HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

September 16, 2015

RFP CALENDAR

DUAL ELIGIBLES CALENDAR

HMA NEWS

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THIS WEEK

IN FOCUS

PENNSYLVANIA ISSUES HEALTHCHOICES MEDICAID MANAGED CARE RFP

This week, our *In Focus* section reviews the Pennsylvania Department of Human Services (DHS) request for proposals (RFP) to rebid the HealthChoices Physical Health Medicaid managed care program statewide. The HealthChoices program currently serves just over 1.9 million members across five regions. This RFP does not include the planned inclusion of managed long-term supports and services (MLTSS), which will be procured separately as early as November of this year.

Covered Populations and Services

The HealthChoices program covers around 1.1 million Temporary Assistance for Needy Families (TANF)/Modified Adjusted Gross Income (MAGI) beneficiaries. The program also covers SSI recipients, women in the Breast and Cervical Cancer Treatment (BCCT) program, and the newly eligible population under the Affordable Care Act (ACA) Medicaid expansion. DHS estimates that

the number of newly eligible enrollees could grow by 150,000 to 200,000 members by the end of the year. Using DHS capitation rates, we estimate this could add between $900 million and $1.2 billion to annual Medicaid managed care organization (MCO) per member per month (PMPM) revenues. This is on top of the estimated $10.5 billion paid to MCOs for 2015. (Table 1)

Table 1 – HealthChoices Enrollment and Spending, Anticipated Awards by Region

Zone	Total Enrollment (July 2015)	Annualized Spending (2015)	Avg. PMPM (2015)	Current MCO Contracts	Anticipated Awards
Southwest	404,814	$2,109,389,526	$434.23	4 MCOs	3-5 MCOs
Southeast	698,296	$4,589,448,714	$547.70	4 MCOs	4-5 MCOs
Lehigh/Capital	413,784	$2,029,908,654	$408.81	5 MCOs	3-5 MCOs
Northeast	259,616	$1,134,911,365	$364.29	4 MCOs	3-4 MCOs
Northwest	142,415	$669,979,986	$392.04	3 MCOs	3-4 MCOs
Total Statewide	**1,918,925**	**$10,533,638,245**	**$457.45**		

Source: DHS RFP documents

The Northeast and Northwest regions were formerly referred to as the "New East" and "New West" zones, respectively.

RFP Highlights, Evaluation Criteria

Bidders may propose to serve statewide or any combination of the five zones. DHS anticipates that the new contracts will include:

- risk adjusted capitation rates for two geographic rating areas within each of the five zones
- maternity care payments
- high cost risk pools, not immediately applicable to a new entrant
- home nursing risk sharing
- specialty drug risk sharing and quality risk pools, and
- pay for performance incentives.

DHS will also pay MCOs for the Health Insurance Providers Fee (HIPF). Neither the HIPF payments nor the pay for performance incentive payments are included in the average PMPM amounts noted in Table 1 above.

Proposals will be evaluated primarily on the technical response, which accounts for 80 percent of the total points available, and bidders must receive at least 70 percent of the available technical response points to be eligible for a contract award. The remaining 20 percent of total points will be awarded for meeting the Small Diverse Business subcontracting criteria. There is no cost proposal element to the RFP.

RFP Timeline, Contract Awards, Term of Contract

Proposals are due on the afternoon of November 17, 2015. DHS has not outlined a timeframe for announcing contract awards; however, with implementation scheduled for January 1, 2017, we would anticipate contract award announcements to be made in the first half of 2016. Awards will be region-based, with three to five MCOs awarded per region, as detailed in Table 1 above. The initial contract term will be for three years, through December 31, 2019, with one, two-year extension period available.

Table 2 – RFP Timeline

Timeline	Date
Deadline for Questions	October 16, 2015
Pre-Proposal Conference	October 20, 2015
Q&A Posted	October 26, 2015
Proposals Due	November 17, 2015
Implementation	January 1, 2017

Existing HealthChoices Market

As of May 2015, the AmeriHealth Caritas family of health plans was the largest in terms of statewide market share, with more than 493,000 enrollees (31 percent of the total) across four of the five regions. Currently, Aetna is the only plan participating in all five regions.

Table 3 – HealthChoices Enrollment by Plan, Region – May 2015

Health Plan	Southeast	Southwest	Lehigh/ Capital	Northwest	Northeast	Total All Regions	Market Share
AmeriHealth Caritas	304,060		121,954	11,377	56,027	**493,418**	31.0%
UPMC		169,292	19,387	69,411		**258,090**	16.2%
Gateway Health Plan		101,159	127,440	20,147		**248,746**	15.6%
Health Partners	168,973					**168,973**	10.6%
United Healthcare	60,158	49,037	48,176			**157,371**	9.9%
Aetna Better Health	51,471	12,330	27,075	15,623	31,800	**138,299**	8.7%
Geisinger Health Plan					124,894	**124,894**	7.9%
Total All MCOs	**584,662**	**331,818**	**344,032**	**116,558**	**212,721**	**1,589,791**	

Source: State enrollment data, May 2015

Link to RFP, Related Documents

http://www.emarketplace.state.pa.us/Solicitations.aspx?SID=RFP%2006-15

HMA Medicaid Roundup

Arkansas

State Misses 45-Day Processing Deadline for 31,400 Medicaid Applications. On September 10, 2015, *Arkansas Online* reported that the state had not processed 31,400 Medicaid applications within the 45 days allowed under federal regulations, largely affecting mothers seeking coverage for newborns. Some of the applications had been pending since the previous year. Applicants waiting longer than the 45 days can request an administrative hearing. As a result, some clinics have tens of thousands of dollars in unpaid claims. The Human Services Department stated that due to problems with the program's computerized enrollment system, applications are being processed manually, but that the backlog should be reduced as more newly hired caseworkers are trained and improvements are made to the enrollment system. Read More

California

HMA Roundup – Varsha Chauhan (Email Varsha)

Proposed Health Plan Tax Stalled. On September 11, 2015, *Los Angeles Times* reported that a new tax on health plans had stalled during the special session on healthcare called by Governor Jerry Brown. California currently imposes a tax, set to expire in 2016, on health plans that accept Medi-Cal patients. Federal officials, however, said the tax must levied on all health plans, even those who do not accept Medi-Cal enrollees, or the state risks losing federal funding for the program. The tax proposal must be approved by a two-thirds majority of the legislature. The special session will remain open until the new legislative year. Read More

District of Columbia

Health Plan Rates to Increase by 4 Percent on District's Marketplace. On September 15, 2015, *The Washington Post* reported that the cost of individual plans on the online marketplace will increase an average of 4 percent. Insurers initially asked for increases ranging from 6.5 percent to 14.5 percent. After the rate review process, the agreed upon rates were an average of 2 percent for CareFirst HMO plans, 4.6 percent for CareFirst PPO plans and 6.6 percent for Kaiser Permanente HMO plans. In Maryland, the most popular plan will cost an average 26 percent more. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Medicaid Predicted to Use 45.9 Percent of Growth in State's General Revenues. On September 15, 2015, *CBS Miami* reported that the Legislature's Office of Economic and Demographic Research predicted Medicaid to use 45.8 percent of the growth in the state's general revenue over the next three years. However, Florida will still see a surplus of $635.4 million for the budget year. Read More

Georgia

HMA Roundup – Kathy Ryland (Email Kathy)

Department of Community Health DCH Board Meeting Held September 10. The DCH Board met on September 10, 2015. At the meeting, the DCH Commissioner reported that the Amended Fiscal Year (AFY) 2016 and AFY 2017 budgets had been submitted to the Governor's Office of Planning and Budget for consideration for the Governor's budget. The Commissioner also reported that the first round of bidder questions for the Medical Management Utilization Review vendor re-procurement had been submitted and that the ICD-10 conversion would occur on October 1st, after a year's extension of the original deadline. At the meeting, the Board also approved for initial adoption a rate increase for Personal Support Services in the Independent Care Waiver Program. The rate increase is $0.75 per hour unit, and will increase Aged, Blind, and Disabled (ABD) expenditures by $1.9 million in state funds. Additionally, two changes were made to the Short Stay Hospital Rules and Regulations. Read More

Iowa

Health Insurers Appeal for Reconsideration to Participate in Medicaid Program. On September 9, 2015, *WCF Courier* reported that Aetna Better Health, Iowa Total Care, and Meridian Health Care Plan of Iowa appealed the state's rejection of their requests for reconsideration to participate in Iowa's risk-based Medicaid managed care program. Attorneys for the insurers claim the process used by the Department of Human Services to award health plan contracts was fundamentally flawed. The winning bidders were Amerigroup, AmeriHealth, UnitedHealthcare, and WellCare. The appeal would overturn the awards and order the department to reevaluate the bids using an independent, disinterested arbiter. Read More

Montana

Bids to Administer Medicaid Expansion Higher than Predicted. On September 14, 2015, *KRTV.com* reported that the four health insurance firms who bid to administer the Medicaid expansion have proved higher than originally predicted. If 25,000 individuals sign up for the program, the proposed costs would be:

- "Blue Cross and Blue Shield of Montana -- $7.8 million for the first year. The per-member amount could drop the next year, if more than 25,000

are on the program. Blue Cross also may ask for reimbursement of up to $3.6 million in one-time technology costs.

- PacificSource – $12.3 million for the first year. The per-member cost would decline the next year if enrollment increases.
- Stanford Health Plan -- $13.2 million for the first year, with no decline the next year.
- Allegiance Benefit Plan Management – Did not provide a cost estimate for the program's first six months. For the next six months, $4.5 million. For 2017, $9 million."

The state had estimated it would cost $6 million next year. Montana would be the only state to use a private third-party administrator to manage its entire Medicaid expansion. Read More

New York

HMA Roundup – Denise Soffel (Email Denise)

Fully Integrated Duals Advantage (FIDA) Update. The Department of Health (DoH) held a webinar (link to slides) to provide an update on the implementation of FIDA, New York's duals demonstration program. The webinar also included a lengthy Q and A session. DoH acknowledged that FIDA implementation has faced some challenges, as the low enrollment numbers demonstrate: on September 1st, enrollment stood at 7,280 with enrollee opt-outs totaling 57,375. Challenges cited include the requirements governing the work of the Interdisciplinary Team and provider participation. DoH has created a user-friendly web page for the FIDA program.

Other program highlights include:

- Expansion of FIDA into Region 2, which includes Suffolk and Westchester Counties, has been delayed until sometime in 2016. Originally scheduled to begin implementation last March, the roll-out has been delayed due to concerns about network adequacy.
- The next wave of passive enrollments (3,731 individuals) will occur on October 1. Passive enrollment will continue into 2016, although the schedule has not yet been determined.
- DoH recognizes that the FIDA Interdisciplinary Team requirements can be onerous and are in the process of proposing modifications that will increase flexibility, which will require CMS approval.
- DoH declined to speculate about how many people would ultimately enroll in the program. They acknowledged that their original estimate of 124,000, which was the number used in the original application to CMS, was too high. Although New York has over 700,000 dually eligible individuals, enrollment in FIDA is limited to eight downstate counties, and to individuals requiring more than 120 days of community-based long-term care services.
- One managed long-term care plan, United Healthcare, chose not to participate in FIDA; three other plans, ArchCare Community Life, Integra MLTC, and Montefiore MLTC, have subsequently withdrawn

from the program. DoH would not comment on whether they expected other plans to withdraw.

- The state is considering whether to extend the FIDA program for an additional two years, in response to a CMS proposal. They have filed a letter requesting the extension, but indicated that the letter is a place-holder while they consider the option. They intend to convene a stakeholder group to consider whether to extend the program, and what changes, if any, they would want to put in place as part of the extension.

North Shore-LIJ Expands Value-Based Arrangements. North Shore-LIJ announced a new value-based arrangement for Humana Medicare Advantage members in New York City and Long Island. The contract will begin in 2016 and promotes the use of the North Shore-LIJ Health System hospital and medical provider network. According to a report in Crain's Health Pulse, the contract follows several previous value-based deals North Shore-LIJ signed for commercial members enrolled in Empire and Aetna plans. The North Shore-LIJ system coordinates care through a network of primary care and specialty doctors who meet quality and clinical requirements and are willing to accept value-based payments.

HealthPlus Amerigroup Rebrands. HealthPlus Amerigroup, one of the largest Medicaid managed care plans in New York City, has announced that it is rebranding. The intent is to strengthen its association with Empire Blue Cross/Blue Shield, a sister company that is also a unit of Anthem. HealthPlus Amerigroup will officially become Empire BlueCross BlueShield Health Plus on October 1. According to a report in Crains HealthPulse, the plan wants to link its Medicaid and commercial products more closely. Empire Blue Cross offers commercial plans through New York's health exchange, but does not participate in the Medicaid market. The concern was that as consumers shopped for plans through the exchange, they might not realize that the two plans were part of the same company. HealthPlus Amerigroup itself is the product of a May 2012 merger, in which Amerigroup bought HealthPlus from Lutheran Medical Center.

Delivery System Reform Incentive Payment Program (DSRIP) Implementation Challenges. A recent report in Politico New York profiles upstate health care providers who are participating in DSRIP, highlighting some of the unique challenges these Performing Provider Systems (PPSs) face. Principal among these are large geographic service areas with inadequate public transportation infrastructure, a Medicaid population that tends to be older and more likely to have chronic illness, and an aging health care workforce leading to a shortage of health care providers. One advantage they have, notes Medicaid Director Jason Helgerson, is that the upstate PPSs are geographically discrete, unlike the downstate region where multiple PPSs operate in a given geography. It is less complex to create an integrated delivery system, the ultimate goal of NY's DSRIP program, when there is only one PPS in a region.

North Shore-LIJ Health System to Change its Name. The North Shore-LIJ Health System announced they are changing their name to Northwell Health. The new Northwell Health name will be the centerpiece of a broad rebranding and marketing campaign that will launch in 2016, to build recognition of the new name and distinguish the organization in a cluttered health care market. The rebranding comes in part as a recognition that the current name does not reflect the geographic spread of the health system, which has evolved into a

system whose service area extends well beyond Long Island's North Shore. The names of the 21 hospitals that are part of the health system will not be changed.

The health system's current name stems from the 1997 merger of the North Shore Health System and Long Island Jewish Medical Center. Since the creation of the North Shore Health System in 1992 and its eventual 1997 merger with LIJ Medical Center that created the North Shore-LIJ Health System, the organization has evolved into a vast clinical, educational and research enterprise. It has grown over the years to become the 14th-largest health system in the nation, with annual revenues of nearly $8 billion. More here.

Revisions to Certificate of Need for Residential Health Care Facilities. The September 24th meeting of the Public Health and Health Planning Council's Committee on Health Planning will include a discussion of revisions to the current need methodology for residential health care facility beds (Title 10, NYCRR Section 709.3, Determination of Public Need for Medical Facility Construction – Residential Health Care Facility Beds), which expires at the end of 2016. Nursing home operators, provider associations, consumers, long-term care advocacy groups, payers and other stakeholders are invited to comment on possible factors for consideration in the revision of the rule. Those wishing to register to speak at the committee meeting should e-mail PHHPC@health.ny.gov no later than Tuesday, September 22, 2015. Comments can be submitted in writing to karen.madden@health.ny.gov no later than noon, Tuesday, September 22, 2015.

North Carolina

Medicaid Reform Not in Final State Budget; To Be Released in Separate Bill. On September 14, 2015, *North Carolina Health News* reported that North Carolina's overhaul of the Medicaid program was not included the state's final budget. Instead, Medicaid reform will be made public in a separate bill later this week or next. The $21.7 billion budget has also not yet been made public. Health care-related changes expected to appear in the budget are listed below:

- Restores tax deduction for medical expenses for all ages, not just seniors.
- Increases support for the medical school at East Carolina University by $8 million a year.
- Provides funding for rural medical residencies in the Mountain Area Health Education Center, with $8 million a year.
- Does not eliminate Community Care of North Carolina.
- Increases support for community mental health services:
    - 7 percent increase for psychiatric beds in local hospitals
    - Adds dozens of mental health beds at Central Prison
    - Establishes mental health treatment units in eight prisons
    - Creates a Medicaid waiver for traumatic brain injury patients
    - Creates training for EMTs for diversion from emergency departments for people in mental health crisis.
- Raises age for foster children to 21 years old, adds funding for extra foster care caseload.

- Restores cuts to seniors in the Home and Community Care Block Grant.
- Provides funds for State Medical Examiner system upgrades.
- Provides $38 million in funding to adjust salaries of hard to recruit employees (such as nurses for state hospitals).
- Provides $186 million for Medicaid contingency fund.

Read More

Ohio

HMA Roundup – Mel Borkan (Email Mel)

Changes to MyCare Ohio (Ohio's Dual Eligible Demonstration). State Medicaid Director John McCarthy discussed recent changes to *MyCare Ohio* intended to improve the program at a recent meeting of the Joint Medicaid Oversight Commettee. These changes include:

- A new requirement that managed care plans provide the Ohio Department of Medicaid (ODM) with at least four months' notice when changing the availability of any provider or combination of providers serving 100 or more *MyCare Ohio* members.
- Updated standards around transportation. Requirements have been added to improve timeliness of pick-up and drop-off for appointments. Transportation vendors must attempt to contact beneficiaries should they not be able to show up for pick-up. They are also prohibited from leaving a pick-up location prior to the scheduled pick-up time.
- Clarified requirements for payment of physician Medicaid claims in accordance with ODM secondary payment methodology related to cost-sharing, unless contract incentives are clearly documented.
- Strengthening the Coordination of Benefits Agreement (COBA) requirements for managed care plans to exchange files with CMS verifying eligibility and accepting Medicare claims for Medicaid payment.
- Requiring *MyCare Ohio* plans to develop a methodology for assigning appropriate caseload sizes for care managers to ensure health, safety and effective care management for beneficiaries.

For more on the Director's testimony, click here.

Ohio Legislators Aim to Improve Infant Mortality. Improving Ohio's infant mortality rate, described as the worst in the nation, was a focus of Ohio's recent budget discussions and a new state panel is now assessing the state's effort to produce a report with recommendations by the end of next year according to the *Canton Repository*. Members of the Infant Mortality Commission had their first meeting August 26. The three leading causes of infant mortality in Ohio are prematurity or pre-term births, sleep related deaths and birth defects. The panel intends to take an inventory of state programs and funding that addresses the problems and report out by December 31. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Pennsylvania Releases Managed Long-Term Services and Supports Plan Concept Paper. The Departments of Human Services (DHS) and Aging (PDA) released a concept paper on September 16, 2015, based on public input, which describes the plan's features and is intended to gather feedback from stakeholders. The MLTSS plan, named Community HealthChoices (CHC), is an integrated system of physical health and long-term services that supports (LTSS) which focuses on improving health outcomes and allowing individuals to live safe and healthy lives with as much independence as possible. CHC supports individuals dually eligible for Medicare and Medicaid, older adults and adults with physical disabilities in the most integrated settings possible. CHC will serve an estimated 450,000 individuals, including 130,000 older persons and adults with physical disabilities who are currently receiving LTSS in the community and in nursing facilities. Read More

Pennsylvania Aims to Promote 'Value-Based' Health Care Approach. The Pennsylvania Department of Health (DOH) wants insurance companies to pay doctors and hospitals based on how effectively they treat patients, not solely on how much care they supply, said Secretary of Health Karen Murphy. DOH will survey insurers statewide to see how that "value-based" approach is catching on. Results of the survey will help set statewide goals for expanding value-based health care payments. Read More

PA Welcomes $900,000 CDC Grant to Combat Prescription Drug Overdose Epidemic. Governor Tom Wolf and Department of Health Secretary Karen Murphy have announced that the Centers for Disease Control and Prevention (CDC) has granted the Pennsylvania Department of Health $900,000 to prevent overdose deaths related to prescription opioids. DOH plans to use the grant to enhance and maximize its Prescription Drug Monitoring Program (PDMP) and promote universal PDMP registration and use. The department will also conduct a rigorous evaluation of existing laws, policies, and regulations designed to prevent opioid overuse, misuse, abuse, and overdose to ensure that the best possible regulations are in place in Pennsylvania. The Administration and DOH anticipate moving forward with the allocation of these much-needed funds upon resolution of the current budget impasse. Read More

Pennsylvania to Dig into Surprise Medical Charges. The Pennsylvania Insurance Department will hold an October hearing in an effort to eliminate or mitigate the impact of unexpected out-of-network bills on consumers. Pennsylvania Insurance Commissioner Teresa Miller said the public hearing will take place October 1, and balance billing will be the main focus. Balance billing occurs when physicians bill patients for services that the health insurance company will not cover, or only partially cover. Although patients receive emergency or routine care at in-network hospitals and facilities, the physicians may not contract with the insurer and only accept out-of-network rates. The Affordable Care Act did not outlaw balance billing, although it did add some protections for emergency health coverage. Pennsylvania is not alone in investigating and regulating surprise medical bills, and more states may follow suit as a national insurance group drafts a law to help states tackle the problem. Read More

National

MACPAC Public Meeting to be Held September 17. The next Medicaid and CHIP Payment and Access Commission meeting will be held on September 17 at the National Guard Association of the United States. The meeting will focus on developing policies that assure affordable and accessible health care coverage for the nation's low- and moderate-income children. The full agenda consists of the following sessions:

- Analytic Plan for the Year Ahead
- Future of Children's Coverage: Next Steps
- Analysis of State Transitions of Children from Separate CHIP to Medicaid (Stairstep Children)
- Estimates of Children's Coverage Under Different Policy Approaches
- Medicaid Disproportionate Share Hospital Payment: Major Policy Questions
- Medicaid Spending Trends
- Behavioral and Physical Health Integration in Medicaid

Read More

Anthem Public Policy Institute White Paper: States Should Use Medicaid Managed Care Innovations to Serve Enrollees. On September 15, 2015, *Fierce Health Payer* reported that according to a new white paper by the Anthem Public Policy Institute, states should look to innovations from Medicaid managed care organizations to better serve Medicaid enrollees. The paper highlights three main initiatives: care delivery and payment reforms, innovative use of technology, and support of non-traditional providers. Read More

Industry News

3M to Explore Strategic Alternatives for Global Health Information Systems Business. 3M Health Information Systems announced that it will explore strategic alternatives for its global Health Information Systems business, including spinning-off, selling, or retaining and investing in the business. Selection of a strategic direction is anticipated by the end of the first quarter of 2016. Read More

Dentsply to Acquire Sirona Dental Systems for $5.5 Billion. On September 15, 2015, Dentsply and Sirona Dental Systems announced a definitive merger agreement. Dentsply would acquire Sirona for $5.5 billion and create a new company worth approximately $13.3 billion. Read More

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
September 16, 2015	Pennsylvania HealthChoices	RFP Release	1,700,000
September 30, 2015	Washington (SW - Fully Integrated)	Proposals Due	100,000
October 1, 2015	Montana Expansion (TPA)	Contract Awards	70,000
October 1, 2015	Florida Healthy Kids	Implementation	185,000
October 1, 2015	Arizona (Behavioral)	Implementation	23,000
October, 2015	Indiana	RFP Release	900,000
November 16, 2015	Pennsylvania MLTSS/Duals	RFP Release	450,000
November 17, 2015	Washington (SW - Fully Integrated)	Contract Awards	100,000
November 17, 2015	Pennsylvania HealthChoices	Proposals Due	1,700,000
December 31, 2015	Indiana	Proposals Due	900,000
January 1, 2016	Michigan	Implementation	1,600,000
January 1, 2016	Iowa	Implementation	550,000
January 15, 2016	Pennsylvania MLTSS/Duals	Proposals Due	450,000
April 1, 2016	Washington (SW - Fully Integrated)	Implementation	100,000
July, 2016	Georgia	Implementation	1,300,000
September 1, 2016	Texas STAR Kids	Implementation	200,000
January 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
January 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	450,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	450,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	450,000

Dual Eligible Financial Alignment Demonstration Calendar

Below is a summary table of the progression of states toward implementing dual eligible financial alignment demonstrations in 2014 and 2015.

State	Model	Duals eligible for demo	RFP Released	RFP Response Due Date	Contract Award Date	Signed MOU with CMS	Opt- in Enrollment Date	Passive Enrollment Date	Health Plans
California	Capitated	350,000	X	3/1/2012	4/4/2012	3/27/2013	4/1/2014	5/1/2014 7/1/2014 1/1/2015	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)
Colorado	MFFS	62,982				2/28/2014		9/1/2014	
Connecticut	MFFS	57,569						TBD	
Illinois	Capitated	136,000	X	6/18/2012	11/9/2012	2/22/2013	4/1/2014	6/1/2014	Aetna; Centene; Health Alliance; Blue Cross Blue Shield of IL; Cigna-Health Spring; Humana; Meridian Health Plan; Molina
Massachusetts	Capitated	90,000	X	8/20/2012	11/5/2012	8/22/2013	10/1/2013	1/1/2014	Commonwealth Care Alliance; Fallon Total Care (*exiting demo*); Network Health
Michigan	Capitated	105,000	X	9/10/2013	11/6/2013	4/3/2014	3/1/2015	5/1/2015	AmeriHealth Michigan; Coventry (Aetna); Fidelis SecureCare; Meridian Health Plan; Midwest Health Plan; Molina Healthcare; Upper Peninsula Health Plan
New York	Capitated	124,000	Application			8/26/2013	1/1/2015 *(Phase 2 Delayed)*	4/1/2015 *(Phase 2 Delayed)*	There are 22 FIDA plans selected to serve the demonstration. A full list is available on the MRT FIDA website.
North Carolina	MFFS	222,151						TBD	
Ohio	Capitated	114,000	X	5/25/2012	6/28/2012	12/11/2012	5/1/2014	1/1/2015	Aetna; CareSource; Centene; Molina; UnitedHealth
Oklahoma	MFFS	104,258						TBD	
Rhode Island*	Capitated	30,000	X	5/12/2014	9/1/2014	7/30/2015	12/1/2015	2/1/2016	Neighborhood INTEGRITY
South Carolina	Capitated	53,600	X		11/1/2013	10/25/2013	2/1/2015	4/1/2016	Absolute Total Care (Centene); Advicare; Molina Healthcare of South Carolina; Select Health of South Carolina (AmeriHealth)
Texas	Capitated	168,000	N/A	N/A	N/A	5/23/2014	3/1/2015	4/1/2015	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	78,596	X	5/15/2013	12/9/2013	5/21/2013	3/1/2014	5/1/2014	Humana; Anthem (HealthKeepers); VA Premier Health
Washington	Capitated	48,500	*Cancelled Capitated Financial Alignment Model*						
	MFFS	66,500	X			10/24/2012		7/1/2013; 10/1/2013	
Totals	**10 Capitated 5 MFFS**	**1.3M Capitated 513K FFS**	***10***			***12***			

** Phase I enrollment of duals only includes Medicaid benefits. Medicare-Medicare integration to occur within 12 months.*

Dual Eligible Financial Alignment Demonstration Enrollment Progress

The table below details state and CMS-reported enrollment data for the dual eligible financial alignment demonstrations in the nine states with active demonstration enrollment.

State	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
California	122,908	123,079	124,239	122,520	122,798	122,846	120,452	116,470
Illinois	63,731	64,199	60,684	58,338	55,672	52,763	52,170	51,631
Massachusetts	17,867	17,763	17,797	17,621	17,637	17,705	17,671	17,518
Michigan					9,216	14,867	28,171	35,102
New York	17	406	539	6,660	7,215	5,031	7,122	9,062
Ohio	68,262	66,892	65,657	63,625	63,446	62,958	61,871	62,418
South Carolina		83	1,205	1,398	1,366	1,317	1,388	1,380
Texas			58	15,335	27,589	37,805	44,931	56,423
Virginia	27,333	26,877	27,765	27,349	30,877	29,970	29,507	29,200
Total Duals Demo Enrollment	**300,118**	**299,299**	**297,944**	**312,846**	**335,816**	**345,262**	**363,283**	**379,204**

HMA NEWS

New this week on the HMA Information Services website:

- **New York** Medicaid Managed Care Enrollment Rises 4.8%, Aug-15 Data
- Medicaid Managed Care MLRs, 34 States, 2013-14 Data
- Public documents including the **New York** DSRIP quarterly report, **Texas** STAR Health proposals and related documents, Medicaid new adult group expenditures data report, 2014

If you would like to subscribe to this online service, which describes the Medicaid programs in 50 states and DC, please contact Carl Mercurio at cmercurio@healthmanagement.com or 212-575-5929.

HMA and AristaMD Announce Strategic Partnership

On September 16, 2015, HMA and AristaMD announced a partnership combining HMA's consulting and content expertise with AristaMD's technology solution to offer healthcare providers a new way to facilitate specialty consults and referrals at significantly decreased costs. The Arista MD Referral Intelligence Platform was designed by practicing clinicians to offer a streamlined and simple approach for primary care providers to triage and facilitate specialty referrals. AristaMD has over 200 clinical guidelines for the most common referral scenarios that ensure an appropriate assessment and work-up before referrals are made. AristaMD also offers access to a broad panel of board-certified specialists to provide e-consults for the primary care provider within 24 hours. This suite of tools was designed to support primary care physicians and effectively replaces a significant portion of routine specialist consults. Read More

HMA Upcoming Webinar: *"Sustainable Evidence-based Integration: A Step-by-Step Guide to Integrating Behavioral Health into the Primary Care Setting"*

Tuesday, Sept. 22, 2015
1 to 2 p.m. EDT

Register here for this free event.

HMA Upcoming Webinar: *"21st Century LTSS: A Roadmap to Improved Outcomes, Lower Costs and Better Lives for Individuals with Complex Healthcare Needs"*

Wednesday, September 23, 2015
1 to 2 p.m. EDT

Register here for this free event.

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; Pacific Northwest; Sacramento, San Francisco, and Southern California; Tallahassee, Florida; and Washington, DC. http://healthmanagement.com/about-us/

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