HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

August 31, 2016

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THIS WEEK

IN FOCUS

ILLINOIS RELEASES DRAFT 1115 WAIVER FOR BEHAVIORAL HEALTH REDESIGN

This week, our *In Focus* section reviews the draft Section 1115 Research and Demonstration waiver, released on August 26, 2016, by the Illinois Department of Healthcare and Family Services (DHFS). The 1115 waiver is proposed as part of the state's broader initiatives around the State Innovation Model (SIM) design grant awards, the State Health Assessment (SHA), and the State Health Improvement Plan (SHIP), with goals of strengthening the state's behavioral health care system, reducing silos in behavioral health care, and promoting greater integration of physical and behavioral health. The waiver specifically proposes the inclusion of a package of new benefits for individuals with severe mental illness (SMI) and substance use disorders (SUD), as well individuals nearing release from the Illinois Department of Corrections (IDOC) and Cook County Jail systems. DHFS estimates $1.2 billion in federal savings over the five-year waiver term, equaling a 2 percent spending reduction across all Medicaid

spending compared to without-waiver spending estimates. DHFS is accepting comments on the draft 1115 waiver through September 26, 2016.

Proposed Benefits, Target Populations

The 1115 waiver requests Medicaid funding for six categories of new benefits, and proposes making these benefits available only for select target populations. The pilot target populations were selected based on stakeholder comments and other information, with the intention to match benefits with those most in need, and where they would be most likely to decrease total cost of care.

Benefit	Target Population(s)
Supportive Housing	Individuals with SMI, at risk of institutionalization or homelessness, or currently in permanent supportive housing
Supported Employment Services	Individuals 14 or older with SUD, serious and persistent mental illness (SPMI), or serious emotional disturbance (SED) needing ongoing support to obtain and maintain a job
Services to ensure successful transitions from IDOC and Cook County Jail	Medicaid-eligible IDOC-justice involved individuals within 30 days of release; Cook County detainees eligible for Medicaid managed care (and not previously enrolled in CountyCare, the Cook County Health and Hospital System's managed care plan)
Extended-release injectable naltrexone; medication assisted treatment (MAT) services	Medicaid-eligible individuals incarcerated at IDOC facility within 30 days of release
Lifting IMD exclusion for short-term residential SUD treatment	Individuals with SUD needing short-term residential treatment
SUD case management	Individuals with SUD receiving any ASAM (American Society of Addiction Medicine) treatment level of care but not receiving case management from other sources
Withdrawal management	Individuals with SUD meeting ASAM criteria for withdrawal management
Recovery coaching for SUD	Individuals with SUD seeking support for long-term recovery
Lifting IMD exclusion for short-term mental health treatment	Individuals with mental health disorders needing short-term residential treatment
Crisis beds	Individuals requiring psychiatric treatment but do not require inpatient stay
Intensive in-home services; Respite care	Families and children (ages 5-21) with high behavioral health needs and/or SED at risk of transition to higher level of care

Additional Waiver Initiatives

In addition to the targeted benefit expansion, DHFS is proposing four initiatives aimed at increasing physical and behavioral health integration and expanding value-based payments in Medicaid.

1. **Behavioral and physical health integration activities**: providing managed care organizations and providers with resources to pursue development of integrated health homes (IHHs). Illinois intends to design and implement IHHs, authorized through a Medicaid state plan amendment, and is requesting support around workforce integration, provider readiness assessment, encouraging partnerships and integration between physical and behavioral providers, the launching of disease-specific pilot projects, and data collection and reporting.
2. **Prevention services to address infant and early childhood mental health interventions**: The waiver seeks to expand the Infant/Early Childhood Mental Health Consultation (I/ECMHC) program, targeting high-need areas initially, as well as rural Illinois.
3. **Behavioral health workforce-strengthening initiatives**: developing and retaining a larger behavioral health care workforce and training providers around cultural and linguistic competency, promoting whole-person care.
4. **Medicaid funding to implement first episode psychosis (FEP) programs**: creation of teams to respond to individuals experiencing initial onset of a Schizophrenias Spectrum Disorder. Illinois is currently developing a FEP program, and is requesting Medicaid funding to expand.

Public Comment, Public Hearings

As mentioned above, DHFS will be accepting public comment on the draft 1115 waiver through September 26, 2016. Additionally, the state will hold two public hearings – on September 8, 2016, in Springfield, Illinois; and on September 9, 2016, in Chicago, Illinois – to present the waiver proposal to and take comments and questions from interested stakeholders.

Link to Waiver Documents

Link to Draft 1115 Waiver

Link to Notice of Public Information

HMA Medicaid Roundup

Alabama

Lottery Bill Fails, Renewing Concerns About Medicaid Funding. The *Montgomery Advertiser* reported on August 26, 2016, that a bill to establish a state lottery to help fund an $85 million Medicaid budget shortfall failed in the Alabama Senate during a special legislative session. Alabama Governor Robert Bentley said the vote also imperils the state's proposal to move Medicaid beneficiaries into regional care organizations. Two key Democrats withdrew their support over concerns that the legislation could negatively impact other parts of the state's gaming industry. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Florida Releases Statewide HCBS Transition Plan for Public Comment. The Agency for Health Care Administration developed a Statewide Transition Plan to comply with federal home and community based services (HCBS) settings requirements. The Transition plan details the steps to be taken to implement the new rule for the following HCBS programs:

- Adult Cystic Fibrosis Waiver
- Developmental Disabilities Individual Budgeting Waiver
- Familial Dysautonomia Waiver
- Long-term Care Managed Care Waiver
- Model Waiver
- Project AIDS Care Waiver
- Traumatic Brain Injury and Spinal Cord Injury Waiver

The latest Statewide Transition Plan is available for public comment from August 26, 2016 to September 25, 2016. The Agency will review all public comments received during the 30-day comment period, revise the plan as necessary, and submit to the Centers for Medicare & Medicaid Services for review. A copy of the plan can be found here.

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Chamber of Commerce Proposes Options for Medicaid Expansion. *AJC.com* reported on August 31, 2016, the Georgia Chamber of Commerce has put forward three options for Medicaid expansion in the state. Although Georgia Governor Nathan Deal has opposed expansion, an increasing number

of state lawmakers have indicated potential support. The first option would extend Medicaid coverage to childless adults up to 100 percent of the federal poverty level. The second option would extend coverage up to 138 percent of poverty. The third option would extend coverage up to 100 percent of poverty and enroll those between 100 percent and 138 percent in a Qualified Health Plan. All three options also include work requirements and cost-sharing and would require federal waivers to be implemented. The Chamber of Commerce plans to release cost projections for the plan before the January 2017 legislative session. Read More

Medicaid Enrollment Growth Prompts Request for More Funding. *Georgia Health News* reported on August 25, 2016, that the Georgia Department of Community Health is requesting $82.8 million in additional funding in 2017 and $121.4 million in 2018, due to a projected 2 percent increase in Medicaid enrollment during that time period. Department chief financial officer Elizabeth Brady says the increase is mostly due to the "woodwork effect," meaning that more people realize that they are eligible for Medicaid due to the publicity around enrollment through the Exchanges. Additionally, the agency is implementing a payment system that would potentially recapture funds from health plans that do not meet quality metrics. Read More

Illinois

Proposed Exchange Rate Increases Averaging 44 to 55 Percent. *Chicago Tribune* reported on August 25, 2016, that the Illinois Department of Insurance submitted Exchange rate increases averaging 44 to 55 percent for 2017 plans. Consumers are reporting concerns around affordability and options, especially after a number of insurers pulled out of the Exchange due to financial losses. Illinois claims the increases are partly due to the federal government not providing payments it promised, as well as rising medical and pharmaceutical costs. However, according to a report by the U.S. Department of Health and Human Services, even if insurance premiums double next year, two-thirds of Illinois residents will pay $100 or less per month after subsidies. Read More

Iowa

Medicaid Managed Care Saves State $22 Million, Report Says. *The Des Moines Register* reported on August 26, 2016, that a report released by the Iowa Department of Human Resources shows that the state has saved $22 million since April 1, 2016, when it implemented a Medicaid managed care program. According to the report, Iowa spent about $332 million on Medicaid in the first three months of the managed care program, compared to the $354 million it would have spent under traditional Medicaid. The report also suggests wide variety in spending among Medicaid managed care plans in the state. Lawmakers and skeptics of Medicaid managed care say the report does not ease their concerns. Read More

Kentucky

State Releases Revised 1115 Waiver Application. The *Courier-Journal* reported on August 24, 2016, that Governor Matt Bevin's administration released its final revised Medicaid 1115 waiver plan, known as Kentucky HEALTH, which takes into account public comments collected since June. The revised plan maintains work requirements, monthly premiums, and optional dental and vision benefits, disappointing some advocates. The Governor's administration argues that the new plan is more financially sustainable, and state Medicaid Commissioner Steve Miller has said that the changes would create savings of $2.2 billion over the next five years. However, federal officials have expressed doubts about the changes, which would impact the 440,000 individuals that gained Medicaid coverage through Kentucky's expansion of the program if approved. Read More

Maryland

Four Medicaid Managed Care Plans Selected to Oversee Diabetes Prevention Program. *The Baltimore Sun* reported on August 31, 2016, that the Maryland Department of Health and Mental Hygiene has selected four Medicaid managed care plans to oversee a federally funded diabetes prevention program for Medicaid patients. Amerigroup, Jai Medical Systems, MedStar Family Choice, and Priority Partners will oversee the two-year pilot program, which will promote healthy lifestyles to low-income individuals with pre-diabetes and those at risk for type 2 diabetes. Maryland is one of two states including Oregon that received funding to participate in the National Diabetes Prevention Programs. Read More

Priority Partners Employee Pleads Guilty to Medicaid Fraud. *The Baltimore Sun* reported on August 26, 2016, that a contracted senior project manager for Priority Partners health plan pleaded guilty to Medicaid fraud. The employee altered medical records between 2011 and 2014, resulting in $875,279 in improper payments from the Maryland Medicaid program. Priority Partners, which is owned by Johns Hopkins HealthCare, has returned all of the funds. Read More

Michigan

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

From the HMA Michigan Update: **MDHHS Issues RFP for Health Innovation Grants.** On August 4, 2016, the Michigan Department of Health and Human Services (MDHHS) announced that it had recently released a Request for Proposals for public, non-profit and private organizations interested in applying for Health Innovation Grants. Intended to support one-time projects to improve the delivery of health services in Michigan, each grantee could receive as much as $35,000. Applications are due to MDHHS on September 1, 2016.

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Governor Christie Holds Medicaid Expansion News Conference. On Monday, August 29, 2016, Governor Chris Christie held a news conference to discuss the state's experience with Medicaid expansion under the Affordable Care Act. He reported that more than 500,000 are receiving care following the implementation of Medicaid expansion and noted a decrease in the state's share of Medicaid expenditures from 45 to 39 percent over two years. Read more.

New York

HMA Roundup – Denise Soffel (Email Denise)

Public Comment on New York's Medicaid Program. As part of its annual review of the Section 1115 Medicaid waiver that governs NY's Medicaid program, the Department of Health hosted two 1115 Waiver Public Comment Day forums on May 4, 2016 and July 12, 2016. More than half the speakers represented community based organizations, including organized labor, who raised concerns about delays in funds flow from Performing Provider Systems in the DSRIP program. Primary care providers expressed concern about the need for capital to foster Primary Care which is fundamental to the delivery of healthcare, as well as the need for more consistent definitions for Health Equity, Cultural Competency and CBO diversity. In addition to live testimony, the Department received written comments from several dozen organizations. Summaries of live testimony during both meetings as well as written comments received have been posted. Read More

Delivery System Reform Incentive Payment Program Update. The Department of Health provided an update on the status of the Delivery System Reform Incentive Payment (DSRIP) program at its monthly managed care policy and planning meeting with health plans that participate in the state's Medicaid managed care program. Among the program highlights it was noted that PPS networks have an open enrollment period, ending September 8, in which they can add providers to their network. The update also provided details on the Midpoint Assessment, a process that will be completed prior to the beginning of DSRIP year 3, in April 2017. PPS provider surveys are being conducted, which are meant to provide a cross-section of all providers in the PPS network and the extent to which they have been involved in project planning and implementation, funds flow and governance. PPS narratives are required of each PPS, intended to describe progress, challenges, successes, barriers overcome, changes to patient population based on changes in community needs. The state will be conducting on-site audits with a focus on governance, cultural competency and health literacy, performance reporting, financial sustainability, IT systems, and expanding access to primary care. Read More

Community First Choice Option (CFCO) Update. The Department of Health recently announced that implementation of the Community First Choice Option (CFCO) has been moved to December 1, 2016. A draft Administrative Directive Memorandum (ADM) designed to introduce CFCO and provide detailed guidance regarding the implementation of this set of services has been circulated for comment and is being finalized. The Department is still working to develop a CFCO operation plan for implementation under FFS, and to develop operational

policies and protocols for new services (Social Transportation, Environmental Modification, Vehicle Modification, Moving Assistance, and Assistive Technology). Read More

Children's Health Homes Update. Health Homes Designated to Serve Children will begin to enroll children December 2016. The enrollment date was recently changed to align the effective date of changes in Health Home payment methodology that will address significant delays in the time it takes payments to flow to care management agencies. Children engaged in Early Intervention will begin enrollment in March 2017. CMS has approved the proposed approach for having the Health Home Care Manager serve as the Ongoing Service Coordinator for children enrolled in both Health Homes and the Early Intervention Program, and the State Health Home and Early Intervention staff have been meeting regularly to identify the methods to integrate HH services with Early Intervention Ongoing Service Coordination. To manage initial capacity (and provide time to build up capacity) Health Homes, local districts and Care Managers and Plans, are being asked to prioritize the enrollment of children that have the highest needs, including children who are already on waiting lists for care management services, children that are within 3 months of foster care discharge, children prescribed 3 or more psychotropic medications, Medically Fragile Children with multiple chronic conditions that have had recent (past 30 days) inpatient stay, and children with multiple system involvement (child welfare, criminal justice).

Accountable Care Organization Performance in New York. *Crain's HealthPulse* reports that few organizations participating in the Medicare Shared Savings Program earned a bonus for 2015. Among the 27 New York-based ACOs, 10 saved Medicare money and six qualified for bonus payments. ProHealth Accountable Care Medical Group earned the largest bonus, at a $6.3 million, followed by New York City Health + Hospitals' HHC ACO, which earned $6.1 million. The public health system has qualified for a bonus in each of the three years it has participated. New York has one participant in the Pioneer ACO Model, Montefiore ACO, which failed to earn shared savings for the first time since it was launched. Read More

Expanding Primary Care. In January 2015, the Fund for Public Health in New York joined in partnership with the New York City Department of Health and Mental Hygiene, United Hospital Fund, and The New York Academy of Medicine to launch the New York City Population Health Improvement Program (PHIP). The NYC PHIP is one of 11 PHIPs created around the state, with funding from the State Department of Health, working to achieve inclusive health planning at the regional and local level. The NYC PHIP recently released a plan laying out strategies to expand and improve the impact of the medical home model of primary care across New York City. The plan is intended to serve as a data-driven strategy for expanding the adoption, and improving the impact of, the medical home in New York City. It sets an aggressive goal—to ensure that 80% of New York City primary care providers achieve medical home status by 2020—and includes specific strategies for addressing the primary barriers to reaching that goal. The report identifies five broad issues New York City will need to address in pursuing that goal:

- How to set priorities in a city the size of New York, and decide where and how to initially invest resources to transform primary care practices into medical homes;

- How best to enable New York City's small practices (those with fewer than five providers, for which implementation is most challenging) to adopt the medical home model;
- How best to integrate behavioral health services with primary care;
- How best to avoid the complexity and potential confusion related to having three simultaneous and similar practice transformation initiatives underway throughout New York State; and
- How to assure that payment systems fairly compensate primary care providers for the added costs and value of the medical home model. Read More

Ohio

HMA Roundup – Jim Downie (Email Jim)

Ohio SBIRT Project Seeking Proposals. The Ohio Department of Mental Health and Addiction Services has issued an RFP seeking partner providers to implement SBIRT Services at medical sites in Ohio. Funds will be used to implement screening for substance use, depression and tobacco use during the course of primary medical care. Training for staff is included in the grant funding to equip them to identify those at risk, provide evidence-based interventions and referrals when necessary. Read More

Health Policy Institute of Ohio Issues 2016 State Health Assessment. *Gongwer Ohio* reports the Health Policy Institute of Ohio has released the annual Health Assessment for 2016 report. Preparation of this assessment was governed by the Ohio Office for Health Transformation and the Ohio Department of Health. Key findings of the report were: opportunities exist to improve health outcomes; opportunities exist to decrease health disparities; access to health care has improved; social determinants of health present cross-cutting challenges; opportunities exist to address health challenges at every stage of life; improved data collection efforts are needed to assess health issues; widespread agreement on health issues identified at local, regional and state levels can be impetus for greater collaboration; and sustainable healthcare spending remains a concern. "The report cited payment reform as one way to invest resources strategically to target certain outcomes. The state's efforts on payment reform include episode-based payments and comprehensive primary care." Read More

Ohio State Medical Association Names New CEO. *The Columbus Dispatch* reports the Ohio State Medical Association has named Todd M. Baker CEO. Mr. Baker replaces D. Brent Mulgrew who is retiring after 42 years with OSMA, the last 24 as executive director. Read More

Oklahoma

Health Care Authority CEO Nico Gomez to Resign Effective September 30. The Oklahoma Health Care Authority announced on August 29, 2016, that Chief Executive Officer Nico Gomez is resigning effective September 30 after sixteen years at the agency, including three and a half years as CEO. The agency said that it has not been decided who will succeed Mr. Gomez, but that the board will likely discuss the topic in their meeting next week.

Pennsylvania

HMA Roundup – Julie George (Email Julie)

DHS Announces Preliminary Community HealthChoices Contract Awards. The Pennsylvania Department of Human Services (DHS) announced its intention to negotiate Community HealthChoices (CHC) contracts with three managed care organizations:

- AmeriHealth Caritas
- Pennsylvania Health and Wellness (Centene)
- UPMC for You

Other bidders on the RFP were Accenda, Aetna, Cedar Woods Care Management, Cigna-Health, Gateway Health Plan, Geisinger Health Plan, Health Partners Plans, Molina Healthcare, Trusted Health Plan, United Healthcare, and WellCare. Implementation of Phase One is expected to begin July 2017. Community HealthChoices is a Managed Long-Term Services and Supports (MLTSS) program covering both LTSS and dual eligible populations, which when fully implemented will represent more than $7 billion in annual spending. Coverage will be implemented in three phases: Southwest Zone in July 2017, Southeast Zone in January 2018; and Lehigh/Capital, Northwest, Northeast Zones in January 2019. Contracts are expected to be five years with two optional one-year extensions. Read More

Redesigned Prescription Drug Monitoring Program under direction of DOH. On August 25, 2016, Governor Tom Wolf announced the launch of the redesigned Prescription Drug Monitoring Program. The redesigned system will be run by the Department of Health and will provide access to clinicians. Prescribers and dispensers can both request and report information regarding the number of opioids prescribed and to whom. Through this revamp, officials hope to address drug abuse and provide better care for patients. By law, physicians and pharmacists must use the database and information about a filled prescription must be entered within 72 hours. Health professionals will have real-time access to the data. Read More

Wolf Administration Implements 25 Additional Centers of Excellence Locations. On August 29, 2016, Governor Tom Wolf announced an additional 25 Centers of Excellence (COE) locations throughout Pennsylvania by January 2017. This brings the total number of COEs to 45. COEs will treat opioid-related substance use disorder with the aim of combining behavioral health, primary care, and evidence-based medication assisted treatment. According to the Governor's Office, the Department of Human Services opened 20 COEs with $10 million in behavioral health funding. DHS then determined they could implement the additional 25 centers with $5 million in state Medicaid funds and $5.4 million in federal funds. Read More

Department of Human Services Launches Improved CHIP website. DHS has launched an updated, user-friendly site for the Children's Health Insurance Program (CHIP). The new site includes a county coverage map to find insurance companies in the area and improved links to social media. Read More

Geisinger Chief Operating Officer Retires. *Becker's Hospital Review* reported on August 25 2016, that Frank Trembulak, Executive Vice President and COO of Geisinger Health System is retiring. Trembulak's career at Geisinger spanned 40 years. Read More

Texas

HHSC Begins Health Agency Restructuring. The Texas Health and Human Services Commission (HHSC) announced on August 31, 2016, the beginning of a restructuring of state health agencies, including the consolidation of five agencies into three. Effective September 1, about 4,000 employees and more than 120 programs and functions will move to HHSC from four other state agencies. Effective September 1, 2017, the state will transition oversight of regulatory programs, state hospitals, and state living centers to HHSC. Also in 2017, the Department of Assistive and Rehabilitative Services and Department of Aging and Disability Services will no longer operate as separate agencies. Selected programs from the Department of State Health Services and the Department of Family and Protective Services will also move to HHSC.

Virginia

Governor Pushes for Medicaid Expansion. *The Washington Post* reported on August 26, 2016, that Virginia Governor Terry McAuliffe is pushing the expansion of Medicaid to help close a $1.48 billion budget shortfall. State Republican leaders quickly dismissed the possibility, saying expansion has been a financial burden on other states. Republican lawmakers have defeated Medicaid expansion proposals for the last three years. Read More

Wisconsin

Centene Subsidiary to Exit Exchange Market in 2017. *Milwaukee-Wisconsin Journal Sentinel* reported on August 24, 2016, that Centene Corp. subsidiary Managed Health Services (MHS) is pulling out of the Exchange market in Wisconsin, which sells plans under the name Ambetter. The plan says it is in the process of notifying individuals that their coverage will expire at the end of 2016. However, MHS will continue to contract with the state to manage care for individuals enrolled in the state's Medicaid program, BadgerCare Plus. United Healthcare also exited the Exchange market in Wisconsin, leaving four plans participating in 2017. Read More

National

HHS Analysis Finds Exchange Rate Increases Will Not Make Coverage Too Costly for Individuals. *CQ Roll Call* reported on August 24, 2016, that according to a new analysis by the U.S. Department of Health and Human Services (HHS), most individuals will be able to afford their Exchange plan despite high premium hikes. If all plans sold through the Exchanges had a 25 percent rate increase, the report found that three-fourths of enrollees would still pay less than $75 a month, after premium tax credits provided by the government. Across the country, the average proposed rate increase is about 25 percent, with some states submitting rate increase requests as high as 50 percent. The analysis explains that subsidies will rise with premiums, keeping individuals' monthly costs in check. Rate increases are still subject to review by regulators and may end up being lower once approved by HHS. Last year, the average rate increase was 12 percent across all states and plans.

HHS Report Shows Medicaid Expansion Leads to Lower Premiums. *The New York Times* reported on August 25, 2016, that a new study published by the Department of Health and Human Services (HHS) shows that Exchange insurance premiums are 7 percent lower in states that expanded Medicaid. The report says that the difference is likely due to the population between 100 and 133 percent of the federal poverty level, who on average have higher health care utilization than those with higher incomes, making up a much larger share of the Exchange population in non-expansion states. Only states that use the federal Exchange marketplace were studied. The report comes as several insurers have pulled out of the Exchange markets, raising concerns about access and premium increases. Read More

A Third of U.S. Counties to Have One Exchange Insurer, Analysis Finds. *The New York Times* reported on August 28, 2016, that according to a Kaiser Family Foundation analysis, 31 percent of U.S. counties will only have one insurer as an option on the Affordable Care Act Exchanges in 2017. An estimated 2.3 million potential enrollees, or 19 percent, will have a choice of only one insurer. United and Aetna have both exited the majority of their respective Exchange markets for 2017. Analysts fear that the lack of competition could result in higher premiums on the Exchanges. Read More

CMS Proposal Would Include Drug Costs in Exchange Plan Risk Adjustments. *Modern Healthcare* reported on August 29, 2016, that the Centers for Medicare & Medicaid Services (CMS) is proposing the inclusion of drug costs and data on members who join after open enrollment when making Exchange plan risk-adjustment payment calculations. Risk-adjustment payments are designed to compensate Exchange plans with an unusually high number of sick members. The changes, which would take effect in 2018, are part of a broader CMS proposal to help stabilize the Affordable Care Act Exchanges after several high-profile plans dropped out. Other changes would include three new types of standardized plans and a requirement that insurers offer at least one Silver and one Gold level health plan as a condition of participation in the Exchanges. Comments on the proposed rules are due October 6. Click here to read the proposed rule. Read More

CMS Offers Tools to States to Help Prevent Improper Medicaid Payments. *Modern Healthcare* reported on August 30, 2016, that the Centers for Medicare & Medicaid Services (CMS) is offering solutions to help prevent states from making improper Medicaid payments. Improper payments totaled $30 billion in 2015. Solutions proposed by CMS include provider screening, site visits, education, and a beneficiary validation processes. Read More

Industry News

Frazier Healthcare Partners to Take Majority Stake in Matrix Medical Networks. Providence Service Corporation announced on August 29, 2016, that it will receive gross cash proceeds of $418 million from the sale of a sixty percent stake in Matrix Medical Network to private equity firm Frazier Healthcare Partners. Providence, which acquired Matrix for $393 million in 2014, will retain a 40% stake. Matrix offers in-home care, chronic care management, and in-home assessments through a network of nurse practitioners. The transaction is expected to close in the last quarter of 2016.

RFP Calendar

Date	State/Program	Event	Beneficiaries
September 1, 2016	Nevada	Proposals Due	420,000
September 6, 2016	Pennsylvania HealthChoices	Proposals Due	1,700,000
September 12, 2016	Rhode Island	Proposals Due	231,000
September 22, 2016	Nevada	Contract Awards	420,000
September, 2016	Massachusetts MassHealth ACO - Pilot	Selection	TBD
September, 2016	Washington, DC	RFP Release	200,000
October 1, 2016	Missouri (Statewide)	Contract Awards	700,000
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	Implementation	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
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.

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