

HEALTH MANAGEMENT ASSOCIATES

HMA Weekly Roundup

Trends in State Health Policy

..... November 16, 2016



THIS WEEK

- IN FOCUS: REVISITING REPUBLICAN GOVERNORS' 2011 MEDICAID REFORM PROPOSALS
- OHIO MEDICAID DIRECTOR JOHN MCCARTHY STEPPING DOWN
- ELECTION RESULTS DERAILED MEDICAID EXPANSION DISCUSSIONS IN GEORGIA, IDAHO, SOUTH DAKOTA
- ANDREW BREMBERG TO LEAD TRUMP HEALTH CARE TRANSITION TEAM
- KANSAS PILOT AIMS TO MOVE INDIVIDUALS WITH I/DD TO HCBS SETTINGS
- AETNA, CENTENE CEOs COMMENT ON HEALTH CARE POLICY OUTLOOK
- HMA WEBINAR: "A COMPREHENSIVE APPROACH TO MANAGED LONG-TERM SERVICES AND SUPPORTS"

IN FOCUS

REVISITING REPUBLICAN GOVERNORS' 2011 MEDICAID REFORM PROPOSALS

This week, our *In Focus* section revisits a 2011 report from the Republican Governors Public Policy Committee Health Care Task Force. The report, titled "*A New Medicaid: A Flexible, Innovative and Accountable Future*," was prepared with input from governors, secretaries of health and human services, Medicaid directors, and other senior policy staff in the 31 states (including two territories) with Republican governors at the time. Across these 31 states, 20 of the governors in office at the time of the report are still in office. Only three of the 31 states (Louisiana, Pennsylvania, and Virginia) now have Democratic governors in office, although Alaska's new governor is an Independent who expanded Medicaid this year. The report provides more than 30 recommended solutions across seven broad principles that would "increase Medicaid's efficiency and effectiveness as a part of the overall health care delivery system regardless of whether or not [the Affordable Care Act (ACA)] is repealed."

[RFP CALENDAR](#)

[DUAL ELIGIBLES CALENDAR](#)

[HMA NEWS](#)

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The solutions highlighted below align with some of the national policy positions coming from Congress and the incoming Administration, but also include additional ideas that the Republican governors offered for consideration. Given that these proposals are now five years old, some solutions are no longer relevant and are not included in the summary below. Additionally, certain concepts proposed in the Governors Public Policy Committee paper have since been incorporated into Medicaid waiver proposals, including value-based purchasing, health savings accounts, and bundled payments, with a mixed record of federal approval.

Principle #1: States are best able to make decisions about the design of their health care systems based on their respective needs, culture and the values of each state.

- Provide states the option to define and negotiate a broad outcome-based Program Operating Agreement (POA) with CMS. The only notification required would be when a state elects to update or change an agreed upon POA. States would publicly report the outcome measures established within the POA on a routine basis. CMS oversight should only be triggered when there is a significant deviation in the reported versus projected measure. The number of measures should be finite. Eliminate the onerous federal review process for operating the Medicaid program within each state, such as requiring waivers for designing systems, benefits, services, and payment and reimbursement rates. The relationship between the federal and state government should be based on the principles of value-based purchasing rather than rigorous, complex and lengthy processes.
- States can create a specific “dashboard” to measure accountability utilizing recognized measures of quality, cost, access and customer satisfaction that reflects the states’ priorities and permits an assessment of program performance over time. Where possible, states will utilize the expertise of state, local and national organizations that have developed appropriate measures. In many cases, states already have developed extensive measures of quality and accountability, including customer satisfaction. These dashboards should utilize those processes instead of recreating onerous administrative burdens for states.
- Program integrity should be the responsibility of the state. Currently, common practice is to utilize federal contractors for program integrity initiatives, most of whom are not familiar with individual state programs and simply engage in “pay and chase,” where claims are paid and then states seek payments afterward. Instead, states and their staffs should be able to utilize existing federal funding sources to proactively fight fraud and abuse activities.
- Require the federal government to take full responsibility for the uncompensated care costs of treating illegal aliens.

Principle #2: States should have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and hold states accountable for efficiency and quality health care. Such mechanisms may include a block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches.

- Allow states to pilot self-directed alignment structures for state and federal health care programs to reduce the incidence of cost-shifting from one program to another, encourage efficiency in complementary programs and ensure program integrity.
- If a state can demonstrate budget neutrality, provide states the ability to use state or local funding, now spent as match funding, for certain health services that would pay for Medicaid services or health system improvements that are currently not “matchable,” but are cost effective and improve the value of the Medicaid program. This could include Health Information Exchanges, increased benefits for some individuals, improved care management and local care coordination, and pilot programs to test innovations.
- States should be encouraged to develop innovative programs to reduce chronic illnesses and the burden of associated health care costs to individuals and the taxpayers. Allow states to invest in alternative programs that reduce hospital emergency room visits and other community-based programs to reduce hospitalizations.
- Program integrity should be the responsibility of the states. In order to properly insure the taxpayers’ investment in Medicaid is protected:
 - All sources of federal funding allocated to combat waste, fraud and abuse should be included in any block grant or alternative financing mechanism proposal.
 - An enhanced contingency fee should be paid to states for increasing their efforts to decrease waste, fraud and abuse. The current system’s development matching rate of 90/10 should be allowed for improvements to states’ current fraud and abuse, and eligibility systems. Innovative programs that show a positive return on investment for both the state and federal governments should be allowed without the onerous waiver process.
 - The entire appeals process for any recoupments and overpayments should be exhausted prior to paying the federal share of the recovery.

Principle #3: Medicaid should be focused on quality, value-based purchasing and patient-centered programs that work in concert to improve the health of states’ citizens and drive value over volume, quality over quantity, and, at the same time, contain costs.

- Provide states with the flexibility, without requesting waivers or initiating the state plan amendment process, to pay providers based on meeting quality care and value-based criteria rather than the current fee-for-service approach. Allow innovative payment methodologies to encourage care coordination for all Medicaid eligibles, without exception. Other options could be capitated payments, shared savings, and incentive arrangements when such payments encourage coordination, reduce cost shifting and improve care delivery.

- Provide states with the ability to implement bundling projects. For example, a provider is paid an amount for a discrete event, such as hip replacement, and that provider pays other providers for all necessary care for the event, with providers sharing in savings.
- Give states the ability to use only one managed care organization if client volume in an area is insufficient to support two. CMS now requires at least two managed care organizations in each area.

Principle #4: States must be able to streamline and simplify the eligibility process to ensure coverage for those most in need, and states must be able to enforce reasonable cost sharing for those able to pay.

- Establish reasonable, rational and consistent asset tests for eligibility. Amend ACA's definitions of income to count child support payments (current law in Medicaid), and reverse the use of Modified Adjusted Gross Income (MAGI) in order to avoid new eligibility for higher-income Americans.
- Give states the flexibility to streamline and improve the eligibility determination system by contracting with private firms.
- Within a state's fair share of federal funding, there should be significant flexibility regarding how a state provides eligibility for its population in need.
- Eliminate the marriage penalty.

Principle #5: States can provide Medicaid recipients a choice in their health care coverage plans, just as many have in the private market, if they are able to leverage the existing insurance marketplace.

- Eliminate the obsolete mandatory and optional benefit requirements. Provide states the flexibility to design appropriate benefit structures to meet the needs of their recipients in a cost-effective and efficient manner as part of the state's negotiated plan.
- Eliminate benefit mandates that exceed the private insurance market benchmark or benchmark equivalent. Design benefit packages that meet the needs of specific populations, including allowing a plan that puts non-disabled populations into Section 1937 benchmark plans. Amend Section 1937 to include cost-sharing provisions and allow states the authority to enforce cost sharing.
- Purchase catastrophic coverage combined with an HSA-like account for the direct purchase of health care and payment of cost sharing for appropriate populations determined by each state.
- Provide states the option of rewarding individuals who participate in health promotion or disease prevention activities.
- Provide states with the ability to offer "value-added" or additional services for individuals choosing a low-cost plan or managed care plan (i.e., additional services and benefits offered by coordinated care companies for successful completion of healthy baby programs, or an adult dental benefit).
- Allow states the option of contributing to a private insurance benefit for all members of the family. Require all members of the family to participate in cost-effective coverage.

- Lower the threshold for premium payments to 100 percent FPL to encourage a sense of shared beneficiary ownership in health care decisions.

Principle #6: Territories must be ensured full integration into the federal health care system so they can provide health care coverage to those in need with the flexibility afforded to the states.

- The territories should be treated consistently, fairly and rationally in funding, services and program design.

Principle #7: States must have greater flexibility in eligibility, financing and service delivery in order to provide long-term services and support that keep pace with the people Medicaid serves.... [T]he innovative power of states should be rewarded by a shared-savings program that allows full flexibility to target and deliver services that are cost effective for both state and federal taxpayers.

- At a state's discretion, permit states to redesign Medicaid into multiple parts. Medicaid Part A would focus on preventive, acute, chronic and palliative care services; and Part B would focus on long-term supports and services (LTSS). This would enable a state to better manage the different needs between populations who only need LTSS. Eligibility for Part B would be based on income and functional screening of an individual's long-term services and LTSS needs.
- Engage in shared savings arrangements for dual eligible members when the state can demonstrate the Medicare program reduced costs as a result of an action by a state Medicaid program.
- Repeal restrictions that impede self-direction of long-term care supports and services (LTSS) and allow states the ability to design programs that meet their needs and are cost effective.
- At the state's option, replace Medicare cost-sharing with state- administered, 100 percent federal grants.
- Give states the flexibility to enroll more members, especially families, in premium assistance programs including Medicare benefits, when it is cost efficient. Medicaid should be the payer and insurer of last resort.
- Extend Medicare coverage of skilled nursing facilities by 60 days.

[Link to Republican Governors Public Policy Committee Paper](http://www.finance.senate.gov/imo/media/doc/RGPPC%20Medicaid%20Report.pdf)

<http://www.finance.senate.gov/imo/media/doc/RGPPC%20Medicaid%20Report.pdf>



HMA MEDICAID ROUNDUP

California

Uninsured Rate Could Double if ACA is Repealed. *California Healthline* reported on November 9, 2016, that California could see significant negative impacts to coverage and funding if the Affordable Care Act (ACA) is repealed. According to a study by the Urban Institute, the number of uninsured residents would double to 7.5 million. Additionally, the state could lose \$15 billion annually in federal funding for Medicaid expansion and insurance subsidies. California Insurance Commissioner Dave Jones stated that California could not afford expansion or the subsidies without that funding. [Read More](#)

Consumer Group Asks Judge to Stop Anthem from Ending Out-of-Network Coverage in PPO Plans. *Los Angeles Times* reported that a Santa Monica, California-based consumer group, Consumer Watchdog, has filed a lawsuit to block Anthem from dropping out-of-network coverage for 500,000 residents formerly enrolled in the company's PPO plans. The suits argues that Anthem failed to properly notify members that effective in 2017 it would convert the PPOs into exclusive provider organizations (EPOs), which would no longer cover out-of-network care except in emergencies. The company stated that the case has no merit and a judge had already approved the EPO transition. [Read More](#)

Delaware

DHHS Seeks 3.6 Percent Increase in Funding. *The Washington Post* reported on November 15, 2016, that the Delaware Department of Health and Social Services (DHSS) is asking state budget officials for a 3.6 percent increase in funding for the next fiscal year. The \$1.22 billion DHSS request includes \$42 million in additional spending, of which \$13 million would be earmarked for Medicaid. It also includes \$4.7 million more for programs serving individuals with developmental disabilities, \$2.8 million more for child care programs, and \$2 million more for substance abuse programs. [Read More](#)

Florida

HMA Roundup – Elaine Peters ([Email Elaine](#))

AHCA to Submit Medicaid Managed Care Extension Request to CMS. *The Herald-Tribune* reported on November 8, 2016, that the Florida Agency for Health Care Administration will submit the final proposal to extend its Medicaid managed care program to the Centers for Medicare & Medicaid Services (CMS) for approval after the public comment period ends on November

10. If approved, AHCA will have authority to continue the statewide managed care program for another three years, into 2020. The current program, which is set to expire in June 2017, covers 3.6 million individuals. [Read More](#)

Georgia

HMA Roundup - Kathy Ryland ([Email Kathy](#))

Medicaid Expansion Efforts Uncertain Following Election. *The Augusta Chronicle* reported on November 13, 2016, that Georgia state officials and legislators are suggesting that any Medicaid expansion discussions be put on hold until the Trump Administration's healthcare policies are clearer. Separately, Georgia Governor Nathan Deal has stated that he would like the Trump Administration to consider changing Medicaid to a block-grant program. [Read More](#)

Idaho

Idaho Unlikely to Expand Medicaid Following Presidential Election Results. *Magicvalley.com* reported on November 10, 2016, that Idaho lawmakers will not continue to work on Medicaid expansion following the election of Donald Trump as president. In the state legislature, the Republicans also expanded their super-majority to 29 of 35 seats in the Senate and 59 of 70 seats in the House. Earlier this year, the Senate passed a bill to authorize the state to apply for a Medicaid expansion waiver; however, the House voted it down the next day. Lawmakers now say they will defer any decision until after President-elect Trump takes office. [Read More](#)

Iowa

State Supreme Court Upholds Governor's Decision to Close Two State Mental Health Hospitals. *The Des Moines Register* reported on November 10, 2016, that the Iowa Supreme Court upheld Governor Terry Branstad's decision to close two state mental health hospitals in Mount Pleasant and Clarinda. Several lawmakers along with the Iowa American Federation of State, County and Municipal Employees (AFSCME) had filed suit to block the closures. The Governor argued that the hospitals represented an outdated institutional model of care for individuals with mental illnesses and that private agencies would be more effective and efficient. Critics say that the closures were rushed, without ensuring adequate replacement services, citing three instances where patients died after they were transferred to private nursing homes. [Read More](#)

Kansas

Pilot Aims to Move Individuals with I/DD to HCBS Settings. *KCUR.org* reported on November 11, 2016, that a Kansas pilot program targeting individuals with intellectual and developmental disabilities (I/DD) is working to move individuals out of state hospitals and into home and community based services (HCBS) settings. The pilot, led by the Kansas Department for Aging and Disability Services along with day and residential services provider Equi-Venture, reviews patients at Osawatomie State Hospital to determine if they are a good fit for HCBS transition. Hospital staff determine which individuals are

ready for discharge while managed care organizations ensure reimbursement for support services covered. Equi-Venture says it hopes to expand the pilot to additional hospitals. [Read More](#)

KDHE Continues to Struggle With Medicaid Applications Backlog. *Kansas Health Institute* reported on November 14, 2016, that Kansas is still struggling with a Medicaid applications backlog, despite efforts to eliminate delays in application approvals before open enrollment began on November 1. The Kansas Department of Health and Environment (KDHE) reported that the backlog had increased from 1,688 in September to 1,823 as of October 9. The delay in application approvals began when the state switched eligibility and enrollment systems in 2015. State officials say that they are frustrated that KDHE was unable to remedy the backlog before open enrollment began. [Read More](#)

New Jersey

HMA Roundup – Karen Brodsky ([Email Karen](#))

S&P Global Ratings Downgrades State Bond Rating. *Governing Magazine* reported on November 15, 2016, that New Jersey's extremely underfunded pension system and a recent move to cut taxes by more than \$1 billion led to a downgrade from "A" to "A-." The latest downgrade is the tenth under Governor Chris Christie, the most on record of any governor in the United States. New Jersey ranks as the second worst rated state after Illinois. [Read More](#)

New York

HMA Roundup – Denise Soffel ([Email Denise](#))

Medicaid Director Releases Post-election DSRIP Update. On Thursday, November 10, NY Medicaid Director Jason Helgerson released the following DSRIP update:

- DSRIP is not part of the Affordable Care Act (ACA) and would not be affected by legislative attempts related to the ACA.
- DSRIP is part of a waiver amendment agreement with CMS, authorized through March 2020 and run by the state government.
- Health care system reform and Value Based Payment efforts will continue as these are industry drivers for improved quality and sustainability. Medicare has adopted VBP as part of their program policy and commercial payers are pursuing similar arrangements.

Helgerson praised the efforts by the State and the PPSs to transform the system under DSRIP and urged all involved to remain focused on the DSRIP goals and projects.

Children's Health Homes to Begin Enrollment in December. The New York State Plan Amendment regarding children's Health Homes has been approved. Health Homes designated to serve children will begin to enroll children in December 2016. Children's Health Homes must provide six core services: Comprehensive Care Management, Care Coordination & Health Promotion, Comprehensive Transitional Care, Patient and Family Support, Referral to Community Supports, and Use of HIT. Sixteen Health Homes applied to serve

children; nine have been approved to begin enrollment. Three of the remaining seven were found not ready on Health Home infrastructure criteria; four have been postponed due to results of a performance review of their adult Health Home program which identified deficiencies that must be corrected prior to launching their children's Health Home activities. [Read More](#)

New York Posts DSRIP Performing Provider System Primary Care Plans. Under New York's DSRIP Program each Performing Provider System was required to develop a Primary Care Plan. The Department of Health has posted the 25 PPS's Primary Care Plans on their website for public comment. The plans address 6 issues:

1. Assessment of current primary care capacity, performance and needs, and a plan for addressing those needs;
2. Primary care expansion, and training and technical assistance for primary care transformation;
3. Strategy for how primary care will play a central role in an integrated delivery system;
4. Strategy to enable primary care to participate effectively in value-based payment;
5. How PPS funds flow supports the primary care strategy;
6. How the PPS is progressing toward integrating primary care and behavioral health.

The Primary Care Plans are open for public comment until December 21, 2016. [Read More](#)

North Carolina

Medicaid Reform Waiver Likely On Hold Until After Inauguration. *The Winston-Salem Journal* reported on November 16, 2016, that the North Carolina Medicaid reform 1115 waiver, submitted on June 1, 2016, and still awaiting federal review, will likely remain on hold until after the inauguration of President-elect Donald Trump. State Representative Donny Lambeth, a key author of the waiver, said it has a better chance of being approved under the incoming Trump administration. Representative Lambeth added that President-elect Trump's support for Medicaid block grants aligns with the waiver's goals. The proposal, which does not include Medicaid expansion, would offer Medicaid beneficiaries a choice of three statewide managed care plans and two provider-led plans per region beginning in summer 2019. [Read More](#)

State Considers Changes to How it Investigates Medicaid Fraud. *WRAL.com* reported on November 15, 2016, that North Carolina is considering changes to how it investigates Medicaid fraud, after a report revealed that the state is spending more investigating fraud than it is recovering. The report, issued by the state legislature's internal Program Evaluation Division, found that North Carolina paid contractors \$3.7 million in fiscal 2014 to investigate fraudulent claims, but only recovered \$500,000. Lawmakers are expected recommend changes to the fraud investigation process next month. [Read More](#)

Ohio

HMA Roundup – Jim Downie ([Email Jim](#))

Medicaid Director John McCarthy Stepping Down. *The Columbus Dispatch* reported that Ohio Medicaid Director John McCarthy will be stepping down in December. Director McCarthy served nearly six years as Medicaid Director. Among Director McCarthy's accomplishments are the implementation of a new Medicaid Management Information Systems (MMIS), implementation of a new Eligibility System, Medicaid Expansion, and the creation of a separate cabinet-level Department of Medicaid. Director McCarthy indicated he was stepping down to pursue opportunities in the private sector. Ohio Office of Health Transformation Assistant Director Barbara Sears will be assuming the Director's position. [Read More](#)

Autism Therapy Provider Turns Over Operations to Franklin County Residential Services. *The Columbus Dispatch* reported on November 14, 2016, that struggling autism therapy services provider Step by Step Academy is turning operations over to not-for-profit agency Franklin County Residential Services. The two entities signed a 120-day management contract, which will likely lead to a merger agreement. Step by Step began operations approximately 15 years ago and serves about 850 children with autism in Ohio. Franklin County Residential Services has provided supported living, respite care, and other services to children and adults with developmental disabilities for 30 years. [Read More](#)

Pennsylvania

HMA Roundup – Julie George ([Email Julie](#))

DHS Awards Nearly \$900,000 in Child Abuse and Neglect Prevention Grants. On October 10, 2016, the Pennsylvania Department of Human Services announced six 2016 Children's Trust Fund grant recipients. Each recipient received \$150,000 to enhance child abuse and neglect prevention programs using evidence or research-based methods to deliver support services to pregnant and parenting teens and young adults. The grants will run from November 1, 2016 through October 31, 2019. The grant recipients are:

- Columbia County Commissioners
- Children's Aid Society in Clearfield County
- Fulton County Family Partnership, Inc.
- Family Services Association of Bucks County
- National Nurse-Led Care Consortium (Philadelphia County)
- Jim Thorpe Area School District (Carbon County)

[Read More](#)

South Dakota

Governor No Longer Pursuing Medicaid Expansion After Meeting with VP-Elect. *Rapid City Journal* reported on November 16, 2016, that South Dakota Governor Dennis Daugaard will no longer pursue an expansion of Medicaid, following a meeting with Vice President-elect Mike Pence on the incoming Administration's plans for repealing or reforming the Affordable Care Act. Governor Daugaard had previously indicated he might propose Medicaid expansion during the 2017 legislative session. [Read More](#)

National

Medicaid Expansion Could Survive Under Trump Administration, With Modifications. *Modern Healthcare* reported on November 9, 2016, that Medicaid expansion could continue under a Trump Administration, with the potential for modifications such as work requirements, health saving accounts (HSAs), and the ability to drop members who don't pay premiums. Another potential option would be to allow states to continue Medicaid expansion initiatives, but cut federal matching to 50 percent, rather than the enhanced rates in place today. Overall, states may be given more flexibility in how they structure expansion programs, with some states hoping to work with the Trump Administration to maintain current expansion coverage levels. [Read More](#)

Health Care Changes Under Trump Administration Could Force Medicaid Cuts, Tax Increases. *CNBC* reported on November 10, 2016, that the Donald Trump administration could force states to cut spending on services or raise taxes as part of the president-elect's plan to shift funding for state Medicaid programs from the federal government to the states. President-elect Trump and House Speaker Paul Ryan both have expressed interest in providing fixed, block grant payments to states instead of having the federal government cover a share of states' Medicaid costs. As a result, states could potentially impose work requirements, charge premiums, or increase taxes to cut costs and make up for a loss in federal funding support. [Read More](#)

Andrew Bremberg to Lead Trump Health Care Transition Team. *Modern Healthcare* reported on November 11, 2016, that Andrew Bremberg will lead President-elect Donald Trump's health care transition team. Bremberg previously worked in the George W. Bush administration and has served as adviser to both Senate Majority Leader Mitch McConnell and Wisconsin Governor Scott Walker. [Read More](#)

Federal Judge Rejects Land of Lincoln's Lawsuit Over Risk Corridor Payments. *CQ Roll Call* reported on November 15, 2016, that a federal judge rejected a lawsuit concerning the Affordable Care Act's (ACA) risk corridor payments filed by Illinois not-for-profit co-op insurer Land of Lincoln Health. Judge Charles Lettow argued that the government did not have a binding contract to pay insurers under the program, and therefore the insurer does not have claim to the payments. The program ended up paying out only 12.6 percent of the amount insurers expected to receive. The decision is the first in a series of at least a dozen lawsuits filed by insurers.



INDUSTRY NEWS

Aetna CEO Expects Some ACA Provisions to Remain in Place Under Trump.

Fox Business reported on November 10, 2016, that Aetna chief executive Mark Bertolini expects certain elements of the Affordable Care Act (ACA) to continue under a Trump Administration, including Medicaid expansion, Exchange subsidies, and family insurance for individuals under twenty-six. However, he does expect modified federal funding mechanisms for Medicaid expansion. Bertolini made the comments at the New York Times Dealbook conference. [Read More](#)

Centene States Commitment to Health Care System Under New Administration.

CNBC reported on November 10, 2016, that Centene chairman and chief executive Michael Neirdorff expects his company to be “an ongoing player” in any new health care system that develops following the election of Donald Trump as President. Neirdorff acknowledged the structural issues of the Affordable Care Act (ACA), expressing the company’s willingness to come to the table to work on solutions, whether under a new system or modifications to the ACA. [Read More](#)

RFP CALENDAR

Date	State/Program	Event	Beneficiaries
November 30, 2016	Oklahoma ABD	RFP Release	177,000
November, 2016	Washington, DC	RFP Release	200,000
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	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
April 1, 2017	Pennsylvania HealthChoices	Implementation	1,700,000
Spring 2017	Virginia Medallion 4.0	RFP Release	700,000
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
Fall 2017	Virginia Medallion 4.0	Contract Awards	700,000
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
August 1, 2018	Virginia Medallion 4.0	Implementation	700,000
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: “A Comprehensive Approach to Managed Long-Term Services and Supports”

Wednesday, December 7, 2016

1:00 to 2:00 PM EST

[Link to Register](#)

HMA Speakers:

[Karen Brodsky](#), Principal, New York

[Liddy Garcia-Bunuel](#), Principal, Washington, DC

Health plans serving the market for Managed Long-Term Services and Supports (MLTSS) have a unique opportunity to strengthen their relationships with existing and new community-based organizational partners to fill important gaps in care for members who are elderly and members with disabilities. During this webinar, HMA Principal Karen Brodsky will discuss how managed care organizations can assess their MLTSS-specific partnerships to better serve members and foster a comprehensive approach to meeting the long-term needs of some of the most vulnerable and high-cost members.

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