HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 21, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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- PENNSYLVANIA COMMUNITY HEALTHCHOICES BIDDERS FILE PROTEST
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IN FOCUS

TELEHEALTH SERVICES – SPOTLIGHT ON ECONSULTS

This week, our *In Focus* section comes to us from HMA principals Greg Vachon, MD, MPH, and Jean Glossa MD, MBA, who provide an overview of econsultations. Greg and Jean define econsults and provide an overview of the spectrum of econsult services in place today, evaluate the benefits and challenges of econsults, and look at recent developments in the econsult market.

Definition of an Econsult

An econsult is a modality in the field of telehealth that falls under the category of “store and forward.” The primary care provider (or other continuity provider) initiates the econsult through a traditional referral pathway, ideally supported by clinical checklists. The specialist then gives advice or renders an opinion that the primary care provider (PCP) receives and acts on. An econsult can be as simple as a “curbside” opinion between the specialist and PCP that is

intentionally general, but most e-consults include signed, patient-specific clinical advice. Unlike a traditional consult, the patient does not have direct contact with the specialist at this point in the process. Oftentimes, the clinical question is answered solely via econsult, although the specialist will sometimes eventually see the patient in a face-to-face encounter. The rate of conversion to face-to-face depends on the clinical condition. When a face-to-face is required, only one visit will often be needed thanks to the pre-visit preparation completed via econsult.

Viewing diagnostic images at a time after data collection is another store and forward telehealth application with radiology, dermatology and ophthalmology (retinal scanning) being common examples. The line between this telehealth application and econsults is somewhat blurry, as econsult platforms are also able to store and forward images attached to the econsult.

Econsult Benefits

A number of factors are leading to rapid adoption of econsults in certain areas of the healthcare marketplace, particularly where specialty access is challenging and pressures to increase value are more acute. The set of common experiences in ambulatory specialty practice described below illustrate opportunities where econsults could be used to improve physician satisfaction, patient experience, quality of care and utilization of specialty services.

- **Incomplete work ups**. Specialists often enter an examination room to see a patient referred by a PCP and find that not all of the tests needed to assess the question or problem have been done.
- **Low value visits**. Studies suggest that a significant percentage of referrals, depending on venue and specialty, are actually for issues that could be resolved and managed at the primary care practice level (Keely et al[1] examples: neurology 17 percent, cardiology 36 percent, hematology 48 percent, nephrology 63 percent).
- **The referral is directed to the wrong specialist**. Much to the frustration of all involved, specialists sometimes see a patient for an initial consultation and discover the question or problem is not appropriate for their specialty practice.
- **Poor access**. PCPs and patients are often faced with long wait times to see a specialist.
- **Feedback delayed/disconnected**. In many systems, the results from a specialty consultation can take weeks or months to be returned to the PCP, decreasing the chances that the PCP will learn from each referral and, over time, make fewer referrals for the same clinical question.

Econsults are designed to address and mitigate each of these negative experiences.

Econsult Challenges

Econsult implementation is not without challenges such as:

- **Dual documentation**. Providers are sometimes required to document in dual systems and are legitimately concerned about dual entry being time consuming and a potential source of errors.

[1] Keely et al, Utilization, Benefits, and Impact of an e-Consultation Service Across Diverse Specialties and Primary Care Providers, Telemedicine and e-Health, October 2013, 10.1089/tmj.2013.0007

- **Lack of payment models**. Payment models for econsults vary. Using econsults in a value based payment system is optimal. Those at risk need to be confident that if specialists are paid for econsults, face-to-face visits will actually decrease.
- **Transitions of care from remote specialists**. Econsults allow a specialist outside of a strained local network to provide access, but if there is a later transition to an in-network, in-person visit based on acuity, the transition can be challenging and can create redundancies and, therefore, must be monitored.
- **Workflow consistency within practices**. Using econsults for some patients and not others (for instance by payer) is difficult and may inhibit adoption.
- **PCP adoption**. Some referring providers will resist change and want their patients to be seen face-to-face. Identifying physician champions who understand the value of econsult is essential to the success of the model.

Market Developments

Evidence for the effectiveness of econsults in safety net healthcare is building. Several articles detailing outcomes in a safety net environment have begun to emerge. [2,3] These studies show high satisfaction among primary care providers, reductions of in-person consults of 40 percent, and overall cost savings.

This growing evidence is also translating into payment. The State of Connecticut's Medicaid program has just begun paying for econsults initiated by PCPs at federally qualified health centers (FQHCs). Colorado and Oklahoma have pilot payment programs and Washington is planning a pilot. In California, where providers bear more risk than providers in other states (including risk for FQHCs in the near future), econsults have been implemented or are currently being implemented in a number of arrangements. The 1115 Waiver Global Payment Program in California specifically calls out econsults under a service category example. Continued dissemination of econsult use should be expected as local departments of public health begin to respond to the global budgets.

Econsultation is a telehealth solution that is gaining more widespread use. Companies have emerged to fulfill the need, offering SaaS models and pre-designed clinical checklists for referrals, as well as additional specialist capacity to address access problems. Market need, proven results, and commercially available products are likely to bring about rapid adoption in settings where specialty access is limited.

More Information

For more information or questions on this examination of econsults, or for more on HMA's telehealth expertise, please contact Greg Vachon, MD, MPH (gvachon@healthmangement.com) and Jean Glossa MD, MBA (jglossa@healthmanagement.com).

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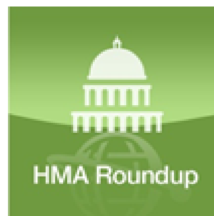
[2] Liddy et al, What are the cost savings associated with providing access to specialist care through the Champlain BASE eConsult service? A costing evaluation. Health Economics, June 2016, 10.1136/bmjopen-2015-010920

[3] Gleason et al, Adoption and impact of an eConsult system in a fee-for-service setting. Healthcare, July 2016, 10.1016/j.hjdsi.2016.05.005



HMA Medicaid Roundup

Alabama

Alabama Medicaid Asks CMS to Delay RCO Implementation to July 2017. The Alabama Medicaid Agency's online newsletter, *Medicaid Matters*, reported on September 14, 2016, that the agency is seeking federal approval to postpone until July 2017 implementation of its planned transition to locally led managed Regional Care Organizations for Medicaid. The transition is part of the state's five-year Section 1115 waiver. Implementation was originally scheduled for October 2016. Read More

Arizona

Centene to Offer HMO Options on Exchange in 2017. Centene Corporation reported on September 14, 2016, that it will offer HMO Exchange plans in Arizona's Maricopa and Pima counties in 2017 under the name Ambetter. Centene projects its 2017 Ambetter offerings in Arizona to generate more than $500 million in additional revenues. The announcement doesn't impact the decision to stop offering PPO Exchange plans through newly acquired Health Net.

Arkansas

Progress Made in Reducing Medicaid Eligibility Review Backlog. *Arkansas Online* reported on September 21, 2016, that the Arkansas Medicaid program is making progress in reducing the backlog of people waiting for an eligibility review. Department of Human Services officials told a state legislative committee that, as of September 6, the number of overdue reviews for Medicaid eligibility and coverage changes stood at less than 88,000, down from more than 98,000 in August. Cases reviewed 45 days late or longer are considered overdue. The backlog, which the state hopes to eliminate by the end of this year, has been costly, requiring $2 million in state funds and another $6.4 million in federal funds to hire extra caseworkers and programmers. The state blames the problem on a new eligibility system. Read More

California

State Seeks Federal Approval for Plan Allowing Undocumented Immigrants to Buy Insurance on Exchange. *The New York Times* reported on September 15, 2016, that California officials are seeking federal approval for a State Innovation Waiver that would allow undocumented immigrants to buy health insurance on the state's Exchange. The plan must be approved by both the U.S. Treasury and

Health and Human Services Departments. Undocumented workers are currently prohibited from buying Exchange coverage. However, California does provide Medicaid coverage to children who are undocumented. The state projects that about 17,000 undocumented individuals would apply to purchase Exchange coverage. All told, the state estimates that 30 percent of its 2 million undocumented immigrants would be eligible. Read More

California Children Gain Access to Medicaid, Dental Care Regardless of Immigration Status. *California Healthline* reported on September 15, 2016, that California's new "Health for All Kids" law took effect May 1, 2016, allowing children to receive full Medi-Cal benefits including dental care regardless of their immigration status. Previously, undocumented children were eligible only for emergency room coverage. About 138,000 children have enrolled, and other 64,500 are expected to sign up over the next year. Read More

Colorado

Medicaid Program Faces Lawsuit Over Hepatitis C Treatment Denials. *The Denver Post* reported on September 19, 2016, that the American Civil Liberties Union (ACLU) has filed a federal class-action lawsuit against Colorado's Medicaid agency for denying hepatitis C treatment to certain members. While the state recently expanded hepatitis C treatment coverage, the ACLU lawsuit argues that the new policy doesn't go far enough. The state covers treatment for people with stage two or higher liver disease. Approximately 14,400 Medicaid beneficiaries in Colorado have hepatitis C, of which 70 percent have stage two or higher liver disease. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

AHCA Secretary Liz Dudek to Retire. On September 21, 2016, Florida Governor Rick Scott announced the retirement of Liz Dudek, secretary of the state's Agency for Health Care Administration (AHCA), effective October 3, 2016. Justin Senior, deputy secretary of AHCA's Division of Medicaid, will serve as interim AHCA secretary. Dudek has served as AHCA Secretary since 2011, and has been an employee of the state of Florida for over 40 years. Along with the Division of Medicaid, AHCA include the Division of Health Quality Assurance and the Florida Center for Health Information and Policy Analysis. Read More

Illinois

Cook County to Offer Primary Care to Low-Income Uninsured. *Chicago Tribune* reported on September 14, 2016, that Cook County, Illinois, has approved a program allowing uninsured county residents earning up to twice the federal poverty level to receive primary care within the Cook County Health and Hospitals System (CCHHS). Patients will have access to Stroger Hospital, Provident Hospital, and more than a dozen clinics. Care received would be free, except for dental services and prescription drugs, which would have copays of a few dollars. The program, which is expected to serve 40,000 in 2017, will initially be limited to individuals already enrolled in the CCHHS financial assistance program CareLink. Medicaid enrollees do not qualify. Read More

Kentucky

Medicaid Waiver Faces Tough Road to Approval. *Herald-Leader* reported on September 14, 2016, that Kentucky is unlikely to win approval for a Medicaid waiver proposal that would allow the state to charge copays and premiums to most recipients. The proposal, which requires approval from the U.S. Department of Health and Human Services (HHS), would also eliminate dental from the standard Medicaid benefit package. HHS official Aviva Aron-Dine said regulators would be reluctant to approve any proposal likely to undermine Kentucky's success under Medicaid expansion. "When we look at any potential changes to Kentucky's, or any other state's Medicaid programs, what we're looking for is changes that build on that success and don't take Kentucky or any other state backward." According to the Census Bureau, the number of Kentuckians without health insurance has dropped by 8.3 percentage points in the last two years. Read More

Louisiana

Medicaid Expansion Enrollment Hits 305,000. *The Advocate* reported on September 19, 2016, that enrollment in Louisiana's Medicaid expansion program has hit 305,000. The goal is 375,000. State officials noted that the program is connecting individuals to potentially life-saving care. Nearly 12,000 people have accessed preventive health care services since expansion, 24 women are getting breast cancer treatment after positive screenings, 160 adults are receiving treatment for diabetes after getting diagnosed, and more than 100 patients had polyps removed following colonoscopies. Read More

Massachusetts

Home Health Providers Overbilled Medicaid by $23 Million, Audit Says. The *Boston Globe* reported on September 18, 2016, that a recent Massachusetts audit found that nine home health care agencies in the state overbilled the MassHealth Medicaid program by approximately $23 million in 2015. The audit found that providers billed for services that were not provided or submitted incomplete documentation. The state required the companies to submit corrective action plans and pay fines of $3,000 to $10,000. Home care agencies in Massachusetts, which plan to appeal the findings, provide Medicaid services like nursing care, physical and occupational therapy under contract to the state. Read More

Michigan

Henry Ford Health System Refinances $1 Billion in Debt. *Detroit Free Press* reported on September 16, 2016, that Henry Ford Health System (HFHS) refinanced $1 billion in debt, a massive restructuring representing nearly all of the organization's debt. The transaction included HFHS selling $1 billion in new 30-year, tax-exempt bonds with an average interest rate of 3.7 percent and buying back older bonds with an average rate of 4.2 percent. HFHS projects savings of $125 million over 30 years. HFHS expects to generate $5.5 billion in revenues in 2016. Read More

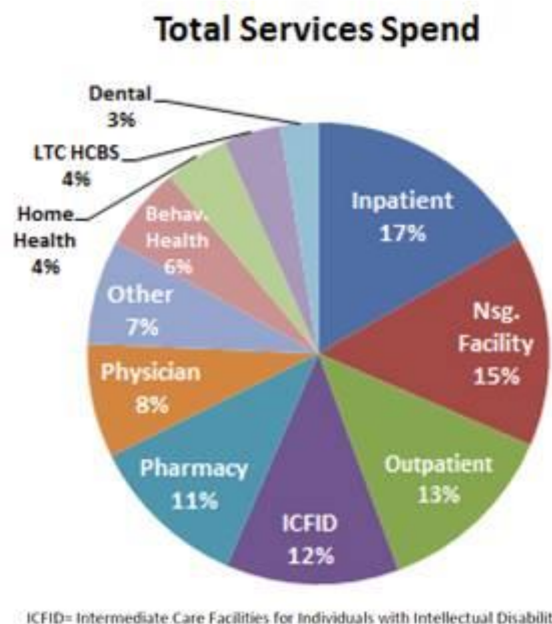
New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Medicaid agency releases NJ FamilyCare 2015 Annual Report. In August 2016, the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) released its annual report addressing key initiatives from FY 2015, health plan best practices, an Infographic on NJ FamilyCare, the status of program eligibility and enrollment, quality results, Medicaid infrastructure, summary fiscal results and projections for FY 2016.

Here are a few highlights from the report.

- **Fiscal.** NJ FamilyCare expenditures totaled $15 billion in state, federal and other funds in FY 2015, an increase of 13.9 percent over the previous year. Of that, $11 billion was spent across the major categories of service illustrated below:



ICFID= Intermediate Care Facilities for Individuals with Intellectual Disability

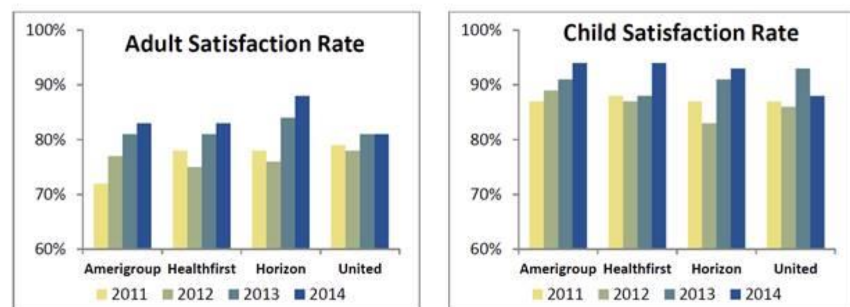
  The remaining $4 billion includes DSH payments, Medicare premiums for dually eligible individuals and administrative costs. Enrollment grew by 24 percent during FY 2015, but the overall average cost per beneficiary decreased by 7.7 percent from $9,690 in FY 2014 to $8,940 in FY 2015.

- **Key Initiatives.** Key initiatives and activities carried out in 2015 include a new Medicaid Management Information System, continuation of the Comprehensive Medicaid Waiver, launching of three Medicaid ACOs, efforts to integrate care and align financing for dual eligible beneficiaries, introduction of value based purchasing arrangements with health plans and hospitals, and implementation of eligibility process improvements.

- **NJ FamilyCare Snapshot.** In FY 2015, NJ FamilyCare served 1.7 million beneficiaries with 93 percent enrolled in managed care, performed on average 10,900 eligibility determinations per day, provided 5.5 million

rides to medical appointments, and paid over $65.8 million in incentive payments to 2,632 providers for implementing Electronic Health Records.

- **Health Plan Best Practices.** Medicaid health plans reported on the following best practices:
    - **Aetna Better Health of New Jersey:** Motivational Training for all Care Managers
    - **Amerigroup:** Program Integrity
    - **Horizon NJ Health:** Managed Long Term Services & Supports Technology-based Platforms
    - **United Healthcare:** Healthify App
    - **WellCare:** Field Outreach Care Management.
- **Quality Results.** Findings from the CAHPS®, HEDIS® and EQRO Annual Survey are provided for each health plan. The CAHPS® "Overall Rating of Health Care" is at a six-year high in both the Adult and Child CAHPS® surveys showing the general satisfaction of beneficiaries in managed care.



- **Looking Ahead to 2016.** Initiatives in 2016 focus on behavioral health, continued upgrades to infrastructure and mobilizing efforts to renew the NJ Comprehensive Waiver. Behavioral Health initiatives include: 1) a contract with an Interim Management Entity (IME) operated by Rutgers University Behavioral Health Care to assist beneficiaries with substance use disorders (SUD). The IME will begin clinical review and prior authorizations for SUD services this year; 2) expansion of the Behavioral Health Home program from two to five counties; 3) implementation of the Community Support Services (CSS) program for individuals with a serious mental illness; 4) presumptive eligibility training for behavioral health providers; 5) implementation of a grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to identify Certified Community Behavioral Health Clinics (CCBHC) and a prospective payment system for them; and 6) statewide efforts to combat the opioid overdose epidemic.

A complete copy of the 2015 Annual Report can be found here.

Departments Join in a Population Health Summit. On September 15, 2016, the Department of Health convened the state's first Population Health Summit. Eight state departments and six Christie Administration cabinet members

attended with community partners to address nutrition, health and wellness, social services, education, housing, transportation and environmental policies. Over 150 leaders from academia, foundations, health care, public health and community groups met to discuss strategies to improve the health of New Jersey residents and their communities. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Value Based Payment Roadmap. As part of its Delivery System Reform Incentive Payment program (DSRIP), the state is committed to shifting payments made by Medicaid managed care plans to providers away from fee-for-service arrangements and toward value-based payment (VBP) methodologies. As part of this transition, the state has convened a series of clinical advisory groups to develop recommendations that are specific to a given clinical condition. Three new recommendation reports have recently been released for review and public comment addressing the following three conditions: (1) chronic heart disease; (2) pulmonary; and (3) diabetes. Each report provides definitions and associated quality measures for each VBP arrangement. The recommendations reports are meant to inform providers and payers of the details of each arrangement, further supporting their transition to VBP. The public comment period ends on October 14, 2016. Read More

Delivery System Reform Incentive Payment (DSRIP) Project Approval and Oversight Panel. As part of the DSRIP program requirements outlined by the Centers for Medicare and Medicaid Services (CMS), the state is required to convene a stakeholder panel to review DSRIP applications. The Department of Health has extended the work of the panel, the Project Approval and Oversight Panel (PAOP), to serve as advisors and reviewers of Performing Provider Systems status and project performance during the five-year DSRIP program. The state is required to conduct a Mid-Point Assessment of all 25 Performing Provider Systems (PPS) around the state. The PAOP will receive a briefing on the mid-point assessment process and PPS progress on Friday, October 7 from 10:30 – 3:30. The meeting, to be held at the Empire State Plaza in Albany (Meeting Room # 6), will be open to the public, although there will be no opportunity for public comment. The meeting will also be webcast. Read More.

Home and Community Based Services Transition Plan. In June 2016, the state submitted a Home and Community Based Services Statewide Transition Plan to CMS, responding to CMS's final rule related to home and community-based services (HCBS) settings for Medicaid-funded, long term services and supports. The state recently held a webinar that provided an overview of its plan to come into compliance with the HCBS final rule, deliverables and priority concepts for agencies and providers of HCBS. In response to the questions received by participants of the webinar, the state recently posted a Q & A on the MRT website. Read More

Oregon

State Settles Lawsuit over Failed Exchange Website. *ABC News* reported on September 15, 2016, that Oregon settled a lawsuit with California-based software company Oracle America over the botched implementation of the state's Cover Oregon Exchange website. Under the terms of the settlement, the state will receive $35 million in cash and $60 million in software licensing agreements to help modernize its IT infrastructure. About $25 million of the cash will be used to offset legal fees, and the rest will help fund math and science programs in state schools. Oregon had paid Oracle $240 million to develop the Cover Oregon website, with most of the money coming from federal funds. The website failed to enroll a single Exchange member online; instead, the state hired 400 people to process paper applications and eventually joined the federal Exchange in March 2015. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Community HealthChoices Bidders File Protests. *Philly.com* reported on September 19, 2016, that four health plans that didn't win contracts to participate in Pennsylvania's Community HealthChoices Medicaid managed long-term services and supports program are protesting the awards. The four plans are Aetna Better Health, Molina Healthcare of Pennsylvania, WellCare of Pennsylvania, and Gateway Health Plan. The protests could delay implementation of the program, which was initially scheduled to begin July 1, 2017. Statewide contracts went to AmeriHealth Caritas, Centene's Pennsylvania Health and Wellness, and UPMC for You. Total annual revenues to the plans are expected to be at least $5.4 billion. Read More

CMS Grants Initial Approval to HCBS Statewide Transition Plan. Pennsylvania received initial approval of its Home and Community Based Services Statewide Transition Plan (STP) from the Centers for Medicare and Medicaid Services (CMS). Included in the approval letter is an attachment that outlines areas requiring additional improvements in order for the state to receive final STP approval. Specific CMS feedback on Office of Developmental Programs (ODP) Waivers and the implementation of Community HealthChoices, is also provided. It is anticipated that the Commonwealth will submit the STP for public comment again prior to resubmitting to CMS for final approval. Read More

Texas

Medicaid Cuts to Pediatric Therapists to Proceed Despite Protests. *The Dallas Morning News* reported on September 19, 2016, that Texas Medicaid payment cuts are proceeding for pediatric therapy providers who serve members of Medicaid managed care plans in rural areas of the state. The cuts are in the range of 10 percent to 30 percent for pediatric outpatient therapy and up to 60 percent for therapy assistants. Similar cuts to Medicaid fee-for-service providers have been temporarily blocked by a state court. The cuts, which will total $350 million, are expected to impact children with Down syndrome, hydrocephalus, and scoliosis, as well as certain foster children. Read More

Lawmakers Hear Criticism Over Medicaid Payment Cuts to Pediatric Therapists. *The Austin American-Statesman* reported on September 15, 2016, that advocates and families of disabled children criticized lawmakers at a public hearing for approving $350 million in Medicaid cuts to pediatric therapy providers. Although the Texas Supreme Court temporarily blocked the cuts, the injunction did not apply to managed care plans. The result, advocates say, has been reduced access to care as plans pass the cuts along to providers. Families are asking Texas lawmakers to restore the money. Read More

West Virginia

Medicaid Managed Care Contract Awards Announced. West Virginia announced its intention to award Medicaid managed care contracts to five managed care organizations, including four incumbents (Aetna's Coventry Cares, The Health Plan of the Upper Ohio Valley, Anthem's UniCare, and West Virginia Family Health) and a new entrant, CareSource. A definitive start date for when CareSource will begin enrolling Medicaid members has not been announced. Read More

State Saves More Than $1 Million by Enrolling Inmates in Medicaid. The *Charleston Gazette-Mail* reported on September 19, 2016, that the West Virginia Division of Corrections estimated that it saved $1.15 million from January to July 2016 by signing up eligible inmates for Medicaid. Medicaid covers inmates when they have been admitted to a hospital for more than 24 hours. Once the individual is enrolled, Medicaid will retroactively pay for the last three months of care delivered outside the prison. The state also helps inmates sign up for Medicaid prior to their release from prison, which may reduce recidivism by promoting access to mental and substance abuse treatment. Read More

Wisconsin

Family Care and Family Care Partnership RFP Released. The Wisconsin Department of Health and Human Services released a request for proposals (RFP) on September 19 for the delivery of the Family Care and Family Care Partnership Programs. Family Care and Family Care Partnership provide long-term care to low-income frail elderly and individuals with intellectual, developmental, or physical disabilities with long-term care needs. Proposals are due Nov. 9, 2016. The RFP can be accessed here.

National

Hospitals, States Oppose Changes to Uncompensated Care Payment Calculations Proposed by CMS. *Modern Healthcare* reported on September 19, 2016, that hospitals and states are concerned that the federal government's proposed changes in calculating uncompensated care reimbursements may be illegal and could destabilize safety net hospitals. Currently, the Centers for Medicare & Medicaid Services (CMS) pays hospitals the difference between the total cost of inpatient and outpatient care for Medicaid patients and total Medicaid payments received, including fee-for-service and managed care. The new rule, proposed in August, would also subtract any payments made by third parties such as Medicare and private insurance. In March, a New Hampshire court ruled that CMS cannot impose the policy as it stands. Industry

stakeholders say implementation of the rule should be on hold until all legal challenges have been resolved. Read More

HHS Grants Health Centers $87 Million for Health Information Technology. The Health and Human Services Commission announced on September 15, 2016, that it awarded $87 million in funding to 1,310 health centers to help pay for health information technology improvements during the transition to value-based care. Centers are required to use funding to purchase technology certified by the Office of the National Coordinator for Health Information Technology. The funding, the largest investment in health information technology directed towards health centers since 2009, is provided through the Affordable Care Act's Community Health Center Fund. Read More

Industry News

Community Health Systems Explores Sale. *Modern Healthcare* reported on September 16, 2016, that publicly traded hospital chain Community Health Systems is in early discussions with advisors about a possible sale of the company; however, the company said a final transaction is uncertain. CHS, which reported a $1.43 billion second-quarter loss, has been attempting to reduce debt and improve its financial performance in part by selling or spinning off certain facilities. Read More

Apollo Global Management Considers Acquiring Assets of Community Health Systems. *Reuters* reported on September 19, 2016, that Apollo Global Management is considering the acquisition of certain assets of hospital chain Community Health Systems, which said last week it was exploring the potential sale of the company. CHS is a publicly traded company with a market capitalization of $1.3 billion and total debt of more than $15 billion. It operators more than 158 hospitals in 22 states. Read More

PSA Healthcare Acquires Professional Pediatric Home Care. PSA Healthcare announced on September 19, 2016, that it has acquired Colorado-based Professional Pediatric Home Care (PPHC) and its subsidiary Reach Pediatric Therapy in Texas. PHHC provides home care services and therapy to medically fragile children. Financial terms were not disclosed. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
September 27, 2016	Nevada	Contract Awards	420,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
September, 2016	Massachusetts MassHealth ACO - Full	Applications Open	TBD
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
October, 2016	Washington, DC	RFP Release	200,000
October, 2016	Massachusetts	RFP Release	860,000
November 1, 2016	Arizona ALTCS (E/PD)	RFP Release	30,000
November 1, 2016	Texas STAR Kids	Implementation	200,000
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	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
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Contract Awards	177,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
August, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
October, 2017	Massachusetts	Implementation	860,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
April, 2018	Oklahoma ABD	Contract Awards	177,000
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 (June 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	119,814	34.2%	CalOptima; Care 1st Partner Plan, LLC; Community Health Group Partner; Health Net; Health Plan of San Mateo; Inland Empire Health Plan; LA Care; Molina; Santa Clara Family Health Plan; Anthem (CareMore)
Illinois	Capitated	4/1/2014	6/1/2014	136,000	48,218	35.5%	Aetna; Centene; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	10/1/2013	1/1/2014	97,000	13,038	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	38,767	38.8%	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; HAP Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	124,000	5,480	4.4%	There are 17 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	217	1.1%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	62,009	54.4%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400			Neighborhood INTEGRITY
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	5,419	10.1%	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	42,069	25.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	26,975	40.7%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**362,006**	**28.9%**	

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

HMA NEWS

HMA, Kaiser Family Foundation Release Report on Medicaid Coverage for Prescription Contraceptives

The Kaiser Family Foundation and Health Management Associates released a report on September 16, 2016, titled, Medicaid Coverage of Family Planning Benefits: Results from a State Survey. HMA's Jenna Walls and Kathy Gifford surveyed 40 states and the District of Columbia and found that Medicaid fee-for-service in all states covers daily oral contraceptives. Most also cover other prescription contraceptive methods, including diaphragms, rings, and patches. However, coverage of over-the-counter medication, including emergency Plan B medication, is more limited than prescription methods. Ten states do not cover condoms, spermicide, and sponges. Read More

Social Determinants of Health to Be Addressed at HMA Conference on Vulnerable Populations in Chicago, October 10-12, 2016

The impact of social determinants of health – including community-related factors such as unemployment, poverty, substance abuse, and inadequate access to care, housing, and education – will be the subject of important panel during HMA's inaugural conference on *"The Future of Publicly Sponsored Healthcare: Building Integrated Delivery Systems for Vulnerable Populations*," October 10-12 in Chicago.

Speakers will include Ross Owen, Director, Hennepin Health (Minnesota); Clemens Hong, MD, Medical Director for Community Health Improvement, LA County Department of Health Services, and Marcia Guida James, Senior Director, National Lead, Value Based Solutions, Aetna Better Health. The panel is titled, "Addressing Social Determinants of Health: Collaborative Approaches to Quality Improvement for Integrated Delivery Systems."

This premier conference, presented 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. More than 200 industry leaders have already registered to attend. Visit https://fpsh.healthmanagement.com/ for complete conference details or contact Carl Mercurio at (212) 575-5929 or cmercurio@healthmanagement.com.

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

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

Among other services, HMA provides generalized information, analysis, and business consultation services to investment professionals; however, HMA is not a registered broker-dealer or investment adviser firm. HMA does not provide advice as to the value of securities or the advisability of investing in, purchasing, or selling particular securities. Research and analysis prepared by HMA on behalf of any particular client is independent of and not influenced by the interests of other clients.