HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 28, 2016

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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IN FOCUS

WISCONSIN ISSUES FAMILY CARE AND FAMILY CARE PARTNERSHIP MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) RFP

This week, our *In Focus* section reviews the request for proposals (RFP) issued by Wisconsin's Department of Health Services (DHS) for the Family Care and Family Care Partnership programs. Family Care and Family Care Partnership provide Medicaid managed long term services and supports (MLTSS) to Medicaid beneficiaries in most counties in Wisconsin, largely through quasi-governmental county or long-term care district entities. However, these entities have been required by legislation, and are in the process of, transition to not-for-profit entities. Family Care and Family Care Partnership currently cover around 46,000 members, with 14,000 members in the 27 counties included in this RFP.

Family Care, Family Care Partnership Overview

Family Care and Family Care Partnership provide MLTSS to Medicaid-only and dual eligible individuals in Wisconsin who are 18 years of age or older and are

elderly, disabled, or have an intellectual or developmental disability. As of July 1, 2016, Family Care is available in 65 of 72 counties, while Family Care Partnership is available in 14 counties. Family Care MCOs provide only Medicaid State Plan LTSS and Medicaid waiver home and community based services (HCBS), while Family Care Partnership MCOs are also at risk for acute care benefits. As a result, Family Care Partnership MCOs must be licensed as a Medicare Advantage Dual Eligible Special Needs Plan (D-SNP). Family Care and Family Care Partnership enrollment is voluntary and is coordinated through local Aging and Disability Resource Centers (ADRCs), which conduct eligibility determinations and helps potential members understand their enrollment options if they should choose to enroll in Family Care.

Scope of RFP

The RFP is seeking to contract with MCOs to service 27 of the 65 existing Family Care counties and six of 14 existing Family Care Partnership counties. This represents around 14,000 out of 46,000 total members. There are six counties under the RFP that will not begin enrolling Family Care members until 2017 and, as a result, will not reach entitlement status until 2020 or beyond. Entitlement status is achieved 36 months after the Family Care benefit is first made available in a county and until then, enrollment will be limited to a certain number of waiting list enrollees per month. As a result, there is the potential for modest gains in enrollment in later contract years.

Family Care and Family Care Partnership Member Totals by Category of Eligibility - Statewide and Residing in RFP GSAs - July 2016

	Individuals with I/DD		Individuals who are Frail Elderly		Individuals w/ Physical Disability		Total - All Members	
	Total	RFP GSAs	Total	RFP GSAs	Total	RFP GSAs	Total	RFP GSAs
Care Wisconsin	3,051	2,132	1,624	1,171	1,424	862	6,099	4,165
Community Care	4,521	1,596	2,302	910	2,795	655	9,618	3,161
Community Care Connections of WI	2,726	1,611	1,728	1,061	1,544	905	5,998	3,577
ContinuUs	2,119	1,135	1,326	781	1,535	774	4,980	2,690
Lakeland Care District	2,092	-	993	-	1,186	-	4,271	-
My Choice Family Care	2,202	19	2,718	30	3,467	30	8,387	79
Western Wisconsin Care	1,499	-	1,025	-	1,255	-	3,779	-
Family Care Total	**18,210**	**6,493**	**11,716**	**3,953**	**13,206**	**3,226**	**43,132**	**13,672**
Care Wisconsin	186	62	514	75	780	72	1,480	209
Community Care	196	27	183	43	284	62	663	132
ICARE	138	-	59	-	637	-	834	-
Family Care Partnership Total	**520**	**89**	**756**	**118**	**1,701**	**134**	**2,977**	**341**
Grand Total	**18,730**	**6,582**	**12,472**	**4,071**	**14,907**	**3,360**	**46,109**	**14,013**

Source: WI DHS, HMA

Based on blended statewide per member per month (PMPM) spending data provided by the state's actuary for each category of assistance, contracts awarded under this RFP will represent close to $500 million in annual spending, assuming roughly 14,000 average members. This RFP amounts to roughly one-third of total statewide spending on Family Care and Family Care Partnership, which is nearly $1.5 billion for more than 46,000 total members.

RFP Timeline, Contract Awards and Term

An optional letter of intent to propose was due to DHS on September 27, with final proposals due on November 9. DHS tentatively plans to select bidders for negotiation and certification on January 17, 2017. Family Care will begin implementation in July 2017, with Family Care Partnership to follow in January 2018.

RFP Timeline	Date
Optional Letter of Intent	September 27, 2016
Written Questions Due	October 6, 2016
Question Responses Posted	October 13, 2016
Proposals Due	November 9, 2016
Notification of Intent to Award	January 17, 2017
Family Care Implementation	July 1, 2017
Family Care Partnership Implementation	January 1, 2018

Bidders must offer to serve an entire geographic service area (GSA) and should submit one proposal for each of the Family Care and Family Care Partnership programs. Bidders are not required to provide both Family Care and Partnership services as a condition of bidding. Contract terms will vary based on the start date of the program or geographic service area. Contracts will be for two years, with two optional renewals of two years each. However, regardless of contract start date, all contracts awarded under this RFP will expire on December 31, 2022.

Link to RFP

https://vendornet.wi.gov/Bid.aspx?NewBid=true&Id=8726501f-a07e-e611-80f7-0050568c7f0f

HMA Medicaid Roundup

Alabama

Alabama Medicaid Reverses Rate Cuts for Primary Care Doctors. *WVTM 13 News* reported on September 23, 2016, that Alabama restored enhanced Medicaid payments to primary care doctors – payments that had been cut earlier this summer – using money from an oil spill settlement. The "primary care bump" raises some reimbursement rates to Medicare levels. Despite the additional oil settlement funding, however, Alabama Medicaid Commissioner Stephanie Azar said that the state's Medicaid program still faces long-term financial challenges. Read More

Alaska

DHSS Settles Dispute with Xerox Over Medicaid Claims Payment System. *Alaska Dispatch News* reported on September 28, 2016, that the Alaska Department of Health and Social Services (DHSS) has settled a dispute with Xerox State Healthcare LLC over the implementation of the state's Medicaid claims payment system. DHSS filed a complaint with the Alaska Department of Administration in 2014 requesting $46.7 million in damages for what the state determined were flaws in the system, including untimely and inaccurate payments to made to Medicaid providers. The settlement ties a portion of the $26 million in payments still owed to Xerox to performance measures. Overall, the 10-year, $124.7 million contract began in 2007 and includes three options for one-year extensions beyond 2017 for approximately $15 million a year. Read More

Arkansas

Medicaid Expansion Enrollment Tops Expectations; Per Member Costs within Budget Cap. *The Times Record* reported on September 23, 2016, that enrollment in Arkansas's Medicaid expansion is higher than expected; however, per member costs of $480 in August were under the budget cap of $523, according to Cindy Gillespie, director of the state's Department of Human Services. Nearly 266,000 individuals have enrolled in the Arkansas's alternative Medicaid expansion program, 23,000 have enrolled in traditional Medicaid, and nearly 29,000 eligible individuals are in the process of enrolling. All told, total enrollment is expected to top 317,000, compared to an original estimate of 250,000. The alternative "private option" provides subsidies allowing individuals up to 138 percent of the federal poverty level to purchase private insurance. Read More

California

Insurance Commissioner Proposes State Public Option. *California Healthline* reported on September 22, 2016, that California Insurance Commissioner Dave Jones wants to create a state-run public option to increase competition for health insurance on the state Exchange. California has 11 plans participating its Exchange in 2017. A state-run public option would likely require both state and federal approval. Read More

Delaware

Day Treatment Programs for Children with Serious Mental Illness Gets Reprieve. *The News Journal* reported on September 22, 2016, that Delaware will continue to fund day treatment programs for children with serious mental and behavioral issues this school year, according to the state Department of Services for Youth, Children and Their Families. Day treatment services are funded by Medicaid and allow students to attend classrooms in settings adjusted to their needs. The Department had previously planned to end the program in December 2016 and replace it with treatment programs that keep students in the public schools in their home district. According to a letter from the department to school officials, the state will continue to evaluate the future of the day treatment program. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

MMA Plans Could Receive 7.5 Percent Rate Increase. *Politico* reported on September 22, 2016, that health plans in Florida's Managed Medical Assistance (MMA) program could receive an average 7.5 percent rate increase to cover the cost of physician incentive payments, access to Hepatitis C drugs without prior authorization, and other recent changes to the state's Medicaid program. The increase would be retroactive to September 1, 2016. Excluding the impact of program changes, the rate increase to MMA plans would be 3.7 percent. The increase applies only to MMA plans, which has have more than 3.1 million Medicaid members. An additional 80,511 Medicaid members are enrolled in managed long-term care plans. Read More

State Wins Ruling in Lawsuit Regarding Placement of Children with Disabilities in Nursing Homes. *The Miami Herald* reported on September 21, 2016, that a federal judge in Florida rejected a three-year-old lawsuit alleging that the state was discriminating against children with intellectual and developmental disabilities by placing them in nursing homes. U.S. District Judge William J. Zloch ruled that the U.S. Department of Justice, which filed the lawsuit, lacked the standing to sue a state under the federal Americans with Disabilities Act. Read More

Idaho

Legislative Committee to Hold Public Hearing on Medicaid Expansion. The *Idaho Statesman* reported on September 27, 2016, that the Idaho legislative committee reviewing Medicaid expansion will hold a public hearing on September 28, with two hours planned for comments from advocates and other stakeholders. The state has 78,000 residents in the health coverage gap between Medicaid and the Exchange who could benefit from expanding Medicaid. Read More

Nebraska

State May Need to Repay $32 Million in Federal Funds for Waiver Services. *The Journal Star* reported on September 27, 2016, that Nebraska may need to pay back $32 million in federal Medicaid funds, after the state uncovered that it had failed to comply with federal guidelines for reimbursing providers of waiver services for individuals with intellectual and developmental disabilities. The Nebraska Department of Health and Human Services found that the state may have been approving payment for services beyond the 35-hour federal limit, a discovery it made while working on a renewal of its home and community-based services (HCBS) waiver. Nebraska and the Centers for Medicaid and Medicare Services will review claims submitted by 39 providers since July 1, 2014. In the meantime, providers are concerned that rates could be cut in half effective October 1 without the federal portion. Read More

BCBS of Nebraska to Exit Exchange in 2017, Citing $140 Million in Losses. *WOWT News* reported on September 23, 2016, that Blue Cross Blue Shield of Nebraska announced it would exit the state's federally run health insurance Exchange in 2017, after reporting losses totaling $140 million. The move will impact 20,000 members in the state. With Blue Cross Blue Shield's exit, Aetna and Medica will be the only two plans offering individual Exchange plans in the state in 2017. Read More

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Senate Works on Legislation to Resolve Balance Billing Disputes. Senator Joseph Vitale spent August meeting with provider representatives, insurance officials, and leaders of the New Jersey Policy Perspective representing patient rights to discuss changes to S-1285, which seeks resolution for unexpected patient balance billing. NJ Spotlight gave an update on the efforts to reach consensus on a plan to "limit 'surprise' out-of-network medical charges for New Jersey residents." Read more.

Quality Institute Plans Medicaid 2.0 Stakeholder Summit. In October 2016 the New Jersey Health Care Quality Institute will hold two Medicaid 2.0 Stakeholder Summits to develop a Blueprint for the future of the New Jersey Medicaid program. The Summits are funded by The Nicholson Foundation and are designed to engage stakeholders on what is working and what isn't working and to identify Medicaid innovations to improve the state's Medicaid program. Breakout sessions will cover: 1) access and quality, 2) behavioral health integration, 3) eligibility and enrollment, 4) NJ purchasing

authority/administration, and 5) value-based purchasing. The Summits will take place on:

- October 6, 2016 from 9 am – 3 pm in New Brunswick
- October 14, 2016 from 9 am – 3 pm in Mt. Laurel

Click here to register.

New York

HMA Roundup – Denise Soffel (Email Denise)

New York Medicaid Spending Coming Down. A recent analysis by the Empire Center indicates that New York is bending the Medicaid cost curve. The report notes that per-recipient spending by New York's Medicaid program has long far exceeded national averages, but that the gap has narrowed significantly during Governor Andrew Cuomo's term, with New York's spending rate falling at about twice the national average between 2010 and 2014. Using CMS data, the Empire Center derived approximations of annual per recipient spending. The analysis found that New York's Medicaid spending per recipient dropped from $10,684 to $8,731, or 18 percent, between 2010 and 2014. The national average fell 9 percent, from $7,645 to $6,987. One explanation for the decline is the state's deliberate effort to control cost, part of the work of the Medicaid Redesign Team. Among other steps, the MRT has led to a global cap on the growth of overall Medicaid spending at the medical inflation rate and eliminated automatic annual increases in provider payments. The Care Management for All strategy, where virtually all beneficiaries are enrolled in managed care plans, and virtually all benefits are provided through managed care arrangements, has also contributed to spending decreases. Read More

The Growth of Medical Homes in New York State. New York State continues to lead the nation in adoption of the patient centered medical home model by primary care practices, according to a recent report by the United Hospital Fund. New York currently accounts for one out of eight patient-centered medical home (PCMH) providers in the nation, as recognized by the National Committee for Quality Assurance (NCQA). The report examines the continued growth of the medical home model in New York, breaking it out by region, degree of certification, and type of facility. For the third year in a row, PCMH growth in New York City has lagged the growth in other regions. Additionally, the settings in which the PCMH providers work is changing. In 2013, New York's PCMH providers were equally split between clinic-based providers and private practices. Since then, PCMH growth in non-clinic settings has slowed, and growth in small practices appears to be stalled. Since 2013, 80 percent of the growth in PCMH providers across the state has been in hospital clinics, most of them outside New York City. The report also describes the number of concurrent and competing medical home models, several of which are being supported by New York State initiatives. The proliferation of models has created some confusion among providers, and raises some logistical questions for the State as it continues to promote primary care: how to align the competing programs, how to encourage multipayer support, how to ensure that medical homes can still start up under value-based payment systems, and how to make sure small practices aren't left behind in these efforts. Read More

New York's E-Prescribing Monitoring System. New York State Attorney General Eric Schneiderman has asked Governor Andrew Cuomo to veto two bills related to the state's three-year-old electronic prescription monitoring system. According to the Albany Times Union, the attorney general is concerned that changes to the Internet System for Tracking Over-Prescribing, would create loopholes in the monitoring system. Implemented in 2013, I-STOP is an attempt to rein in the overuse of prescriptions painkillers. It requires doctors to write prescriptions electronically in most cases and to check a database of prescriptions for controlled substances before writing the prescription, to prevent patients from conning multiple physicians into giving them scripts for narcotics. One bill would exempt nursing home doctors from the e-prescribing rule; the other bill would exempt providers who write paper prescriptions in certain situations, such as when a prescription will be filled out of state, from a rule requiring them to report the prescriptions to the state Department of Health. The attorney general fears that these changes would allow doctors to avoid compliance with I-STOP and allow patients who are "doctor shopping" for prescriptions to falsely claim they will fill the prescription out of state. Both bills are under review in the Governor's office. Read More

Delivery System Reform Incentive Payment (DSRIP) Program Learning Symposium. The NYS Department of Health hosted its 2nd Annual DSRIP Statewide Learning Symposium last week in Syracuse. The symposium brought together representatives from the 25 regional Performing Provider Systems that are responsible for implementing the Delivery System Reform Incentive Payment (DSRIP) Program, an initiative aimed at promoting community-level collaborations and focus on system reform, specifically a goal to achieve a 25 percent reduction in avoidable hospital use over five years. The purpose of the NYS DSRIP PPS Learning Symposium is to promote and support an environment of learning and information sharing based on data transparency within the New York healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in New York. The Learning Symposium brings PPSs together for a multi-day opportunity to focus on DSRIP and seek peer-to-peer (provider-to provider) and community stakeholder input on project level development of action plans, implementation approaches and project assessment. The state has posted links to many of the Learning Symposium presentations here.

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio Joint Medicaid Oversight Committee Receives Actuary Report. *Gongwer Ohio* reports that the Joint Medicaid Oversight Committee (JMOC) received the actuary report (link to report) setting preliminary estimates of Medicaid inflation. Optumas projected the per-member per-month cost for Medicaid in the 2018-2019 biennium to be an average of 2.6% to 3.9% higher per year. The main drivers of inflation were pharmacy spending and population mix. The committee plans to select the target rate at its October 20 meeting. State law requires that the Ohio Department of Medicaid stay under the rate set by JMOC or the three-year average consumer price index, whichever is lower. Read More

Changes to Medicaid Billing Codes for Behavioral Health Services Is Driving Workforce Concerns. *Gongwer Ohio* reports the Joint Medicaid Oversight Committee heard concerns that changes proposed in behavioral health redesign will preclude certain employees from delivering services. "The behavioral health redesign is placing an emphasis on the value of individuals with a higher level credential," said Nicholas Rees, president of the Buckeye Ranch. The administration says the changes are need to come into alignment with national billing standards and drive more patients toward highly skilled mental health professionals. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Consortium Can Help More People with Mental Health Needs Get Insurance because of Grant Award. As reported by *Newsworks*, a consortium of behavioral health groups in Pennsylvania has won a $453,000 grant to help people with mental health needs get insurance through the Affordable Care Act. That grant is part of $63 million awarded to hire "navigators" to guide people through enrollment. "Before the Affordable Care Act, it was very difficult for people with mental health needs to easily get a plan that worked for them" said Lynn Keltz, executive director of the Pennsylvania Mental Health Consumers Association, which is part of the consortium that has helped over 3000 people get health insurance in the last three years. Read More

Pennsylvania Governor Wolf's Administration Addressing Food Security in the Commonwealth. Governor Wolf's administration unveiled, in a press release, its food security plan called, "Setting the Table: A Blueprint for a Hunger-Free PA" as well announcing the receipt of a federal grant to address hunger in younger children. The plan will be administered by the Governor's Food Security Partnership which is comprised of 6 state agencies (Aging, Agriculture, Community and Economic Development, Human Services, Health and Education). "Over the last year, the Partnership has worked with public, charitable, and private leaders in food security to develop the goals and initiatives needed to create a hunger-free Pennsylvania," said DHS Secretary Ted Dallas. "For many Pennsylvanians, food insecurity is a daily part of life. It is estimated that more than 1.7 million Pennsylvanians, or 13.8 percent, experience food insecurity – we believe that the goals established in the blueprint will change that." Read More

Texas

State Cleared to Proceed with Medicaid Cuts to Children's Therapy Services. *The Texas Tribune* reported on September 23, 2016, that the Texas Supreme Court declined to hear a lawsuit seeking to block Medicaid payment cuts for children's therapy services. Therapists, including speech, physical, and occupational therapy providers who treat children with disabilities, will see reimbursement rates cut by up to 25 percent. Rachel Hammon, executive director of the Texas Association of Home Care and Hospice, called on Texas Governor Greg Abbott to intervene. Providers and advocates fear that the cuts will put providers out of business and potentially prevent as many as 60,000 children from receiving services. Read More

Virginia

DMAS Selects Plans for Negotiation Phase of MLTSS RFP. The Virginia Department of Medical Assistance Services has announced the health plans selected for negotiation of contracts for the state's new managed long-term services and supports (MLTSS) program. The seven health plans selected for negotiations for all six regions are:

- Aetna Better Health of Virginia
- Anthem HealthKeepers Plus
- Humana
- Magellan Complete Care of Virginia
- Optima Health
- United Healthcare,
- Virginia Premier Health Plan

With the exception of United and Magellan, all the selected plans are incumbents in the state's Medallion 3.0 program for the traditional Medicaid population and individuals in the aged, blind, and disabled category of eligibility or the Commonwealth Coordinated Care program for dual eligibles. However, Magellan does hold a managed behavioral health contract in the state. Final contract awards are anticipated by the end of the year. The statewide program will be phased in across the six regions, with implementation expected to begin in the summer of 2017. Enrollees in Commonwealth Coordinated Care and the aged, blind, and disabled population enrolled in Medallion 3.0 are expected to be transitioned to the MLTSS program starting in 2018. The initial period of the contract will be five years with five one-year renewal options.

National

NCQA Releases 2016 Health Insurance Plan Ratings. The National Committee for Quality Assurance (NCQA) announced that it has released its annual Health Insurance Plan Ratings for 2016, available here. NCQA analyzed 1,401 health plans and rated 1,012. Of these, 503 were private, 338 were Medicare, and 171 were Medicaid. A total of 105 plans received scores of 4.5 or 5.0, the highest score possible. Twenty-seven earned the ratings of 1.5 or 2.0. States with the most high-ranking plans included Massachusetts, Rhode Island, Wisconsin, Maine, New Hampshire, Minnesota, Vermont, New York, Hawaii, and Iowa. Read More

Majority of States Join Antitrust Lawsuit Against Manufacturers of Suboxone. *Governing* reported on September 23, 2016, that a group of 36 states have joined in a federal antitrust lawsuit against the manufacturers of Suboxone, a prescription drug used to combat opioid addiction. The suit was filed on September 22, 2016, in the U.S. District Court for the Eastern Division of Pennsylvania and claims that three companies – Reckitt Benckiser Pharmaceuticals, Indivior, and MonoSol Rx – conspired to keep generic versions of Suboxone off the market by making unnecessary changes to maintain the drug's patent. Suboxone costs between $137 and $477 for a 30-day prescription. The suit seeks to recoup costs for purchasers of the drug. Read More

National Council on Disability to Host Medicaid Managed Care Meeting. *Kansas Health Institute* reported on September 26, 2016, that the National Council on Disability will host a meeting in Baltimore for state legislators and federal officials concerning the privatization of state Medicaid programs. In addition to

representatives from the Centers for Medicaid and Medicare Services, officials and disability advocates from Arizona, Florida, Kansas, Maryland, New Hampshire, Pennsylvania and Wisconsin are expected to attend. Other federal officials will include Gary Graca of the Civil Rights Division of the U.S. Department of Justice, Aaron Bishop of the U.S. Department of Health and Human Services, and Maria Town, associate director of the White House Office of Public Engagement. Read More

Industry Research

Health Plan Consolidation Drove Down Total Number of Medicaid MCOs in 2016. *Modern Healthcare* reported on September 23, 2016, that consolidation among health plans resulted in a decrease in the number of plans in the Medicaid managed care market for the first time in three years, with the total number of plans falling to 183 in 2016, compared to 195 in 2015. Mergers and acquisitions were the biggest driver, affecting 16 Medicaid managed care plans in 2016. Another five plans exited the market. All told, only 11 Medicaid managed care plans have more than 1 million members. Read More

Industry News

Steward Health Care System Receives $1.25 Billion Investment From MPT. Boston, Massachusetts-based Steward Health Care System announced on September 26, 2016, that it had received a $1.25 billion investment from Medical Properties Trust (MPT), including $1.2 billion in a real estate sale-leaseback transaction and $50 million for a limited equity stake. MPT has also committed to participate in up to $1 billion in future Steward hospital acquisitions. The transaction is expected to close during in 2016. Read More

Tianqiao Chen Increases Stake in Community Health Systems. *Modern Healthcare* reported on September 28, 2016, that Chinese investor Tianqiao Chen has bought nearly 4.5 million shares in Community Health Systems (CHS) over the past month. He now holds 15.5 million shares, making him the company's largest shareholder with a 13.8 percent stake. CHS is exploring options, and private equity group Apollo Global Management is reportedly interested in purchasing CHS assets. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
September, 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
November 9, 2016	Wisconsin Family Care/Partnership (MLTSS)	Proposals Due	14,000
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 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
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	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
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 Behavioral Health Expertise on Display at Conferences

HMA's behavioral health team has extensive clinical, policy, operations and funding expertise in mental health and substance use disorder prevention and treatment. Recently members of our behavioral health team shared their expertise at two notable conferences.

HMA Principal Meggan Schilkie was a featured speaker at The USA National Clubhouse Conference, Sept. 18-20 in Washington, DC. Meggan joined Maine Gov. Paul LePage and Melissa Harris of CMS in talking about the importance of and strategies for advocating with government - especially around the long-term sustainability of clubhouse programs in an increasingly Medicaid-funded environment. Clubhouses are an evidence-based practice for providing psychosocial rehabilitation and vocational supports to people with serious mental illness. Over 320 local Clubhouses around the world offer people living with mental illness opportunities for friendship, employment, housing, education and access to medical and psychiatric services.

The conference was presented by Clubhouse International. Other conference speakers included Ron Honberg, J.D., senior policy advisor, Advocacy & Public Policy, National Alliance on Mental Illness (NAMI); Andrew Sperling, J.D., director of the Federal Legislative Advocacy Program, National Alliance on Mental Illness (NAMI); and Rebecca Farley, senior director, Policy & Advocacy, the National Council for Behavioral Health.

Some 200 people attended a conference HMA colleagues from our Boston office and our behavioral health team helped organize for the Association for Behavioral Healthcare and in partnership with the Massachusetts Association for Mental Health. Ellen Breslin and Tom Dehner from HMA's Boston office worked with behavioral health experts Meggan Schilkie and Barbara Leadholm to organize content for the Sept. 27 conference, "Hitting the Ground Running: What Behavioral Health Providers Need to Know About Accountable Care Organizations (ACOs) and Value-Based Purchasing. The conference was designed to de-mystify the complexity of MassHealth payment and care delivery reform and to help behavioral health providers plan for the transition to value-based purchasing.

HMA has extensive experience helping organizations shift from volume-based to value-based payment. Our new web-based, self-assessment will help you evaluate your readiness across multiple domains and identify critical care delivery, financial, and operational elements that will help you become ready to succeed under existing and emerging value-based payment models.

Learn more about our Value-Based Payment Readiness Assessment Tool.

Read the article HMA Principals Meggan Schilkie and Josh Rubin wrote, "The Promise and Peril of Value Based Behavioral Health Care," as featured in the summer issue of the Behavioral Health News.

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.

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