HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

January 10, 2018

RFP CALENDAR

HMA News

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THIS WEEK

IN FOCUS

MEDICAID MANAGED CARE ENROLLMENT UPDATE – Q4 2017

This week, our *In Focus* section reviews recent Medicaid enrollment trends in capitated, risk-based managed care in 27 states.[1] Many state Medicaid agencies post monthly enrollment figures by health plan for their Medicaid managed care population to their websites. This data allows for the timeliest analysis of enrollment trends across states and managed care organizations. Nearly all 27 states highlighted in this review have released monthly Medicaid managed care enrollment data into the fourth quarter (Q4) of 2017. This report reflects the most recent data posted. HMA has made the following observations related to the enrollment data shown on Table 1 (below):

- Seventeen of the 27 states– Arizona, California, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, New Mexico, New York, Ohio, Oregon, Pennsylvania, Washington, and West Virginia – expanded Medicaid under the Affordable Care Act and have seen increased Medicaid managed care enrollment as a result of expansion.
- The 27 states in this report account for an estimated 49.3 million Medicaid managed care enrollees as of the end of Q4 2017. Based on HMA estimates of MCO enrollment in states not covered in this report, we believe that, nationwide, Medicaid MCO enrollment is has likely surpassed 55 million in the second half of 2017. As such, the enrollment data across these 27 states represents nearly 90 percent of all Medicaid MCO enrollment.
- States with managed care that do not publish monthly enrollment reports are Delaware, District of Columbia, Kansas, Massachusetts, New Hampshire, New Jersey, Nevada, Rhode Island, Utah, and Virginia.
- Across the 27 states tracked in this report, Medicaid managed care enrollment is up nearly 1.4 percent year-over-year as of December 2017, adding more than 660,000 net new enrollees since December 2016.
- The 18 expansion states listed above have seen net Medicaid managed care enrollment increase by more than 580,000 members, or 1.6 percent, in the past year, to 36.2 million members at the end of Q4 2017.
- The nine states that have not yet expanded Medicaid have seen net Medicaid managed care enrollment increase by roughly 80,000 members, or 0.6% percent, to just over 13 million members at the end of Q4 2017.

[1] Arizona, California, Florida, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, New Mexico, New York, Ohio, Oregon, Pennsylvania, South Carolina, Tennessee, Texas, Washington, West Virginia, Wisconsin.

Table 1 - Monthly MCO Enrollment by State – July 2017 through December 2017

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Arizona	**1,620,085**	**1,620,192**	**1,637,478**	**1,618,483**	**1,614,995**	**1,604,208**
+/- m/m	(406)	107	17,286	(18,995)	(3,488)	(10,787)
% y/y	3.6%	2.8%	2.8%	1.0%	0.2%	-0.7%
California	**10,829,903**	**10,884,621**	**10,844,725**	**10,864,882**	**10,796,603**	
+/- m/m	(4,070)	54,718	(39,896)	*20,157*	*(68,279)*	*N/A*
% y/y	2.4%	2.6%	2.5%	*1.7%*	*0.8%*	
Florida	**3,353,736**	**3,322,506**	**3,307,974**	**3,330,954**	**3,287,134**	**3,289,290**
+/- m/m	(16,566)	(31,230)	(14,532)	*22,980*	*(43,820)*	*174,646*
% y/y	0.0%	-1.8%	-2.0%	*-1.4%*	*-3.2%*	*-3.0%*
Georgia	**1,328,215**	**1,329,310**	**1,327,516**	**1,368,880**	**1,367,217**	
+/- m/m	35,812	1,095	*(1,794)*	*41,364*	*(1,663)*	*N/A*
% y/y	0.9%	0.9%	1.3%	*5.0%*	*4.8%*	
Hawaii	**360,811**	**359,568**	**358,235**			
+/- m/m	*360,811*	*(1,243)*	*(1,333)*	*N/A*	*N/A*	*N/A*
% y/y	1.8%	1.2%	0.6%			
Illinois	**1,963,582**	**1,961,762**	**1,955,614**	**1,939,416**	**1,935,826**	
+/- m/m	13,840	(1,820)	*(6,148)*	*(16,198)*	*(3,590)*	*N/A*
% y/y	-2.8%	-5.2%	-8.0%	N/A	*-5.3%*	
Indiana	**1,131,036**	**1,137,168**	**1,144,509**	**1,147,082**	**1,167,137**	
+/- m/m	(2,176)	6,132	*7,341*	*2,573*	*20,055*	*N/A*
% y/y	3.1%	2.9%	3.1%	*2.4%*	*4.0%*	
Iowa	**602,331**	**602,076**	**600,072**	***601,178***	***599,775***	
+/- m/m	(9,257)	(255)	(2,004)	*1,106*	*(1,403)*	*N/A*
% y/y	-0.4%	-0.9%	-1.0%	*-1.2%*	*-1.3%*	
Kentucky	**1,246,330**	**1,251,329**	**1,250,945**	**1,251,502**	**1,256,608**	**1,255,901**
+/- m/m	(4,943)	4,999	*(384)*	*557*	*5,106*	*(707)*
% y/y	2.2%	5.1%	3.2%	*2.9%*	*1.9%*	*2.1%*
Louisiana	**1,469,284**	**1,460,561**	**1,461,055**	**1,466,343**	**1,465,999**	
+/- m/m	4,768	(8,723)	*494*	*5,288*	*(344)*	*N/A*
% y/y	13.7%	9.2%	7.9%	*6.8%*	*4.6%*	
Maryland	**1,170,589**	**1,168,250**	**1,162,384**	**1,167,422**	**1,177,078**	
+/- m/m	(503)	(2,339)	(5,866)	*5,038*	*9,656*	*N/A*
% y/y	6.6%	5.5%	4.9%	*4.0%*	*4.1%*	
Michigan	**1,858,504**	**1,850,962**	**1,811,803**	**1,821,517**	**1,815,035**	**1,817,398**
+/- m/m	14,945	(7,542)	(39,159)	*9,714*	*(6,482)*	*2,363*
% y/y	7.0%	7.0%	4.2%	*3.2%*	*2.3%*	*2.2%*
Minnesota	**935,560**	**937,339**	**944,489**	**956,733**	**962,267**	**958,284**
+/- m/m	14,187	1,779	7,150	*12,244*	*5,534*	*(3,983)*
% y/y	2.3%	2.8%	1.0%	*5.9%*	*6.1%*	*6.2%*
Mississippi	**487,201**	**483,337**	**480,956**	**481,590**	**479,267**	**476,166**
+/- m/m	(1,975)	(3,864)	*(2,381)*	*634*	*(2,323)*	*(3,101)*

% y/y	-3.0%	-2.7%	-2.2%	-1.6%	-1.8%	-2.5%
Missouri	**730,146**	**724,123**	**719,995**	**715,390**	**717,160**	
+/- m/m	(2,974)	(6,023)	(4,128)	(4,605)	1,770	N/A
% y/y	45.2%	45.5%	43.7%	41.8%	41.4%	
Nebraska	**228,669**	**227,522**	**228,152**		**229,008**	**228,555**
+/- m/m	822	(1,147)	630	N/A	229,008	(453)
% y/y	N/A	N/A	N/A		N/A	N/A
New Mexico	**686,609**	**678,199**	**662,472**	**663,833**	**663,240**	**664,825**
+/- m/m	(6,178)	(8,410)	(15,727)	1,361	(593)	1,585
% y/y	1.8%	-0.3%	-3.0%	-3.0%	-3.5%	-3.7%
New York	**4,711,750**	**4,687,101**	**4,680,603**	**4,693,915**	**4,700,662**	**4,715,691**
+/- m/m	12,520	(24,649)	(6,498)	13,312	6,747	15,029
% y/y	1.0%	0.6%	0.4%	0.5%	1.0%	1.7%
Ohio	**2,539,594**	**2,529,935**	**2,513,145**	**2,505,567**	**2,493,524**	
+/- m/m	(14,964)	(9,659)	(16,790)	(7,578)	(12,043)	N/A
% y/y	3.1%	2.4%	1.7%	1.8%	1.5%	
Oregon	**871,376**	**869,945**	**861,734**	**866,012**	**876,218**	
+/- m/m	(21,334)	(1,431)	(8,211)	4,278	10,206	N/A
% y/y	1.1%	0.9%	1.8%	2.3%	1.2%	
Pennsylvania	**2,299,146**	**2,302,215**	**2,302,833**	**2,303,264**	**2,305,217**	
+/- m/m	2,476	3,069	618	431	1,953	N/A
% y/y	3.2%	2.9%	2.5%	2.2%	2.1%	
South Carolina	**779,599**	**777,699**	**767,964**			**777,298**
+/- m/m	4,057	(1,900)	(9,735)	N/A	N/A	777,298
% y/y	3.5%	2.3%	0.9%			1.8%
Tennessee	**1,401,418**	**1,422,877**	**1,433,139**	**1,446,576**	**1,460,973**	
+/- m/m	(10,645)	21,459	10,262	13,437	14,397	N/A
% y/y	-10.0%	-8.4%	-7.7%	-6.4%	-6.7%	
Texas						
+/- m/m	N/A	N/A	N/A	N/A	N/A	N/A
% y/y						
Washington	**1,619,153**	**1,611,961**	**1,596,655**	**1,593,903**	**1,598,855**	**1,608,031**
+/- m/m	(14,019)	(7,192)	(15,306)	(2,752)	4,952	9,176
% y/y	3.3%	2.9%	1.6%	1.2%	0.3%	0.0%
West Virginia	**424,753**	**421,890**	**419,951**	***418,084***	***416,881***	***416,621***
+/- m/m	(913)	(2,863)	(1,939)	(1,867)	(1,203)	(260)
% y/y	8.8%	8.4%	7.7%	7.3%	7.4%	8.2%
Wisconsin	**797,589**	**793,387**	**792,978**	***790,351***	***788,805***	***786,667***
+/- m/m	873	(4,202)	(409)	(2,627)	(1,546)	(2,138)
% y/y	-0.4%	-0.3%	-0.8%	-0.4%	-0.7%	-0.8%

Note: In Table 1 above and the state tables below, "+/- m/m" refers to the enrollment change from the previous month. "% y/y" refers to the percentage change in enrollment from the same month in the previous year.

Below, we provide a state-specific analysis of recent enrollment trends in the states where HMA tracks data.

It is important to note the limitations of the data presented. First, not all states report the data at the same time during the month. Some of these figures reflect beginning-of-the-month totals, while others reflect an end-of-the-month snapshot. Second, in some cases the data is comprehensive in that it covers all state-sponsored health programs for which the state offers managed care; in other cases, the data reflects only a subset of the broader managed Medicaid population. This is the key limiting factor in comparing the data described below and figures reported by publicly traded Medicaid MCOs. Consequently, the data we review in Table 1 and throughout the *In Focus* section should be viewed as a sampling of enrollment trends across these states rather than a comprehensive comparison, which cannot be developed based on publicly available monthly enrollment data.

State-Specific Analysis

Arizona

Medicaid Expansion Status: Expanded January 1, 2014

Enrollment in Arizona's two Medicaid managed care programs has declined slightly through 2017, down nearly 11,000 since year-end 2016. At the end of Q4 2017, Arizona's MCO enrollment stands at more than 1.6 million, down 0.7 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Acute Care	1,560,122	1,560,148	1,577,181	1,557,997	1,554,352	1,543,248
ALTCS	59,963	60,044	60,297	60,486	60,643	60,960
Total Arizona	**1,620,085**	**1,620,192**	**1,637,478**	**1,618,483**	**1,614,995**	**1,604,208**
+/- m/m	*(406)*	*107*	*17,286*	*(18,995)*	*(3,488)*	*(10,787)*
% y/y	*3.6%*	*2.8%*	*2.8%*	*1.0%*	*0.2%*	*-0.7%*

California

Medicaid Expansion Status: Expanded January 1, 2014

Medi-Cal managed care enrollment data through November 2017 shows an increase of 0.8 percent from the previous year, with managed care enrollment up roughly 90,000 since that time. As of November 2017, enrollment in managed care is approximately 10.8 million.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Two-Plan Counties	6,982,331	7,009,853	6,984,296	7,001,047	6,969,354	
Imperial/San Benito	84,622	84,680	84,333	84,411	84,242	
Regional Model	302,079	301,464	301,012	301,530	300,221	
GMC Counties	1,166,944	1,177,455	1,170,482	1,172,901	1,155,865	
COHS Counties	2,177,641	2,195,117	2,188,404	2,188,642	2,170,635	
Duals Demonstration	116,286	116,052	116,198	116,351	116,286	
Total California	**10,829,903**	**10,884,621**	**10,844,725**	**10,864,882**	**10,796,603**	
+/- m/m	*(4,070)*	*54,718*	*(39,896)*	*20,157*	*(68,279)*	
% y/y	*2.4%*	*2.6%*	*2.5%*	*1.7%*	*0.8%*	

Florida

Medicaid Expansion Status: Not Expanded

Florida's statewide Medicaid managed care program has seen a net decline in total covered lives over the last year, and now covers under 3.3 million beneficiaries as of December 2017, down 3 percent from the prior year. (*Note*

that the managed LTC enrollment figures listed below are a subset of the Managed Medical Assistance (MMA) enrollments and are included in the MMA number; they are not separately added to the total to avoid double counting; note also that FL Healthy Kids enrollment was not available for November 2017, so the previous month's enrollment for that program was used).

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
MMA	3,021,387	2,986,385	2,971,117	2,987,191	2,944,047	2,940,820
LTC (Subset of MMA)	*97,638*	*97,601*	*98,420*	*98,850*	98,414	93,843
SMMC Specialty Plan	159,701	162,308	160,915	171,273	170,597	171,387
FL Healthy Kids	172,648	173,813	175,942	172,490	172,490	177,083
Total Florida	**3,353,736**	**3,322,506**	**3,307,974**	**3,330,954**	**3,287,134**	**3,289,290**
+/- m/m	*(16,566)*	*(31,230)*	*(14,532)*	*22,980*	*(43,820)*	*2,156*
% y/y	*0.0%*	*-1.8%*	*-2.0%*	*-1.4%*	*-3.2%*	*-3.0%*

Georgia

Medicaid Expansion Status: Not Expanded

As of November 2017, Georgia's Medicaid managed care program covered nearly 1.37 million members, up 4.8 percent from the previous year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Georgia	**1,328,215**	**1,329,310**	**1,327,516**	**1,368,880**	**1,367,217**	
+/- m/m	*35,812*	*1,095*	*(1,794)*	*41,364*	*(1,663)*	
% y/y	*0.9%*	*0.9%*	*1.3%*	*5.0%*	*4.8%*	

Hawaii

Medicaid Expansion Status: Expanded January 1, 2014

Through September 2017, enrollment in the Hawaii Medicaid managed care program stands at more than 358,000, up 0.6 percent from September 2016. Hawaii has not reported Q4 2017 enrollment figures at the time of publication.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Hawaii	**360,811**	**359,568**	**358,235**			
+/- m/m	*360,811*	*(1,243)*	*(1,333)*			
% y/y	*1.8%*	*1.2%*	*0.6%*			

Illinois

Medicaid Expansion Status: Expanded January 1, 2014

Illinois enrollment across the state's four managed care programs sits at just under 2 million as of November 2017, down 5.3 percent from November 2016.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Family Health Program	1,770,180	1,766,406	1,760,482	1,745,386	1,742,316	
Integrated Care Program	114,364	114,813	114,762	113,952	113,209	
Duals Demonstration	50,398	51,767	51,476	51,431	52,015	
MLTSS	28,640	28,776	28,894	28,647	28,286	
Total Illinois	**1,963,582**	**1,961,762**	**1,955,614**	**1,939,416**	**1,935,826**	
+/- m/m	*13,840*	*(1,820)*	*(6,148)*	*(16,198)*	*(3,590)*	
% y/y	*-2.8%*	*-5.2%*	*-8.0%*		*-5.3%*	

Indiana

Medicaid Expansion Status: Expanded in 2015 through HIP 2.0

As of November 2017, enrollment in Indiana's managed care programs—Hoosier Healthwise, Hoosier Care Connect, and Healthy Indiana Program (HIP)—is nearing 1.2 million, up 4 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Hoosier Healthwise	616,341	624,369	633,374	636,393	630,576	
Hoosier Care Connect	91,775	91,590	91,146	91,027	90,759	
HIP	422,920	421,209	419,989	419,662	445,802	
Indiana Total	**1,131,036**	**1,137,168**	**1,144,509**	**1,147,082**	**1,167,137**	
+/- m/m	*(2,176)*	*6,132*	*7,341*	*2,573*	*20,055*	
% y/y	*3.1%*	*2.9%*	*3.1%*	*2.4%*	*4.0%*	

Iowa

Medicaid Expansion Status: Expanded January 1, 2014

Iowa launched its statewide Medicaid managed care program in April of 2016. Enrollment across all populations sits at nearly 600,000 as of November 2017. Enrollment is down 1.3 percent from the previous November.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Traditional Medicaid	417,084	416,775	415,774	416,313	414554	
Iowa Wellness Plan	142,495	142,508	141,539	141,697	141757	
hawk-i	42,752	42,793	42,759	43,168	43464	
Total Iowa	**602,331**	**602,076**	**600,072**	**601,178**	**599,775**	
+/- m/m	*(9,257)*	*(255)*	*(2,004)*	*1,106*	*(1,403)*	
% y/y	*-0.4%*	*-0.9%*	*-1.0%*	*-1.2%*	*-1.3%*	

Kentucky

Medicaid Expansion Status: Expanded January 1, 2014

As of December 2017, Kentucky covered more than 1.25 million beneficiaries in risk-based managed care. Total enrollment is up more than 2 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Kentucky	**1,246,330**	**1,251,329**	**1,250,945**	**1,251,502**	**1,256,608**	**1,255,901**
+/- m/m	*(4,943)*	*4,999*	*(384)*	*557*	*5,106*	*(707)*
% y/y	*2.2%*	*5.1%*	*3.2%*	*2.9%*	*1.9%*	*2.1%*

Louisiana

Medicaid Expansion Status: Expanded July 1, 2016

Medicaid managed care enrollment in Bayou Health stands at more than 1.5 million as of November 2017, up 4.6 percent from the previous year. Louisiana's Medicaid expansion, which began on July 1, 2016, has been a major driver of MCO enrollment growth over the past five quarters. Enrollment is up 37 percent since June of 2016.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Louisiana	**1,469,284**	**1,460,561**	**1,461,055**	**1,466,343**	**1,465,999**	
+/- m/m	*4,768*	*(8,723)*	*494*	*5,288*	*(344)*	
% y/y	*13.7%*	*9.2%*	*7.9%*	*6.8%*	*4.6%*	

Maryland

Medicaid Expansion Status: Expanded January 1, 2014

Maryland's Medicaid managed care program covered nearly 1.18 million as of November 2017, up 4.1 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Maryland	**1,170,589**	**1,168,250**	**1,162,384**	**1,167,422**	**1,177,078**	
+/- m/m	*(503)*	*(2,339)*	*(5,866)*	*5,038*	*9,656*	
% y/y	*6.6%*	*5.5%*	*4.9%*	*4.0%*	*4.1%*	

Michigan

Medicaid Expansion Status: Expanded April 1, 2014

Michigan's Medicaid managed care growth trend over the past year generally continued through the end of the year. As of December 2017, managed care enrollment sits at more than 1.8 million, up 2.2 percent from the previous year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Medicaid	1,820,299	1,812,671	1,773,428	1,783,087	1,776,455	1,778,889
MI Health Link (Duals)	38,205	38,291	38,375	38,430	38,580	38,509
Total Michigan	**1,858,504**	**1,850,962**	**1,811,803**	**1,821,517**	**1,815,035**	**1,817,398**
+/- m/m	*14,945*	*(7,542)*	*(39,159)*	*9,714*	*(6,482)*	*2,363*
% y/y	*7.0%*	*7.0%*	*4.2%*	*3.2%*	*2.3%*	*2.2%*

Minnesota

Medicaid Expansion Status: Expanded January 1, 2014

As of December 2017, enrollment across Minnesota's multiple managed Medicaid programs sits at more than 958,000, up nearly 6.2 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Parents/Kids	561,538	561,311	565,296	575,408	580,125	579,391
Expansion Adults	179,196	179,687	180,651	181,542	181,481	179,058
Senior Care Plus	16,275	16,265	16,338	16,302	16,436	16,347
Senior Health Options	37,653	37,649	37,982	38,000	38,153	38,135
Special Needs BasicCare	51,453	51,487	51,789	51,906	52,497	52,712
Minnesota Care	89,445	90,940	92,433	93,575	93,575	92,641
Total Minnesota	**935,560**	**937,339**	**944,489**	**956,733**	**962,267**	**958,284**
+/- m/m	*14,187*	*1,779*	*7,150*	*12,244*	*5,534*	*(3,983)*
% y/y	*2.3%*	*2.8%*	*1.0%*	*5.9%*	*6.1%*	*6.2%*

Mississippi

Medicaid Expansion Status: Not Expanded

MississippiCAN, the state's Medicaid managed care program, grew significantly in 2015. However, net enrollment declines over the past two years have reversed some of this growth. Medicaid managed care membership stands at just over 476,000 as of December 2017, down 2.5 percent from last year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Mississippi	**487,201**	**483,337**	**480,956**	**481,590**	**479,267**	**476,166**
+/- m/m	*(1,975)*	*(3,864)*	*(2,381)*	*634*	*(2,323)*	*(3,101)*
% y/y	*-3.0%*	*-2.7%*	*-2.2%*	*-1.6%*	*-1.8%*	*-2.5%*

Missouri

Medicaid Expansion Status: Not Expanded

Missouri managed care enrollment in the Medicaid and CHIP programs sits at more than 717,000 as of November 2017. In May, the first month of the state's geographic managed care expansion, roughly 240,000 new members were added in the new region. Despite a few months of enrollment decline since, November enrollment is up more than 41 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Medicaid	705,737	699,542	695,401	690,882	692,491	
Total CHIP	24,409	24,581	24,594	24,508	24,669	
Total Missouri	**730,146**	**724,123**	**719,995**	**715,390**	**717,160**	
+/- m/m	*(2,974)*	*(6,023)*	*(4,128)*	*(4,605)*	*1,770*	
% y/y	*45.2%*	*45.5%*	*43.7%*	*41.8%*	*41.4%*	

Nebraska

Medicaid Expansion Status: Not Expanded

This is now our third quarterly report to include Nebraska, which began reporting monthly enrollment data with the launch of the Heritage Health Medicaid managed care program. As of December 2017, the program enrolled nearly 229,000 members.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Nebraska	**228,669**	**227,522**	**228,152**		**229,008**	**228,555**
+/- m/m	*822*	*(1,147)*	*630*			*(453)*

New Mexico

Medicaid Expansion Status: Expanded January 1, 2014

As of December 2017, New Mexico's Centennial Care program covers more than 664,000 members, a 3.7 percent decline compared to year-end 2016.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total New Mexico	**686,609**	**678,199**	**662,472**	**663,833**	**663,240**	**664,825**
+/- m/m	*(6,178)*	*(8,410)*	*(15,727)*	*1,361*	*(593)*	*1,585*
% y/y	*1.8%*	*-0.3%*	*-3.0%*	*-3.0%*	*-3.5%*	*-3.7%*

New York

Medicaid Expansion Status: Expanded January 1, 2014

New York's Medicaid managed care programs collectively covered more than 4.7 million beneficiaries as of December 2017, a 1.7 percent increase from the previous year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Mainstream MCOs	4,411,269	4,381,873	4,370,138	4,379,448	4,380,595	4,391,939
Managed LTC	190,529	192,331	194,772	198,010	200,201	202,585
Medicaid Advantage	8,083	7,926	7,871	7,838	7,728	7,594
Medicaid Advantage Plus	8,020	8,356	8,598	8,725	8,928	9,057
HARP	88,577	91,407	94,033	94,725	98,041	99,916
FIDA/FIDA-IDD (Duals)	5,272	5,208	5,191	5,169	5,169	4,600
Total New York	**4,711,750**	**4,687,101**	**4,680,603**	**4,693,915**	**4,700,662**	**4,715,691**
+/- m/m	*12,520*	*(24,649)*	*(6,498)*	*13,312*	*6,747*	*15,029*
% y/y	*1.0%*	*0.6%*	*0.4%*	*0.5%*	*1.0%*	*1.7%*

Ohio

Medicaid Expansion Status: Expanded January 1, 2014

As of November 2017, enrollment across all four Ohio Medicaid managed care programs was nearly 2.5 million, up 1.5 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
CFC Program	1,609,053	1,596,596	1,581,240	1,575,554	1,565,446	
ABD Program	190,089	191,045	191,415	192,866	196,700	
Group 8 (Expansion)	631,933	633,384	630,471	626,851	619,872	
MyCare Ohio (Duals)	108,519	108,910	110,019	110,296	111,506	
Total Ohio	**2,539,594**	**2,529,935**	**2,513,145**	**2,505,567**	**2,493,524**	
+/- m/m	*(14,964)*	*(9,659)*	*(16,790)*	*(7,578)*	*(12,043)*	
% y/y	*3.1%*	*2.4%*	*1.7%*	*1.8%*	*1.5%*	

Oregon

Medicaid Expansion Status: Expanded January 1, 2014

As of November 2017, enrollment in the Oregon Coordinated Care Organization (CCO) Medicaid managed care program is more than 876,000, up 1.2 percent from the prior year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Oregon (CCO)	**871,376**	**869,945**	**861,734**	**866,012**	876,218	
+/- m/m	*(21,334)*	*(1,431)*	*(8,211)*	*4,278*	*10,206*	
% y/y	*1.1%*	*0.9%*	*1.8%*	*2.3%*	*1.2%*	

Pennsylvania

Medicaid Expansion Status: Expanded as of 2015

As of November 2017, Pennsylvania's Medicaid managed care enrollment sits at more than 2.3 million, up 2.1 percent in the past year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Pennsylvania	**2,299,146**	**2,302,215**	**2,302,833**	**2,303,264**	**2,305,217**	
+/- m/m	*2,476*	*3,069*	*618*	*431*	*1,953*	
% y/y	*3.2%*	*2.9%*	*2.5%*	*2.2%*	*2.1%*	

South Carolina

Medicaid Expansion Status: Not Expanded

South Carolina's Medicaid managed care programs collectively enroll more than 777,000 members as of December 2017, which represents growth of 1.8 percent in the past year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Medicaid	771,781	766,231	756,265			765,787
Total Duals Demo	7,818	11,468	11,699	11,493	11,532	11,511
Total South Carolina	**779,599**	**777,699**	**767,964**			**777,298**
+/- m/m	*4,057*	*(1,900)*	*(9,735)*			
% y/y	*3.5%*	*2.3%*	*0.9%*			*1.8%*

Tennessee

Medicaid Expansion Status: Not Expanded

As of November 2017, TennCare managed care enrollment totaled 1.46 million, down 6.7 percent from the prior year. However, enrollment has increased in each of the last four months.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Tennessee	**1,401,418**	**1,422,877**	**1,433,139**	**1,446,576**	**1,460,973**	
+/- m/m	*(10,645)*	*21,459*	*10,262*	*13,437*	*14,397*	
% y/y	*-10.0%*	*-8.4%*	*-7.7%*	*-6.4%*	*-6.7%*	

Texas

Medicaid Expansion Status: Not Expanded

Enrollment reporting out of Texas has been limited in the past year. As of February 2017, Texas managed care enrollment stood at more than 3.94 million across the state's six managed care programs, having launched STAR KIDS in the second half of 2016. Enrollment was up 2.6 percent from the prior year.

Washington

Medicaid Expansion Status: Expanded January 1, 2014

Enrollment growth in Washington's Medicaid managed care is flat as of December 2017, compared to year-end 2016. Total enrollment stands at more than 1.6 million.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Washington	**1,619,153**	**1,611,961**	**1,596,655**	**1,593,903**	**1,598,855**	**1,608,031**
+/- m/m	*(14,019)*	*(7,192)*	*(15,306)*	*(2,752)*	*4,952*	*9,176*
% y/y	*3.3%*	*2.9%*	*1.6%*	*1.2%*	*0.3%*	*0.0%*

West Virginia

Medicaid Expansion Status: Expanded January 1, 2014

As of December 2017, West Virginia's managed care program covers roughly 416,000 members, up more than 8 percent year-over-year.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total West Virginia	**424,753**	**421,890**	**419,951**	**418,084**	**416,881**	**416,621**
+/- m/m	*(913)*	*(2,863)*	*(1,939)*	*(1,867)*	*(1,203)*	*(260)*
% y/y	*8.8%*	*8.4%*	*7.7%*	*7.3%*	*7.4%*	*8.2%*

Wisconsin

Medicaid Expansion Status: Not Expanded

Across Wisconsin's three managed care programs, December 2017 enrollment totals nearly 787,000 down less than 1 percent from the year before.

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
BadgerCare+	710,924	706,598	705,831	703,038	701,852	700,221
SSI	36,434	36,293	36,509	36,371	35,984	35,599
LTC	50,231	50,496	50,638	50,942	50,969	50,847
Total Wisconsin	**797,589**	**793,387**	**792,978**	**790,351**	**788,805**	**786,667**
+/- m/m	*873*	*(4,202)*	*(409)*	*(2,627)*	*(1,546)*	*(2,138)*
% y/y	*-0.4%*	*-0.3%*	*-0.8%*	*-0.4%*	*-0.7%*	*-0.8%*

More Information Available from HMA Information Services

More detailed information on the Medicaid managed care landscape is available from HMA Information Services (HMAIS), which collects Medicaid enrollment data, health plan financials, and the latest on expansions, waivers, duals, ABD populations, long-term care, accountable care organizations, and patient-centered medical homes. HMAIS also includes a public documents library with copies of Medicaid RFPs, responses, model contracts, and scoring sheets.

HMA enhances this publicly available information with an overview of the structure of Medicaid in each state, as well as a proprietary HMA Medicaid Managed Care Opportunity Assessment.

For additional information on how to subscribe to HMA Information Services, contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagaement.com.

HMA MEDICAID ROUNDUP

Arizona

Arizona Submits Waiver Request for Medicaid Work Requirements, Lifetime Limit. *The Hill* reported on December 20, 2017, that Arizona has submitted a waiver to the Centers for Medicare & Medicaid Services (CMS) seeking permission to impose Medicaid work requirements and a five-year lifetime limit on Medicaid coverage. Arizona submitted a similar waiver before, but it was rejected by the Obama administration. There are currently about 400,000 Medicaid beneficiaries that would be subject to the work requirement. Read More

Arkansas

Medicaid Enrollment Declines After Program Changes. *ArkansasMatters.com* reported on January 4, 2018, that Medicaid enrollment in Arkansas fell by 117,260 after the state implemented member premiums and work training requirements under the Arkansas Works waiver. The Arkansas Department of Human Services projects that the changes will reduce Medicaid spending by another $477.9 million in fiscal 2019. Read More

Arkansas Expects $3.3 Million in Premium Rebates from Centene. *Arkansas Online* reported on January 8, 2018, that Arkansas expects to receive $3.3 million in premium rebates from Centene Corp., one of the plans that participates in the state's private-option Medicaid expansion program. Individual plans like the one offered in the Arkansas Works expansion must rebate premiums if the medical loss ratio is under 80 percent. Read More

Medicaid Cuts, Future of Expansion to Highlight Budget Talks. *AP News* reported on January 7, 2018, that the Arkansas Medicaid program will take center stage during fiscal 2019 state budget talks after Governor Asa Hutchinson releases his proposed budget this week. The proposal is expected to seek $488 million less than originally planned for Medicaid, largely because of a reduction in enrollment. The budget also anticipates continuation of the state's hybrid Medicaid expansion. Read More

Governor Asa Hutchinson Seeks $138 Million Increase for Medicaid. *The Modesto Bee* reported on January 9, 2018, that Governor Asa Hutchinson is seeking a Medicaid funding increase of nearly $138 million as part of the state's proposed fiscal 2019 budget. As previously reported, Governor Hutchinson is seeking less funding for Medicaid than originally planned given a drop in enrollment. The increased funding would offset an expected increase in Medicaid expansion costs as well as a decrease in the federal matching rate for traditional Medicaid. Lawmakers will convene in February to address the budget. Read More

California

Golden Shore Medical Takes Over 17 Molina Clinics. Golden Shore Medical announced on January 2, 2018, that it had officially taken over 17 clinics in California from Molina Healthcare. Golden Shore is led by J. Mario Molina, M.D., former chief executive of Molina Healthcare, who announced his intention to acquire the clinics last year. The clinics serve 120,000 patients in four counties. Read More

California Restores Medi-Cal Coverage of Certain Dental Services. *Los Angeles Times* reported on December 22, 2017, that California is restoring coverage of root canals, partial dentures and many other services to 7.5 million Medi-Cal beneficiaries effective January 2018. Coverage for these services had been eliminated eight years ago amid a state budget crunch. To address provider access concerns, the state increased rates for hundreds of dental procedures by 40 percent in 2017. Read More

Colorado

Kim Bimestefer Is Named Executive Director of Department of Health Care Policy and Financing. *The Denver Post* reported on January 2, 2018, that Kim Bimestefer will replace Sue Birch as executive director of the Colorado Department of Health Care Policy and Financing effective January 8. Bimestefer was most recently a health care consultant and previously president of Cigna's Mountain States region. Read More

Delaware

Medicaid to Cover Treatment for Obesity. *Delaware Online* reported on January 2, 2017, that the Delaware Division of Medicaid and Medical Assistance will begin covering treatment for obesity in 2019. Coverage includes 12 visits per year with a medical professional for Medicaid members with a body mass index of 30 or higher. Members with a body mass index of 25 or with cardiovascular health risks can see a medical professional six hours per year. Children will also have regular access to obesity visits. Coverage will also include community-based programs that have been shown reduce weight. Read More

Georgia

Georgia to Establish Health Innovation Centers. *Georgia Health News* reported on January 8, 2018, that Georgia lawmakers approved a proposal to create a Health Coordination and Innovation Council and a Healthy System Innovation Center. Formation of the two centers, which was proposed by the Georgia Health Care Reform Task Force, is aimed at improving collaboration and efficiency of care delivery in the state. Read More

Idaho

Advocacy Group Launches Medicaid Expansion Ballot Initiative. *Local News 8* reported on January 5, 2018, that an organization called Medicaid Expansion for Idaho has launched a ballot initiative in hopes of expanding coverage to 50,000 individuals in the state. The initiative will require signatures from 6 percent of registered voters to appear on the November 2018 ballot. Read More

Illinois

Illinois Begins Implementing HealthChoice Medicaid Managed Care. *U.S. News/Associated Press* reported on December 31, 2017, that Illinois has begun implementing its HealthChoice Medicaid managed care program, which will result in about 80 percent of the state's Medicaid eligibles being enrolled in managed care plans. The four-year program (with options for four more) will eventually implement Medicaid managed care in all of Illinois' 102 counties statewide, up from 30 counties previously. The additional counties will add about 800,000 members to Medicaid managed care plans, bringing total Medicaid managed care enrollment to 2.7 million. Members already served by Medicaid managed care plans were enrolled in HealthChoice effective January 1. The remainder will enroll effective April 1. Read More

Centene Reveals Medicaid PMPM Rates. *Crain's Chicago Business* reported on January 3, 2018, that Centene/IlliniCare has joined several other Illinois insurers in revealing its contracted per member per month rates under the state's Medicaid managed care program. Initially Centene/IlliniCare had requested the rates be redacted from publicly available copies of its contract with the state. However, plans like Centene/IlliniCare and NextLevel reversed course. Lawmakers in Illinois have been calling for more transparency in the state's Medicaid managed care program. Among other Illinois plans, Harmony and Meridian redact their rates; Health Care Service Corp,/Blue Cross Blue Shield of Illinois, CountyCare, and Molina do not. Read More

Hospitals Are Concerned About Potential Changes to Assessment. *Crain's Chicago Business* reported on January 9, 2018, that Illinois hospitals are concerned over a potential overhaul of the state's hospital assessment, a tax that helps the state generate additional federal Medicaid matching funds. Lawmakers want to change the program, which expires July 1, to better align funding with hospitals serving the most patients. A special fund would also be set up to help hospitals with lots of vacant beds. In addition, hospitals that

depend on Medicaid would be prioritized. A public hearing on the changes will held on January 11. Read More

Indiana

Child Services Director Resigns. *The Indianapolis Star* reported on January 9, 2018, that Indiana Department of Child Services director Mary Beth Bonaventura resigned last month, stating that the administration of Indiana Governor Eric Holcomb was putting children at risk. The state has begun a search for a replacement for Bonaventura, who was appointed by former governor and now Vice President Mike Pence. Read More

Iowa

UnityPoint, Anthem Continue Network Contract Talks. *The Gazette* reported on December 31, 2017, that UnityPoint Health will remain in the Anthem/Amerigroup Medicaid managed care network in Iowa for now, as the two organizations agreed to a temporary extension as they continue to negotiate a network contract renewal. The original contract expired on December 31. UnityPoint Health expects to have a final decision on the contract by January 12. Read More

Medicaid Managed Care Program to Save $47 Million. *U.S. News & World Report* reported on January 6, 2018, that the Iowa Medicaid managed care program is expected to save the state $47 million in fiscal 2018, according to the Iowa Department of Human Services. That's less than original savings projections made by Former Governor Terry Branstad, who supported the initiative. Read More

Iowa Considers Adding a Fourth Medicaid Managed Care Plan. *The Gazette* reported on January 8, 2018, that Iowa Medicaid Director Michael Randol is open to further changes in the state's Medicaid managed care program, including the possible addition of a fourth health plan. The state already has an RFP out seeking a third Medicaid plan. Currently, the state has two Medicaid plans, Amerigroup Iowa and UnitedHealthcare of the River Valley. Read More

Kansas

Kansas Names Darian Dernovish Interim Health Secretary. *The Topeka Capital-Journal* reported on January 3, 2018, that Kansas Governor Sam Brownback has appointed Darian Dernovish interim secretary for the state Department of Health and Environment (KDHE), which oversees Medicaid. Dernovish, who is a KDHE attorney, will hold the position while the state searches for a replacement for Susan Mosier, who left the post in January. Brownback also appointed Rep. Greg Lakin (R-Wichita) as KDHE chief medical officer. Read More

Providers Express Concerns Over KanCare 2.0 Medicaid Waiver Renewal. *Modern Healthcare* reported on January 3, 2018, that Kansas providers are concerned that the state's KanCare 2.0 Medicaid managed care waiver renewal proposal may hurt access to care. The proposal includes work requirements with a 36-month lockout and a 36-month eligibility cap on beneficiaries who don't comply. Providers are concerned about rural areas with few job opportunities and whether there are adequate administrative resources to track the work requirement. The Centers for Medicare & Medicaid Services is accepting public comments on the waiver application through January 27. Read More

Maine

Maine Expects CMS to Demand Return of $51 Million Spent on State Psychiatric Center. *U.S. News/Associated Press* reported on December 31, 2017, Maine expects to receive a letter from federal regulators demanding the return of $51 million spent on the operation of Riverview Psychiatric Center. The demand would come as the state is attempting to find a projected $54.5 million to fund Medicaid expansion. The Centers for Medicare & Medicaid Services took control of Riverview after discovering mistreatment of patients, medication errors, and paperwork problems. Read More

Massachusetts

Massachusetts Files Lawsuit Against Mental Health Provider Over Medicaid Claims. The *Boston Globe* reported on January 9, 2018, that Massachusetts has filed a lawsuit against South Bay Community Services, alleging that the company wrongly billed the state's MassHealth Medicaid program for a substantial portion of more than $123 million in claims. South Bay provides mental health services to approximately 30,000 MassHealth members in 17 clinics in Boston, Cape Code, Fall River, Lawrence, Springfield, and Worcester. Read More

Michigan

Michigan Seeks Renewal of Medicaid Expansion Waiver. *HealthPayer Intelligence* reported on December 27, 2017, that Michigan has asked federal regulators to renew the state's Healthy Michigan Plan 1115 waiver, which is the state's version of Medicaid expansion. The program expanded Medicaid coverage to about 650,000 adults and offered reductions in premiums for those who filled out a health risk assessment and changed certain unhealthy behaviors. The waiver renewal request, which was submitted to the Centers for Medicare & Medicaid Services, is open for public comment until January 21. Read More

Mississippi

Mississippi Names Drew Snyder Interim Medicaid Director. *The Seattle Times* reported on December 20, 2017, that Mississippi Governor Phil Bryant has named Deputy Chief of Staff Drew Snyder as the state's interim Medicaid director. Mississippi will continue to seek a permanent director. Snyder, who was a close Bryant aide, previously worked with Secretary of State Delbert Hosemann. Read More

Mississippi Obtains Approval for First Ever 10-Year Medicaid Waiver. *Modern Healthcare* reported on December 28, 2017, that the Centers for Medicare & Medicaid Services (CMS) approved the first ever 10-year 1115 Medicaid waiver extension to Mississippi. Section 1115 waivers are normally approved for five years. Mississippi will continue to provide family planning services for people ages 13 through 44 who are not enrolled in Medicaid, Medicare, or the Children's Health Insurance Program (CHIP) with income of up to 194% of the federal poverty level. The per member per month spending cap is $67 for 2018, rising to nearly $96 in 2027. CMS stated that the longer extension is part of the effort to streamline waivers and give states greater flexibility. Read More

True Poised to Get Medicaid Managed Care Contract Under Draft Bill. *Clarion Ledger* reported on January 6, 2018, that provider-owned Mississippi True health plan would be positioned to win a Medicaid managed care contract under a draft Medicaid bill. The legislation would require that 25 percent of the state's Medicaid members are enrolled in a provider-led plan. Mississippi True is the state's only provider-led plan. The goal is to compare the performance of provider-led Medicaid plans against other Medicaid plans in the market. Measures would include health outcomes, administrative costs, provider satisfaction, and access. The bill is also expected to address provider payment concerns and develop a standardized credentialing process for providers. Read More

Montana

Medicaid Provider Rate Cuts Take Effect. *Montana Public Radio* reported on December 28, 2017, that a 0.5 percent Medicaid provider rate cut took effect on January 1, after the Montana Children, Families, Health and Human Services Interim Committee dropped its objection. As previously reported, the state had proposed a 3.5 percent cut, which the committee voted to block in November. The committee agreed to reverse its objections after the Department of Public Health & Human Services reduced the amount of the cut. Read More

Nevada

Nevada Approves Additional Funding for MMIS Replacement. *Nevada Appeal* reported on January 9, 2018, that Nevada approved another $34 million to complete the replacement of the state's Medicaid Management Information System. The total cost is $439.2 million, with most of the funds going to HP Enterprise Services, which is building the replacement system. The first two phases of the project have already gone live, handling Medicaid enrollment and prior authorization of medical services. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Dual Eligible Special Needs Plans Expand into More Counties in 2018. Two of the four Dual Eligible Special Needs Plans (D-SNP) serving New Jersey residents eligible for Medicare and Medicaid have been approved by the State to expand operations into additional counties in 2018. Amerivantage Dual Coordination, run by Amerigroup will begin serving members in Camden county, making the plan available in all but four counties (Cape May, Hunterdon, Salem, Warren). UnitedHealthcare Dual Complete ONE will expand its service area to serve members in Cumberland, Salem and Sussex counties, making the plan available in all but two counties (Cape May and Warren).

2018 Marketplace Enrollment Drops 7 Percent. *NJ 101.5* reported on January 1, 2018, that the number of New Jerseyans who signed up for 2018 Marketplace coverage is down by more than 20,000 since last year. Enrollment totaled 274,782 and represents a 7 percent reduction from 2017, exceeding the nation's overall drop in enrollment of 5 percent among the 39 states that use www.healthcare.gov as its marketplace. Read More

Medicaid Agency Publishes July 2017 MCO Contract. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) has posted the most recent Medicaid managed care organization (MCO) contract on its website. The contract amendments reflect program, policy, and procedural changes effective July 1, 2017 recently approved by the Centers for Medicare & Medicaid Services. HMA compared the July 2017 contract with the preceding version. The new version is reduced in size by 145 pages, which is largely attributed to the removal of the Financial Reporting Manual. There were numerous additions, deletions, and revisions to the content. These are summarized under seven categories: 1) Provider Network, 2) Pharmacy, 3) MLTSS, 4) Quality, 6) Finance, and 7) Other. The contract can be found on the DMAHS website, which can be accessed by clicking here.

Provider Network

Provider Network, MLTSS
1. Any Willing Provider. Extends the MLTSS Any Willing Provider status by one year until June 30, 2018 (4.8.1.M).
2. Any Willing and Qualified Provider. A new provision describes the creation of an Any Willing and Qualified Provider (AWQP) that applies to nursing facilities that meet any four of seven defined quality performance measures under the new Nursing Facility Quality Improvement Initiative (4.8.1.N).

Provider Network, Reimbursement
1. Hospice services. A new section was added to specify the coordination of and payment for hospice services (4.2.12)
2. Coordination of Benefits. MCOs must enter into a COB agreement with Medicare and participate in the automated claims crossover process (3.4.2).
3. Personal care assistant and home based supportive care. Reimbursement rates cannot be reduced as those services are defined by regulation, without notice to DMAHS at least 90 days before the effective date (4.11.1)

Provider Network, Other
1. Network capacity. A provision was added that MCOs are not required to

contract with more providers than necessary to meet the needs of its members (4.8)
2. Network changes. MCOs must obtain written authorization from DMAHS to add, delete or otherwise change the provider network before proceeding (4.11)
3. Provider directory. A list of behavioral health providers by service description should be listed in the MCO's on-line provider directory; the list of service descriptions is included (4.8.4.B)

Pharmacy

1. Drug Utilization Review (DUR). MCOs must provide a description of DUR activities annually (4.2.4.F.7).
2. Antipsychotics and children. Use of multiple concurrent antipsychotics in children and adolescents has been added to the HEDIS Reporting Set Measures (4.6.2.P).
3. Formulary. The MCO's published formulary must include which generic and brand name medications are covered, and what tier each medication is on (4.2.4.B.6.d).

MLTSS

1. Eligibility. Provisions were added to clarify when children who qualify for EPSDT should be assessed/referred for new MLTSS enrollment, and when an individual receiving hospice benefits is under MLTSS (4.1.2.A).
2. Involuntary disenrollment. A provision updates the conditions and procedures for involuntary disenrollment from MLTSS and potential loss of Medicaid eligibility when a member who is non-compliant with care management requirements (9.4.3)
3. Plan of Care (POC). Clarifications were made about the development of a member's MLTSS POC (9.6.4).
4. Performance based contracting. The Nursing Facility Performance-Improvement Incentive Program that offered MCOs an incentive for transitioning individuals from nursing facilities (NF) to the community over the last two years has been updated. It is moving from performance incentives based on NF transitions to an incentive based on performance with MLTSS members residing in the community and receiving HCBS. A total of $3 million in payments will occur under a new demonstration project in SFY18 that will incorporate a one-year sliding-scale bonus payment to each of the three highest scoring MCOs (8.5.8).
5. Performance measures. Six new MLTSS performance measures were added to the contract and the two MLTSS performance measures for provider network were removed (9.11.G). The additions are:

4a) Timeliness of NF LOC (Division of Aging Services – DoAS)
9a) Plan of Care (POC) amended based on change of member condition
42) Percentage of MLTSS HCBS members with follow-up after Emergency Department visit for mental illness
43) Percentage of MLTSS NF members with follow-up after Emergency Department visit for mental illness
44) Percentage of MLTSS HCBS Members with follow-up after Emergency Department visit for alcohol and other drug dependence
45) Percentage of MLTSS NF Members with follow-up after Emergency Department visit for alcohol and other drug dependence

Quality

1. Reporting. Added language to describe accurate reporting requirements (7.16.4)
2. Blood lead threshold. Revised the elevated blood lead threshold for when a fingerstick must be confirmed with a venous sample if they measure ≥ 5 micrograms per one deciliter (replaces 10 micrograms) (4.2.6.B)
3. Accreditation. Requires MCOs to report on their accreditation status (8.5.7)
4. State monitoring requirements. Added a section about State Monitoring Requirements in Appendix B.3.1.2.

Finance

1. Medical Loss Ratio. Relocated MLR compliance language and updated the MLR assumptions (8.4)
2. Financial Reporting Manual. Removed the "Contractor Financial Reporting Manual for Medicaid/NJ FamilyCare Rate Cell Grouping Costs" from the contract. This document is now included only by reference.

Other

1. Grievances and Appeals. Updates and clarifies grievances and appeals language throughout the contract.
2. Staffing. Adds a requirement that the MCO have a dedicated housing specialist on staff (7.3)
3. Records. Clarifies requirements for records retention (7.28)

Department of Health Creates New Integrated Health Services Branch. In response to the recent reorganization of New Jersey state government that moved the Division of Mental Health and Addiction Services (DMHAS) from the Department of Human Services to the Department of Health (DOH), DOH formed the Integrated Health Services branch, which houses DMHAS and the Division of Community Health Services. The new branch seeks to build a seamless system of care to serve primary and behavioral health care needs. The web page can be accessed by clicking here.

New Jersey's Hackensack Meridian Health Acquires JFK Health. *NJ.com* reported on January 3, 2018, that Hackensack Meridian Health finalized an agreement to acquire JFK Health. Together, they plan to launch a Seton Hall University-affiliated medical school and cardiac catheterization lab, expand its neurological and cancer service lines, and offer virtual reality (VR) in neurosurgery. The combined entity is now the largest healthcare system in the state with 160 ambulatory care facilities and 16 hospitals, including two academic medical centers and two children's hospitals. Read More

Governor-elect Murphy Nominates Department of Human Services Lead. *NJ.com* reported on January 3, 2018, that Phil Murphy introduced Carole Johnson to run the Department of Human Services (DHS), which includes the division that oversees the Medicaid program. Ms. Johnson formerly served as Senior Policy Advisor on the White House Domestic Policy Council health team in the Obama administration and was previously on the faculty of George Washington University's Center for Health Policy Research. Read More

Governor Christie Signs Numerous Health Bills into Law. *The Princeton Patch* reported on January 8, 2018, that Governor Christie signed 40 bills into law just one week before his term ends, 14 of which are health related. We highlight a few of the bills below:

S-2705/A-4539 – Establishes "New Jersey Hearing Impairment Task Force"

S-2964/A-4707 – Prohibits residential substance use disorder treatment facilities and aftercare facilities from denying admission to individuals receiving medication assisted treatment for substance use disorder

A-2294/S-2709 – Expands civil rights protections to include breastfeeding; requires employers to provide reasonable accommodations for breastfeeding mothers

A-2336/S-3108 – Prohibits health insurance carriers from requiring optometrists to become providers with vision care plans as condition of becoming providers in carriers' panel of providers; prohibits certain practices under vision care provider contracts

A-3824/SCS for S-2392 and 2472 – Establishes Office of Ombudsman for Individuals with Intellectual or Developmental Disabilities and their Families. Read More

New Mexico

New Mexico Launches Website to Compare Hospital Costs. *Albuquerque Business First* reported on January 5, 2018, that the New Mexico Department of Health launched a website allowing consumers to compare procedure costs at 44 hospitals. Currently, the site shows average Medicaid prices for nine non-emergency procedures. It will eventually provide price information for services for individual, employer-sponsored, and Medicare coverage. Read More

Molina Confirms Loss of Medicaid Managed Care Contract. The *Albuquerque Journal* reported on January 9, 2018, that Molina Healthcare was not among the health plans selected by New Mexico in the state's recent Medicaid managed care procurement. Molina is in discussions with the state over the decision, which is effective in 2019. Molina is the largest Medicaid plan in New Mexico, with about 236,000 members through its Centennial Care operation. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Fully Integrated Duals Advantage Plans Closing. Five additional plans participating in New York's duals demonstration, the Fully Integrated Duals Advantage program, are closing as of January 1. The five plans, Aetna, Fidelis, Guildnet (closing in Nassau County only), ICS, and North Shore –LIJ, had a total enrollment of 534 members (GuildNet has an additional 469 members in New York City). Enrollment in FIDA continues to decline, with 3,934 members in the eight-county demonstration region as of December 2017. Out of the 23 plans that originally participated in FIDA, only nine remain in the program. Read More

Hospital Consolidation Continues. Northwell Health finalized on December 22, 2017, an agreement with John T. Mather Memorial Hospital in Port Jefferson to merge with the Northwell Health System. Mather Hospital, a 248-bed community hospital, will become the 23rd hospital in the Northwell System and its fifth hospital in Suffolk County. Read More

Health Insurance Enrollment Increases. Enrollment in health insurance through NY State of Health, the state's official health plan marketplace, reached over 4.1 million on December 15, the deadline for January 1, 2018 coverage. That exceeded the previous year's enrollment by 700,000. The numbers include 2.9 million individuals who enrolled in Medicaid, 229,000 people who signed up for a private health insurance plan, 364,000 who enrolled in Child Health Plus; and 716,000 who signed up for the Essential Plan, New York's Basic Health Program, which provides a low cost insurance plan for those who make less than twice the federal poverty level. Enrollment in private insurance through the exchange is up 11 percent year-over-year. Read More

New York Releases Community-based Organization Survey to Catalog Activities Addressing Social Determinants of Health. The New York State Department of Health has released a statewide survey to all Community Based Organizations (CBOs). The purpose of the survey is to capture current services CBOs are providing that address Social Determinants of Health (SDH) and gauge CBO integration with the New York State Value Based Payment (VBP) program. The goal is also for the State to learn about SDH initiatives to share with the community at large, and to use the information provided to build a public inventory of CBOs that can be used to facilitate VBP contracting. CBOs will be asked to complete this survey on an annual basis. The survey asks CBOs to identify the populations they serve, the geographic regions they serve, and the type of Social Determinant of Health intervention they provide. The survey can be accessed here.

New York Releases Statewide Health Care Facility Transformation Program Request for Applications. The New York State Department of Health has released a Request for Applications for the second phase of its Statewide Health Care Facility Transformation Program. A total of up to $203,782,888 is available through this RFA to health care providers that fulfill a health care need for acute inpatient, outpatient, primary, home care or residential health care services in a community. A minimum of $46,995,507 of this total amount is available for community-based health care providers, which are defined as diagnostic and treatment centers, mental health and alcohol and substance abuse treatment clinics, primary care providers and home care providers. The objective of the "Statewide Health Care Facility Transformation Program II" is to support capital projects, debt retirement, working capital or other non-capital projects that facilitate health care transformation activities including merger, consolidation, acquisition or other activities intended to create financially sustainable systems of care or preserve or expand essential health care services.

In determining awards for Eligible Projects, the DOH shall consider criteria including, but not limited to:

1. The extent to which the Eligible Project contributes to the integration of health care services or the long-term sustainability of the Eligible Applicant or

preservation of essential health services in the community or communities served by the Eligible Applicant.

2. The extent to which the Eligible Project or purpose is aligned with Delivery System Reform Incentive Payment (DSRIP) program goals and objectives.

3. Consideration of geographic distribution of funds.

4. The relationship between the Eligible Project and an identified community need.

5. The extent to which the Eligible Applicant has access to alternative funding.

6. The extent that the Eligible Project furthers the development of primary care and other outpatient services.

7. The extent to which the Eligible Project benefits Medicaid enrollees and uninsured individuals.

8. The extent to which the Eligible Applicant has engaged the community affected by the proposed Eligible Project and the manner in which community engagement has shaped the Eligible Project.

9. The extent to which the Eligible Project addresses potential risk to patient safety and welfare.

Awards made under this RFA are determined on a non-competitive, discretionary basis. Funding will be awarded at the discretion of the Commissioner of Health. The decision to award, or not to award, or to award a grant at a funding level that is less than the amount requested by the applicant, is discretionary and cannot be appealed. Applications are due Wednesday, March 14, 2018; awards are expected in July. Read More

New York Awards $60 Million to Behavioral Health Providers to Improve Integrated Models of Care. New York Governor Andrew Cuomo announced $60 million in awards over three years to mental health and addiction services providers as part of the transformation of the state's Medicaid system. The awards are meant to assist behavioral health providers in transforming to a business model of Value-Based Payment. The funds will be awarded to 19 selected networks of behavioral healthcare providers, called Behavioral Health Care Collaboratives helping them to integrate care across the entire spectrum of physical and behavioral health services. Awards will be used for a wide variety of healthcare improvements, including:

- Identifying gaps in the continuum of care, to better connect the patient to the next level of integrated healthcare;
- Ensuring ongoing monitoring of care planning to avoid unnecessary costs and avoidable complications;
- Identifying opportunities for performance improvement and cost reduction;
- Improving IT capabilities to more efficiently share data with other providers and partners;
- Developing a quality improvement process for responding when issues are not being addressed or quality indicators are not being met. Read More

BlueCross BlueShield of Western NY Expands. *Lockport Union-Sun & Journal* reported on January 3, 2018, that BlueCross BlueShield of Western NY has received approval from the Department of Health to expand its Medicaid Managed Care offering, HealthNow, to an additional two counties. The plan currently operates in 6 counties in the western part of the state, with a total enrollment of 28,764. BlueCross BlueShield of Western New York began a partnership with Amerigroup Partnership Plan in 2016 to help administer and manage the company's Medicaid managed care programs to avoid exiting the market following $40 million in losses over three years (2011-14). The plan spent over two years evaluating its participation in Medicaid managed care, including possible partnerships with other plans. Their enrollment was frozen pending resolution, and declined by over 50 percent from its one-time high of 46,000. Since the alliance with Amerigroup began, enrollment has begun to climb, increasing 25 percent in one year. Read More

Labor Department Maintains Emergency Regulation Limiting Home Care Payments. *Crain's HealthPulse* reported on January 8, 2018, that a New York Appellate Court ruled in September that state home care agencies must pay live-in home health aids 24 hours per day, and not the 13 hours that is the industry standard. The 13-hour standard is based on the notion that live-in aids sleep 8 hours, and spend 3 hours/day for meals, and are therefore only working 13 hours. Last week the NY Department of Labor renewed an emergency regulation that maintains the policy of allowing employers to pay home care workers for 13 hours of a 24-hour shift. The emergency regulations were first issued in October, after state appellate court judges ruled in the workers' favor in two class-action suits. As reported in Crain's HealthPulse, "The Home Care Association said in an email to members before Friday's hearing that it had "worked vigorously" to get the Labor Department to issue the emergency rule and the corresponding impact statement saying it was necessary to prevent the collapse of the home care industry and the institutionalization of patients."

The case was brought by two home care workers who argued that New York's minimum wage law requires that workers be paid for the time an employee is required to be available for work. If the decision stands, it means that agencies must pay for an additional 11 hours of care per day, almost doubling the cost of care. It is estimated that it will increase costs for home care in NY's Medicaid program by tens of millions of dollars. Further, the court has allowed a class action suit to move forward that could potentially leave home care agencies liable for up to six years of back pay for thousands of employees. A final decision will be made by the Industrial Board of Appeals, an oversight body. A decision is expected by the end of the month.

School-based Health Center Carve-in Delayed. As part of New York's "Care Management for All" policy, the state has been carving virtually all populations and services into Medicaid managed care. School-based health centers were scheduled to be carved in as of July 2018. The carve-in has been protested by the school-based health centers due to concerns about significant loss of revenue as a result of managed care contracting. Both houses of the legislature passed a bill that would have required that school based health centers be permanently reimbursed on a fee-for-service basis. The Governor vetoed the bill, but agreed to delay implementation of the carve-in until 2021.

Governor Gives State of the State Address. New York Governor Andrew Cuomo gave his annual State of the State address on January 3. He described unprecedented challenges facing the state, and announced a three-part war: fighting racial discrimination and sexism; fighting challenges including terrorism, climate change, and the opioid epidemic; and responding to federal assaults that damage NY's economic standing. The governor warned of a fiscally challenging year, with the state facing a $4 billion budget gap, and an additional $2 billion loss in federal support, mostly due to health care cuts. The governor articulated a three-point response to what he described as an economic civil war aimed at hurting NY. He said NY will challenge the federal tax bill in court, that he will launch an economic justice campaign, and that the state will develop a shift in its tax structure to reduce reliance in income tax, and instead adopt a statewide payroll tax.

The governor mentioned health care only briefly. He said that NY will preserve Medicaid and CHIP, although he did not provide any details. He said that health care is a human right, and that NY must keep the health care industry strong, as it is a vibrant economic engine across the state. The State of the State book included a few specific health care proposals, including support for the recently-launched First 1,000 Days on Medicaid, 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.

Ohio

Medicaid Expands Specialty Behavioral Services, Readies for Integration. *Open Minds* reported on January 7, 2018, that Ohio expanded coverage of Medicaid specialty behavioral health services on January 1 and updated its claims coding system. The move is aimed at aligning state Medicaid billing codes with national standards ahead of the July 2018 integration of behavioral health into Medicaid managed care. Read More

Oklahoma

Oklahoma Funds Medicaid, Health Agencies Through April. *U.S. World & News Report* reported on December 22, 2017, that Oklahoma Governor Mary Fallin signed two bills providing $17.7 million in operating funds for the Oklahoma Health Care Authority and $26.5 million for the state Department of Human Services through April. The state legislature plans to reconvene in January to address a budget shortfall. Read More

Oklahoma Postpones Rate Cuts to Medicaid Providers. *NewsOK* reported on December 29, 2017, that the Oklahoma Health Care Authority (OHCA) board voted to postpone implementation of a series of planned rate cuts to health care providers serving the state's SoonerCare Medicaid program. The planned cuts, which are still possible later in the fiscal year, would have affected more than 45,000 providers. Read More

Oregon

Oregon to Hold Statewide Election on Provider, CCO Assessment. *KATU News* reported in January 2018, that Oregonians will vote in a special election this month to decide whether a 1.5 percent assessment, called Measure 101, on hospitals, CCOs, and insurance companies will be implemented. State legislators passed the assessment as part of House Bill 2391 in order to ensure continued funding for the state's Medicaid expansion population of adults with income up to 138 percent of the poverty level. Additional funding was needed as the federal portion of program costs are reduced to 90 percent by 2020. The assessment would be levied on carrier premiums and the premium equivalents from managed care organizations and the Public Employees' Benefit Board. Carriers supported the passage of HB 2391, but several Republican legislators argued the particular assessment was not needed. Oregon is an entirely vote-by-mail state, and ballots are due by January 23. Read More

Oregon's FamilyCare to End Operations February 1. FamilyCare, one of Oregon's 16 Coordinated Care Organizations (Medicaid managed care plans), which enrolls 113,000 people in Portland and the surrounding areas, decided to shut down by February 1, 2018 rather than accept the state's 2018 contract and rates. FamilyCare has disputed reimbursement rates from the Oregon Health Authority (OHA) for the past three years. The plan says that it is losing money and cannot sustain operations at the current rates, and has decided to lay off all 322 employees. FamilyCare is known for paying primary care and mental health providers more than the other area CCO, HealthShare, and FamilyCare CEO Jeff Heatherington has long argued that rate-setting was biased against his plan. Last year, FamilyCare sued OHA over its rate-setting practices. Heatherington has indicated that he will maintain the litigation even after the company shuts down its business operations. Oregon House Speaker Tina Kotek (D-Portland) said she will not call a special session to deal with the FamilyCare Health shutdown, but instead wants to focus on a smooth transition for plan members. Read More 2 3

Pennsylvania

Pennsylvania Announces Effort to Reduce Waiting List for People with Disabilities. The Pennsylvania Department of Human Services implemented a Community Living Waiver, effective January 1, 2018, for services to individuals with an intellectual disability or autism. This waiver is intended to address the approximately 1,000 individuals on the waiting list for other Medical Assistance waiver services. The Community Living Waiver offers in-home supports, durable medical equipment and medical supplies, and home modifications that support independent living, employment in a competitive job, and full engagement in community activities. Read More

Pennsylvania Announces New Highmark-UPMC Agreement. Pennsylvania Governor Tom Wolf announced on January 4, 2018, that Highmark health insurance members will continue to have in-network access to specialty UPMC hospitals in the Pittsburgh area and at least 10 other UPMC hospitals in Pennsylvania as part of an agreement reached between the two health systems. The deal assures access through 2024. This agreement extends an earlier one, set to expire in 2019. The agreement ensures in-network access for customers of both companies to facilities that provide one-of-a-kind services. The agreement also provides in-network access to UPMC facilities that are the only hospital in a community. Consumers who live in communities where a choice of providers, facilities, and services is available will be bound by Highmark's in-network/out-of network coverage rules when the consent decrees expire at the end of June 2019. Read More

Puerto Rico

Medicaid May Benefit from Senate Disaster Relief Bill. *Modern Healthcare* reported on January 9, 2018, that the Senate may include two years of funding for the Puerto Rico Medicaid program as part of a proposed disaster relief bill, according to Congressional aides. Puerto Rico is expected to run out of Medicaid funding by March. An earlier disaster relief bill passed by the House didn't including funding for Medicaid. Read More

Rhode Island

Rhode Island Hit With Class Action Lawsuit For Disenrolling Medicaid Beneficiaries Without Notice. The *Providence Journal* reported on January 3, 2018, that the American Civil Liberties Union of Rhode Island has filed another class action lawsuit against Rhode Island for disenrolling Medicaid beneficiaries without proper notice. According to the lawsuit, the problem stems from state's public benefits computer system or Unified Health Infrastructure Project. The lawsuit claims the state "has failed to fix the problem systematically and reinstate every individual" disenrolled from Medicaid. Read More

South Dakota

South Dakota to Seek Medicaid Work Requirements. *Thew New Haven Register* reported on January 9, 2018, that South Dakota is seeking permission from the Trump administration to implement Medicaid work requirements, a move that would affect 4,500 beneficiaries. South Dakota Governor Dennis Daugaarrd revealed the proposal during his State of the State address. Read More

Texas

Texas Obtains Five-Year Medicaid Waiver Renewal. The Texas Health and Human Services Commission announced on December 21, 2017, that it had received federal approval for a five-year renewal of the state's 1115 Medicaid demonstration waiver. The Centers for Medicare & Medicaid Services (CMS) approved the renewal, which will allow Texas to continue to offer Medicaid managed care and fund supplemental payments to hospitals and other Medicaid providers. Read More

Utah

Utah Poll Shows Majority Support Medicaid Expansion. *The Hill* reported on December 28, 2017, that 59 percent of individuals in Utah support full Medicaid expansion, according to a poll conducted by Dan Jones and Associates. Utah is one of 18 states that has not expanded Medicaid under the Affordable Care Act. Supporters of expansion in both Utah and Idaho are seeking to expand Medicaid through voter referendums in November 2018. Read More

National

Medicaid May Have Missed Out on $1.3 Billion in Prescription Drug Rebates. *CQ Healthbeat News* reported on December 20, 2017, that the Medicaid Drug Rebate Program may have lost out on $1.3 billion in prescription drugs rebates because pharmaceutical companies misclassified medications. According to a report by the U.S. Department of Health & Human Services, at least 885 drugs were misclassified, 10 of which accounted for more than $1 billion in lost rebates from 2012 to 2016. The Centers for Medicare & Medicaid Services is developing a new system to identify and reduce similar errors in drug classification. Read More

House Proposes $2.85 Billion CHIP Stopgap. *Modern Healthcare* reported on December 21, 2017, that the House has proposed $2.85 billion in stopgap funding for the Children's Health Insurance Program as part of a short-term spending proposal designed to avoid a government shutdown. The measure would also allow the Centers for Medicare & Medicaid Services to reallocate funds from other states, potentially accelerating the rate at which some states run out of money. "There is no way that is enough through March," said Bruce Lesley of First Focus, an advocacy group. Read More

Senate Leader McConnell Willing to "Move on" From ACA Repeal in 2018. *Politico* reported on December 21, 2017, that Senate Majority Leader Mitch McConnell stated that he will not focus on repealing the Affordable Care Act (ACA) in 2018. Repealing the individual mandate "takes the heart out of Obamacare," said McConnell in an interview with NPR. Instead, McConnell will focus on stabilizing insurance markets and working on entitlement reform. Senator Lindsey Graham, however, issued a statement that he is fully committed to repealing the ACA. Read More

GOP May Seek Medicaid Cuts in 2018. *The Hill* reported on December 29, 2017, that Republicans may seek cuts to Medicaid in 2018 to help offset deficit

projections under recently passed tax reform legislation. House Speaker Paul Ryan (R-WI) said in December that Medicare and Medicaid are among the biggest drivers of debt. However, Senate Majority Leader Mitch McConnell (R-KY) said entitlement reform is not expected to be on the agenda next year. Read More

U.S. Recovers $2.4 Billion from Medicare, Medicaid, TriCare Fraud Cases in 2017. *Modern Healthcare* reported on December 26, 2017, that the U.S. Department of Justice recovered $2.4 billion from Medicare, Medicaid, and TriCare fraud cases in fiscal 2017, ending September 30. Some of the largest cases involved electronic health record system vendors, skilled nursing facilities, and pharmaceutical companies. Read More

Labor Department Proposes New Rules to Expand Association Health Plans. *Politico* reported on January 4, 2018, that the U.S. Department of Labor has proposed new rules aimed at expanding association health plans. The new rules would expand the number of groups that can qualify as associations, allow businesses from different sectors and states to band together, and allow self-employed individuals to join association health plans instead of buying plans on the Affordable Care Act exchanges. Read More

Trump Administration to Release Guidance on Medicaid Work Requirements. *The Hill* reported on January 5, 2018, that the Trump administration is expected to release guidance for states seeking to implement work requirements for Medicaid recipients. Opponents are expected to resist the measure, arguing that work requirements are an attempt to undermine Medicaid eligibility expansion under the Affordable Care Act (ACA). Nine states have submitted waiver requests that include work requirements. Read More

CBO Predicts CHIP Renewal Would Add $800 Million to Deficit. *CQ News* reported on January 5, 2018, that the reauthorization of funding for the Children's Health Insurance Program (CHIP) would add $800 million to the federal deficit over 10 years, according to a Congressional Budget Office (CBO) analysis. In October 2017, CBO predicted that the CHIP reauthorization would increase the deficit by $8.2 billion over the same period. CBO expects that without CHIP, children would be enrolled in Exchange plans at a greater cost to the government than previously expected, given higher Exchange premiums following repeal of the individual mandate.

Senate Finance Committee to Hear from HHS Secretary Nominee Alex Azar. *Modern Healthcare* reported on January 6, 2018, that the Senate Finance Committee will hold confirmation hearings on January 9 for Alex Azar, who is nominated to be Secretary of the U.S. Department of Health and Human Services. Azar met with the Senate Health, Education, Labor and Pensions Committee in November. Read More

Some States To Run Out of CHIP Funding January 19. *Kaiser Health News* reported on January 5, 2018, that some states will begin to run out of funding for the Children's Health Insurance Program after January 19, according to the Centers for Medicare & Medicaid Services (CMS). Congress had previously approved stopgap funding, which was expected to last through March. CMS is working with states to address the funding shortfall. Read More

Medicaid Expansion Lowers Likelihood of Hospital Closures, Study Finds. *Health Affairs* published a study in January 2018, which found that Medicaid expansion was associated with improved hospital financial performance and lower likelihood of hospital closures, especially in rural counties and counties with a large number of uninsured individuals prior to expansion. The study warns lawmakers that repealing Medicaid expansion could lead to large increases in rural hospital closures, which would reduce access to care and cause layoffs. Read More.

HHS Nominee Supports Medicaid Block Grants, ACA Repeal. *Talking Points Memo* reported on January 9, 2018, that Alex Azar, who is President Trump's nominee for secretary of Health and Human Services, said he supports Medicaid block grants and repeal of the Affordable Care Act. Alex Azar made the remarks during his confirmation hearing, noting that failed legislation introduced by Senators Lindsey Graham (R-SC) and Bill Cassidy (R-LA) would have offered states more flexibility to run their own Medicaid programs. Read More

GAO Finds $36.7 Billion in Medicaid Payment Errors in 2017. *Healthcare IT News* reported on January 9, 2018, that the Government Accountability Office (GAO) found $36.7 billion in Medicaid payment errors in 2017, up $14.4 billion from 2013. GAO attributed the improper payments to a lack of effective government oversight of the Medicaid Statistical Information System, a national repository of data used to identify potential fraud and improve program efficiency. Read More

Industry News

WellCare Selects VirtualHealth for Care Management Platform. *Globe Newswire* reported on January 4, 2017, that WellCare Health Plans has selected VirtualHealth's care management platform for use across 20 states and 3.2 million Medicaid and Medicare members. Read More

Cityblock Health Receives $20.8 Million in Funding. Cityblock Health, a subsidiary of Alphabet Inc, announced on January 4, 2018, that it had received $20.8 million in funding from Maverick Ventures, Thrive Capital and Sidewalk Labs. Cityblock helps urban Medicaid and Medicare beneficiaries receive personalized care. J. Mario Molina, M.D., former chief executive of Molina Healthcare, and a new investment firm formed by Andy Slavitt, the former acting administrator of the Centers for Medicare and Medicaid Services, are investors in the company. Cityblock hopes to open the first healthcare hub in Spring 2018 in New York. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
Timeline to be Revised	Alabama ICN (MLTSS)	RFP Release	25,000
2018	Massachusetts One Care (Duals Demo)	RFP Release	TBD
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
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	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
January 1, 2020	Massachusetts One Care (Duals Demo)	Implementation	TBD

HMA WELCOMES…

Dana McHugh - Principal

Dana McHugh joins HMA most recently from Florida Association of Homes for the Aging Health and Services Corporation (FAHA H&S), a subsidiary of LeadingAge Florida representing Florida nonprofit long-term care communities, where she served as Executive Director. In this role, Dana facilitated managed care initiatives throughout the state of Florida and enabled LeadingAge Florida members to participate in managed care networks. She developed FAHA H&S from the ground up and was responsible for contract negotiation, health system relationships, and education resources for Leading Age Florida/FAHA H&S member providers. Dana developed an FAHA H&S network that provided housing for approximately 10,650 seniors. Due to the growth and quality of the network, members could access, dependent on geographic region, 41 managed care contracts for all lines of business. Dana provided revenue generating assistance for her clients with credentialing, billing, proper prior authorization processing, best practices, and management of quality data related to current contract payment requirements.

Prior to FAHA H&S, Dana served as the Florida State Director of Provider Operations at Prestige Health Choice. In this role, Dana was pivotal in expanding Prestige's Medicaid network from three counties to 60. As a result, Prestige was awarded contracts for eight regions. Dana was responsible for contracts and maintenance of the network for the state of Florida, which included 134 hospitals, 2,000+ primary care physicians, and 16,000+ specialists.

Prior to Prestige Health Choice, Dana served as Executive Director of the North Florida Region at Freedom Health, Inc. In this role, Dana contracted the Medicare, Medicaid, and commercial expansion market for four counties and completed required documentation to open counties with applicable state and federal agencies.

Dana has more than 20 years of management experience in the healthcare industry, with expertise in managed care (Medicare, Medicaid, and commercial), network development, association leadership, and long-term care administration and insurance contracting.

Dana earned her bachelor's degree in business administration and management from Barry University.

Gail Mayeaux – Principal

Gail Mayeaux joins HMA most recently from Southern Tier Community Health Center Network, Inc. (doing business as Universal Primary Care) where she served as Chief Executive Officer/Executive Officer. In this role, Gail had direct oversight of the organization's leadership team, including recruiting of medical and dental staff. Gail managed three clinical delivery sites, and managed the contractual relationship to operate as the teaching site of a rural residency program. She had strategic, operational, and financial oversight authority, including budgetary and regulatory oversight. Under Gail's direction, the clinic achieved several Health Resources and Services Administration (HRSA) grant awards, including a Health Improvement Infrastructure Program $1 million grant, HRSA Section 330 grant, and several

service expansion grants. Gail oversaw the successful turnaround of a near-bankrupt Article 28 Diagnostic & Treatment Center (D&TC) center into a Federally Qualified Health Center (FQHC) Look-Alike and then a FQHC grantee in 2012. Gail doubled the growth of the clinic from an income statement of just under $3 million in 2006 to an expected achievement of $9.4 million in 2017.

Prior to Universal Primary Care, Gail served as Assistant Vice President/Marketing, Events and Public Relations Manager at Five Star Bank. In this role, Gail managed the bank's rebranding initiative which merged four "sister banks" into one surviving corporate entity. This included rebranding and marketing materials for all 50 branches in the Western and Central New York area. Gail managed the bank's public relations strategy, including managing the public relations and advertising agencies contracted to provide services to the bank. She also managed a $1.9 million annual budget, a $6 million rebranding budget, all corporate giving for 50+ communities, and branding for 50 branches.

Additional roles Gail has held include Adjunct Professor of Journalism/Mass Communications at St. Bonaventure University, Director of Communications at Olean General Hospital, Lifestyles Editor/Staff Writer for Olean Times Herald, and Sports Editor for Salamanca Press.

Gail earned her bachelor's degree in journalism from The Ohio State University.

Fred Pampel – HMACS Principal

Fred Pampel joins HMA Community Strategies from the University of Colorado Boulder where he most recently served as Research Professor of Sociology and Senior Research Associate, Institute of Behavioral Science. For nearly three decades, Fred has taught undergraduate and graduate statistics courses. He specializes in population health, program evaluation, and statistical analysis.

Fred helps lead the Blueprints Project for Healthy Youth Development at the University of Colorado Boulder. The project evaluates the methodological quality of experimental studies of social programs for youth and adults. Most recently, Fred participated in evaluations of programs to improve the literacy of minority preschoolers, provide short-term counseling for government workers, integrate care for Medicaid patients with chronic health problems, and reduce violence in disadvantaged neighborhoods.

Fred is the author of 13 books, including *Logistic Regression: A Primer*, and 80-plus peer-reviewed research articles on topics relating to health, inequality, and research methods. He has received research funding from the National Institutes of Health, the National Science Foundation, the Annie E. Casey Foundation, and the Arnold Foundation.

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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; Raleigh, North Carolina; Sacramento, San Francisco, and Southern California; Seattle, Washington; Tallahassee, Florida; and Washington, DC.

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