HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

November 2, 2016

Edited by:
Greg Nersessian, CFA
Email

Andrew Fairgrieve
Email

Alona Nenko
Email

Julia Scully
Email

THIS WEEK

IN FOCUS

ARIZONA ISSUES REQUEST FOR PROPOSALS FOR ARIZONA LONG TERM CARE SYSTEM (ALTCS)

This week, our *In Focus* section reviews the request for proposals (RFP) issued by the Arizona Health Care Cost Containment System (AHCCCS) on November 1, 2016, to reprocure Medicaid managed care contracts for the Arizona Long Term Care System (ALTCS) program. ALTCS is one of the oldest Medicaid managed long term services and supports (MLTSS) programs in the country, providing integrated acute care, LTSS, and behavioral health services to individuals who are elderly, individuals with physical disabilities, and individuals with intellectual or developmental disabilities (I/DD). However, this RFP only covers the roughly 26,500 individuals who are elderly or individuals with a physical disability (E/PD); this RFP does not include individuals with I/DD, who are covered through a state-run model.

Covered Populations, Estimated Annual Spending

The ALTCS E/PD RFP covers nearly all Medicaid and Medicaid-Medicare dual eligible members statewide who are elderly or have a physical disability. As of October 1, 2016, there were 26,532 ALTCS E/PD members covered by one of three existing MCOs. The ALTCS program is currently broken out into seven geographic services areas (GSAs), which will be consolidated down to three GSAs under this RFP. As detailed in the table below, based on the 2017 actuarial certification for ALTCS E/PD rates, the average statewide per-member-per-month (PMPM) rate is around $3,300. Based on this PMPM membership of roughly 26,500, annual payments to MCOs under ALTCS E/PD contracts exceed $1 billion.

	Est. Member Months	Est. Avg. Monthly Members	Est. 2017 Capitation	Est. PMPM
E/PD - Dual	263,834	21,986	$789,083,305	$2,991
E/PD - Non-Dual	53,044	4,420	$303,381,119	$5,719
Prior Period Cost (PPC)	10,946	912	$10,897,075	$996
Acute Only	5,124	427	$3,147,957	$614
Total	**332,948**	**27,746**	**$1,106,509,456**	**$3,323**

Source: ALTCS Actuarial Certification, 2017

D-SNP Requirements

ALTCS E/PD health plans awarded under this RFP must operate a Medicare Dual Eligible Special Needs Plan (D-SNP) by January 1, 2018. Bidders must submit a non-binding notice of intent to apply as a D-SNP no later than November 10, 2016, with the final application due by February 1, 2017. The RFP states that AHCCCS will not contract with any D-SNP to serve the ALTCS E/PD Medicaid population outside of awarded ALTCS E/PD contracts. Going forward, the state intends to continue to take steps to improve alignment for dual eligible members.

RFP Timeline

AHCCCS will conduct three rounds of questions and answers over the next two months, with proposals due to the state on January 23, 2017. AHCCCS intends to award contracts and begin transition activities in March, 2017, with operational implementation set for October 1, 2017.

RFP Milestone	Date
RFP Issued	November 1, 2016
Pre-Proposal Conference	November 8, 2016
RFP Questions Due	November 10, 2016
Responses to Questions Issued	November 30, 2016
Second Set of RFP Questions Due	December 7, 2016
Capitation Rate Ranges Released	December 19, 2016
Responses to Second Questions Issued	December 21, 2016
Capitation Rate Questions Due	December 27, 2016
Responses to Capitation Rate Questions Issued	January 5, 2017
Proposals Due	**January 23, 2017**
Contracts Awarded	**March 7, 2017**
Implementation	**October 1, 2017**

Proposal Evaluation

ALTCS E/PD proposals will be evaluated across the following four categories, and will be weighted in order from high to low, although weighting is not

specified in the RFP documents, with program and capitation sections weighted higher than access/network and administrative.

- Program (including oral presentations)
- Capitation
- Access to Care/Network
- Administrative

The Capitation section will be scored separately for each GSA, while the other three categories will be scored statewide.

Contract Awards, Terms

AHCCCS intends to award a maximum of three contracts in the Central GSA, and a maximum of one contract in each of the North and South GSAs, with the exception of potentially awarding two contracts for Pima County in the South GSA.

GSA	Counties		ALTCS E/PD Awards
North	Mohave Cocnino Apache	Navajo Yavapai	Maximum of 1
South	Cochise Graham Greenlee La Paz	Pima Santa Cruz Yuma	Maximum of 1 *(Pima Co. Max.of 2)*
Central	Maricopa Gila Pinal		Maximum of 3

To be eligible for an ALTCS E/PD contract award in the Central GSA, bidders must also submit a bid for the North GSA. AHCCCS does not intend to award any bidders a statewide contract to cover all three GSAs. Contracts will begin October 1, 2017, with an initial three year term. There are three contract renewal terms available – one two-year renewal term, followed by two one-year renewal terms.

Current ALCTS Market

There are three MCOs currently serving the ALTCS E/PD market. Mercy Care Plan, which has an ASO arrangement with Aetna, is the largest, with more than 41 percent of the market, followed by United at more than 38 percent. Centene's Bridgeway Health Solutions is the third plan, with just under 20 percent market share. UnitedHealthcare is the only ALTCS MCO currently operating in all three of the redesigned GSAs.

	Central GSA	North GSA	South GSA	Total	% Market
Mercy Care Plan (Aetna ASO)	9,370	0	1,705	11,075	41.7%
UnitedHealthcare	3,716	2,614	3,846	10,176	38.4%
Bridgeway Health Solutions (Centene)	4,499	0	782	5,281	19.9%
Total - All ALTCS MCOs	**17,585**	**2,614**	**6,333**	**26,532**	

Note: GSAs in table above based on RFP, not current GSA design.
Source: AHCCCS Enrollment Data, October 2016.

RFP Documents, Bidders Library

The ALTCS E/PD RFP, bidders library, and other documents are available at: https://www.azahcccs.gov/PlansProviders/HealthPlans/YH18-0001.html

HMA Medicaid Roundup

Colorado

Accountable Care Collaborative Reports Savings, Prepares for Phase Two. The Colorado Department of Health Care Policy and Financing reported on November 1, 2016, that the state's net savings from its Accountable Care Collaborative (ACC) were $62 million in fiscal 2016, with total net savings of $139 million since the program began in 2011. Emergency room use decreased under the program, while follow-up care after hospital discharge and well-child visits increased. The figures were part of a report in response to a Joint Budget Committee Request for Information regarding the ACC. The state is preparing to launch a second phase of the program. Read More

Connecticut

State Panel Submits Initial Recommendations to Form CCOs, Control Health Care Costs. The *CT Mirror* reported on November 2, 2016, that provider-led consumer care organizations (CCOs) are part of a package of recommendations presented to legislators this week, despite the opposition of the state's Medicaid agency. The Health Care Cabinet – a panel established by state law and including representatives of state agencies, the health care industry, and others – submitted initial recommendations to state legislators, including CCOs along with other initiatives to control health care costs. Under the CCO model, which is the most controversial of the initial recommendations, the provider-led entities would be at risk for hitting quality and cost targets. The Cabinet will meet on November 15 to hear public input before submitting the final recommendations. Read More

Hospitals Seek CMS Intervention on Medicaid Rates, Assessment Tax. *The CT Mirror* reported on November 1, 2016, that Connecticut hospitals have filed a petition asking the Centers for Medicare & Medicaid Services (CMS) to declare the state's Medicaid reimbursement rates inadequate and a state hospital tax illegal. The petition, backed by the Connecticut Hospital Association and 20 hospitals, argues that state Medicaid reimbursement rates threaten hospital financial stability, quality of care, and access to care for Medicaid beneficiaries. Hospitals in the state have laid off 1,390 workers and eliminated over 1,700 open positions since 2014. Read More

Florida

HMA Roundup – Elaine Peters (Email Elaine)

Hospitals Challenge Medicaid Outpatient Rate Reductions. *Politico* reported on November 1, 2016, that two of Florida's largest for-profit hospital groups, HCA Florida and Tenet Healthcare, plan to challenge the state's proposed Medicaid outpatient rate reductions. Over the summer, the Florida Agency for Health Care Administration announced that rates would be $132 million less than what the state legislature had authorized, a move hospital executives say oversteps legislative authority. The reductions come as the state continues to deal with rising Medicaid costs and a Medicaid budget shortfall. HCA has 46 hospitals in Florida; Tenet has nine.

Illinois

Advocate, NorthShore Sent Back to Court Over Proposed Merger. *Modern Healthcare* reported on October 31, 2016, that the proposed merger of Advocate Health Care and NorthShore University HealthSystem is going back to court. The 7th U.S. Circuit Court of Appeals ruled that a previous decision by a lower court to allow the merger was flawed. The Federal Trade Commission is challenging the merger on antitrust grounds, arguing that insurers and patients will be negatively impacted by the consolidation. The merger will remain on hold until the federal district court in Chicago reevaluates the FTC's request for a preliminary injunction to block the deal. Read More

Cook County Clinic Opens to Keep Individuals with Mental Illness Out of Jails, Hospitals. *The Chicago Tribune* reported on November 1, 2016, that a new Cook County clinic has opened on Chicago's South Side aimed at keeping individuals with mental illnesses and substance use disorders out of the jail system and hospital emergency departments. Community Triage Center is open 24 hours a day and provides walk-in assessments, support, and referrals. The clinic also allows police officers to bring in individuals. The program was modeled off of similar clinics in Arizona, Nevada, and Texas. Approximately 20 percent of detainees at the Cook County Jail have mental health needs. Read More

Iowa

Medicaid Managed Care Plans to Receive $33 Million Increase in Payments. *Globe Gazette* reported on October 31, 2016, that Iowa will increase payments to the state's three Medicaid managed care plans by $33 million in fiscal 2017 to help offset higher-than-expected costs for prescription drugs and expansion members. Governor Terry Branstad said that state still expects to save $100 million to $110 million in Medicaid spending because of the recent transition to Medicaid managed care. Read More

Maryland

Report Finds Medicaid Managed Care Spending Twice as Much for Individuals with Diabetes. *The Baltimore Sun* reported on October 27, 2016, that according to a study published by Hilltop Institute at the University of Maryland, individuals with diabetes are costing the Medicaid program twice as much than those without the condition. Hilltop, commissioned by MedChi, analyzed adults aged 35 to 64 enrolled in HealthChoice, the state's Medicaid managed care program. In 2014, average annual Medicaid spending for a patient with diabetes was $24,387, compared to $10,880 for a member without a diabetes diagnosis. Overall, HealthChoice spent over $471 million treating people with diabetes in 2014 and $312 million in 2013. Read More

Massachusetts

Neighborhood Health Plan Temporarily Freezes Medicaid Enrollment. *The Boston Globe* reported on October 27, 2016, that Neighborhood Health Plan has temporarily frozen new Medicaid enrollments due to financial struggles. The plan lost $110 million on operations in fiscal year 2014, $75 million in fiscal year 2015, and $56 million in the nine-month period ending June 30, 2016. The enrollment freeze is part of a corrective action plan developed in collaboration with MassHealth officials. Neighborhood Health Plan has around 300,000 Medicaid members, an increase of 30 percent over the last two years. Read More

Michigan

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

From HMA's "The Michigan Update":

Governor Snyder Vetoes HICA Repeal/Replacement. In previous editions of *The Michigan Update*, most recently in July, we reported on four bills introduced in the Michigan Senate (SB 987 - 990) that would eliminate the Health Insurance Claims Assessment (HICA) tax - a one percent tax on health insurance claims - and replace it with a revised Use Tax on Medicaid HMOs and Prepaid Inpatient Health Plans. The HICA tax has been very controversial since its inception, and very much disliked by business groups. On October 20, 2016, the Michigan Legislature approved the four bills and sent them to Governor Rick Snyder for signature. On October 27th, the Governor vetoed them. "This legislation would sunset HICA 18 months earlier than the extension that just passed the Legislature earlier this year," Mr. Snyder said in a statement. "I am very concerned that the federal government would not recognize this tax structure as an eligible Medicaid matching fund source, putting at risk federal funding for critical state health programs and leaving our state budget out of balance."

MDHHS Issues RFPs. On October 17, 2016, the Michigan Department of Health and Human Services (MDHHS) announced that it is issuing two Requests for Proposals (RFPs) to support individuals with intellectual and developmental disabilities (I/DD) and their families. The *Leadership Development Opportunities RFP* seeks an organization to create leadership development opportunities for individuals with I/DD, and the *Self-Determination in Michigan RFP* seeks an organization to establish a statewide effort to address availability and access to tools and supports that people with I/DD need to control the services they

receive and to live self-directed lives. Each RFP is open to private non-profit organizations, institutions of higher education, and governmental agencies and will result in five-year grant awards of $650,000. Applications are due to MDHHS by November 15, 2016. Full RFP details are available here.

Matt Lori Replacing Elizabeth Hertel. On October 31, 2016, the Michigan Department of Health and Human Services (MDHHS) announced that Matt Lori will serve as Acting Senior Deputy Director of the Policy, Planning and Legislative Services Administration, effective immediately. Mr. Lori is assuming the position vacated by Elizabeth Hertel, who recently left the department to join Trinity Health as director of state advocacy. A former state representative and most recently the health care administrator at MDHHS, in his new role Mr. Lori will oversee Michigan Rehabilitation Services, Health Policy and Innovation, Legislative and Constituent Services, and the Office of Planning which includes the Pathways to Potential program and Certificate of Need. Read More

New CEO at Health Alliance Plan. In early October 2016, *Crain's Detroit Business* reported that Health Alliance Plan of Michigan has hired a new Chief Executive Officer who will assume her position effective November 21, 2016. Teresa Kline is a native Michigander who most recently was a health care consultant in Georgia. She has also served in leadership positions at Health Care Service Corporation in Chicago (a multi-state Blue Cross plan), Aetna Health Plans, CHA Health and UnitedHealthcare of Georgia. She replaces Jim Connelly, who retired in August 2015.

New Jersey

HMA Roundup – Karen Brodsky (Email Karen)

Bill would check opioids patient-safety protocols before prescribing. On October 25, 2016, *NJSpotlight* reported that Senator Ray Lesniak introduced S2703, which would prohibit an insurance company from providing coverage on opioids unless the prescribing health care professional provides documentation that is consistent with the regulations adopted by the State of Board of Medical Examiners. Due to the growing opioid and heroin epidemic in New Jersey, Senator Lesniak introduced this bill as a means of ensuring that highly addictive drugs are only prescribed as necessary. This bill would require that health professionals prescribing opioids abide by the Centers for Disease Control and Prevention guidelines and provide documentation that alternative drug-free methods were unsuccessful. If passed, New Jersey would be the first state in the nation to hold insurance companies accountable for ensuring that opioids are appropriately prescribed to patients.

Assembly Committee votes on the latest bill to support out-of-network protections; providers oppose. On October 28, 2016, *NJSpotlight* reported that the New Jersey Assembly Appropriations Committee voted to support the latest version of the "Out-of-Network Consumer Protection, Transparency, Cost Containment and Accountability Act" (A1952), which would require doctors and hospitals to be transparent with their rates for standard treatments and their participation in a patient's insurance network. Additionally, the bill would protect patients from being caught in payment disputes and establish a binding dispute resolution process for providers and insurers who cannot come to an agreement on their own. Although this bill is expected to save hundreds of

millions of dollars each year for New Jersey, provider representatives are still opposing the bill as it may reduce hospital revenue and exacerbate physicians' concerns about over-regulation.

DHS plans a 2017 Budget Listening Session. On November 22, 2016 the Department of Human Services will hold a 2017 budget listening session for stakeholders and the public to provide suggestions regarding the FY17 state budget. The meeting will take place at the DHS Central Office, first floor conference room from 10 am – 4 pm. Written testimony may be delivered at the session, emailed to DHSBudgetInput@dhs.state.nj.us or mailed parcel post to:

DHS Budget Input
222 South Warren Street
PO Box 700
Trenton, NJ 08625-700

New Mexico

HSD Seeks Federal Approval to Charge Some Medicaid Patients Co-Pays. *The Washington Times* reported on October 26, 2016, that the New Mexico Human Services Department (HSD) is seeking federal approval to charge Medicaid patients small co-payments in hopes of driving down unnecessary utilization, such as emergency room visits for primary care. Children and pregnant women, as well as Native American beneficiaries, would likely be exempt from the co-payments. The agency has not yet decided how much the co-payments would be. Read More

Pennsylvania

HMA Roundup – Julie George (Email Julie)

Medical Assistance Advisory Committee Meeting Procurement Updates. The Pennsylvania Department of Human Services provided updates on recent procurements during their monthly Medical Assistance Advisory Committee meeting held on October 27, 2016. Leesa Allen, Deputy Secretary of the Office of Medical Assistance Programs, announced that the submissions for the physical health HealthChoices program were still under review. Allen said it was very likely that DHS would announce winning bidders in the next four weeks. Kevin Hancock, Chief of Staff for the Office of Long Term Living, informed meeting attendees that OLTL was still reviewing protests to the Community HealthChoices awards. Hancock said that the department would have final decisions by late fall.

Draft RFP for Independent Enrollment Broker Released for Comment. On October 28, 2016, the Pennsylvania Department of Human Services released a draft Request for Proposals (RFP) for an Independent Enrollment Broker (IEB) to manage the enrollment processes for the Office of Long-Term Living's (OLTL) programs. Along with the draft RFP, DHS posted a summary document, and a template for submitting comments. The department is seeking input from any current or future consumer of services, caregivers, professional service providers, and other citizens concerned about the enrollment process. Questions, concerns, and suggestions will be considered for incorporation in the final RFP. Comments to the draft RFP by are due by 5 p.m. on November 21, 2016. The draft RFP documents can be viewed here.

Rhode Island

Medicaid Enrollment, Costs Top Expectations. *Providence Journal* reported on October 31, 2016, that Medicaid spending in Rhode Island is running ahead of projections, largely attributed to continued growth in the state's Medicaid population. Medicaid spending is projected to be $72 million over budget in fiscal 2017, with the state's share coming in at $9.5 million over budget. Enrollment is up 4 percent this year to 287,618. State officials are trying to understand why Medicaid enrollment is rising despite an improving economy and lower unemployment, an issue reported in other states as well. Read More

Texas

Decline in Utilization of Therapy for Children with Disabilities Seen Following Funding Cuts. *Austin-American Statesman* reported on November 1, 2016, that the number of children with disabilities under age three receiving physical, speech, and occupational therapy declined 14 percent from 2011 through 2015. These findings were released in a new report by child advocacy group Texans Care for Children as the state is implementing funding cuts for early childhood intervention services passed by the state legislature in 2015. Both the number of services offered and the number of therapy providers have fallen as well. Read More

Vermont

All-Payer ACO Model Set to Begin in January 2017. *Modern Healthcare* reported on October 26, 2016, that Vermont's voluntary all-payer accountable care organization (ACO) model, the first in the nation of its kind, will begin in January 2017. Vermont's model will require Medicare, Medicaid, and commercial payers to pay similar rates for all services. The demonstration will continue for five years and be funded through an 1115 waiver, with the Centers for Medicare & Medicaid Services (CMS) initially contributing $9.5 million to the program. The state is hoping to have 70 percent of its insured residents enrolled in an ACO by 2022. Read More

Virginia

Medicaid Costs to Rise $281 Million Over Next Two Years. *The Richmond Times-Dispatch* reported on November 1, 2016, that Medicaid costs in Virginia are projected to rise $281 million in the current two-year budget period, straining Governor Terry McAuliffe's ability to push through Medicaid expansion in the state. Overall, the state is projected to have $1.48 billion budget shortfall over the same period. The Medicaid increased spending forecast is driven largely by higher costs for services to the elderly and individuals with disabilities. Governor McAuliffe argues that expansion would free up $211 million in state funds; however, Republican legislators continue to oppose expansion. Read More

West Virginia

HCBS Transition Plan Approved by CMS. The West Virginia Bureau for Medical Services announced on October 27, 2016, that the state had received initial federal approval for a State-wide Transition Plan for Medicaid home and community-based services (HCBS). The transition plan, approved by the Centers for Medicare & Medicaid Services, hopes to bring all West Virginia HCBS waivers into compliance with federal requirements. The state has three HCBS waivers: the Aged and Disabled Waiver, the Individuals with Intellectual and/or Developmental Disabilities Waiver, and the Traumatic Brain Injury Waiver. The initial approval and plan can be accessed here.

National

Medicaid Expansion, CHIPRA Drive 95 Percent Insured Rate for Children, Report Finds. *The Columbus Dispatch* reported on October 27, 2016, that the rate of children with health insurance hit a historic high of 95 percent in 2015, driven by Medicaid expansion and the Children's Health Insurance Program Reauthorization Act. The report was published by the Georgetown University Center for Children and Families. Between 2013 and 2015, the rate of uninsured children went from 7.1 percent to 4.8 percent, according to the report. Read More

States to Begin Push for CHIP Funding Extension. *CQ Roll Call* reported on October 31, 2016, that state officials and advocates are preparing to push for a funding extension for the Children's Health Insurance Program (CHIP). Funding for the program runs out in 2017, and states are hoping for a two-year extension at current levels. The entire CHIP program requires reauthorization in 2019.

Off-Exchange Plans Have Broader Networks, Higher Premiums, RWJF Study Finds. *Kaiser Health News* reported on October 28, 2016, that individual health insurance plans sold off the Exchanges in 2016 had higher premiums and deductibles than plans offered on the Exchange, according to a study conducted by the Robert Wood Johnson Foundation. However, provider networks were broader for off-Exchange plans. While silver plans made up two-thirds of all plans offered on the Exchanges, plans with equivalent silver-level benefits made up only a third of all plans sold outside the Exchanges. Read More

Insurers, Providers at Odds Over Premium Assistance Programs. *Kaiser Health News* reported on October 31, 2016, that insurers and providers are in disagreement over premium assistance programs, in which community-based organizations, providers and advocates help individuals pay for Exchange coverage. America's Health Insurance Plans argues that the programs steer individuals into the Exchanges and skew the risk pool. Providers and patient advocates say the programs are important in expanding coverage and maintaining affordability. Read More

Industry News

Trusted Health Plan Acquires Detroit Medical Center's Harbor Health Plan. *Crain's Detroit Business* reported on October 31, 2016, that Washington, DC-based Medicaid plan Trusted Health Plans Inc. has acquired Harbor Health Plan from Tenet's Detroit Medical Center for $16 million. Harbor Health had net income of $4.3 million on revenues of $36.6 million in 2015. Tenet/DMC has owned Harbor since 2014.

Community Health Systems Stock Drops Nearly 50 Percent On 3Q16 Losses. *Modern Healthcare* reported on October 27, 2016, that shares in Community Health Systems (CHS) fell nearly 50 percent to $5.05 a share after the company reported an $83 million operating loss from continuing operations as well as a decline in revenues. Tennessee-based CHS attributed the loss to hospital divestitures, lower volumes, and decreases in supplemental hospital reimbursements from states. Read More

Molina Reports 3Q16 Net Income of $42 Million. *The Long Beach Press-Telegram* reported on October 27, 2016, that Molina Healthcare had third quarter 2016 net income of $42 million on revenues of $4.2 billion. Earnings per share rose 31 percent compared to the second quarter of 2016, while revenues were up 26 percent from the third quarter of 2015. Mario Molina, chief executive, said the insurer's biggest challenge concerns risk pool payments mandated by the Affordable Care Act. Read More

Heavy Debt a Consideration in Possible Merger of Dignity Health, Catholic Health Initiatives. *Modern Healthcare* reported on October 29, 2016, that Dignity Health and Catholic Health Initiatives (CHI) hope to decide on a possible merger by early 2017, with initial due diligence confirming complementary geographic footprints and heavy debt loads. The merger would establish the country's largest not-for-profit hospital chain, with 142 hospitals and combined annual revenues of $27.8 billion. However, the two organizations have about $14 billion in debt combined. In July, Fitch downgraded CHI's debt to BBB+ from A+. Read More

Kindred, Mercy Medical Center to Build Inpatient Rehab Hospital in Iowa. *Business Wire* reported on October 27, 2016, that Kindred Healthcare and Mercy Medical Center – Des Moines have signed a definitive agreement to jointly build and operate a 50-bed inpatient rehabilitation hospital in Clive, IA, the first of its kind in the state. The venture has received Certificate of Need approval from the state, but requires additional regulatory approvals. The hospital plans to open in the second quarter of 2018. Read More

DaVita Kidney Care Halts Support for Charitable Premium Assistance Applications. *PR Newswire* reported on October 31, 2016, that DaVita Kidney Care, a division of DaVita Inc., announced that it is temporarily halting support for applications to the American Kidney Fund for premium assistance. Under the program, patients on dialysis with minimum essential Medicaid coverage

can potentially receive additional coverage through an Exchange plan. The change is expected to impact approximately 2,000 individuals, or one percent of the company's total patients. Read More

RFP Calendar

Date	State/Program	Event	Beneficiaries
November, 2016	Nevada	Contract Awards	420,000
November, 2016	Washington, DC	RFP Release	200,000
November, 2016	Oklahoma ABD	RFP Release	177,000
November 9, 2016	Wisconsin Family Care/Partnership (MLTSS)	Proposals Due	14,000
December 1, 2016	Massachusetts MassHealth ACO - Pilot	Implementation	TBD
December 9, 2016	Virginia MLTSS	Contract Awards	212,000
December, 2016	Massachusetts	RFP Release	860,000
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
December, 2016	Massachusetts MassHealth ACO - Full	Proposals Due	TBD
January 17, 2017	Wisconsin Family Care/Partnership (MLTSS)	Contract Awards	14,000
January 23, 2017	Arizona ALTCS (E/PD)	Proposals Due	30,000
January, 2017	Oklahoma ABD	Proposals Due	177,000
February, 2017	Rhode Island	Implementation	231,000
March 7, 2017	Arizona ALTCS (E/PD)	Contract Awards	30,000
May 1, 2017	Missouri (Statewide)	Implementation	700,000
May, 2017	Oklahoma ABD	Contract Awards	177,000
July 1, 2017	Wisconsin Family Care/Partnership (MLTSS)	Implementation	14,000
July 1, 2017	Nevada	Implementation	420,000
July 1, 2017	Pennsylvania MLTSS/Duals	Implementation (SW Region)	100,000
July 1, 2017	Virginia MLTSS	Implementation	212,000
August, 2017	Georgia	Implementation	1,300,000
October 1, 2017	Arizona ALTCS (E/PD)	Implementation	30,000
October, 2017	Massachusetts MassHealth ACO - Full	Implementation	TBD
October, 2017	Massachusetts	Implementation	860,000
January 1, 2018	Pennsylvania MLTSS/Duals	Implementation (SE Region)	145,000
March, 2018	North Carolina	RFP Release	1,500,000
April, 2018	Oklahoma ABD	Contract Awards	177,000
June, 2018	North Carolina	Proposals Due	1,500,000
September, 2018	North Carolina	Contract awards	1,500,000
January 1, 2019	Pennsylvania MLTSS/Duals	Implementation (Remaining Regions)	175,000
July 1, 2019	North Carolina	Implementation	1,500,000

Dual Eligible Financial Alignment Demonstration Implementation Status

Below is a summary table of the progression of states toward implementing a dual eligible financial alignment demonstration.

State	Model	Opt- in Enrollment Date	Passive Enrollment Date	Duals Eligible For Demo	Demo Enrollment (Sept. 2016)	Percent of Eligible Enrolled	Health Plans
California	Capitated	4/1/2014	5/1/2014 7/1/2014 1/1/2015	350,000	115,736	33.1%	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	46,330	34.1%	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	13,012	13.4%	Commonwealth Care Alliance; Network Health
Michigan	Capitated	3/1/2015	5/1/2015	100,000	36,982	37.0%	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	4,990	4.0%	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	310	1.6%	Partners Health Plan
Ohio	Capitated	5/1/2014	1/1/2015	114,000	61,651	54.1%	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	8,156	15.2%	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	38,658	23.0%	Anthem (Amerigroup), Cigna-HealthSpring, Molina, Superior (Centene), United
Virginia	Capitated	3/1/2014	5/1/2014	66,200	27,477	41.5%	Humana; Anthem (HealthKeepers); VA Premier Health
Total Capitated	**10 States**			**1,254,200**	**353,302**	**28.2%**	

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: "What Matters Most: Essential Attributes of a High-Quality System of Care for Adults with Complex Care Needs"

Tuesday, November 22, 2016

1 to 2 p.m. EST

Link to Webinar Registration

What are the Essential Attributes of a high-performing healthcare system for adults with complex care needs? The SCAN Foundation convened a working group of national experts that identified four "Essential Attributes," based on person-centered care that serves the goals and needs of individuals, their families, and caregivers.

During this webinar, representatives from Health Management Associates, The SCAN Foundation, and leading quality measurement organizations will discuss how a growing understanding of the Essential Attributes of high-performing healthcare systems will impact quality reporting and measurement in the future – fostering systems of care that support the independence, health, and well-being of adults with complex care needs in the least restrictive settings possible.

Speakers

- Bruce Chernof, MD, President, Chief Executive, The SCAN Foundation
- Sarah Barth, JD, Principal, Health Management Associates
- Tracy Lustig, DPM, MPH, Senior Director, National Quality Forum
- Jessica Briefer French, MHSA, Assistant Vice President, Research, National Committee for Quality Assurance

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