HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

April 19, 2017

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

ALABAMA, OHIO PROVIDE DETAILS ON MEDICAID MLTSS PROGRAM DESIGNS

This week, our *In Focus* section reviews two proposed statewide Medicaid managed long-term services and supports (MLTSS) program designs. Alabama is currently accepting public comments on a plan to implement provider-driven Integrated Care Networks (ICNs) to provide MLTSS statewide to roughly 25,000 beneficiaries who are residing in nursing facilities or receiving home and community based services (HCBS) through three of the state's Medicaid HCBS waiver programs. Meanwhile, Ohio Governor John Kasich proposed in his upcoming state budget to implement a statewide MLTSS program for more than 100,000 beneficiaries in the state. We review both states' plans for MLTSS, including market sizes, implementation timing, and existing Medicaid managed care plans in the states.

Alabama

On April 5, 2017, the Alabama Medicaid Agency published a concept paper for public comment on the planned ICN program. The program would implement MLTSS statewide for around 25,000 Medicaid beneficiaries residing in a nursing facility or enrolled in one of three of the state's home and community based services (HCBS) waiver programs.

The ICN program targets enrolling just over 16,000 Medicaid beneficiaries who are currently long-term stay nursing home residents. Additionally targeted for inclusion in the ICN program are around 9,000 HCBS waiver enrollees in the Elderly and Disabled Waiver, the HIV/AIDS Waiver, and the Alabama Community Transition Waiver. Nearly all potential ICN HCBS enrollees are in the Elderly and Disabled Waiver. Alabama Medicaid nursing facility spending amounts to around $900 million in recent years, while the three HCBS waiver programs included in the ICN program account for more than $65 million in annual Medicaid HCBS spending.

Per the concept paper, a competitive procurement would be issued in August 2017 to contract with no more than two statewide ICNs, which are organizations of health care providers that will receive monthly risk-based capitation payments.

ICNs can be for-profit or not-for-profit entities, and must have a governing board composed of 20 members: 12 members representing risk-bearing participants in the ICN and eight members who do not represent risk-bearing participants. The state is targeting implementation in July 2018. Comments on the concept paper are due May 4, 2017.

The ICN Concept Paper posted for public comment is available at:

http://www.medicaid.alabama.gov/documents/5.0_Managed_Care/5.2_Other_Managed_Care_Programs/5.2.4_ICNs/5.2.4_ICN_Key_Concept_Paper_DRAFT_4-5-17.pdf

Ohio

On March 31, 2017, the Ohio Department of Medicaid published a slide presentation including information and updates from a recent stakeholder meeting about the state's Medicaid Managed Long-Term Services and Supports (MLTSS) procurement. As proposed by Governor John Kasich in his upcoming budget, the state intends to implement MLTSS statewide in 2018. The state's dual eligible demonstration, known as MyCare, currently provides MLTSS to many dual eligibles in the demonstration regions, and includes mandatory enrollment in MLTSS in the event that an eligible dual opts out of the MyCare program.

Based on the current proposal, which excludes MyCare enrollees, as well as individuals with I/DD, we conservatively estimate the potential MLTSS population at roughly 100,000 members, although eventual enrollment could be as high as 130,000, depending on final program design. Total Ohio LTSS spending is more than $7 billion, although due to program design, only a portion of this total spending would be moved to the MLTSS program.

Ohio plans to issue a request for applications (RFA) in July 2017 to procure at least three statewide MLTSS plans. Plans will be selected in October 2017 and fee-for-service members will begin transitioning to MLTSS in July 2018, phased in over 6 months, with transitions occurring every 60 days.

Ohio's MyCare program is currently served by five of the state's six Medicaid health plans, with enrollment relatively evenly distributed across the five plans.

	CFC	ABD	Group 8	MyCare	Total - All Programs
Aetna Better Health				22,694	**22,694**
Buckeye Health Plan (Centene)	182,905	17,535	89,748	17,652	**307,840**
CareSource	932,626	71,480	302,331	26,452	**1,332,889**
Molina Healthcare	204,520	20,728	80,120	17,754	**323,122**
Paramount Advantage	155,707	7,651	71,326		**234,684**
UnitedHealth	171,396	14,468	90,731	20,317	**296,912**
Total - All Plans	**1,647,154**	**131,862**	**634,256**	**104,869**	**2,518,141**

It was reported on April 7, 2017, that opponents to statewide MLTSS testified on the budget proposal, citing the lack of experience serving individuals with complex needs and less local, independent care management.

The Ohio MLTSS presentation slides are available at:

http://www.medicaid.ohio.gov/Portals/0/Providers/PR-News/Managed-LongTerm-Services-and-Supports-Stakeholder-Meeting-2017.pdf

HMA MEDICAID ROUNDUP

Arkansas

Dental Benefit Management Award Contested by DentaQuest. *Arkansas Online* reported on April 13, 2017, that DentaQuest, a dental benefit management company, filed a lawsuit against the Arkansas Medicaid agency contesting the company's disqualification from an award to manage the state's Medicaid dental benefits beginning January 1, 2018. Contracts were awarded to Delta Dental and Managed Care of North America. The lawsuit, filed in Pulaski County Circuit Court on April 10, alleges that the state's procurement director improperly disqualified DentaQuest for failing to disclose information about a federal lawsuit in Massachusetts. The director also disqualified bidder Liberty Dental for failing to disclose fines. DentaQuest's lawsuit asks for Managed Care of North America to be disqualified and for the contracts to be rebid, or for the state to reimburse the company for the cost of preparing the bid. Read More

California

In-Home Supportive Services Program Remains Source of Budget Friction. *Los Angeles Times* reported on April 18, 2017, that California's In-Home Supportive Services (IHSS) program for low-income individuals who are elderly or with disabilities is again at the center of a budget standoff. The latest budget dispute concerns how the state and various counties will split the cost of IHSS, which provides home cares to more than 500,000 Medi-Cal beneficiaries. Read More

Bills Would Increase Medicaid Dental Rates in Hopes of Improving Access. *California Healthcare* reported on April 17, 2017, that California is considering legislation that would increase funding and provider reimbursement rates for the state's Medicaid dental program, Denti-Cal, in an effort to improve access to services. Critics of Denti-Cal maintain that low reimbursement rates have kept dentists from participating in the program, limiting access to services. A state audit found that less than half of the children eligible for Denti-Cal actually saw a dentist in 2013. Proposed legislation would use funds from the state's new tobacco tax to improve access to Denti-Cal services. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

CMS Approves Restoration of $1.5 Billion in Low Income Pool Funds. *The Miami Herald* reported on April 12, 2017, that the Centers for Medicare & Medicaid Services (CMS) has agreed to restore $1.5 billion to the state's Low Income Pool (LIP), a program that reimburses hospitals for uncompensated care. In 2014, the LIP was worth over $2 billion, with funding coming from both the state and federal government. The program had seen reduced funding under former President Obama's administration. The new funding is expected to help offset some of the proposed budget cuts to hospitals. Read More

House, Senate Are $2 Billion Apart on Budget Proposals, Potentially Impacting Hospital Funding for Uncompensated Care. *Naples Daily News* reported on April 13, 2017, that the Florida House and Senate are $2 billion apart in separate budget bills passed this week, setting the stage for negotiations that could impact hospital funding for uncompensated care costs. The Senate's $81.2 billion budget set aside $608 million to reimburse hospitals for uncompensated care through the state's Low Income Pool. The House approved a $83.2 billion budget, with no funding for uncompensated care. Negotiations between the two chambers could begin as early as next week. Read More

House Advances Bill to Eliminate Cap on Number of Trauma Centers. *Health News Florida* reported on April 18, 2017, that the Florida House Health Appropriations Subcommittee has advanced a bill that would eliminate limits on the number of trauma centers in the state. State law currently caps the number of trauma centers at 44 facilities statewide and limits those centers to 19 different geographic regions. The bill comes after years of discussions around whether the Florida Department of Health should approve new trauma centers. Hospitals have long opposed the proposal, arguing that that trauma centers need a consistent flow of patients, and that new centers would lower the quality of care overall. House leaders are also advancing bills to eliminate certificate of need approvals and make other changes to the state's Medicaid program, including the potential addition of premium requirements for beneficiaries. Read More

House Republican Health Care Bills Stall in State Senate. *Naples Daily News* reported on April 18, 2017, that several Florida House health care bills have stalled in the state Senate. House Republicans had hoped the Senate would pass at least two of the initiatives, including a bill allowing patients to stay in ambulatory surgical centers for up to 24 hours and another allowing patients to sidestep insurance companies by prepaying physicians for primary care services. Other stalled Florida bills include initiatives on the deregulation of hospitals and trauma centers, telehealth, and expanding the scope of practice for advanced registered nurses to diagnose patients with mental health needs. Read More

Illinois

Cook County Sees Dramatic Financial Improvement Under ACA. *The New York Times* reported on April 16, 2017, that Cook County Health & Hospitals System in Chicago has been able to break even for the first time in its 180-year-

history, largely because of the impact of the Affordable Care Act (ACA), according to chief executive Jay Shannon, MD. The ACA has boosted the system's revenues by $200 million to $300 million annually, Shannon said. Furthermore, about 70 percent of the system's patients now have health insurance, compared to just 30 percent before the ACA expanded coverage. From a patient standpoint, Shannon said, the ACA has meant expanded access to care coordination, community mental health, substance use disorder services, and preventive services like vaccinations. Shannon noted that his biggest concern is the potential repeal of the law. Read More

Indiana

HIP 2.0 Could Gain Influence as Model for Other States. *Politico* reported on April 15, 2017, that the Healthy Indiana Plan (HIP) 2.0 Medicaid expansion program is likely to garner attention as a model for other states, given the growing influence of Vice President Mike Pence, who embraced the program when he was Governor of Indiana. HIP 2.0 promoted expansion aligned with more conservative principles, requiring beneficiaries to take personal responsibility by making small monthly contributions to help cover the cost of care. Despite fears that the requirement would diminish sign-ups, the program expanded coverage to 400,000 individuals over two years. States that have already implemented elements of HIP 2.0 include Kentucky and Arizona. Meanwhile, many republican states might turn to HIP 2.0 as a model to promote expansion initiatives acceptable to their conservative base. Read More

Kansas

Democrats May Again Propose Medicaid Expansion, Despite Governor's Veto. *The Wichita Eagle* reported on April 16, 2017, that Kansas Democrats may once again propose Medicaid expansion when the legislative session reconvenes on May 1, 2017. House supporters were recently three votes short in overturning Governor Sam Brownback's veto of expansion legislation that had passed both chambers with strong majorities. In a joint statement, 16 Republican lawmakers who voted against overturning the veto said it is not the time to expand Medicaid under a "perilous budget situation." Read More

Medicaid Expansion Effort Driven by Hospitals' Financial Situation. *KCUR* reported on April 17, 2017, that struggling Kansas hospitals are contributing to the renewed effort to expand Medicaid in the state after Governor Sam Brownback vetoed an expansion bill earlier this year. Medicaid expansion advocates say expanding KanCare could help hospitals financially, and are leveraging concerns around potential hospital closures to attempt to build a veto-proof majority. Lawmakers will need to pass a new bill, allowing them to modify the previous legislation. Possible changes include requiring certain adults to work or participate in job training programs. Opponents argue that expanding Medicaid would not generate enough additional federal revenues to save the struggling hospitals. Read More

Louisiana

Poll Shows Residents Support Medicaid Expansion, Divided on ACA. *The Advocate* reported on April 11, 2017, that although half of Louisiana residents

have an unfavorable view of the Affordable Care Act (ACA), 72 percent support the state's Medicaid expansion, according to the 2017 Louisiana Survey. Respondents with an unfavorable opinion of the ACA are down seven percentage points since 2014. Louisiana expanded Medicaid in July 2016. Since then, 415,000 residents have signed up for Medicaid. Read More

Maine

State Considers Adding Medicaid Work Requirements. *The Wall Street Journal* reported on April 14, 2017, that Maine is considering adding work requirements as a condition of Medicaid eligibility. In 2014, Maine required individuals receiving Supplemental Nutrition Assistance Program to be working, receiving job training, or volunteering. As a result, enrollment fell 90 percent. The state hopes that, similarly, Medicaid enrollment would decrease in order to prioritize resources for children, older adults, and individuals with disabilities. However, the plan is drawing heavy criticism from advocates, who say individuals in rural areas with limited access to jobs and transportation, will be unfairly impacted by the requirements. Read More

Michigan

Plan to Shift Medicaid Behavioral Funds to MCOs Faces Opposition. *Crain's Detroit Business* reported on April 18, 2017, that mental health advocates are urging Michigan Governor Rick Snyder and state legislators to oppose a budget proposal that would divert specialty behavioral health funding from public mental health agencies to Medicaid managed care plans to coordinate physical and behavioral health benefits. In an April 17, 2017, letter, 14 advocacy organizations said they feared health plans would initiate programs contrary to the recommendations of a Michigan Department of Health and Human Services workgroup on how to improve the state's mental health system. Advocates questioned prior efforts among health plans to build adequate networks to provide mild and moderate psychiatric and psychotherapy services. Michigan health plans countered that plans must meet state network adequacy requirements.Read More

Montana

CMS to Evaluate Use of Premiums, Copays in Medicaid Expansion Program. *Modern Healthcare* reported on April 18, 2017, that federal regulators will evaluate whether the use of premiums and copays in Montana's Medicaid expansion program is encouraging beneficiaries to avoid emergency departments in favor of other care settings. The Centers for Medicare & Medicaid Services (CMS) has already begun surveying beneficiaries, before formally asking the Office of Management and Budget (OMB) to begin the evaluation. Montana has not yet hired its own independent contractor to evaluate the program, which is administered by Blue Cross Blue Shield of Montana. Montana launched the expansion program, called Health and Economic Livelihood Partnership (HELP), in January 1, 2016. The HELP program is authorized through 2020. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Leapfrog Group Report on Patient Safety Scores Gives One-third of New Jersey Hospitals an "A" Grade. On April 12, 2017, *NJ BIZ* reported on the results of a national non-profit advocacy organization that promotes transparency in hospital safety. The Leapfrog Hospital Safety Grade examined 30 national performance measures for over 2,600 acute care hospitals in all states to assign a letter grade of "A" through "F" to each hospital. On a positive note, no New Jersey hospitals received an "F" score while 27 of the 68 state hospitals received an "A" score. Scores by New Jersey hospital can be viewed on the Leapfrog Hospital Safety Grade website here.

New York

HMA Roundup – Denise Soffel (Email Denise)

Value Based Payment Innovator Program. New York has posted for public comment a draft application package for its Value Based Payment Innovator Program. The VBP Innovator Program is a voluntary program for VBP contractors prepared to participate in VBP Level 2 (full risk or near full risk) or Level 3 Total Care for General Population and/or Subpopulation arrangements. By taking on further management and administrative functions, contractors approved as Innovators will be eligible for an increased premium pass through. Applications will be assessed on five criteria: 1) a commitment to contracting for a high- or full-risk VBP Level 2 or Level 3 Total Care for General Population (TCGP) or Subpopulation arrangement; 2) upholding health plan network adequacy; 3) past success in VBP contracting for TCGP or Subpopulation arrangements; 4) the ability to meet minimum attribution thresholds; and 5) financial solvency and appropriate net worth. Public comments can be submitted through May 12, 2017. Read More

Approval of Value Based Purchasing Road Map. New York has received Centers for Medicare & Medicaid Services (CMS) approval of its annual update to the New York State Roadmap for Medicaid Payment Reform, "A Path toward Value Based Payment: Annual Update June 2016: Year 2." The roadmap provides a path forward for payment reform as part of New York´s delivery system reform efforts and serves as one of several methods to help support financial sustainability of the state´s Medicaid program. In the approval letter, CMS has requested that the next update include a strategy to work toward an alternative payment model that includes both upside and downside risk for providers. The Annual Update and the CMS approval letter are available on the DSRIP website. Read More

Health Care Facility Transformation Grants to be Awarded. New York is preparing to announce $495 million in capital grants to health care facilities. Crain's reports that the Health Care Facility Transformation grants will be announced by the end of May. The funding includes $195 million in the previous year's budget and $300 million from the budget for fiscal 2018, which began April 1. The rest of this fiscal year's $500 million program will be awarded at a later time. The awards are intended to support capital projects that help strengthen and promote access to essential health services including projects that will improve infrastructure, promote integrated health systems,

and support the development of additional primary care capacity. According to the original grant announcement, "Capital grant projects include but are not limited to closures, mergers, restructuring, improvements to infrastructure, development of primary care service capacity, development of telehealth infrastructure, the promotion of integrated delivery systems that strengthen and protect continued access to essential health care services and other transformational projects." Read More

Delay in Children's Behavioral Health Waiver Request. *Politico* reports that New York has decided to delay submitting a Section 1115 Medicaid waiver request that would address program redesign for children's behavioral health services. According to Politico, the state is apprehensive about potentially reopening examination of other aspects of the state's Medicaid waiver, which was renewed for a five-year period in December 2016, prior to the start of the Trump administration. The waiver request would carve children's behavioral health services into the Medicaid managed care program. Read More

Medicaid Redesign Team "Boo-Yah" Report. New York has announced a new publication designed to highlight accomplishments of the state's Medicaid Redesign Team (MRT) efforts. The report, entitled the MRT "Boo-Yah!" Report, provides a compilation of completed MRT projects and activities. The first report provides updates on 11 MRT projects, including creating risk-bearing entities for high-needs behavioral health populations, enrolling children in health homes, establishing a managed long-term care technology demonstration program, and an initiative for the comprehensive coverage and promotion of long acting reversible contraception. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Passes Bill Requiring Insurers to Cover Autism-Spectrum Disorders. *The Columbus Dispatch* reported on April 13, 2017, that Ohio passed House Bill 463, mandating insurer coverage of individuals with autism-spectrum disorders. HB 463 requires insurers to provide coverage for the screening, diagnosis, and treatment of autism-spectrum disorders, and will not be able to terminate coverage in the instance of an autism-spectrum diagnosis. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

CMS Announces $10 Million for Pennsylvania's Medicare Rural Health Model. On April 14, 2017, the Centers for Medicare & Medicaid Services (CMS) announced that $10 million in startup funds is now available for the Pennsylvania Department of Health to set up its new alternative payment model for Medicare in rural hospitals. The model will be tested over seven years, four of which will be partially funded by CMS. The initial $10 million for the Pennsylvania Rural Health Model is authorized through CMS' innovation center; after 24 months, Pennsylvania can apply for an additional $15 million. Read More

Governor's Budget Proposal to Boost Minimum Wage to Cut Medicaid Costs. In Governor Tom Wolf's proposed state budget, administration officials say increasing the state's minimum wage to $12 an hour would shave almost

$50 million from public-benefit costs, the bulk of which would be from the roughly 100,000 people who, because of higher income, would no longer be Medicaid-eligible, per budget estimates. The current minimum wage is $7.25. Several bills in the legislature propose to increase the minimum wage. The idea has the support of Governor Wolf but is generally opposed by business groups. A review of the governor's budget proposal by the Independent Fiscal Office, noted that someone working full time at the current minimum wage would earn only $15,080 annually and would qualify for Medicaid. A person working full time at $12 per hour wage would earn $23,960 annually and would no longer be Medicaid-eligible. Groups such as the Pennsylvania Chamber of Business and Industry and the Pennsylvania Restaurant & Lodging Association say such an increase would ultimately lead to job losses and would hurt small businesses. Alex Halper, director of government affairs at the Pennsylvania Chamber of Business and Industry, argues that low-income families would be better served by programs such as job training, education or a state Earned Income Tax Credit targeted at low-wage working families (such a tax credit exists at the federal but not state level). Pennsylvania last raised its minimum wage on July 24, 2009, from $7.15 to $7.25, when the federal minimum wage was increased to $7.25. Read More

Bill Seeks to Reform Pennsylvania Medicaid Spending. Pennsylvania Senate Bill 600 was introduced by Senator Scott Martin as Medicaid reform legislation. SB600 proposes that Pennsylvania adopt new technology to monitor and identify unnecessary or wasteful health care services and procedures in the Medicaid program. The legislation would require the state to pick a technology company and launch a program within 90 days of the bill's passage. In March, Senator Martin invited MedExpert, the California-based technology firm, to discuss its record in other states during a hearing of the Senate Majority Policy Committee in Harrisburg. Read More

South Carolina

Departing Medicaid Director to Join Hospital Association. *The Post and Courier* reported on April 12, 2017, that former South Carolina Medicaid director Christian Soura, who resigned on April 7, will become vice president of policy and finance at the South Carolina Hospital Association. Soura is the second Medicaid director to leave the agency for the hospital industry. Read More

Wisconsin

Governor, DHS Propose Medicaid Premiums, Drug Screening, Work Requirements. *Modern Healthcare* reported on April 17, 2017, that the Wisconsin Department of Health Services has released a plan to reform the state's Medicaid program, including requiring members to pay premiums and to undergo drug screening. If approved, Wisconsin would be the first state to mandate drug testing. Childless adults would be charged premiums from $1 to $10 per household; those with incomes up to 20 percent of the federal poverty level would be exempted. Beneficiaries would also be required to make copayments for emergency department visits. The proposal also limits Medicaid eligibility to 48 months unless the beneficiary is employed or in the process of job training. Many elements of the proposal are similar to Indiana's

Healthy Indiana Plan 2.0 (HIP 2.0) Medicaid expansion waiver. The department says it plans to submit a waiver request to the Centers for Medicare & Medicaid Services on May 26, following a public comment period. Read More

National

MACPAC Posts April 2017 Public Meeting Agenda. The Medicaid and CHIP Payment and Access Commission (MACPAC) posted an agenda for its April 20-21, 2017 public meeting. Discussion topics include federal CHIP funding, program integrity in Medicaid managed care, the Medicaid opioid epidemic, Medicare savings programs, 1115 waivers, and managed long-term services and supports, among others. Read More

HHS Shortens Open Enrollment Period in Bid to Stabilize Exchanges. *Kaiser Health News* reported on April 13, 2017, that the U.S. Health and Human Services Department (HHS) issued a final rule on April 7, 2017, meant to help stabilize the Affordable Care Act Exchanges. The rule reduces the length of the Exchange open enrollment period, limits the ability of individual to enroll during special enrollment periods, requires some individuals to show proof of previous insurance coverage, and mandates that individuals repay past-due premiums from the previous 12 months before gaining coverage. Over 4,000 organizations provided public comments during the 20-day period that ended in March. Many consumer groups voiced concern that the changes would make it harder for individuals to gain coverage, while the insurance industry voiced support of the changes. Read More

Federal Funding Sufficiently Covered Increased Costs from Medicaid Expansion, Report Finds. *Kaiser Health News* reported on April 12, 2017, that federal funding was sufficient to cover the cost of Medicaid expansion from fiscal 2010 to 2015, according to a recently published *Health Affairs* report. The report analyzed data from the National Association of State Budget Officers and found that expansion led to an 11.7 percent increase in overall spending on Medicaid, accompanied by a 12.2 percent increase in spending from federal funds. The report supports the notion that expansion does not result in additional costs that would require states to reduce spending in other areas, such as education or transportation. However, the report only looked at years when the federal government funded 100 percent of Medicaid expansion; by 2020, states will be paying 10 percent of expansion costs. Read More

CMS Proposes $3 Billion Increase in Fiscal 2018 Hospital Reimbursements. *Modern Healthcare* reported on April 14, 2017, that the Centers for Medicare & Medicaid Services (CMS) is proposing to raise inpatient hospital reimbursements by $3 billion in fiscal 2018, largely by altering the formula for calculating uncompensated care payments. The new formula would mostly use the amounts of uncompensated care and charitable care each hospital claims on its Medicare cost report. Previously, the formula relied on the number of Medicaid patients, dual eligible patients, and individuals with disabilities served. Based on these changes, CMS expects to distribute $7 billion in uncompensated care payments next fiscal year. However, the change would have a negative impact on long-term care hospitals, which would see payments from CMS fall 3.75 percent in fiscal 2018. Read More

Seema Verma Removes Self from Indiana, Iowa Waiver Discussions. *Modern Healthcare* reported on April 13, 2017, Seema Verma, administrator of the Centers for Medicare & Medicaid Services, is sitting out on decisions regarding Medicaid expansion waivers in Indiana and Iowa. Verma has also already removed herself from discussions about Kentucky's pending Medicaid expansion wavier. Verma was involved in crafting expansion plans in Indiana, Iowa, Kentucky, and Ohio through her consulting firm SVC Inc. SVC is now HMA Medicaid Market Solutions, a part of Health Management Associates. Read More

Medicaid MCO Rates May Not be High Enough, Report Finds. *Modern Healthcare* reported on April 13, 2017, that many states may not be paying Medicaid managed care plans enough to sustain adequate profit margins, according to a new report from The Society of Actuaries. Medicaid margins average around 2 percent, before income taxes, unexpected expenses, and IT investments for new Medicaid requirements, such as alternative payment models. Unless states increase rates, the study concludes, Medicaid managed care plans may reconsider their participation in Medicaid lines of business. Health Management Associates assisted The Society of Actuaries with the report. Read More

Industry News

United First Quarter Profits Rise 35 Percent after Exchange Market Exits. *The New York Times* reported on April 18, 2017, that UnitedHealth Group saw profits rise 35 percent in the first quarter of 2017, following the company's decision scale back its Exchange market participation. United reduced Exchange participation to just three states in 2017, having previously participated in as many as 34 states. Individual enrollment fell, while Medicaid and Medicare enrollment at the company rose. United did not disclose at this time if it will remain in the Exchanges next year. Read More

Trinity Health to Expand Telemedicine Offering Beyond Michigan. *Crain's* reported on April 16, 2017, that Trinity Health is expanding its Home Care Connect remote telemedicine service beyond its home state of Michigan to all of the organization's home health agencies in Indiana, Iowa, Illinois, California, Maryland, and Ohio. The service provides two-way video conferencing, allowing patients at home to communicate with nurses at any time of day. The technology is from Vivify Health and includes a wireless tablet and devices that allow patients to collect weight, blood pressure, and other vital information. Trinity conducted a successful pilot program with 62 older adults in Michigan last year. Read More

TMG by Magellan Health to Expand LTSS Self-Directed Care Services Statewide in Wisconsin. TMG by Magellan Health announced on April 18, 2017, that it will expand statewide in Wisconsin in an effort to cut waiting lists for people who need help self-directing their long-term services and supports (LTSS). TMG works with the state's LTSS program (known as IRIS) as an IRIS Consultant Agency, receiving a fee from the state to help LTSS members to self-direct their care. TMG will expand to 72 counties effective early 2018, up from 65 currently. TMG develops customized plans related to employment, housing, health, safety, community, transportation, and long-term relationships for thousands of adults with disabilities and who are elderly. Read More

Company Announcements

- **"ConcertoHealth Names Kellie J. Rice Executive Director for Michigan Market"** Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
April 27, 2017	Alaska Coordinated Care Demonstration	Proposals Due	TBD
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May 15, 2017	Illinois	Proposals Due	2,700,000
May 22, 2017	Washington (FIMC - North Central RSA)	Contract Awards	66,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
June 30, 2017	Illinois	Contract Awards	2,700,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Georgia	Implementation	1,300,000
July 17, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
July, 2017	Ohio MLTSS	RFA Release	130,000
August 1, 2017	Virginia MLTSS	Implementation - Tidewater	20,000
August, 2017	Alabama ICN (MLTSS)	RFP Release	25,000
September 1, 2017	Virginia MLTSS	Implementation - Central	23,000
Summer 2017	Florida	RFP Release	3,100,000
Summer 2017	Massachusetts One Care (Duals Demo)	Procurement Release	TBD
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October 1, 2017	Virginia MLTSS	Implementation - Charlottesville/Western	17,000
October 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October, 2017	Alabama ICN (MLTSS)	Proposals Due	25,000
October, 2017	Ohio MLTSS	Contract Awards	130,000
November 1, 2017	Virginia MLTSS	Implementation - Roanoke/Alleghany, Southwest	23,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 1, 2017	Virginia MLTSS	Implementation - Northern/Winchester	26,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Virginia MLTSS	Implementation - CCC Demo, ABD in Medallion 3.0	105,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
Winter 2018	Massachusetts One Care (Duals Demo)	Contract Awards	TBD
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
July, 2018	Alabama ICN (MLTSS)	Implementation	25,000
July, 2018	Ohio MLTSS	Implementation	130,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
January, 2019	Massachusetts One Care (Duals Demo)	Implementation	TBD
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of state dual eligible financial alignment demonstration status.

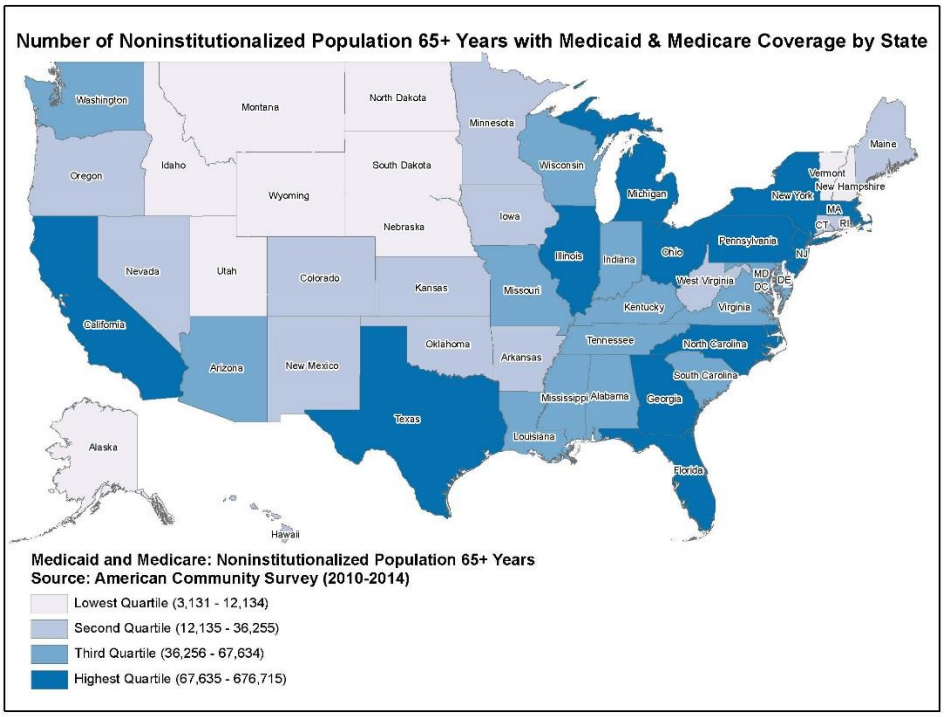
State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Jan. 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	114,804	32.8%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	45,469	33.4%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	16,039	16.5%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,752	36.8%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York*	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	4,827	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	448	2.2%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	69,634	61.1%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	9,934	39.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	8,981	16.8%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	50,924	30.3%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	28,835	43.6%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**386,647**	**30.8%**	

** New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment.*

Note: Enrollment figures in the above chart are based on state enrollment reporting, where available, and on CMS monthly reporting otherwise.

HMA News

Over the next few weeks, the HMA Weekly Roundup and HMA Information Services (HMAIS) will showcase a series of maps and other key informatics. Our second map in the series highlights data on **the number of noninstitutionalized individuals 65 years and older with Medicaid and Medicare coverage by state.** Half of dual eligibles have three or more chronic conditions and are more likely to live in long-term care facilities than non-dual eligibles.



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

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

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