HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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RFP CALENDAR

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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 November 2017, more than 400,000 duals are enrolled in an MMP, the second-highest monthly enrollment since the demonstrations began, according to state and CMS enrollment reports.

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, likely due to discrepancies in the timing of reports.

Dual Demonstration Enrollment Overview

As of November 2017, more than 400,000 dual eligibles were enrolled in a demonstration plan across the ten states below. Since November 2016, enrollment in Dual Demonstrations across all states is up by nearly 36,000 members, a 9.8 percent year-over-year increase. As noted in the introduction, November 2017 represents the second-highest ever duals demonstration enrollment total, due in part to the launch of Rhode Island's demonstration in late 2016. Virginia's Dual Demonstration enrollment is the only program that has experienced steady declines in enrollment over the last six months, which is likely related to the program sunsetting at the end of 2017, with any remaining members transitioning to the state's new managed long-term services and supports program in 2018.

Dual Eligible Financial Alignment Demonstration Enrollment by State - June 2017 to November 2017

State	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
California	117,302	116,286	116,052	116,198	116,351	117,165
Illinois	50,064	50,398	51,767	51,476	51,431	51,292
Massachusetts	16,809	17,967	17,552	17,573	18,594	18,423
Michigan	39,046	38,205	38,291	38,375	38,430	38,580
New York	4,566	4,683	4,610	4,566	4,507	4,468
New York - IDD	561	589	598	625	662	701
Ohio	74,347	74,931	75,915	76,428	76,291	76,878
Rhode Island	13,717	13,560	13,462	13,342	14,245	14,140
South Carolina	7,915	7,818	11,468	11,699	11,493	11,532
Texas	39,919	39,214	40,252	44,917	44,778	44,347
Virginia	27,194	26,166	25,335	24,575	23,870	23,100
Total Duals Demo Enrollment	**391,440**	**389,817**	**395,302**	**399,774**	**400,652**	**400,626**

Source: State-Reported Enrollment Data; CMS Medicare Advantage Enrollment Data

So far, enrollment in these ten states represents nearly 32 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 55 percent participation.

Dual Eligible Financial Alignment Demonstration Enrollment Timing; Current and Potential Enrollment - As of November 2017					
	Opt-In Enrollment Date	First Passive Enrollment Date	Current Enrollment	Potential Enrollment	% Enrolled (Full Potential)
California	4/1/2014	5/1/2014	117,165	350,000	33.5%
Illinois	4/1/2014	6/1/2014	51,292	136,000	37.7%
Massachusetts	10/1/2013	1/1/2014	18,423	97,000	19.0%
Michigan	3/1/2015	5/1/2015	38,580	100,000	38.6%
New York	1/1/2015	4/1/2015	4,468	124,000	3.6%
New York - IDD	4/1/2016	No Passive	701	20,000	3.5%
Ohio	5/1/2014	1/1/2015	76,878	114,000	67.4%
Rhode Island	7/1/2016	10/1/2016	14,140	25,400	55.7%
South Carolina	2/1/2015	4/1/2016	11,532	53,600	21.5%
Texas	3/1/2015	4/1/2015	44,347	168,000	26.4%
Virginia	3/1/2014	5/1/2014	23,100	66,200	34.9%
Total (All States)			**400,626**	**1,254,200**	**31.9%**

Source: State-Reported Enrollment Data; CMS Medicare Advantage Enrollment Data

Dual Demonstration Enrollment by Health Plan

As of November 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 57,000 and 49,000 demonstration enrollees, respectively.

Dual Eligible Financial Alignment Demonstration Enrollment by Publicly Traded Health Plan - June 2017 to November 2017						
Health Plan	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Molina	53,379	53,116	56,140	57,112	57,244	57,071
Centene	47,464	46,800	48,353	49,588	49,659	49,688
Anthem	32,759	31,931	31,817	32,732	32,254	31,643
Aetna	30,255	30,177	30,343	30,236	30,132	30,076
United	18,520	18,441	18,697	20,718	21,318	21,027
Humana	15,498	15,323	15,045	15,271	14,877	14,591
CIGNA/HealthSpring	5,842	5,628	5,496	5,349	5,246	6,049
Total Publicy Traded Plans	**203,717**	**201,416**	**205,891**	**211,006**	**210,730**	**210,145**

Source: State-Reported Enrollment Data; CMS Medicare Advantage Enrollment Data

Among non-publicly traded health plans, Inland Empire in California is the largest, with nearly 25,000 members, making it the fifth largest MMP nationwide. CareSource (Ohio), CalOptima (California), Blue Cross Blue Shield 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 November 2017. Enrollment by non-publicly traded health plans for the past six months is detailed below.

Dual Eligible Financial Alignment Demonstration Enrollment by Local/Other Plans - June 2017 to November 2017						
Health Plan	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Inland Empire (CA)	23,813	23,963	24,185	24,526	24,706	24,983
CareSource (OH)	19,652	19,828	20,055	19,388	18,341	18,563
CalOptima (CA)	15,727	15,469	15,268	15,214	15,199	15,213
BCBS of Illinois (HCSC) (IL)	15,722	15,976	16,221	16,325	16,373	16,476
LA Care (CA)	14,646	14,881	14,988	15,100	15,337	15,489
Commonwealth Care Alliance (MA)	13,447	14,626	14,332	14,430	15,533	15,419
Meridian Health Plan (IL, MI)	12,243	12,228	12,231	12,092	12,103	12,089
Neighborhood Health Plan of Rhode Island (RI)	13,717	13,560	13,462	13,342	14,245	14,140
Health Plan of San Mateo (CA)	9,371	9,247	9,203	9,193	9,196	9,201
AmeriHealth Caritas (MI, SC)	7,167	7,007	8,313	8,410	8,347	8,357
Santa Clara Family Health Plan (CA)	7,437	7,186	7,145	7,112	7,135	7,249
Care 1st (CA)	6,327	6,168	6,112	6,044	5,992	6,023
Virginia Premier (VA)	5,503	5,273	5,119	4,923	4,764	4,609
HAP Midwest Health Plan (MI)	5,075	4,874	4,817	4,753	4,766	4,786
Community Health Group Partner (CA)	5,184	5,271	5,301	5,353	5,427	5,439
Upper Peninsula Health Plan (MI)	4,252	4,286	4,289	4,285	4,285	4,320
Network Health (MA)	3,362	3,341	3,220	3,143	3,061	3,004
VNS Choice (NY)	1,553	1,535	1,510	1,491	1,442	1,451
Managed Health Inc. (NY)	972	973	955	954	963	971
GuildNet (NY)	688	680	654	639	629	606
Partners Health Plan - IDD (NY)	561	589	598	625	662	701
The New York State Catholic Health Plan (NY)	331	332	325	314	315	303
Elderplan (NY)	378	389	382	383	378	379
MetroPlus Health Plan (NY)	184	191	185	190	187	189
Independence Care System (NY)	141	138	137	134	128	105
Senior Whole Health (NY)	143	141	139	136	137	138
AgeWell New York (NY)	88	156	171	176	177	183
North Shore-LIJ (NY)	28	44	44	42	42	38
Centers Plan for Healthy Living (NY)	11	22	23	24	26	25
Village Senior Services Corp. (NY)	N/A	19	16	17	17	18
Elderserve Health (NY)	N/A	8	11	10	9	14
Total Local/Other Plans	**187,723**	**188,401**	**189,411**	**188,768**	**189,922**	**190,481**

Source: State-Reported Enrollment Data; CMS Medicare Advantage Enrollment Data

HMA MEDICAID ROUNDUP

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Proposed Children's Medical Services Has $25 Million Fiscal 2017 Deficit. *The Ledger* reported on December 11, 2017, that the Florida Children's Medical Services program had an estimated $25 million budget deficit in fiscal 2017, driven by higher than anticipated medical costs. The state has increased its cost projections by nearly 17 percent and does not anticipate any further shortfalls in fiscal 2018. Either way, lawmakers will need to address the fiscal 2017 deficit in the next legislative session. Children's Medical Services is a Medicaid managed care program that covers approximately 51,000 of the state's sickest children. Read More

Senate President to Seek Increase in Medicaid Reimbursements to Nursing Homes. *Health News Florida* reported on December 11, 2017, that Florida Senate President Joe Negron (R-Stuart) will attempt to increase Medicaid reimbursement rates for nursing homes during the upcoming legislative session. The increase would come as Florida is expected to move from a cost-based reimbursement system to prospective payments in 2018. Negron also made nursing homes a priority last year, when he unsuccessfully attempted to carve out nursing homes from Medicaid managed care. Read More

Agency Requests $89 Million for Developmental Disabilities Waiver Program. *Health News Florida* reported on December 8, 2017, that the Florida Agency for Persons with Disabilities is seeking $89.3 million in 2018 for the Home and Community Based Services Medicaid waiver program for individuals with developmental disabilities. Without the additional funding, which includes more than $55 million in federal matching dollars, the program would face a deficit. Florida House Health Care Appropriations Chairman Jason Brodeur (R-Sanford) said that providing the additional funding would be a hit to the state budget. Read More

Georgia

Commission Recommends Improvements to Children's Mental Health Services. *Georgia Health News* reported on December 12, 2017, that a Georgia commission has recommended several ways the state can improve mental health services for children, including expanded access, suicide prevention, and opioid abuse intervention. Among other recommendations, the commission called for expanding and sustaining the Georgia Apex Program

for school-based mental health services; funding employment education programs; increasing telemedicine; and investing in coordinated training in priority areas, including evidence-based practices, trauma-informed care, and administrative practices. Read More

Idaho

Idaho Receives Positive Comments on Waiver Proposals to Expand Medicaid to 38,000 Adults. *The Seattle Times* reported on December 11, 2017 that public comments on two Idaho waiver proposals that would expand Medicaid to a projected 38,000 adults were mostly positive at a recent hearing. Idaho is seeking one waiver to allow working adults to buy subsidized Exchange plans and another to allow the sickest adults to qualify for Medicaid. The waivers still must be approved by the state's Republican-controlled legislature, which have previously voted against expanding coverage. Read More

Illinois

Home Health Agencies Rife with Fraud, Report Says. The *Chicago Tribune* reported on December 12, 2017, the Illinois home care industry is rife with fraud, especially in Chicago where federal investigators estimate agencies have improperly collected more than $104 million in the last five years. A *Tribune* analysis reveals that thousands of patients were given false diagnoses and received unnecessary medical treatments and medications. The analysis suggests that state health regulators issued home health licenses too fast and without adequate oversight. Read More

Louisiana

'Emergency' Medicaid Contract Renewals May Lack Legal Standing. *The Times-Picayune* reported on December 10, 2017, that Louisiana Governor John Bel Edwards does not have the legal authority to issue Medicaid managed care contract extensions without the Legislature's approval, according to the office of state Attorney General Jeff Landry. In a letter to 16 state senators, Landry's office stated that if challenged, the contracts "could be declared null and void." As previously reported, Edwards intends to use emergency powers to extend contracts with the state's five Medicaid plans for 23 months, bypassing the state legislature. The decision was made after Louisiana House Republicans voted twice to block the contract renewals. Contracts expire on January 31, 2018. Read More

Louisiana Spends Less Than Expected on Medicaid. *U.S. News* reported on December 6, 2017, that Louisiana is spending less than expected on Medicaid and could end up as much as $650 million under budget in the fiscal year ending June 30, 2018. The state's Medicaid expansion program is accounting for much of the lower-than-expected spend. Read More

Maine

Governor Says He Won't Implement Medicaid Expansion Without 'Adequate Funding.' *Bangor Daily News* reported on December 11, 2017, that

Maine Governor Paul LePage said he will not implement a Medicaid expansion program approved by voters in a referendum "without adequate funding." LePage, who has vetoed expansion five times, reiterated a list of funding conditions he says must be met before his administration will implement the initiative. These include no tax increases and no use of budget stabilization funds. He also says that any funding mechanism must be ongoing and that waitlists for services for elderly and disabled people must be addressed. Read More

Massachusetts

Boston Medical Center to Invest $6.5 Million in Affordable Housing. The *Boston Globe* reported on December 7, 2018, that Boston Medical Center (BMC) will invest $6.5 million over five years on affordable housing projects throughout Boston. BMC will partner with local housing organizations and development corporations, including Pine Street Inn, Boston Health Care for the Homeless Program, Fields Corner, and the Boston Housing Authority, to build and renovate homes. Read More

State Settles Medicaid Claims Dispute with Home Care Provider. *The New York Times* reported on December 6, 2017, that Centrus Premier Home Care, which operates as Maxim Healthcare Services in Massachusetts, will pay $14 million to settle allegations that it improperly billed the state's Medicaid program for unnecessary nursing or skilled therapy services. Maxim Health says that it self-reported the error, adding that the improper billing was a result of misinterpretation of a regulation. Read More

Michigan

McLaren on Pace to Become One of Largest Michigan Health Systems in 2018. *Crain's Detroit Business* reported on December 10, 2017, that McLaren Health Care Corp. is on pace to become one of the largest health systems in Michigan in 2018, with $5.6 billion in revenues. A series of acquisitions is driving the growth, including deals to buy Huron Medical Center, Caro Community Hospital, two Lansing hospitals, and MDwise, an Indiana Medicaid health plan with 360,000 members. Read More

Half of Medicaid Expansion Enrollees Work, Study Says. *The News & Observer* reported on December 11, 2017, that approximately half of Michigan's Medicaid expansion enrollees have a job, according to a study by the University of Michigan Institute for Healthcare Policy and Innovation. The study, commissioned by the Michigan Department of Health and Human Services, also found that a quarter of those who are unemployed are in poor health. The Institute stated that work requirements can significantly disrupt health coverage for these individuals and increase administrative costs related to enforcement for the state. Read More

Missouri

Medicaid Oversight Committee Warns of Possible Cuts. *Missourinet* reported on December 13, 2017, that additional cuts to Medicaid are likely, according to the Missouri Medicaid Oversight Committee. Committee Chairman Timothy

McBride pointed to rising healthcare costs, increases in enrollment, and an aging population. The state has already trimmed provider reimbursements, eliminated vacant administration positions, and narrowed eligibility to senior nursing care and prescription drugs. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

New Jersey Announces Schedule for 2018 MAAC Meetings. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services announced the 2018 schedule for the Medical Assistance Advisory Council quarterly meetings:

Wednesday, January 24, 2018 10:00 AM – 1:00 PM
Wednesday, April 11, 2018 10:00 AM – 1:00 PM
Wednesday, July 18, 2018 10:00 AM – 1:00 PM
Wednesday, October 17, 2018 10:00 AM – 1:00 PM

The meetings are open to the public. Read More

New York

HMA Roundup – Denise Soffel (*Email Denise*)

Medicaid Managed Care Advisory Review Panel Holds Quarterly Meeting. The New York Medicaid Managed Care Advisory Review Panel, the legislatively mandated oversight body for New York's Medicaid managed care program, held its quarterly meeting on December 7. Jonathan Bick, Director of the Division of Health Plan Contracting and Oversight for the New York Department of Health (DoH), provided a program update. In addition, the panel received a report on the integration of behavioral health into managed care, an update on the status of managed long-term care, and a report on the financial status of mainstream Medicaid managed care plans. Slides are available on request.

Program Updates

- The Department of Health is reviewing several plan requests to expand service areas, including Capital District Physicians' Health Plan (CDPHP), YourCare, Excellus, VNS Choice and HealthNow.
- Centene has applied for an Article 44 license under the name of New York Quality Health Care Corporation to operate as a health maintenance organization in the state of NY. The application is under review by DoH.
- The proposed purchase of Fidelis Health by Centene is also being reviewed by DoH, the Department of Financial Services, and the Charities Bureau of the Attorney General's office.
- Clotting factor was carved into the Medicaid managed care benefit in July 2017.
- Adding Harm Reduction Services to the Medicaid managed care benefit has been delayed from January to April 2018.
- Real-time continuous glucose monitoring for Type 1 diabetes will be added to the benefit as of January 2018.

Behavioral Health Transition

• NY has submitted its final draft of the Children's Behavioral Health Transition Plan to Centers for Medicare & Medicaid Services (CMS); it has not yet been approved.
• Managed care plans submitted their qualification documents for approval to provide the new children's behavioral health services in October; interim reports will be sent back to plans in mid-January. Readiness reviews are scheduled for March and April, and the behavioral health carve-in will occur July 1, 2018.
• Plans continue to struggle to enroll eligible Health and Recovery Plan members into home and community-based services. Part of the problem is a significant lag in claims payment, which is typically 6 – 8 months.
• NY received 10 applications from entities that are interested in establishing a Care Coordination Organization to provide health home services to individuals with intellectual/developmental disabilities.

Managed Long-Term Care

• Managed Long-Term Care (MLTC) enrollment continues to grow, and is now almost 215,000.
• Fully Integrated Duals Advantage (FIDA) has expanded to Region 2 (Suffolk and Westchester counties). Three plans – Agewell New York, Health First Absolute Care, and River Spring – are now operating. Total FIDA enrollment remains below 5,000 across the eight counties.
• Four plans have dropped out of participation in the FIDA program, leaving 14 plans. NY still has more plans operating in its duals demonstration than any other states.
• MLTC plans must convert their contracts with providers to value-based payment arrangements by December 31. New contracts must include at least an upside bonus arrangement. Plans are also responsible for monitoring avoidable hospitalizations.

Medicaid Managed Care Surplus and Loss Statistics

• The financial status of the 18 Medicaid managed care plans operating in NY deteriorated between 2015 and 2016. In 2015, six plans reported operating loss; in 2016 it increased to 11 plans.
• Not-for-profit plans are doing less well than for-profit plans. Fourteen not-for-profit plans were operating in 2015 and 6 reported operating losses. In 2016 13 plans were operating and 9 reported operating losses.
• In 2015 across the four F-P plans none reported operating losses; in 2016 two of the four reported operating losses.
• DoH representatives were unable to provide any explanation for the differences between the NFP and the FP plans.
• DoH indicated that the financial pressure on Medicaid is worsening as federal policy directions continue to emerge. Several expectations that the state had for financial relief from Washington (restoration of DSH payments, maintenance of Cost Sharing Reduction payments) are now seen as unlikely, putting new pressure on the Global Spending Cap.

NY Medicaid Initiative Focusing on Young Children Drafts Ten-Point Agenda. In August, the New York Department of Health launched a new focus for Medicaid Redesign: The First 1000 Days on Medicaid initiative. The initiative brought together stakeholders in a series of work groups, culminating in a ten–point agenda that focuses on enhancing access to services

and improving outcomes for children on Medicaid in their first 1000 days of life.

1. Create a Preventive Pediatric Care Clinical Advisory Group – convene a Preventive Pediatric Care clinical advisory group charged with developing a framework model for how best to organize well–child visits/pediatric care in order to implement the Bright Futures Guidelines (the American Academy of Pediatrics´ standard of care).

2. Promote Early Literacy through Local Strategies launch one or more three–year pilots for mainstream managed care organization to expand the use of Reach Out and Read (ROR) in pediatric primary care and foster local cross–sector collaboration focused on improving early language development skills in children ages 0 – 3.

3. Expand Centering Pregnancy – support a pilot project in the neighborhoods/communities of poorest birth outcomes to encourage obstetrical providers serving Medicaid patients to adopt the Centering Pregnancy group–based model of prenatal care, designed to enhance pregnancy outcomes through a combination of prenatal education (gestational development, healthy behaviors) and social support.

4. New York State Developmental Inventory Upon Kindergarten Entry – agree upon a measurement tool to assess child development upon Kindergarten entry to allow population–level tracking of trends over time in child development; assessment of how policy and programmatic changes are possibly affecting child development; and identification of areas (e.g. whether regions of the state, areas within child development) in need of improvement, investment, and policy change.

5. Statewide Home Visiting – ensure the sustainability of home visiting so every child and pregnant woman who is eligible and desiring of the services receives them. Home visiting consists of a variable but comprehensive set of services including medical care, behavioral health care, social services and health education.

6. Require Managed Care Plans to have a Kids Quality Agenda – develop a two–year effort to improve managed care plan performance on children and perinatal health care quality measures. DOH would develop a two–year common Performance Improvement Project for all Medicaid managed care plans focused on increasing performance on young child related Quality Assurance Reporting Requirements (QARR) measures (well–child visits, lead screening, child immunization combo); enhancing rates of developmental, vision, hearing and maternal depression screenings and/or evaluations; and improving select performance on existing QARR perinatal health measures.

7. Data system development for cross–sector referrals – purchase a Medicaid–determined hub–and–spoke data system that enables screening and referrals across clinical and community settings for at least 3 communities.

8. Braided funding for Early Childhood Mental Health Consultations – explore a braided funding approach for paying for mental health consultation services to early childhood professionals in early care and education settings.

9. Parent/Caregiver Diagnosis as Eligibility Criteria for Dyadic Therapy – allow providers to bill for the provision of evidence–based parent/caregiver–child therapy (also called dyadic therapy) based solely on the parent/caregiver

being diagnosed with a mood, anxiety, or substance use disorder rather than only in instances where the child has a diagnosed mental health condition.

10. Pilot and Evaluate Peer Family Navigators in Multiple Settings – develop, implement and evaluate a total of nine pilots that would provide peer family navigator services. Read More

Federal Funding for NY's Essential Plan in Jeopardy. *Politico* reported on December 8, 2017, that the Centers for Medicare & Medicaid Services (CMS) has indicated that it may stop providing funding for New York's Essential Plan. CMS has told the state's budget office that if Congress does not fund the cost-sharing reduction program in the next three weeks, the federal government will stop paying for a portion of the state's Essential Plan, creating a nearly $1 billion hole in the upcoming budget. The Essential Plan is a Basic Health Program established by the Affordable Care Act, and funded in part with money from the cost-sharing reduction program. According to Politico, the state relies on roughly $900 million per year in Cost Sharing Reduction (CSR) funding to keep the Essential Plan afloat, covering 25 percent of the cost of the program. New York is already facing a budget deficit of $4.4 billion for the coming fiscal year. Over 710,000 people are enrolled in the Essential Plan, which offers coverage to individuals with income below 200 percent of the federal poverty level who are not eligible for Medicaid coverage. Read More

New Mexico

New Mexico Scales Back, Delays Some Proposed Medicaid Cuts. *Santa Fe New Mexican* reported on December 6, 2017, that New Mexico is scaling back or delaying certain proposed cuts to the state's Medicaid program in the face of opposition from providers and advocates. For example, the state has eased up on proposed premium and copay requirements for Medicaid recipients and will also delay full implementation of a plan to end retroactive Medicaid coverage. The revisions were made in a final waiver request submitted to federal regulators by the state Human Services Department. Read More

Molina to Expand Program to Link Inmates with Medicaid. *Albuquerque Journal* reported on December 11, 2017, that Molina Healthcare of New Mexico will expand to 27 detention centers a pilot program that helps inmates take full advantage of their Medicaid benefits before they are released from jail. Before an inmate's Medicaid benefits are reinstated, Molina representatives visit detention centers to help schedule appointments, make arrangements with pharmacies, and get members connected with housing, employment, and others social services. An analysis found that the average per member per month cost for Medicaid members who participated in the program was $3,941, compared to $11,795 for those that didn't. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

General Assembly Reauthorizes State CHIP; Sends to Governor's Desk. *Penn Live* reported on December 11, 2017, that the Pennsylvania Senate, in a 43-6 vote, passed a bill to reauthorize the Children's Health Insurance Program through 2019. The House voted last spring to approve the reauthorization. While Governor Wolf is expected to sign the legislation, in the absence of

federal reauthorization, the state program remains at risk. Federal funding covers approximately 90 percent of the $450 million cost of Pennsylvania's CHIP program. Read More

Wisconsin

Governor Names Heather Smith Medicaid Director. *The Seattle Times* reported on December 11, 2017, that Wisconsin Governor Scott Walker has named Heather Smith Medicaid director. She will replace Michael Heifetz, who announced that he will resign. Smith is currently the deputy chief of staff for budget, legislative, and intergovernmental affairs. Read More

National

House Republicans Propose Roll Back of Medical Device, Cadillac Taxes. *Reuters* reported on December 12, 2017, that House Republicans are proposing suspension of the Affordable Care Act medical device tax for five years and a one-year delay in implementation of the "Cadillac" tax on high-cost insurance until 2021. Republicans also want to retroactively eliminate penalties for employers that did not offer insurance over the last three years and next year. Congress is already in the final stages of a tax overhaul, which would eliminate the individual health insurance mandate. Read More

Bipartisan Group of Governors Calls for CHIP Funding Reauthorization. *The Hill* reported on December 12, 2017, that a bipartisan group of governors, led by John Kasich of Ohio and John Hickenlooper of Colorado, are urging Congress to reauthorize funding for the Children's Health Insurance Program (CHIP). Federal funding for CHIP expired on September 30, and states have begun informing families that coverage may end on January 31. Read More

House Considers Suspending ACA Health Insurer Tax. *Politico* reported on December 7, 2017, that House Republicans are considering a plan to suspend the Affordable Care Act health insurance tax for plans sold in the large employer group market, the Exchange market and Medicare Advantage plans in 2018, and across the board in 2019. In 2018, the tax would still apply to small businesses and possibly some Medicaid plans. Also on the table is a two-year delay of the medical device tax, loosened restrictions on health savings accounts, and a delay of the Cadillac tax. Read More

Medicaid Members Are Motivated to Improve Their Health, Study Says. *The Associated Press* reported on December 7, 2017, that Medicaid patients are motivated to improve their health, including eating healthy foods, exercising, and having a personal physician, according to the Gallup-Sharecare Well-Being Index. Still, Medicaid members are less healthy than members of Medicare or employer-sponsored insurance, the index showed. Medicaid members are also more likely to suffer from depression and obesity. Read More

Hospitals Issue Flood of Bonds Ahead of Tax Overhaul. *Modern Healthcare* reported on December 7, 2018, that not-for-profit hospitals are rushing to take on debt before proposed tax legislation eliminates their ability to issue tax-exempt bonds. The proposed tax overhaul could also prohibit advance re-funding of existing bonds. Hospitals argue that the changes will increase their borrowing costs. Read More

Exchange Enrollment Lags Significantly Compared to Prior Years. *Modern Healthcare* reported on December 6, 2017, that more than 3.6 million individuals signed up for an Affordable Care Act Exchange plan through five weeks of open enrollment, significantly behind prior years. The data from the Centers from Medicare & Medicaid Services doesn't include auto-enrollments. Read More

Medicaid Members Are Increasingly Offered Financial Incentives to Stay Healthy. *Kaiser Health News* reported on December 5, 2017, that Medicaid members are increasingly being offered financial incentives to engage in preventive care programs aimed at reducing the prevalence of chronic diseases. Financial incentives do tend to persuade Medicaid members to engage in preventive care activities, research suggests. However, the impact of these programs on measurable improvements in member health and savings to Medicaid programs is less clear. Read More

Industry News

J. Mario Molina Resigns from Molina Healthcare Board. Molina Healthcare announced on December 13, 2017 that J. Mario Molina, M.D., has resigned from the company's board of directors. Molina was a board member since 1996 and was also previously the company's president and chief executive. Molina is president of Golden Shore Medical Group. Read More

Ascension, Providence St. Joseph Consider Merger. *The Wall Street Journal* reported on December 10, 2017, that Ascension and Providence St. Joseph Health, two not-for-profit hospital systems, are considering a merger. The combined system would be the largest in the nation, with 191 hospitals in 27 states and annual revenues of $44.8 billion. Read More

BCBS Insurers on Pace to Post ACA Exchange Profits in 2017. *Politico* reported on December 7, 2017, that many Blue Cross Blue Shield plans are on pace to post profits on the Affordable Care Act Exchanges in 2017, driven by rate increases averaging 20 percent for the most popular plans. A *Politico* study showed that 31 BCBS plans spent an average of 78 percent of premiums on medical claims through the first nine months of 2017, and operating margins for most plans improved. A repeal of the individual mandate and the end of cost-sharing subsidies will impact Exchange plan financial performance. Read More

Dignity Health, Catholic Health Initiatives to Merge. *Modern Healthcare* reported on December 7, 2017, that Dignity Health and Catholic Health Initiatives (CHI) signed a definitive agreement to merge. The deal would create the largest national not-for-profit hospital system, with combined revenues of $28.4 billion and operations in 28 states. CHI chief executive Kevin Lofton and Dignity chief executive Lloyd Dean will serve as co-CEOs. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
January 1, 2018	Delaware	Implementation	200,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices (Delay Likely)	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)	Implementation	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 5, 2018	Iowa	Proposals Due	600,000
January 25, 2018	Arizona	Proposals Due	1,600,000
January, 2018	Kansas KanCare	Proposals Due	380,000
February 27, 2018	Iowa	Contract Awards	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 (Delay Likely)	Implementation (NE Zone)	315,000
March 1, 2018	Massachusetts	Implementation	850,000
March 6, 2018	Texas STAR+PLUS Statewide	Proposals Due	530,000
March 8, 2018	Arizona	Contract Awards	1,600,000
March 15, 2018	New Mexico	Contract Awards	700,000
April 1, 2018	New Hampshire	RFP Release	160,000
April 16, 2018	Florida Statewide Medicaid Managed Care (SMMC)	Contract Awards	3,100,000
June, 2018	North Carolina	Proposals Due	1,500,000
June, 2018	Kansas KanCare	Contract Awards	380,000
July 1, 2018	Pennsylvania HealthChoices (Delay Likely)	Implementation (SE Zone)	830,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona	Implementation	1,600,000
October 1, 2018	Texas STAR+PLUS Statewide	Contract Start	530,000
November 1, 2018	New Hampshire	Proposals Due	160,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
January 1, 2019	Florida Statewide Medicaid Managed Care (SMMC)	Implementation	3,100,000
January 1, 2019	Pennsylvania HealthChoices (Delay Likely)	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	New Mexico	Implementation	700,000
January 1, 2019	New Hampshire	Contract Awards	160,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
January, 2019	Kansas KanCare	Implementation	380,000
July 1, 2019	North Carolina	Implementation	1,500,000
July 1, 2019	New Hampshire	Implementation	160,000
July 1, 2019	Iowa	Implementation	600,000
September 1, 2019	Texas STAR, CHIP Statewide	Implementation	3,400,000
January 1, 2020	Texas STAR+PLUS Statewide	Operational Start Date	530,000
January 1, 2020	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000

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