

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... June 15, 2016



THIS WEEK

- IN FOCUS: HMA INTEGRATED DELIVERY SYSTEMS CONFERENCE
- INDIANA MEDICAID MCO AWARD RECOMMENDATIONS ANNOUNCED
- FLORIDA MEDICAID MCOs OWED \$433 MILLION IN UNDERPAYMENTS
- NEW YORK DOH RELEASES TRANSITION PLAN FOR WAIVER PROGRAMS
- PENNSYLVANIA DELAYS MLTSS IMPLEMENTATION
- WISCONSIN WITHDRAWS PLAN FOR MLTSS REFORMS
- MEDDATA TO ACQUIRE CARDON OUTREACH FOR \$400 MILLION

IN FOCUS

HMA ANNOUNCES AGENDA, 30-PLUS SPEAKERS FOR CONFERENCE ON INTEGRATED CARE DELIVERY

This week, our *In Focus* section highlights the agenda for HMA's inaugural conference on *The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*, October 10-12, 2016, in Chicago. This premier three-day event, which is produced by HMA and HMA's Accountable Care Institute, will address key issues facing health systems, hospitals, clinics and provider practices seeking to integrate care in an environment of rising quality and cost expectations. Thirty speakers have been confirmed to date. **Early Bird registration is now open.** Visit the conference website for complete details: <https://fpsh.healthmanagement.com/>

The Future of Care Delivery

Healthcare providers are being inundated with new quality and cost requirements along with rising expectations about what it means to care for patients effectively.

[RFP CALENDAR](#)

[DUAL ELIGIBLES CALENDAR](#)

[HMA NEWS](#)

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What began as a conceptual framework established by the Affordable Care Act has now evolved into a very specific set of directives and expectations aimed at transforming the nation's healthcare delivery system.

This new framework is rooted in the understanding that a patient's health and wellness needs are best served when care is integrated across the spectrum of services and that linkages are needed among medical providers and other programs when addressing care for medically and socially vulnerable patients, populations and communities.

HMA's inaugural conference, *The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*, will identify best practices, resources, tools and approaches to help providers deliver integrated care effectively within single systems and through collaboration among multiple providers and community-based services.

Unparalleled Lineup of 30-plus Industry Speakers

Keynote speakers and panelists from provider organizations, health plans, and government will identify proven strategies for implementing accountable care models, developing population health management infrastructures, and reengineering operational capabilities around care integration.

Breakout sessions and workshops will focus on the nuts and bolts of building integrated delivery systems, including important insights into care management, social determinants of health, behavioral health integration, leadership training, operational priorities, and information technology needs.

The list of industry leaders confirmed as speakers for this event is unparalleled.

Confirmed Keynote Speakers

- *Frederick Cerise, MD, President and CEO, Parkland Health & Hospital System*
- *Barbara Garcia, Director of Health, San Francisco Department of Public Health*
- *Andrea Gelzer, MD, SVP, Corporate Chief Medical Officer, AmeriHealth Caritas*
- *Arthur Gianelli, President of Mount Sinai St. Luke's and Mount Sinai PPS, LLC*
- *Bruce Goldberg, MD, former Director, Oregon Health Authority*
- *Larry Goodman, MD, CEO, Rush University Medical Center*
- *Cindy Mann, Partner, Manatt Health*
- *Ramanathan (Ram) Raju, MD, President and CEO, NYC Health + Hospitals*
- *John Jay Shannon, MD, CEO, Cook County Health & Hospitals System*
- *Francisco (Paco) Trilla, MD, Chief Medical Officer, Neighborhood Health Plan of Rhode Island*

Confirmed Breakout Session Speakers to Date

- *Wendy Burkholder, Chief Clinical Operating Officer, District Medical Group, Provider to Maricopa Health System*
- *Dan Castillo, CEO, LAC + USC Medical Center*
- *Pat Curran, Former CEO, CareOregon*
- *Karen Duncan, MD, Principal, HMA (Atlanta)*
- *Doug Etkell, Deputy CEO, Finance and Strategy, Cook County Health and Hospitals System*
- *Lee Francis, MD, President and CEO, Erie Family Health Center*

- Hope Glassberg, VP, Strategic Initiatives & Policy, Hudson River HealthCare
- Deborah Gracey, Principal, HMA (Chicago)
- Clemens Hong, MD, Medical Director, Community Health Improvement, LA County Department of Health Services
- David Horrocks, President, Chesapeake Regional Information System for Our Patients (CRISP)
- Frances Isbell, CEO, Healthcare for the Homeless – Houston
- Art Jones, MD., Principal, HMA (Chicago)
- Cheryl Lulias, Executive Director, Medical Home Network (Chicago)
- Dennis Mauer, Community Mental Health Director, Community University Health Care Center
- Ross Owen, Director, Hennepin Health
- Anthony Perry, MD, VP, Population Health and Ambulatory Services, Rush University Medical Center
- Bonnie Pilon, Alexander Heard Distinguished Service Professor, Vanderbilt School of Nursing
- Jim Sinkoff, EVP, CFO, Hudson River HealthCare
- Rachel Solotaroff, MD, Chief Medical Director, Central City Concern (Portland)
- Pat Terrell, Vice President, HMA; Executive Director, Accountable Care Institute
- Sharon Youmans, Professor, Vice Dean, UCSF School of Pharmacy

Speakers will discuss their specific care integration initiatives. HMA has designed panels and breakout sessions to inspire discussion about real-world approaches to meeting new requirements and positively impacting the health of patients and populations.

The goals of these sessions are to help provider organizations improve the health status of entire patient populations, lower costs, and ensure a more satisfactory patient experience.

The complete agenda for this landmark event appears below. For additional information about the conference, visit our website at <https://fpsh.healthmanagement.com/> or contact Carl Mercurio at 212-575-5929 or cmercurio@healthmanagement.com. Early Bird registration is now open. Group rates are available.

The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations

Oct. 10-12, 2016, The Palmer House, Chicago, IL

AGENDA

Day One: October 10, 2016

7:00 - 8:00 am	Registration and Breakfast
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8:00 - 8:15 am	<p>Introduction and Welcome</p> <p><u>Speaker</u> <i>Pat Terrell, Vice President, HMA; Executive Director, HMA Accountable Care Institute</i></p>
8:15 - 9:00 am	<p><u>Keynote Address</u></p> <p>The Changing Role of Academic Medical Centers in Delivering Integrated Care to Vulnerable Populations</p> <p>Academic medical centers have historically been somewhat isolated from the communities around them. Care for patients, while technically excellent, has often been provided apart from community-based services and other resources essential to ensuring a patient’s overall health maintenance and improvement. Moreover, medical training and research have not traditionally focused on areas such as team-based care, population health and other issues central to the paradigm of patient-centered care. In this keynote address, Larry Goodman, MD, will discuss how Rush University Medical Center is moving toward a new model centered on provider collaboration and the incorporation of local services and activities that help build communities and provide integrated care to vulnerable populations. Goodman will focus on Rush’s successes and challenges in making this shift, including a frank discussion of how these new initiatives impact care delivery and the training of healthcare professionals within an academic medical center setting.</p> <p><u>Speaker</u> <i>Larry Goodman, MD, CEO, Rush University Medical Center</i></p> <p><u>Moderator</u> <i>Art Jones, MD, Principal, HMA (Chicago)</i></p>
9:00 - 10:30 am	<p><u>Keynote Q&A Session</u></p> <p>Breaking Down Barriers: How Traditional Safety Net Hospitals Are Integrating Care to Serve the Needs of Vulnerable Populations</p> <p>Safety net hospitals are being forced to change. Driven by the demands of new quality and cost targets imposed by federal and state regulators, public systems are integrating care to ensure access to an array of services and to sustain their vital role as the backbone of care delivery for vulnerable populations. During this keynote Q&A session, leaders from top public systems in Chicago, Dallas, New York and San Francisco will engage in a frank and high-level assessment of their ongoing efforts to reevaluate every aspect of how they coordinate, integrate and deliver care within their own systems and through expanded partnerships with local community-based organizations. The discussion will outline successes, challenges and opportunities for public systems faced with the imperative to move beyond clinical siloes and embrace new and innovative approaches to organizing care delivery.</p>

	<p><u>Speakers</u></p> <p><i>Frederick Cerise, MD, President and CEO, Parkland Health & Hospital System</i> <i>Barbara Garcia, MPA, Director of Health, San Francisco Department of Public Health</i> <i>Ramanathan (Ram) Raju, MD, President and CEO, NYC Health + Hospitals</i> <i>John Jay Shannon, MD, CEO, Cook County Health & Hospitals System</i></p> <p><u>Moderator</u></p> <p><i>Karen Duncan, MD, Principal, HMA (Atlanta)</i></p>
10:30 - 10:45 am	Break
10:45 am - 12:15 pm	<p>The Emergence of Provider-led Managed Care: How Innovative State Models Are Transforming the Relationship Between Payers and Providers</p> <p>States are fostering an integrated approach to healthcare delivery by moving toward innovative models that rely on provider-led organizations to coordinate care for Medicaid patients under global or capitated payment arrangements. Oregon, for example, led the shift four years ago by contracting with provider-led Coordinated Care Organizations (CCOs) to handle the entire spectrum of care for Medicaid patients within a geographic area, and in return, were given significant flexibility in developing a care model that best meets the needs of the population. Similar initiatives are under way in Alabama, Colorado, North Carolina, and other states. New York and Texas, meanwhile, are several years into their Delivery System Reform Incentive Payment (DSRIP) program; and California is embarking on a renewed 1115 Waiver that will incentivize significant changes in the way that care is delivered and paid for. During this presentation, leaders who have been involved in these state initiatives will provide important insights into the results of their programs, outline best practices for incentivizing delivery system change, and discuss whether these innovations could potentially be replicated in other states.</p> <p><u>Speakers</u></p> <p><i>Arthur Gianelli, President of Mount Sinai St. Luke's and Mount Sinai PPS, LLC</i> <i>Bruce Goldberg, MD, former Director, Oregon Health Authority</i> <i>Cindy Mann, Partner, Manatt Health</i></p> <p><u>Moderator</u></p> <p><i>Tina Edlund, Managing Principal, HMA (Portland)</i></p>
12:15 - 2:00 pm	<u>Lunch</u>
2:00 - 3:30 pm	<p><u>Concurrent Breakout Session</u></p> <p>Addressing Social Determinants of Health: Collaborative Approaches to Quality Improvement for Integrated Delivery Systems</p> <p>The impact of services addressing the social determinants of health on efforts to provide</p>

comprehensive and integrated care cannot be overstated. A significant portion of the overall health of a patient population is tied to community-related factors such as unemployment, poverty, housing instability, lack of education, substance abuse and inadequate access to care. Understanding the role of social determinants of health is critical to developing and maintaining a high-functioning, integrated delivery system. During this breakout session, representatives of providers, plans and community-based organizations will provide important insights and examples of how entities can collaborate in addressing social determinants of health to improve healthcare outcomes among the populations they serve.

Speakers

Clemens Hong, MD, Medical Director, Community Health Improvement, LA County Department of Health Services

Ross Owen, Director, Hennepin Health

Moderator

Cathy Kaufman, Principal, HMA (Portland)

Concurrent Breakout Session

Operational and Organizational Priorities Facilitating the Transition to Integrated Care Delivery

The shift to integrated care delivery requires a commitment by healthcare organizations to implementing system-wide operational, organizational, and policy changes. These transformations need to take place at all levels of the healthcare continuum, including hospitals, clinics, behavioral health organizations, and physician groups. Priorities include systems redesign, training, and establishing a new mindset throughout the organization that focuses on the whole patient throughout the continuum of care. During this breakout session, providers will discuss key operational and organizational priorities in facilitating the shift toward integrated care delivery as well as creative approaches to making these transitions.

Speakers

Wendy Burkholder, Chief Clinical Operating Officer, District Medical Group, Provider to Maricopa Health System

Dan Castillo, CEO, LAC + USC Medical Center

Moderators

Warren Lyons, Principal, HMA (San Francisco)

Rob Werner, Senior Consultant, HMA (Chicago)

Concurrent Breakout Session

Care Management for Vulnerable Populations: Evidence-based Tools and Models for Managing Complex Medical Conditions

Care management has emerged as a critical component of efforts by integrated delivery systems to improve quality and control costs among vulnerable populations. The best care management programs rely on evidence-based tools and models that allow providers to identify members in need of interventions, design effective care plans, and track results. During this breakout session, healthcare industry experts will outline the steps integrated delivery systems must consider when designing and implementing a successful, evidence-based care management program – including the type of infrastructure and workflow redesign needed to ensure care management efforts deliver measureable results.

Speakers

Bonnie Pilon, Alexander Heard Distinguished Service Professor, Vanderbilt School of Nursing at Scarritt Place

Dennis Mauer, Community Mental Health Director, Community University Health Care Center (CUHCC)

Moderators

Pat Dennehy, Principal, HMA

Nancy Jaeckels Kamp, Managing Principal, HMA

3:30 - 4:00 pm

Break

4:00 - 5:30 pm

Concurrent Breakout Session

Integrating Behavioral Health: A Strategic and Operational Framework for Integrated Delivery Systems

Behavioral health has never been more relevant to integrated care delivery. Not only have the costs of caring for those with behavioral health needs become a focal point of delivery system reform, but healthcare organizations have also come to value the type of person-centered care and social supports that the behavioral health sector provides. Leading healthcare systems are already taking advantage of the significant opportunities for advancing behavioral health within the framework of delivery system redesign. This discussion will outline strategies for integrating behavioral health, managing organizational change, and pursuing collaborative working relationships with community-based organizations.

Speakers

Frances Isbell, CEO, Healthcare for the Homeless – Houston

Rachel Solotaroff, M.D., Chief Medical Director, Central City Concern

Moderators

Karen Batia, Principal, HMA (Chicago)

Linda Follenweider, Principal, HMA (Chicago)

Concurrent Breakout Session**Clinical Leadership: How Integrated Care for Vulnerable Populations Requires New Skills for Providers in Management Roles**

The emergence of integrated care for vulnerable patient populations is driving the need for a new type of clinical leader, one who is capable of managing a team of providers and being accountable for quality and cost for an entire patient population. That means coordinating services for people not just when they are sick, but also when they require the type of non-medical support that helps keep them healthy and out of the hospital. It also means developing a culture of service that enhances not just the quality of care but the overall patient experience. During this breakout, panelists will discuss best practices for identifying, developing, and supporting emerging clinical leaders.

Speakers

Sharon Youmans, Professor, Vice Dean, UCSF School of Pharmacy

Lee Francis, MD, President and CEO, Erie Family Health Center

Anthony Perry, MD, VP, Population Health and Ambulatory Services, Rush University Medical Center

Moderators

Pat Dennehy, Principal, HMA (San Francisco)

Jean Glossa, Principal, HMA (District of Columbia)

Concurrent Breakout Session**Leveraging Data and Healthcare IT Solutions for Population Health Management of Vulnerable Populations**

Data is king when it comes to population health management. The challenge for integrated delivery systems serving vulnerable populations, however, is that data isn't always available in a form that lends itself to adequately stratifying and developing programs for members with complex medical conditions. What's needed is an IT framework in which integrated delivery systems take advantage of existing EHR, analytics and IT capabilities to tap available data resources – demographic, socioeconomic, clinical, and administrative. During this breakout session, healthcare IT experts from hospitals, health plans and government will outline how the right type of IT framework can be used to target, profile, and stratify vulnerable populations. This allows integrated delivery systems to create individualized care management plans that address the interrelated health and human services needs of their clients.

Speakers

David Horrocks, President, Chesapeake Regional Information System for Our Patients (CRISP)

Jim Sinkoff, EVP, CFO, Hudson River HealthCare

Hope Glassberg, VP, Strategic Initiatives & Policy, Hudson River HealthCare

	<p><u>Moderators</u> <i>Juan Montanez, Principal, HMA (District of Columbia)</i> <i>Greg Vachon, MD, Principal, HMA (Chicago)</i></p>
5:30 - 7:00 pm	Reception
Day Two: October 11, 2016	
7:00 - 8:00 am	Breakfast
8:00 - 8:20 am	<p><u>HMA Skit</u> Helping Health Plans and Providers See Eye to Eye on Integrated Care Before health systems and Medicaid managed care plans can collaborate on integrated care, they need to truly understand the goals and needs of the other side. That means opening the lines of communication, aligning expectations, building trust, and listening. During this skit, HMA Principals Dr. Art Jones and Deborah Gracey will demonstrate how health plans and providers often talk past each other and outline how to best overcome the barriers and false assumptions that can derail even the best-intentioned joint efforts.</p> <p><u>Speakers</u> <i>Art Jones, MD, Principal, HMA (Chicago)</i> <i>Deborah Gracey, Principal, HMA (Chicago)</i></p>
8:20 - 10:00 am	<p><u>Keynote Q&A Session</u> Blueprint For Collaboration: How Medicaid Managed Care and Health Systems Can Work Together on Integrated Delivery for Vulnerable Populations Health plan and health system collaboration on integrated delivery of care for vulnerable populations has often been more talk than action. But it doesn't have to be that way. Health plans and delivery systems have a vested interest in working together to build the type of partnerships that incentivize and effectively drive implementation of integrated care delivery. During this interactive Q&A session, leaders from both Medicaid managed care plans and healthcare providers will outline what works and what doesn't when it comes to payer-provider collaborations. The session will also address some of the key barriers to collaboration - including the type of misaligned assumptions and expectations that can cause even the best-intentioned efforts to falter.</p> <p><u>Speakers</u> <i>Francisco (Paco) Trilla, MD, Chief Medical Officer, Neighborhood Health Plan of Rhode Island</i> <i>Andrea Gelzer, MD, SVP, Corporate Chief Medical Officer, AmeriHealth Caritas</i></p> <p><u>Moderator</u> <i>Art Jones, MD, Principal, HMA (Chicago)</i></p>

10:00 - 10:30 am	Break
10:30 am - 12:30 pm	<p>Successful Strategies: Models and Case Studies of Healthcare Organizations that Are Making Integrated Care Work</p> <p>A variety of healthcare organizations are already making progress toward becoming fully integrated delivery systems, offering important lessons for others hoping to make the same leap. Successful integration requires a commitment to system-wide changes in organizational structure, incentives, IT infrastructure, training and management. It's hard work, but the payoff is immense, including improved patient care, higher employee satisfaction, and reduced cost. During this session, Doug Elwell of Cook County Health and Hospitals System and Cheryl Lulias of Medical Home Network (MHN) will discuss the MHN model. Pat Curran, former chief executive of CareOregon, will discuss the state's Coordinated Care Organization model. Representatives of other models will also discuss their approaches and what they have learned, addressing key strengths and weaknesses. This session will provide a real-world summary of the various elements of integrated care for vulnerable populations discussed in the conference keynotes and breakout sessions.</p> <p><u>Speakers</u> <i>Doug Elwell, Deputy CEO, Finance and Strategy, Cook County Health and Hospitals System</i> <i>Cheryl Lulias, Executive Director, Medical Home Network</i> <i>Pat Curran, Former CEO, CareOregon</i> <i>Deb Gracey, Principal, HMA (Chicago)</i></p> <p><u>Moderator</u> <i>Pat Terrell, Vice President, HMA; Executive Director, HMA Accountable Care Institute</i></p>
12:30 pm	Adjourn
<p>Post-Conference Workshop: October 12, 2016</p> <p>Empowered Leadership Can Transform Care for Vulnerable Populations</p>	
7:45 - 8:30 am	Registration and Breakfast
8:30 - 9:15 am	<p><u>Keynote Address</u></p> <p><i>Speaker to be Announced</i></p>

9:15 - 9:45 am	<p>Creating a Three-Year Strategy to Align Empowered Leadership Identify the steps necessary to build a successful leadership team that is empowered and aligned to drive progress toward your organization's broader goals and mission.</p> <p><u>Speaker</u> <i>Cathy Dimou, MD, Associate Dean of Medical Services, Rush University Medical Center</i></p>
9:45 - 10:00 am	Break
10:00 - 10:45 am	<p>Understanding Adaptive Leadership Understand the key elements, skills, and characteristics of Adaptive Leadership, including how to identify, foster, and best use this unique approach to leading.</p> <p><u>Speaker</u> <i>Nancy Jaeckels Kamp Managing Principal, HMA (Chicago)</i></p>
10:45 am - 12:00 pm	<p><u>Breakout Workgroups</u></p> <ol style="list-style-type: none"> 1. Changing world of new payment models 2. Team approach for care management and care coordination models 3. Quality improvement and population management <p><i>Workgroup facilitators to be announced</i></p>
12:00 - 12:45 pm	Lunch
12:45 - 1:45 pm	<p>Assessing and Promoting Adaptive Leadership Identifying leadership capabilities among staff is a critical but often difficult task for healthcare organizations. The rapid changes in delivery systems require a systematic plan to appraise and prepare leaders for the new healthcare landscape.</p> <p><u>Speaker</u> <i>Maurice Lemon, MD, Principal, HMA (Chicago)</i></p>
1:45 - 2:00 pm	Break
2:00 - 3:15 pm	<p><u>Breakout Workgroups</u></p> <ol style="list-style-type: none"> 1. Consumer Engagement 2. Provider Engagement 3. Partnership with Community Groups

	<i>Workgroup facilitators to be announced.</i>
3:15 - 4:00 pm	Future State and Next Steps <u>Speaker</u> <i>Pat Dennehy, Principal, HMA (San Francisco)</i>
4:00 pm	Adjourn



HMA MEDICAID ROUNDUP

Alaska

Legislature Passes Bill to Help Exchange Insurer Cover High-Cost Exchange Members. *Politico* reported on June 10, 2016, that the Alaska legislature passed a bill to establish a \$55 million fund, which would be used to subsidize the cost of Exchange members with serious illnesses and high medical costs to help ensure that the state's lone remaining Exchange plan for 2017 doesn't exit the market. The legislation, which awaits the signature of Governor Bill Walker, is aimed at ensuring that 23,000 individuals enrolled in an Exchange plan this year are not left without a coverage option. In 2017, Premera Blue Cross Blue Shield will be the only Exchange plan in Alaska, after Moda Health announced it would leave the market at the end of 2016. State officials feared that a single remaining plan wouldn't realistically be able to raise premiums enough to cover member costs. Proposed premiums for 2017 will be filed next month. [Read More](#)

Arkansas

Medicaid Expansion Enrollment Continues to Rise. *Arkansas Online* reported on June 9, 2016, that Medicaid expansion enrollment in Arkansas topped 292,500 as of April 30, 2016, with the state adding 25,000 expansion members from February through April alone. There is also a backlog of 100,000 Medicaid cases, including more than 34,000 applications for coverage that have been pending for more than 45 days. Arkansas Department of Human Services Director Cindy Gillespie hopes to hire about 250 temporary caseworkers to help clear the backlog. The expansion figures include 238,050 under the state's private option alternative Medicaid expansion and nearly 54,500 under traditional, fee-for-service Medicaid. The state's traditional Medicaid program has enrollment of more than 630,000. [Read More](#)

DHS Looks to Maximus to Address Medicaid Enrollment, Eligibility Determination Backlog. *Times Record* reported on June 10, 2016, that the Arkansas Department of Human Services (DHS) will seek legislative approval to contract with Maximus to eliminate a Medicaid enrollment and eligibility verification backlog of more than 110,000 cases. DHS Director Cindy Gillespie told the state legislature's Health Reform Legislative Task Force that the plan is to eliminate the backlog by December 31, 2016, which is when the contract with Maximus would expire with no option for extension. The estimated total cost of the plan is \$8.4 million, with the state responsible for \$2.1 million. [Read More](#)

Florida

HMA Roundup – Elaine Peters ([Email Elaine](#))

Medicaid Plans Owed \$433 Million in State, Federal Underpayments. *The Miami Herald* reported on June 13, 2016, that 11 Medicaid managed care plans in Florida are owed a combined \$433 million in unpaid reimbursements from the state and federal governments, including \$173 million from the state alone. Florida Agency for Health Care Administration Secretary Liz Dudek said the state has taken immediate action to properly reimburse the plans, which were underpaid over the two year period of May 2014 to June 2016. The article quotes sources saying that the state mistakenly paid plans lower rates for Medicaid beneficiaries who qualified for higher reimbursement because of their health status. However, it is unclear how much each of the plans was underpaid. While critics of Florida's Medicaid program say that the underpayments demonstrate a need for increased accountability and transparency, Centene's Sunshine State Health Plan and WellCare issued statements praising the agency's immediate disclosure of the underpayments and commitment to a long-term solution. [Read More](#)

Pediatricians Frustrated With Medicaid Plan Reassignments, Rates. *The Herald Tribune* reported on June 12, 2016, that more than 80% of Florida pediatricians recently surveyed have in one or more cases been unable to provide children with needed care because of Medicaid plan coverage or authorization limitations. About 70% said they have seen an increase in the number of children who have been reassigned to a different Medicaid plan without a parent's approval. The results are based on a survey of pediatricians who are members of the Florida chapter of the American Academy of Pediatrics. Pediatricians also report having a difficult time connecting Medicaid patients with specialists that accept Medicaid and are frustrated with low reimbursement rates. In April 2016, pediatricians and parents settled a 10-year lawsuit with the state Medicaid program for \$12 million. As part of the settlement, the state agreed to work with pediatricians and parents to improve access to care for children. [Read More](#)

Georgia

HMA Roundup – Kathy Ryland ([Email Kathy](#))

State Senator Suggests Waiver to Expand Medicaid. *WABE.org* reported on June 7, 2016, that Georgia Senator Renee Unterman wants the state to consider expanding Medicaid through a federal waiver. Senator Unterman, who is head of the state Senate Committee on Health and Human Services, said expansion would bring in federal Medicaid matching funds needed to bolster struggling Georgia hospitals. An estimated 400,000 Georgians fall in the coverage gap, meaning they do not qualify for Medicaid but are not eligible for federal subsidies on the Exchange. [Read More](#)

Illinois

HMA Roundup – Andrew Fairgrieve ([Email Andrew](#))

Advocate, NorthShore Merger Approved by Federal Judge. *Crain's Chicago Business* reported on June 14, 2016, that a federal judge has cleared the way for Advocate Health Care and NorthShore University HealthSystem to merge. Citing antitrust concerns, the Federal Trade Commission (FTC) had sought a preliminary injunction to block the merger; however, the FTC's motion was denied by U.S. Northern District Judge Jorge Alonso. The FTC had argued that the merged hospital network would control 60 percent of general acute inpatient hospital services in Chicago's north suburbs and could leverage its market power over insurers to increase prices by about 8 percent. The two systems said that their combined market share would be closer to 28 percent, adding that value-based payments would allow them to better manage care. [Read More](#)

Indiana

Hoosier Healthwise/HIP Award Recommendations Released. The state of Indiana has released its contract award recommendation to provide Risk-Based Managed Care Services for Medicaid Beneficiaries (Hoosier Healthwise/HIP). Anthem, CareSource, MDwise, and Centene's Indiana subsidiary Managed Health Services have been recommended to begin contract negotiations with the state. The estimated first year contract values are:

- Anthem: \$822,163,303.57
- CareSource: \$822,163,303.57
- MDwise: \$831,191,428.77
- MHS: \$822,163,303.57

State Has Yet to Respond to CMS Request for Medicaid Expansion Member Data. *Modern Healthcare* reported on June 14, 2016, that Indiana has not yet responded to a request from the Centers for Medicare & Medicaid Services (CMS) for access to state Medicaid expansion beneficiary data. CMS has asked the state to enter into a data-sharing agreement, which would provide CMS with the information needed to survey beneficiaries and evaluate the state's alternative approach to Medicaid expansion. CMS has set a June 17 deadline for the state to accept the terms of the agreement. Indiana officials have expressed concerns that the survey questions may be biased, noting that the enrollees would be asked about their level of dissatisfaction with the program, but not their level of satisfaction. [Read More](#)

Louisiana

Medicaid Expansion Enrollment at 197,000. *AP/DailyComet.com* reported on June 8, 2016, that more than 197,000 individuals have been enrolled in the new Louisiana Medicaid expansion program, with coverage effective July 1. Of the total, 187,000 were automatically enrolled and 10,000 actively enrolled, including those deemed eligible because they were receiving SNAP benefits. [Read More](#)

Maryland

Evergreen Health Files Lawsuit against CMS Over Risk Adjustment Payments. *The Washington Post* reported on June 13, 2016, that Maryland Exchange cooperative plan Evergreen Health has filed a federal lawsuit against the Centers for Medicare & Medicaid Services (CMS) in an attempt to avoid having to make a \$22 million risk adjustment payment. Risk adjustment payments, which in this particular case would go to CareFirst Blue Cross Blue Shield, are designed to bolster Exchange plans that serve members with greater service needs and higher costs. Evergreen Health criticized flaws in the risk adjustment program and is asking for an injunction allowing it to hold off on making payments until CMS issues new risk adjustment guidelines. [Read More](#)

Michigan

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

The following stories come from HMA's *The Michigan Update*:

2016-2017 Michigan Department of Health and Human Services (MDHHS) Budget. Michigan's Revenue Estimating Conference, held on May 17, 2016, resulted in a reduction of \$460 million in estimated revenues for the 2016-2017 fiscal year (FY), which will begin October 1, 2016. Based on the revised revenue estimates, new targets were established for the budgets for state agencies and programs. The state general fund target for MDHHS was reduced by \$33 million from Governor Rick Snyder's original Executive Budget Recommendation. [Read More](#)

Health Insurance Claims Assessment (HICA) and Use Tax. On May 24, 2016, a set of four bills was introduced in the Michigan Senate to continue the Use Tax on Medicaid Health Plans (HMOs) and Prepaid Inpatient Health Plans (PIHPs) under a revised structure as of January 1, 2017 and would eliminate the HICA tax as of that same date (which is otherwise scheduled to increase from 0.75 percent to 1.0 percent on January 1, 2017). [Read More](#)

State Innovation Model: Patient-Centered Medical Homes. The Michigan Department of Health and Human Services (MDHSS) recently announced the first phase of Accountable Systems of Care within the Blueprint for Health Innovation initiative, Michigan's State Innovation Model (SIM). The first phase of this multi-payer initiative will focus on Patient-Centered Medical Homes (PCMH). The PCMH initiative is scheduled to begin on January 1, 2017, to coincide with the December 31, 2016 end of the Michigan Primary Care Transformation (MiPCT) initiative. Physician practices interested in the SIM PCMH initiative must submit an "Intent to Participate" (ITP) by June 30, 2016. [Read More](#)

MDHHS Chief Deputy Director. On May 31, 2016, Michigan Department of Health and Human Services Director Nick Lyon announced that his Chief Deputy Director, Tim Becker, will be leaving the department on July 8, 2016 to join Hope Network as executive vice president. His successor has not yet been named. [Read More](#)

Missouri

New Law Raises Asset Limit for Medicaid ABD Eligibility. *The Charlotte Observer/AP* reported on June 9, 2016, that a new law signed by Missouri Governor Jay Nixon raises the asset limit for Medicaid eligibility among individuals in the aged, blind, and disabled (ABD) category of eligibility, a change that is expected to allow an additional 10,000 individuals to enroll by fiscal year 2021. Some legislators are concerned about cost of the initiative, which is expected total an additional \$28 million in fiscal year 2018 and \$45 million by 2020. Beginning in July 2017, asset limits will be \$2,000 for individuals and \$4,000 for married couples, double the current limits of \$1,000 and \$2,000. The limits will increase annually until July 2020, when they reach \$5,000 for individuals and \$10,000 for married couples. After that, limits will increase annually with cost-of-living adjustments. [Read More](#)

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

DOH Releases Transition Plan for Waiver Programs. The New York Department of Health has released a draft of its plan to eliminate the 1915c Home and Community-Based Services (HCBS) Waiver for the Nursing Home Transition and Diversion (NHTD) and Traumatic Brain Injury (TBI) programs. As part of the state's Care Management for All strategy, waiver participants will be transitioned into mainstream Medicaid managed care and managed long term care plans. The draft transition plan indicates that benefits will be coordinated with the Community First Choice Option, an initiative of the Affordable Care Act designed to expand state plan home and community based services and supports, which was approved in NY in October 2015 and made retroactive to July 2015. In addition, the managed care benefits package will be expanded to include all the waiver services currently utilized by waiver participants that are not included in the Community First Choice Option. The timeline for this transition has been delayed several times due to concerns about plan readiness to provide appropriate care to waiver program members. In response to those concerns, the state has established a NHTD/TBI Waiver Program Stakeholder workgroup. The target date for the transition to begin is January 1, 2018. Comments on the draft are being accepted through August 24, 2016, at waivertransition@health.ny.gov. [Read More](#)

Children's Behavioral Health Managed Care Transition Delayed. As New York plans the transition of behavioral health services for children into Medicaid managed care, an interagency work group, including representatives from the Department of Health, the Office of Children and Family Services, the Office of Mental Health and the Office for Alcohol and Substance Abuse Services, has been finalizing the details of the design. The group recently announced a delay in the implementation of tasks and approvals required to ensure a smooth transition, including:

- Feedback from CMS on Conflict of Interest and its Impact on 1915(c) Waiver Transitions and the overall children's design
- State Plan and 1115 CMS Waiver Approvals
- Request for Qualifications for Medicaid Managed Care plans

- Readiness and Training Activities for Plans, Providers, and Stakeholders
- Designation of State Plan Amendment and HCBS Providers
- Work to transition payments related to the foster care population, including “residual per diem”
- Stakeholder collaboration
- Assess costs and how to accomplish the design elements within the Global Spending Cap.

Six new State Plan Amendment (SPA) services, approved in the 2017 budget, will be added to the fee-for-service payment system on January 1, 2017. In July 2017 all SPA services for children will be transitioned into Medicaid managed care (MMC) in New York City and Long Island, along with Children’s Home and Community-Based Services. Children in the care of Voluntary Foster Care Agencies (VFCA) in those regions will also move to MMC. The transition of children’s services in the rest of the state is scheduled for January 2018.

Medicaid Global Spending Cap \$3 Million Below Target. The March 2016 Medicaid Global Spending Cap Report summarizes spending for State Fiscal Year 2016. Spending under the 2016 Medicaid Global Spending Cap was \$3 million below the \$17.7 billion target. The global cap is tied to the 10-year average of the medical care consumer price index, which was 3.4 percent for the fiscal year ending on March 31. The global cap does not include Medicaid payments for medical services provided at state facilities operated by the Office of Mental Health, the Office for People with Developmental Disabilities or the Office of Alcoholism and Substance Abuse Services, and excludes any other payments not appropriated within DOH, as well as the local and federal shares of New York Medicaid disbursements. The state attributes savings to a number of factors:

- Continuing the Care Management for All initiative which transitioned a number of populations and benefits into a managed care setting. Both the Nursing Home and Health and Recovery Plan (HARP) recipients were transitioned this year.
- Continuing the Balancing Incentive Program (BIP).
- Implementing Value Based Payment (VBP) Reform designed to transform the Medicaid payment structure from volume-driven to value-based.
- Implementation of New York’s Basic Health Plan (known as the Essential Plan), which brings a higher federal match for certain populations.

Read More

Albany Medical Center Adds Affiliation. Albany Medical Center and Saratoga Hospital have finalized an affiliation agreement and Saratoga Hospital has filed an application with the New York Department of Health that would make Albany Medical Center its parent and co-operator. The 170-bed Saratoga Hospital is located 40 miles north of Albany. The agreement is similar to the arrangement Albany Medical Center established with Columbia Memorial Health, south of Albany, at the beginning of the year. The proposal would give Albany Medical Center authority over Saratoga Hospital’s budgets and strategic

plans, the hiring and firing of Saratoga Hospital's chief executive, incurrence of debt, and hospital policies and procedures. Each health system would have representation on the other's boards. The agreement's goals are to establish efficiencies through clinical and administrative integration, and create a better delivery system for communities served by Albany Medical Center and Saratoga Hospital. [Read More](#)

Kaleida Health Adds Affiliation. Cuba Memorial Hospital and Kaleida Health have entered into an affiliation agreement. The new partnership is expected to help the Allegany County health system transform the way it delivers care. Cuba Memorial, a designated Critical Access Hospital, operates a 20-bed medical acute care unit, an urgent care center and a 61-bed residential health care facility. This latest affiliation agreement for Kaleida Health, which has expanded its footprint in Western New York, comes weeks after the organization announced a partnership with Upper Allegheny Health System. In March, TLC Health Network (Lake Shore Health Care Center) and Brooks Memorial Hospital announced their intentions to affiliate with Kaleida Health, allowing Kaleida Health to develop a strong Southern Tier health care delivery system. [Read More](#)

North Carolina

Carolinas HealthCare System Faces Antitrust Lawsuit. *The Charlotte Observer* reported on June 9, 2016, that a newly filed federal antitrust lawsuit claims that Carolinas HealthCare System (CHS) is unfairly limiting competition in the Charlotte marketplace, driving up costs and limiting choice for consumers. The lawsuit, filed by the U.S. Justice Department and NC Attorney General, claims CHS uses its market power to negotiate unlawful contract restrictions, preventing consumers from using lower cost hospitals and encouraging insurers to steer patients to CHS facilities. CHS operates Carolinas Medical Center and nine hospitals in Charlotte, controlling 50 percent of the market, the lawsuit claims. CHS said its "arrangements with insurers are similar to those in place between insurers and healthcare systems across the country," saying it has "neither violated any law nor deviated from accepted healthcare industry practices." [Read More](#)

Ohio

HMA Roundup - Jim Downie ([Email Jim](#))

Office of Health Transformation Seeks Designation as Statewide Comprehensive Primary Care (CPC) Region. The Ohio Office of Health Transformation has announced that Ohio Medicaid and the state's four largest commercial health insurance plans have applied to the federal government to be designated a statewide CPC region. [Read More](#)

Nationwide Children's Hospital Announces Major Expansion. *The Columbus Dispatch* is reporting Nationwide Children's Hospital has announced a \$730 million expansion. The expansion includes the Behavioral Health Pavilion, a comprehensive center devoted to mental health care for children and adolescents. "It's unique for a children's hospital to commit to a comprehensive behavioral health facility with all of these components," said Dr. David Axelson, Chief of Behavioral Health at Nationwide Children's. "I think that the

community at large has recognized that mental and behavioral health is an incredibly important problem.” [Read More](#)

Pennsylvania

HMA Roundup – Julie George ([Email Julie](#))

Community HealthChoices Phase One Pushed Back. Pennsylvania’s Department of Human Services and Department of Aging announced a delay in the start of their Medicaid managed long term services and supports (MLTSS) program, Community HealthChoices (CHC). The decision was made to lengthen the transition time, beginning the first phase (in the southwest zone) on July 1, 2017, instead of January 1, 2017. The rest of the CHC implementation timeline remains intact, including the selection of managed care companies and changes in the commonwealth’s IT systems. Rollout to the southeast zone and the remainder of the Commonwealth is still scheduled for 2018 and 2019, respectively. [Read More](#)

Community HealthChoices Evaluation Plan Available for Comment. The Department of Human Services is making available for public review and comment a draft of the Evaluation Plan developed by the University of Pittsburgh for Community HealthChoices, Pennsylvania’s new Medicaid MLTSS program. The department asks that this form be used when providing comments. Comments received by June 24, 2016, will be reviewed before the Evaluation Plan is finalized. [Read More](#)

Availability of Preventive Health and Health Services Block Grant Application; Public Hearing. The Pennsylvania Department of Health will be releasing their proposed Preventative Health and Health Services Block Grant Application for Federal Fiscal Year 2016 on June 16, 2016. The proposed application will be available for public comment. The Public Health Council will hold a meeting and teleconference call on June 16 and DOH will hold a public hearing, for the purpose of receiving testimony on the application, on June 21. Written comments should be received no later than June 20 at 4 p.m. For additional information, contact Terry L. Walker, Administrative Officer at 717-787-6214. This application serves as the Commonwealth’s request to the U.S. Department of Health and Human Services for block grant funding to address the Healthy People 2020 Health Status Objectives. [Read More](#)

Texas

State to Cut Payments for Pediatric Therapy Services Up to \$295 Million Over 2 Years. *The Texas Tribune* reported on June 14, 2016, that Texas will cut payments to Medicaid speech, physical, and occupational therapy providers by up to \$295 million over the next two years. The cuts, which will begin taking effect in July 2016, will impact therapy programs for children with disabilities. The cuts were first proposed a year ago, but delayed by a lawsuit filed by children’s advocates and providers. The state won the lawsuit in April. [Read More](#)

Washington

HMA Roundup – Ian Randall ([Email Ian](#))

General Fund Revenues Higher than Expected. General Fund state revenue collections for April 11 through May 10, 2016, were \$66.5 million (4.7%) higher than expected in the initial February forecast. Cumulatively, 2016 collections are now \$140 million (3.8%) higher than expected. This comes after Washington passed a FY 2016 supplemental budget that drew from the state's Rainy Day Fund and did not make significant investments in K-12 education, per the state's McCleary ruling, which mandates state legislators to adequately fund K-12 education. [Read More](#)

Lawmakers Work on Legislation to Restrict Balance Billing. Washington is one of a limited number of states that allows balance billing, a practice where a provider bills a patient for the portion of a bill not covered by a patient's insurance when there is no contractually agreed upon amount between the provider and payer. The state's Insurance Commissioner, Mike Kriedler, and key legislators, such as Representative Eileen Cody, Chair of the State House and Wellness Committee, are working on a bill to restrict a provider's ability to balance bill patients for emergency care or in situations when the patient isn't made aware that a provider is out of network. [Read More](#)

West Virginia

Critical Access Hospitals Fear Closure if CMS Requirements Force Medicaid Repayments. *Charleston Gazette-Mail* reported on June 11, 2016, that CMS may require seven West Virginia critical access hospitals that run rural clinics to pay back a total of \$8 million in Medicaid disproportionate share (DSH) payments dating back to 2011. The affected hospitals are Boone Memorial Hospital, Minnie Hamilton Health System, Roane General Hospital, Grafton City Hospital, Jackson General Hospital, Pocahontas Memorial Hospital, and Sistersville General Hospital. Each hospital has received claims payments for uncompensated rural clinic costs, payments that CMS has disavowed. The hospitals now fear closure if required to make the repayments and have asked CMS and state officials to reconsider the issue. CMS stated that the issue can be temporarily resolved through a Medicaid state plan amendment. [Read More](#)

Wisconsin

DHS Withdraws Plan for Medicaid Long-Term Care Changes. *Wisconsin State Journal* reported on June 10, 2016, that the Wisconsin Department of Health Services is no longer seeking approval to alter the state's Family Care and IRIS long-term care programs, having withdrawn the plan it had submitted to the state legislature. Family Care and IRIS (Include, Respect, I Self-Direct) are aimed at keeping people out of nursing homes by providing long term services and supports, including home care, job support, and other services to more than 55,000 Wisconsin residents with disabilities or who are elderly. The changes would have meant replacing eight regional managed care organizations with integrated health agencies under a competitive procurement. [Read More](#)

Wyoming

Hospital Layoffs May Bolster Case for Medicaid Expansion. *Casper Star Tribune* reported on June 11, 2016, that 58 employees were recently laid off at Wyoming Medical Center (WMC), the state's largest hospital. Officials at the hospital say the number would have been greatly reduced if Wyoming's Republican-led Legislature passed Medicaid expansion legislation. State Democrats running for office this election period hope to get expansion back on the table and alleviate financial pressures faced by not-for-profit providers like WMC. [Read More](#)

National

CMS Announces Outreach, Enrollment Funding Awards for Connecting Kids to Coverage. CMS announced on June 13, 2016, that it had awarded 38 community organizations with \$32 million in outreach and enrollment funding for the Connecting Kids to Coverage campaign. The awards were authorized under the Medicare Access and CHIP Reauthorization Act (MACRA) Pub. L. 114. Connecting Kids to Coverage identifies children who are eligible for Medicaid and CHIP and helps families enroll and renew coverage. The program aims to increase the number eligible children enrolled and retained. CMS also released an informational bulletin, titled "Strategies to Enroll and Retain Eligible Children in Medicaid and CHIP."



INDUSTRY NEWS

MedData to Acquire Cardon Outreach for \$400 Million. MedData Inc. announced on June 13, 2016, that it has agreed to acquire Cardon Outreach LLC, a Texas-based provider of integrated revenue cycle management services for \$400 million. Cardon provides services to over 800 hospitals and healthcare facilities in 46 states. It is expected to generate \$36 million in non-GAAP annualized earnings in 2016. The deal is expected to close within the next 30 days. [Read More](#)

Investors Attracted to Opioid Addiction Treatment Facilities. *NPR* reported on June 10, 2016, that investors are increasingly seeking opportunities in opioid addiction treatment facilities, resulting in a large increase in the number of programs over the last 10 years. Investors are attracted to growing demand for treatment programs, driven by the opioid addiction crisis as well as laws like the Mental Health Parity Act and the Affordable Care Act. Acadia Healthcare, a national addiction treatment chain, grew from six facilities in 2010 to 587 in 2016. The company bought CRC Health, a chain of inpatient detox and rehab centers and methadone clinics from Bain Capital in 2014 for \$1.18 billion. [Read More](#)

BeneStream Sees Opportunity in Louisiana Medicaid Expansion. *The Times-Picayune* reported on June 13, 2016, that New York-based BeneStream will look to Louisiana's Medicaid expansion for business opportunities. BeneStream is hired by employers to help working individuals who may be eligible into Medicaid. Housekeepers, dishwashers, and cooks are examples of the type of working individuals with lower incomes BeneStream typically helps. Often these workers can't afford to purchase private insurance or enroll in plans offered by their employer. Employers pay BeneStream \$250 per employee per year to help these employees apply for Medicaid. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
June 24, 2016	Massachusetts MassHealth ACO - Pilot	Responses Due	TBD
June 30, 2016	Virginia MLTSS	Proposals Due	212,000
June, 2016	Nevada	RFP Release	420,000
July 1, 2016	Missouri (Statewide)	Proposals Due	700,000
July 1, 2016	West Virginia	Implementation	450,000
July 1, 2016	Minnesota SNBC	Implementation (Northern Counties)	45,600
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
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November, 2016	Oklahoma ABD	RFP Release	177,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
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	Minnesota SNBC	Implementation (Remaining Counties)	45,600
January 18, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Implementation	177,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
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
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

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

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