS Users and Non-Users, CY 2012



Note: *FFS (fee-for-service), LTSS (long-term services and supports), CY (calendar year), HCBS (home- and community-based services). Exhibit is limited to full-benefit dual-eligible beneficiaries in Medicare and Medicaid FFS. End-stage renal disease is excluded. Medicaid spending amounts for dual-eligible beneficiaries exclude Medicaid payments of Medicare premiums. Exhibit excludes administrative spending. Medicare and Medicaid spending components sum to an amount greater than the total because combined per user spending includes a small number of individuals who used either Medicare or Medicaid services, but not both.*

- In 2012, Medicaid covers the majority of spending for dual eligible beneficiaries who are users of LTSS, while Medicare covers the majority for beneficiaries with no LTSS needs.
- The only category of LTSS beneficiaries for which Medicare spends more than Medicaid is those using only state plan home and community based services (HCBS).

Table 7 – Selected Conditions for FFS Dual Eligible Beneficiaries by Age Group, CY 2012

Condition	FFS dual-eligible beneficiaries	
	Under age 65	Ages 65 and older
Cognitive impairment		
Alzheimer's disease or related dementia	3%	23%
Intellectual disabilities and related conditions	8	1
Medical conditions		
Diabetes	23%	35%
Heart failure	8	23
Hypertension	40	66
Ischemic heart disease	14	34
Behavioral health conditions		
Anxiety disorders	23%	14%
Bipolar disorder	15	3
Depression	32	22
Schizophrenia and other psychotic disorders	14	7

Note: *FFS (fee-for-service), CY (calendar year). Chronic conditions are identified using Medicare FFS claims. Exhibit excludes beneficiaries enrolled in Medicare Advantage plans because Medicare FFS claims are not available for those individuals. Beneficiaries with end-stage renal disease are also excluded.*

- Dual eligible beneficiaries have high incidences of medical conditions, including diabetes, heart failure, hypertension, and heart disease, particularly those over age 65.
- Alzheimer's disease or dementia is common in the dual eligible population over 65, while around 8 percent of duals under 65 have an intellectual or developmental disability.
- On the behavioral health side, dual eligibles under 65 have higher incidences of anxiety disorders, bipolar disorder, depression, and schizophrenia than duals who are over the age of 65.

The tables above are available in the January 2017 edition of the MACPAC/MedPAC data book, *"Beneficiaries Dually Eligible for Medicare and Medicaid,"* available at: https://www.macpac.gov/publication/data-book-beneficiaries-dually-eligible-for-medicare-and-medicaid-3/

HMA MEDICAID ROUNDUP

California

Medi-Cal Plan Quality Standards Scores for 2016 Released. *California Healthline* reported on February 9, 2017, that California released its 2016 Medi-Cal managed care plan quality standards scores. Plans are scored from zero to 100 percent in meeting quality standards. The state average score for all 53 Medi-Cal plans was 60 percent. Two plans exceeded 90 percent – Kaiser Permanente in San Diego (97 percent) and Kaiser's Sacramento plan (96 percent). Plans with low scores are required by the state to implement corrective action plans. Read More

Report Finds Flawed Provider Directories; Insurers May Face Fines. *California Healthline* reported on February 10, 2017, that health plans have inaccurately reported information on which providers are in their networks, according to a new report by the California Department of Managed Health Care (DMHC). The report, which analyzed 2015 data for commercial and Medicaid plans, could result in fines for 36 of the 40 health insurers in the state. Outdated or inaccurate provider directories can prevent patients from getting treatment or result in large medical bills. Information submitted by insurers to the state showed that provider lists used during the year varied dramatically from year-end lists. Read More

Colorado

Attorney General Approves United's Acquisition of Rocky Mountain Health Plans. *The Denver Post* reported on February 9, 2017, that Colorado Attorney General Cynthia Coffman approved UnitedHealthcare's acquisition of Rocky Mountain Health Plans. The state Division of Insurance is currently reviewing the proposed sale. Not-for-profit Rocky Mountain will need to be converted to a for-profit company, and proceeds from the sale – projected to be $36 million – must go to the Rocky Mountain Health Plans Foundation to be used on charitable projects. The plan has posted losses for the last three years. Read More

Connecticut

Governor Proposes Cuts to Medicaid Program. *The CT Mirror* reported on February 8, 2017, that Connecticut would reduce Medicaid eligibility and cut a number of health care services under Governor Dannel Malloy's proposed budget for fiscal 2018. Under the proposal, an estimated 9,500 low-income parents would no longer qualify for Medicaid, fewer seniors would get home care, behavioral health providers would see $4.7 million in funding reductions, and school-based health centers would see a 10 percent funding cut. The budget would also scale back the number of seniors eligible for the Medicare Savings Program, which allows seniors to receive financial support for drug co-pays. Despite the large number of reductions, stakeholders say that the cuts are actually less significant than expected, given Governor Malloy's reductions in prior years. The proposals are all part of the Governor's plan to attempt to close a projected $1.7 billion budget deficit. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Lawmaker Proposes Medicaid Managed Care Exemption for Certain Nursing Home Residents. *Health News Florida* reported on February 14, 2017, that Florida state Senator Kelli Stargel (R-Lakeland) has proposed a bill to carve out some nursing home residents from the statewide Medicaid managed care program. The exemption would apply to residents who have been living in a nursing home for 60 consecutive days and residents in hospice care. The state nursing home industry argues that enrolling these patients in managed care adds unnecessary costs. Read More

Lawmaker Proposes Medicaid Managed Care Changes. *CBS Miami* reported on February 14, 2017, that Florida Senator Denise Grimsley (R-Sebring) has proposed legislation that would reduce the number of Medicaid managed care regions in the state from 11 to eight and specify the number of plans that the state could contract with in each region. The bill will be considered in the next legislative session beginning March 7, 2017. Read More

House to Take Up Three Bills Aimed at Health Care Regulations. *Health News Florida* reported on February 10, 2017, that the Florida House Health Innovation Subcommittee will take up three bills that would impact health care regulations in the state. The first would eliminate the certificate of need process for hospitals, nursing homes, and hospice facilities. The second would allow patients to stay up to 24 hours at ambulatory surgical centers; it would also create operation recovery centers that can house patients for up to 72 hours after surgery. The third bill would allow patients or employers to make monthly payments directly to primary care doctors to cover routine services, cutting out insurers. Read More

Senate Bill Proposes Medicaid Prospective Payment System for Nursing Facilities. *Florida Politics* reported on February 9, 2017, that Florida State Senator Aaron Bean (R-Fernandina Beach) introduced legislation to create a prospective payment system for nursing facilities serving Medicaid members. Rates would be based on audited cost reports. The Florida legislature had previously set aside funds to develop a proposal to change Medicaid reimbursement from its current cost-based system. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Governor Signs Bill to Extend Hospital Assessment Program for Three Years. *Georgia Health News* reported on February 10, 2017, that the Georgia legislature voted to renew the state's hospital assessment program for three years, a move that is expected to help cover a $900 million gap in the state Medicaid budget. Georgia collects approximately $310 million from hospitals through the assessment program, receiving $600 million in federal matching funds, all of which help fund Medicaid. The money is returned to hospitals through reimbursements based on their share of the state's Medicaid business. The bill now goes to Governor Nathan Deal for signature. Read More

State Lawmakers Support Per-capita Cap Medicaid Waiver. *Modern Healthcare* reported on February 8, 2017, that Georgia state legislators introduced a resolution urging Governor Nathan Deal to pursue an 1115 waiver to transition the state's Medicaid program to per-capita cap funding. State Representative Brad Raffensperger, who introduced the resolution along with four co-sponsors, said the change would expand Medicaid to more low-income people and reduce uncompensated care costs. The resolution is currently under review by Georgia's House Appropriations Committee. Read More

'Surprise Medical Bills' Legislation Tied Up in State Senate. *Georgia Health News* reported on February 14, 2017, that a bill that would prevent surprise medical bills has stalled in the state Senate. Surprise medical bills can arise when a patient goes to an in-network hospital, but is treated by an out-of-network physician or provider. Senator Renee Unterman (R-Buford), who sponsored the legislation, said that providers and insurance companies remain divided over a methodology for determining payment rates for procedures. Senator Unterman plans to hold a meeting with state senators on February 16, 2017, to seek a compromise. Read More

Iowa

Medicaid MCO Lowers In-home LTSS Rates. *The Courier* reported on February 9, 2017, that AmeriHealth Caritas Iowa will lower in-home Medicaid provider reimbursement rates for long-term services and supports (LTSS) to the Medicaid rate floor in an effort to "establish a more sustainable program," effective April 1. The state of Iowa set the Medicaid rate based on what providers were paid prior to the implementation of managed care. All three insurers participating in Iowa's new Medicaid managed care program have previously reported financial losses since the program's implementation. Read More

Massachusetts

Governor Proposes 25 Percent Reduction in Long-term Home Health Rates. *The Boston Globe* reported on February 12, 2017, that Massachusetts Governor Charlie Baker is considering a 25 percent reduction in rates for home health providers serving some 7,000 individuals who require more than 180 days of care. Rates would fall from $69.59 to $52.19 per visit under the proposal. Rates

for short-term care would remain unchanged at $89.21 per visit. Several agencies are pushing back saying that the reduction would make it financially unfeasible for them to continue providing home-based care and could cause some individuals to end up in nursing homes. Officials say the cuts, which would go into effect July 1, 2017, if approved, would save the state $13.7 million annually. Officials say they are considering public input before making a final decision on payment rates. Read More

Michigan

HMA Roundup – Eileen Ellis & Esther Reagan (Email Eileen /Esther)

Governor's Proposed Budget Includes NEMT Contract Expansions, Wage Increases for Direct Care Workers. On February 8, 2017, Governor Rick Snyder released his Executive Budget Recommendations for Fiscal Years 2018 and 2019. The proposed budget allocates $3.4 million in General Funds to invest in the implementation of non-emergency medical transportation (NEMT) broker contracts for Medicaid fee-for-service in additional counties, with the goal of statewide implementation in a few years. The Governor also proposes allocating $14.2 million in General Funds to increase wages for direct care workers in the state's Pre-Paid Inpatient Health Plan (PIHP) system. PIHPs would be required to use the additional funds to increase hourly wages by $0.50 for direct care workers, who deliver many behavioral health services and supports to individuals in the state's community mental health system. Read More

New Hampshire

Governor Applauds Success of Medicaid Expansion. *New Hampshire Public Radio* reported on February 13, 2017, that New Hampshire Governor Chris Sununu, a Republican, applauded the success of the state's Medicaid expansion. The statement represents a shift for Governor Sununu, who had previously voiced concerns about the costs of expansion. The Governor also noted that he would support federal action to turn Medicaid into a block grant program. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Medicaid Budget Update. New York State Medicaid Director Jason Helgerson gave a webinar to review the status of New York's Medicaid budget and to provide some observations about the Governor's Executive Budget proposal. He noted that for the current fiscal year, Medicaid spending is slightly above the Global Cap. New York's Medicaid program has operated under a Global Spending Cap since 2012, limiting the rate of growth in Medicaid spending to the ten-year average of the Medical Care Consumer Price Index. Total state Medicaid expenditures through November 2016 were $26 million above projections, largely due to spending on managed long-term care and other long-term care services. Growth in enrollment in managed long-term care continues to exceed projections, and may be reflective of the demographic wave of baby boomers. In addition, drug spending is the biggest driver of cost in the Medicaid program, and has risen by $1 billion/year for the

last several years. Helgerson reported that due to financial constraints, no new investments were planned in Medicaid Redesign Team initiatives for the current fiscal year. In fact, he reported some cuts in spending on important MRT priorities, including cuts in quality incentive programs, and reduced spending in supportive housing, patient centered medical home enhanced funding, and the hospital quality pool. He also noted that uncertainty about future federal funding for the Medicaid program has led the state to put aside $245 million, which would potentially be available for new investment. A major projected source of savings is tied to a series of pharmacy initiatives that would save the state $93.6 million in the next fiscal year if approved by the legislature. The budget proposes price ceilings for high-cost prescription drugs, and would impose a 100 percent supplemental rebate for any amount that exceeds a benchmark price recommended by the Drug Utilization Review Board. The budget also proposes the elimination of the "prescriber prevails" policy for all drugs except atypical antipsychotics and antidepressants. Read More

DOH Posts HCBS Statewide Transition Plan Slides. The New York State Department of Health posted a presentation on the MRT website regarding its Home and Community-based Services (HCBS) Statewide Transition Plan. The presentation and the HCBS Statewide Transition Plan can be accessed by clicking here.

Delivery System Reform Incentive Payment Program Learning Series. As part of its Delivery System Reform Incentive Payment (DSRIP) Program, New York has put together a series of learning collaboratives known as the Medicaid Accelerated eXchange (MAX) Series Program. The MAX program was meant to bring together teams from various Performing Provider Systems participating in DSRIP. MAX offered a structured program of facilitated support to interdisciplinary teams designed to accelerate delivery system redesign and process improvement. Since October 2015, the Department of Health has run the MAX Series Program three times: two programs focused on "Improving Care for Super Utilizers" and one program focused on the "Integration of Behavioral Health and Primary Care." They have recently released Final Reports on both topics that detail the achievements of the Action Teams as well as lessons learned and best practices. Read More

New York State Health Foundation Special Projects Fund. The New York State Health Foundation has recently released an RFP for grants under its Special Projects Fund. The foundation was established to receive the charitable funds resulting from the conversion of Empire Blue Cross Blue Shield from a nonprofit organization to a for-profit corporation. A 2002 statute allocated 5 percent of the market value of Empire Blue Cross Blue Shield to create the foundation; it began operation in 2006. Most of the health foundation's efforts are concentrated on two priority areas: Building Healthy Communities and Empowering Health Care Consumers. The Special Projects Fund is meant to support projects outside of those priority areas. The RFP places emphasis on initiatives that have a large-scale regional or statewide impact on New York State's health system. Special Projects Fund grants are typically in the $250,000 range. Read More

Primary Care Development Corporation Hosts Annual Innovation Circle. The Primary Care Development Corporation hosted its annual Innovation Circle summit meeting. They provided a panel discussion on the implications of the new presidential administration for primary care. The event featured a

panel of experts who discussed the political and operational realities of new reforms and their views on how primary care can achieve better outcomes and healthier patients. The discussion included focus on community health centers, behavioral health, and women's health. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Study Shows Managed Care Saves Ohio Medicaid over $1 Billion. On February 15, 2017, the *Columbus Dispatch* reported on a study titled "*The Impact of Private Industry on Public Health Care: How Managed Care is Reshaping Medicaid in Ohio,*" which found savings under the state's Medicaid managed care program of more than $1 billion. The study was released by the Ohio Association of Health Plans. In addition to the savings, the report addresses how managed care can drive increases quality and innovation. Read More

Nurses Advocate for Law to Set Nurse-Patient Ratios. On February 15, 2017, the *Columbus Dispatch* reported the introduction of a bill that would create new nurse-to-patient ratios and protect nurses who refuse to comply with violations of the law. Senate Bill 55 is similar to a law passed in California in 2004. The bill would set the nurse-to-patient ratio at 1-to-1 for patients in an operating room, in a trauma unit, needing resuscitation, or for unstable newborns. It would rise to 1-to-3 for pediatric units and pregnant patients not in active labor. For situations not specified, a hospital-wide committee would implement ratios, which would have to be posted in public view. Read More

Oregon

Moda Health Awarded $124 Million in Risk Corridor Lawsuit. *Modern Healthcare* reported on February 9, 2017, that U.S. Court of Federal Claims Judge Thomas Wheeler ruled that the Centers for Medicare & Medicaid Services (CMS) is required to make $124 million in risk-corridor payments to Oregon insurer Moda Health. Moda filed a $191 million lawsuit in June 2016, claiming that it lost millions by participating on the Exchanges. The risk-corridor program was created under the Affordable Care Act to help protect insurers from losses in the first three years of the Exchanges. CMS has reimbursed Moda $11.3 million so far. The decision comes after another federal judge ruled against Land of Lincoln Mutual Health Insurance Co., which sought $72.8 million in risk-corridor payments. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Governor Wolf Delivers 2017-2018 Executive Budget Proposal. Governor Tom Wolf's 2017-18 budget proposal proposes nearly $2.1 billion in General Fund cuts and savings to avoid broad-based tax increases for Pennsylvanians. The General Fund financial statement shows the challenges facing Pennsylvania, estimating a $3 billion deficit for 2017-18 absent any executive action. At a budget briefing specifically addressing the recently announced reorganization of four departments (Human Services, Health, Aging and Drug and Alcohol Programs) into one Department of Health and Human Services,

the general theme was touting the benefits and savings that will result from this "new, unified department." Referencing CHIP's move from the Department of Insurance to DHS, the presentation highlighted the streamlining and increased efficiency that would result. Some projected savings were:

- Streamlining Prescription Drug Services for $45 million in savings annually
- Consolidating back office functions of CAOs to processing centers for $7 million in savings

The presentation also included the proposed budget of $26.5 million for adults with intellectual or developmental disabilities and autism to expand waivers and have a new intermediate Community Support waiver, the goal being to address the 1,000 individuals currently on a waiting list. Budget Secretary Randy Albright stated that Allegheny County is an in-state model for the consolidation and that the anticipated effective date for the change is July 1, 2017. "From the budget assumptions we've been making we assume the unified agency is statutorily put in place July 1 of the current calendar year. From this point forward this is a constant work in progress." There has been no word on who will be named to lead the new department. For the DHHS presentation, as well as other Executive Budget materials click here.

DHS Provides Grants Aimed at Improving Coordination of Care for Medicaid Patients. A grant of $8.1 million from the federal Centers for Medicare and Medicaid Services is enabling the Pennsylvania Department of Human Services (DHS) to distribute funds to help hospitals and ambulatory practices connect to the state's health information exchange, called Pennsylvania Patient & Provider Network, or P3N. Under the federal grant, 90% of the onboarding grant will be provided by CMS and 10% will be funded by the commonwealth. The program will support information exchange of data for Medicaid patients through health information organizations (HIO). HIOs will receive the funds to enable connectivity between inpatient hospitals, other inpatient facilities, physician practices and other outpatient facilities. Each eligible inpatient hospital or facility can receive as much as $75,000 to link to an HIO; eligible outpatient organizations can get as much as $35,000; and other providers that want to connect to an HIO via a portal can get as much as $5,000. The anticipated performance period for this grant runs through September 30, 2017. Read More

DHS Receives Technical Assistance Grant for Early Childhood Mental Health. On February 10, 2017, Department of Human Services Secretary Ted Dallas announced the department is a recipient of an Intensive Technical Assistance grant through the Center of Excellence for Infant and Early Childhood Mental Health Consultation (IECMHC). The grant allows the department to leverage the IECMHC toolkit over three years for planning, implementation, evaluation, and sustainability efforts. Read More

South Carolina

Magellan Rx Management Selected for $34.2 Million PBM Contract. The South Carolina Department of Health & Human Services announced on February 8, 2017, its intent to award incumbent Magellan Rx Management a $34.2 million contract for Pharmacy Benefit Administration. The pharmacy program covers 700,000 Medicaid managed care, 125,000 fee-for-service, 130,000 dual-eligible, and 125,000 family planning members. The contract period will begin on February 22, 2017, and run through February 21, 2024.

Tennessee

TennCare Seeks Help With Member Communication, Engagement. *The Tennessean* reported on February 8, 2017, that Tennessee is seeking technology companies to help Medicaid managed care plans in the state with member communication and engagement. Tech companies interested in participating can apply through Health:Further, a Nashville-based organization that links tech start-ups, health care leaders, and policy makers. The Tennessee Medicaid managed care program, called TennCare, is currently served by Anthem/Amerigroup, Blue Cross Blue Shield of Tennessee, and UnitedHealth. Read More

Utah

State Senate Committee Recommends Medicaid Block Grant Bill. *Deseret News* reported on February 13, 2017, that the Utah Senate Health and Human Services Committee approved a Medicaid block grant bill for a vote on the state Senate floor. Republican lawmakers say the bill would give greater control over how Medicaid dollars are distributed. Two Democrats on the committee voted against the measure, citing concerns that it would reduce federal funding for the state's Medicaid program and potentially increase the uninsured rate. Read More

Vermont

Vermont Contracts with OneCare for One-year ACO Pilot. *WAMC.org* reported on February 8, 2017, that Vermont has entered into a one-year agreement with OneCare to launch an accountable care organization (ACO) pilot program serving 30,000 Medicaid beneficiaries. The ACO will receive prospective rather than fee-for-service payments. Four hospitals, federally qualified health centers, independent practices, skilled nursing agencies, and home health providers will work with the state on the pilot. If the pilot meets its goal to save $93 million by the end of the year, the state will expand the initiative. Read More

Virginia

DMAS Announces Final MLTSS Awards to Six Plans. The Virginia Department of Medical Assistance Services (DMAS) announced that it has awarded contracts to six managed care organizations to administer the state's upcoming Managed Long Term Services and Supports (MLTSS) program, set to go-live July 1, 2017. The plans awarded contracts are Aetna Better Health of Virginia, Anthem HealthKeepers Plus, Magellan Complete Care of Virginia, Optima Health, United Healthcare, and Virginia Premier Health Plan. Aside from United and Magellan Complete Care, all selected plans are incumbents in the state's Medallion 3.0 Medicaid managed care program. Read More

National

HHS Proposes Rule Changes Aimed at Stabilizing Exchange Markets. *Bloomberg* reported on February 15, 2017, that a proposed rule from the U.S. Department of Health & Human Services (HHS) would shorten the open enrollment period for Exchanges and restrict special enrollment periods. The changes are aimed at helping to stabilize Exchange markets. The rule, which would take effect in 2018, would give individuals about a month and a half to pick plans, approximately half the current open enrollment period. Read More

U.S. Senate Confirms Tom Price as HHS Secretary. *The Hill* reported on February 10, 2017, that the Senate confirmed Representative Tom Price (D-Georgia) as Secretary of the U.S. Department Health and Human Services (HHS) in a 52-47 vote. No Democrat voted in favor of the confirmation. Republican lawmakers are hopeful Secretary Price will speed up the process to repeal and replace the Affordable Care Act. Read More

Uninsured Rate Hits All-time Low of 8.8 Percent in 2016. *CNBC* reported on February 14, 2017, that the U.S. uninsured rate hit an all-time low of 8.8 percent through the first nine months of 2016, according to a report from the National Center for Health Statistics, part of the Centers for Disease Control and Prevention (CDC). The figure represents about 28.2 million uninsured individuals. Since the Affordable Care Act took effect in 2010, the uninsured rate has dropped from 16 percent. Adults 25 to 34 years old have the highest uninsured rate at 16.4 percent, while adults age 45 to 64 have an uninsured rate of just 8.6 percent. Read More

Republicans May Insert Medicaid Reforms into CHIP Renewal, Other Legislation. *The Hill* reported on February 8, 2017, that Congressional Republicans are considering various options for Medicaid reform. Since it would likely be difficult to pass Medicaid block grants, per-capita caps, or other changes as standalone bills without Democratic support, Republicans are looking to tack reforms onto a separate funding renewal for the Children's Health Insurance Program (CHIP). CHIP is seen as a must-pass bill and is historically bipartisan. However, advocates believe Democrats would not be willing to negotiate on restructuring Medicaid and may let CHIP run out of money. CHIP must be reauthorized by September 30, 2017. Republicans are also considering other "must-pass" bills, including Food and Drug Administration user fees and the Affordable Care Act reconciliation bill. Read More

Safety Net Hospitals Could Lose $40 Billion Following ACA Repeal, Study Says. *Modern Healthcare* reported on February 9, 2017, that safety net hospitals across the country could lose $40 billion in funding over the next decade following repeal of the Affordable Care Act (ACA), according to an analysis by trade association America's Essential Hospitals. Declines in individual coverage and cuts to disproportionate share hospital (DSH) payments would drive the funding shortfall. Safety-net hospitals serving low-income individuals post break-even financial results on average and provide 20 percent of the nation's uncompensated care. Read More

Exchange Enrollment at 12.2 Million, Down 4 Percent from Last Year. *The Herald/Associated Press* reported on February 10, 2017, that 12.2 million people signed up for coverage through the Affordable Care Act Exchanges in the most recent open enrollment period, 4 percent lower than last year. The U.S. Department of Health and Human Services reported that 9.2 million enrolled through the federal marketplaces in 39 states and 3 million enrolled through the 11 state marketplaces. Read More

Republican Lawmakers Divided Over Repealing ACA Taxes Worth $1.1 Trillion. *The New York Times* reported on February 13, 2017, that Congressional Republicans are divided over whether to repeal taxes that help fund the Affordable Care Act (ACA). According to the Congressional Budget Office, taxes on insurers, pharmaceutical manufacturers, device makers, and others are worth $1.1 trillion over 10 years. While many lawmakers are hoping to repeal the ACA completely, some are reluctant to get rid of a revenue source that can potentially fund a replacement plan. If the taxes are repealed, Republicans will need to find a different way to pay for a replacement, such as higher federal deficits, cutting Medicaid, cutting Medicare, or raising other taxes. Additionally, Republicans will need billions of dollars to deliver on their promise not to abruptly end coverage for 20 million people when repealing the law. Read More

Industry News

U.S. District Judge Blocks Anthem, Cigna Merger. *Modern Healthcare* reported on February 8, 2017, that U.S. District Judge Amy Berman Jackson blocked the $54 billion proposed merger of Anthem and Cigna. The District Court concluded the merger would result in higher prices and reduced innovation. Anthem argued that the deal could deliver medical cost savings of more than $2 billion. The merger deal was first agreed upon in July 2015. The ruling comes after a proposed merger of Aetna and Humana was blocked last month. Read More

Cigna Terminates Merger with Anthem, Sues for $14.9 Billion. *CNBC* reported on February 14, 2017, that Cigna terminated its merger agreement with Anthem following U.S. District Judge Amy Berman Jackson's ruling to block the merger. Cigna also filed suit against Anthem claiming $13 billion in damages and a $1.9 billion reverse termination fee. Anthem responded that Cigna does not have the right to terminate the agreement. Read More

Anthem Seeks Restraining Order Against Cigna. *Modern Healthcare* reported on February 14, 2017, that Anthem Inc. is seeking a restraining order to prevent Cigna Corp. from terminating a merger agreement between the two companies. Cigna announced the termination of the agreement following a ruling by U.S. District Judge Amy Berman Jackson to block the merger. Cigna also filed suit against Anthem claiming $13 billion in damages and a $1.9 billion reverse termination fee. Anthem says that Cigna has been trying to sabotage the deal throughout the merger process and has no right to exit the deal. Anthem has also filed a notice to appeal the judge's ruling. Read More

Aetna, Humana End Merger Agreement Following Judge's Ruling. Aetna Inc. announced on February 14, 2017, that following U.S. District Judge John Bates' ruling to block a proposed merger with Humana, the two companies have mutually agreed to end the merger agreement after 19 months of planning. Aetna will pay Humana $1 billion under the terms of the termination. Aetna will also terminate a previously announced agreement to sell certain Medicare Advantage assets to Molina Healthcare, Inc. Read More

Humana Plans to Exit All Exchange Markets in 2018. *The New York Times* reported on February 14, 2017, that Humana announced plans to end its participation in all Affordable Care Act (ACA) Exchange markets for the 2018 plan year. The company had already scaled back its participation significantly in 2017, offering plans in only 11 states. Humana stated that the Exchange market is an unbalanced risk pool, with greater numbers of high utilization, high cost members. Read More

COMPANY ANNOUNCEMENTS

- **"MCG Health and InterSystems Partner to Support Evidence-Based Decision Making for Health Plans, Care Providers"** Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
February 16, 2017	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
February 21, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	RFP Release	83,000
February 24, 2017	MississippiCAN	Mandatory LOI Due	500,000
February 28, 2017	Oklahoma ABD	Proposals Due	155,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
March 15, 2017	Massachusetts	Proposals Due	850,000
March, 2017	Washington, DC	Contract Awards	190,000
April 7, 2017	MississippiCAN	Proposals Due	500,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
June 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
July 1, 2017	Georgia	Implementation	1,300,000
Summer 2017	Florida	RFP Release	3,100,000
September 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	83,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	83,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

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 (Jan. 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	114,804	32.8%	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	45,469	33.4%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	16,039	16.5%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,752	36.8%	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	4,827	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	448	2.2%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	69,634	61.1%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	9,934	39.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	8,981	16.8%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	50,924	30.3%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	28,835	43.6%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**386,647**	**30.8%**	

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

HMA News

HMA's Margaret Kirkegaard and Jeff Ring Author Paper on *"The Case for Relationship-Centered Care and How to Achieve It"*

HMA Principals Margaret Kirkegaard, MD, and Jeff Ring, PhD, co-authored a paper, published on February 9, 2017, titled *"The Case for Relationship-Centered Care and How to Achieve It."* The paper seeks to examine whether relationship-centered care can actually help achieve the Triple Aim — lower costs, better health outcomes, and better experience of care, examining the value of relationships in healthcare within four domains:

- Social connectedness or supportive interpersonal relationships outside of health care;
- Therapeutic relationships between patients and their health care team;
- Relationships within the health care team; and
- Relationships between the health care team and the community.

Assembling the available research, the paper outlines a framework for primary care practices to assess their ability to foster therapeutic relationships and harness the power of relationships to improve health outcomes. Read More

HMA's Ellen Breslin to Present at World Congress Workshop

February 27, 2017
Arlington, Virginia

The World Congress 10th Annual Medicaid Managed Care Summit coming up on February 27-28, 2017. Visit www.worldcongress.com/MMC for more information.

HMA Welcomes…

Lynne Lyon, Senior Consultant – Columbus, Ohio

Lynne Lyon joins HMA most recently from Buckeye Health Plan where she served as Director of Compliance. In this role, Lynne monitored state and federal regulatory and legislative initiatives to assess potential impact and develop policy positions. She maintained external relationships and coordinated communication with state Medicaid and insurance agencies. Additionally, Lynne facilitated enforcement of contract compliance for Medicaid, Medicare-Medicaid Program (MMP), and Health Insurance Marketplace products and coordinated monthly compliance risk assessment of three lines of business for executive leadership review.

Prior to her work at Buckeye Health Plan, Lynne held a range of positions in Ohio state agencies over 16 years. With the Department of Medicaid, Lynne served as Policy Management and Development Section Chief and acted as the agency's liaison to the Centers for Medicare and Medicaid Services (CMS) for state plan amendments. During this time, Lynne led a policy team to gain Federal approval and successfully implement a Section 1115 Demonstration

Waiver for early Medicaid expansion in Cuyahoga County, which was later followed by CMS' approval of Ohio's Medicaid expansion state plan.

Lynne also served as Medicaid Policy Manager for the Ohio Department of Mental Health. In this position, Lynne used her in-depth understanding of Medicaid to lead extensive policy analysis to help state agency leadership and community stakeholders understand and better define the Medicaid behavioral health benefit to prepare for future system redesign, which is now currently underway. Lynne served as Medicaid Health Systems Administrator for Ohio's Medicaid program for seven years where she worked on many strategic policy initiatives including the development of supplemental payment programs, Disproportionate Share Hospital policy and uncompensated care programs, and the implementation of Health Insurance Portability and Accountability Act billing standards.

Lynne received her Master of Health Administration degree (with a concentration in Health Services Management and Policy) from The Ohio State University. She received her Bachelor of Arts degree in Psychology from University of Findlay.