HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

March 8, 2017

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THIS WEEK

IN FOCUS

NEW JERSEY HEALTH CARE QUALITY INSTITUTE ISSUES MEDICAID 2.0 BLUEPRINT FOR THE FUTURE

This week, our *In Focus* section comes to us from HMA Principal Karen Brodsky and Research Assistant Anh Pham, both of our New York City office. Anh and Karen provide a review of the "Medicaid 2.0 Blueprint for the Future" issued by the New Jersey Health Care Quality Institute (Quality Institute).

Funded by The Nicholson Foundation, the Quality Institute embarked on a year-long project convening a wide variety of stakeholders in New Jersey with the goal of redesigning and modernizing the State's Medicaid program. The report is a culmination of 24 recommendations to promote the efficient delivery of quality healthcare services to New Jersey's most vulnerable populations.

Overview

New Jersey's Medicaid program covers 1.7 million residents and 46 percent of the children in the state. It operates with a budget of approximately $15 billion or close to 20 percent of the state's budget. In the last few years the state implemented Medicaid Expansion, which added over 500,000 additional lives to Medicaid enrollment. As a Medicaid managed care application state, meaning contracts are not competitively bid, 95 percent of its Medicaid enrollees receive their benefits from one of five managed care organizations. The Division of Medical Assistance and Health Services (DMAHS) oversees the Medicaid program and has made improvements under the 1115 waiver, such as implementing managed long term services and supports (MLTSS) for 32,500 older beneficiaries and individuals with physical disabilities. It has also managed the implementation of a Medicaid Accountable Care Organization (ACO) demonstration, integrated care and aligned financing for dual eligible beneficiaries, and a new Medicaid Management Information System.

While the report recognizes the strides the Medicaid program has made in recent years under the comprehensive 1115 Waiver, it also seeks to address program limitations concerning outdated technology, misaligned incentives, and lack of access to timely and accurate data, which can affect the delivery of quality care.

Methodology

This project assigned healthcare experts to one of five Transformation Teams: 1) Access and Quality, 2) Behavioral Health Integration, 3) Eligibility and Enrollment, 4) Purchasing Authority, and 5) Value Based Purchasing. Over ten weeks, each of the teams met to assess the problems of each area and make consensus recommendations.

Modern Foundation

Given the outdated governing structure of New Jersey's Medicaid program, the report provides recommendations to update the infrastructure of the program in a way that promotes higher quality, efficiency, and effectiveness. These recommendations include:

1. establishing a New Jersey Office of Health Transformation;
2. increasing transparency of Medicaid data;
3. improving eligibility processing;
4. expanding use of telehealth services;
5. establishing a unified single license system for integrated health;
6. upgrading Medicaid regulations and the managed care contract;
7. and reducing fraud, waste, and abuse.

Foundational Medicaid Reforms

Additionally, the report stresses the importance of implementing pending State reform initiatives to enhance the administrative function of the system. These recommendations include:

1. implementing a statewide universal provider credentialing system;
2. improving the accuracy of provider network directories; and
3. standardizing Medicaid quality measures.

Upgrades to the Medicaid Model

Due to New Jersey's fragmented healthcare system, the report makes recommendations to advance the integration of care. These recommendations include:

1. integrating physical, mental health and substance use disorder service delivery;
2. establishing Medicaid coverage for long-term residential services for substance use disorders; and
3. reconvening the Behavioral Health Integration Advisory Council.

Financing Reform

Taking into consideration the State's current fiscal situation and the potential loss of federal funding, the report makes two sets of recommendations: one set of recommendations leveraging the purchasers' powers and another leveraging value-based purchasing and alternative payment models. These recommendations include:

Purchaser Power:

1. maximizing pharmaceutical cost savings; and
2. enhancing MCO performance incentives.

Value Based Purchasing and Alternative Payment Models:

1. initiating Episode of Care demonstration;
2. expanding Patient Centered Medical Home statewide;
3. developing clinically integrated networks of care for children;
4. developing Patient Centered Medical Home for medically complex children; and
5. establishing a Value-Based Purchasing Advisory Council.

Path to Population Health

The last set of recommendations seek to address the long-term health of the Medicaid population. These recommendations include:

1. improving maternal and family health;
2. evolving the Medicaid ACO demonstration;
3. advancing a Next Generation Delivery System Reform Incentive Payment (DSRIP) program; and
4. improving end of life care.

Conclusion

The Quality Institute anticipates that implementing these recommendations could save New Jersey's Medicaid program between $100-300 million of New Jersey's projected annual direct spending of $11 billion. With the support of

The Nicholson Foundation, the Quality Institute will continue to engage stakeholders to transform New Jersey's Medicaid program.

Link to Report, More Information

http://www.njhcqi.org/initiative/medicaid-2-0/

HMA Medicaid Roundup

Arizona

AHCCCS Announces ALTCS Contract Awards. The Arizona Health Care Cost Containment System announced on March 3, 2017, that it awarded contracts for the Arizona Long Term Care System (ALTCS) program for individuals who are elderly and/or have a physical disability. UnitedHealthcare Community Plan, Southwest Catholic Health Network Corporation dba Mercy Care Plan, and Banner-University Family Care will serve more than 26,000 members who are elderly, blind, or disabled and at risk of institutionalization. Contracts will be effective October 1, 2017, and will run for up to seven years. United, Mercy Care, and Centene's Bridgeway Health Solutions were the incumbents. Read More

Arkansas

Governor Seeks Medicaid Expansion Work Requirements, Limits on Eligibility. *The AP/SFGate* reported on March 6, 2017, that Governor Asa Hutchinson plans to ask the Centers for Medicare & Medicaid Services (CMS) for approval to add work requirements to the state's Medicaid expansion and lower its eligibility cap from 138 percent of the federal poverty level (FPL) to 100 percent, potentially removing 60,000 individuals from the program. Those removed from the program would be likely be eligible for subsidies to buy coverage through the Exchange. The expansion program currently requires the state to refer beneficiaries to job and training programs, but members are not required to participate. The hybrid Medicaid expansion, which provides Medicaid funds for the purchase of private insurance, currently covers 300,000 individuals. Governor Hutchinson is asking CMS to approve the modifications by June of this year in order to implement by 2018. Read More

Colorado

UnitedHealthcare Completes Acquisition of Rocky Mountain Health Plans. *Denver Business Journal* reported on March 2, 2017, that UnitedHealthcare had completed its acquisition of Rocky Mountain Health Plans, a Colorado health plan that operates largely in Mesa County. Funds from the acquisition will be used to create a $36.5 million foundation serving Colorado's Western Slope. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

House Panel Approves Bill to Repeal Certificate of Need Process for Hospitals, Other Facilities. *Health News Florida* reported on March 8, 2017, that the Florida House Health Care Appropriations Subcommittee approved legislation to repeal the certificate-of-need (CON) regulatory process for the building of new hospitals, nursing homes, and hospice facilities. State Representative Alex Miller (R-Sarasota) stated that the CON process, which requires approval from the Agency for Health Care Administration (AHCA) for new projects, reduces competition and impacts access to care. Others argue that eliminating the CON process would lead to new facilities that could cut off patients from existing providers, lowering occupancy rates and diminishing quality of care. Read More

Illinois

Advocate Health Care, NorthShore Abandon Plans to Merge. *Modern Healthcare* reported on March 7, 2017, that Advocate Health Care and NorthShore University HealthSystem will not merge after a federal judge ruled against the proposed deal. In 2015, the Federal Trade Commission (FTC) sought to block the merger. While U.S. District Judge Jorge Alonso sided with the health systems, the FTC appealed and the ruling was eventually reversed. The FTC argued that the merger would ultimately lead to higher prices for consumers. Read More

Governor Rauner Looks to Arizona, Ohio to Revamp Medicaid Managed Care Program. *Modern Healthcare* reported on March 7, 2017, that Illinois Governor Bruce Rauner is planning to revamp the state's Medicaid managed care program to save money. Currently, 57 percent of the state's proposed fiscal 2018 budget is allotted to health care. Rauner is looking to other states, including Arizona and Ohio, as potential cost-saving models. Rauner plans to reduce the number of Medicaid managed care plans, expand managed care statewide, and focus on mental health and addiction. Illinois currently contracts with 12 MCOs, covering around 65 percent of all Medicaid enrollees. According to a 2015 state report card, about a third of the state's Medicaid plans received below-average grades on addiction treatment and continued care for individuals with a mental illness. Read More

Iowa

Medicaid MCOs' Losses in First Year Detailed in Financial Reports. *The Gazette* reported on March 6, 2017, that two of the three Medicaid managed care organizations (MCOs) in Iowa lost hundreds of millions of dollars in their first year, according to financial reports filed with the Iowa Insurance Division on March 1, 2017. AmeriHealth Caritas reported losses of $300 million, and Amerigroup reported losses of more than $133 million. The results are in line with projections reported to legislators in February. While UnitedHealthcare is not required to file a financial report for its Medicaid business in the state given that it operates other lines of business, the company stated it lost approximately $100 million. The Department of Human Services maintains that capitated payment rates made to plans are actuarially sound. The state

and insurers will negotiate new capitated rates in April for the fiscal year starting July 1, 2017. Read More

Massachusetts

MassHealth Selects Optum as the Third Party Administrator for LTSS Programs. Massachusetts announced February 28, 2017, a three-year contract with Optum Government Solutions, which will serve as Third Party Administrator of the state's MassHealth fee-for-service Long-Term Services and Supports (LTSS) program. The LTSS program provides home health care services, adult day health and durable medical equipment for individuals with physical, intellectual or developmental disabilities, or who need support with activities of daily living. The contract begins April 15, 2017. Read More

New Hampshire

Implementation of Lower DSH Payments to Hospitals Blocked by District Court. *New Hampshire Union Leader* reported on March 3, 2017, that U.S. District Court Judge Landya McCafferty sided with the New Hampshire Hospital Association regarding a $33 million shortfall in state Medicaid Disproportionate Share Hospital (DSH) payments. New Hampshire hospitals were expecting $224 million in DSH payments. However, the state only budgeted $191 million after factoring in third-party payments hospitals receive, primarily from Medicare, which hospitals successfully argued was a break with long-standing federal policy. The ruling means that New Hampshire Governor Chris Sununu will have to revise his budget for the next two fiscal years with higher DSH payments to hospitals. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

OSCAR Insurance Plan Continues to Lose Money. *Bloomberg News* reported that Oscar Insurance Corp lost more than $200 million in 2016. The company offered plans in four states in 2016 and lost about $204.9 million on premium revenue of $425.9 million, according to filings. The loss widened from $121.7 million in 2015. In New York, its largest market, Oscar reported $246,266,928 in premium revenue, and $124,072,278 in net losses for 2016. The plan has enrolled over 54,000 people for 2017. Oscar has moved to cut costs by narrowing its network to a smaller set of hospitals and doctors; it also raised premiums about 20 percent in New York. The company is also planning to sell health insurance to small businesses. Read More

New York Republican House Delegation Supports Maintaining Medicaid Expansion, Opposes Block Grants. *Politico* reported that all nine Republican members of New York's Congressional delegation support maintaining the Medicaid expansion that was part of the Affordable Care Act, and oppose any efforts to block-grant the Medicaid program. New York's Medicaid program has always been generous, and is one of the most expensive in the country. Covering over 6 million people, roughly one-third of the state's population relies on Medicaid. The delegation is not opposed to a per capita grant, provided that New York is fairly compensated for the cost of covering an individual. Read More

DOH Issues RFA for Children's Environmental Health Center of Excellence. The New York State Department of Health, Division of Environmental Health Assessment, Bureau of Environmental and Occupational Epidemiology, is soliciting applications from not-for-profit organizations to contract for a Children's Environmental Health Center of Excellence (The Center of Excellence). A contract will be awarded to one not-for-profit organization to establish this Children's Environmental Health Center of Excellence. The Center of Excellence that is chosen will develop a statewide network of Children's Environmental Health Centers (the Network Centers). These statewide Network Centers will serve as a valuable resource in the recognition and treatment of environmental exposures adversely affecting the health of New York's children. Approximately $2,000,000 will be awarded annually. The award will be distributed on a competitive basis to one Center of Excellence within New York State that demonstrates the capability to coordinate a statewide network that provides all New York State families reasonable access to services. Questions are due by March 9, 2017; proposals are due April 26, 2017. Read More

Oregon

Oregon Study Highlights Upsides, Limitations of Medicaid Expansion. *Vox* reported on March 6, 2017, that according to the Oregon Health Insurance Experiment study, Medicaid expansion coverage resulted in improvements in diabetes care, access to care, and perceived health status, as well as a significant reduction in the risk of depression. Medicaid coverage also reduced financial strain on individuals. However, the study found Medicaid coverage had little-to-no measurable impact on common health measures like blood sugar levels, or the prevalence of high cholesterol and of high blood pressure. Generally, the randomized study concluded those who gained Medicaid coverage were better off than those who did not. Medicaid coverage increased utilization of health care services, including increased physician visits, prescription drugs, and mammograms. Additionally, out-of-pocket medical expenses that exceeded 30 percent of income were nearly eliminated and the number of medical bills sent to collections agencies dropped by 25 percent. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medicaid Managed Care Contract Start Date Again Delayed. The Pennsylvania Department of Human Services announced another delay in the rollout for new Medicaid management contracts. The new initial effective date for the Southwest and Northwest Zones is January 2018, postponed from June 2017.

Region	HealthChoices Start Date	Community HealthChoices Start Date
Southwest	January 2018	January 2018
Northwest	January 2018	January 2019
Northeast	March 2018	January 2019
Southeast	July 2018	July 2018
Lehigh/Capital	January 2019	January 2019

This postponement is to allow sufficient time for transition after bid protests from non-selected bidders are resolved. The delay is also part of the Commonwealth's response to the concerns of consumers and stakeholders concerning the timeline of implementation, as well as how the HealthChoices agreements will affect the planned implementation of Community HealthChoices, Pennsylvania's managed long-term services and supports program. Read More

Pennsylvania Tightens Medication Rules to Help Combat Opioid Crisis. Governor Tom Wolf announced several new steps Pennsylvania is taking to help combat the opioid addiction crisis. These steps, involving rules around cash payments, required office visits, and provider eligibility, will help tighten the rules under which medication such as buprenorphine can be prescribed under the Medicaid program. High-volume providers with poor quality records will be referred to the DHS Bureau of Program Integrity. In addition to the latest actions, the Commonwealth has developed new prescribing guidelines, limited the amount of opioids that can be prescribed to a minor to seven days, and strengthened the Prescription Drug Monitoring Program (PDMP) so that doctors are required and able to check the system each time they prescribe opioids. New investments in battling the opioid epidemic in the 2017-2018 budget total $108.3 million in state and federal funds. Read More

DHS Releases Amendment to the Adult Autism Waiver. The Department of Human Services made available for public review and comments the Department's proposed amendment to the Adult Autism Waiver. There is no anticipated fiscal impact in Fiscal Year 2017-2018. The Department has proposed the seven changes to the Adult Autism Waiver effective July 1, 2017. These changes include revised definitions and bringing the waiver into compliance with the Centers for Medicare & Medicaid Services (CMS) final rule for home and community-based services. Read More

Texas

House, Senate Pass Bills to Overhaul Child Welfare System. *The Texas Tribune* reported on March 1, 2017, that both the Texas House and Senate have passed bills to change how the Texas Department of Family and Protective Services cares for children through the state's child welfare system. Overhauling the system is a priority of Texas Governor Greg Abbott. The Senate passed:

- Senate Bill 11: creates a community based care program in which the Department contracts with local not-for-profit organizations to handle casework. SB 11 includes a pilot program for not-for-profit organizations to handle behavioral health care for children, requiring that managed care organizations be notified of a child's placement change within 24 hours, and requiring children under conservatorship to have medical exams within three days of entering into the system. It also requires the Department to retain abuse and neglect records for longer periods of time.

The House passed:

- House Bill 4: allows monthly payments for relatives caring for children in their families who have been abused.

- House Bill 5: makes the Department of Family and Protective Services a standalone agency.

Read More

National

House Republicans Release ACA Replacement Plan, To Cap Federal Medicaid Funding. *Kaiser Health News* reported on March 6, 2017, that U.S. House Republicans released an Affordable Care Act (ACA) replacement plan, which includes capping federal funding for Medicaid, ending extra federal funding for Medicaid expansion in 2020, and eliminating both the individual and employer mandates. Under the plan, states would receive per capita funding amounts for select groups of Medicaid beneficiaries, based on historical spending and updated annually based on changes in the Consumer Price Index. The House Republican plan maintains provisions that allow children to stay on their parents' insurance plan until age 26 and that prohibit insurers from refusing coverage to individuals on the basis of preexisting medical conditions. While the legislation would continue tax credits for individuals, starting in 2020 those credits would be based on household income and age and limited to $14,000 per family. Individuals would also be allowed to put more money into health savings accounts. The Energy and Commerce Committee and Ways and Means Committee are expected to review the legislation on March 8, 2017. House Republican leaders say they hope to have a bill to President Donald Trump next month. Read More

Republican Governors Criticize House ACA Bill, Continue Drafting Alternative Proposal. *The Washington Post* reported on March 8, 2017, that Republican Governors across the country are criticizing the American Health Care Act, which was recently introduced by U.S. House Republicans as a proposed replacement to the Affordable Care Act. Governors argue that the plan would jeopardize coverage for 11 million individuals Medicaid expansion members and that a proposed per capita cap on federal Medicaid fund would not account for rapidly rising costs. Republican Governors are currently working on their own proposal, aimed at increasing state flexibility in the design and operation of their Medicaid programs. Read More

Hospitals Raise Concerns Over House Republicans' American Health Care Act. The American Hospital Association (AHA) said on March 7, 2017, that it doesn't support the proposed American Health Care Act in its current form and urges Congress to wait until the plan can be reviewed and scored by the Congressional Budget Office before moving forward. The legislation, which was introduced by U.S. House Republicans this week, is designed to be a replacement to the Affordable Care Act. AHA cited the need for CBO scoring to assess the bill's impact and raised concerns about the bill's restructuring of the Medicaid program, citing the potential for significant reductions in coverage and funding. AHA recommends giving states flexibility through the expanded use of waivers instead of per capita caps. The Association also objects to reductions to payments for hospitals services. Read More

Providers, Advocates Fear American Health Care Act Would Reduce Eligibility, Benefits, Provider Payments. *Modern Healthcare* reported on March 7, 2017, that health care providers and advocates fear that the American Health Care Act, unveiled this week by U.S. House Republicans, would reduce funding and lead to reductions in eligibility, benefits, and provider payments. A preliminary analysis from Standard & Poor's projected that four million to six million people could lose Medicaid coverage under the bill. Advocates are urging Congress to wait until the Congressional Budget Office scores the bill's impact on federal spending and coverage levels before moving forward. The American Health Care Act would convert federal Medicaid funding to a per capita structure in an effort to control costs. Beginning in 2020, the bill would also phase out enhanced federal matching funds to Medicaid expansion states. Read More

Republican State Legislators Work to Expand Medicaid. *Vox* reported on March 6, 2017, Republican state legislators have begun introducing bills and supporting ballot initiatives to expand Medicaid in several states, even as efforts to repeal the Affordable Care Act continue at the national level. Kansas state Representative Susan Concannon, a Republican, has repeatedly introduced Medicaid expansion bills, and in February, a proposal passed the Kansas House for the first time. Maine state Senator Tom Saviello has also repeatedly introduced expansion bills, though none have passed the Maine Senate. Senator Saviello now supports a ballot initiative that will appear on the November 2017 ballot in the state. Of the 31 states that have expanded Medicaid, 15 are led by Republican governors. Despite interest by Republican legislators in additional states, Medicaid expansion proposals still face challenges from those who see it as a costly program that states cannot afford. Read More

Brian Neale Nominated as Director of the Center for Medicaid and CHIP Services. *Modern Healthcare* reported on March 1, 2017, that President Trump has nominated Brian Neale to be director of the Center for Medicaid and CHIP Services, a division of the Centers for Medicare & Medicaid Services. Neale had previously served as health care policy director for then-Indiana Governor Mike Pence, helping to create the Healthy Indiana Plan, known as HIP 2.0. Read More

HHS Secretary Tom Price Said to Support Medicaid Per Capita Caps, High-Risk Pools. *Modern Healthcare* reported on March 7, 2017, that during his confirmation process, U.S. Department of Health and Human Services (HHS) Secretary Tom Price voiced interest in Affordable Care Act (ACA) reforms that allow states to charge women more for coverage, cap Medicaid funding, and implement high-risk pools to cover individuals with pre-existing conditions. Policy experts argue that allowing for price differences between men and women has the potential to shift more high costs associated with pregnancy to public programs like Medicaid. Secretary Price has also voiced support for transitioning Medicaid to a per capita structure and that more states could benefit from adopting a similar approach to Indiana's HIP 2.0 Medicaid program, which charges premiums and can disenroll beneficiaries if they are unable to pay. Many of the ideas that Secretary Price supports are part of a bill introduced by House Republican on March 6, 2017, which are set to be reviewed by House committees this week. Read More

Industry Research

JAMA Publishes ACA Primary Care Access Study, Finds Appointment Availability Slowed. *Kaiser Health News* reported on March 3, 2017, that according to the American Medical Association study, titled *Changes in Primary Care Access Between 2012 and 2016 for New Patients with Medicaid and Private Coverage*, newly insured individuals under the Affordable Care Act are generally able to get timely appointments for primary care. Policymakers created initiatives to strengthen primary care delivery, such as raising Medicaid reimbursement to Medicare levels for certain primary care providers in 2013 and 2014, increasing funds for federally qualified health centers, and expanding the penetration of Medicaid managed care. The study looked at primary care practices in Arkansas, Georgia, Illinois, Iowa, Massachusetts, Montana, New Jersey, Oregon, Pennsylvania, and Texas in 2012-13 and again in 2016. However, in 2016, the proportion of Medicaid callers who waited a week or less for an appointment decreased by 6.7 percentage points, to 49.1 percent. Read More

Industry News

GuideWell Announces Acquisition of PopHealthCare. GuideWell Mutual Holding Corporation announced on March 2, 2017, that it had acquired PopHealthCare, LLC. PopHealthCare provides risk adjustment, care management, and in-home care programs for Medicaid managed care, dual eligible, Medicare Advantage, Exchange, and long-term care markets. PopHealthCare will operate as a subsidiary of GuideWell, with corporate offices in Tennessee and Arizona. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
March, 2017	Washington, DC	Contract Awards	190,000
April 7, 2017	MississippiCAN	Proposals Due	500,000
April 10, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Proposals Due	85,000
April 13, 2017	Wisconsin Family Care (GSR 2, 3, 11, 12)	Proposals Due	11,000
April 13, 2017	Massachusetts	Proposals Due	850,000
April 14, 2017	Washington (FIMC - North Central RSA)	Proposals Due	66,000
April 27, 2017	Alaska Coordinated Care Demonstration	Proposals Due	TBD
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May 15, 2017	Illinois	Proposals Due	2,700,000
May 22, 2017	Washington (FIMC - North Central RSA)	Contract Awards	66,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
June 12, 2017	MississippiCAN	Contract Awards	500,000
June 30, 2017	Illinois	Contract Awards	2,700,000
July 1, 2017	Wisconsin Family Care (GSR 1, 4, 5, 6)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
July 1, 2017	Georgia	Implementation	1,300,000
Summer 2017	Florida	RFP Release	3,100,000
September 1, 2017	Texas CHIP (Rural, Hidalgo Service Areas)	Contract Awards	85,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
November 2, 2017	Arizona Acute Care/CRS	RFP Release	1,600,000
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
December 18, 2017	Massachusetts	Implementation	850,000
January 1, 2018	Illinois	Implementation	2,700,000
January 1, 2018	Pennsylvania HealthChoices	Implementation (SW, NW Zones)	640,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SW Zone)	100,000
January 1, 2018	Alaska Coordinated Care Demonstration	Implementation	TBD
January 1, 2018	Washington (FIMC - North Central RSA)	Contract Awards	66,000
January 1, 2018	Wisconsin Family Care (GSR 2, 3, 11, 12)	Implementation	11,000
January 25, 2018	Arizona Acute Care/CRS	Proposals Due	1,600,000
March, 2018	North Carolina	RFP Release	1,500,000
March 1, 2018	Pennsylvania HealthChoices	Implementation (NE Zone)	315,000
March 8, 2018	Arizona Acute Care/CRS	Contract Awards	1,600,000
April, 2018	Oklahoma ABD	Implementation	155,000
June, 2018	North Carolina	Proposals Due	1,500,000
July 1, 2018	Pennsylvania HealthChoices	Implementation (SE Zone)	830,000
July 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Zone)	145,000
July 1, 2018	MississippiCAN	Implementation	500,000
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
September 1, 2018	Texas CHIP (Rural, Hidalgo Service Areas)	Implementation	85,000
September, 2018	North Carolina	Contract awards	1,500,000
October 1, 2018	Arizona Acute Care/CRS	Implementation	1,600,000
January 1, 2019	Pennsylvania HealthChoices	Implementation (Lehigh/Capital Zone)	490,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Zones)	175,000
January 1, 2019	Texas STAR+PLUS Statewide	Implementation	530,000
July 1, 2019	North Carolina	Implementation	1,500,000
January 1, 2020	Texas STAR, CHIP Statewide	Implementation	3,400,000

DUAL ELIGIBLE FINANCIAL ALIGNMENT DEMONSTRATION IMPLEMENTATION STATUS

Below is a summary table of states dual eligible financial alignment demonstration status.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Jan. 2017)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	114,804	32.8%	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	136,000	45,469	33.4%	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	16,039	16.5%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,752	36.8%	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	4,827	3.9%	There are 15 FIDA plans currenting serving the demonstration. A full list is available on the MRT FIDA website.
New York - IDD	Capitated	4/1/2016	None	20,000	448	2.2%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	69,634	61.1%	Aetna; CareSource; Centene; Molina; UnitedHealth
Rhode Island	Capitated	7/1/2016	10/1/2016	25,400	9,934	39.1%	Neighborhood Health Plan of RI
South Carolina	Capitated	2/1/2015	4/1/2016	53,600	8,981	16.8%	Absolute Total Care (Centene); Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	3/1/2015	4/1/2015	168,000	50,924	30.3%	Anthem (Amerigroup); Cigna-HealthSpring; Molina; Superior (Centene); United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	28,835	43.6%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**386,647**	**30.8%**	

** New York's Duals Demonstration program, FIDA, has been extended through December 2019. FIDA will be expanding into Region 2, which includes Suffolk and Westchester Counties, effective March 1, 2017. FIDA began in NYC and Nassau Counties in 2014, but expansion into Region 2 was delayed. Currently one plan has been approved to offer FIDA in Region 2; other plans will be added as they complete readiness review. Enrollment in FIDA in Region 2 will be voluntary; no passive enrollment.*

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

HMA News

HMA Webinar Replays:

"Relationship-Centered Care: A Healthcare Provider's Guide to Patient Engagement, Shared Decision Making, and Improved Outcomes"

Webinar Replay

On February 16, 2017, HMA Information Services hosted the webinar, "Relationship-Centered Care: A Healthcare Provider's Guide to Patient Engagement, Shared Decision Making, and Improved Outcomes." During this webinar, HMA experts Margaret Kirkegaard, MD, family physician, and Jeffrey Ring, PhD, health psychologist, provide a deep appreciation of the value of relationships in the provision of medical care, including data that illustrates the efficacy of the relationship-centered approach. The webinar also provides a roadmap for provider organizations striving to enhance relationship-centered care initiatives that involve providers, patients, and the entire medical and administrative staff.

"An Assessment of Potential Healthcare Policy Changes that Could Impact Original Medicare and Medicare Advantage"

Webinar Replay

On February 15, 2017, HMA Information Services hosted the webinar, "An Assessment of Potential Healthcare Policy Changes that Could Impact Original Medicare and Medicare Advantage." During this webinar, HMA Principal Mary Hsieh and Senior Consultants Aimee Lashbrook and Jason Silva outline some of the key Medicare reforms being considered, which – if any – are likely to make it to the President's desk, and how healthcare organizations can best navigate the evolving Medicare business and regulatory environment.