

HEALTH MANAGEMENT ASSOCIATES
HMA Weekly Roundup

Trends in State Health Policy

..... May 24, 2017



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THIS WEEK

- **IN FOCUS: HMA CONFERENCE ON THE FUTURE OF MEDICAID**
- WASHINGTON AWARDS MANAGED CARE CONTRACTS FOR NORTH CENTRAL REGION
- INDIANA MEDICAID DIRECTOR MOSER RESIGNS
- MISSOURI GOVERNOR NAMES CORSI DSS DIRECTOR
- BCBS-NC, ANTHEM TO JOINTLY BID FOR NORTH CAROLINA MEDICAID MANAGED CARE CONTRACT
- PENNSYLVANIA GOVERNOR TO NOMINATE INSURANCE COMMISSIONER AS INAUGURAL DHHS SECRETARY
- CBO PUBLISHES SCORE OF HOUSE REPUBLICAN AHCA BILL
- PRESIDENT'S BUDGET PROPOSAL REDUCES MEDICAID FUNDING BY \$610 BILLION OVER NEXT DECADE
- SENATORS PROPOSE EASING RESTRICTIONS ON MEDICAID REIMBURSEMENT FOR SUBSTANCE USE TREATMENT
- STEWARD HEALTH CARE, IASIS HEALTHCARE TO MERGE
- COMMUNITY HEALTH SYSTEMS REJECTS \$2.4 BILLION BUYOUT OF FORT WAYNE HOSPITALS
- HMA'S LORI RANEY, GINA LASKY EDIT BOOK THAT SERVES AS GUIDE FOR IMPLEMENTING INTEGRATED CARE
- HMA WELCOMES: SCOTT ACKERSON (SAN ANTONIO); TRUDI CARTER, M.D. (COSTA MESA); FLINT MICHELS (PHOENIX); AND JEREMY MARTINEZ (ATLANTA)

IN FOCUS

HMA CONFERENCE ON THE FUTURE OF MEDICAID TO FEATURE INSIGHTS FROM 35 SPEAKERS, HEALTH PLAN CEOs, STATE MEDICAID DIRECTORS

This week, our *In Focus* section previews the agenda for HMA's second conference in a series on the future of state-sponsored health care, to be held September 11-12, 2017, at the Renaissance Chicago Downtown Hotel in Chicago, Illinois. Waivers, block grants and per capita caps, member premiums and copays, health savings accounts, expansion, clinical integration, value-based payments, and innovative benefit design and funding models will take center stage as 35 speakers from leading health plans, states and providers join Health Management Associates for a high-level, two-day conference on *The Future of Medicaid is Here: Implications for Payers, Providers and States*.

Early Bird registration is now open for the event, which will take place September 11-12, 2017, at the Renaissance Chicago Downtown Hotel. Last year's event attracted more than 250 attendees. Visit the conference website for complete details: <https://2017futureofmedicaid.healthmanagement.com/> or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Group rates and sponsorships are available. The complete conference agenda appears below. Speakers include six state Medicaid directors and 13 top Medicaid managed care executives, among others.

Speakers will address the potential for broad-based initiatives at the state and federal level aimed at dramatically altering the structure of Medicaid. Everything is on the table, and the choices could reshape the Medicaid program for years to come.

Agenda	
Day One: Sept. 11, 2017	
7:00 - 8:00 am	Registration
8:00 - 8:10 am	Introduction and Welcome <i>Joan Henneberry, Vice President, HMA (Denver, CO)</i>
8:10 - 9:00 am:	Keynote Address The Future of Medicaid is Here: Implications for Payers, Providers and States The election of Donald Trump coupled with Republican control of Congress opens the door to the potential for broad-based changes to the structure of the 50-year-old Medicaid program. Everything is on the table: Waivers, block grants, per capita caps, shared responsibility, health savings accounts, expansion, and other benefit design and funding options. All of which could reshape Medicaid for years to come. This keynote address will address opportunities and implications for payers, providers and states as they work to develop Medicaid programs that serve the unique needs of each state's most vulnerable populations – ensuring access, improving quality, and

	<p>controlling costs.</p> <p><i>Speaker</i> To be announced</p> <p><i>Moderator</i> Joan Henneberry, Vice President, HMA (Denver, CO)</p>
<p>9:00 - 10:30 am</p>	<p>State Q&A Keynote Session The Future of State Innovation in Medicaid</p> <p>States have always been leaders in Medicaid innovation, consistently pushing federal regulators for flexibility in benefit design and funding models. That role will only increase during the Trump Administration, which is almost certain to give states unprecedented license to structure Medicaid programs to meet the unique needs of vulnerable populations in their states. During this Keynote Q&A Session, Medicaid directors from some of the nation’s most innovative states will engage in a wide-ranging discussion on the exciting new possibilities now open to forward-thinking regulators and policymakers.</p> <p><i>Speakers</i> 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 Health and Human Services MaryAnne Lindeblad, State Medicaid Director, Washington Health Care Authority Other speakers to be announced.</p> <p><i>Moderator</i> Kathleen Nolan, Managing Principal, HMA (Washington, DC)</p>
<p>10:30 - 11:00 am</p>	<p>Break</p>
<p>11:00 - 12:30 am</p>	<p>Health Plan Q&A Keynote Session Managed Care and the Brave New World of Medicaid Innovation</p> <p>Managed care organizations are uniquely positioned to help states explore a wide variety of potential innovations to Medicaid programs. MCOs already play a central role in serving the healthcare needs of more than 50 million Medicaid members, including children, adults, and a growing number of individuals with complex conditions, developmental disabilities, and long-term care needs. As states evaluate block grants, shared responsibility, and other innovations, they will almost certainly rely on MCOs to ensure these initiatives are implemented thoughtfully and efficiently. During this session, leading managed care CEOs will engage in a spirited Q&A session about the future of Medicaid managed care and the potential for working closely with states on effective solutions for serving vulnerable populations, improving quality, and reducing costs.</p> <p><i>Speakers</i> Laurie Brubaker, Head of Aetna Medicaid J. Mario Molina, MD, Former President, CEO, Molina Healthcare Pamela Morris, President, CEO, CareSource Fran Soistman, EVP, Government Services, Aetna, Inc. Paul Tufano, Chairman, CEO, AmeriHealth Caritas</p>

	<p><u>Moderator</u> <i>Donna Checkett, VP, Business Development, HMA</i></p>
<p>12:30 - 2:00 pm</p>	<p><u>Luncheon Keynote</u> <i>Matt Salo, Executive Director, National Association of Medicaid Directors</i></p>
	<p><u>Concurrent Breakout Session</u> Medicaid Waivers – A Future of Innovation, A Danger of Disruption The word on the street is that the Trump Administration will allow states far more leeway in designing Medicaid waivers that include provocative elements like block grants, shared member responsibility, and employment requirements. Numerous waiver proposals historically rejected by federal regulators are bound to get a new hearing, and the opportunity to develop innovative programs that successfully meet the unique needs of local populations is great. But so are the chances that a poorly designed or poorly implemented program will cause disruption. This breakout session will address the possibilities and limitations of various waiver proposals, with a special emphasis on what these initiatives could mean for members, Medicaid managed care organizations, and safety net providers.</p> <p><u>Speakers</u> <i>David Cotton, CEO, Meridian Health Plans</i> <i>Judy Mohr Peterson, Medicaid Director, Hawaii State Dept. of Human Services</i> <i>Chris Priest, Medicaid Director, Michigan Dept. of Health and Human Services</i></p> <p><u>Moderator</u> <i>Tina Edlund, Managing Principal, HMA (Portland, OR)</i></p>
<p>2:00 - 3:30 pm</p>	<p><u>Concurrent Breakout Session</u> Value-Based Payments and the Future of Payer-Provider Collaboration Medicaid programs across the nation are likely to experience a growing reliance on value-based payment arrangements in the Trump era. The simple truth is that as states take on more responsibility for controlling costs and ensuring quality in their Medicaid programs, they are almost certain to turn to managed care plans for help. Medicaid managed care will in turn rely on payer-provider collaboration to meet emerging quality, accountability and cost requirements. This breakout session will outline value-based payment strategies that can help move state Medicaid programs from volume-based payment models to quality-based models. Panelists will also address how health plans and providers can work together to help drive policies that promote more efficient use of Medicaid funding and services.</p> <p><u>Speakers</u> <i>Susan Fleischman, MD, VP, Medicaid, CHIP, and Charitable Care, Kaiser Permanente</i> <i>Nathan Johnson, Chief Policy Officer, Washington Health Care Authority</i> <i>Francisco “Paco” Trilla, MD, Medical Director, Neighborhood Health Plan of Rhode Island</i></p> <p><u>Moderators</u> <i>Jeanene Smith, MD, Principal, HMA (Portland, OR)</i> <i>Margaret Tatar, Managing Principal, HMA (Sacramento, CA)</i></p> <p><u>Concurrent Breakout Session</u></p>

	<p>Opportunities and Challenges for Community-based Organizations There is growing recognition of the importance of community-based organizations (CBOs) as a vital component in addressing social determinants of health and ensuring continuity of care for Medicaid recipients. This breakout session will provide real-world examples of CBOs that have worked closely with states and Medicaid managed care plans to drive improved outcomes and reduced costs among some of the nation’s most vulnerable populations. Panelists will also discuss how CBOs can best add value to health delivery systems, even if Medicaid funding shifts and new funding models like block grants are considered.</p> <p><u>Speakers</u> <i>June Simmons, President, CEO, Partners in Care Foundation</i> <i>Pamme Taylor, VP for Advocacy and Community Based Programs, WellCare</i> <i>Other speakers to be announced.</i></p> <p><u>Moderator</u> <i>Marci Eads, Managing Director, HMA Community Strategies (Denver, CO)</i></p>
<p>3:30 - 4:00</p>	<p>Break</p>
<p>4:00 - 5:30</p>	<p><u>Concurrent Breakout Session</u> Medicaid Managed Care and the Future of Long-Term Services and Supports Two things are sometimes overlooked in the debate over the future of Medicaid. 1. Long-Term Services and Supports are a major driver of Medicaid costs. 2. Managed care is playing a growing role in controlling LTSS expenditures and ensuring quality. This session will explore the use of managed care in serving LTSS populations, including a frank discussion of how proposed changes to the Medicaid program may impact the future of Managed LTSS initiatives. Potential changes include the use of performance metrics, value-based purchasing, dual eligible coordination, increased state flexibility in program design, and caps on growth in federal spending share – all of which could have important implications for managing LTSS populations.</p> <p><u>Speakers</u> <i>Michael Monson, Corporate VP, Long Term Care & Dual Eligibles, Centene Corp.</i> <i>Patti Killingsworth, Assistant Commissioner, Chief of Long Term Services and Supports, Bureau of TennCare, Long Term Services and Supports</i> <i>Melanie Bella, National Consultant, Former Director, Medicare-Medicaid Coordination Office, Centers for Medicare and Medicaid Services</i></p> <p><u>Moderator</u> <i>Barb Edwards, Principal, HMA (Columbus, OH)</i></p> <p><u>Concurrent Breakout Session</u> Behavioral Health Integration: A Care Management Imperative Behavioral health integration is now a focal point of Medicaid managed care, delivery system reform, and other initiatives aimed at better managing the cost and quality of care for vulnerable patient populations. That’s true whether behavioral health is integrated into primary care settings or the reverse, in which primary care is integrated into behavioral health settings. This breakout session will highlight integration efforts that have successfully</p>

	<p>driven improvement in care management and core coordination for vulnerable populations. It will also address how potential changes in the way Medicaid is funded could impact future behavioral integration efforts.</p> <p><u>Speakers</u> <i>Patrick Gordon, Associate VP, Rocky Mountain Health Plan, a UnitedHealthcare plan</i> <i>Tamara Hamlish, Executive Director, ECHO-Chicago, Project Manager, HepCCATT</i> <i>Joe Parks, MD, Medicaid Director, Missouri Department of Social Services; Medical Director, National Council for Behavioral Health</i> <i>Virna Little, Senior Vice President, Psychosocial Services and Community Affairs, Instituteor Family Health</i></p> <p><u>Moderators</u> <i>Lori Raney, MD, Principal, HMA (Denver, CO)</i> <i>Josh Rubin, Principal, HMA (New York)</i></p> <hr/> <p><u>Concurrent Breakout Session</u> Investor Views on the Future of Publicly Sponsored Healthcare Healthcare investors looking for the next big thing are keeping a close eye on the Medicaid market – seeking outsized returns from investments in models of care best positioned to succeed in an evolving Medicaid landscape. During this panel, leading Wall Street analysts and private equity investors will discuss some of the key market trends and investment opportunities they’re tracking. They will also assess scenarios for Medicaid reform, with an eye toward how these various possibilities inform their investment priorities.</p> <p><u>Speakers</u> <i>David Caluori, Principal, General Atlantic</i> <i>Josh Raskin, Managing Director, Barclays Capital</i> <i>Todd Rudsenske, Managing Director, Cain Brothers & Company LLC</i> <i>Tim Sheehan, Managing Director, Beecken Petty O'Keefe</i> <i>David Schuppan, Private Equity Investor (Formerly with Cressey & Company LP)</i></p> <p><u>Moderator</u> <i>Greg Nersessian, Principal, HMA (New York)</i></p>
5:30 - 7:00	Cocktail Party
Day Two: Sept. 12, 2017	
7:00 - 8:00 am	Breakfast
8:00 - 8:15 am:	<p>Introduction and Welcome <i>Joan Henneberry, Vice President, HMA (Denver, CO)</i></p>
8:15 - 9:00 am:	<p>Keynote Address The Pros and Cons of Shared Responsibility in Medicaid Shared responsibility in Medicaid is the concept that individuals who receive Medicaid benefits should be responsible for picking up some of the cost, for example, through premiums, copays, or deductibles. Shared responsibility may also include additional eligibility requirements, such as requiring Medicaid recipients to demonstrate that they are actively looking for a job. Indiana is one of the earliest adopters of shared responsibility in Medicaid. During this Keynote Address, Joe Moser, Director of Medicaid for the Indiana Family and Social Services Administration, will discuss some of the</p>

	<p>key lessons learned during his state’s implementation of shared responsibility - including a frank discussion of the pros and cons of the initiative.</p> <p><i><u>Speaker</u></i> <i>Joe Moser, Former Director of Medicaid, Indiana Family and Social Services Administration</i></p> <p><i><u>Moderator</u></i> <i>Jonathan Freedman, Managing Principal, HMA (Southern California)</i></p>
<p>9:00 - 10:30 am</p>	<p><u>Keynote Q&A Session</u> The Pros and Cons of Shared Responsibility in Medicaid One of the most provocative concepts in Medicaid is that of “shared responsibility,” the idea that recipients of Medicaid benefits should be required to pay some of the cost through premiums, copays or deductibles. Proponents argue that shared responsibility helps to control costs and ensure efficient utilization of healthcare services. Opponents say it only creates barriers for people from gaining access to the care they need. During this Keynote Q&A session, leading Medicaid experts will engage in a spirited discussion on the pros and cons of shared responsibility in Medicaid, including the likelihood that shared responsibility will be embraced more broadly.</p> <p><i><u>Speakers</u></i> <i>Joe Moser, Former Director of Medicaid, Indiana Family and Social Services Administration</i> <i>Jesse Hunter, EVP, Products, Centene Corp.</i> <i>Christopher Perrone, Director, Improving Access, California Health Care Foundation</i></p> <p><i><u>Moderator</u></i> <i>Jonathan Freedman, Managing Principal, HMA (Southern California)</i></p>
<p>10:30 - 11:00 am</p>	<p>Break</p>
<p>11:00 am - 12:30 pm</p>	<p><u>Provider Keynote Q&A Session</u> Trends in Provider Innovation and Delivery System Reform Even as penetration of Medicaid managed care continues to grow, several states are also increasingly focused on encouraging the development of clinically and financially integrated delivery systems like Accountable Care Organizations to further improve quality, cost and member experience of care. In some cases, they are requiring health plans to contract using alternative payment methodologies with glide paths to increasing provider accountability for outcomes. Some states are using funding from State Innovation Model Testing, CPC Plus, Delivery System Reform Incentive Payment programs and other Federal initiatives to support innovation and reform. Under the Trump Administration, states will likely have even more leeway to experiment with these types of innovative new financing and care models. This Keynote Q&A Session will offer important insights into opportunities, challenges and early experience with these provider-led Medicaid delivery system reform initiatives, best practices for incentivizing delivery system change, and an assessment of whether these same innovations could potentially be replicated in other states.</p>

	<p><u>Speakers</u> <i>Allison McGuire, MPH, Executive Director, Montefiore Hudson Valley Collaborative</i> <i>Francisco "Paco" Trilla, M.D., Medical Director, Neighborhood Health Plan of Rhode Island</i> <i>L. Allen Dobson Jr., MD, President and CEO, Community Care of North Carolina</i></p> <p><u>Moderators</u> <i>Art Jones, Principal, HMA (Chicago)</i> <i>Meggan Schilkie, Principal, HMA (New York)</i></p>
12:30	Adjourn



HMA MEDICAID ROUNDUP

Arkansas

Medicaid Expansion Proposal Retains Cost Cap, Adds Work Requirement, Eliminates Retroactive Coverage. *Arkansas Online* reported on May 19, 2017, that Arkansas has proposed changes to its Medicaid expansion program. A draft of the request to amend the Arkansas Works expansion waiver published by the state Department of Human Services would retain an overall cost cap for the program, eliminate retroactive coverage for enrollees, remove around 60,000 individuals from the program by limiting eligibility, and impose a work requirement. The state will accept comments at two public hearings as well as written comments over the coming weeks before finalizing a proposal. [Read More](#)

California

HMA Roundup – Julia Elitzer ([Email Julia](#))

Medicaid Expansion to Cost State \$1.3 Billion in 2017. *California Healthline* reported on May 18, 2017, that Medicaid expansion in California will cost the state about \$1.3 billion in 2017, as states must begin to pay a small percentage of the costs of expansion members under the Affordable Care Act matching formula. The remainder is paid by the federal government; prior to 2017, the federal government paid 100 percent of the cost. California added nearly 4 million Medicaid expansion members. [Read More](#)

Single-payer Health Care Proposal Could Cost \$400 Billion Annually. *Los Angeles Times* reported on May 22, 2017, that California's proposed single-payer health care bill could cost a total of \$400 billion annually, according to a legislative analysis released this week. The bill, SB 562, proposed by State Senators Ricardo Lara (D-Bell Gardens) and Toni Atkins (D-San Diego), would cover medical care for every resident in California, including individuals without legal immigration status. To pay for the initiative, California would use \$200 billion of existing federal, state, and local funds, and raise an additional \$200 billion through new taxes, including a proposed payroll tax on employers of 15 percent of earned income. The analysis also said that the single-payer structure would likely reduce spending by employers and employees across the state, resulting in net new spending under the bill of between \$50 billion and \$100 billion each year. [Read More](#)

Illinois

Federal Court to Decide on Medicaid MCO Priority Payments. *Crain's Chicago Business* reported on May 24, 2017, that a federal judge may decide next week whether Illinois should prioritize paying Medicaid managed care organizations (MCOs). Illinois owes more than \$2 billion in capitated payments to Medicaid MCOs that manage care for roughly two-thirds of the state's Medicaid program. MCOs are pushing for priority in payments from the state to avoid delaying payments to providers. The \$2 billion owed to Medicaid MCOs is part of a broader state billing backlog that has surpassed \$14.4 billion. [Read More](#)

Indiana

Medicaid Director Joe Moser Resigns. *Modern Healthcare* reported on May 23, 2017 that Joe Moser has resigned as Indiana's Medicaid Director to pursue other opportunities. Appointed in 2013 by former Governor Mike Pence, he was a key architect of Healthy Indiana Plan 2.0 (HIP 2.0), Indiana's Medicaid expansion program. As the state's Medicaid Director, he worked with Seema Verma, now the Centers for Medicare & Medicaid Services (CMS) Administrator, who was a consultant for HIP 2.0, and Brian Neale, now the Director of the CMS Center for Medicaid and CHIP Services. Moser has stated that he has no plans to work for the Trump Administration. [Read More](#)

Iowa

Medicaid Managed Care Shows Potential Savings of \$600 Per Member. *The Des Moines Register* reported on May 23, 2017, that a comparison of state and federal costs shows Iowa will potentially be spending \$600 less per Medicaid recipient under managed care, compared to the last full year of the state's fee-for-service Medicaid program. Iowa implemented a statewide Medicaid managed care program in April of 2016, awarding contracts to AmeriHealth Caritas, UnitedHealthcare, and Anthem's Amerigroup. State Representative Dave Heaton is attributing the cost savings to better management and the elimination of unnecessary costs. The data does not account for payments the state will make to health plans to make up for losses in the first year of the program or increased rates the state will be paying in July. [Read More](#)

Kansas

CMS Approves Corrective Action Plan for KanCare Program. *The Kansas City Star* reported on May 23, 2017, that the Centers for Medicare & Medicaid Services (CMS) has approved Kansas' corrective action plan for its KanCare Medicaid program. Kansas must still receive approval for an extension of the KanCare waiver. In January, CMS rejected a proposal to extend KanCare through 2018 because the program was "substantively out of compliance" with federal regulations. CMS said the state lacked oversight of managed care organizations and failed to communicate clear information to the program's beneficiaries. [Read More](#)

Kentucky

KentuckyOne Health CEO Ruth Brinkley to Step Down. *Courier-Journal* reported on May 19, 2017, that KentuckyOne Health announced that CEO Ruth Brinkley is stepping down on July 14, 2017. The announcement comes a week after KentuckyOne, a subsidiary of Catholic Health Initiatives, announced it would sell most of its Louisville, KY, assets. Current University of Louisville Hospital interim president Chuck Neumann is set to take over as interim president and CEO. [Read More](#)

Louisiana

Lawmakers Increase Financing for Medicaid Expansion Program. *WDSU News* reported on May 23, 2017, that state lawmakers agreed to increase total financing for Louisiana's Medicaid expansion program by \$368 million to a projected \$2.3 billion this year. The Medicaid expansion has enrolled more than 428,000 people this year, significantly higher than what was originally projected. [Read More](#)

Missouri

Governor Names Wyoming Official Steve Corsi as New DSS Director. *St. Louis Post-Dispatch* reported on May 20, 2017, that Missouri Governor Eric Greitens has named the current head of the Wyoming Department of Family Services, Steve Corsi, as the new Missouri Department of Social Services (DSS) Director. Corsi will serve as Interim Director until his appointment is confirmed by the Missouri Senate. [Read More](#)

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

State Aims to Limit Prescription Drug Spending Through Payment Caps, Reviews. *Kaiser Health News* reported on May 22, 2017, that New York has established new rules that could put pressure on prescription drug manufacturers to give additional discounts to the state Medicaid program or undergo a review of the effectiveness and profitability of their drugs. The state is also imposing an annual cap on Medicaid prescription drug spending. Total payments will be limited to the sum of medical inflation plus 5 percent. If the spending cap is exceeded, manufacturers will either undergo reviews or must agree to additional discounts. The rules, signed into law in April as part of the state's budget, are the latest in a series of actions by states aimed at targeting high prescription drug costs. [Read More](#)

Elderplan Withdrawing from Suffolk County. Elderplan has announced that its managed long-term care plan HomeFirst will no longer provide services in Suffolk County. Elderplan is a not-for-profit plan that currently serves 12,340 members, 86 percent of whom reside in New York City. Their Suffolk County enrollment represents three percent of their enrollment. This is the second plan to withdraw from Suffolk County this year: GuildNet, the largest provider in the county, began the transfer of its members to other plans earlier this month, and is accepting no new enrollments. As with the GuildNet withdrawal,

Elderplan will continue to provide services to its members until they enroll in a new plan. According to Crain's HealthPulse, the decision was driven by difficulties in staffing and providing services over a large geographic region. [Read More](#)

Single Payer Bill Passes New York Assembly. A plan to create a universal single-payer health insurance plan in New York passed the Assembly on Tuesday, May 16 with a vote of 87 to 38. This is the third consecutive year that the bill has passed the Assembly; the Senate has never taken up the bill. The New York Health Act would establish a universal health care system within the state, and expand coverage eligibility to include all residents, regardless of income, age or pre-existing condition. In addition, every enrollee would have access to the full range of doctors and service providers offered. State funding would be combined with federal funds that are currently received for Medicare, Medicaid and Child Health Plus to create the New York Health Trust Fund. The state would also seek federal waivers that will allow New York to completely fold those programs into New York Health. [Read More](#)

Insurance Plans Report Losses in New York. EmblemHealth reported a \$3 million underwriting loss through the first quarter of 2017, a significant improvement over its performance in 2016, when it reported a \$29 million loss for the same period. EmblemHealth is made up of Group Health Incorporated (GHI), which has roughly 1.5 million members, and Health Insurance Plan Greater New York (HIP), which has about 624,000 members. HIP serves 160,000 Medicaid beneficiaries in New York City. According to *Politico NY*, HIP lost \$24 million through the first three months of the year, up from a \$4 million underwriting loss during the same period in 2016, largely due to an increase in reserves. [Read More.](#) After years of large losses, Oscar Insurance Company, a start-up insurance company that was established in response to the Affordable Care Act, has stemmed losses in recent months. According to a report by Bloomberg, the privately held health insurer lost \$25.8 million across three states in the first three months of this year, compared with a loss of \$48.5 million a year earlier. In response to the challenges of the individual marketplace, Oscar has increased premiums, pulled out of two regions (New Jersey and part of Texas), and sharply limited its network of hospitals and doctors in New York. Its biggest losses continue to be in NY, where the plan reported revenue of \$38 million and a net loss of \$21 million. [Read More.](#) CareConnect, the insurance company started by Northwell Health, reported a \$23.6 million underwriting loss during the first three months of 2017, up from a \$5 million underwriting loss during the same period in 2016. According to *Politico NY*, the company has been hit particularly hard by the Affordable Care Act's risk adjustment program, paying \$29 million this quarter. Risk adjustment seeks to move money from insurers that cared for a healthier population to the ones that cared for a less-healthy population, but many insurance companies argue that the distribution formula is flawed.

New York Launches the Managed Long Term Care (MLTC) Workforce Investment Program. New York has announced the launch of the Managed Long Term Care (MLTC) Workforce Investment Program, part of New York's Section 1115 waiver, the Medicaid Redesign Team (MRT) Demonstration. The MLTC Workforce Program is designed to enhance the workforce of the state's long-term care services to ensure that the workforce is ready for the greater emphasis on non-institutional care in the state's healthcare. This initiative will target direct care workers by allowing MLTC plans to invest in workforce

training for providers in their network. Through the workforce program investment, the state will require MLTC plans to contract with Department of Health - designated Workforce Centers of Excellence to invest in initiatives to attract, recruit and retain long term care workers; develop plans to address reductions in health disparities by focusing on the placement of long term care workers in medically underserved communities; train needed workers to care for currently uninsured populations who will seek care under the Affordable Care Act expansion; and support the expansion of home care and respite care, enabling those in need of long term care to remain in their homes and communities. To kick off the MLTC Workforce Program, the state is hosting a webinar to discuss an overview of the program as well as a timeline and next steps. The webinar will be on **Thursday, May 25, 2017, at 2:00pm**. [Webinar Registration](#)

New York City Mayor Approves Supportive Housing Units. New York City Mayor Bill DeBlasio has included funding for 280 units of supported housing in his 2018 budget. *Politico NY* reports that the state will create 280 community-based supportive housing units for New Yorkers with mental health problems. The units will offer affordable housing and on-site access to health care, the result of a years-long effort to move mental health patients out of state-run residential facilities and into less-restrictive settings. [Read More](#)

North Carolina

BCBS-NC, Anthem/Amerigroup to Jointly Bid For NC Medicaid Managed Care Contract. Blue Cross and Blue Shield of North Carolina (BCBS-NC) and Anthem/Amerigroup announced on May 17, 2017, that they will submit a joint bid to serve North Carolina's statewide Medicaid managed care program, which is being procured for the first time as part of the state's broader Medicaid reform effort. The collaboration seeks to improve health care outcomes by eliminating unnecessary services, closing care gaps, and improving the health of communities. [Read More](#)

Audit Finds 'Unreasonable Spending' by LME/MCO. *WUNC 91.5* reported on May 18, 2017, that a North Carolina audit found that Cardinal Innovations Healthcare Solutions, a Local Management Entity/Managed Care Organization (LME/MCO) that manages mental and behavioral health for 850,000 individuals in 20 counties, engaged in "unreasonable spending" of Medicaid funds. The report found that Cardinal overpaid its executives by \$1.2 million and spent money on retreats, Christmas parties, charter flights, CEO benefits, and executive credit card expenses, including alcohol and first-class airline tickets. In response, Cardinal argued that it is not a government entity and must compete for employees with large for-profit corporations. [Read More](#)

Liberty Healthcare Group and UNC Hospitals Expand Facilities. *Triangle Business Journal* reported on May 22, 2017, that Liberty Healthcare Group has submitted a proposal for the construction of a \$36 million nursing and adult care facility in Cary, North Carolina, and UNC Hospitals filed two Certificate of Need applications for expansions in Chapel Hill and Hillsborough. UNC Hospitals' \$9.9 million expansion will add nine acute care beds in Chapel Hill and 32 beds in Hillsborough. The nursing and adult care facility is expected to be completed in June 2021, while the UNC Hospital expansions are scheduled for completion in 2020. [Read More](#)

Pennsylvania

HMA Roundup - Julie George ([Email Julie](#))

Governor Wolf to Nominate Insurance Commissioner to be Inaugural DHHS Secretary. On May 23, 2017, Pennsylvania Governor Tom Wolf announced his intention to nominate current Pennsylvania Insurance Commissioner Teresa Miller to serve as the inaugural Secretary of the prospective unified Department of Health and Human Services (DHHS). The proposed department would consolidate the Department of Human Services, the Department of Health, the Department of Aging and the Department of Drug and Alcohol Programs. Governor Wolf also announced his intention to nominate Jessica Altman, current Insurance Department Chief of Staff, to be Miller's eventual replacement. [Read More](#)

Department of Health Secretary Karen Murphy to Leave the Wolf Administration. Pennsylvania Department of Health Secretary Karen Murphy announced her departure from the state for a position in the private sector. During her tenure at DOH, Dr. Murphy implemented the Prescription Drug Monitoring Program and the medical marijuana program. She also took on challenges facing public health, including the heroin and opioid epidemic, reforming the oversight of nursing homes and developing a transformation initiative for rural hospitals. On the subject of her departure, Governor Wolf said, "We will miss Secretary Murphy, and we wish her well as she pursues new opportunities to improve public health." [Read More](#)

Pennsylvania DOH Fining Nursing Homes More Frequently. Following an auditor general report issued last summer that charged the Pennsylvania Department of Health (DOH) with going easy on substandard care in nursing homes, DOH has adopted a more rigorous penalty system. The department has fined nursing homes more in the first four months of 2017 (\$796,750), than they have in 2014-2016, combined (\$639,500). State surveyors sanctioned 86 facilities so far this year, compared with 72 in all of last year and 47 in 2014 and 2015 combined. Industry spokesman, Russ McDaid, president of the PA Health Care Association and Center for Assisted Living Management, said the heavier sanctions are a financial strain on operators but are not likely to produce better outcomes for residents. However, advocate for the elderly, Sam Brooks, attorney at Community Legal Services, welcomes the change as a signal that the days of lax oversight are over. [Read More](#)

Jersey Shore Hospital to Merge with Geisinger Health System. Jersey Shore Hospital, the only remaining independent hospital in Lycoming County, Pennsylvania, signed a letter of intent to merge with Geisinger Health System. The other three hospitals in Lycoming County, were part of Susquehanna Health and now UPMC. Under terms of the deal, Geisinger will take on Jersey Shore's assets, revenue and debt. The hospital's name will also likely be changed to Geisinger Jersey Shore Hospital, and it will be the smallest hospital in the system. Jersey Shore Hospital is a 25-bed critical access hospital with 300 employees that primarily serves western Lycoming County and eastern Clinton County. Geisinger officials would not say if the move was related to UPMC's expansion eastward, but talked instead about the increased options patients will have. The intended merger with Jersey Shore was announced just one week after Geisinger struck a joint venture with Highmark Health to expand access to its services throughout north central Pennsylvania. The deal

is subject to regulatory approval and is expected to take a few months. [Read More](#)

Washington

HCA Awards Fully Integrated Managed Care Contracts for North Central Region. It was reported on *State of Reform* on May 23, 2017, that the Washington Health Care Authority (HCA) has awarded contracts for the Fully Integrated Managed Care (FIMC) Mid-Adopter RFP for the North Central region to Molina Healthcare, Coordinated Care of Washington (Centene), and Anthem's Amerigroup. Implementation is scheduled begin January 1, 2018. The state will also announce successful bidders for the Behavioral Health Administration Services Organization (ASO) RFP on June 9, 2017. MCOs will work closely with the ASO to fully integrate physical and behavioral health services. There are around 66,000 members in the North Central region covered under this RFP. [Read More](#)

National

CBO Publishes Score of AHCA Bill as Passed. On May 24, 2017, the Congressional Budget Office (CBO) released the cost estimate on H.R. 1628, the American Health Care Act of 2017 (AHCA), as passed by the House of Representatives on May 4, 2017. The estimates detail budgetary and enrollment impacts of the bill over the 2017 to 2026 time period. The CBO projects that 23 million will be uninsured by 2026 as compared to the current baseline estimates, with 14 million more uninsured in 2018. Medicaid enrollment is projected to be 14 million less than the current baseline by 2026, while Medicaid expenditures over the ten-year period are projected to decrease by \$834 billion, with an overall reduction of \$119 billion to the federal deficit. The CBO estimates that by 2020, one-sixth of Americans will reside in states that waive provisions such as essential health benefits and lifetime coverage limits, resulting in healthier individuals purchasing nongroup coverage with relatively low premiums. However, CBO also finds that community-rated premiums would likely rise over time, and "people who are less healthy (including those with preexisting or newly acquired medical conditions) would ultimately be unable to purchase comprehensive nongroup health insurance at premiums comparable to those under current law, if they could purchase it at all." [Read More](#)

President's Budget Proposal Reduces Medicaid Funding by \$610 Billion Over Next Decade. *The Hill* reported on May 22, 2017, that President Trump's 2018 budget proposal, titled "A New Foundation for American Greatness," includes significant cuts to health care and other safety net programs, including Medicaid, Social Security for individuals with disabilities, and nutrition assistance. The President's budget would reform Medicaid into either a capped per-capita or block grant structure, reducing federal Medicaid expenditures by \$610 billion over the 2018 to 2027 period. The budget also cuts \$192 billion from nutritional assistance and \$272 billion from other safety net programs, including more than \$72 billion to disability benefits. [Read More](#)

Republican Senators Fight to Preserve Medicaid as President's Budget Proposes Major Cuts. *Politico* reported on May 23, 2017, that President Trump's proposed budget cuts to Medicaid undermine the negotiating

position of a number of Republican Senators who are fighting to preserve Medicaid. By reducing Medicaid funding, the President has aligned the administration with fiscal conservatives, mostly from non-expansion states, who want to constrain the Medicaid program. Trump's budget proposal includes ending Medicaid's entitlement status, capping funding, and adding a strict limit on the growth of federal funding. Several fiscal conservatives said that the President's budget plan was in line with their own ideas for Medicaid reform. Meanwhile, over a dozen Republican Senators have been meeting with state governors to discuss how to preserve Medicaid. [Read More](#)

State Medicaid Directors Say Major Medicaid Changes Unlikely Under Trump Administration. *Modern Healthcare* reported on May 23, 2017, that state Medicaid directors have said it is unlikely there will be major changes to Medicaid under President Trump's administration. The President's budget proposal would cut more than \$600 billion from Medicaid over 10 years. However, many lawmakers have said the budget is unlikely to gain any traction in Congress. Joe Moser, the former Indiana Medicaid Director, believes there will be a stalemate on major reform and states will push back on major cuts. He also believes the Centers for Medicare & Medicaid Services will offer states more flexibility in their Medicaid programs. [Read More](#)

State Governors Push Their Own ACA Replacement Proposal. *The New York Times* reported on May 17, 2017, that about a dozen state governors, led by Ohio Governor John Kasich, are pushing their own Affordable Care Act replacement proposal to U.S. Senators. The proposal calls for a continuation of Medicaid expansion and limits on federal spending for certain populations. Governor Kasich stated that the House American Health Care Act is inadequate and would leave millions of people without affordable coverage. [Read More](#)

Trump Administration, House Republicans Ask for 90-Day Extension on Exchange Subsidies Decision; BCBS Plans Release Blueprint on Market Stability. *The Washington Post* reported on May 22, 2017, that the Trump administration and House Republicans have asked a federal appeals court for a 90-day extension in a case involving the future of \$7 billion in insurer cost-sharing subsidies for Exchange plans. The subsidies help keep copays and deductibles down for low-income individuals. Meanwhile, the BlueCross BlueShield Association released a blueprint for market stability hours before the extension was filed. The blueprint asks for continued protection for individuals with preexisting medical conditions and sustained funding to offset their cost, as well as continued safeguards for consumers, including no lifetime caps, no premium discrimination based on gender, and a required 80 percent medical loss ratio. The blueprint also encourages continued tax penalties for not having insurance and continued insurer subsidies. [Read More](#)

Democratic Attorneys General Move to Protect ACA Subsidies for Health Plans. *Reuters* reported on May 18, 2017, that Democratic attorneys general have filed a motion aimed at protecting subsidy payments made to insurance companies under the Affordable Care Act. The motion to intervene was filed in a lawsuit brought by the U.S. House of Representatives against former-President Barack Obama's administration to block the subsidies, which help insurance companies reduce deductibles and co-pays for eligible individuals. In 2016, a judge ruled in favor of the House; the Obama administration appealed, and the case was put on hold before the 2016 Presidential election. [Read More](#)

Senators Propose Easing Restrictions on Medicaid Reimbursement for Substance Use Treatment. *Politico* reported on May 18, 2017, that a group of six U.S. Senators have introduced legislation to ease federal restrictions on Medicaid reimbursement for substance use disorder (SUD) treatment centers. The bill would allow centers with up to 40 beds to receive reimbursements from Medicaid for stays of up to 60 consecutive days. Under current law, institutions for mental disease, commonly known as IMDs, are banned from receiving Medicaid reimbursements at facilities with more than 16 beds. Senators Dick Durbin (D-Illinois), Rob Portman (R-Ohio), Sherrod Brown (D-Ohio), Shelley Moore Capito (R-West Virginia), Angus King (I-Maine), and Susan Collins (R-Maine), who introduced the bill, are from states that have been hit hard by the opioid addiction epidemic. [Read More](#)

CMS Opens Second Round of Applications for CPC+ Health Home Model in Four States. *AHA News* reported on May 17, 2017, that the Centers for Medicare & Medicaid Services (CMS) announced it will accept a second round of applications from eligible physician practices in Louisiana, Nebraska, North Dakota, and the Buffalo, New York, region to participate in the Comprehensive Primary Care Plus (CPC+) multi-payer primary care medical home model, which runs from 2018 to 2022. Round one began this year in 16 states, involving 53 payers and 2,891 physician practices. CPC+ seeks to promote value and quality through alternative payment models and involves partnerships between practices and health plans. [Read More](#)

Medicaid Innovation Accelerator Program National Webinar Scheduled for June 6, 2017. Through the Medicaid Innovation Accelerator Program's (IAP), 2016 State Medicaid-Housing Agency Partnerships Track, eight states received technical support to develop partnerships between state Medicaid agencies and their state housing systems. IAP worked closely with the US Department of Housing and Urban Development; the Substance Abuse and Mental Health Services Administration; the Office of the Assistant Secretary for Planning and Evaluation; and the US Interagency Council on Homelessness to plan and coordinate the technical support offered. Over the next year, IAP will hold a series of webinars to share insights gleaned from the 2016 Partnerships Track states and to share lessons learned that all state Medicaid and housing agencies can apply as they work to foster collaborative partnerships. The first webinar to be held on June 6, 2017, 2:30 pm - 4:00 pm ET, will provide webinar attendees with examples of lessons from two of the state Medicaid agency and housing agency partnerships that participated in the 2016 Partnerships Track. Medicaid agency and housing agency partners from New Jersey and Oregon will discuss how they developed their partnerships, share examples of their accomplishments, and describe how they have addressed challenges in working across Medicaid and housing agencies. *HMA is one of several organizations working as a subcontractor under a Center for Medicaid and CHIP Services (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 Research

Medicaid Expansion Improved Health, Access to Care, Study Finds. *Los Angeles Times* reported on May 17, 2017, that health care access and self-reported health improved for low-income individuals in states that expanded Medicaid, according to a *Health Affairs* [study](#). The study found that individuals in expansion states were more likely to receive regular check-ups and ongoing care for chronic conditions, compared to those in states that have not expanded Medicaid. [Read More](#)



INDUSTRY NEWS

Steward Health Care, IASIS Healthcare to Merge. Steward Health Care LLC and IASIS Healthcare LLC announced on May 19, 2017, a definitive agreement to merge, a deal that will make Steward the largest private, for-profit hospital company in the United States, with 36 hospitals. Steward currently operates in Massachusetts, Ohio, Florida, and Pennsylvania while IASIS operates in Utah, Arizona, Colorado, Texas, Arkansas, and Louisiana. Steward will also begin managing IASIS Health Choice managed care operations. The deal is expected to close in the third quarter of 2017. [Read More](#)

Care Advantage Acquires Stay at Home Personal Care. *Richmond Times-Dispatch* reported on May 19, 2017, that Virginia-based Care Advantage, a home health care services provider, acquired Stay at Home Personal Care on May 8, 2017. The acquisition adds three locations - Norfolk, Hampton, and Christiansburg - and six new counties of coverage for Care Advantage. Financial terms were not disclosed. [Read More](#)

Community Health Systems Rejects \$2.4 Billion Buyout of Fort Wayne, IN Hospitals. *Modern Healthcare* reported on May 22, 2017, that Community Health Systems (CHS), the second-largest investor-owned hospital operator, has rejected Fort Wayne Physicians' \$2.4 billion buyout of Lutheran Health Network, which consists of CHS's most profitable hospitals, citing that the offer was short at least \$1 billion. CHS has been divesting select hospitals as part of a strategy to reduce their \$15 billion debt, and Fort Wayne Physicians approached the company in November of last year regarding the potential buyout of their eight Fort Wayne hospitals. CHS announced a \$500 million capital-spending program to upgrade Fort Wayne's facilities and equipment last week at their annual shareholder meeting. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
May 22, 2017	Washington (FIMC - North Central RSA)	Contract Awards	66,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
June 15, 2017	Delaware	Proposals Due	200,000
June 30, 2017	Illinois	Contract Awards	2,700,000
June, 2017	Oklahoma ABD	Contract Awards	155,000
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 10, 2017	Delaware	Contract Awards (Optional)	200,000
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	Delaware	Implementation (Optional)	200,000
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

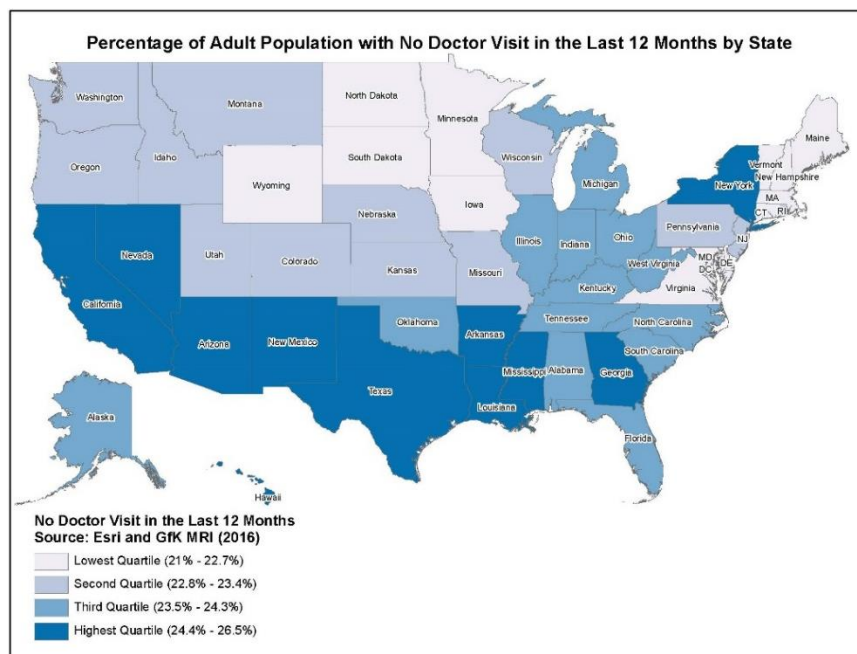
HMA’s Lori Raney, MD, and Gina Lasky, PhD, MAPL, Edit Book that Serves as Guide for Implementing Integrated Care

Integrated Care: A Guide for Effective Implementation is co-edited by HMA’s Lori Raney, MD, and Gina Lasky, PhD, MAPL, and Collaborative Care Consulting’s Clare Scott, LCSW. The book provides a detailed, thoughtful, and experience-based guide to effective implementation of integrated behavioral healthcare. Using evidence and on the ground experience, the authors share practical and actionable advice for a complex model of care. The book is organized into three sections: design elements and organizational readiness, changing practice as a provider, and operational considerations, including policy and performance measurement. Additionally, HMA’s Gaylee Morgan, Rob Werner and Kristan McIntosh co-authored a chapter on financing integrated care programs.

Integrated Care: A Guide for Effective Implementation is available for purchase through American Psychiatric Association Publishing (APPI). To purchase the book, visit the [APPI website](#). For more information or to provide feedback, email the HMA co-editors at lraney@healthmanagement.com and glasky@healthmanagement.com.

HMA Weekly Informatics Series Continues

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 seventh map in the series highlights data on **the percentage of the adult population with no doctor visit in the last 12 months by state**. Irregular and unreliable access to health services has been shown to adversely affect an individual’s health and well-being.



What does your service area look like? HMA can drill down to county, zip code, or census tract - adding to the depth and breadth of knowledge around the health indicators affecting your community. For more information, contact **Anissa Lambertino** at alambertino@healthmanagement.com or (312)641-5007.

HMA WELCOMES...

Scott Ackerson, Principal - San Antonio, Texas

Scott comes to HMA most recently from the Center for Healthcare Services where he served as Vice President of Community Transformation Services. In this role, Scott provided administrative and programmatic oversight over Center for Healthcare Services homeless services, including supportive housing, addiction and mental health recovery programs. He was tasked with fully integrating Haven for Hope and Center for Healthcare Services programs on the Haven for Hope Campus. He simultaneously served as Vice President of Strategic Relationships for Haven for Hope of Bexar County, where he coordinated services and resources among Continuum of Care organizations. Scott developed and implemented a community-wide strategic housing plan and led local, statewide and national advocacy for homeless services.

As Chief Program Officer at San Antonio Metropolitan Ministries, Inc. (SAMMinistries), Scott was responsible for management of all programs, including 350 bed emergency shelter, 40 family residential facility and two scattered site housing programs. He developed programming in response to emerging community needs including additional housing and prevention programs and was responsible for oversight of all continuous quality improvement and quality assurance processes for residential services.

Additional roles Scott has held include Vice President of Residential Services for The Children's Shelter and Community Program Director with Casey Family Programs. Additionally, Scott has worked at several different residential treatment centers for children in both California and Minnesota. He is currently an Adjunct Professor of Social Work at Our Lady of the Lake University and serves on several non-profit boards in the community.

He received a Master of Social Work degree from Our Lady of the Lake University and his Bachelor of Social Work degree from St. Cloud State University in Minnesota. Scott is a Licensed Master Social Worker.

Trudi Carter, M.D., Principal - Costa Mesa, California

Trudi comes to HMA most recently from L.A. Care Health Plan where she served as Chief Medical Officer. In this role, Trudi worked closely with the leadership team to develop and implement strategies and initiatives to ensure quality healthcare delivery to all of L.A. Care's million plus members - some of the most vulnerable in the county. She oversaw the medical leadership of the organization and focused on enhancing access and the quality of care provided through contracted plans and providers.

Prior to L.A. Care, Trudi served as Chief Medical Officer at CalOptima, a public health plan and the second largest insurer in Orange County, where she spearheaded several innovative programs that focused on care delivery for special populations including children with special health care needs, end stage renal disease, and high risk members. She also led quality efforts that resulted in the organization achieving four stars performance for the Special Needs Plan, top quality performance for the Medi-Cal plan, and outstanding quality performance in the Healthy Families program.

Prior to her position at CalOptima, Trudi served as Chief Medical Officer for Schaller Anderson, Inc., a national healthcare management and consulting

company that administers Medicaid health plans. Early in her career, she held director and officer level roles at Catholic Healthcare West, Schaller Anderson, MedPartners, Mullikin Medical Centers and Hawthorne Community Medical Group (HCMG). She was also a board certified practicing pediatrician at HCMG.

Trudi received her M.D. from Johns Hopkins Medical School and completed her internship and residency in pediatrics at Children's Hospital of Pittsburgh. She earned her Bachelor of Science degree in Chemistry from Howard University and received a Graduate Certificate in Medical Management from the University of Southern California, Los Angeles.

Flint Michels, Principal – Phoenix, Arizona

Flint comes to HMA most recently from Wellframe where he served as Vice President of Business Development. In this role, Flint was an operational consultant for care management workflow. He also served as a Clinical Liaison and was the primary contact to the Western US market where he oversaw new client engagement with payers, providers and other entities. Prior to Wellframe, Flint served as Vice President of National Sales with Imagine Health where he created the sales process in a dynamic and rapidly expanding organization. He built strategic relationships directly with prospective clients, as well as channel partners such as consultants.

Flint previously served in a variety of roles with United HealthGroup – Optum (Ingenix) and AmeriChoice – over an 11-year span. As Area Vice President of Optum Analytics and Accountable Care Solutions, Flint was charged with the strategic selling of a broad-scale analytic platform, including predictive modeling, cost, quality, and utilization reporting and benchmarking. As Vice President of Strategic Solutions and Specialty Networks at Optum, Flint led the strategic selling of physical health, behavioral health, and complex medical care networks which combine large discount networks and comprehensive UM and care management services.

Additional roles Flint has held include Symmetry National Sales Director with Ingenix, Director of Implementation with AmeriChoice Management Services Organization, Senior Consultant with Mercer Government Human Services Consulting, Medical Case Manager and Workers Compensation Case Manager with VRI/Managed Care Montana, and Staff Nurse at Banner (Valley Lutheran) Hospital and the Billings Clinic (Deaconess Medical Center).

Flint received his Master of Business Administration degree and his Master of Health Administration degree from Arizona State University. He received his Bachelor of Arts degree in Nursing from Carroll College.

Jeremy Martinez, Senior Associate (HMACS) – Atlanta, Georgia

Jeremy comes to HMA most recently from the American Cancer Society (ACS) where he served as the Project and Program Manager of Evaluation Research. In this role, Jeremy advised on program structure and procedures, data metrics and funding structures. He developed data capture processes to facilitate ongoing evaluation for continuous process/project improvement. Additionally, he served as the Lead Evaluator for Creating a National Network of Partners to Promote Cancer Prevention through Human Papillomavirus (HPV) Vaccination, a joint effort between ACS and the CDC.

Prior to ACS, Jeremy served as a Senior Associate with ICF International where he worked on various public health evaluation projects ranging from children's oral health promotion; HIV/AIDS prevention efforts; child abuse and neglect prevention; suicide, bullying and violence prevention; and youth with serious emotional disturbances. For a majority of these projects, Jeremy was the Data Collection Team Lead managing other data collection liaisons.

Jeremy previously held the position of Youth Suicide and Violence Prevention Coordinator with the Colorado Department of Public Health and Environment where his responsibilities included coordinating CDC and SAMHSA grants to reduce youth suicide and violence and providing technical assistance to statewide grantees concerning evidence-based and promising practice interventions.

Jeremy earned his Master of Arts degree in Sociology from the University of Colorado, Denver. He received his Bachelor of Arts degree in Sociology with a minor in American Sign Language/Deaf Studies from Maryville College.

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

<http://healthmanagement.com/about-us/>

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.