HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

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Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

THIS WEEK

The HMA Weekly Roundup will not publish for the next two weeks. We will resume weekly publication on Wednesday, January 6, 2016, with a preview of key Medicaid and legislative issues to watch for in our states in the coming year. HMA and the Weekly Roundup team wish all our readers a happy and safe holiday season!

IN FOCUS

VIRGINIA TO SUBMIT 1115 WAIVER ON MLTSS AND DSRIP INITIATIVES

This week, our *In Focus* section reviews Virginia's Section 1115 demonstration waiver, which is currently posted for stakeholder review and a public comment period. The 1115 waiver seeks approval from the Centers for Medicare & Medicaid Services (CMS) to implement two initiatives: (1) a Medicaid managed long-term services and supports (MLTSS) program; and (2) a Delivery System Reform Incentive Payment (DSRIP) program. The MLTSS initiative would mandate enrollment in managed care for around 130,000 individuals receiving

LTSS benefits, including enrollees in three of the state's existing 1915(c) home and community based services (HCBS) waivers. Meanwhile, the DSRIP seeks to establish high-performing provider collaborations to provide patient-centered care and explore alternative payment models. The public comment period on the 1115 waiver runs from December 4, 2015, through January 6, 2015. If approved by CMS, the 1115 demonstration will operate from January 2017 through December 2022.

MLTSS Overview

Under the proposed MLTSS program, Virginia will competitively bid contracts for Medicaid managed care organizations (MCOs) to provide a fully integrated managed care model that includes physical, behavioral, substance use, and LTSS benefits. The program will operate statewide, but will be implemented regionally; as such, it is unclear at this time whether MCOs will contract with the state on a regional basis or a statewide basis. The MLTSS program will include three existing 1915(c) HCBS waivers – the Alzheimer's waiver (57 enrollees), the technology assisted waiver (287 enrollees), and the elderly or disabled with consumer direction waiver (32,386 enrollees). Enrollees on the individuals with an intellectual disability (ID), individual and family developmental disabilities support (DD), and day support (DS) waivers will remain in Medicaid fee-for-service. The estimated enrolled populations include:

- 46,000 dual eligibles who are excluded from enrollment in the state's dual eligible financial alignment demonstration, known as Commonwealth Coordinated Care (CCC);
- 18,000 non-duals in nursing facilities and waivers; and
- 66,000 dual eligibles either enrolled or opted-out of the CCC demonstration (to be transition to MLTSS after the demonstration ends at the end of 2017).

Virginia intends to issue a request for proposals (RFP) to procure MLTSS plans in spring of 2016, with a phased implementation beginning January 2017, pending CMS approval.

DSRIP Overview

Virginia's proposed DSRIP program would provide funding and support for the development of Medicaid provider partnerships into Virginia Integrated Partners (VIPs) that will work with the state's Medicaid MCOs. Virginia's goal for the VIPs is a structure of financial incentives for providers to organize and deliver care of a higher quality for a lower overall cost of care, slowing the rate of Medicaid spending in the state. The number of VIPs in Virginia will be determined by available funding, interest level and commitment.

VIPs will be established through contractual arrangements between public and private Medicaid providers, and will include community supports such as federally qualified health centers and area agencies on aging, as well as care navigators, like community health workers. A VIP will have a coordinating health system, which provides administrative support, oversees contracting relationships, and provides management leadership. MLTSS plans and existing Medillion 3.0 (Virginia's existing Medcaid managed care program) plans will have a role in DSRIP demonstration as partners with VIPs, with a long-term goal of VIPs and MCOs developing alternative payment arrangements under the DSRIP.

VIPs will select from a menu of DSRIP projects, including:

- System Transformation Projects, focused on development of the VIP model of care, ensuring provider capacity, and better integration and utilization of data;
- Financial Incentive Alignment Projects, focused on transition to value-based and alternative payment models; and
- Clinical Improvement Transformation Projects, focused on initatives such as integrated behavioral and primary care, emergency department diversions, expanded supported housing and employment supports, and telehealth, among other projects.

Further details on the DSRIP program design and initiatives is available in the proposed 1115 waiver. Virginia anticipates launching the DSRIP initiative in January 2017, pending CMS approval.

Funding and Budget Neutrality

Virginia is requesting a federal investment of $1 billion over the five-year 1115 waiver period, proposing to leverage a portion of federal savings achieved in recent years, and anticipated savings in coming years, by expanding Medicaid managed care and through LTSS rebalancing. The 1115 waiver assumes savings of 5 percent from the Medallion 3.0 over what would have been spent in FFS, and an increase of individuals receiving LTSS in HCBS settings from 31.5 percent in 2004 to 60.3 percent in 2016. Virginia estimates federal savings from these two efforts at $2.3 million from 2004 through 2017, and $1.7 billion to be achieved from 2018 through 2022. Additionally, the state is currently working to identify designated state health programs (DSHPs) and intergovernmental transfers (IGTs) as non-federal funding sources for the DSRIP effort.

Links to 1115 Waiver, More Information

1115 Waiver Demonstration:
http://dmasva.dmas.virginia.gov/Content_atchs/mltss/PUBLIC%20COMMENT%20DOCUMENT%20Combined%201115%20Innovation%20Waiver%20Application.pdf

MLTSS website:
http://dmasva.dmas.virginia.gov/Content_pgs/mltss-home.aspx

DSRIP website:
http://www.dmas.virginia.gov/Content_pgs/dsrip.aspx

HMA Medicaid Roundup

Arkansas

Health Reform Legislative Task Force Begins Meetings to Finalize Medicaid Recommendations. On December 16, 2015, *Times Record* reported that the Health Reform Legislative Task Force held its first of three meetings to finalize the recommendations for Medicaid redesign in Arkansas. The discussion was largely about ways to achieve cost savings across the entire Medicaid system. A consultant hired by the state, The Stephen Group, said the state could cut costs through managed care. Some members of the task force had concerns with managed care and presented an alternate proposal, called DiamondCare. It calls for expanding and enhancing the patient-centered medical home model for the traditional Medicaid population. Read More. Additionally, long-term care providers and advocates in the legislature are rumored to have struck a deal with the governor to "carve out" long-term care from the proposed Medicaid managed care plan. Under the agreement, long-term care providers would agree to make changes on their own that would be equivalent to the savings projected by The Stephen Group for putting long-term care populations in managed care, amounting to more than $200 million over five years. Read More

California

HMA Roundup – Don Novo (Email Don)

California's Exchange Targets Communities with High Rates of Uninsured. On December 11, 2015, *Kaiser Health News* reported that California's health insurance exchange is targeting parts of the state with exceptionally high rates of uninsured residents in efforts to sign more people up before the deadline. The areas include San Francisco's Mission district, Oakland's Fruitvale neighborhood and the East San Jose and Berryessa communities of Silicon Valley. Covered California estimates that 750,000 Californians are eligible for the health insurance subsidies but remain uninsured, including 16,000 in San Francisco County, 20,000 in Contra Costa County, 33,000 in Alameda County and 34,000 in Santa Clara County. Read More

Report Ranks California 16th Healthiest State in the U.S. On December 11, 2015, *California Healthline* reported that a United Health Foundation and American Public Health Association report found that California ranked as the 16th healthiest state in the U.S. Hawaii ranked first for the fourth year in a row. Louisiana ranked as the unhealthiest state. The report used data from federal agencies and other groups to assess states on 27 core health measures. Read More

California Overhauling Substance Abuse Treatment System for Medicaid Recipients. On December 10, 2015, *Kaiser Health News* reported that California received federal permission to revamp its drug and alcohol treatment system for Medicaid beneficiaries through a waiver. Officials will have new spending flexibility to expand treatment services, including inpatient care, case management, recovery services, and added medication. Beginning next year, drug treatment centers will be able to be reimbursed for providing these options to people on Medi-Cal. However, drug rehabilitation providers fear the state won't raise traditionally low Medi-Cal reimbursement rates for treatment, making it harder to provide the new services and produce the outcomes California hopes to achieve. The Medi-Cal drug treatment program currently costs $180 million annually. Nearly 14 percent of Medicaid recipients are believed to have a substance use disorder. Read More

Audit Finds Three Medi-Cal MCOs Vulnerable to Data Security Breaches. On December 10, 2015, *California Healthline* reported that an audit by the HHS Office of Inspector General found that three Medi-Cal managed care organizations have security lapses, making them vulnerable to data breaches. The investigation revealed a total of 74 high-risk security vulnerabilities with access controls, database security, and information storage. Read More

California's Three Biggest Insurers Account for Half of National Profit Under ACA in 2014. On December 9, 2015, *Los Angeles Times* reported that California's three largest health insurers were among a few to show profits selling policies on the ACA exchange in 2014. Nationwide, insurers reported a total of only $362 million in profit. Blue Shield of California made up $107 million of the total, Kaiser Permanente with $66 million, and Anthem Blue Cross with $9 million. The majority of insurers reported $2.87 billion in losses. United Health recently warned that it may quit selling on the exchange because the business is so unprofitable. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Request to Amend Florida's Section 1915(c) LTC Waiver. On December 14, 2015, The Agency for Health Care Administration submitted to the Centers for Medicare and Medicaid Services (CMS) a request to amend the Long-term Care (LTC) waiver that operates under the authority of Section 1915 (c) of the Social Security Act. The program uses a managed care service delivery model to provide home and community-based services to eligible waiver recipients. The waiver amendment requests approval to: 1) revise case management qualifications; 2) remove Structured Family Caregiving from the waiver service menu; 3) revise performance measures; 4) update the spousal impoverishment policy; 5) update the physical therapy providers and 6) update the unduplicated recipient count and related Appendix J tables. The 30 day comment period will begin on Monday, December 14, 2015 and end on Thursday, January 14, 2016. Read More

Kansas

Governor Brownback Names Tim Keck Interim KDADS Secretary. On December 10, 2015, *Kaiser Health Institute* reported that Governor Sam Brownback named Tim Keck as the interim secretary of the Kansas Department for Aging and Disability Services, filling in for Kari Bruffett. Bruffett is moving on to work as the director of policy for the Kansas Health Institute. Keck has served as deputy chief counsel at the Kansas Department of Health and Environment since 2011. Read More

Maryland

Maryland Terminates MMIS Contract with Computer Sciences Corp.; Seeks Potential Refunds. On December 9, 2015, *The Baltimore Sun* reported that the Maryland Department of Health and Mental Hygiene terminated its contract for upgrading state's MMIS system with Computer Sciences Corp. on October 14, 2015. The state plans to hire an outside counsel to review if it is due any refunds. The department stopped paying Computer Sciences Corp. in February after notifying the company about unacceptable work. The state continues to use its old system. Read More

Michigan

HMA Roundup – Eileen Ellis (Email Eileen) & Esther Reagan (Email Esther)

Legislature to Vote on Extending Michigan's Health Insurance Tax Until 2025. On December 15, 2015, *The News & Observer* reported that the Legislature is scheduled to vote on extending a 0.75 percent health insurance claims assessment until 2025. The tax currently helps fund Medicaid and is scheduled to end in two years. If it is not extended, Medicaid spending would be cut by approximately $1 billion annually starting in the 2017-18 budget year. Read More

Minnesota

State Terminates Payments to Large Mental Health Provider Accused of Overbilling Medicaid. On December 15, 2015, *Star Tribune* reported that the Minnesota Department of Human Services terminated payments to Complementary Support Services (CSS), a large Twin Cities mental health provider accused of overbilling Medicaid by millions, as part of a state crackdown on Medicaid fraud. The move will affect approximately 100 Minnesotans receiving services form the firm through Medical Assistance. CSS has denied the allegations. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Out-of-network Bills Headed to Senate Committee Despite Concerns from Hospital Group. *NJBIZ* reported that the New Jersey State Senate Commerce Committee would meet on December 10, 2015 to consider the latest versions of out-of-network health care bills. Both the New Jersey Hospital Association

(NJHA) and the Medical Society of New Jersey have issued statements in opposition, mainly due to problems arising in the proposed processes of arbitration between insurance companies and health facilities. A spokesperson from NJHA, Kerry McKean Kelly, has stated, "We totally agree with the sponsors that something needs to be done to protect consumers. But we can't support the bill in its current draft." Read More

New Jersey pushes Enrollment on Last Day to Buy 2016 Marketplace Coverage. December 15, 2015 marked the deadline to buy healthcare through the federal insurance marketplace, using the new online system on the federal government's healthcare website (healthcare.gov), without financial penalty. A penalty clause was included in the Affordable Care Act, stating that those who didn't enroll would be responsible for paying a $695 penalty fee or 2.5 percent of their household income, whichever is higher. Concerns arose that fewer people were enrolled compared to last year, which, in turn, could raise the price of future premiums. As of December 5, 2015, enrollment numbers were down in New Jersey by 25,154 from the previous year. According to *NJ Spotlight*, "Insurers have been advertising new plans and taking other steps to bolster enrollment."

'Housing First' pilot shows how it can help improve health of New Jersey's homeless. A pilot for the Housing First program has shown promising results in improving the health of New Jersey's homeless population. NJ Spotlight reported on December 10, 2015 that the program is being praised for bridging the gaps between medical outcomes and social determinants of health by providing individuals who are homeless with vouchers for stable housing. Virtua Health's Executive Vice President of strategic business growth and analytics, Alfred Campanella, said "we find that the social determinants of health are just as impactful as medical determinants." While the program has achieved success in other parts of the country as well as in Mercer and Bergen counties, the opportunity to launch the program in Camden gained support from providers with leadership from the Camden Coalition of Healthcare Providers and its president, Dr. Jeffrey Brenner.

New York

HMA Roundup – Denise Soffel (Email Denise)

Fully Integrated Duals Advantage Reforms. The Department of Health and CMS have finalized agreement on reforms to the FIDA program. The changes are driven by disappointing enrollment figures. Since FIDA began early in 2015, 7,540 beneficiaries have enrolled in the program; over 50,000 beneficiaries have opted out. A recent letter from the Office of Long-Term Care indicates that "as a result of the stakeholder engagement process, DOH is hitting the reset button on FIDA to address barriers to enrollment." Information about the reforms, which are intended to improve flexibility for the participant, plans, and providers, is posted on the Medicaid Redesign website. Some of the changes include:

- The participant's right to choose the Interdisciplinary Team (IDT) members.
- A more flexible IDT, with added accommodations and fewer restrictions for IDT training, provider participation, member meeting times, and the development of the participant's Person-Centered Service Plan (PCSP).

- Primary Care Providers may sign off on a completed PCSP without attending IDT meetings.
- Plans have authorization over any medically necessary services included in the PCSP that are outside of the scope of practice of IDT members
- Ease of transition and timing of assessments for FIDA Plan enrollment.
- Simplified procedures for information sharing and communication.

The letter also indicated that expansion of FIDA into Suffolk and Westchester counties, originally scheduled for March 2015 will be delayed until DOH has had the opportunity to monitor the impact of these changes.

In addition to these changes, *LeadingAge NY* reports that CMS has committed to an upward adjustment related to the Medicare Part A and B rates for all of 2016 and 2017. CMS is also conducting an additional analysis of the Part D bids.

Medicaid Spending on Hepatitis C Drugs. *Capital New York* reported on Medicaid spending for drugs related to the treatment of hepatitis C. The Medicaid program spent nearly $185 million on hepatitis C drugs during the second quarter of 2015, accounting for more than 6 percent of all drug spending, up nearly 50 percent from spending during the first three months of the year. More than 200,000 New Yorkers suffer from hepatitis C. Access to medication will ultimately save money as the need for liver transplants and maintenance medications is reduced, but the immediate expense is high, and has led to the decision to limit access to the drugs to only the sickest patients. Read More

Insurance Enrollment Deadline Extended. New York State of Health (NYSOH), the state's official health plan Marketplace, announced that due to the high volume of activity, the December 15, 2015, deadline for individuals enrolling or renewing health insurance coverage that takes effect January 1, 2016 has been extended through December 19, 2015.

Medicaid Managed Care Access and Availability Study. Findings from the 2014 Access and Availability Study indicate that Medicaid managed care plan performance has again declined. The study is conducted annually by IPRO as a "secret shopper" telephone survey meant to assess access and availability in three categories: routine office appointments during normal office hours, non-urgent "sick" appointments during normal office hours and after-hours access to care (measured by contact with a live voice). Compliance varies by region and by indicator, with rates varying from a high of 78 percent to a low of 46 percent. A compliance rate of 75 percent or greater is considered passing; only one region (New Rochelle) achieved those scores, and only on two of three measures. Scores in NYC were 72 percent for routine care, 68 percent for non-urgent sick care, and 50 percent for after-hours care. Given the need to reduce avoidable hospital visits, part of the DSRIP program, the findings on after-hours access is particularly troubling. Findings from the study are posted on the *LeadingAge NY* website.

North Carolina

Eleven Health Systems Looking to Partner on New Medicaid Managed Care Entity. On December 15, 2015, *Triad Business Journal* reported that 11 health systems statewide will join to form a new company to manage the delivery of health care to Medicaid recipients. The partnership will include Cone Health, Novant Health, Wake Forest Baptist Medical Center, Carolinas HealthCare

System, Duke University Health System, UNC Health Care, Vidant Health, and Mission Health. The partnership comes in response to the state's planned managed care transition, which is open to provider-led entities alongside traditional Medicaid MCOs. Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Bill to Ban Criminal History Check Box & Clarify That Independent Providers of Aide Services or Nursing Services Under the Medicaid Program Are Not State Employees. HB 56 was headed to the Governor to sign December 9, 2015, after agreement by both the House and Senate. While its primary intent is to ban boxes indicating criminal history on state government job applications, codifying an executive order by the Governor earlier this year, it also contains language specifying that an independent provider (definition included in law) is not an employee of the state, or any political subdivision of the state, for any purpose under state law due to being an independent provider or any actions taken to become or remain an independent provider.

According to *Gongwer,* discussion on the bill saw a number of other amendments offered both on the floor and during a Senate State & Local Government Committee on December 9, including efforts to restore collective bargaining rights to independent healthcare providers. One amendment offered would have required Medicaid to implement a survey of independent providers on information such as work hours and travel time in an annual report. Another amendment would have stripped committee added bill language that specifies independent providers are not state employees (see above). Neither amendment passed. Read More

HB 56 can be found here.

Oklahoma

Medicaid Agency Approves 3 Percent Provider Rate Cuts for 2017. On December 11, 2015, *Times Record* reported that a proposal from the Oklahoma Health Care Authority to cut provider rates by 3 percent has been approved by the state Medicaid agency. The state anticipates saving $20 million in fiscal year 2017. Rate reductions go into effect January 1, 2016. Read More

Oregon

HMA Roundup – Nora Leibowitz (Email Nora)

Lori Coyner Named State Medicaid Director. On December 15, 2015, *Statesman Journal* reported that the Oregon Health Authority (OHA) named Lori Coyner as the state's next Medicaid director. Coyner will be the liaison between Oregon and the Centers for Medicare and Medicaid Services, oversee Medicaid policy changes and negotiate with the federal government for Oregon's demonstration waiver that allows the state to implement the Coordinated Care Organizations (CCO) system. Coyner was previously the director of health analytics for OHA. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

December Release of Draft MLTSS Agreement from Department of Human Services. The draft agreement, December release, and a summary document for the upcoming Community HealthChoices (MLTSS program) are now available here. Responses should be sent via email to RA-MLTSS@pa.gov (include "Community HealthChoices" in the subject line). Comments must be received by January 8, 2016.

500,000 Pennsylvanians Enrolled in Medicaid Expansion. Governor Tom Wolf announced that more than half a million Pennsylvanians have enrolled in HealthChoices since Pennsylvania expanded its Medicaid program. Wolf expanded Medicaid eligibility under the federal Affordable Care Act soon after he took office in January and says he hopes the number of enrollments will continue to grow. Pennsylvania's uninsured population dropped from 14 percent in 2013 to 8 percent this year. A press release found at www.healthchoicespa.com provides the following breakdown:

- Pennsylvanians age 21– 30 years old represent 34 percent of the newly eligible. The second largest age group are those age 31 – 40 year, at 24 percent.
- 55 percent are woman and 45 percent are men
- 59 percent are white, 23 percent are African-American, 10 percent are Hispanic and 4 percent are Asian
- Every county has had a resident able to obtain access to health care coverage
- Philadelphia is home to 22 percent of the newly eligible enrollees
- 14 counties have 10,000 or more newly eligible individuals
- Sullivan, Pennsylvania's smallest county, now has 217 newly eligible residents covered under Medicaid. Read More

Utah

Medicaid Director Michael Hales Steps Down. On December 10, 2015, *The Salt Lake Tribune* reported that state Medicaid Director, Michael Hales, is stepping down to join the private sector. Hale's deputy, Nathan Checketts, will become interim director December 31, 2015. In October, House Republicans shot down another proposed Medicaid expansion plan. As a result, the proposed governor's budget unveiled last week did not include any comprehensive plan to grow Medicaid, but did include a $10 million safety measure to assign to low-income Utahns whose incomes are too high to qualify for Medicaid, but too low to obtain federal insurance subsidies. Read More

Wyoming

Department of Health Asks Lawmakers to Reconsider Medicaid Proposal. On December 14, 2015, *Casper Star Tribune* reported that the Wyoming Department of Health Director Tom Forslund is asking lawmakers to reconsider Medicaid expansion. Forslund told the Joint Appropriations Committee that Governor Matt Mead's Medicaid expansion plan would cover rising costs in the Department's budget and extend health coverage to an estimated 20,000 low-

income adults. Additionally, expansion would free up general fund money that the state is already spending on legislatively mandated health programs for residents in need. Some lawmakers remain skeptical of the model. Read More

National

Budget Deal Includes One-Year Suspension of HIF, Other Tax Delays. On December 16, 2015, *The Washington Post* reported that the health insurer fee (HIF) will be suspended in 2017, but not 2016, under the Omnibus Appropriations bill. The medical device tax will be suspended for two years, and "Cadillac Tax" delayed for two years. Read More. On December 14, 2015, *CG Roll Call* reported that a proposed tax policy bill may suspend the health insurance tax for one or two years. The short-term suspension is included in a broader package extending tax policies, along with a two-year suspension of a tax on medical devices and a two-year delay of a "Cadillac" tax on high-cost employer health plans scheduled for 2018. Insurers are strongly pushing for the bill. The aggregate tax for all insurers was $8 billion in 2014 and $11.3 billion in 2015. Insurers also cited a $2.5 billion shortfall in the risk corridor health law program designed to limit insurers' losses.

Hepatitis C Drug Sovaldi Among Costliest for Medicaid in 2014. On December 15, 2015, *NPR* reported that according to newly released data, 33 states spent over $1 billion to treat only 2.4 percent of Medicaid patients infected with Hepatitis C with Gilead Sciences' Sovaldi. New York spent the most on Sovaldi - $360 million to treat about 4,000 of its nearly 60,000 Medicaid recipients who have hepatitis C. Pennsylvania spent $98 million to treat 1,059 Medicaid recipients. Read More

ACA Third Open-Enrollment Season Signs Up 1 Million New Subscribers. On December 9, 2015, *The New York Times* reported that the Affordable Care Act's third open enrollment season signed up one million new customers, according to federal officials. Including those who already have coverage and are renewing or switching plans, a total of 2.8 million people have selected plans in the federal marketplace this period. States with the highest enrollment were Florida (598,279), Texas (317,094), North Carolina (192,760), Georgia (151,600), and Pennsylvania (146,975). Read More

Industry News

BCBS of Illinois and UI Health Form Agreement to Serve Medicaid Members. On December 10, 2015, Blue Cross and Blue Shield of Illinois, a subsidiary of the Health Care Service Corporation, announced an agreement with University of Illinois Hospital & Health Sciences System (UI Health), registered as a Medicaid Accountable Care Entity (ACE), to serve Medicaid members. As of January 1, 2016, UI Health Plus's 40,000 Medicaid members will become Blue Cross Community members. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 5, 2016	Nebraska	Proposals Due	239,000
January 7, 2016	Indiana	Technical Proposals Due	900,000
January, 2016	Pennsylvania MLTSS/Duals	RFP Released	450,000
February 5, 2016	Nebraska	Letter of Intent to Contract	239,000
March 15, 2016	Nebraska	Contract Awards	239,000
TBD (60 Days After RFP)	Pennsylvania MLTSS/Duals	Proposals Due	450,000
March, 2016	Oklahoma ABD	DRAFT RFP Released	177,000
TBD Winter/Spring 2016	Virginia MLTSS	RFP Released	130,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
May 11, 2016	Indiana	Cost Proposals Due	900,000
June, 2016	Indiana	Contract Awards	900,000
June, 2016	Oklahoma ABD	RFP Released	177,000
July, 2016	Georgia	Implementation	1,300,000
August, 2016	Oklahoma ABD	Proposals Due	177,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Nebraska	Implementation	239,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
March 1, 2017	Virginia MLTSS	Implementation	130,000
TBD 2017	Oklahoma ABD	Implementation	177,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	450,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	450,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	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)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care (*exiting demo*); Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	30,000	X	5/12/2014	9/1/2014	7/30/2015	12/1/2015	2/1/2016	Neighborhood INTEGRITY
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	4/1/2016	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***12***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

Dual Eligible Financial Alignment Demonstration Enrollment Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active demonstration enrollment.

State	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
California	122,520	122,798	122,846	120,452	117,449	117,307	117,179	116,538
Illinois	58,338	55,672	52,763	52,170	50,631	49,586	48,779	53,136
Massachusetts	17,621	17,637	17,705	17,671	17,518	17,179	12,657	12,366
Michigan		9,216	14,867	28,171	35,102	42,728	37,072	36,335
New York	6,660	7,215	5,031	7,122	9,062	8,028	9,942	8,005
Ohio	63,625	63,446	62,958	61,871	62,418	59,697	61,428	61,333
South Carolina	1,398	1,366	1,317	1,388	1,380	1,530	1,355	1,359
Texas	15,335	27,589	37,805	44,931	56,423	45,949	56,737	52,232
Virginia	27,349	30,877	29,970	29,507	29,200	29,176	27,138	28,644
Total Duals Demo Enrollment	**312,846**	**335,816**	**345,262**	**363,283**	**379,183**	**371,180**	**372,287**	**369,948**

HMA NEWS

New this week on the HMA Information Services website:

- **MLRs** Average 85.7% at 199 Medicaid MCOs, 9 Months 2015 Data
- Medicaid Managed Care **Value-Based Purchasing** Requirements by State, Dec-15 Data
- Public documents such as the **Colorado** Accountable Care Collaborative 2015 Annual Report and the **Massachusetts** 2015 Health Care System Annual Performance Report
- Plus upcoming webinars on *"Transgender Transitioning: Implications of New Health Insurance Coverage Guidelines"* and *"Making Healthcare Data Actionable: Solutions for Converting Data into Information for More Effective Reporting, Decision Making and Strategic Planning"*

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Webinar Replays Available:

- ***"Transforming Care: From Volume to Value"***
- ***"Provider Network Adequacy Monitoring: Findings and Recommendations from the 2015 Robert Wood Johnson Foundation-Funded Survey of States and Health Plans"***
- ***"Care Management Essentials: Practical Approaches to Implementing a Successful Care Management Program"***

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 Atlanta, Georgia; Austin, Texas; Boston, Massachusetts; Chicago, Illinois; Columbus, Ohio; Denver, Colorado; Harrisburg, Pennsylvania; Indianapolis, Indiana; Lansing, Michigan; New York, New York; Olympia and Seattle, Washington; Portland, Oregon; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC.

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