HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

May 18, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

HMA WEBINAR REPLAY: PREPARING YOUR ORGANIZATION FOR THE NEW MEDICAID MANAGED CARE REGULATIONS

This week, we present our first ever *Digital In Focus* section, providing key highlights from and a replay of this week's HMA Webinar, *"Preparing Your Organization for the New Medicaid Managed Care Regulations: Impact Analysis and Implementation Tool."* After months of comment, discussion and revision, the Centers for Medicare & Medicaid Services (CMS) has released the final version of its new Medicaid managed care regulations, and now it's up to health plans, states and providers to comply. What's required is not just an understanding of what's in the final rule, but how it impacts your organization, specifically the procedures, processes, staffing, technology, and operational changes required to implement the regulations.

During a May 17, 2016, webinar, HMA's Kathleen Nolan and Debby McNamara provided a framework for assessing the final rule, analyzing organizational needs, and implementing the operational and functional changes needed. The webinar provides an overview of the final rule and outlines the HMA Impact Analysis and Implementation Tool, a rigorous process for identifying opportunities and challenges posed to managed care organizations (MCOs).

Key Highlights and Takeaways

The webinar provides an overview of the regulations from the perspective of MCOs, addressing areas of major change, standardization and state flexibility, and implementation issues.

Broad Implications for Health Plans

- More standardized approaches across and within states, particularly in financial management
- Specific policy standards and requirements related to managed long-term services and supports (MLTSS)
- Substantial new reporting and oversight requirements
- Some areas of considerable state flexibility, particularly in delivery system reform
- Quality strategy still to be developed

This regulation will require adaptations in practice, policy, technology and coordination from plans, states and providers. In some states, the current approach may be relatively close to the requirements, but changes will still be needed. In others, they may be unlikely to achieve the end point envisioned without intermediate steps. Plans will need to be part of the discussion in both environments.

Overview of HMA Developed Tool

A team of HMA colleagues with managed care expertise reviewed the existing, proposed and final regulations. Drawing on their backgrounds in managed care, reviewers identified how changes would impact managed care plans. The rationale in the regulation's preamble provided insight into CMS' intent for the changes. The analysis focused on both major policy changes and those changes that didn't make headlines but have significant impact on the plans.

Divided into sections that correspond with the subparts of the regulation, the tool's format serves as a project plan. Part analysis and part action steps, the tool moves through the regulation in chronological order and includes:

- Summary of Requirements
- Potential Impact on Organization
- Follow Up Required
- Functional/Operation Areas

For more information about how your organization can access and use HMA's Impact Analysis and Implementation Tool, please contact Kathleen Nolan (KNolan@healthmanagement.com) or Debby McNamara (DMcNamara@healthmanagent.com).

Link to HMA Webinar Replay

https://vimeo.com/167126494

HMA Medicaid Roundup

Arizona

HMA Roundup – Jeff Smith (Email Jeff)

Governor Ducey Signs Two Bills to Combat Opioid Addiction. Arizona Governor Doug Ducey has signed two bills to help prevent and treat opioid addiction in the state. SB1283 addresses "doctor shopping" by requiring physicians to update the state's Controlled Substance Prescription Monitoring Program (CSPMP) database prior to prescribing controlled substances. The second bill, HB2355, allows pharmacists to dispense Naloxone without a prescription to individuals at risk of an opioid overdose. Read More

Governor Ducey Passes Bill to Attract Doctors to State. *The Arizona Republic* reported on May 11, 2016, that Governor Doug Ducey signed a bill permitting Arizona to participate in a medical-licensing compact that allows doctors to become licensed in multiple states. The bill is an effort to attract more doctors by decreasing licensing time. Read More

California

California Tax on Managed Care Organizations Approved by CMS. On May 17, 2016, the California Department of Health Care Services received CMS' approval of its new managed care organization (MCO) tax under provisions of a waiver. Other states have been closely following the California proposal. California is one of several states that has relied on MCO taxes as a major source of revenue for its Medicaid program. In 2005, the Deficit Reduction Act eliminated the ability of states to use any tax that only applied to Medicaid MCOs as a source of Medicaid matching funds. California was one of several states that subsequently extended an existing tax to Medicaid MCO services. In July 2014, CMS wrote to all state Medicaid directors that these strategies were not acceptable under federal statutes and regulations because Medicaid MCOs were treated differently than other MCOs. States were given until the end of their next regular legislative session to remediate. For California the deadline was June 30, 2016. California proposed a new MCO tax that applies to all MCOs in the state, but is not a uniform tax. The tax is based on the number of members each plan has. The tax rate varies with the number of cumulative member months a plan has during each state fiscal year and is higher for Medi-Cal members than for commercial members. Federal law allows the U.S. Secretary of Health and Human Services to waive the uniformity requirements if the net impact of the tax is generally redistributive. Based on required statistical tests, the California waiver request was approved.

All Low-Income Children Regardless of Immigration Status Now Eligible for Medi-Cal Coverage. *The Ventura County Star* reported on May 15, 2016, that California's Health 4 All Kids law went into effect May 16, 2016, making all low-income children, regardless of legal documentation status, eligible for Medi-Cal coverage. At least 170,000 children are expected to qualify for the new program, according to one estimate. Rene Mollow, deputy director of health care benefits and eligibility for the Department of Health Care Services, expects the program to cost about $177.7 million annually, with about 80% coming from the state. Currently, the law qualifies children without legal documentation for emergency care only. Under Health 4 All Kids, these children will also receive preventative care, which proponents of the program argue can ultimately save taxpayers money. Read More

Connecticut

Budget Proposal Fails to Restore Medicaid Radiology Cuts. *The Hartford Courant* reported on May 11, 2016, that a proposed Connecticut state budget fails to restore $7 million in Medicaid radiology funding cuts implemented last fiscal year. The bill is scheduled for a state Senate vote on May 12. Several legislative caucuses fought to restore the funding, which supports mammograms and other imaging services for poor and minority women. Radiologists receive $20 for analyzing a screening mammogram and $25 for a diagnostic mammogram for high-risk patients under Medicaid, far less than what private insurers pay, the article said. Read More

Illinois

HMA Roundup – Andrew Fairgrieve (Email Andrew)

Lawmakers Approve $700 Million for Human Services Programs Amid Budget Standoff. *The Chicago Daily Herald/AP* reported on May 12, 2016, that Illinois legislators approved $700 million in funding for human services programs, a short-term fix as the state's budget standoff continues. The funding is 46 percent of what human services programs expected to receive if the budget was passed last July. The money will go to homelessness prevention, rental assistance, addiction treatment, and veterans' rehabilitation, among other services. Governor Bruce Rauner had hoped to pass a full budget by the end of the month. A bipartisan group of lawmakers is working on a budget proposal that reportedly includes an income tax hike and $2.4 billion in cuts, including $400 million in Medicaid cuts. Read More

Kansas

Medicaid Agency to Hold Public Meetings on KanCare Contract Renewals. *The Wichita Eagle* reported on May 12, 2016, that Kansas will host a series of meetings across the state to discuss renewing contracts for KanCare, the state's Medicaid managed care program that began in 2013. During the meetings, the state will discuss expected changes to the program and gather public feedback. Centene's Sunflower State Health Plan, UnitedHealthcare, and Anthem's Amerigroup are currently under contract to serve the KanCare program statewide. Read More

State May Cut Medicaid MCO PMPMs, Provider Fees to Balance Budget. *The Wichita Eagle* reported on May 17, 2016, that Kansas is eyeing potential cuts to Medicaid provider fee schedules and to Medicaid managed care per member per month rates to close a budget gap, according to state Senator Jim Denning (R-Overland Park), who is vice chair of the Senate budget committee. Along with reduced reimbursements to providers, health plans are likely to take "a little bit of the pain as well," Dunning said. Governor Sam Brownback's Administration needs to find $40 million to $50 million in cuts to balance the state budget bill before signing or vetoing the bill. A provision in bill does not allow for funding cuts to K-12 education, leading lawmakers to believe that the additional cuts will have to come from KanCare. The Governor's office declined to comment until final decisions are made. Read More

Louisiana

Budget Proposal Could Mean Medicaid Cuts. *The Baltimore Sun/AP* reported on May 16, 2016, that a budget proposal passed by the Louisiana House would result in cuts to certain Medicaid services – part of the state's efforts to deal with a potential $600 million budget shortfall next fiscal year. The state Senate Finance Committee is now reviewing the budget proposal. Louisiana Department of Health and Hospitals Secretary Rebekah Gee has voiced concern that the current budget proposal includes the elimination of several programs for individuals who are elderly or have disabilities, while hospital representatives are concerned about losing $150 million in funding. Hospitals argue that the savings estimates from the state's Medicaid expansion are too high, and that they need more than the $1.1 billion in proposed funding to provide care. Governor John Bel Edwards wants to hold a special legislative session in June to discuss ways to address the shortfall, including taxes; however, the legislature needs to pass a budget proposal before a special session can begin. Read More

Lawmakers Approve Bill to Delay New Pediatric Day Health Care Centers. *The Washington Times* reported on May 12, 2016, that Louisiana lawmakers approved a bill to suspend for one year, effective July 1, the creation of new Medicaid-financed, pediatric day health care centers serving children deemed "medically fragile." Proponents argue that the temporary suspension would allow the state to improve oversight of the program, which is expected to cost about $30 million this year. Opponents fear children with disabilities will be denied necessary specialized services. Read More

Michigan

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

MDHHS Begins Special Medicaid Expansion for Pregnant Women, Children in Flint. *MLive* reported on May 12, 2016, that the Michigan Department of Health and Human Services (MDHHS) announced that pregnant women and individuals under 21 who have been exposed to contaminated Flint water are eligible for a special Medicaid expansion program. CMS approved the state's request to extend Medicaid to approximately 15,000 women and children up to 400 percent of the federal poverty level. Those who do not live in Flint, but have been exposed to Flint water, may also be eligible. Open enrollment began May 9, and the program is free to individuals. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Thirty New Jersey Hospitals Filed Tax Appeals after Morristown Property Tax Ruling. On May 13, 2016, *NJBiz* reported that 30 municipalities filed tax appeals against not-for-profit hospitals in New Jersey. This occurred after a tax court decision ruling in favor of Morristown over a property tax dispute with Atlantic Health. Governor Chris Christie recently pocket-vetoed S3299, which would have required hospitals to pay the municipality $2.50 per day for each hospital bed and pay $250 per day for each satellite emergency care facility, and would have initiated a two-year moratorium on property taxes for not-for-profit hospitals that were previously exempted, while a committee studies the issue further. Read more

New Jersey Consumers Paying Less in 2016 on the Health Care Exchange. *NJBiz* reported on May 11, 2016, that New Jersey health insurance premiums have decreased from last year. While many health insurers across the country are considering increases in their premiums of 8 percent to 10 percent, the U.S. Department of Health and Human Services reported that premiums have decreased by two percent in New Jersey. A total of 288,573 individuals signed up for a New Jersey Marketplace plan in 2016. Highlights from the report also noted:

- Sixty-six percent of New Jersey Marketplace consumers selected new Health Care Exchange plans for 2016 of which 42 percent were returning consumers.
- Fifty percent of New Jersey Marketplace consumers could choose a plan with a $75 or lower monthly premium after tax credits.
- New Jersey residents had, on average, 54 marketplace plans per county from which to choose.

Read more

New Mexico

Home Health Visits May Be Eligible for Federal Medicaid Match. *The Charlotte Observer/AP* reported on May 11, 2016, that home health visits from nurses and counselors in New Mexico could be eligible for federal Medicaid matching funds, according to a policy analyst hired by the state to review funding sources for the home visit program. Kay Johnson told legislators the state could receive up to 70 cents in federal Medicaid matching funds for every dollar spent on the program. The state has allocated $7.7 million from its general fund for home visits in the next fiscal year. Johnson noted that at least 15 other states currently receive matching for home visits. The program has grown rapidly in New Mexico, with state contractors logging 33,000 home visits last year. Home visits can improve early childhood health and development, and even prevent child abuse or emotional trauma. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

DSRIP Spending Slow to Begin. A recent report in *Politico NY* finds that the Delivery System Reform Incentive Payment program (DSRIP) is behind schedule in spending the money that has been allocated for the program. Through the first nine months, only one Performing Provider System (PPS) spent more than half of the funds allotted, while 6 of the 25 PPSs spent less than 10 percent. Three reasons were posited for the slow rate of spending: new money for capital projects was awarded later than expected, contracting with managed care companies took longer than anticipated, and claims data from the state has not been robust. While the first two issues seem to be one-time start-up issues, the data issues appear to be more troubling. Timely data is essential to PPSs being able to identify high-cost members and the providers treating them, so interventions can be targeted. But the individual provider attribution list, which links each patient to a primary care doctor, arrived in April, more than a year after the DSRIP program launched. Downstream providers within the PPSs, including community-based organizations considered essential to successful implementation of DSRIP projects, have complained about the slow pace of project implementation and flow of funds. Read More

Funding Opportunity for Community-Based Organizations Participating in DSRIP. The Department of Health has released a Request for Applications (RFA) announcing the availability of funds to support strategic planning activities for community-based organizations (CBOs) to facilitate their engagement in DSRIP activities. CBOs are seen as essential for PPSs to be able to impact the social determinants of health. The state is concerned that smaller CBOs can be challenged in their ability to engage and contract with the lead organizations running the PPSs in DSRIP. These organizations tend to be administratively lean, have fewer resources and also compete with other CBOs for similar funding grants. The RFA is intended to solicit applications for grants to assist CBO consortiums in planning activities to identify business requirements and formulate strategies for short-term needs as well as longer-term plans that the CBO consortium may envision for sustainability in system transformation. Overall, this will allow CBOs to better position themselves for continuing engagement with PPSs in DSRIP projects, and consequently, value-based payment and contracting. The state intends to make one award for each of the three regions: New York City, Long Island and Mid-Hudson, and Rest of State. A maximum funding amount for each region is $2.5 million. The contract term is December 2016 – November 2017; applications are due on August 16. To learn more about this opportunity, go to the NYS Grants Gateway and search by the opportunity name "Community Based Organization (CBO) Planning Grant." Read More

Managed Long-Term Care Technology Demonstration. The Department of Health (DoH) has issued a Request for Applications (RFA) for a Managed Long Term Care (MLTC) Technology Demonstration. The goal of the initiative is to examine whether the availability of technology in a home and community-based setting can play a role in keeping individuals in their desired setting. Specifically, DoH is looking at whether increased use of technology will help decrease unnecessary institutionalization. The RFA specifies the following four technology categories that plans may select for the demonstration: in-home monitoring, communication (between the enrolled individual and their

family/community supports), telemedicine, and pill dispensing and reminding. The demonstration is limited to not-for-profit MLTC plans, for example, Partially Capitated, Medicaid Advantage Plus (MAP), and Program for All-Inclusive Care for the Elderly (PACE), approved to serve at least one rural county. DoH will make $1 million available to fund at least two projects in upstate and rural counties, and anticipates selecting two MLTC plans to participate in the demonstration. The funding contract period is expected to last for two years, starting December 1, 2016. Read More

Health Workforce Retraining Program/Initiative. The Department of Health, in consultation with the New York State Department of Labor, is soliciting applications from organizations proposing to train or retrain health industry workers, or individuals laid off from health industry jobs, to obtain new positions, meet the new job requirements of existing positions, or otherwise meet the requirements for serving more diverse populations in the changing public health and health care markets. In addition, organizations may submit applications for the expansion of educational capacity in shortage occupations. Organizations eligible to apply include: health worker unions, general hospitals, long term care facilities, other health care facilities/agencies, health care facilities trade associations, labor-management committees, joint labor-management training funds established pursuant to the provisions of the Federal Taft-Hartley Act, and educational institutions. Up to $24.2 million is available to support this Request for Applications for a two- year period. Applications are due June 27, 2016. Read More

Regional Planning for Behavioral Health Transition. The Conference of Local Mental Hygiene Directors (CLMHD), in concert with New York State, has developed a plan to address and monitor the behavioral health transition through Regional Planning Consortiums (RPCs). CLMHD envisions the RPCs as a place where collaboration, problem solving and system improvements for the integration of mental health, addiction treatment services and physical health care can occur in a way that is data-informed, person- and family-centered, cost-efficient and results in improved overall health for adults and children in their communities. New York is preparing to expand the carve-in of behavioral health services in counties outside of New York City, and Health and Recovery Plans (HARPs) will begin enrollment of eligible recipients with Serious Mental Illness (SMI) and Substance Use Disorders (SUD), effective July 1, 2016. Beginning October 1, 2016, HARPs located outside New York City will offer members access to enhanced behavioral health home and community-based services. CLMHD is partnering with the New York State Department of Health, Office of Mental Health, and Office of Alcoholism and Substance Abuse Services to hold a series of kick-off events to begin RPCs across the state. They hope to bring together key stakeholders, including consumers, families, providers, local governments, and managed care organizations. Read More

Oscar Health Plan Seeks Rate Increase. *POLITICO New York Health Care* reports that Oscar, the three-year-old health insurance start-up, is asking the state to allow up to a 30 percent rate increase for plans the company sells on the health insurance Exchange. Oscar reported losses of $105.2 million in 2015 for plans it operated through Exchanges in New York and New Jersey. Oscar is proposing to increase rates between 8 percent and 30 percent on individual plans, citing rising medical costs. Oscar also notes that its members needed more care than expected, furthering the need for a price correction. As part of New York's prior approval law, any increase in rates must be approved by the Department of

Financial Services, which has often reduced requested rate increases for some insurers. Last year, Oscar asked for and received a 4.54 percent average increase. *POLITICO* also noted that Oscar continued to lose money in both its New York and New Jersey operations in the first three months of 2016, with a combined net underwriting loss of $42.3 million. Read More

Oklahoma

Medicaid Expansion Proposal Gains Momentum. *The New York Times/ AP* reported on May 16, 2016, that support is growing in Oklahoma's overwhelmingly Republican legislature for a proposed plan to implement an alternative Medicaid expansion in the state. Oklahoma faces a $1.3 billion budget hole, and the state's Medicaid agency is warning of potential provider reimbursement cuts of up to 25%. State hospital representatives say additional cuts would mean closures and reduced access to care for Medicaid recipients. The article quotes Republican state Rep. Doug Cox stating, "We're to the point where the provider rates are going to be cut so much that providers won't be able to survive, particularly the nursing homes." The plan would offer premium assistance to 175,000 uninsured adults, while moving another 175,000 off of Medicaid and into the exchange. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Hospital Merger Fight Continues. Last Monday, U.S. District Court Judge John Jones III denied the Federal Trade Commission's request for a preliminary injunction to temporarily stop the merger of Penn State Milton S. Hershey Medical Center and PinnacleHealth System. In an atypical move, the FTC is appealing the federal court ruling. Jeff Miles, an antitrust expert at law firm Ober Kaler, posits that the FTC likely has serious concerns with the methodology Judge Jones used to define the geographic market in the case. The court rejected the FTC's geographic market definition, citing large numbers of patients who travel into the defined market. However, the FTC has successfully argued in the past that there is evidence hospitals are able to raise prices even in these situations. By appealing this case, the FTC is hoping to effectively reset the decade-old legal precedent. Read More

Advisory Committee Recommends Medicaid Cover Hepatitis C Drugs for All Patients. *Philly.com* reported on May 18, 2016, that a state advisory committee has recommended that Medicaid cover treatment for all fee-for-service patients with Hepatitis C. Medicaid managed care plans in the state would need to offer substantially similar coverage under the recommendation. The recommendations now go to the Secretary of the Department of Human Services, Ted Dallas, for review. Many states have imposed strict guidelines on who can receive treatment, which costs up to $80,000 for a full drug regimen. Read More

Virginia

DMAS Holds Mandatory Pre-Proposal Conference for MLTSS RFP. Virginia held a mandatory Managed Long-Term Services and Supports RFP pre-proposal conference on May 16, 2016. Representatives from the following companies were in attendance:

- Aetna
- AmeriHealth Caritas
- Anthem
- Arlington Health Group
- CareFirst
- CareSource
- Edwards Performance Solutions
- Gateway Health Plan
- Humana
- INTotalHealth
- Kiaser Permanente
- LifeWorks Advantage
- Magellan Complete Care
- Millennium Home Healthcare
- Molina
- Optima Health
- Optum
- Piedmont Community Health Plan
- Shared Health
- Trusted Health Plans
- UnitedHealthcare
- Virginia Premier Health Plan
- WellCare

Wisconsin

Wisconsin Ranks Last in Medicaid Reimbursement Rates for Nursing Homes, AHCA Study Finds. *WKWOW* reported on May 17, 2016, that according to a study by the American Health Care Association (AHCA), Wisconsin had the lowest Medicaid reimbursement rates for nursing homes in the country. It costs a nursing home in Wisconsin about $221 per day to serve a Medicaid recipient, the study said; however, the state pays just $168, representing a $53 shortfall. Medicaid beneficiaries make up 65 percent of nursing home residents in the state. Among other states, North Dakota and Virginia had the highest reimbursement rates. Read More

National

CDC Study Finds Uninsured Rate Falls Below 10 Percent in 2015. *CQ Roll Call* reported on May 16, 2016, that a new Centers for Disease Control and Prevention study shows that the nation's uninsured rate fell to 9.1 percent in 2015. It is the first time that the uninsured rate dipped below 10 percent since the CDC began consistently tracking the number more than three decades ago. Before the Affordable Care Act took effect, approximately 14.4 percent of Americans were uninsured. The study says 28.6 million were still uninsured in 2015. However, 16.2 million gained coverage since the ACA took effect, including about 9.1 million through the Exchanges. Through February 2016, the numbers may even be higher, with the Obama Administration reporting 20 million have gained coverage since the law was enacted.

Federal Judge Rules Against ACA Out-of-Pocket Subsidies. *The New York Times* reported on May 12, 2016, that a Federal District Court Judge in Washington ruled that the U.S. Department of Health & Human Services (HHS) does not have the authority to subsidize deductibles, co-payments, and other out-of-pocket insurance expenses under the Affordable Care Act. The ruling in House v. Burwell found that funding for the subsidies wasn't explicitly

provided for by Congress and that an appropriation can't be inferred by the Obama Administration without violating the Appropriations Clause. The judge blocked further spending on the program; however, the order is being suspended pending the outcome of an appeal filed by the Obama Administration. The ruling impacts subsidies that go to insurance companies to help keep premium rates down. An earlier ruling in King v. Burwell affirmed the outlay of premium tax credits to people purchasing coverage in state or federal exchanges. Read More

Urban Institute: Health Coverage for Medicaid/CHIP Eligible Children Continues to Improve. *Kaiser Health News* reported on May 13, 2016, that according to a study by the Urban Institute with the support of the Robert Wood Johnson Foundation, health coverage for low income children is improving. In 2014, over 90 percent of children eligible for Medicaid/CHIP were enrolled. In the first year of the Affordable Cart Act's full implementation, the number of uninsured children dropped from 5.4 million to 4.5 million. Of the 4.5 million, nearly two-thirds were eligible for Medicaid or CHIP. In 2013, 88.7 percent of eligible children were enrolled, compared to 81.7 percent in 2008. In 2014, the largest coverage gains occurred in states that expanded Medicaid. However, progress has been slower for some groups, including adolescents between age 13 and 18 and Hispanic children in families without a parent who speaks English. Read More

Industry News

Care Finders Total Care Expands NJ Home Care Services with Two New Acquisitions. *NJ Biz* reported on May 16, 2016, that Care Finders Total Care is acquiring two New Jersey home care providers, Emerald Health Care Services and Family First Health Care, giving the company nine New Jersey locations. Care Finders has now completed 10 acquisitions in the past two years in an effort to grow their private duty home care services. Financial terms of the deals were not disclosed. Read More

Welsh, Carson, Anderson & Stowe Completes Investment in InnovAge. InnovAge, a provider of senior care programs and services, announced on May 16, 2016, that it finalized an investment agreement with private equity firm Welsh, Carson, Anderson & Stowe. The agreement converts InnovAge to a for-profit entity from a not-for-profit. The company and its management team will continue to lead strategic direction and day-to-day operations. Net proceed from the sale, totaling about $196 million, will be used to create an independent, Colorado-based not-for-profit to fund community-oriented senior care-related initiatives. Read More

Blue Wolf Capital Acquires National Home Health Care Corporation for $65 Million. *Home Health Care News* reported on May 17, 2016, that New York-based private equity firm Blue Wolf Capital is buying the National Home Health Care Corporation (NHHC) for $65 million. NHHC is based in Scarsdale, NY, and offers personal care and home health care services in New York, Connecticut, and New Jersey, as well as behavioral health, pediatric skilled nursing, social work, rehabilitative therapy, and paraprofessional and staffing services in Massachusetts and Connecticut. The article notes that this is one of the largest home health transactions in recent months, eclipsing Amedisys Inc.'s $63 million acquisition of Infinity HomeCare in November 2015. Read More

LLR Partners Acquires Learn It Systems Behavioral Health Company. *PE Hub* reported on May 17, 2016, that LLR Partners has acquired Learn It Systems, a national behavioral health services company serving children with autism and special needs, from Milestone Partners. The company is headquartered in Baltimore, MD. Financial terms of the deal were not disclosed. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
May, 2016	Minnesota SNBC	Contract Awards	45,600
May, 2016	Massachusetts MassHealth ACO - Pilot	Applications Open	TBD
May, 2016	Oklahoma ABD	DRAFT RFP Release	177,000
June, 2016	Indiana	Contract Awards	900,000
June 30, 2016	Virginia MLTSS	Proposals Due	212,000
July 1, 2016	Missouri (Statewide)	Proposals Due	700,000
July 1, 2016	West Virginia	Implementation	450,000
July 1, 2016	Minnesota SNBC	Impementation (Northern Counties)	45,600
August, 2016	Oklahoma ABD	RFP Release	177,000
July-August, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
September 1, 2016	Texas STAR Kids	Implementation	200,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Oklahoma ABD	Proposals Due	177,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December, 2016	Massachusetts MassHealth ACO - Full	Selection	TBD
January 1, 2017	Georgia	Implementation	1,300,000
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)	100,000
January 1, 2017	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
TBD 2017/2018	Oklahoma ABD	Implementation	177,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000

Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (April 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	431,000	123,981	28.8%	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	148,000	48,272	32.6%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	94,000	12,307	13.1%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	105,000	31,766	30.3%	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	5,617	4.5%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
Ohio	Capitated	5/1/2014	1/1/2015	95,000	61,535	64.8%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	5/1/2016	7/1/2016	30,000			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,954	11.1%	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	45,219	26.9%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	70,500	27,116	38.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,319,100**	**361,767**	**27.4%**	

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

HMA NEWS

HMA Information Services Launches Daily Roundup

HMA Information Services is pleased to announce the launch of the *Daily Roundup*, which includes breaking industry news and state-by-state updates from HMA consultants in the field. The *Daily Roundup* will be available only to HMAIS subscribers and will include advance content from *the HMA Weekly Roundup*, which will otherwise remain unchanged and continue to be distributed to readers every Wednesday evening. For more information about the Daily Roundup please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA Upcoming Webinars

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May 24, 2016

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