HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 7, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

TEXAS BUDGET AND HEALTH CARE LEGISLATION SUMMARY - 2017

This week, our *In Focus* section comes to us from HMA Principal Dianne Longley, of our Austin, Texas, office. Dianne provides an update on and summary of the Texas Legislature's adoption of a state fiscal year (SFY) 2018-2019 budget, as well as a review of health care legislation passed by the Legislature this session.

Texas Legislature Adopts SFY 2018-2019 Budget

The Texas Legislature adjourned May 29, 2017, after adopting a $217 billion (all funds) two-year budget, reflecting a 0.2 percent increase over the current 2016-17 biennial budget. The budget includes $106.7 billion in general revenue, which must be certified by the State Comptroller. Legislative budget leaders estimate the legislature will face a $1 billion shortfall when they reconvene in 2019. The budget is estimated to be as much as six percent lower than the prior biennium when considering inflation costs and population growth. The Texas state fiscal year (SFY) begins September 1 and ends August 31. Funding for Medicaid includes $64.2 billion in all funds, a reduction of $1.9 billion from SFY 2016-2017 (including a reduction of $0.4 billion in GR funds). Funding includes:

Funding Category	SFY 2017-18	Decrease from SFY 2016-17
Medicaid Client Services	$57.4 billion	$1.3 billion
Other Programs supported by Medicaid Funding	$1.7 billion	$0.1 billion
Medicaid Program Administration	$3.3 billion	$0.6 billion
Total	**$64.2 billion**	

One of the biggest Medicaid compromises resolves differences between the Senate and House versions of the budget for funding to reinstate pediatric therapy rate cuts for services for children with developmental disabilities. The final budget restores 25 percent of the Medicaid pediatric therapy rate cuts which were enacted earlier this year as required by the 2015 Legislature. The House budget had included funds for a 50 percent rate restoration, and the Senate version included no rate increase. HHSC is required to monitor changes in the availability of therapy providers and notify the Legislature if covered children are unable to access covered services as a result of the rate cut. Following is additional information on funding details:

- The budget includes funds for Medicaid caseload growth in 2018, but provides no funds for FY 2019 caseload growth. While the Legislative Budget Board (LBB) has not yet released projections for unfunded amounts, earlier projections estimated costs associated with caseload growth at $700 million in General Revenue (state funds) for the biennium. HHSC previously estimated the two-year cost of enrollment growth plus inflation could be as high as $1.9 billion. The budget is based on a projection that full-benefit Medicaid caseloads will increase by approximately 80,000 enrollees over the two-year period.
- The budget includes no funding for projected cost growth per Medicaid participant for 2018 or 2019.
- Funding for CHIP client services includes 2.0 billion in All Funds, an increase of $156.3 million in funding due to projected caseload growth and maintenance of FY 2017 premium levels without any increase in per enrollee costs.
- The budget includes funding for an additional 735 enrollees in the Home and Community-based Services (HCS) waiver by the end of 2019. An additional 276 enrollment slots are included for children in Child Protective Services custody who are expected to require Long

Term Supports and Services (LTSS). All other funding for long term care waivers is maintained at the August 2017 level, which is the first time in 10 years the legislature has failed to appropriate funds to reduce waiver "interest" (i.e., wait) lists.

- Funding for the Texas Integrated Eligibility Redesign System (TIERS) includes $392.6 million (all funds), reflecting an increase of $0.6 million in total spending from 2016-17. Note: Rider 152 specifies that of these budgeted funds, $114.4 million must be spent for capital enhancements and maintenance; HHSC must also provide a quarterly report detailing spending and progress towards implementing the TIERS project.

Behavioral Health Funding

- Spending for behavioral health (BH) services for the biennium is estimated at $3.5 billion for Medicaid, and $48.7 million for CHIP.
- Funding for non-Medicaid/CHIP behavioral health totals $4.0 billion. This includes funding for programs across 18 agencies, and includes inpatient client services at state hospitals and community hospitals; outpatient services provided through Local Mental Health Authorities; Substance Abuse prevention, intervention, and treatment services, mental health care and substance abuse treatment for incarcerated individuals; mental health care for veterans, and other services.
- Funding includes $62.6 million for the biennium to address waitlists for community mental health services for adults and children, and an additional $69.0 million in General Revenue contingency funding for several bills that would provide grants to community organizations for BH services and peer supports. The budget also includes $10.3 million to increase maximum security forensic bed capacity, and $366 million for new construction and maintenance at state hospitals and other inpatient mental health facilities.

The Legislature also enacted separate supplemental legislation (House Bill 2) to close the gap for unmet costs expected for the current fiscal year. HB 2 funding includes $794 million to address the Medicaid shortfall, which will bring in an additional $1.6 billion in federal funds. Based on estimated growth projections and funding, the Center for Public Policy Priorities estimates the 2018-19 Medicaid shortfall will be at least $1.2 billion when the Legislature returns in 2019.

Budget Riders

The Appropriations legislation for the Health and Human Services Commission also includes more than 230 "riders" that address additional requirements related to program operations, funding, and budget guidance. For example, budgeted Medicaid funding levels assume $1 billion in cost containment for Medicaid client services based on budget riders that reduce the risk margin for Medicaid managed care organizations and that direct HHSC to contain costs through a variety of specific actions. Following is a summary of some of the more significant Medicaid riders.

- *Rider 5 – Cost Comparison Report*: requires HHSC to analyze and report on residential and nonresidential services in HCS, Texas Home Living, and Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions. The report must include detailed

cost analysis across facilities and based on types of coverage and services. The report is due no later than August 31, 2018.

- *Rider 8 – Additional Funding Sources, Medicaid*: if the appropriations for Medicaid are insufficient to meet mandated services, the LBB and Governor are authorized to transfer funds as necessary to HHSC.
- *Rider 13 – Local reporting on DSH, Uncompensated Care, DSRIP, and Indigent Care Expenditures*: requires HHSC to develop a report that non-state public hospitals, private hospitals, hospital districts, physician and private administrators use to describe any expenditures they make through the Disproportionate Share Hospital (DSH) program, the Uncompensated Care (UC) Pool, the Delivery System Reform Incentive Payment (DSRIP) Pool and the Indigent Care Program. The report must include expenditures by method of finance per year. HHSC also shall require contracted hospital providers to report payments to entities who provide consultative services regarding revenue maximization under the medical assistance program, UC, DSRIP and DSH.
- *Rider 16 – Dental and Orthodontia Providers in the Texas Medicaid Program*: requires HHSC to strengthen the capacity of the HHSC Office of Inspector General to investigate and prosecute abuse by dentists and orthodontists, and conduct more extensive reviews of medical necessity for orthodontia services in the Medicaid program.
- *Rider 21 – Report on Pay for Quality Measures*: requires HHSC to evaluate how Managed Care Organizations (MCOs) use pay for quality measures to improve health care and whether these initiatives are successful. A report is due to the Legislature no later than October 1, 2018 and must include recommendations for improving current pay for quality measures, areas requiring additional studies, and how the findings could be used to expand pay for quality measures into outpatient settings.
- *Rider 29 – Medicaid Substance Abuse Treatment*: requires HHSC to evaluate spending on substance abuse services and submit a report by December 1, 2017.
- *Rider 34 – Medicaid Funding Reduction and Cost Containment*: requires HHSC to implement cost containment measures that will reduce Medicaid spending by $830 million from all funds ($350 million in General Revenue). The Rider includes 18 initiatives that can be used, including increasing Fraud, Waste, and Abuse collections; evaluating reimbursement for dual eligibles; reviewing utilization and rates for durable medical equipment; strengthening and expanding prior authorization and utilization reviews; and implementing fee-for-service payment and MCO premium adjustments that incentivize the most appropriate and effective use of services. It also includes an option to identify and execute savings by conducting an independent audit of MCO premiums every two years; evaluating trend factors; and using a competitive procurement process with price as one component of the procurement evaluations. HHSC is required to submit a plan to the LBB to implement cost containment initiatives by December 1,

2017. The plan must include an analysis of initiatives determined not to be cost effective.

- *Rider 157 – Medicaid Provider Enrollment Portal*: contingent upon submitting a plan to the LBB and the Governor, HHSC will receive an additional $30 million in SFY 2019 to develop a centralized Medicaid provider enrollment portal.
- *Rider 158 – Managed Care Risk Margin*: the approved budget includes a reduction of $182.6 million based on HHSC reducing the risk margin in managed care premiums from 2.0 percent to 1.5 percent for STAR and STAR Health, and from 2.0 to 1.75 percent for STAR+PLUS and STAR Kids. An additional reduction of $11 million is included based on HHSC reducing the risk margin in CHIP managed care premiums from 2.0 percent to 1.5 percent.
- *Rider 167 – Office of Inspector General: Managed Care Organization Performance, Reporting Requirement:* requires the Office of Inspector General (OIG) to review cost avoidance and waste prevention activities used by MCOs to prevent waste; the OIG must submit a report on its findings to the LBB and Governor by March 2, 2018, and provide recommendations for performance measures related to cost avoidance and waste prevention activities that should be applicable to all MCOs.
- *Rider 175 – Managed Care Organization Services for Individuals with Serious Mental Illness*: requires HHSC to develop performance metrics to hold MCOs accountable for care of enrollees with serious mental illness. Metrics should include performance measures for integrated care, jail and emergency department diversion, integration of care and enhanced cost control HHSC must submit a report no later than November 1, 208 detailing performance metrics.
- *Rider 180 – Hospital payments*: the budget includes $356.9 million in SFY 2018 and $357.7 million in SFY 2019 to provide Medicaid hospital add-on payments for trauma care, safety net hospitals and rural hospitals. To the extent possible, HHSC shall ensure any funds identified in the rider that are included in Medicaid managed care capitation rates are distributed by the MCOs to the hospitals.
- *Rider 202 – Evaluation of Rural Hospital Funding Initiatives*: requires HHSC to evaluate Medicaid funding initiatives for rural hospital services and submit a progress report by August 1, 2018, and a final report by August 1, 2019. The study must include determining the percentage of estimated allowable hospital costs reimbursed by payments for services providers provided to managed care clients; the percentage of wrongful denials; the average wait tine for final payment; and any remedies taken by HHSC to improve vendor compliance.
- *Rider 205 – Operational and Administrative Efficiencies related to Technology and Electronic Visit Verification*: requires HHSC to review technology usage and Electronic Visit Verification (EVV), including opportunities to improve operational efficiencies and general cost savings; strategies to improve collection and maintenance of accurate contact information for individuals receiving services; and strategies to

streamline the administrative requirements imposed on health providers using EVV. HHSC must submit a report no later than March 31, 2018.

- *Rider 212 – Texas Medicaid Pre-term Births and Low Birthweight Births*: requires HHSC to work with the Comptroller of Public Accounts and the Legislative Budget Board to study opportunities for Medicaid savings from increasing the minimum legal age for access to tobacco products from 18 to 21.
- *Rider 214 – Exemption from waiver Rate Reduction*: exempts providers of consumer directed services from rate reductions for supported home living services in the HCS waiver and Community Support Services in the Texas Home Living waiver.
- *Rider 215 – Medicaid Therapy Services Reporting*: requires HHSC to track and report information related to access to pediatric therapy services. Information must include complaint data received by HHSC and by MCOs, the number of therapy provider terminations, the utilization of therapy services, the number of members on wait lists due to an insufficient network, and the number of providers no longer accepting new clients and the reason. Reports are due quarterly to the LBB and the Governor beginning December 1, 2018.
- *Rider 218 – Adjustment of Therapy Rate Reductions*: provides funds to restore 25 percent of the reductions made to reimbursement rates for acute care therapy services during the 2016-17 biennium. Also includes funds to phase in and delay the planned reduction of rates for therapy assistants. Reductions will not begin until December 1, 2017 and rates will remain at 85 percent of the rate paid to a licensed therapist until September 1, 2018, when rates will be reduced to 70 percent of the rate paid to a licensed therapist.
- *Rider 219 – Prescription Drug Benefit Administration in Medicaid, CHIP, and Other Health-Related Services:* requires HHSC to study potential cost savings achieved from a single statewide claims processor to deliver drug benefits in the Medicaid, CHIP, Women's Health, Children with Special Health Care Needs (CSHCN), and Kidney Health Care programs; reduction of the Affordable Care Act Health Providers Fee, guaranteed risk margin, and administrative services fees from decreasing capitation related to pharmacy benefits; and transitioning to a pricing methodology based on National Average Drug Acquisition Cost with a professional dispensing fee.
- *Rider 220 – Evaluation of Medicaid Managed care*: 1) requires HHSC to contract with an independent organization to conduct a comprehensive evaluation of Medicaid managed care. The evaluation must include a review of the delivery system, assessment of the performance of managed care including analysis of costs, cost savings, cost trends, the impact of caseload growth, cost containment initiatives, and contractual mandates, and how cost trends in Texas compare to other states. The report must include recommendations on additional operational efficiencies, delivery system reforms, and cost containment initiatives. 2) Requires HHSC to evaluate the contract management and oversight function for Medicaid and CHIP managed

care contracts and consider existing contract requirements and enforcement, including penalties, and the need for additional training and resources for effective contract management. 3) Requires HHSC to conduct a study of Medicaid managed care rate setting processes and methodologies in other states. 4) requires HHSC to conduct an audit of administrative expenditures made by managed care organizations in Medicaid and CHIP, and use the audit to identify opportunities for savings. Findings are to be reported to the Governor, LBB, and legislative committees not late than September 1, 2018.

Links to applicable budget documents used in developing this summary are available at: http://www.lbb.state.tx.us/budget.aspx

Texas State Legislation Summary

In addition to the state biennial budget, the Legislature enacted numerous legislative proposals that impact public and private insurance plans. Not all enacted bills have been signed by the governor. The Governor has 10 days after receipt of a bill to sign or veto a bill, or allow it to become law without signature. For bills sent to the governor within 10 days of final adjournment (May 29th), the governor has until 20 days after adjournment (June 18th) to sign or veto a bill, or allow it to become law without signature. Links to all legislation are available at: http://www.legis.state.tx.us/MnuLegislation.aspx

Enacted Senate Legislation:

- *SB 74* – BH Services Access: Expands the authorization of a Medicaid/CHIP provider enrolled in a managed care organization to provide behavioral health services to provide targeted case management and psychiatric rehabilitative services to children, adolescents, and their families, as a means of expanding access to certain services.
- *SB 507* – Balance Billing: Expands the balance billing mediation process for commercial health plans to include all physicians and other providers that provide out-of-network services at certain in-network facilities.
- *SB 680* – Medicaid Step Therapy: Authorizes physicians to override health plans' step therapy protocols, enabling patients to continue receiving effective medication.
- *SB 894* –MCO Audit Oversight: Imposes several requirements intended to improve HHSC's oversight and use of audit resources for monitoring MCO compliance and operations. Includes changes to the electronic visit verification system and strategies for verifying the accuracy of program and financial information reported by Medicaid managed care organizations.
- *SB 922* – Telemedicine: requires HHSC to ensure that Medicaid reimbursement is provided to a public-school district or open-enrollment charter school for telehealth services provided through the district or charter school by a health professional, even if the health professional is not the patient's primary care provider.
- *SB 1107* - Telemedicine: Establishes a statutory definition for telemedicine and provides that the standard of care for a traditional, in-person medical setting also applies for telemedicine services.

Clarifies that telemedicine is not a distinct service but a tool physicians can use. Prohibits health plans from excluding telemedicine from coverage solely because it isn't provided in-person.

- *SB 1148* – Maintenance of Certification: With a few exceptions, prohibits the state from using Maintenance of Certification (MOC) as a requirement for state licensure or renewal, or insurance participation; prohibits certain hospitals and health facilities, and managed care plans from using MOC to differentiate among physicians for payment, contracting or credentialing.
- *SB 1462* – Local Health Care Funding Programs: Enacts several provisions related to the funding of local health care districts, county healthcare provider participation programs, and municipal health care provider participation programs, including requirements related to the funding of intergovernmental transfers and funding of Medicaid supplemental payment program payments.
- *SB 2087* – Temporary Health Risk Pool: Authorizes the Commissioner of Insurance to establish and administer a temporary health insurance risk pool with federal funds, to the extent those funds become available.

Enacted House Legislation

- *HB 10* – Access to Behavioral Health Services: Increases the Texas Department of Insurance's authority to enforce existing mental health parity law and creates a BH ombudsman to help consumers and providers navigate the BH health care system and benefits. Establishes a state mental health parity work group and clarifies benefits for mental health and substance use.
- *HB 490* – Cochlear Implant Coverage: amends the Insurance Code to require certain commercial health benefit plans to cover hearing aids and cochlear implants for individuals who are 18 years of age or younger.
- *HB 1036* –Mammography Benefits: Requires certain commercial insurance plans to include digital mammography and breast tomosynthesis coverage under annual breast cancer screenings for females 35 years of age or older
- *HB 1296* – Medication Synchronization: Requires certain commercial insurance plans to provide coverage for medications in cases where physicians, working in conjunction with the patient's health plan and the pharmacy, determine which medications should be aligned to properly treat chronic diseases. Eliminates barriers to medication synchronization by requiring health plans to prorate any cost-sharing amount charged for a prescription drug dispensed in a quantity that is less than the full amount as part of a recommended medication synchronization program, resulting in reduced upfront costs for patients.
- *HB 1600* – Mental Health Screenings for Adolescents: Authorizes Medicaid/CHIP payment for mental health screenings during each annual well-child exam. Currently, payment for applicable screening

medical codes is authorized only once between the ages of 12 and 18 for each adolescent.

- *HB 1629* – HIV Viral Loads Quality Oversight: Requires HHSC to adopt Medicaid/CHIP quality measures related to ensuring persons with HIV maintain a low viral load, thus improving the health of individuals with HIV and reducing the transmission of HIV.
- *HB 1917* – Medicaid Vendor Drug Program: Retains the Medicaid Preferred Drug List (PDL) under HHSC oversight, delaying until 2023 previous plans to put the PDL under the oversight of managed care organizations.
- *HB 2379* – Fraud, Waste and Abuse: Enacts numerous changes to the FWA program oversight and penalty payments.
- *HB 2590* – LTSS Administrative Amendments: Amends the appeal process for LTSS providers, to be consistent with the process for other providers participating in Medicaid waiver programs. Includes establishing an informal dispute resolution process for HCS and Texas Home Living (TxHmL). Grants HHSC the authority to use amelioration as a tool to assist providers with compliance, and allows a provider to use a portion of an administrative penalty toward compliance and program improvement.
- *HB 2466* – Maternal Depression Screening: Requires Medicaid/CHIP coverage of maternal depression screening for an enrolled child's mother during a covered well-baby visit or other office visit to a pediatric provider. Also allows pregnant women enrolled in Medicaid to sign up for texts, emails, or phone calls from their MCO to receive appointment reminders and health information to maintain a healthy pregnancy.
- *HB 3295* – LTSS Pilot Programs: Extends the statutory deadline by one year for pilot programs intended to test one or more service delivery models for long term services and supports under Medicaid managed care. The new expiration date is moved from September 1, 2018 to September 1, 2019, and is necessary to provide consistency with the 24-month period state law allows for program operations.
- *HB 3675* – Ophthalmology benefits: clarifies that patients covered by a Medicaid MCO have direct access to ophthalmologists and optometrists for non-surgical eye care services, without a requirement that the provider or the patient obtain prior authorization for those services. Clarifies that an ophthalmologist or an optometrist who joins an established practice may become a network provider for the MCOs with which the practice already has a valid contract. Allows institutions of higher learning with accredited ophthalmology or optometry training programs to contract with MCOs as network providers. Amends current law relating to the provision of eye health care by certain professionals and institutions as providers in the Medicaid managed care program.

Special Legislative Session Likely

Due to the failure to pass several key legislative proposals (including the Sunset legislation that authorizes continuation of the Texas Medical Board, the

licensing agency for medical providers), the Governor is expected to call a special session sometime this summer. Governor Abbot was expected to announce his decision last week, but has not yet done so. The special session will be limited to only those items specifically identified by the Governor.

HMA Medicaid Roundup

California

HMA Roundup – Julia Elitzer (Email Julia)

California Senate Approves Bill to Establish Single-Payer Health System. *AP News* reported on June 1, 2017, the California State Senate approved Senate Bill 562, which would establish a single-payer health system in California. According to the California Senate Committee on Appropriations, the system would cost the state $400 billion per year to operate, while additionally requiring the state to raise as much as $100 billion each year in new revenues. SB 562 is now under consideration in the State Assembly. Read More

Colorado

Governor Signs Medicaid Home Health, Conflict-Free Case Management Bills. The Colorado Department of Health Care Policy and Financing announced on June 5, 2017, that Colorado Governor John Hickenlooper has signed Senate Bill 17-091, which will allow Medicaid to cover home health services in the community effective July 1, 2017. The state's Medicaid Program, Health First Colorado, currently covers certain home health services in a member's place of residence. Hickenlooper has also signed HB 17-1343, a conflict-free case management bill that would allow Medicaid recipients to select the agency providing their case management services for home and community-based services. In Colorado, case management services and direct services have usually been provided by the same organization. Read More

Florida

Senate Drafting Legislation to Reduce Budget Cuts to Hospitals. *The Miami Herald* reported on June 6, 2017, that Florida Senate leaders are drafting legislation to restore half of the $200 million in hospital budget cuts recently approved by the House, according to a memo from Senate President Joe Negron (R-Stuart). The legislation, to be sponsored by Senator Anitere Flores (R-Miami), would require support in the House. Read More.

State Asks Judge to Dismiss Prisoner Arguments in Hepatitis C Lawsuit. *Health News Florida* reported on June 2, 2017, that Florida has asked a federal judge to dismiss arguments that the state violated the Americans with Disabilities Act (ADA) by not providing prisoners with certain hepatitis C treatment options. The lawsuit, which was filed by three inmates, claims the Florida Department of Corrections violated the ADA, the Rehabilitation Act, and the Eighth Amendment, which bars cruel and unusual punishment. The

motion would dismiss arguments under the ADA and the Rehabilitation Act, but not the Constitutional claim. Read More

Tampa General Hires Former CEO of Jupiter Medical Center. *Health News Florida* reported on June 5, 2017, that Tampa General has announced the hiring of John Couris, the former head of Jupiter Medical Center, as its new chief executive. Steve Short will continue to serve as the acting president and chief executive until September. Read More

Georgia

BCBS of Georgia to Limit ED Coverage for Exchange Plan Members. *The Atlanta Journal-Constitution* reported on May 31, 2017, that Blue Cross Blue Shield of Georgia (BCBS-GA) will limit coverage for emergency department (ED) visits for individual Exchange plans effective July 1 if the reason for the visit is not determined to be an emergency. The insurer will make the final decision on what constitutes an emergency based on "prudent layperson" criteria. The policy will not apply to children aged 13 and younger, members who do not have an urgent care clinic within 15 miles, or visits on Sundays and major holidays. BCBS-GA is the only Exchange insurer in 96 of Georgia's 159 counties. Read More

Illinois

Federal Judge Unlikely to Order Prioritized Medicaid MCO Payments. *Chicago Tribune* reported on June 6, 2017, that U.S. District Judge Joan Lefkow said she is unlikely to direct the Illinois State Comptroller to prioritize payments to Medicaid managed care organizations (MCOs). As previously reported, Medicaid MCOs have been pressing the Comptroller to prioritize $2 billion in overdue Medicaid payments, warning that further delays could jeopardize provider reimbursements. Lefkow is expected to issue a ruling in the next few days. Illinois faces a backlog of unpaid bills drive by an ongoing budget stalemate. Read More

Iowa

AmeriHealth Caritas, Mercy Health Network Reach Agreement on Northern Iowa Network. *Globe Gazette* reported on June 5, 2017, that the Mercy Health Network and AmeriHealth Caritas have reached an agreement to maintain access to Mercy's hospitals, clinics, and other health care facilities in Northern Iowa. As previously reported, AmeriHealth Caritas was working to renegotiate contract terms with Mercy by July 1 in order to guarantee continued access for approximately 213,000 members. Read More

Kansas

Legislature Passes HMO Fee Increase to Offset Medicaid Provider Cuts. *KCUR 89.3* reported on June 7, 2017, that the Kansas legislature has approved an increase in the state HMO fee, with funds going to offset previous cuts in Medicaid provider reimbursements and community mental health center funding. The bill, which now heads to Governor Sam Brownback's desk for

signature, would increase the HMO fee from 3.31 percent to 5.77 percent. In May 2016, Kansas cut Medicaid provider reimbursements by about $56 million to address a budget shortfall. Funding for community health centers is down about $20 million since 2007. Read More

Michigan

HMA Roundup – Esther Reagan (Email Esther)

Children's Medicaid Dental Care RFP Released. Michigan released a Request for Proposals (RFP) on May 12, 2017, for the state's Healthy Kids Dental (HKD) program, which would impact nearly 1 million children enrolled in Medicaid and the Children's Health Insurance Program (CHIP). The Michigan Department of Health and Human Services (MDHHS) is seeking to award risk-based contracts to two qualified statewide vendors. MDHHS may also consider awarding a third risk-based contract to a bidder serving Region 10, which consists of Wayne, Oakland, and Macomb counties. Proposals are due June 30, 2017. Following a two-month transition period in November and December of 2017, the new contracts will be implemented January 1, 2018. The contracts will be for a period of 35 months, with an option for five one-year renewals. The HKD program has been in place for several years to help ensure that children have access to dental care. The program was initially implemented in a few counties, gradually expanded geographically, and gained statewide coverage as of October 1, 2016. The current vendor is Delta Dental of Michigan.

As stated in the RFP, the HKD program is a key component of Michigan's comprehensive oral health plan. "Specific goals include:

1. Leveraging the HKD model to promote good oral health practices among the HKD population that result in:
    - Increased utilization of preventive Dental Services
    - Increased oral health education that emphasizes the importance of good oral health and practices
    - Decreased dental anxiety
2. Promoting a patient-centered approach that recognizes the importance of dental care in overall health care and promoting professional integration and coordination of care across provider types.
3. Increasing the number of dental providers participating in the HKD program.
4. Increasing access to oral health care.
5. Designing and implementing best practices for Dental Service delivery in dental care health shortage areas with limited dental providers.
6. Collaborating with community organizations and stakeholders resulting in partnerships that leverage existing dental programs (i.e. school based, dental clinics etc.).
7. Increasing education and Dental Service usage among Enrollees who are pregnant and Children with Special Needs."

Successful vendors will need to maintain a dentist-to-enrollee ratio of at least one full-time unique general dentist per 650 members with a minimum of 20 hours per week per practice location, with a few exceptions identified in the RFP. The vendors will be required to adhere to all applicable federal and state managed care rules and requirements. Read More

Nebraska

State Supreme Court Rules Medicaid Can Collect from Estates for Nursing Facility Room and Board. *McKnight's Long-Term Care News* reported on June 5, 2017, that the Nebraska State Supreme Court ruled that Medicaid can collect payment for skilled nursing facility room and board from the beneficiaries of a recipient's estate. The justices found "no distinction" between medical and room-and-board costs. As previously reported, the court found that the state does not profit from collecting such funds, but rather uses the money to pay costs owed to the federal government. Read More

Nevada

Legislature Passes Bill to Create Medicaid Buy-in Program. *Vox* reported on June 6, 2017, that the Nevada legislature passed a bill now awaiting Governor Brian Sandoval's approval that would allow any resident without health insurance coverage to "buy-in" to the state's Medicaid program. Assembly Bill 374, which passed both the state Assembly and Senate in the past week, would create the Nevada Care Plan, and direct the Nevada Department of Health and Human Services to seek any necessary federal waivers to implement the program and to contract with one or more insurers to provide coverage under the plan. The Nevada Care Plan would be available for purchase on the state's Exchange, with coverage identical to that provided under Medicaid fee-for-service, excluding the non-emergency medical transportation benefit. The bill's author, Nevada Assembly member Michael Sprinkle, stated there has not yet been an estimate on how much the Nevada Care Plan would cost per month, or whether members would have to meet a deductible or make copayments. The Governor has until June 16 to sign or veto the bill. Read More

Governor Vetoes Pharmaceutical Transparency Bill. *The Nevada Independent* reported on June 2, 2017, that Nevada Governor Brian Sandoval vetoed a pharmaceutical transparency bill that would have required drug manufacturers to disclose costs of producing and marketing diabetes drugs. The bill, which was aimed at lowering the cost of insulin, would have also required drug companies to disclose rebates and required pharmaceutical sales representatives to report details of interactions with doctors, including gifts. Governor Sandoval stated that the bill could lead to higher health care costs and may pose a risk to patients. The bill was sponsored by Nevada state Senator Yvanna Cancela (D-Las Vegas). Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey hospitals, Departments of Health and Human Services await CMS approval to extend Next Generation DSRIP. The Department of Health issued an update to DSRIP participants on May 25, 2017. The current 5-year DSRIP demonstration project is scheduled to conclude on June 30, 2017. The state's Department of Health and the Department of Human Services submitted a proposal to CMS to extend the current DSRIP project for two years, and then implement a 3-year DSRIP 2.0, which would begin July 1, 2019. CMS has acknowledged the importance of DSRIP and its funding in New Jersey, and has been open to discussions regarding an extension. Hospitals

have been informed that if they chose to discontinue DSRIP participation, there may not be an opportunity to rejoin the program. In addition, if CMS grants a DSRIP extension, activities to support the extension may require prompt action, such as a renewal application and budget for the next demonstration year.

New York

HMA Roundup – Denise Soffel (Email Denise)

Emergency Regulations Promulgated to Protect Health Insurance Coverage. Governor Andrew Cuomo has directed the New York State Department of Financial Services to promulgate new emergency regulations mandating that health insurance providers not discriminate against New Yorkers with preexisting conditions or based on age or gender. The measure will include requiring any private company doing business on the state's insurance marketplace to guarantee the 10 "essential health benefits" required by the Affordable Care Act. Further, the Department of Health will ban all insurers who withdraw from offering Qualified Health Plans on the exchange from future participation in Medicaid. The Governor will also direct state agencies to ban insurers who withdraw from the exchange from contracting with the state. Finally, the administration finalized regulations that will ensure that contraceptive drugs and devices, as well as all medically necessary abortion services, are covered by commercial health insurance policies without co-pays, coinsurance, or deductibles. Under the new regulations, DFS will require that individual and small group health insurance policies, as well as student accident and health insurance policies, cover the same categories of essential health benefits and be subject to the same benchmark plan rules that currently apply through the Affordable Care Act. Insurers must comply with the new regulations as a requirement of their license in New York. Read More

NYC Health + Hospitals Reports Operating Loss, Layoffs. NYC Health + Hospitals, New York City's public hospital system, concluded the third quarter of its fiscal year with an operating loss of $673 million. NYC H + H operates 11 acute care hospitals, six Diagnostic and Treatment Centers, four long-term care facilities, a certified home health care agency and more than 80 community health clinics. The system provides care for nearly 1.2 million people, of which more than 425,000 are uninsured. Becker Hospital Review reports that NYC H+H recorded operating revenues of $6.7 billion in the three-month period ended March 31, up 1.8 percent from revenues of $6.6 billion in the same period of the prior year. While total operating revenues increased from the prior year, net patient service revenues declined 9 percent due to lower payments from the Medicaid disproportionate share hospital and upper payment limit programs. Revenue gains were also offset by higher expenses. The system ended the third quarter of fiscal year 2017 with an operating loss of $673.3 million, compared to an operating loss of $349.6 million in the same quarter of fiscal year 2016. Despite its financial performance in the third quarter, the system says it is still on track to shrink its budget gap this fiscal year.

One strategy for improving the financial performance of NYC H+H is a reorganization which resulted in the removal of 476 management positions, including 396 layoffs and the elimination of 80 currently unfilled positions. *Modern Healthcare* notes that the layoff comes just months after 70 employees

were let go in February. The health system had 47,304 full time employees at the end of 2016. The job cuts are expected to net $60 million in personnel savings in the 2018 fiscal year. In March, NYC Mayor Bill de Blasio released findings from his Commission on Health Care for Our Neighborhoods, a Blue Ribbon commission established by the mayor in response to the on-going financial challenges of NYC H + H. The Commission report highlights three areas for transformation: clinical infrastructure, building clinical partnerships, and sustaining the safety net. The commission recommends a significant restructuring of clinical services, including new investments to expand ambulatory care. Read More

Northwell Health's Insurance Plan Seeks Large Rate Increase. *Politico NY* reports that CareConnect, the financially struggling health insurance arm of Northwell Health, has requested a 30 percent premium increase for its individual product, and increases of as much as 24 percent in its small group product, for 2018. The company lost $157 million in 2016. CareConnect was formed in response to the Affordable Care Act, and currently has 117,000 members; more than 86,000 of those in the small group market. CareConnect argues that its financial struggles in the small group market are related to the federal risk adjustment program. Although the intent behind the risk adjustment program is to move money from insurers that cared for a healthier population to the ones that cared for a less-healthy population, many insurance companies believe that the formula is flawed. Politico notes that this is the second consecutive year that CareConnect has requested a 30 percent rate hike on the individual market, as it continued to see customers with more expensive than anticipated medical needs. Last year, the Cuomo administration granted the request. Read More

Ohio

Anthem to Exit Exchange Market Statewide in 2018. *The Wall Street Journal* reported on June 6, 2017, that Anthem has announced it will no longer participate in Ohio's Affordable Care Act (ACA) Exchange market in 2018, the company's first Exchange market exit. The insurer cited a shrinking individual market, uncertainty about the future of ACA insurer subsidies, and continued changes in federal operations, rules and guidance as key reasons behind the decision. As a result, 20 counties in the state may be without an Exchange insurer next year. Anthem has filed to participate in its 13 other Exchange states in 2018. Read More

Oregon

Bill Aims to Reduce Deficit, Averting Cuts to State Programs. *Oregon Live* reported on June 5, 2017, that Oregon State Senator Peter Courtney (D-Salem) has introduced a deficit-reduction bill in hopes of avoiding cuts to state programs and other services in light of a potential $1.4 billion shortfall in the next two-year budget. If passed, Senate Bill 1067 is expected to save Oregon $270 million every two years through a number of initiatives, including a package of health care taxes aimed at avoiding Medicaid cuts. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Awards $5.6 Million to Improve Coordination of Care for Medicaid Beneficiaries. On June 1, 2017, Pennsylvania's Department of Human Services (DHS) announced approximately $5.6 million in onboarding grants to help connect inpatient hospitals/ facilities, outpatient practices/providers, and other eligible providers to the Pennsylvania Patient & Provider Network (P3N) or Public Health Gateway. The grant program is available to providers participating in the Medicaid Electronic Health Records (EHR) Incentive Program and the performance period ends September 30, 2017. The onboarding grant will incentivize individual providers to join an HIO and incentivize HIOs to join the P3N. Through this federal grant, CMS will provide 90 percent of the funding and DHS will pay the remaining 10 percent. Read More

Insurance Commissioner Announces Single-Digit Aggregate 2018 Individual and Small Group Market Rate Requests. Pennsylvania Insurance Commissioner Teresa Miller announced that the five health insurers that sell on Pennsylvania's individual market will stay in the market. These insurers filed plans for 2018 with aggregate statewide rate increases of 8.8 percent for individual plans and 6.6 for small group plans. If the individual mandate is repealed or cost-sharing reductions are not paid, insurers say their rate increase requests will increase significantly. Rate change requests vary by plan and region. Complete rate filings for UPMC, Highmark, Independence Blue Cross, Geisinger, and Capital Blue Cross, including plan-specific information, will be available on July 21 at the Pennsylvania Insurance Department website. Read More

Texas

Independent Hospitals Struggle with Value-based Payments. *Modern Healthcare* reported on June 5, 2017, that independent hospitals in Texas are struggling to adjust to the shift to value-based payments. Independent hospitals struggle with a lack of capital and an inability to build share in outpatient settings, which makes it difficult to pursue value-based contracts with payers. More broadly, the number of independent hospitals in the state has fallen from 5,008 to 4,862 since 2009 amid declining patient volumes. Read More

West Virginia

Medicaid Pharmacy Benefits to Transition Back to Fee-For-Service. West Virginia's Bureau for Medical Services announced on May 31, 2017, that the state will revert back to traditional fee-for-service pharmacy benefits for Medicaid managed care members effective July 1, 2017. The state's Preferred Drug List will remain in effect. Read More

National

State, Federal Officials Seek End to Some Medicaid Reimbursement Limits on Behavioral Health, SUD. *Modern Healthcare* reported on May 31, 2017, that state and federal officials have been working to end some limits on Medicaid reimbursements for behavioral health and substance use disorder (SUD) treatment. Medicaid does not reimburse residential treatment facilities with more than 16 beds for mental health and SUD for individuals 21 years old and older. California, Maryland, Massachusetts, and Virginia have received waiver approval to remove the bed-limit restriction. Other states, including Arizona and Wisconsin, have submitted or are planning to submit waivers to remove the day limit finalized last year allowing Medicaid managed care organizations to pay facilities for short-term stays lasting 15 days or fewer. They also hope to expand the new policy to their fee-for-service populations. Meanwhile, a bipartisan group of U.S. senators have introduced a bill, called the Medicaid Coverage for Addiction Recovery Expansion Act, or Medicaid CARE Act, earlier this month that would allow centers with up to 40 beds to receive reimbursement from Medicaid for stays of up to 60 consecutive days for SUD treatment. Read More

Senate Republicans Align on a More Moderate ACA Repeal, Replacement Bill. *Politico* reported on June 6, 2017, that a meeting with Senator Mitch McConnell (R-KY) renewed Senate Republican confidence in their ability to repeal and replace the Affordable Care Act (ACA). Although no draft legislation or framework was provided during the meeting, and no final decisions have been reached, there was reportedly general consensus for a more moderate bill that would provide a longer timeline to ending the Medicaid expansion and more funding to stabilize the market. Senate Republicans tentatively plan to submit a framework of the bill to the Congressional Budget Office by the end of the week and are pressing for a vote before the Fourth of July recess. Read More

Senate Leaders Press for June Vote on ACA Repeal, Replacement. *Politico* reported on June 5, 2017, that Senate Majority Leader Mitch McConnell (R-Kentucky) is pressing for a vote at the end of June on the potential repeal and replacement of the Affordable Care Act (ACA). Senate leaders reportedly want a vote before the July 4 recess to ensure time for tax reform. To get a vote by June 30, the Senate must submit the bill approximately two weeks prior. Senators have reportedly been drafting legislation, but have left several key decisions blank, including when to roll back Medicaid expansion and the overall magnitude of Medicaid funding reductions. There is, however, general agreement on more generous tax subsidies than those in the bill passed by the House in early May. An early draft of the Senate bill may be released by the end of this week. Read More

AHCA Could Threaten Medicaid Managed Care Plans. *Modern Healthcare* reported on June 6, 2017, that the American Health Care Act (AHCA) passed by the House in early May could threaten Medicaid managed care plans by converting Medicaid to a system of per capita caps or block grants. Some Medicaid health plans have warned the new system would not provide adequate funding during an unexpected economic downturn, if major new public health needs develop, or if expensive new prescription drugs become available. Analysts say that if enrollment or medical costs rise, rates would likely be cut for managed care plans. Read More

Medicaid Cuts Under AHCA Bill Would Hit Rural America Hardest, Report Says. *Kaiser Health News* reported on June 7, 2017, that rural counties would be hit hardest by Medicaid cuts proposed under the American Health Care Act (AHCA), according to a report by the Georgetown University Center for Children and Families. The report found that Medicaid covered 45 percent of children and 16 percent of adults in small towns and rural areas in 2015, compared to 38 percent of children and 15 percent of adults in metropolitan areas. In fourteen states, including California, Florida, Mississippi, Oregon, and South Carolina, more than half of all children in rural areas are covered by Medicaid. Rural areas also have higher rates of individuals with disabilities and higher unemployment rates. The House-passed AHCA would cut Medicaid funding by more than $800 billion over 10 years. Read More

Lawmakers Seek Rule Change on Third-party Premium Payments for Exchange Plans. *Modern Healthcare* reported on May 31, 2017, that a group of lawmakers have asked President Donald Trump's administration to require Exchange plans to accept premiums and cost-sharing assistance paid on behalf of members by not-for-profit charitable organizations, places of worship, and local civic organizations. In a letter to Secretary of Health and Human Services Tom Price, lawmakers said current rules allow insurers to avoid covering certain members. Read More

Health Insurance Industry Takes More Nuanced Role in Current Reform Debate. *Politico* on June 3, 2017, quoted representatives of America's Health Insurance Plans (AHIP) saying that the health insurance industry is taking a more nuanced approach in the debate over healthcare reform. AHIP's strategy has been to engage Senators and Trump administration officials as well as attempt to strengthen relationships with influential Republican members of Congress. AHIP took a far more visible role in prior debates over healthcare reform, including the Affordable Care Act and the Clinton healthcare plan. Read More

Health Insurers Make Progress in Tracking, Enrolling Dual Demo Members. *Modern Healthcare* reported on June 1, 2017, that health plans are doing a better job of enrolling and tracking members in dual-eligible demonstration projects. The number of completed health risk assessments is rising, for example, which is attributed in part to mining of claims data and community partnerships. The dual demo project, which is formally known as the Financial Alignment Initiative, has been hampered by outdated patient contact information, making it hard for plans to locate and enroll members. Read More

Republican Senators Consider Taxing Employer-sponsored Health Insurance. *The Wall Street Journal* reported on June 1, 2017, that Senate Republicans are considering a proposal to tax employer-sponsored health insurance as income. The proposal, which is part of the Senate's Affordable Care Act repeal and replace discussion, could raise billions in revenues to help stabilize the individual insurance market; however, it would increase the tax burden for individuals who receive health coverage through their employer. Read More

Senator Collins Looks to Fix ACA Subsidy Cliff. *The New York Times* reported on June 4, 2017, that U.S. Senator Susan Collins (R-Maine) is looking to address the Affordable Care Act (ACA) "subsidy cliff," which impacts seasonal workers whose incomes fluctuate greatly over the year. Seasonal spikes in income can result in an individual losing eligibility for ACA subsidies. Senator

Collins has been a critic of the ACA since its enactment, but has also shown openness to fixes rather than wholesale replacement. Senator Collins has also voiced support for a Medicaid expansion program in Maine similar to the Indiana private option model. Read More

OIG Says Mylan May Have Overcharged Medicaid for EpiPen Allergy Treatment. *The Hill* reported on May 31, 2017, that pharmaceutical company Mylan may have overcharged Medicaid by approximately $1.27 billion over the past decade by classifying the company's EpiPen allergy treatment as generic rather than brand name, according to a report by the U.S. Office of Inspector General. Medicaid requires steeper discounts on brand name drugs. Mylan reportedly reached a settlement with the Department of Justice regarding the classification issue last year. Read More

Industry News

Mercy Acquires Missouri-Based St. Anthony's Medical Center. *St. Louis Post-Dispatch* reported on June 1, 2017, that Mercy has finalized the acquisition of St. Anthony's Medical Center, based in St. Louis, Missouri. Mike McCurry, Mercy's chief operating officer, will serve as president at St. Anthony's, replacing interim chief executive Kelly Wetzler. Mercy will invest $300 million in the facility over the next seven years. St. Anthony's is the third largest medical center in the St. Louis metropolitan area. Read More

Molina Discusses Situation Surrounding Executive Changes. *The Wall Street Journal* reported on May 31, 2017, on the circumstances surrounding the recent senior executive changes at Molina Healthcare. The article quotes former chairman and chief executive J. Mario Molina as well as members of the investment community. The company named chief accounting officer Joseph White as interim president, chief executive, and chief financial officer. Dale Wolf, who is a Molina board member and former chief executive of Coventry Health Care, has been named chairman. Read More

Ensign Group Acquires Rehab Facilities in Utah, Idaho. The Ensign Group announced on June 5, 2017, the acquisition of three rehab facilities and an intermediate care facility in Utah and Idaho. The Utah facilities include Utah Valley Healthcare and Rehabilitation in Provo; Heritage Park Healthcare and Rehabilitation in Roy; and Wide Horizons Intermediate Care Facility in Ogden. The Idaho facility is Meadow View Nursing and Rehabilitation in Nampa. Ensign operates a total of 216 healthcare facilities, 20 hospice agencies, 18 home health agencies and three home care businesses in 14 states. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
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
Spring/Summer 2017	Virginia Medallion 4.0	RFP Release	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 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	New Mexico	RFP Release	700,000
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
November 15, 2017	New Mexico	Proposals Due	700,000
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
March 15, 2018	New Mexico	Contract Awards	700,000
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 1, 2019	New Mexico	Implementation	700,000
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.

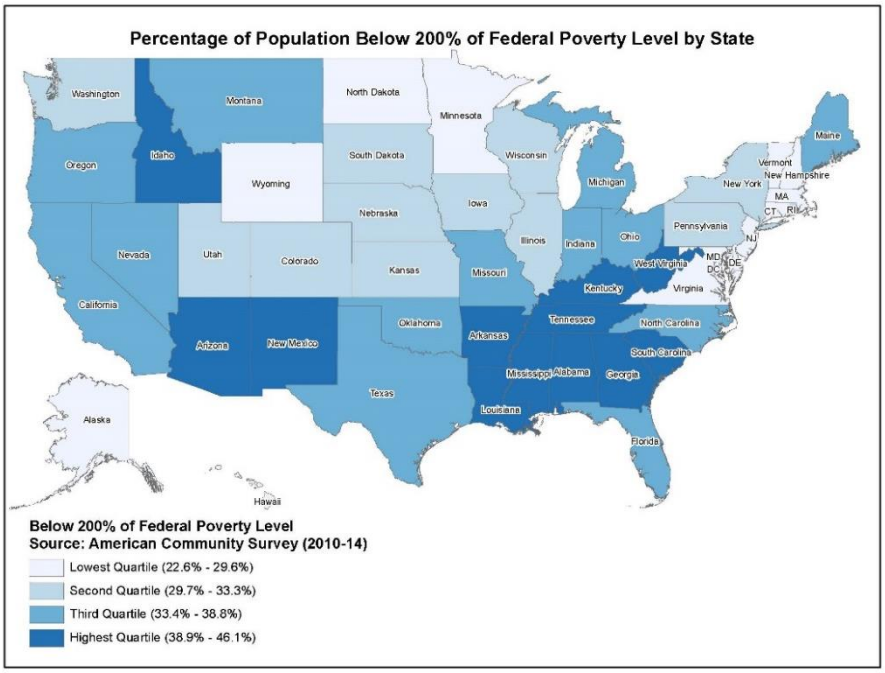
HMA News

Medicaid Managed Care Executives to Discuss Opportunities for Innovation at HMA Conference on the Future of Medicaid in September

Top executives from some of the nation's largest Medicaid managed care plans will discuss emerging opportunities for innovation, waivers, value-based payments, long-term services and supports, behavioral integration and a host of other topics at HMA's conference, *The Future of Medicaid is Here: Implications for Payers, Providers and States*, September 11-12, at the Renaissance Chicago Downtown Hotel**.** At least a dozen Medicaid plan C-suite executives, including CEOs, division presidents, and medical directors, will speak at the conference, including representatives from Aetna Inc., AmeriHealth Caritas, Anthem Inc., CareSource, Centene, Kaiser Permanente, Meridian Health Plans, Molina Healthcare, Neighborhood Health Plan of Rhode Island, UnitedHealth Group, and WellCare. **Early Bird registration is now open.** Last year's conference 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.

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 ninth map in the series highlights data on **the percentage of the population below 200 percent of the federal poverty level by state**. There is a growing recognition that there are disparities in health and healthcare related to social determinants of health, including neighborhood and built environment, education and economic stability.



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.

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/

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