HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

June 14, 2017

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION ENROLLMENT UPDATE

This week, our *In Focus* section reviews publicly available data on enrollment in capitated financial and administrative alignment demonstrations ("Duals Demonstrations") for beneficiaries dually eligible for Medicare and Medicaid (duals) in 10 states: California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia. Each of these states has begun either voluntary or passive enrollment of duals into fully integrated plans providing both Medicaid and Medicare benefits ("Medicare-Medicaid Plans," or "MMPs") under three-way contracts between the state, the Centers for Medicare & Medicaid Services (CMS), and the MMP. As of June 2017, more than 391,000 duals are enrolled in an MMP, according to state and CMS

enrollment reports, the highest monthly enrollment total since the demonstrations began in late 2013.

Note on Enrollment Data

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

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

Dual Demonstration Enrollment Overview

As of June 2017, more than 391,000 dual eligibles were enrolled in a demonstration plan across the ten states below. Since June 2016, enrollment in Dual Demonstrations across all states is up early 30,000 members, an 8.2 percent year-over-year increase. As noted in the introduction, June 2017 represents the highest ever duals demonstration enrollment total, due in part to the launch of Rhode Island's demonstration in late 2016.

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

State	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
California	114,804	115,777	115,613	115,991	116,371	117,302
Illinois	45,511	47,492	49,435	50,147	49,393	50,064
Massachusetts	16,089	15,850	15,630	17,181	16,985	16,809
Michigan	36,752	36,771	37,414	37,649	37,900	39,046
New York	4,827	4,711	4,654	4,599	4,602	4,566
New York - IDD	448	485	511	540	553	561
Ohio	69,634	72,358	73,445	73,650	72,494	74,347
Rhode Island	9,934	10,982	11,880	12,278	12,885	13,717
South Carolina	8,981	8,694	8,496	8,261	8,087	7,915
Texas	50,924	47,302	44,613	42,495	43,032	39,919
Virginia	28,835	29,453	28,917	28,476	28,249	27,194
Total Duals Demo Enrollment	**386,739**	**389,875**	**390,608**	**391,267**	**390,551**	**391,440**

Sources: State Enrollment Data, CMS Enrollment Data

So far, enrollment in these ten states represents just over 31 percent of the potential enrollment of more than 1.25 million across all ten capitated demonstration states. Participation rates range from a low of less than 4 percent in New York to more than 65 percent in Ohio. The newest demonstration state, Rhode Island, is already at more than 50 percent participation.

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

	Opt-In Enrollment Date	First Passive Enrollment Date	Current Enrollment	Potential Enrollment	% Enrolled (Full Potential)
California	4/1/2014	5/1/2014	117,302	350,000	33.5%
Illinois	4/1/2014	6/1/2014	50,064	136,000	36.8%
Massachusetts	10/1/2013	1/1/2014	16,809	97,000	17.3%
Michigan	3/1/2015	5/1/2015	39,046	100,000	39.0%
New York	1/1/2015	4/1/2015	4,566	124,000	3.7%
New York - IDD	4/1/2016	No Passive	561	20,000	2.8%
Ohio	5/1/2014	1/1/2015	74,347	114,000	65.2%
Rhode Island	7/1/2016	10/1/2016	13,717	25,400	54.0%
South Carolina	2/1/2015	4/1/2016	7,915	53,600	14.8%
Texas	3/1/2015	4/1/2015	39,919	168,000	23.8%
Virginia	3/1/2014	5/1/2014	27,194	66,200	41.1%
Total (All States)			**391,440**	**1,254,200**	**31.2%**

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

Dual Demonstration Enrollment by Health Plan

As of June 2017, more than half (52 percent) of all duals in the demonstrations are enrolled in a publicly-traded MMP. This is down slightly from more than 54 percent in January 2017. Molina and Centene are the largest in terms of enrollment with more than 53,000 and 47,000 demonstration enrollees, respectively.

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

Health Plan	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Molina	54,853	56,058	55,049	55,928	54,740	53,379
Centene	47,653	47,737	47,925	47,189	47,011	47,464
Anthem	36,580	35,565	34,669	33,913	33,504	32,759
Aetna	27,933	28,389	29,266	29,278	29,457	30,255
United	19,976	19,988	19,466	18,990	18,498	18,520
Humana	16,570	16,860	16,379	15,834	15,498	15,498
CIGNA/HealthSpring	6,807	6,623	6,434	6,299	6,200	5,842
Total Publicly Traded Health Plans	**210,384**	**211,220**	**209,188**	**207,431**	**204,908**	**203,717**

Sources: State Enrollment Data, CMS Enrollment Data

Among non-publicly traded health plans, Inland Empire in California is the largest, with more than 23,000 members, making it the fifth largest MMP nationwide. CareSource (Ohio), CalOptima (California), BCBS of Illinois (Illinois), LA Care (California), Commonwealth Care Alliance (Massachusetts), Meridian (Illinois and Michigan), and now Neighborhood Health Plan of Rhode Island all have more than 10,000 enrolled members as of June 2017. Enrollment by non-publicly traded health plans for the past six months is detailed below.

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

Health Plan	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
Inland Empire (CA)	22,286	22,685	22,876	23,239	23,426	23,813
CareSource (OH)	18,352	18,969	19,230	19,354	19,218	19,652
CalOptima (CA)	16,463	16,303	16,152	15,923	15,873	15,727
BCBS of Illinois (HCSC) (IL)	13,917	13,985	14,915	15,046	15,562	15,722
LA Care (CA)	12,850	13,277	13,517	13,959	14,351	14,646
Commonwealth Care Alliance (MA)	12,763	12,708	12,628	13,537	13,506	13,447
Meridian Health Plan (IL, MI)	10,772	10,925	11,583	11,471	11,955	12,243
Neighborhood Health Plan of Rhode Island (RI)	9,934	10,982	11,880	12,278	12,885	13,717
Health Plan of San Mateo (CA)	9,529	9,448	9,374	9,386	9,372	9,371
AmeriHealth Caritas (MI, SC)	7,437	7,244	7,220	7,162	7,108	7,167
Santa Clara Family Health Plan (CA)	7,377	7,407	7,373	7,320	7,333	7,437
Care 1st (CA)	6,376	6,457	6,376	6,303	6,264	6,327
Virginia Premier (VA)	5,657	5,790	5,786	5,738	5,804	5,503
HAP Midwest Health Plan (MI)	5,095	5,051	5,143	5,046	5,000	5,075
Community Health Group Partner (CA)	4,949	5,032	5,061	5,138	5,166	5,184
Upper Peninsula Health Plan (MI)	4,053	4,097	4,181	4,196	4,233	4,252
Network Health (MA)	3,326	3,142	3,002	3,644	3,479	3,362
VNS Choice (NY)	1,697	1,655	1,624	1,598	1,564	1,553
Managed Health Inc. (NY)	1,003	988	982	976	965	972
GuildNet (NY)	800	758	737	721	716	688
Partners Health Plan - IDD (NY)	448	485	511	540	553	561
The New York State Catholic Health Plan (NY)	341	337	332	323	332	331
Elderplan (NY)	339	343	340	348	362	378
MetroPlus Health Plan (NY)	173	174	178	176	179	184
Independence Care System (NY)	153	151	149	145	141	141
Senior Whole Health (NY)	137	146	155	152	154	143
AgeWell New York (NY)	38	36	36	36	57	88
North Shore-LIJ (NY)	26	27	27	29	32	28
Centers Plan for Healthy Living (NY)	22	21	21	22	21	11
Village Senior Services Corp. (NY)	22	24	20	20	20	N/A
Elderserve Health (NY)	8	8	11	10	12	N/A
Total Local/Other Plans	**176,355**	**178,655**	**181,420**	**183,836**	**185,643**	**187,723**

Sources: State Enrollment Data, CMS Enrollment Data

HMA Medicaid Roundup

California

HMA Roundup – Julia Elitzer (Email Julia)

Lawmakers Reach Deal on Tobacco Tax Spending. *Capital Public Radio r*eported on June 12, 2017, that Democratic lawmakers reached a deal with Governor Jerry Brown over how to spend the revenue from the Proposition 56 tobacco tax. Half of the over $1 billion in revenues would go toward increasing Medi-Cal reimbursement rates for doctors and dentists. A small portion of the funds may also go toward women's health, services for individuals with developmental disabilities, and HIV/AIDS treatment. Before finalization by the state Capitol, all provisions will need to be approved by the Centers for Medicare & Medicaid Services. Read More

California Not Seeing Decline in ED Visits Since Affordable Care Act Passage. *CaliforniaHealthline* reported on June 12, 2017, that contrary to predictions of many that the Affordable Care Act would reduce emergency department (ED) visits, California has seen a 75 percent increase in ED visits since the legislation was passed. Some industry experts have pointed to a shortage of physicians accepting Medicaid and the likelihood that newly covered patients might utilize the ED, rather than a primary care physician, out of habit. Oregon has also seen a similar increase in ED visits. Read More

California to Award Grants Aimed at Keeping Recently Released Non-violent Offenders Out of Prison. *Los Angeles Times* reported on March 29, 2017, that California is awarding $103 million in grants aimed at keeping certain recently released non-violent offenders out of prison. The grants will be funded by costs savings from Proposition 47, a state ballot measure that reduced six drug and theft crimes to misdemeanors. Funding will go to cities, counties, and public agencies and will be used to support housing and employment programs, mental health and substance use disorder treatment, and social services. That state is evaluating 58 applications for grants. Read More

Colorado

Governor Considers Blocking Anthem from State Medicaid Contracts If It Exits Exchange. *Colorado Public Radio* reported on June 7, 2017, that Colorado Governor John Hickenlooper is considering blocking Anthem from the state's Medicaid contracts if the insurer pulls out of the state's Connect for Health Colorado insurance Exchange. Anthem said that it is "maintaining an active dialogue with state leaders and regulators regarding the stability of Colorado's individual market." If Anthem were to exit, 14 Colorado counties will be left

without an Exchange plan in 2018. The deadline for insurers to submit plans is June 19, 2017. New York Governor Andrew Cuomo has also announced a plan to block insurers that withdraw from the Exchange from participating in Medicaid or CHIP. Read More

Mental Health Institute at Risk of Losing Federal Funding Over Patient Safety Concerns. *The Denver Post* reported on June 9, 2017, that Colorado Mental Health Institute, a 449-bed mental health hospital, has until June 28 to correct a staffing shortage that poses a reported "immediate and serious threat to the health and safety" of patients or lose federal funding. Investigators from the Colorado Department of Human Services found that the hospital failed to meet federal regulations. The hospital will need to submit a correction plan, which regulators must approve by June 28, to maintain Medicaid and Medicare funding. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA Holds Public Meeting on Low-Income Pool Program. The Florida Agency for Health Care Administration held a public meeting in Orlando on June 13, 2017, regarding the Low Income Pool (LIP) Program and the flexibility of LIP funding. The Agency received agreement in principle of $1.5 billion. The Agency is required, subject to federal approval, to submit a budget amendment requesting release of the funds and include a funding methodology, a proposed distribution model by entity and a proposed listing of entities contributing Intergovernmental Transfers (IGTs) to support the state match required. The Agency discussed the proposed FY 2017-18 LIP provisions allow expenditure of funds for Hospitals, FQHCs/RHCs and Medical School Physician practices. Additionally, up to 20% or $300 million is available for creation of an Uncompensated Care Diversion Sub-Pool. Proposed LIP models are to be submitted to the Agency by June 30, 2017 for review prior to the next public meeting scheduled for July 25, 2017 in Tallahassee. The Agency plans to submit the budget amendment by August 11, 2017. Local governmental entities must submit final executed letters of agreement (LOA) to the Agency by October 1, 2017. Local governmental funds must be received by the Agency no later than October 31, 2017. The presentation is available by clicking here.

Florida Blue to Remain on Individual Exchange in 2018. *Central Florida Future* reported on June 11, 2017, that Florida Blue will remain on the state's individual Exchange in 2018. In an interview with *The News-Press*, Florida Blue did not reveal what premium increases it will seek. David Pizzo, Florida Blue market president for the company's west region, said premium rate requests will be based on the assumption that the federal government will preserve Exchange market cost-sharing subsidies. Last year, the state approved an average 19.1 percent rate increase for the insurer. Read More

Florida Health Choices Exchange at Risk of Closing After Loss of Funding. *The Florida Times-Union* reported on June 12, 2017, that the Florida Health Choices (FHC) health insurance exchange, created to compete with the Affordable Care Act's Exchange, is at risk of closing after Governor Rick Scott vetoed $250,000 in funding for fiscal 2018. FHC has 712 customers, short of the 3,000 to 4,000 it needs to be self-sufficient. The FHC board of directors will

meet on June 23 to discuss options for the exchange, including possibly dissolving it in 2018. Read More

State Wins Ruling in Children with Disabilities Lawsuit. *Health News Florida* reported on June 13, 2017, that Senior U.S. District Judge William Zloch has ruled in favor of Florida in a 2012 lawsuit alleging that the state's Medicaid program violated the Americans with Disabilities Act by not providing appropriate home and community-based care to children with severe medical conditions. The court approved the March 22 recommendations of U.S. Magistrate Judge Patrick Hunt, who stated that the plaintiffs could no longer show they were in danger of being denied medically necessary private-duty nursing services, rendering their claims moot. In January 2017, the Florida Agency for Health Care Administration and the Florida Department of Health announced that they made changes to the policies addressed in the lawsuit. Read More

Illinois

Illinois to Delay Medicaid Managed Care Awards. *Crain's Chicago Business* reported on June 13, 2017, that Illinois is delaying the award of an estimated $9 billion in Medicaid managed care contracts to further evaluate bids from nine competing health plans. The awards, originally scheduled to be announced around June 30, will be delayed several weeks. Bidders include Aetna Better Health, Blue Cross Blue Shield of Illinois, County Care Health Plan, Harmony Health Plan (WellCare), IlliniCare Health Plan (Centene), Meridian Health, Molina Healthcare of Illinois Inc., NextLevel Health, and Trusted Health Plan. Read More

State Bonds Plummet on Medicaid Provider Ruling. *The New York Times* reported on June 8, 2017, Illinois general obligation bond prices plummeted after U.S. District Court Judge Joan Lefkow ruled that the state has until June 20 to agree to a plan to pay Medicaid providers a substantial portion of past-due bills. Payments have been delayed by a two-year budget impasse. Read More

Indiana

Medicaid Waiver Request Reportedly Submitted Before End of Comment Period. *Modern Healthcare* reported on June 12, 2017, that Indiana appears to have bypassed the required 30-day public comment period in submitting its Healthy Indiana Plan 2.0 Waiver renewal application to federal regulators. The application calls for the implementation of Medicaid work requirements. According to the article, Indiana submitted its application on May 25; however, the public comment period does not end until June 23. Read More

Iowa

Iowa Proposes Waiver to Avert Withdrawal of Remaining Exchange Plans. *The New York Times* reported on June 12, 2017, that Iowa is facing the potential withdrawal of its remaining Exchange plans and is proposing a waiver to federal regulators in hopes of averting a situation in which the state has no participating insurers. Iowa wants to use the federal cost-sharing subsidies to

attract younger members in hopes of improving the Exchange risk pool, a move that would require approval from the Centers for Medicare & Medicaid Services. The plan also calls for federal reinsurance to help plans cover high-cost claims. Among the state's remaining Exchange plans, Wellmark Blue Cross & Blue Shield and Aetna have announced plans to withdraw, while Medica has indicated it would likely drop out unless changes are made, according to Iowa Insurance Commissioner Doug Ommen. Read More

Governor Faces Lawsuit Over Medicaid Managed Care Impact on Individuals with Disabilities. *The Des Moines Register* reported on June 13, 2017, that a group of individuals with disabilities has filed a class action lawsuit against Iowa Governor Kim Reynolds, claiming that the state's transition to Medicaid managed care is improperly depriving them of adequate in-home care. The suit, organized by Disability Rights Iowa and filed in U.S. District Court in Iowa, seeks an end to "discriminatory" cuts to services for 15,000 people with serious disabilities. Read More

Kentucky

State Awaits Decision on Medicaid Work Requirements, Premiums. *The Wall Street Journal* reported on June 11, 2017, that Kentucky is currently waiting for federal regulators to decide on a waiver proposal to add work requirements and premiums to the state's Medicaid program. The proposal, which Kentucky Governor Matt Bevin estimates would save the state $2.2 billion over five years, requires approval by the Centers for Medicare & Medicaid Services (CMS). CMS Administrator Seema Verma, who helped craft the proposal, has recused herself from the decision, as previously reported. Certain Medicaid beneficiaries would be required to pay premiums of up to $15 a month and perform employment-related or community-service activities. Opponents say the proposal would reduce Medicaid enrollment. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

State Assembly Progresses Legislation to Establish a Transgender Equality Task Force. In February 2017, a bill was introduced to the New Jersey Assembly Human Services Committee (A4567) that would establish a Transgender Equality Task Force. The bill was passed by the Assembly in March. The task force would assess the legal and societal barriers to equality for transgender individuals in New Jersey and provide recommendations to the Governor and Legislature on how to insure equality with attention to: healthcare access, long term care, education, housing, employment and criminal justice. The latest version of SB 3068 adds Task Force members from the Department of Banking and Insurance, Department of Human Services, and the Department of Health, among others.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Department of Health Sued over Lack of Protections in Managed Long-Term Care Plan Transitions. The New York Legal Assistance Group has filed suit in federal court on behalf of disabled recipients of Medicaid-funded long-term home care services, challenging the failure of the New York State Department of Health (DOH) to protect them from reductions and terminations of their care without due process of law. Since 2012, New York has required dual-eligible recipients in need of community-based long-term care services to enroll in Managed Long Term Care plans in order to obtain home care services. DOH has failed to create a transition plan to protect MLTC enrollees if their plans close or choose to withdraw from a specific region or county. The case stems from GuildNet's decision to stop serving Nassau, Suffolk and Westchester Counties, leaving 4,400 people searching for a new managed long-term care plan. While GuildNet sent a letter to all enrollees in those counties announcing that it would terminate services effective June 1, the letter did not inform enrollees that they have a right to keep the same level of care, whether from GuildNet or a new plan, until and unless they have an opportunity for a Fair Hearing at which to challenge any reduction. The class action alleges that DOH is violating the rights of GuildNet enrollees under the Medicaid Act, the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and the Due Process Clause of the Fourteenth Amendment to the U.S. Constitution. Read More

Value Based Payment Innovator Program Application Package Finalized. New York has finalized the Value Based Payment (VBP) Innovator Application Package. The VBP Innovator Program is a voluntary program intended to support experienced VBP contractors prepared to participate in VBP Level 2 (full risk or near full risk) or Level 3 Total Care for General Population and/or Subpopulation arrangements. By taking on further management and administrative functions, contractors approved as Innovators will be eligible for an increased premium pass through. VBP Innovator Application Criteria Prospective Innovators must submit applications that provide sufficient information to demonstrate proficiency across five criteria:

1. A commitment to contracting for a high or full risk VBP Level 2 or Level 3 Total Care for General Population (TCGP) or Subpopulation arrangement;
2. Upholding health plan network adequacy;
3. Past success in VBP contracting for TCGP or Subpopulation arrangements;
4. The ability to meet minimum attribution thresholds; and
5. Financial solvency and appropriate net worth.

Applications for Innovator designation are now being accepted at any time on an ongoing basis. Read More

Health Plan 2018 Premium Rate Requests Posted. The New York Department of Financial Services has posted the premium rate increases that health plans have requested for 2018. Sixteen insurers have submitted individual rates and 20 insurers have submitted small group rates for 2018. Increases in the individual insurance market average 16.6 percent, ranging from a low of 4.4 percent (Excellus) to a high of 47.3 percent (HealthNow). In the small group

market the average rate adjustment is 11.5 percent, ranging from Oscar Health Plan's request of a 3.2 percent rate cut to Capital District Physicians' Health Plan's request for a 21.1 percent increase. These are the rates insurers have requested and may not be the final premium rates DFS will approve. Under New York's Prior Approval Law, the Superintendent may deny or modify the requested rates if she finds that the insurer's request is unreasonable, excessive, discriminatory or inadequate based on sound actuarial assumptions and methods. DFS is accepting public comments on the proposed rates for a 30-day period. Read More

New York Vulnerable to Federal Cuts and Caps in Medicaid, Study Finds. The Kaiser Family Foundation has released a report that reviews factors affecting state capacity to respond to federal Medicaid cuts and/or caps. New York is vulnerable in two significant ways. The number of Medicaid enrollees who fall into the Affordable Care Act expansion population is high in New York, representing 44 percent of all Medicaid beneficiaries. If the enhanced federal match for these enrollees is cut, New York will have to make up the difference or make plan adjustments to meet reduced funding limits. And New York's health care costs are high, significantly above national averages, which leaves the state at higher risk under reductions or caps in federal financing. Read More

Impact of the American Health Care Act on New York's Insurance Markets. The United Hospital Fund released a report that examines the potential impact that the American Health Care Act (AHCA) would have on New York's insurance markets. The report finds that the AHCA would undermine many of New York State's recent gains in coverage and market stability, and has financial and affordability effects particular to New York.

- The AHCA's proposed flat, age-based tax credits—which are untethered from the actual cost of coverage and out of sync with New York's market rules—would disadvantage New Yorkers in many ways. Because of New York's longstanding and unique pure community rating system, under which premiums are the same regardless of age, the AHCA credits would significantly increase premiums for younger, lower-income individuals and reduce them for older and higher-income enrollees.
- New York's Essential Plan, a program authorized under the ACA and covering more than 650,000 lower-income New Yorkers for premiums of $0 or $20 per month, is financed in part through ACA cost-sharing subsidies. The AHCA would remove those subsidies, jeopardizing this coverage option.
- One of the main benefits of the ACA for New York has been a larger and healthier individual market risk pool—particularly compared to the pre-ACA individual market, which had very low enrollment and high premiums. The combined effect of AHCA subsidy changes and other provisions would reverse those gains.

Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Senate Proposes Medicaid Cuts To Fill Budget Gap. *Cleveland.com* reported on June 12, 2017, that the Ohio Senate Finance Committee introduced a substitute amended budget bill that will close a $1 billion shortfall in the next two-year state budget. The budget savings rely heavily on across-the-board cuts to state agencies and targeted cuts to Medicaid, including a $75 million cut to hospitals. Read More

Oklahoma

Oklahoma Health Care Authority Cancels SoonerHealth+ Procurement. The Oklahoma Health Care Authority (OHCA) announced on June 14, 2017, that it has canceled the procurement for SonnerHealth+, the state's planned Medicaid managed care program for individuals in the aged, blind, and disabled (ABD) categories of eligibility. OHCA CEO Becky Pasternik-Ikard stated that the agency's request for an additional $52 million to fund the care coordination model was rejected so it can no longer move forward with the RFP. The RFP was originally issued in November 2016. Read More

Oregon

State Moves Ahead with Medicaid IT System Despite Reported Issues. *The Oregonian* reported on June 13, 2017, that Oregon continues to move forward with its ONE information technology system designed to automate Medicaid enrollment, despite reported cost overruns and technology issues. The Oregon Health Authority has spent $166.7 million developing the ONE system over the past three years. The state has also entered into a $100 million contract with ONE lead developer Deloitte Consulting to expand the system to cover food stamps and other state assistance programs. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

State Announces Partnership for MLTSS Implementation. The Pennsylvania Departments of Aging and Human Services announced on June 7, 2017, an agreement with Aging Well to partner on the implementation of Community HealthChoices, the new managed long term services and supports program. Aging Well is a subsidiary of the Pennsylvania Association of Area Agencies on Aging (P4A), the association that represents all Area Agencies on Aging in their business relationships. Under the agreement, AgingWell will be responsible for completing the Functional Eligibility Determinations (FEDs), conducting the PA Preadmission Screening Resident Review Evaluation (PASRR-EV Level II Tool), annual re-determinations, and conducting statewide outreach and education.

UPMC Susquehanna Buying Two Hospitals from Quorum Health Corp. *Healthcare Finance* reported on June 8, 2017, that UPMC Susquehanna will be adding two Pennsylvania hospitals, Sunbury Community Hospital and Lock Haven Hospital. The two facilities currently belong to Quorum Health Corp.

UPMC Susquehanna was itself recently acquired by University of Pittsburgh Medical Center. The deal is expected to close by the end of September. Read More

Wisconsin

Governor Walker Requests Medicaid Work, Drug Testing Requirements. *Milwaukee Journal Sentinel* reported on June 7, 2017, that Wisconsin Governor Scott Walker has requested federal approval of work and drug testing requirements for able-bodied, childless adults covered by the state's Medicaid program, BadgerCare. The proposal, approved by the state legislature last month, would go into effect April 2019 and potentially affect 148,000 individuals. A decision from the administration is expected within approximately 75 days. Critics of the proposal say the plan may end up costing taxpayers more and trigger lawsuits. The waiver would offer employment training for individuals who are unemployed, as well as expanded treatment options for individuals with substance abuse disorder. Read More

National

States Continue to Lag in Shift to HCBS, Report Says. *Kaiser Health News* reported on June 14, 2017, that states continue to lag in efforts to keep older adults and individuals with disabilities out of nursing homes and in home and community-based settings, according to a recent report. On average, states spent 41 percent of long-term services and supports (LTSS) dollars on home and community-based services (HCBS) in 2014. However, spending levels vary greatly, and only nine states, and the District of Columbia, spent more on HCBS than on nursing homes. Read More

AHCA Could Result in 13 Million More Uninsured, HHS Says. *The Hill* reported on June 13, 2017, that the American Health Care Act (AHCA) as passed by House Republicans could result in an additional 13 million people losing health care coverage, according to the U.S. Department of Health and Human Services (HHS). The projection is 10 million lower than legislative scoring by the Congressional Budget Office. HHS also says that AHCA could save the government $328 billion over 10 years, raise cost-sharing by 61 percent, increase premiums for people who receive Exchange plan subsidies, and lower premiums for those who do not. Both HHS and CBO agree that allowing states to opt out of certain Affordable Care Act regulations could destabilize the individual health insurance market. Read More

Moderate Senate Republicans Propose Ending Federal Funding for Medicaid Expansion by 2027. *The Hill* reported on June 7, 2017, that some moderate Republicans in the Senate are open to ending federal funding for Medicaid expansion by 2027, which could signal an agreement on a repeal-and-replace bill for the Affordable Care Act. Senators Rob Portman (R-Ohio) and Shelley Moore Capito (R-West Virginia) have proposed a seven-year phase-out of federal expansion funding. Senate Majority Leader Mitch McConnell (R-Kentucky), in contrast, has called for a three-year phase-out, with funding ending in 2023. Republican Senate leaders have also been supportive of protecting people with pre-existing conditions and have discussed adding funding for substance abuse and opioid treatment as part of a health care reform package. Read More

Community Health Plans Warn of Implications of Republican Health Reform Proposals. *Modern Healthcare* reported on June 12, 2017, that community health plans are warning that Medicaid funding cuts proposed by Republican lawmakers would negatively impact vulnerable beneficiaries. Not-for-profit Geisinger Health Plan and UCare expressed their concerns in a teleconference hosted by the Alliance of Community Health Plans (ACHP). Plans are expressing concerns that health care reform proposals like the American Health Care Act would result in reductions in Medicaid care, coverage, and funding for care management programs. Read More

Accreditation Agencies Push Back on CMS Rule to Increase Transparency of Audits. *Modern Healthcare* reported on June 8, 2017, that stakeholders are pushing back against a proposed federal rule, which would require private health care accreditation organizations to publicly release quality audits and corrective action plans of hospitals and other facilities within 90 days of a site visit. The Centers for Medicare & Medicaid Services (CMS) said the new rule will help consumers make better decisions and drive quality improvement at health care facilities. Hospitals and accreditation organizations argue the audits and corrective action plans could cast organizations in an unfair light as well as increase administrative burdens. Read More

Medicaid Innovation Accelerator Program National Webinar Scheduled for June 28. As part of the Centers for Medicare & Medicaid Services (CMS) Medicaid Innovation Accelerator Program (IAP) Reducing Substance Use Disorder (SUD) program area, the IAP continues to share what has been learned from working with states on SUD delivery system reform through a series of national learning webinars. The next national learning webinar, "Strategies for Enhancing SUD Treatment Workforce Skills," will be held on **Wednesday, June 28, 2017 from 3:30PM – 5:00 PM EDT**, and will feature state and provider partners discussing their experiences creating opportunities for providers to enhance their competency, including using patient assessment tools in treatment planning and coordinating care for patients receiving Medication Assisted Treatment (MAT). Strategies presented on this webinar will be applicable to a variety of states and providers interested in augmenting their SUD workforce skills. On this webinar:

- California will describe how they increased provider competence using the American Society of Addiction Medicine Criteria patient needs assessment through county-directed training efforts;
- Missouri will share how they established training requirements and educational resources for counselors working with MAT clients to enhance care quality and support client treatment needs; and
- Rhode Island will discuss two statewide initiatives that expanded SUD treatment access and provider competencies by establishing new care coordination standards for working with clients receiving MAT.

HMA is one of several organizations working as a subcontractor under a CMCS contract with Truven Health Analytics, an IBM company, to provide support to CMCS on the Medicaid Innovation Accelerator Program (IAP). HMA is providing CMCS with subject matter expert assistance for the Reducing Substance Use Disorder (SUD) and Beneficiaries with Complex Needs and High Costs (BCN) tracks through webinars, coaching assistance to participating states, resource papers and bi-weekly program updates. Link to register

Industry News

Centene to Expand Exchange Market Presence in 2018. Centene Corporation announced on June 13, 2017, plans to expand its Exchange market presence in 2018. Centene is seeking regulatory approval to enter Kansas, Missouri, and Nevada, and is expanding its presence in Florida, Georgia, Indiana, Ohio, Texas, and Washington. As of March 2017, Centene had 1.2 million Exchange members. Read More

Evergreen Health Suitors Testify in Support of Acquisition. *Washington Business Journal* reported on June 9, 2017, that a group of investors seeking to acquire Evergreen Health testified before the Maryland Insurance Administration in support of allowing the deal to move forward. A decision is expected by the end of next week. Anne Arundel Health System, LifeBridge Health, and JARS Health Investments are seeking to acquire Evergreen Health, a not-for-profit Exchange plan. State regulators must approve Evergreen's conversion to for-profit status for the deal to go through. Evergreen has 35,000 members. Read More

Civitas Solutions Acquires Mi Casa Es Su Casa ADH Center. Civitas Solutions announced on June 13, 2017, the acquisition of Mi Casa Es Su Casa, Inc., an adult day health (ADH) center in Paterson, New Jersey. Civitas now operates 24 ADH centers in Massachusetts, Maryland, and New Jersey. More broadly, Civitas provides home and community-based services to individuals with intellectual, developmental, physical, or behavioral disabilities, as well as other special needs in a total of 35 states. Read More

MIMA Healthcare Acquires Pennsylvania Nursing Homes from Mid-Atlantic Health Care. *Philly.com* reported on June 8, 2017, MIMA Healthcare, a nursing and rehabilitation company based in New Jersey, purchased six nursing homes owned by Mid-Atlantic Health Care, the largest nursing-home operator in Philadelphia. The purchase included Care Pavilion, Cliveden, Maplewood, Tucker House, and York, all of which are located in Philadelphia, and Parkhouse in Royersford, Pennsylvania. MIMA Healthcare now has a total of 10 facilities in New Jersey, Pennsylvania, and Vermont. Read More

AccentCare, Baylor Scott & White to Enter Home Health, Hospice Partnership. *Modern Healthcare* reported on June 7, 2017, AccentCare, a home health and hospice company with six facilities in Texas, has agreed to enter into a joint venture with Baylor Scott & White Health, the largest health system in Texas, to integrate their home health businesses. Together, they will have 10 home health and hospice facilities operating in Texas. The joint venture is expected to be completed this summer. Read More

HCR ManorCare Defaults on Debt; Carlyle Group Announces Exit. *New York Post* reported on June 11, 2017, that Carlyle Group announced it has given up control of HCR ManorCare, after the nursing home chain was found to be in

default on $380 million in senior loans. Quality Care Properties is in discussions about repossessing HCR ManorCare. Read More

CHS Fires Lutheran Health Network CEO Brian Bauer. *Modern Healthcare* reported on June 13, 2017, that Community Health Systems (CHS) has removed Brian Bauer as chief executive of Lutheran Health Network. Mike Poore, vice president of operations for CHS's Professional Services Corporation, will serve as the new CEO. The news comes three weeks after CHS rejected a $2.4 billion offer from a physician-lead buyout group, calling it too low. CHS posted a net loss of $1.7 billion in 2016. The system is in the process of selling 30 hospitals as part of a strategy to reduce $15 billion in debt. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
June 15, 2017	Delaware	Proposals Due	200,000
June, 2017	Oklahoma ABD	CANCELLED	155,000
June, 2017	MississippiCAN	Contract Awards	500,000
Spring/Summer 2017	Virginia Medallion 4.0	RFP Release	700,000
Summer 2017	Illinois	Contract Awards	2,700,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Georgia	Implementation	1,300,000
July 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 Statewide Medicaid Managed Care (SMMC)	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
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 (June 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	117,302	33.5%	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	50,064	36.8%	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	16,809	17.3%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	39,046	39.0%	AmeriHealth Michigan; Coventry (Aetna); Michigan Complete Health; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York*	Capitated	1/1/2015	4/1/2015	124,000	4,566	3.7%	There are 14 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	561	2.8%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	74,347	65.2%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	13,717	54.0%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	7,915	14.8%	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	39,919	23.8%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,194	41.1%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**391,440**	**31.2%**	

** 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

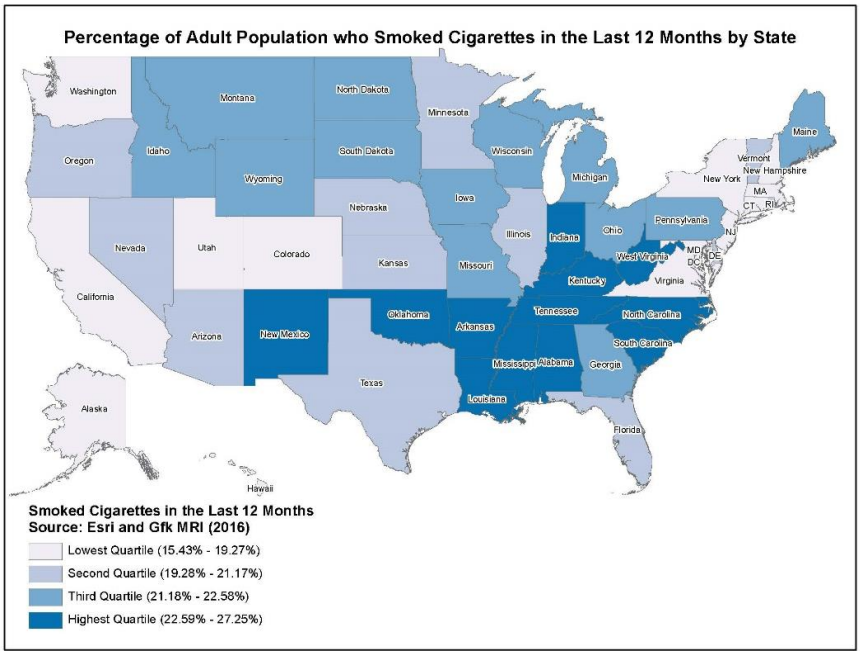
HMA Conference Session on Medicaid Waivers to Feature CEO of Meridian Health Plans, Medicaid Directors from Michigan, Hawaii

A special breakout session titled "Medicaid Waivers – A Future of Innovation, A Danger of Disruption" will feature as speakers David Cotton, chief executive of Meridian Health Plans; Judy Mohr Peterson, Medicaid Director, Hawaii State Dept. of Human Services; and Chris Priest, Medicaid Director, Michigan Dept. of Health and Human Services. The session will take place during HMA's annual conference on *The Future of Medicaid is Here: Implications for Payers, Providers and States,* September 11-12, 2017, at the Renaissance Chicago Downtown Hotel**.** The event, which features more than 35 industry-leading speakers, will address the challenges and opportunities for organizations serving Medicaid and other vulnerable populations given the priorities of the new Administration and Congress

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

Over the past ten weeks, the HMA Weekly Roundup and HMA Information Services (HMAIS) has showcased a series of maps and other key informatics. Our final map in the series highlights data on **the percentage of the adult population who smoked cigarettes in the last 12 months by state**. Tobacco use is one of the nation's deadliest and most costly public health challenges. Significant disparities in tobacco use exist geographically – generally resulting from differences among states in smoke-free protections, tobacco prices, and program funding for tobacco control.



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/

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.