HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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THIS WEEK

IN FOCUS

REPORT ON INDIANA SMOKING-ATTRIBUTABLE MEDICAID EXPENSES FROM SVC, NOW HMA MEDICAID MARKET SOLUTIONS

This week, our *In Focus* section highlights the executive summary and key findings of a report from SVC, Inc. (SVC), *"Indiana Smoking Attributable Medicaid Expenditures Final Report,"* published in March 2017. The report estimates Medicaid expenditures attributable to individuals who smoke, as compared with those who do not, in the state of Indiana. On March 31, 2017, SVC became HMA Medicaid Market Solutions (HMA MMS), a subsidiary of

HMA, and the *HMA Weekly Roundup* is pleased to showcase the work of our new colleagues.

Report Background

On December 8, 2016, the Richard M. Fairbanks Foundation (the Foundation) contracted with SVC to develop a report identifying Indiana Medicaid spending attributable to smoking. As part of this analysis, several factors were considered, including but not limited to: existing methodologies used to identify Medicaid spending attributable to smoking, available State data, and potential limiting factors. On March 14, 2017, SVC completed an analysis based on Indiana Medicaid Members ages 35-64, and this report was made available on the Foundation's website. On March 31, 2017, SVC added individuals ages 18-34 to the analysis, thereby providing an estimate of smoking attributable Medicaid expenditures among Indiana Medicaid members age 18-64.

Executive Summary & Key Findings

Despite a decline in smoking prevalence over the past ten years, smoking remains the leading cause of preventable disease and death in the United States and is responsible for more than one in five deaths annually. Describing the negative health effects of smoking is powerful in the effort to reduce overall smoking prevalence; however, translating these negative effects into economic terms may be more persuasive. The U.S. Centers for Disease Control and Prevention (CDC) estimates the total economic cost of smoking is more than $300 billion annually, including nearly $170 billion in direct medical care for adults.[1] This report provides an estimate of smoking attributable Medicaid expenditures in Indiana. The results of this current analysis are consistent with the prevailing research and indicate that smokers are nearly 17 percentage points more likely to have smoking-attributable health consequences relative to non- smokers (35.8 percent vs. 19.2 percent), which likely drives the fact that smokers have 51 percent higher monthly Medicaid expenditures than non-smokers. This translates to an estimated $540 million in smoking-attributable health care expenditures annually. A complete analysis of the data received is provided in Section VI of this report; however, key findings are highlighted below:

- The self-reported tobacco use and direct tobacco-related expenditures indicate that the prevalence of smoking among Indiana Medicaid members is 23.0 percent, which is comparable to the national estimate for Medicaid members reported by the CDC (27.8 percent). We note that self-reported tobacco use may be underreported, due to individual discomfort disclosing smoking habits to a health care provider.
- Indiana Medicaid members who smoke have higher health care costs compared to members who do not smoke. The overall per member per month (PMPM) Medicaid expenditures for smokers ($904.61) is 51.4 percent ($307.03) higher compared to those for non-smokers ($597.58). This equates to an annual difference of $3,684.27 between smokers ($10,855.29) and non-smokers ($7,171.02). There were 637,031 adults (ages 18-64) enrolled in Medicaid during the final month for timeframe for this analysis (June, 2016). As stated previously, this analysis finds that the smoking rate among Indiana Medicaid members is 23.0

[1] Centers for Disease Control and Prevention.

percent, which yields a total of 146,517 individual smokers. Thus, the annual difference ($3,684.27) between these smokers and non-smoking Indiana Medicaid members calculates to $539,808,666.55 in Medicaid costs.

Per Member Per Month (PMPM) and Annual Estimates of Medicaid Expenditures among Indiana Medicaid Member, FY 2016

Gender	Age	PMPM		Annual Estimate	
		Smoker	Non-Smoker	Smoker	Non-Smoker
Male	18-34	$732.08	$534.13	$8,784.96	$6,409.56
Male	35-44	$971.87	$639.86	$11,662.44	$7,678.32
Male	45-54	$1,174.56	$822.89	$14,094.72	$9,874.68
Male	55-64	$1,246.37	$971.78	$14,956.44	$11,661.36
Subtotal		*$1,025.60**	*$693.50*	*$12,307.20**	*$8,322.00**
Female	18-34	$603.69	$368.14	$7,244.28	$4,417.68
Female	35-44	$859.31	$524.49	$10,311.72	$6,293.88
Female	45-54	$1,077.50	$782.35	$12,930.00	$9,388.20
Female	55-64	$1,100.38	$902.28	$13,204.56	$10,827.36
Subtotal		*$836.30**	*$541.84**	*$10,035.60 **	*$6,502.08**
Total		**$904.61**	**$597.58**	**$10,855.29**	**$7,171.02**

- The annual difference in Medicaid expenditures between smokers ($10,855.29) and non- smokers ($7,171.02) is $3,684.27, which calculates to $539,808,666.55 in smoking- attributable Medicaid costs annually.
- Older Indiana Medicaid members who smoke have higher medical costs compared to younger members who smoke. The PMPM Medicaid expenditures for male smokers age 55-64 ($1,246.37) is 70.3 percent ($514.29) higher compared to male smokers age 18-34 ($732.08). The PMPM Medicaid expenditures for female smokers age 55-64 ($1,100.38) is 82.3 percent ($496.69) higher compared to female smokers age 18-34 ($603.69).
- The difference in health care costs between smokers and non-smokers is greater among younger adults. Among males age 35-44, the PMPM expenditures for smokers ($971.87) was $332.01 (51.9 percent) higher compared to those for non-smokers ($639.86). Among females age 18-34, the PMPM expenditures for smokers ($603.69) was $235.55 (64.0 percent) higher compared to those for non-smokers ($368.14).
- Male smokers have higher health care costs compared to female smokers. The overall PMPM Medicaid expenditures for male smokers ($1,025.60) is 22.6 percent ($189.30) higher compared to those for female smokers ($836.30).
- The overall prevalence of smoking-attributable health consequences (listed in Table 1) is 16.6 percentage points higher among smokers (35.8 percent) compared to non-smokers (19.2 percent). Among males, the prevalence of smoking-attributable health consequences is 18.6 percentage points higher for smokers (38.6 percent) compared to non-smokers (20.0 percent). Among females, the prevalence of smoking-attributable health consequences is 14.6 percentage points higher for smokers (34.3 percent) compared to non-smokers (18.7 percent).

- Among individuals with smoking-attributable health consequences, such as lung cancer or stroke, there is minimal variation in PMPM expenditures ($59.92; 4.3 percent) among smokers ($1,439.38) versus non-smokers ($1,379.46), which suggests that the higher overall health care costs among smokers is driven by the fact that smokers experience a higher number of health consequences compared to non-smokers. Put differently, the cost of smoking-related health problems is approximately the same between smokers and non-smokers; however, since smokers have more smoking-related health problems compared to non-smokers, their overall costs are higher.

For More Information

For questions or more information on the SVC report, contact:

- Desmond Banks (dbanks@hmamedicaidmarketsolutions.com) or
- Jana Finder (jfinder@hmamedicaidmarketsolutions.com)

The SVC report is available on the website of the Richard M. Fairbanks Foundation, here.

SVC is Now HMA Medicaid Market Solutions

SVC, founded by CMS Administrator Seema Verma, is now part of Health Management Associates (HMA). The acquisition, announced March 13, 2017, by HMA founder Jay Rosen, was finalized Friday, March 31. SVC is now known as HMA Medicaid Market Solutions (HMA MMS), a subsidiary of HMA.

Working closely with state officials and others, our newest colleagues at HMA MMS have established innovative Medicaid solutions that advance alternatives to traditional Medicaid. Together, our team of experts at HMA and HMA MMS offer unmatched experience and expertise to help organizations navigate what is expected to be an era of expanded state flexibility.

Learn about HMA MMS and meet our newest colleagues at:
https://www.hmamedicaidmarketsolutions.com/

HMA Medicaid Roundup

Alabama

Alabama Publishes MLTSS Concept Paper for Comment. On April 5, 2017, the Alabama Medicaid Agency published a concept paper for public comment on the planned Integrated Care Network (ICN) Program. The ICN program plans to implement Medicaid managed long term services and supports (MLTSS) statewide for around 25,000 Medicaid beneficiaries residing in a nursing facility or enrolled in one of three of the state's home and community based services (HCBS) waiver programs. Per the concept paper, a competitive procurement would be issued in August 2017 to contract with no more than two statewide ICNs, which are organizations of health care providers that will receive monthly risk-based capitation payments. ICNs can be for-profit or not-for-profit entities, and must have a governing board composed of 20 members: 12 members representing risk-bearing participants in the ICN and eight members who do not represent risk-bearing participants. The state is targeting implementation in July 2018. Comments on the concept paper are due May 4, 2017. Read More

Connecticut

Hospitals Push Back Against Proposed Tax Increases. *The CT Mirror* reported on April 5, 2017, that Connecticut hospitals are pushing back against tax increases proposed by Governor Dannel Malloy. The Connecticut Hospital Association projects that hospital taxes would increase to $623 million in fiscal 2018 and $625 million in 2019, compared to $556 million in fiscal 2017, driven by changes to the hospital provider assessment and the elimination of the not-for-profit municipal property tax exemption for hospitals. Read More

Centers for Independent Living Urge Rejection of Governor's Proposal to Eliminate State Funding. *The CT Mirror* reported on April 11, 2017, that Connecticut's five centers for independent living are asking legislators to reject a proposal that would eliminate state funding for their facilities. Governor Dannel P. Malloy has proposed eliminating the state funding next fiscal year to help alleviate a state budget deficit. Funding is already down in the current fiscal year from $529,000 to $202,005. State funds currently represent approximately 45 percent of the centers' annual funding, with federal grants making up the rest. The centers fear that further funding reduction could lead to further reductions in the number of clients served, and possibly the closing of facilities. The centers provide training, guidance, employment, education, and housing support services in 25 communities across the state. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Houses Advances Bill for Medicaid Work Requirements, Premiums. *Tampa Bay Times* reported on April 6, 2017, that the Florida House is advancing a bill that includes work requirements and premiums for able-bodied Medicaid beneficiaries. These individuals would be required to pay premiums of $10 to $15 per month and demonstrate that they are employed or searching for work in order to receive Medicaid benefits. Failure to meet those requirements would result in the loss of Medicaid coverage for a year. The House Health and Human Services Committee passed the proposal as part of broader legislation that would make a number of changes to Florida's Medicaid program. However, the state Senate has still not signed off on the work requirements and premiums, and the changes would require federal approval. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Bill Allows Dental Hygienists to Provide Basic Dental Care in Attempt to Improve Access. *AJC.com* reported on April 6, 2017, that the Georgia House approved a bill that will allow dental hygienists to provide basic dental care in safety net settings such as qualified health centers, school-based clinics, and dental offices without a dentist present. Supporters say the change will help alleviate issues around access to dental care for Medicaid beneficiaries. Georgia ranked 49th in the country in dentists per capita in 2012, with only 22 percent of dentists accepting Medicaid. The bill will now go to Governor Nathan Deal's desk for his signature. Read More

Illinois

HFS to Shift 26,000 MCO Members to Fee-For-Service, Citing Access Concerns. *The State Journal-Register* reported on April 7, 2017, that Illinois Department of Healthcare and Family Services (HFS) officials will shift more than 26,000 Medicaid managed care members in the Springfield area to fee-for-service Medicaid effective May 1, 2017. The move, which impacts several counties in the Central Illinois managed care region, is due to provider access concerns following Health Alliance's exit from the Medicaid managed care market at the end of 2016. Since January 1, 2017, Molina Healthcare has been the only Medicaid managed care plan serving the impacted counties. Illinois is currently rebidding nearly all Medicaid managed care contracts and expanding managed care statewide, with a projected implementation date of January 1, 2018. Read More

Family Health Network Expresses Concern for Future of Operations. *Crain's Chicago Business* reported on April 6, 2017, that provider-led Medicaid managed care plan Family Health Network (FHN), which has 200,000 members in Cook County, fears it may be forced to cease operations in 2018. Under the ongoing Medicaid managed care procurement, the state will require Medicaid plans to operate statewide, unless they are minority owned or operated by a local government, effective January 1, 2018. A group of Chicago-area state legislators are expressing concerns that the closure of FHN would

also negatively impact the financial condition of the hospitals that own the plan, including Norwegian Hospital, St. Bernard Hospital, Sinai Health System, St. Anthony Hospital, and Presence Health. Read More

Iowa

Aetna to Exit Iowa Exchange Market in 2018. *Modern Healthcare* reported on April 6, 2017, that Aetna will stop selling individual policies in Iowa in 2018 and will exit the Exchange. The announcement comes shortly after Wellmark decided to pull out of the market as well. Iowa is now left with only one insurer in 99 counties, Medica, and two insurers in the remaining five counties, Medica and Gundersen. However, it is unclear if Medica will remain on the Iowa Exchange. Meanwhile, Aetna is still deciding whether it will sell plans in its remaining ACA marketplaces, including Virginia, Delaware, and Nebraska. In most states, insurers have until June 21 to decide. Read More

Governor Says Medicaid Managed Care Cut Hospital Admissions in Half; Hospitals Disagree. *The Des Moines Register* reported on April 5, 2017, that Iowa hospitals are questioning Governor Terry Branstad's claim that the transition to Medicaid managed care resulted in a 54 percent reduction in hospital admissions among Medicaid recipients. The Iowa Department of Human Services said the figure is based on data reported to the agency by three managed care plans serving more than 500,000 Medicaid enrollees. However, the Iowa Hospital Association says its data shows that the number of Medicaid recipients being discharged from Iowa hospitals declined by four percent in the past year. Read More

Kansas

House to Vote on HMO Fee Increase to Reverse Medicaid Provider Payment Cuts. *The Topeka Capital-Journal* reported on April 5, 2017, that the Kansas House is ready to vote on raising the "privilege fee" for HMOs doing business in Kansas from 3.31 percent to 5.77 percent of premiums. The funds raised would be used to reverse a 4 percent reimbursement cut to providers serving Kansas Medicaid members from last year. Under current law, the fee could be reduced to 2 percent in January 2018, but pending legislation would delay that until 2023. Read More

Kentucky

Medicaid Work Requirements Proposal to be Reviewed Without CMS Administrator's Input. *Kaiser Health News* reported on April 5, 2017, that a pending Kentucky proposal to require some Medicaid beneficiaries meet work requirements will be decided without the input of Seema Verma, Administrator of the Centers for Medicare & Medicaid Services (CMS). Prior to joining CMS, Verma was a consultant who helped write the Kentucky proposal, which was submitted in August 2016. If approved, Kentucky would be the first state in the country to introduce work requirements in Medicaid. Read More

Massachusetts

EOHHS Seeks Waiver Flexibility in Letter to CMS. Massachusetts Executive Office of Health and Human Services (EOHHS) Secretary Marylou Sudders submitted a letter on March 22, 2017, to the Centers for Medicare & Medicaid Services requesting "immediate relief" from certain federal rules and requirements. Massachusetts is seeking:

- Expanded flexibility in designing Medicaid benefit packages
- Expanded flexibility on recent federal rules on outpatient drug coverage and managed care that limit states' abilities to manage their programs
- A waiver to significantly expand flexibility for states to manage care for dual eligibles
- A waiver for immediate reprieve for employers from reporting requirements associated with the federal mandate in employer-sponsored health insurance
- A waiver to provide flexibility on utilization of small business tax credits and request to be allowed to access funds immediately to disburse using state-specific criteria for eligible small businesses
- Extended flexibility to continue using state-specific rating factors
- HHS to maintain risk corridor and reinsurance payments in 2017 during transition period

House Proposes Budget, Excludes Employer Assessment. *AP/The Virginian-Pilot* reported on April 10, 2017, that the Massachusetts House unveiled a $40.3 billion state budget, excluding a plan to help fund Medicaid through a fee on certain employers. Governor Charlie Baker had proposed a fee of $2,000 per employee for companies with more than 10 employees that do not offer health insurance. The House budget instead suggests public hearings on the proposal. Governor Baker estimated the fee would bring in $300 million, but the House estimates it would be $180 million. The budget proposal does call for a waiver prohibiting employees who are offered health insurance through their employer from enrolling in MassHealth. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Representative Faso Proposes Bill to End County Contributions to Medicaid. U.S. Representative John Faso has introduced a bill in Congress that would end county contributions to Medicaid for all New York State counties outside of New York City. The proposal was initially floated during Congressional efforts to repeal and replace the Affordable Care Act, and was designed to encourage the New York delegation to support Republican efforts. New York is unusual in the role counties play in financing the state's Medicaid program, which historically had counties providing 25 percent of the cost (along with the state's 25 percent share and the federal 50 percent match). Recognizing that the growth in Medicaid costs was outpacing the ability of counties to generate tax revenue to finance those costs, the state has gradually been taking on a greater share of those costs. The amendment, the "Property Tax Reduction Act of

2017," would eliminate the federal match for any Medicaid costs paid for directly by counties. Read More

FIDA Update. The New York Department of Health Division of Long Term Care will be providing a stakeholder webinar with a status update on the Fully Integrated Duals Advantage (FIDA) program. The webinar will be on Friday, April 28, 2017 from 2 – 3 pm. Link to Register

New York-Presbyterian Awarded Accountable Health Communities Funding. New York-Presbyterian Hospital was awarded funding through the CMS Accountable Health Communities initiative (Press Release). The Accountable Health Communities (AHC) model is designed to address a critical gap between clinical care and community services in the current delivery system. The AHC model will test whether increased awareness of and access to services addressing health-related social needs will impact total health care costs and improve health and quality of care for Medicare and Medicaid beneficiaries in targeted communities. Under the program, New York–Presbyterian will screen Medicare and Medicaid patients in the Washington Heights/Inwood area to assess whether it can connect them with social services. The health system will work with community-based organizations to address patients' issues with housing, food, utilities, interpersonal violence and nonmedical transportation. New York-Presbyterian was one of 20 organizations nationwide funded under the AHC Alignment Track, which is meant to provide community service navigation services, as well as encourage community-level partner alignment to ensure that needed services and supports are available and responsive to beneficiaries' needs. Read More

North Carolina

House Speaker Opposes Medicaid Expansion. *The News & Observer* reported on April 10, 2017, that a recent North Carolina proposal to expand Medicaid may have a difficult time passing given the opposition of House Speaker Tim Moore. The bill would expand Medicaid to adults earning up to 133 percent of the federal poverty level. Adults would be required to pay annual premiums equal to two percent of their household income and would need to be working or actively seeking work. The bill also proposes that hospitals would help fund the state's share of the cost of the expansion. Read More

Bill Introduced to Expand Medicaid, Impose Premiums and Work Requirements. *North Carolina Health News* reported on April 11, 2017, that the North Carolina legislature has introduced a Medicaid expansion bill called Carolina Cares, including work requirements and premium payments for beneficiaries. Individuals would also be required to have a primary care doctor and to engage in wellness activities such as annual screenings. Governor Roy Cooper has proposed using a hospital assessment to fund the state portion of the expansion cost. Read More

Legislators, DOJ at Odds Over Medicaid Expansion Lawsuit. *The News & Observer* reported on April 8, 2017, that the U.S. Department of Justice (DOJ) asked a Federal judge to dismiss a lawsuit filed by North Carolina legislators opposed to Medicaid expansion. Two state legislators filed a federal lawsuit in an attempt to block plans by Governor Roy Cooper to expand Medicaid. The DOJ wants the suit dismissed, arguing that until the plan is actually submitted

the legislators do not have a valid claim. Governor Cooper announced his intention to submit a proposal to expand Medicaid in January; although he still has not formally released a plan. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Department of Medicaid Releases New Information on Medicaid MLTSS Procurement. The Ohio Department of Medicaid on March 31, 2017, published a slide presentation including information and updates from a recent stakeholder meeting about the state's Medicaid Managed Long-Term Services and Supports (MLTSS) procurement. Ohio plans to issue a request for applications (RFA) in July 2017 to procure at least three statewide MLTSS plans. Plans will be selected in October 2017 and fee-for-service members will begin transitioning to MLTSS in July 2018, phased in over 6 months, with transitions occurring every 60 days. Read More

House Finance Committee Debates Managed Long Term Services and Supports Proposal. *Gongwer-Ohio* reported on April 7, 2017, that opponents and proponents testified on Governor John Kasich's budget proposal to enroll individuals receiving community and facility based long term services and supports (LTSS) and others in managed LTSS (MLTSS). The proposal would exclude Ohio MyCare (duals demonstration) enrollees. Under the administration's proposal, three MLTSS plan contracts would be competitively bid this summer. Proponents of the proposal cite the success of the MyCare demonstration, better care management, cost savings, and good customer satisfaction. Opponents of the proposal, meanwhile, cite the lack of experience serving individuals with complex needs and less local, independent care management. Read More

Oklahoma

Health Care Authority Outlines Potential Medicaid Cuts Required Under Budget Shortfall. *Tulsa World* reported on April 11, 2017, that the Oklahoma Health Care Authority outlined options for cuts to the state's SoonerCare Medicaid program assuming a budget shortfall for the upcoming fiscal year. Assuming a 15 percent reduction in Medicaid appropriations, the state proposed a potential 25 percent cut in Medicaid provider rates along with the elimination of benefits such as pharmacy, behavioral health, durable medical equipment, and programs for breast and cervical cancer treatment. Other programs potentially targeted for cuts could include private-duty nursing services, adult organ transplants, dialysis, hospice services, physical and occupational therapy, and speech, hearing, and language disorder services. Read More

SoonerHealth+ Transition Raises Provider Concerns on Future of Supplemental Payments. *The Oklahoman* reported on April 7, 2017, that as Oklahoma moves closer to implementation of the SoonerHealth+ Medicaid managed care program for individuals in the aged, blind, and disabled (ABD) category of eligibility, providers and other health care experts in the state are expressing concerns over the potential impact on supplemental provider payments. Recent decisions from the Centers for Medicare & Medicaid Services (CMS) on the continued use of supplemental payments when transitioning to

managed care have raised concerns that as much as $650 million in current payments are at risk. Some provider systems have claimed the revised federal rule, which came in the middle of the SoonerHealth+ procurement process, could cause them to lose money on each Medicaid patient. Nico Gomez, president of the Oklahoma Association of Health Care Providers, is encouraging state Medicaid officials to delay the SoonerHealth+ rollout. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Releases Independent Enrollment Broker Request for Proposals. On April 8, 2017, Pennsylvania's Department of Human Services (DHS) issued a request for proposals (RFP) for the Independent Enrollment Broker (IEB) for Community HealthChoices (CHC) and other long-term services and supports (LTSS) programs. The IEB will provide choice counseling and enrollment assistance services to individuals who apply for, or are eligible to receive health-related services and LTSS through programs administered by DHS' Office of Long Term Living (OLTL). The selected offeror will provide enrollment assistance for CHC and LIFE, PA's PACE program. The IEB will also serve the following Home and Community Based Services programs: Aging Waiver, Attendant Care Waiver, Independence Waiver, OBRA Waiver and the Act 150 Attendant Care Program. Read More

April 5th Managed Long Term Services and Supports Subcommittee Meeting. At the April 5, 2017, Managed Long Term Services and Supports (MLTSS) Medical Assistance Advisory Committee meeting the Office of Long Term Living (OLTL) provided an update on the Community HealthChoices (CHC) procurement. The department is moving forward with contract and rate negotiations with the three selected offerors: AmeriHealth Caritas, UPMC for You, and PA Health and Wellness (Centene). OLTL has held initial implementation and readiness review meetings with the MCOs. Representatives will be available to answer stakeholder questions at the next MTLSS Subcommittee meeting on May 3, 2017 and it is encouraged to submit questions in advance to RA-PWCHC@pa.gov. Additionally, Jennifer Burnett, OLTL Deputy Secretary, is hopeful that the CHC Waiver application will be submitted to CMS by the end of the month.

New health care company begins work to enhance value-based health care in Pennsylvania. The Care Centered Collaborative, formed by the Pennsylvania Medical Society (PAMED), supports the provision of value-based care by Pennsylvania physicians. One new service will enable care excellence in the federal government's Quality Payment Program (QPP). Care Centered Collaborative will also partner with physicians to gain greater efficiencies including accurate insurance claims handling, care management services, and health informatics technology. Joint programs designed to improve patient care with other health care organizations are also planned. Read More

Senate Proposes Nurse Practitioners Care Bill. *Modern Healthcare* reported on April 11, 2017, that the Pennsylvania Senate has proposed a bill allowing nurse practitioners to provide care without the supervision of a physician. The bill aims to ease the shortage of health care providers in rural and underserved areas. According to state Senator Camera Bartolotta (R-Carroll), who

introduced the bill, 35 percent of state residents live in an area with inadequate access to care. Physicians groups are opposing the legislation, saying nurse practitioners are not trained to provide the care necessary. The Senate Consumer Protection and Professional Licensure Committee will vote on the bill. Read More

Texas

Senate Committee Advances Bill to Increase Oversight of Nursing Homes. *The Houston Chronicle* reported on April 5, 2017, that the Texas Senate Health and Human Services Committee voted unanimously to advance a bill that would increase regulatory oversight of nursing homes, raise penalties, and limit the ability of nursing home operators to self-correct violations. Currently, long-term care providers have the right to correct violations within 45 days to avoid sanction. The bill would also direct the Texas Health and Human Services Commission to create a system for evaluating penalties based on severity and number of violations. The bill comes after an *AARP* report issued in January found inadequate conditions in many long term care facilities and raised questions about quality. Read More

Advocates Push Back Against $70 Million in Medicaid Rate Cuts for Home Care Attendants. *American-Statesman* reported on April 6, 2017, that patient advocates are speaking out against $70 million in proposed rate reductions over the next two years for providers of Medicaid home care services for individuals with intellectual disabilities. The Texas Health and Human Services Commission proposed cutting reimbursement rates for home care attendants in two different Medicaid waiver programs by 21 percent down to $17.73 per hour beginning July 1, 2017. Combined, the programs serve approximately 32,000 individuals. The commission will hold another public hearing to gather feedback on the rate reductions on May 6, 2017. Read More

Virginia

House Rejects Medicaid Expansion; Lawmakers Form Subcommittee on Health Care. *Richmond Times-Dispatch* reported on April 5, 2017, that the Virginia House rejected a Medicaid expansion budget amendment proposed by Governor Terry McAuliffe. Meanwhile, Republican lawmakers are forming a new joint legislative subcommittee to come up with other ways to improve health care that do not negatively impact the budget. The Virginia House and Senate approved 15 of the 27 budget amendments Governor McAuliffe proposed, including a new payment structure for the Virginia Birth-Related Neurological Injury Program. Both chambers also agreed on removing a proposal that would have allowed 25 private hospitals to receive supplemental Medicaid payments. Read More

Medicaid Enrollment Applications Top Expectations. *The News & Observer* reported on April 10, 2017, that the number of enrollment applications for Virginia's Medicaid program doubled expectations for the fourth quarter of 2016. State officials anticipated around 21,000 applications during the last three months of the year, but instead received over 41,000. As a result, Virginia Medicaid now faces a backlog of enrollment applications, with pregnant women and individuals with urgent medical needs being expedited. The state

is working with a private contractor to address the application backlog. Read More

Wisconsin

Medicaid Director Defends Plan to Require Drug Screening for Certain Enrollees. *Star Tribune/Associated Press* reported on April 6, 2017, that Wisconsin Medicaid Director Michael Heifetz is defending the state's plan to require drug screening for childless adult Medicaid beneficiaries. Governor Scott Walker will submit the waiver proposal to the Trump administration later this month. Read More

National

States Increasingly Seeking Waiver Funds for SUD Treatment Facilities Amid Opioid Crisis. *PEW Trusts* reported on April 5, 2017, that an increasing number of states are pursuing waivers that would allow the use of federal Medicaid funding for substance use disorder (SUD) treatment in facilities with more than 16 beds. States are seeking the waivers in response to the opioid epidemic, which has resulted in a shortage of residential treatment options for Medicaid beneficiaries. California, Maryland, Massachusetts, and New York have already been granted waivers. Seven other states, including Arizona, Indiana, Illinois, Kentucky, Michigan, Utah, and Virginia, are seeking waivers. The 16-bed provision was originally meant to encourage community-based mental health treatment. President Donald Trump's administration is expected to continue to grant the waivers. Read More

House Republicans Add Risk-Sharing Program Worth $15 Billion to AHCA Bill. *The New York Times* reported on April 6, 2017, that House Republicans added an amendment to the American Health Care Act Bill that would provide an extra $15 billion for insurers to help pay for the sickest customers. The risk-sharing program's goal is to stabilize insurance markets by lowering premiums and in turn attracting more individuals to buy insurance. Insurers continue to pull out of the Exchanges, with Aetna being the latest to leave Iowa. The measure passed by a party-line vote of nine to two. The legislative session is currently on break, so the earliest that Congress can review the new amended bill is April 25. Read More

Trump Administration Still Weighing Continuation of Exchange Subsidies. *The Hill* reported on April 11, 2017, that the Trump administration is still weighing whether to continue cost-sharing reduction subsidies for low-income individuals who purchase health coverage in the Exchange market. U.S. Department of Health and Human Services (HHS) spokeswoman Alleigh Marré stated on April 11 that a *The New York Times* report claiming the administration would continue to pay the subsidies is "inaccurate." Marré stated that no decisions have been made regarding how the administration will proceed. The administration did state earlier that it would continue the payments until the resolution of a lawsuit filed against the Obama administration by the U.S. House, which argues that the payments were never appropriated by Congress. Read More. On April 12, 2017, several organizations sent a letter to President Trump urging the administration to stabilize the individual market for 2017 and 2018 by ensuring the subsidies are funded. The organizations consist of America's Health Insurance Plans, American Academy

of Family Physicians, American Benefits Council, American Hospital Association, American Medical Association, Blue Cross Blue Shield Association, Federation of American Hospitals, and the U.S. Chamber of Commerce. Read More

CMS to Grant $120 Million to 32 Organizations to Participate in Accountable Health Communities. *Modern Healthcare* reported on April 6, 2017, that the CMS Innovation Center will grant $120 million to 32 organizations to participate in Accountable Health Communities over the next five years. The program will screen Medicare and Medicaid beneficiaries to identify and assist with unmet health-related social needs such as housing instability, food insecurity, domestic violence, and transportation. The goal is improved care and lower cost by improving collaboration between communities and clinical care providers. Read More

Economist Stephen Parente Nominated as HHS Assistant Secretary of Planning, Evaluation. *Modern Healthcare* reported on April 10, 2017, that healthcare economist Stephen Parente has been nominated to be the Assistant Secretary of Planning and Evaluation for Department of Health and Human Services (HHS) Secretary Tom Price. Parente, a University of Minnesota professor, will take over the post from Harvard economist Richard Frank and advise the Secretary on issues related to policy, legislative efforts, and strategic planning and research. Read More

Hospitals Still Rely on DSH Payments Despite Drop in Uncompensated Care, Per MACPAC Report. *Modern Healthcare* reported on April 11, 2017, that despite a drop in uncompensated care costs in the past few years, hospitals still find disproportionate-share hospital (DSH) payments an important source of funding, according to a recent report from the Medicaid and CHIP Payment and Access Commission (MACPAC). Federal DSH funding is scheduled to be cut on September 30, 2017, extended from the initial planned date for DSH fund reductions in 2014. The funding cuts will equal $2 billion in fiscal 2018, growing to $8 billion by fiscal 2025. Safety net hospitals continue to struggle financially, with many reporting negative operating margins. According to the MACPAC report, 20 states will face fiscal 2018 cuts larger than recent declines in uncompensated care. MACPAC recommends recalculating DSH payments based on the efficacy of value-based care initiatives. Read More

Medicaid Innovation Accelerator Program National Webinar scheduled for April 19. As part of CMS's Medicaid Innovation Accelerator Program (IAP) Reducing Substance Use Disorder (SUD) program area, the SUD program area is sharing what it has learned from working with states on SUD delivery system reform through national learning webinars. The IAP SUD program area is hosting a national learning webinar on Wednesday, April 19, 2017, from 3:30 PM – 5:00 PM ET. The April webinar, entitled "*Introduction to the American Society of Addiction Medicine Criteria for Clinical and Program Standards,*" will provide an overview of the SUD treatment care continuum and standards described in the American Society of Addiction Medicine (ASAM) Criteria, the most recent and comprehensive set of industry guidelines concerning the treatment of SUDs. The webinar will provide an overview of all the ASAM Criteria levels of care before focusing discussion on complex levels of care, including withdrawal management, early intervention, partial hospitalization, and clinically managed low-intensity residential services. In addition, this webinar will provide participants with information regarding the ASAM clinical standards including the biopsychosocial assessment used to

identify the most appropriate level of care for individuals with SUD. ASAM Criteria authors David Gastfriend, MD and George Kolodner, MD will be on the webinar to respond to questions. HMA is one of several organizations working as a subcontractor under a CMCS contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Beneficiaries with Complex Needs and High Costs (BCN) tracks through webinars, coaching assistance to participating states, resource papers, and bi-weekly program updates. Link to Register

Industry News

Massachusetts Files Lawsuit Against UHS for Submitting False MassHealth Claims. *Modern Healthcare* reported on April 11, 2017, that Massachusetts filed a lawsuit against Universal Health Services (UHS) for submitting false claims to MassHealth, the state's Medicaid program. The state is seeking treble damages on some $94.2 million in reimbursements made between 2005 and 2013. Read More

Company Announcements

- "UnitedHealthcare Global Receives 2016 Doyle Award for its Efforts to Improve Quality of Care Delivery and Health Outcomes for People Traveling and Living Abroad" Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
April 13, 2017	Massachusetts	Proposals Due	850,000
April 14, 2017	Washington (FIMC - North Central RSA)	Proposals Due	66,000
April 27, 2017	Alaska Coordinated Care Demonstration	Proposals Due	TBD
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May 15, 2017	Illinois	Proposals Due	2,700,000
May 22, 2017	Washington (FIMC - North Central RSA)	Contract Awards	66,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
June 30, 2017	Illinois	Contract Awards	2,700,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Georgia	Implementation	1,300,000
July 17, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
July, 2017	Ohio MLTSS	RFA Release	130,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
August, 2017	Alabama ICN (MLTSS)	RFP Release	25,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
Summer 2017	Florida	RFP Release	3,100,000
Summer 2017	Massachusetts One Care (Duals Demo)	Procurement Release	TBD
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October, 2017	Alabama ICN (MLTSS)	Proposals Due	25,000
October, 2017	Ohio MLTSS	Contract Awards	130,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 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 HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
July, 2018	Alabama ICN (MLTSS)	Implementation	25,000
July, 2018	Ohio MLTSS	Implementation	130,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
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 state dual eligible financial alignment demonstration status.

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%**	

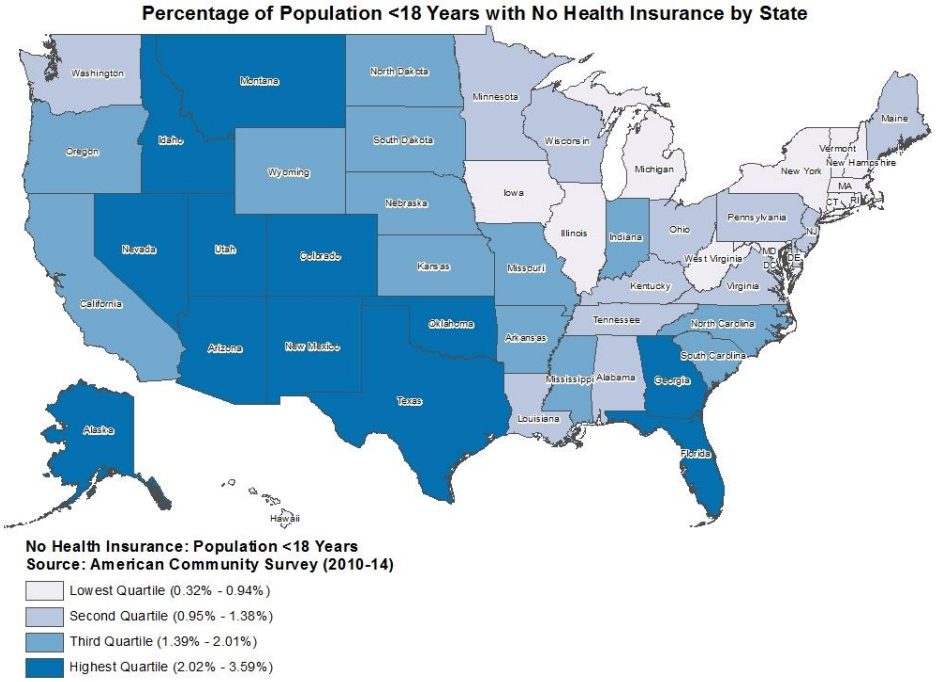
** New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment.*

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

HMA News

HMA Launches Weekly Informatics Series

Over the next few weeks, the HMA Weekly Roundup and HMA Information Services (HMAIS) will showcase a series of maps and other key informatics. Our first map in the series highlights data on **children without health insurance.** With decreased access to preventative care, children without health insurance are less likely to receive timely and effective treatment when the need arises.



What does your service area look like? Utilizing sophisticated geo-mapping software, HMA prepares detailed maps at the state, county, zip code, or census tract level, to communicate key data at a glance. This includes demographic, health status, and service gap issues.

For more information on this map or to create your own maps and charts to assist your community needs assessments, planning, marketing, and advocacy efforts please contact HMA Chicago's **Anissa Lambertino** at: alambertino@healthmanagement.com or (312) 641-5007.

Sponsorship Opportunities Available for HMA's 2017 Conference on *The Future of Medicaid: Implications for Payers, Providers and States*

Health Management Associates is happy to announce that sponsorship opportunities are available for our 2nd conference on *Trends in Publicly Sponsored Healthcare*, September 11-12, 2017, at the Renaissance Chicago Downtown Hotel. The theme of this year's event is *The Future of Medicaid is Here: Implications for Payers, Providers and States*.

A limited number of eight tabletop exhibits will be available to sponsors. The package includes:

- An 8-foot table in the foyer area for display of Sponsor materials (consistent with hotel requirements: Link to Exhibitor Information).
- Two full conference registrations
- Logo on conference signs, website and materials
- Other promotional considerations

Projected conference attendance is 250, including executives from Medicaid managed care plans, states, providers, community-based organizations, investors, and others. Featured speakers include some of the nation's most innovative healthcare leaders.

Confirmed Speakers to Date

(in alphabetical order; others to be announced)

Medicaid Managed Care Speakers

- Laurie Brubaker, SVP, Aetna Medicaid
- David Cotton, CEO, Meridian Health Plans
- Susan Fleischman, MD, VP, Medicaid, CHIP, and Charitable Care, Kaiser Permanente
- Patrick Gordon, Associate VP, Rocky Mountain Health Plan, a UnitedHealthcare plan
- Jesse Hunter, EVP, Products, Centene Corp.
- J. Mario Molina, MD, President, CEO, Molina Healthcare
- John Molina, CFO, Molina Healthcare
- Michael Monson, Corporate VP, Long Term Care & Dual Eligibles, Centene Corp.
- Pamela Morris, President, CEO, CareSource
- Fran Soistman, EVP, Government Services, Aetna, Inc.
- Paco Trilla, M.D., Medical Director, Neighborhood Health Plan of Rhode Island
- Paul Tufano, Chairman, CEO, AmeriHealth Caritas

State Medicaid Speakers

- Mari Cantwell, California State Medicaid Director & Chief Deputy Director, Health Care Programs, California Department of Health Care Services
- Gary Jessee, Deputy Executive Commissioner, Medical and Social Services, Texas HHS
- Nathan Johnson, Chief Policy Officer, Washington Health Care Authority

- Patti Killingsworth, Assistant Commissioner, Chief of Long Term Services and Supports, Bureau of TennCare, Long Term Services and Supports
- MaryAnne Lindeblad, State Medicaid Director, Washington Health Care Authority
- Joe Moser, Director of Medicaid, Indiana Family and Social Services Administration

Providers and Other Speakers

- Tamara Hamlish, Executive Director, ECHO-Chicago, Project Manager, HepCCATT
- Allison McGuire, MPH, Executive Director, Montefiore Hudson Valley Collaborative
- Christopher Perrone, Director, Improving Access, California Health Care Foundation
- June Simmons, President, CEO, Partners in Care Foundation

For information on group rates and sponsorship opportunities contact Carl Mercurio at cmercurio@healthmanagement.com or 646-590-5929.